VA ACCOUNTABILITY: ASSESSING ACTIONS TAKEN IN RESPONSE TO SUBCOMMITTEE OVERSIGHT

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VA ACCOUNTABILITY: ASSESSING ACTIONS TAKEN IN RESPONSE TO SUBCOMMITTEE OVERSIGHT

Wednesday, February 26, 2014

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:04 a.m., in Room 334, Cannon House Office Building, Hon. Dan Benishek [chairman of the subcommittee] presiding.

Present: Representatives Benishek, Huelskamp, Wenstrup, Brownley, Ruiz, Negrete-McLeod, and Kuster.

OPENING STATEMENT OF DAN BENISHEK, CHAIRMAN

Dr. BENISHEK. Good morning. The subcommittee will come to order.

Thank you for joining us today for the oversight hearing VA Accountability: Actions Taken in Response to Subcommittee Oversight.

Almost one year ago today during my first hearing as chairman of the Subcommittee on Health, we met to discuss the persistent lack of productivity and staffing standards for specialty care services at Department of Veterans Affairs' medical facilities.

We learned that VA had yet to implement these standards despite more than 30 years of reports and recommendations directing the department to do so.

I was so alarmed by VA's decades long lack of action that I quickly introduced H.R. 2072, the Demanding Accountability for Veterans Act. H.R. 2072 would require VA to ensure that inspector general recommendations concerning a public health or patient safety issue were addressed, identify those within VA medical facilities who are responsible for implementing needed changes, and prohibit the VA from awarding a bonus or performance award to any employee who does not fully address a recommendation under his or her purview.

The goal of this legislation is to create a culture of accountability within VA, a culture where problems are identified and immediately corrected and leaders are held responsible for their actions.

Were H.R. 2072 in place 30 years ago, VA would have been required long before now to implement productivity and staffing standards for all specialty care services and who knows how the health and well-being of a veteran seeking care through VA would have improved as a result.

I wish I could say that the first hearing was the only time that we have seen evidence of a lack of timely action taken by VA in response to serious problems. Unfortunately, that is not true.

Since the conclusion of that hearing, we have held other hearings and roundtables on topics ranging from the care provided to veterans with chronic pain and who have experienced military sexual trauma to concerns regarding department-wide procurement reform and third-party collections.

At each of these oversight forums, we have heard example after example of VA failing to act swiftly to address important issues or respond to the subcommittee's requests for information in a timely manner.

I am a surgeon. When a serious problem is identified, my instinct is to act without delay, to cut out what needs cutting out, and to fix what needs fixing.

While I understand that large-scale changes often happen slowly, especially where large government bureaucracies like VA are concerned, I think we can all agree that our veterans deserve more than what we have seen in the last year.

I am hopeful that H.R. 2072 will be heard on the House floor in the coming weeks. However, I am not content to wait for what can often be a lengthy legislative process to ensure that VA is on track to address the many issues the subcommittee has identified through last year's oversight efforts.

During today's hearing, we will assess the progress, if any, that VA has made in response to the subcommittee's hearings and roundtables, determine whether appropriate steps have been taken to ensure accountability when and where deficiencies in care have been highlighted, and identify what further actions may be necessary to improve the care and services provided to our veterans.

Though the topics we address today are wide ranging, they are undoubtedly interconnected. If we do not ensure the department is on track to implement appropriate productivity and staffing standards, then we cannot be sure that we have the right staff in place to care for veterans experiencing chronic pain.

Similarly, if we do not ensure that the VA is taking necessary actions to improve the collection where appropriate of third-party revenue, then we cannot be sure that we are collecting every available dollar that could be used to improve the care and services provided to veteran survivors of military sexual trauma.

Last week, I had the privilege of conducting an oversight visit to the West LA VA Medical Center. During my conversations with the clinicians and support staff there, each of the issues we will discuss today were brought up by the providers when I asked them what needed to be improved in order to make it easier for them to care for our veterans.

I cannot state enough how critical it is for VA to take responsibility for gaps in care and, more importantly, to take immediate and definitive steps to address them.

Unfortunately, I have seen little concrete evidence in the past year that the department is doing either. Concurring with IG and GAO reports is simply not enough. Sending out guidelines without accountability is not enough. I sincerely hope that today's conversation will change my mind.

[THE PREPARED STATEMENT HON. DAN BENISHEK APPEARS IN THE APPENDIX]

With that, I will recognize Ranking Member Brownley for any opening statement she may have.

OPENING STATEMENT OF JULIA BROWNLEY, RANKING MEMBER

Ms. BROWNLEY. Thank you, Mr. Chairman, and good morning.

Today's hearing is intended to follow-up on various oversight hearings and roundtables held during the first session of the 113th Congress and to assess the progress that the department has made in addressing these critical issues.

The subcommittee will also determine whether appropriate steps have been taken by the VA to ensure accountability and identify what further actions may be necessary in response to subcommittee oversight.

Last session, this subcommittee held oversight hearings on physician staffing standards, care and treatment for military sexual trauma survivors, and VA's overuse of prescription painkillers to treat veterans with chronic pain.

In addition to the oversight hearings, two roundtables were held, one focusing on procurement reform and access to care and one on billing and collecting from third-party health insurance companies for nonservice-connected care.

There were many issues raised during these hearings and roundtables, issues such as developing a plan to establish productivity standards for all specialty care services within three years, decreasing the amount of time it takes to procure large medical equipment through the national acquisition center, assessing the department's programs for veterans who have experienced military sexual trauma, and ensuring the effective use of opiate therapy for patients with chronic pain.

Mr. Chairman, these are but a few of the concerns that were brought up during testimony and conversations we had with the witnesses and participants during these forums. While we have a lot of ground to cover today, I am especially interested in hearing from the VA on improvements made in the military sexual trauma program and in procurement reform.

At the MST hearing held last session, we heard firsthand the experiences of veterans who have found the system unfriendly and intimidating.

According to the VA, fiscal year 2013 saw an increase of 9.3 percent in rates of engagement of military sexual trauma related care at VHA. Additionally, the VA reports an increase of 14.6 percent in military sexual trauma related visits in fiscal year 2013.

I would like to hear from the VA how they are addressing these increases. I am sure we all agree that it is critical that Congress do all that we can to make it easier for victims of military sexual trauma to access needed benefits and services and receive treatment. Compassion and care are a significant part of healing those that have been sexually assaulted.

Turning now to procurement reform, Mr. Chairman, last session, we held a roundtable and during that roundtable discussion, we

heard about the long delays, some for up to two years, in the delivery of medical equipment.

While I understand that VA is streamlining the procurement process to decrease the amount of time it takes to procure large medical equipment through the national acquisition center, I do not feel confident that much progress has been made in that area.

Stakeholders continue to report increased difficulties accessing needed prosthetic equipment through VA and significant delays in contract awards at the national acquisition center. I find this very frustrating and unnecessary. I hope the VA has good news on this front today.

Mr. Chairman, thank you for holding this hearing today, and I want to thank everyone in attendance. There is obvious concern for veterans and VA's ability to meet their healthcare needs.

Thank you, Mr. Chairman, and I yield back the balance of my time.

[THE PREPARED STATEMENT OF HON. JULIA BROWNLEY APPEARS IN THE APPENDIX]

Dr. BENISHEK. Thank you, Ms. Brownley.

With that, I will introduce our first and only witness panel. Representing the department is the Honorable Under Secretary for Health, Dr. Robert Petzel.

Dr. Petzel is accompanied by Dr. Jesse, the principal deputy under secretary for Health; Dr. Agarwal, the deputy under secretary for Health for Policy and Services; Dr. Jain, the assistant deputy under secretary for Patient Care Services; and Mr. Philip Matkovsky, the assistant deputy under secretary for Health for Administrative Operations.

Together each of you represent the lead VA witnesses at the three oversight hearings and the two roundtable discussions that will be the focus of today's hearing. Thank you all for being here today.

Dr. Petzel, please proceed with your testimony.

STATEMENT OF ROBERT PETZEL, UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY ROBERT JESSE, PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; MADHULIKA AGARWAL, DEPUTY UNDER SECRETARY FOR HEALTH FOR POLICY AND SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; RAJIV JAIN, ASSISTANT DEPUTY UNDER SECRETARY FOR PATIENT CARE SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; PHILIP MATKOVSKY, ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH FOR ADMINISTRATIVE OPERATIONS, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF ROBERT PETZEL

Dr. PETZEL. Good morning, Chairman Benishek and Ranking Member Brownley and Members of the committee. Thank you for the opportunity to discuss the progress that we have made regarding Veterans Health Administration's physician staffing, productivity standards, treatment for veterans who experience military sexual trauma, pain management, and procurement reform.

The chairman has already mentioned the people that are accompanying me.

The Veterans Health Administration is the largest integrated healthcare delivery system in the country providing 85 million total healthcare appointments and last year, we had 25 million consultation requests. And we deliver this care at 1,700 VA healthcare sites.

I want to address first the issue of accountability. Allegations of misconduct by employees are taken seriously by VA. When we learn of credible allegations of misconduct, VA addresses them immediately. When incidents occur, we identify, mitigate, and prevent additional risks.

Prompt reviews prevent similar events in the future and hold those responsible accountable. If an employee misconduct or failure to meet performance is identified, VA does take appropriate action.

Effectively treating veterans who experience military sexual trauma continues to be a top priority for VA. We are committed to ensuring that appropriate MST services are available to meet the treatment needs of both men and women.

Since last year's hearing on military sexual trauma, VA has taken a number of steps that have resulted in improvements. VA is in the process of administrating and implementing an enhanced universal MST screening to include a clinical reminder for referrals. We are providing military sexual trauma telemental health for rural veterans and recently we distributed to all affected employees an information bulletin on managing military sexual trauma.

A number of roundtables were hosted to examine the impact of department-wide acquisition reform. Since that roundtable discussion, the department has expanded its use of authorities to acquire care from community healthcare providers, successfully launching

the patient centered care in the community or PC3. VA has completed its consolidation of billing through the consolidated patient account centers. And, additionally, we have welcomed the oversight from the Health Subcommittee during our roundtables. We have used this oversight process to inform continued improvements in our administrative processes which we will illuminate during the hearing.

Last year, we also participated in a hearing regarding VA productivity and staffing. Today I am pleased to report that by the end of March 2014, we will have productivity and staffing standards in place for 25 different specialties representing 81 percent of our total physician workforce. And we are on target to deliver productivity and staffing standards for all VA physicians by the end of fiscal year 2014.

In October of 2013, VA briefed the OIG on its progress. Based on VA's briefing, the OIG has closed out all of its recommendations related to physician staffing. The work continues and will not be finished until all physician specialty productivity and staffing standards are complete, implemented, and ready access to high-quality, efficient specialty care is available to all of our Nation's veterans.

Lastly, VA is providing comprehensive pain management services to improve the health of veterans. As an update to last year's pain management hearing, VA recently developed and implemented an opioid safety initiative program to ensure opioid medications are used safely, effectively, and judiciously.

The program is already bringing positive results. The basis for this program is to make visible the totality of opioid use at all levels, patient, provider, and facility, in order to identify high-risk situations.

To support a system-wide approach, VA disseminated guidance and tools to help providers to communicate long-term opioid therapy expectations to the staff and to their patients.

In addition, a multi-module, team-based, stepped-care model has been implemented throughout VA. Every VA medical center has a pain clinic and a consultation service for pain and opioid monitoring and provider feedback program and the capacity to provide interdisciplinary treatment such as physical therapy, behavioral therapy, non-opioid medications, and alternative medical care such as acupuncture and meditation.

VA prescribers also have the ability to participate in the state prescription drug monitoring program to determine if a patient of theirs is receiving controlled substance prescriptions from non-VA sources.

Mr. Chairman, the Department of Veterans Affairs is committed to providing the highest quality of care that our veterans have earned and that they deserve.

As mentioned earlier, important progress has been made regarding these programs. We at VA will continue to identify, mitigate, and prevent vulnerabilities within our healthcare system wherever we find them. VA will continue to ensure accountability and when adverse events do occur, we will learn from them, improve our system to prevent these incidents from happening again.

This concludes my testimony. I appreciate the subcommittee's continued interest in the health and the welfare of America's veterans. And at this time, my colleagues and I are prepared to answer your questions.

[THE PREPARED STATEMENT OF ROBERT PETZEL APPEARS IN THE APPENDIX]

Dr. BENISHEK. Thank you, Dr. Petzel. I appreciate your response.

I expect we will have multiple rounds of questions today, and I will begin by yielding myself five minutes.

While the purpose of this hearing is to go over, the issues that we raised over the past year in the hearings and roundtables that we have done, I just want to ask a few questions about your statement.

Specifically you said allegations of misconduct by employees are taken seriously. When we learn of credible allegations of misconduct, VA addresses them immediately.

So within the past year, the committee has examined, you know, disturbing lapses of leadership including, several incidents around VA like at the Pittsburgh VA Medical Center where several veterans succumbed to Legionnaires' disease.

There was apparently some improper emergency room care that led to three preventable patient deaths at the Memphis VA according to the VA inspector general's report and recently 19 preventable deaths were reported nationwide including six deaths at the Columbia, South Carolina VAMC and three deaths at the Augusta, Georgia VAMC due to avoidable delays in care.

So were these instances I just reported to you, were they considered credible allegations of misconduct?

Dr. PETZEL. Yes, Mr. Chairman, they were.

Dr. BENISHEK. So then what specific actions were taken immediately upon your being aware of these?

Dr. PETZEL. Let's go back and go through each one of them individually. At Memphis, two physicians have been disciplined. One has been removed as a result of the actions in Memphis. At Columbia, three senior executives have resigned under threat of discipline.

And at Pittsburgh, as you may remember, there was a criminal investigation done by our criminal IG and by the Department of Justice. When they finished, they found that there was no criminal activity. In fact, they found that only one of those six patients had actually died from legionella and the others died from other illnesses.

At any rate, we were forbidden from doing any further investigation or taking any action until after those investigations were finished. They finished and we're now in the process of evaluating disciplinary action for people at Pittsburgh.

Dr. BENISHEK. There was some other references to mismanagement not linked to deaths or discipline described as temporary written warnings.

Tell me more about that. it seems inadequate, that mismanagement was not linked to deaths. What is the appropriate action for that type of behavior?

Dr. PETZEL. That is in my mind a hypothetical question. It depends on what has happened. The range of discipline that can be incurred is anywhere from an admonishment to removal. I would point out that last year, VA removed 3,000 employees, approximately one percent of its workforce.

They over the last two years have either removed or seen resignations on threat of discipline from 14 senior executives and an additional number of senior executives on probationary periods were fired during their probationary period.

So, sir, we do discipline our workforce. We do hold our workforce accountable.

Dr. BENISHEK. It is amazing when I keep hearing this, but the specific instances seem to me to be a little bit more difficult. I am happy to hear what you have to say about those particular cases, but it seems from, you know, my experience that finding the person responsible, seems to be difficult as we talked about in the, physician staffing hearings that we had.

Dr. PETZEL. Let me just make just a couple more comments if I could, Mr. Chairman.

We have got a pretty extensive oversight system that includes the activities of this committee, the special counsel, the Office of the Inspector General, the GAO, and the Office of the Medical Inspector. These all help us determine whether or not people were accountable for the action.

The IG investigated Pittsburgh as an example and did not find that there was any individual——

Dr. BENISHEK. Well——

Dr. PETZEL [continuing]. They felt was——

Dr. BENISHEK. Right. Well, you know, my best example of that to tell you the truth, Dr. Petzel, is the example of when we had at the physician staffing hearing. The IG over the last 30 years has eight times said that there should be a centralized plan for physician staffing and, yet, that centralized plan over the last 30 years does not exist.

When I asked the fellow testifying, he said, "we will have a plan in three years" and, yet, I could not find out the name of the person who was supposed to respond to that inspector general report and make that plan happen.

The IG said you need a central plan. You agreed. Eight times over 30 years and, yet, it did not happen. And we could not find out who the person who was supposed to be doing that is. This is the frustration that I have as chairman.

I am over time now, but maybe we will get back to that. I would like to yield to Ms. Brownley for her five minutes.

Ms. BROWNLEY. Well, thank you, Mr. Chair. I certainly want your question answered.

And, you know, I wanted to just kind of follow-up as well on the productivity standards for specialty physicians, too.

And if I heard you correctly, Dr. Petzel, you said that all will be done by March 2014?

Dr. PETZEL. That is correct, Congressman Brownley.

Ms. BROWNLEY. Okay. So all of them will be done by 2014. So then I have to assume that all of the various milestones and both

stage one and stage two as was laid out by you to me have all been completed then at this particular point in time?

Dr. PETZEL. I would ask Dr. Agarwal to comment on it.

Dr. AGARWAL. So, Ranking Member Brownley, you are correct. You know, we had stated in our testimony at that hearing that we will complete all specialty physician standards within three years. However, we have accelerated that path.

And at this point as Dr. Petzel mentioned, we have completed the standards for 81 percent of our specialties and we intend to complete all of them this fiscal year. So, yes, ma'am, we——

Ms. BROWNLEY. Could you give me an idea of what the outstanding ones are?

Dr. AGARWAL. Of the specialties?

Ms. BROWNLEY. Yes.

Dr. AGARWAL. Yes, ma'am. I do have a list with me. If you would like me to go through, I will be happy to do so.

Ms. BROWNLEY. Well, if you could just give me a few off the top of your head just to have an idea of what they may be.

Dr. AGARWAL. The ones that are remaining?

Ms. BROWNLEY. Correct.

Dr. AGARWAL. Okay. So we have for thoracic surgery, vascular surgery, cardiology surgery, anesthesia, emergency medicine, pathology amongst a few that we still need to complete. The ones that we have already completed are as follows:

When I had initially testified, we had the staffing models for primary care as well as radiology and mental health was on its way. And I am pleased to say that the directive for mental health staffing went out a couple of months later after the hearing.

Subsequently the standards that we have placed are for dermatology, gastroenterology, neurology, ophthalmology, orthopedic surgery, urology, as well as allergy, immunology, endocrine, and I have the list with me. So I would be happy to share that with you.

Ms. BROWNLEY. Thank you very much.

And just again as a follow-up question that once all of these are established, then can you explain to me how we will then measure sort of the accuracy and the effectiveness of these standards for all of the specialties that you have developed? So are you creating metrics for us to measure the effectiveness and the quality responses?

Dr. PETZEL. I will let Dr. Agarwal give you some details about that. But just it is sort of an overview. The staffing standards look at the delivery of services within a department, say cardiology or ophthalmology, and they also blend with that the access that we have to those services. So we look at the access standards and we get a picture of the productivity of our staffing and the effect that it is having on the ability of people to access the care which I think is the ultimate thing that we are looking for.

We want to have enough people to provide good access, not so many people that we are not being effective in the way we administer that program.

And Dr. Agarwal might add anything to that.

Dr. AGARWAL. Sure. So subsequent to the hearing, ma'am, we have gone ahead and we have developed many tools that will assist the local facilities in managing the specialty resources appro-

priately. We would like all our specialists to work at the top of their license which entails that they also need to have the necessary support staff so that they are able to perform their specialist duties in helping veterans.

And to that end, I will reference back to the tool that Dr. Petzel just mentioned. It is an algorithm that links access with specialty productivity. All our leadership has been trained to use this tool and how they manage the specialty resources in the clinics and appointments.

Ms. BROWNLEY. I think what I am trying to drive at and I think it is important for you as the experts to be able to evaluate the effectiveness and the quality of delivery of services, what kind of tools will Congress have, will the veteran community have to also be able to measure the quality and effectiveness of these specialties?

Dr. AGARWAL. That is an excellent point, ma'am. So this tool has been currently distributed to all our facilities and they are using it to manage the resources within their medical centers.

So the ultimate outcome of this is going to be better access of specialty services to the veterans as well as our ability to use our specialists most efficiently and effectively.

To that end, we would like to share that information with Congress as and when you would like to have it. We can do that periodically at your request.

Ms. BROWNLEY. Thank you.

And, Mr. Chair, I yield back. I exceeded my time.

Dr. BENISHEK. Thank you, Ms. Brownley.

I would like to yield five minutes to Dr. Huelskamp.

Dr. HUELSKAMP. Thank you, Mr. Chairman. I appreciate the opportunity to follow-up on some issues we have discussed in the last year. I appreciate your line of questioning and hopefully you will take that up when you return to that.

But one thing I would like to first ask the VA is in reference to a year ago, approximately a year ago during a March 6 hearing, I asked the GAO some questions regarding the scheduling practices at the VA. During the course of my questioning, the GAO noted the dates were changed to game the system at several clinics.

And I believe, Mr. Matkovsky, you were in attendance at the hearing and I asked your colleague, Mr. Shonnard, what was being done to prevent this from happening again and whether any penalties were imposed on the employees caught doing this.

My question for the VA is this. Who has been held accountable for these actions?

Dr. PETZEL. Before I turn to Mr. Matkovsky, Congressman Huelskamp, let me answer that.

The GAO was referring to a system that we used for scheduling that we have since abandoned which had in it the possibilities of both misunderstanding of what might be scheduled and what the times might mean.

We have moved to having the fundamental scheduling criteria be what we call the create date. And that create date is not fungible. That is the date that the individual calls into the medical center or wherever it might be and asks for an appointment. That becomes then the starting point for measuring whether or not we

have accomplished seeing that patient within the 14-day criteria that we set out.

So that should not occur. I cannot speak to what has happened previously. I——

Dr. HUELSKAMP. Doctor, so you have abandoned the system that allowed and permitted employees to falsify and game the system.

My question is, have you held anybody accountable for the actions that were identified by the GAO?

Dr. PETZEL. I would have to go back, sir, and look to see if there were any disciplinary actions in those 3,000 that I mentioned that were specifically related to that issue. I do not know the answer to that question here.

Dr. HUELSKAMP. Any of the other conferees, can you answer that question, whether anybody was held accountable for gaming the system?

Dr. JESSE. I cannot answer the question directly because there are 70 some thousand people who have scheduling keys on our system. So I do not know, you know, specifically whom you are referring.

I think the important point is——

Dr. HUELSKAMP. Did you follow-up with the GAO? They had evidence of that. They had identified specific instances.

Dr. JESSE. Like I say, I cannot give you the specifics on that.

Dr. HUELSKAMP. No one here followed up on the GAO? And you saw this report yesterday suggesting that is going on elsewhere in the system in which the VA purged thousands of medical tests, this is just yesterday's article, to game its backlog stats.

So first question, follow-up of the GAO report, it was just ignored then?

Mr. MATKOVSKY. No, Congressman Huelskamp. I went back and asked some of our team to identify, if we could, the allegations that were presented by the GAO during that hearing. We were not able to find concrete evidence that the GAO had and they did not actually give us the specifics so that we could go to the individual and find it.

So we did follow-up. We could not find the concrete evidence to engage an appropriate disciplinary action, sir.

Dr. HUELSKAMP. So you just abandoned the system and those employees that were followed up?

A little more on the GAO. So the GAO made allegations and you never reported back to the committee that I am aware that GAO was mistaken or provided no evidence of that. I have appreciated the product from the GAO and you are saying here they had no evidence of that?

Mr. MATKOVSKY. That is not what I am saying. I am saying that we did not have independent evidence outside of the GAO report that could identify an individual who engaged in the——

Dr. HUELSKAMP. Well, where did they come up with that, sir?

Mr. MATKOVSKY. They had their evidence.

Dr. HUELSKAMP. Their evidence is from your system.

Mr. MATKOVSKY. That is correct, sir.

Dr. HUELSKAMP. So their evidence was inaccurate?

Mr. MATKOVSKY. It was interview based, if you recall, so they had a series of clinics that they visited and then they went through

and monitored the behavior. They measured that behavior against the policy and they identified that someone instead of selecting the desired date of the veteran, they were asking the veteran when they wanted to be seen and using that as the desired date.

So they were monitoring behavior specifically and we were attempting to find evidence of that on our own and we could not.

Dr. HUELSKAMP. And, lastly, any responses to this report again of gaming the system that came out yesterday? Apparently any request for documents describing when the practice began or how many employments have been cancelled was refused.

Dr. PETZEL. That was almost what I would call a scurrilous newspaper report. Several years ago, the West LA Greater Los Angeles healthcare system embarked on a very carefully thought out review of past requests for consultation or x-rays in the imaging department to see if indeed there were requests that had not yet been closed out.

They identified 300 requests that had not been closed out. They had not been closed out because the patients had moved, because the patients had failed to show up for the appointment or repeat appointments.

There was nobody who needed the care that was denied the care. There was no attempt to eliminate a backlog by destroying records. You cannot destroy the records. They are electronic and they are there forever.

Dr. HUELSKAMP. But they were administratively closed, is that——

Dr. PETZEL. They were administratively closed.

Dr. HUELSKAMP. And according to the article, it is not a few thousand. It is 40,000 in LA and 13,000 in Dallas. And I appreciate it.

One last thing. It does say in the article, and I would like to follow-up on each of these, Mr. Chairman, if I might, it says performance reviews and bonuses of top hospital administrators are linked to meeting those goals. I would like to see if there is a connection like that as indicated in the article.

I yield back, Mr. Chairman.

Dr. BENISHEK. Thank you, Mr. Huelskamp.

Ms. Negrete-McLeod.

Ms. NEGRETE-MCLEOD. [Nonverbal response.]

Dr. BENISHEK. Dr. Ruiz.

Dr. RUIZ. Thank you for being here. I thank you for your service and thank you for all your hard work.

We definitely have to continue your efforts. There is a lot of problems that we need to fix and I appreciate that we are moving in the right direction albeit it perhaps impatiently slow, but we have to continue to move in that direction.

You know, Mr. Matkovsky, I wrote a letter to you dated February 6 about procuring three ultrasound machines for my regional VA hospital. They have been waiting for a long time to get three simple ultrasound machines.

When I was in Haiti after the disaster as the medical director for the largest internally displaced camp in Port-au-Prince with about 60,000 Haitians living under sheets and sticks in the midst

of our western hemisphere's most severe disaster, we needed ultrasound machines.

And I made a phone call to a local hospital in my area. Two weeks later, we get an ultrasound machine. And you talk about logistical nightmares. You talk about bureaucracy. You talk about the difficulty in transporting ultrasound and getting the right one, et cetera, to an earthquake stricken country.

Why does it take so long to get those ultrasounds? Two, when can we get those ultrasounds?

Mr. MATKOVSKY. Thank you, Congressman Ruiz.

That letter is actually being responded to by Mr. Frye. He is our senior procurement executive as well. I think it was co-addressed.

If I may, I may just address a little bit of the consolidation process that we have historically used in VA. We have a national acquisition center that has all of our national contracts for what we call high cost medical equipment. The high cost, high tech ultrasound, MRIs, CT scans, et cetera, are all acquired through that central service.

What we have typically done historically is we consolidate our purchases. We did that under the premise that through consolidation, we would achieve better price competition and then achieve some measure of return.

We have looked at that process in 2012. At the end of 2012, our consolidation was 909 pieces of equipment. These ultrasound machines were part of that consolidated purchase. We expect to finish all of the delivery orders for those by April of this year.

So in answer to your question, the delivery orders, if they have not been issued, will be issued by April.

Now, we are looking at that process and figuring out how we can do it a little bit faster and a little bit different.

Dr. RUIZ. Can I ask you a question there?

Mr. MATKOVSKY. Yes.

Dr. RUIZ. You said delivery orders. My goal is the end goal, the actual outcome. So tell me the time it takes between delivery order and then actually the Loma Linda VA receiving the ultrasound.

Mr. MATKOVSKY. Sir, I do not have an answer for that. That would depend on the manufacturer that gets the ultimate delivery order, but it can be as quick as three months or less depending upon the manufacturer.

We ran a separate process. Let me just—I can see your expression, sir. So we ran a separate process as a result of our roundtable which Chairman Benishek and Ranking Member Brownley held. And we carved out some different cost items, portable x-rays, C-arms, and we ran those at the network level in VISN 15 which is the heartland of the country, Missouri.

And those that we purchase through that process from the beginning of the requirement through the actual contract award was 90 days, right, as compared to 400 or so days for a consolidated process. That equipment began arriving, the portable x-rays began arriving before the end of calendar year 2013. Start to finish, less than six months.

Not exactly the same as your Haiti example, but considerably faster. We are going to try that again in Network 23 just to make sure we can iron out some of the kinks and we are going to use

that process system-wide from here on out once we finalize just a couple of details.

We hope that is going to speed it up a lot and then we are also going to look at the consolidation process and change that as well.

Dr. RUIZ. Thank you very much.

I am going to continue to follow the natural life history of requesting three ultrasound machines until they are born in the womb of our Loma Linda VA Hospital. So, you know, thank you so much and I will follow-up with you.

Dr. BENISHEK. How long has it been that this is going on?

Dr. RUIZ. How long has it—it has been two years, my friend, two years for three ultrasound machines.

Dr. BENISHEK. All right.

Mr. MATKOVSKY. It is too long, I agree.

Dr. RUIZ. Thanks for that.

Dr. BENISHEK. Five minutes for Dr. Wenstrup.

Dr. WENSTRUP. Thank you, Mr. Chairman.

I appreciate you all being here today.

And forgive my ignorance on my first question, but I am curious if any of you have ever as doctors been in private practice where you ran your own business. Have any of you been in private practice?

Dr. PETZEL. I have not. I have worked in academic medicine, but not private practice.

Dr. WENSTRUP. Okay. Because this is where I draw the line on so many things. For example, if the VA hospitals and their providers operated under Medicare rates, for example, or even, say, 105 percent of Medicare rates and providers were paid fee for service, do you think the VA hospitals would be in the black?

Dr. PETZEL. Yes, personally I do. We have done several studies going back as many as ten years and looked at our cost to providing a service as opposed to the private sector cost of providing a service or compared to the Medicare reimbursement. And in virtually every instance, we are talking 15 to 25 percent less cost associated with providing that service. So, yes, I think we could survive very well on Medicare rates, very well.

Dr. WENSTRUP. Because there is a part of it sometimes that makes me curious as to what motivates the VA system, the way it is funded, et cetera, to really be effective and efficient compared to, say, private practice because I have operated under both systems.

And besides personal pride in the work that I do and besides motivated to try and see as many patients as I possibly can effectively, those are personal things, but what within the system motivates that?

For example, because I found, and I will use DoD as an example, as a reservist in private practice, in the time that I would see 45 patients effectively and efficiently in my private practice because of the way military hospitals are set up and the physician staffing, et cetera, I could only see 15. I mean, that is just a fact.

And I have offered to you in the past to come into the VAs and work with you on the staffing issues. And I have not heard anything from anybody on that, and I mentioned it to Secretary Shinseki as well.

So what within the system motivates, stimulates the entire system to be extremely effective and efficient? What does that?

Dr. PETZEL. Well, thank you, Congressman Wenstrup. That is an excellent question.

First of all, it is the mission. I mean, we are taking care of people who have earned and deserve the care that we are delivering.

The second thing is that we have an unlimited demand on the service with a limited budget. We do not generate more money if we do more work. We get our budget at the beginning of the year and we have to take all comers because of that. That has driven tremendous efficiencies in this system, tremendous efficiencies. We roll by one to 1.5 percent in terms of the number of people we treat every year.

Our models for funding have in them productivity standards which say that we have to increase our productivity by one to two percent every year. That is a tremendous, tremendous motivator. I would match our efficiency and our cost of doing business against the private sector at any time.

Dr. WENSTRUP. Okay. In the effort that you are making with providing appropriate staffing, you know, in our private practices, are we increasing our staffing so that we can treat patients more effectively, increase access, things like that as well as have good outcomes? You know, there is a real number value to that.

So are you doing a follow-up on that that will show, yes, we are now seeing more patients at least cost and being efficient and will we have access to those types of numbers?

Dr. PETZEL. I would ask Dr. Agarwal to comment on that.

Dr. WENSTRUP. Sure.

Dr. AGARWAL. This is an excellent question, sir. And that is exactly what we recently asked since we have provided these tools to our local managers in managing these resources as to how it is that they are using it to make the clinics much more efficient and ensure that all the specialists are working at the top of their license. And the information that we have gotten back has actually been very good. Managers are looking at the resources that they are providing to the clinics and understanding what is the output, what is the value that they are achieving I think was made possible by these tools. So to be able to tell a specialist that you need to spend more time in the clinic or take care of, certain groups of patients has been possible because now when the access data and the productivity is aligned and it is sort of placed in a way that people can understand much better, it gives you insight into whether additional resources are needed or enough resources have already been provided but some other changes need to be made in specialty clinic. So we believe that in the longer run once this becomes the norm in how we practice, especially with the resource management part, this is going to be extremely beneficial.

Dr. WENSTRUP. Yes, I think it can be. I mean, assuming you are going to see everyone eventually that needs care we actually have a tremendous savings if we see them sooner and do it more efficiently and effectively. So you want to make sure that when you add a staffer it is because you get a better result and better outcomes.

Dr. AGARWAL. Exactly. Exactly.

Dr. WENSTRUP. I think that is what we want to hear back from you on over time as this is implemented.

Dr. AGARWAL. Thank you.

Dr. WENSTRUP. Thank you, and I yield back.

Dr. BENISHEK. I just want to comment for a moment. Dr. Petzel, that answer you just gave Dr. Wenstrup, that is just completely ridiculous.

Dr. PETZEL. I am sorry?

Dr. BENISHEK. You know, I worked at VA? In order to get the number of cases that I had done in the private sector in VA it took me a year to get the staff up to speed so I could do the same amount of cases at VA that I could do in the private sector. Motivating the staff at a VA hospital to get things moving and to use your time effectively is a tremendous, tremendous problem. And that answer that you gave, that said that you would put VA up against the private sector anytime, that is a complete fabrication of what actually occurs at the VA. I worked at VA for 20 years. I know that that is just not true. And having people from the outside who have been in the private sector whose time is valuable sitting in the doctor's office doing nothing for a half a day with you, a turnover time of a half an hour which is done in like seven minutes in the private sector is very frustrating to physicians. That kind of answer is not going to wash it here. With that I am going to give Ms. Kuster an opportunity to ask a question. Thank you.

Ms. KUSTER. Thank you very much, Chair Benishek, I appreciate it. And thank you to Vice Chair Brownley for your leadership on these issues. I have two questions, if I could. One has to do with a company in my district in New Hampshire, Salem, New Hampshire, the company is named Gamma Medica. And they make a medical device that produces bone density imaging to help with early detection of breast cancer. And my question is not specifically about them but my understanding is in New England many of our VA health facilities have requested this life saving device but due to over two-year-long delays many veterans seeking early breast cancer detection are not receiving the treatment that they, delays at the NAC. And my question, this is to Dr. Petzel, can you tell me how VA is actively engaged with improving delays for new technology at local facilities? And what steps have you taken since the round table last April on procurement wait times that we had to work with NAC on improving the amount of time it takes to deliver lifesaving devices?

Dr. PETZEL. I would defer in a moment to Mr. Matkovsky who has gone through that. But just to say that we are, we are not happy with the two-year process as well. The bundling, from my personal perspective, puts delays on this acquisition that I think are unnecessary. There is a compromise here between trying to save money by bundling on the one hand and on the other hand delaying the acquisitions because we are bundling. But Mr. Matkovsky, why do you not just go through again what you had said about what we are trying to do to reduce that time?

Mr. MATKOVSKY. Yes, sir.

Ms. KUSTER. Thank you. And I apologize that I had to come in late.

Mr. MATKOVSKY. No, that is okay. Congresswoman Kuster, the one thing I would state is that in our efforts to establish a structure that was more economical we left out a critical variable in history, which was speed. Our supply chain should also focus on speed. Procurement reform should establish compliant, economical acquisitions, but they should also be fast.

Following our round table we did review how we do the consolidations. We are trying to change those. It is going to take us a little bit of time. The big focus was the end of fiscal year 2012 orders that went in. There were 900 of those. The bone densitometers for Gamma Medica may in that consolidated process. But it is not a process that is working in terms of speeding the new technology for application. What we are trying to do now is move the less complex items so that they can be purchased at our 21 network offices through their contracting officers. In a sense instantaneously you have 21 additional work teams now focusing on it rather than just the one up in Chicago.

We wanted to make sure we could test it. We found out that there were some clauses that were competitive with our national contracts. We are going to extend the test a little bit more and then beginning in fiscal year 2015 that will become that way of business. That will free up these national acquisitions to be a little bit faster as well.

By April of this year we expect to be finished with all of the delivery orders from that last major consolidation. Then it will still take some time for the technology to be in medical center.

Ms. KUSTER. Okay. Thank you very much. My other question has to do with an issue that many of us have been involved with in the past year on military sexual assault treatment. I have been visiting the VAs in White River Junction and in Manchester and have actually been quite impressed by the protocols there but I am not familiar across the country.

We had a hearing last July where we had some very compelling testimony from veterans. And we were talking about whether veterans are being adequately screened for military sexual trauma. I think if I recall the testimony they were only asked on the initial visit and they were not asked on subsequent visits. So I would like to hear how the VA is following up with the local VA health facilities to measure the effectiveness of screenings and follow ups and also how are you providing local smaller VA facilities the information and tools they need to train and educate providers to treat survivors of MST?

Dr. PETZEL. Dr. Jain was at that hearing, as you remember. And I would ask him to comment on the changes and improvements we have made since then.

Ms. KUSTER. Great. Thank you.

Dr. JAIN. Thank you, Congresswoman Kuster, for that question. So as you mentioned this was fairly compelling testimony that we heard last year. So we have taken several steps. First of all the entire screening has now been revised. So that questions are being revised. We believe that the questions were not very clear before so we added a little more clarity. We have also added an option where the veteran could decline to answer the question. So they could answer the question whenever they felt they were ready, and

to whom they felt comfortable with answering the question. So if the veteran were to decline to answer the question, then within the year the reminder would kick back in and the question would be asked again so we do not lose that opportunity.

Ms. KUSTER. Oh, that sounds good. Instead of people assuming that that is a no answer——

Dr. JAIN. Yes, ma'am.

Ms. KUSTER [continuing]. It is a decline answer and then you would revisit it?

Dr. JAIN. We will revisit that. We will also have added actually a functionality where a third question has been now added. Through the pilot we learned that the veterans want to be referred to mental health or to specialty care and now we will be able to track those referrals and will be able to follow up through our data and numbers to see how the individual facilities are doing with following up on the reminders.

Ms. KUSTER. That sounds great. And could, I do not know if this would be possible to add to your protocol but I just want you all to be aware and maybe there is a way it could be factored in, we were successful in passing a bill to provide whistleblower protection to members of the military who come forward with claims of sexual assault, men and women. And I think it is an important piece of information because of the history on this issue and because of the retribution and retaliation in some cases in people's careers, that there was good reason not to come forward. And so I am hoping that you will find a way to incorporate this, to reassure victims to come forward that this whistleblower protection will be in place.

Dr. JAIN. We can certainly look into that, Congresswoman, and see how we could incorporate that.

Ms. KUSTER. Thank you. Thank you very much. Thank you, Mr. Chair.

Dr. BENISHEK. Yes. I am going to start another round of questions, and I have got a couple of things. Dr. Petzel, would you provide the committee for the record the circumstances surrounding the 14 SES employees you said the VA forced to step down in the past two years? We would like to have that by the end of the week, if we could.

Dr. PETZEL. If I could clarify that, Mr. Chairman. Let me clarify that, sir. I had the numbers wrong. There were 14 serious disciplinary actions taken. Six SES employees were dismissed over the last two fiscal years, three non-probationary, and three first-year probationary. And we will provide whatever information you want related to that.

Dr. BENISHEK. All right. All right, thank you. I am going to go back to one of the hearings that we did in the past to follow up. It is concerning the care and treatment of military sexual trauma and I think Dr. Jain was the, primary witness at that hearing. And I just want to follow up a bit more. You said we are going to take a critical look at how we structure services and what we can do to address some of the gaps. And you also said, "I think there are many points that the veteran witnesses made in terms of suggestion that we would take to heart, and we will go back and review our current policies and procedures." So Dr. Jain, what specific actions have you taken to improve the situation? You mentioned, the

questioning or the asking about sexual trauma. But what else specifically have you done to address the concerns that we brought up in that hearing, and that were brought forth by that testimony?

Dr. JAIN. Thank you, Mr. Chairman, for that question. So as I was just stating to Congresswoman Kuster, so the first big thing we did is to do a careful analysis of our screening process. And as I was indicating earlier——

Dr. BENISHEK. All right. You went through that. But go through something else.

Dr. JAIN. So that was number one. Secondly, we have also looked at our outreach activities that we are doing. So we have modified our outreach posters where the male and the female, survivors are, included in the posters. We are also doing outreach with the Department of Defense so that at the time of transition this is an activity we have taken in the last few months. So as the servicemembers transition from DoD to the VA the information regarding MST services is now provided to them so they know and they understand what services will be available to them in the veteran status. So that is an improvement.

We have also taken education and training activities. So we have trained the MST coordinators on the sensitivity relating to the male survivor issue that was presented at the hearing. We want to make sure that our male survivors can receive care in a gender sensitive manner in our outpatient clinics so they do not have to go for a women's clinic, for example, to receive services.

We have also made sure that the——

Dr. BENISHEK. That change has occurred, then, you are saying?

Dr. JAIN. Yes, sir. That training has already occurred. We have also trained the VISN leads that provide the MST services to monitor that activity. We also make site visits. And so we are tracking this as part of the site visits to make sure the facilities are providing the care in a gender sensitive manner. And then we are also doing a mystery shopper type sort of activity where both the male and the female staff members would call, randomly call the VA facilities to speak to the MST coordinator to just understand how will it take them to reach an MST coordinator, whether they are able to address the questions in a sensitive manner. So these are all the changes——

Dr. BENISHEK. How is that working out?

Dr. JAIN. That is actually going quite well. We have been very pleased with the training and how that has taken hold.

Dr. BENISHEK. Well I would like to see a report on what you——

Dr. JAIN. Yes, sir. We can certainly.

Dr. BENISHEK. That is a great idea, I think. Having somebody just call in anonymously and figure out what is actually happening. So if I could get a report on that, I would like to see that.

Dr. JAIN. We would be happy to——

Dr. BENISHEK. How many times you called, the response, all of that. I appreciate your answer there. I think I will yield to Ms. Brownley. I want to keep the questions coming. Thank you.

Ms. BROWNLEY. Thank you, Mr. Chair. You know, I wanted to also follow up on the military sexual trauma issue as well. You talked about the outreach that you are doing and thanks to the chairman we had a hearing in my district last week talking about

mental health services but a component of that discussion was about outreach. And one of the problems that was discovered in the various testimony is that the West L.A. facility was doing the outreach for mental health services for Ventura County, and Ventura County was not providing the outreach. And it was clear that the West L.A. facility was not aware of all of the programs that were accessible to programs in the county. So their outreach is basically ineffective because they have no idea about all of the nonprofits and volunteer organizations and so forth that could help our veterans. So when you talk about outreach for the, for our victims, or survivors I should say, of military sexual trauma, what does that outreach really look like? And I know that the IG had recommended and thought it would be very, very beneficial to have a central sort of program resource list that would be, at every VA medical clinic or in every community-based outpatient clinic, across the country. So if you could respond to that, please?

Dr. JAIN. So thank you, Ranking Member Brownley. I think there are a couple of things that we have done so I may not have a complete answer for you. But part of the outreach, as I mentioned earlier, is with our Department of Defense colleagues. But the other part of the work that we have done is reached out to OEF/OIF counselors within our own system. As you know, within the VA the majority of the outreach work in the communities is done by our OEF/OIF counselors. So our MST team has now trained the OEF/OIF counselors to begin to do the kind of outreach that you are referring to so that we can reach out into the community with nonprofits and also with other types of resources that are out there. So I cannot honestly say to you that it is completely functioning. But this is part of the process that we are now beginning to go beyond just the DoD into the community.

Ms. BROWNLEY. Thank you. And I also wanted to get a clarification in the testimony. Dr. Petzel's testimony indicated that the VA established a benchmark of .2 full time equivalent employees per 100 veterans who screen positive for MST. So help me to understand what that means. Is that the equivalent of a full FTE per 500 veterans affected by MST?

Dr. JAIN. So thank you, Ranking Member Brownley, for that question. So the process, the way it works is that in our Office of Productivity and Efficiency we have created a tool that monitors the numbers of MST survivors that we are treating and the staff resources that are dedicated to treat this MST survivors. So from that tool what we have determined is that it takes on an average two staff per thousand, or 0.2 per hundred. The staff would include all of the mental health staff, not just a particular staff member. So those facilities, so the last report that we have available is for fiscal year 2012. For fiscal year 2012 99 percent of the facilities met that staffing standard. There was only one facility that fell off. So after the hearing we immediately got after that particular facility, developed an action plan, and since then they have made the corrections. The fiscal year 2013 report would be available within the next few weeks. And we will be able to see how the facilities are doing to these staffing standards.

Ms. BROWNLEY. Okay. Well we would certainly like to see that report. It is hard for me to comprehend honestly that when we

have a veteran who is in dire need and who is experiencing very, very deep trauma that a .2 FTE is adequate. And I know you said that is from a variety of services, but kind of culled together it equates to a .2 FTE correct?

Dr. JAIN. So let me clarify again, Congresswoman. This is at a larger data trend issue. But for that individual veteran, we will provide them whatever services they need through our mental health clinic. Now what we emphasized right after the hearing, as you recall, some of our witnesses were very concerned that when the VA was not able to provide the care in a timely manner that we did not refer them to a non-VA care. So we continue to emphasize to our staff that non-VA care is an available option. And I think as Dr. Petzel said PC3 and the availability of PC3 that would happen starting April and beyond will make it easier to reach out to community providers. So for individual veterans the .2 issue does not apply. This is for monitoring purposes that we keep track of what staffing resources are being dedicated to provide the services.

Ms. BROWNLEY. I am just, so if that is the benchmark of what you are going to measure, then it is hard to measure that a veteran who, again, is in deep trauma in the moment that they need our help, if they have gotten all of the resources, because your measurement is going to be, you know, a .2, sort of a, kind of a across the board in the aggregate. So you know, it is, I am not sure that that is a good metric. Maybe I need to understand the metric in further detail. But I think we are all most interested, you know, in the, obviously the screening part that you have talked about. But when, you know, when we have a veteran who has gone through this kind of trauma and needs our help in that moment, you know, it takes a lot of, I think a lot of attention and a lot of support. So it does not translate for me.

Dr. PETZEL. Just if I could respond a little bit to that, Congresswoman Brownley. The metric looks at the system overall, that. We would be evaluating the effectiveness of caring for individual patients through a variety of different ways. I am not familiar exactly with what we do in military sexual trauma. But as an example with depression, they would take a survey beforehand, they would take a survey after one year that they have been treated to look at their score on a depression scale. Those are the kinds of things——

Ms. BROWNLEY. A survey which is to ask veterans——

Dr. PETZEL. Yes.

Ms. BROWNLEY [continuing]. How the VA responded to their needs?

Dr. PETZEL. Exactly. Or how did they feel.

Ms. BROWNLEY. Right.

Dr. PETZEL. The Beck Depression Scale measures your level of depression. I am just using that as an example. That is the kind of thing that we would use to measure the effectiveness of what we are doing. Not this metric of, this is just a gross way to say the facility appears to be devoting in the aggregate the resources needed. But you are absolutely right. We need to look——

Ms. BROWNLEY. But the report, I am sorry, may I just have one more second? But the report you are saying that was in 2012 and we are going to get in 2013 is a measurement based on this metric?

Dr. PETZEL. Correct.

Ms. BROWNLEY. Not a survey of veterans who are survivors of military sexual trauma and how the VA responded to them?

Dr. PETZEL. Correct.

Ms. BROWNLEY. That data we will not get?

Dr. PETZEL. Not in that 2013 report. But Dr. Jain and I will talk about what we can do to provide you with information about the effect of what we are doing.

Ms. BROWNLEY. I yield back, Mr. Chair, thank you.

Dr. BENISHEK. Thank you. Mr. Huelskamp?

Dr. HUELSKAMP. Thank you, Mr. Chairman. If I might, I would like to follow up on a few of your questions and drill down some of the accountability issues with employees and these preventable deaths which have I guess been confirmed by the VA to committee staff. But in the Columbia, South Carolina, which were six preventable deaths, were there any employees held accountable for those preventable deaths?

Dr. PETZEL. Well first of all, the concept of preventable deaths I think requires some discussion, not here. Yes, there were. There were three employees at senior levels who resigned——

Dr. HUELSKAMP. Resigned or——

Dr. PETZEL [continuing]. Under threat of discipline.

Dr. HUELSKAMP. But they were not disciplined? Is that, they left——

Dr. PETZEL. They left before they could be disciplined, correct.

Dr. HUELSKAMP. So perhaps, and I guess we are arguing about whether they were preventable deaths, they were allowed to resign and move on——

Dr. PETZEL. Allowed to resign? It is their right to retire or resign.

Dr. HUELSKAMP. There is no way to hold them accountable when people die because of their failures?

Dr. PETZEL. If somebody wishes to retire or resign, we cannot prevent that from happening.

Dr. HUELSKAMP. There is no way, no criminal investigation, nothing along those lines to hold these former VA employees accountable?

Dr. PETZEL. There is no criminal, there was no criminal charges or intent involved in any of these situations.

Dr. HUELSKAMP. And then the three deaths at the Augusta, Georgia center? I do not know if you answered that. Was anyone held accountable for those three preventable deaths?

Dr. PETZEL. We had a similar situation where a number of people have either retired or resigned.

Dr. HUELSKAMP. And of course I would hope you could provide that information to the committee within 30 days. The other one that I did not see was the VA Pittsburgh system with Legionnaires', and we had a hearing and it was just a shocking hearing to me. I guess it is arguable in your mind how many veterans died as a result of that, but you did indicate at least one actually died of Legionella. Was any VA employee held accountable for the failures that led to this death?

Dr. PETZEL. Yes, as I said earlier Congressman Huelskamp, we are in the process of evaluating the disciplinary action taken at Pittsburgh. It was delayed because of the criminal investigation, which did not allow us to do anything.

Dr. HUELSKAMP. So you had a criminal investigation there, but you did not pursue that, no one pursued that at Columbia where there were six preventable deaths?

Dr. PETZEL. The IG pursued a criminal investigation. There was no indication, nobody raised the question of whether there was criminal intent at any of these other facilities.

Dr. HUELSKAMP. The preventable death, at least the one that you confirm here, when did that occur at the Pittsburgh VA Center?

Dr. PETZEL. One moment, sir. July 12, 2012.

Dr. HUELSKAMP. How quickly do you expect, the criminal investigation is complete or not and when will you move to some accountability action?

Dr. PETZEL. Criminal investigation by the criminal IG is complete. They found no criminal activity or intent. And I am hoping that very quickly we will have the evaluation of disciplinary action at Pittsburgh concluded and we will know what we are going to do.

Dr. HUELSKAMP. Okay. I look forward to that report. And lastly, at the Atlanta VA Medical Center the Inspector General linked three preventable patient deaths to widespread mismanagement. Yet we heard that the Medical Center Director maintained no employees responsible for the mismanagement linked to the deaths should be fired. Is that still the case?

Dr. PETZEL. Well first of all the IG did not link any deaths to the activity at Atlanta. There were three mental health deaths but the IG made no comment in their report on the quality of care that was delivered to them or the course of action. And seven people at Atlanta have been disciplined in various ways as a result of that activity.

Dr. HUELSKAMP. The IG's report I thought linked that to mismanagement issues. You are saying it did not but you disciplined someone anyway?

Dr. PETZEL. Yes, specifically the IG said that there had been mismanagement of the contract for contract mental health services and there had been mismanagement on the mental health ward. They did not link any deaths to those activities.

Dr. HUELSKAMP. But you do say that seven employees have received some type of disciplinary action. Last we had heard in the Fall it was three employees received temporary written warnings. Can you describe the seven, the actions of the seven employees that were held accountable?

Dr. PETZEL. Congressman Huelskamp, I do not have the specifics of what happened with the seven but we certainly can provide that generically to you.

Dr. HUELSKAMP. Well I would like it, rather than generic I would like it answered obviously——

Dr. PETZEL. Well we cannot name the individuals but we can tell you exactly what was done.

Dr. HUELSKAMP. Oh, absolutely. But again, last Fall this committee was told there was temporary written warnings for three in-

dividuals and so I would like clarification. Apparently you have done some more since then.

Dr. PETZEL. There were, yes, at the time of the previous hearing there were three actions that actually had been taken and there were four actions pending. All have been now taken.

Dr. HUELSKAMP. Okay. I look forward to that report. Thank you, Mr. Chairman.

Dr. BENISHEK. Thank you, Mr. Huelskamp. Dr. Wenstrup.

Dr. WENSTRUP. Thank you, Mr. Chairman. You know, I appreciate all of your level of expertise and your medical backgrounds. But to be honest I am a little surprised that there is not people involved with administration that have been in the private sector. I think it would be extremely helpful. And I did not come to Congress to sit here and to complain about things but to try and bring solutions. And that is the drive of my efforts here.

Let me ask you Dr. Agarwal a question on, for example, in an eight-hour day in the VA system on average how many patients would an orthopaedic surgeon see?

Dr. AGARWAL. Sir, you know, that would be hard for me to sort of say. If it is an outpatient clinic I would assume that——

Dr. WENSTRUP. I am talking about in the outpatient clinic setting. Assuming their surgery day is different, we can get to that later. But just in an eight-hour day, in the outpatient clinic, doing their post-ops, etcetera, how many patients do they see on average? And if you do not know, that is okay.

Dr. AGARWAL. I actually do not know.

Dr. WENSTRUP. Okay. See, this is the type of thing I am talking about when I am talking about measuring productivity. And you say you have been doing this, and we have talked about it for the last year, and you do not have an idea. So what are you measuring? Because I was operations chair for a 26-doctor orthopaedic group. These are the things we looked at and how do we improve our staffing so that we can be more productive and still provide the care. And our reputations are on the line with this, too. So it is important. So I would like to know what type of metrics you are going to use, and that goes back to my previous question before. And I am not trying to be a pain. But are you going to do something that is effective and efficient. And if you do not know those numbers then you do not even have a baseline to start with.

That being said, let me go back to where Dr. Benishek weighed in having his experience at a VA and your comments to Dr. Petzel. You know, I am just curious to know if a VA hospital budget was based on the previous year's activities submissions at a Medicare rate, fee for service. If that was your budget based on your previous year's productivity, based on Medicare rates, you say that yes you would be in the black. So it would be interesting to know if that actually would cost the taxpayers more or less, if that is how your budget was based. And based on your comments it almost sounds like that would come in less than what we actually budget for you. And so would you be comfortable exploring that notion?

Dr. PETZEL. Certainly.

Dr. WENSTRUP. Thank you. And I yield back.

Dr. BENISHEK. Thanks, Dr. Wenstrup. I have another question and I am just trying to cover the issues that we have covered over

the last year, and one of them is the third party billing issue that we had talked about. Perhaps Mr. Matkovsky can answer this. Can you tell us about what is happening since you gave us the testimony there? Are you, are you collecting better? Have you changed anything since I talked to you last? I have got a couple of follow ups, too.

Mr. MATKOVSKY. Yes, sir. We covered two topics there. One of them was non-VA medical care. And if you want I can give you a little update on where we are with——

Dr. BENISHEK. Well let us start with the collection——

Mr. MATKOVSKY. Yes, sir.

Dr. MATKOVSKY [continuing]. Because that is what we are here for. And then for collections, as a result of that round table discussion we had public requests for information, which is a precedent to a request for proposals, to look at are there industry systems that would allow us to automate the billing process a little bit better. When we analyzed the turn around time for billing we noticed that one of the longest times that it takes us is actually from the outpatient event, the inpatient event, to the generation of the bill. And a lot of that is because of the manual process. So we had a competitive RFI, request for information, and we are evaluating those responses. We are also working with our IT organization to determine whether or not the systems enhancements would be considered IT and subject to that funding or whether we could use them under administrative funds.

Dr. BENISHEK. All right. Okay. Well I think that gives me an idea of where you are at.

Mr. MATKOVSKY. Yes, sir.

Dr. BENISHEK. The only other question, I know you talked about this PC3 thing and you kind of led me to believe that this is going to help solve the problem of getting outside care to our veterans in a more timely fashion. But my concern frankly is two things. The reimbursement rate that providers are going to be provided through VA. And like sort of what is the take from the insurance people? What percentage of the total spending is going to be made to get these third party networks on board? Can you tell me about that?

Mr. MATKOVSKY. Sure. First I would tell you that we kicked it off in January on time. There was a little bit of a delay, but it is now running. It is in 47 of the initial 50 medical centers are referring patients through to the PC3 networks. There are somewhere north of 5,000 referrals that have been made to the network. I will tell you that our agreement, however, is with the intermediaries not with the firms themselves. So we have an agreement with TriWest, we have an agreement with Health Net organizations, not with their provider networks. However, both contractors are required by their contract to have a built out network for us. So the incentive for them is to have as competitive a network as they can for us to provide them referrals, and that is actually by the basis of the contract as well.

Dr. BENISHEK. But the question I asked was the reimbursement to the providers, what level is that going to be at? And what percentage of the total money that you are spending on TriWest or wherever it is, what percentage of the total spending is going to go

to their management fees and which is going to go to actual provider care? Do you understand?

Mr. MATKOVSKY. Yes I do, sir. So there——

Dr. BENISHEK. Can you answer that question?

Mr. MATKOVSKY. I will.

Dr. BENISHEK. Or is it not available?

Mr. MATKOVSKY. First of all, our agreement is with TriWest and Health Net. Not with their subcontractors. Second of all, though, the structure of the contract is that we pay at a CMS rate to TriWest and Health Net and then they will have a rate somewhere below that but we are not privy to that. There is an administrative fee which is separate to the direct clinical fee, which TriWest and Health Net would also bill us. And we expect that their administrative charges would be captured there and not to the detriment of their network. There are incentive structures in the contract as well. So based on the ability of those organizations to build out their networks they get an incentive payment as well.

Dr. BENISHEK. So there is a separate administration fee?

Mr. MATKOVSKY. Yes, sir.

Dr. BENISHEK. And then there is a payment that you are saying is based of off Medicare rates to the providers?

Mr. MATKOVSKY. Yes, sir.

Dr. BENISHEK. Or that is to Tricare, and they are going to pay the providers less than that then? Is that what you said?

Mr. MATKOVSKY. We are not privy to the information about their agreements with their subcontractors.

Dr. BENISHEK. Well I am just trying to be sure that the system actually is able to procure providers. Because if somebody is offering, a very low rate of reimbursement you are not going to get very many people to sign up.

Mr. MATKOVSKY. So far we are not seeing it, be the case across the country. That we are actively starting up the sites where we are. In VISN 23 it is up and running. There are a number of referrals. We should not be seeing the inability to build out networks at this point.

Dr. BENISHEK. All right.

Ms. BROWNLEY. Thank you, Mr. Chair. And I will promise you I will watch my time. I wanted to go back to the one question that I did not think got answered. Maybe it did but I did not hear it about the IG's recommendation for establishing a central program resource list for MST related programs? Is that something the VA is going to do? Or believes that it is also beneficial?

Dr. JAIN. I am not sure, Congresswoman Brownley, about the question. I am not aware of any central program list in the OIG recommendation that is outstanding that I know of. The only one that we know of that is outstanding is the whole issue of travel and any travel issue. That was the only one that we were aware of. The only other thing that does occur to me, so there was one issue in OIG, yes, I do recall. And that was the issue that within the VA's intranet there is the availability of different programs and who are the MST coordinators. And we have addressed that concern and we have updated that list, make sure that the staff is aware that when they need to refer a patient to a larger VA, for example, for MST

related services, who is the contact person? Who do they need to contact? That has been updated and has been addressed.

Ms. BROWNLEY. Okay. Thank you very much. And I just wanted to go to the issue of chronic pain and I am wondering about in testimony before we have had testimony with the Tampa Chronic Pain Rehabilitation Program and sort of what are we learning, you know, best practices, lessons learned there?

Dr. PETZEL. Congresswoman Brownley, let me make a couple of comments then I am going to turn it over to Dr. Jesse, who was at that pain, at that hearing. The VA has developed what I think is probably the most robust pain management program for a large integrated delivery system in the country. The Tampa inpatient program for pain management is an example of the kinds of services that we have to offer. We have taken very seriously the problem with opioid management and pain. I think the physicians in this room will remember that 15 years ago it was felt that pain was undermanaged, and pain medications were pushed. You need to get rid of the pain. That has obviously led, and I am not talking about the VA, I am talking about medicine in general, led to a problem in this country of the overuse of opioids in managing pain. And the VA I think is very seriously addressing that problem. And Dr. Jesse?

Dr. JESSE. Thank you. So there are some very long and detailed explanation I can give. I think the VA has a very good story to tell. But if coming back specifically to Tampa, Tampa is an inpatient rehabilitation facility that is unlike almost anything else you can get. That a patient get this without paying out of pocket is unheard of in this country. It is a CARF-accredited program. In 2000, we had I think one CARF-accredited program. We now have ten. We have 14 in process, that accreditation process. Our goal is to ensure that every VISN, every network has at least one. And that is part of the overall strategy that Dr. Petzel referenced of a stepwise pain management program, beginning with a very comprehensive base in primary care including the ability to use therapies other than pharmacologic. You heard about acupuncture, about medication, imaging therapy, behavioral therapy, and escalating, the ability to have consultation from pain experts, and escalating up to the higher level pain centers where in fact we use a much, we can use much more technical programs like spinal stimulation, which was discussed at the last hearing, like nerve blocks, injections, thermal nerve ablations. And frankly those are the kind of very intensive inpatient rehabilitation programs that Tampa offered.

Ms. BROWNLEY. So you believe that that is moving really across the country in terms of looking at all of the alternative therapies that you just suggested?

Dr. JESSE. Oh yes, absolutely. And so, you know, we have our, we have as part of this strategy not just the opioid safety initiative, which is key, but it is also the ability to use other strategies to relieve pain rather than just masking them, that is not the right way to say that, but rather than just using, you know, pharmacological therapy. So for instance as part of the joint program with the Department of Defense there is a program called ATAX, I think is the acronym, I do not remember exactly what it stands for, but it is to train acupuncturists in what is called battlefield acupuncture,

auricular acupuncture. Relatively effective at managing pain. The goal, we presently have I think just shy of 20 trainers. The goal is to have 400 enrolling that program out. Developing that capacity is key. And you know, frankly the whole goal of VA as we have discussed in the past is to provide personalized, patient driven care. Which really includes a wholesale embracement of I think what the industry would call integrative care, integrative medicine. And that is, you know, that is part of our fundamental plan of healthcare deliver in VA.

Ms. BROWNLEY. Thank you. I will yield.

Dr. BENISHEK. Thank you, Ms. Brownley. Dr. Jesse, I also want to ask a couple of questions on that.

Dr. JESSE. Sure.

Dr. BENISHEK. On our pain hearing that we had. And I do not know, I just want to hear that specifically, you give some, generalized answer here. But specifically since our hearing, what have you done to educate the physicians within VA about pain management? What has anything changed since our hearing last year? What have you done?

Dr. JESSE. If I may, clearly things have changed because since the hearing last year there are 20,000-some fewer veterans on opioids. You know, we have been rolling out these initiatives not since the hearing but literally since, for four to five years. They take time to get in place, they take time to build the infrastructure. The opioid safety initiative began to be rolled out prior to that hearing and since the hearing there has been a significant acceleration of that. The pilots at Minneapolis, for instance, there has been over a 50 percent reduction in the use of opioids. There is a, what is called JPEP, it is the Joint Pain Education Program that is done, run jointly with the Department of Defense. Because as we have discussed in the past one of the key issues, and this came up in the past hearing if you remember, we do not want a lapse between somebody who is being treated on the military side and coming over to the VA. And part of that is to ensure that we actually have the same approaches to managing pain across the spectrum of the delivery systems, the military system and into the VA system. So that program is being rolled out. As I mentioned, the acupuncture training program is ramping up. So yes, there are a number of issues that are in play that have been much more accelerated since that past, that past hearing.

The Post Deployment Health has calls that average about 400 people on those monthly calls. We have another set of specific pain management calls that have been averaging about 300 in the past several months, it is moving up to close to 400. Primary care providers are mostly engaging in these calls. So I think the answer is yes. There is concrete and accelerated activity in these areas.

Dr. BENISHEK. Well I thank you for that answer. I do not mean to be overcritical. We just went to the West L.A. Medical Center and, met with a couple of their pain specialist providers. And the system they had in place there, at least the way they explained it to me, it sounded like it was actually pretty effective with, alternative modalities, being incorporated, and having the pain specialist involved in the case at a certain level. And they had a pretty good criteria. And so I do not mean to say that everything is bad.

But the purpose of today was for me to get a follow up on what, is happening. Because I hate to have these hearings where we bring up these issues and then, nothing else gets done. I do not know the follow up being done. So I truly appreciate you all being here today for me to try to get some more information.

I understand Dr. Wenstrup has a follow up question he would like to ask.

Dr. WENSTRUP. Thank you, Mr. Chairman. Actually sort of on that subject, do you know what percentage of the VA hospitals are participating in the prescription drug monitoring programs in cooperation with the states?

Dr. PETZEL. That is a very good question, Congressman. Everybody is querying, that is our providers are asking the state about their patients. As near as we know, that is happening across the country. The reporting of our activity is an IT issue. We have six pilots in places like Kentucky and Tennessee, which have been very successful and the process is in place now to roll this out to the rest of the country. The limitation is IT, is getting the right people, it is complex. You have got different reporting phenomena in each state. And you have got 152 medical centers. And getting that stuff married up IT-wise is taking us some time.

Dr. WENSTRUP. Is there anything we can do?

Dr. PETZEL. Oh dare I say it, IT money. You know. IT is our lifeblood. You know, everything anymore that we do in medicine has an IT component to it one way or the other. But I think that the money is in place to do this. The people are in place to do it. It is just a matter of getting it done.

Dr. WENSTRUP. Do you have a timeline, do you think? We have a pretty big problem in my district with prescription drug abuse. It has been cracked down on——

Dr. PETZEL. In——

Dr. WENSTRUP. In Ohio.

Dr. PETZEL. In Ohio.

Dr. WENSTRUP. Yeah. And it has been cracked down a lot. We have closed down a lot of the pill mills. That has all been done at a local level within the state. But it is still an existing problem. Plus, we border other states. Some sometimes we have got it within Ohio, but not necessarily in the other states. And having the VA information would be helpful as well.

Dr. PETZEL. It is. And I would like to take for the record the question of how long. And we will get back to you quickly about exactly what the timeline is.

Dr. WENSTRUP. Okay, thank you.

Dr. PETZEL. Just a little bit about that, it is very important and from our perspective to know the prescriptions are going on on the outside.

Dr. WENSTRUP. Right.

Dr. PETZEL. Are people, doctor shopping? Are they using other people? And it is important for the states to know what we are doing——

Dr. WENSTRUP. Right.

Dr. PETZEL [continuing]. So that they can put that and make that information available to the private sector. This is very important.

Dr. WENSTRUP. It is helpful both ways, there is not doubt about it.

Dr. PETZEL. Yes, absolutely.

Dr. WENSTRUP. Thank you, and I yield back.

Dr. BENISHEK. Well I think that concludes the questions that we have today. I do have to ask before we adjourn that we do have some further written questions we would like to have submitted for the record. I suspect that you guys hopefully will get those answers to us. There is a lot of lengthy stuff there that I would like to get some follow up for but we do not need to have it here today.

Dr. PETZEL. Yes, sir.

Dr. BENISHEK. So I appreciate you all being here. I ask unanimous consent that all members have five legislative days to revise and extend their remarks and to include extraneous materials. Without objection, it is so ordered. And the hearing is now adjourned.

[Whereupon, at 11:40 a.m., the subcommittee was adjourned.]

APPENDIX

PREPARED STATEMENT OF HON. DAN BENISHEK M.D., CHAIRMAN

Good morning and thank you for joining us for today's oversight hearing, "VA Accountability: Actions Taken in Response to Subcommittee Oversight."

Almost one year ago today—during my first hearing as Chairman of the Subcommittee on Health—we met to discuss the persistent lack of productivity and staffing standards for specialty care services at Department of Veterans Affairs (VA) medical facilities.

We learned that VA had yet to implement such standards despite more than thirty years of reports and recommendations directing the Department to do so.

I was so alarmed by VA's decades-long lack of action that I quickly introduced H.R. 2072, the Demanding Accountability for Veterans Act.

H.R. 2072 would:

- Require VA to ensure that IG recommendations concerning a public health or patient safety issue were addressed;
- identify those within VA medical facilities who are responsible for implementing needed changes; and,
- prohibit VA from awarding a bonus or performance award to any employee who does not fully address a recommendation under his or her purview.

The goal of this legislation is to create a culture of accountability within VA—a culture where problems are identified and immediately corrected and leaders are held responsible for their actions.

Were H.R. 2072 in place thirty years ago, VA would have been required long before now to implement productivity and staffing standards for all specialty care services and who knows how the health and well-being of the veterans seeking care through VA would have improved as a result.

I wish I could say that first hearing was the only time that we have seen evidence of a lack of timely action taken by VA in response to serious problems.

Unfortunately, that is not true.

Since the conclusion of that hearing, we have held other hearings and roundtables on topics ranging from the care provided to veterans with chronic pain and who have experienced military sexual trauma to concerns regarding Department-wide procurement reform and third-party collections.

At each of these oversight forums, we heard example after example of VA failing to act swiftly to address important issues or respond to the Subcommittee's requests for information in a timely manner.

I am a surgeon by trade.

When a serious problem is identified, my instinct is to act without delay to cut out what needs cutting out and fix what needs fixing.

And, while I understand that large-scale changes often happen slowly—especially where large government bureaucracies like VA are concerned—I think we can all agree that our veterans deserve more than what we have seen in the last year.

I am hopeful that H.R. 2072 will be heard on the House floor in the coming weeks.

However, I am not content to wait for what can oftentimes be a lengthy legislative process to ensure that VA is on track to address the many issues the Subcommittee identified through last year's oversight efforts.

During today's hearing we will:

- Assess the progress, if any, that VA has made in response to the Subcommittee's hearings and roundtables;
- Determine whether appropriate steps have been taken to ensure accountability when and where deficiencies in care have been highlighted; and,
- Identify what further actions may be necessary to improve the care and services provided to our veterans.

Though the topics we will address today are wide-ranging, they are undoubtedly interconnected.

If we do not ensure that the Department is on track to implement appropriate productivity and staffing standards, then we cannot be sure that we have the right staff in place to care for veterans experiencing chronic pain.

Similarly, if we do not ensure that VA is taking all necessary actions to improve the collection, where appropriate, of third-party revenue, then we cannot be sure that we are collecting every available dollar that could then, in turn, be used to improve the care and services provided to veteran survivors of military sexual trauma.

Last week, I had the privilege of conducting an oversight visit to the West LA VA Medical Center.

During my conversations with the clinicians and support staff there, each of the issues we will discuss today were brought up by the providers when I asked them what needed to be improved in order to make it easier for them to care for our veterans.

I cannot state enough how critical it is for VA to take responsibility for gaps in care and, more importantly, take immediate and definitive steps to address them.

Unfortunately, I have seen little concrete evidence in the last year that the Department is doing either.

Concurring with IG and GAO reports is simply not enough.

Sending out guidelines without accountability in not enough.

I sincerely hope that today's conversation will change my mind.

PREPARED STATEMENT OF JULIA BROWNLEY, RANKING MEMBER

Good morning. Today's hearing is intended to follow up on various oversight hearings and roundtables held during the first session of the 113th Congress and to assess the progress that the Department has made in addressing the issues.

The Subcommittee will also determine whether appropriate steps have been taken by VA to ensure accountability, and identify what further actions may be necessary in response to Subcommittee oversight.

Last session, this Subcommittee held oversight hearings on physician staffing standards, care and treatment for military sexual trauma survivors, and VA's overuse of prescription painkillers to treat veterans with chronic pain.

In addition to the oversight hearings, two roundtables were held, one focusing on procurement reform and access to care and one on billing and collecting from third-party health insurance companies for nonservice-connected care.

There were many issues raised during these hearings and roundtables. Issues such as developing a plan to establish productivity standards for all specialty care services within three years, decreasing the amount of time it takes to procure large medical equipment through the National Acquisition Center, assessing the Department's programs for veterans who have experienced military sexual trauma, and ensuring the effective use of opioid therapy for patients with chronic pain.

Mr. Chairman, these are but a few of the concerns that were brought up during testimony and conversations we had with the witnesses and participants during the forums.

While we have a lot of ground to cover today, I am especially interested in hearing from the VA on improvements made in the MST program and in procurement reform.

At the MST hearing held last session, we heard first hand the experiences of veterans who have found the system unfriendly and intimidating.

According to the VA, fiscal year 2013 saw an increase of 9.3 percent in rates of engagement of MST-related care at VHA. Additionally, VA reports an increase of 14.6 percent in MST-related visits in fiscal year 2013. I would like to hear from VA how they are addressing this increase.

I am sure we all agree that it is critical that Congress do all that we can to make it easier for victims of MST to access needed benefits and services, and receive treatment.

Compassion and care are a significant part of healing those that have been sexually assaulted.

Turning now to procurement reform, Mr. Chairman, last session we held a roundtable and during that roundtable discussion, we heard about the long delays, some for up to two years, in the delivery of medical equipment.

While I understand that VA is streamlining the procurement process to decrease the amount of time it takes to procure large medical equipment through the National Acquisition Center, I do not feel confident that much progress has been made in that area.

Stakeholders continue to report increased difficulties accessing needed prosthetic equipment through VA and significant delays in contract awards at the National Acquisition Center.

I find this very frustrating and unnecessary. I hope VA has good news on this front today.

Mr. Chairman, thank you for holding this hearing today and I want to thank everyone in attendance. There is obvious concern for veterans and VA's ability to meet their health care needs.

Thank you, Mr. Chairman and I yield back the balance of my time.

PREPARED STATEMENT OF ROBERT PETZEL, M.D.

Good morning, Chairman Benishek, Ranking Member Brownley, and members of the Committee. Thank you for the opportunity to discuss the progress made regarding the Veterans Health Administration's (VHA) physician staffing and productivity standards, treatment for Veterans who experienced military sexual trauma, pain management programs, and procurement reform. I am accompanied today by Dr. Robert Jesse, Principal Deputy Under Secretary for Health, Dr. Madhulika Agarwal, Deputy Under Secretary for Health for Policy and Services, Dr. Rajiv Jain, Assistant Deputy Under Secretary for Health for Patient Care Services, and Mr. Philip Matkovsky, Assistant Deputy Under Secretary for Health for Administrative Operations.

The Department of Veterans Affairs (VA) is committed to providing the highest quality care, which our Veterans have earned and deserve. VA operates the largest integrated health care delivery system in the country, with over 1,700 sites of care. It is important to acknowledge that each year, over 200,000 VHA leaders and health care employees provide exceptional care to approximately 6.3 million Veterans. The high quality health care VA provides is consistently recognized by The Joint Commission and other internal and external reviews.

I want to address the issue of accountability. The Veterans Health Administration is the largest integrated health care system in the country, providing 85 million total health care appointments last year and 25 million consultations at more than 1,700 VA health care sites. Allegations of misconduct by employees are taken seriously. When we learn of credible allegations of misconduct, VA addresses them immediately.

When incidents occur, we identify, mitigate and prevent additional risks. Prompt reviews prevent similar events in the future and hold those responsible accountable. If employee misconduct or failure to meet performance standards is identified, VA takes the appropriate action.

I would point out that VA appreciates and values the role that Congress, this Committee, VA's Office of the Inspector General (OIG), the Office of Special Counsel, and the Government Accountability Office have played in identifying areas where the VHA can improve. VA utilizes their insights when forming policy and taking action to strengthen our healthcare delivery programs.

CARE AND TREATMENT AVAILABLE TO SURVIVORS OF MILITARY SEXUAL TRAUMA

Effectively treating Veterans who experienced military sexual trauma (MST) continues to be a top VA priority. We are committed to ensuring that appropriate MST services are available to meet the treatment needs of both men and women Veterans. Rates of engagement in care and the amount of care provided have increased every year that VA has monitored MST-related treatment. In fiscal year (FY) 2013, 93,439 Veterans received MST-related care at VHA. This is an increase of 9.3 percent (from 85,474) from FY 2012. These Veterans had a total of 1,027,810 MST-related visits in FY 2013, which represents an increase of 14.6 percent (from 896,947) from FY 2012.

At last year's hearing on care and treatment available to survivors of MST, we discussed VA initiatives to provide counseling and care to Veterans who experienced MST; monitor MST-related screening and treatment; provide VA staff with training; and inform Veterans about available services. Since that hearing, VHA has made significant improvements in these areas. VA has implemented improvements in MST care to include enhanced screening, expanded telemental health services, and expanded guidance.

As discussed during the hearing, VHA has a universal screening program for MST. A Clinical Reminder in the electronic medical record alerts providers of the need to screen the Veteran, provides language to use in asking the Veteran about MST, and documents the Veteran's response to the screen. Because a revision of the MST Clinical Reminder will be rolled out by the end of FY 2014, VHA will implement several changes including changing the Clinical Reminder language to make the questions asked more readily understandable to Veterans. Also, an explicit option to "decline" has been added, to allow Veterans to choose when and with whom they would prefer to disclose their experience. Veterans who "decline" are automatically re-screened again in a year. Although the intent of these changes is to facilitate disclosure, the revised Reminder language also capitalizes on screening as an opportunity to provide all Veterans with information about VHA's specialized MST services, regardless of whether or not they disclose having experienced MST. Veterans who express interest in MST-related treatment will have streamlined access to care via an option in the Reminder itself to initiate a referral for services.

In conjunction with the rollout of the revised Clinical Reminder, VHA has engaged in efforts to provide staff with additional training on how to screen and respond sensitively to disclosures of MST. National educational resources have also shifted to clarify the importance of creating multiple opportunities for disclosure of experiences for MST—for example, re-screening all Veterans who are seen in clinics for posttraumatic stress disorder (PTSD) or other specialty services.

The addition of the referral question to the Clinical Reminder will allow for increased accountability with respect to the MST-related treatment provided by VHA. First, it will provide national monitoring data that will allow VHA to track whether Veterans who request MST-related mental health services are able to access those services. Second, it will allow VHA to establish benchmarks for what percent of Veterans (on average) might be expected to access MST-related care after screening positive. Veterans who screen positive for MST will vary in their need and interest in MST-related treatment through VHA; without some indication of what percent of Veterans are interested in treatment, it is currently difficult to know the extent to which VA is reaching the subset of Veterans who actually need care.

Given the increases in MST-related treatment mentioned earlier, it is important to ensure that facilities have adequate capacity to meet the demand for care. Analyses conducted by VHA's national MST Support Team established a minimum staffing benchmark of 0.2 full time equivalent employees per 100 Veterans who screen positive for MST. Annual monitoring of all VHA facilities using this benchmark demonstrated a positive impact on the availability of services. These analyses, in conjunction with the new referral question associated with the Clinical Reminder, will assist VHA in assessing continued progress towards the goal of ensuring that all Veterans who would benefit from MST-related care are able to readily access that care.

During the previous hearing on MST, we discussed the geographic challenges some Veterans face when seeking to access care. VHA is providing services via information and telecommunication technologies that give Veterans more options and have improved access to care. Telemental health approaches can be used to treat most every mental health condition and deliver all Evidence-based Psychotherapies (EBP). As part of its strong commitment toward providing high quality mental health care, VHA has nationally disseminated and implemented specific EBPs for PTSD and other mental and behavioral health conditions. Because PTSD, depression and anxiety are commonly associated with MST, these national initiatives are important means of expanding MST survivors' access to treatments. Furthermore, several of these treatments were originally developed to treat sexual assault survivors and have a particularly strong research base with this population.

Veterans who experienced MST can receive EBPs at every VA medical center and increasingly via telehealth. VHA's work in this area is supported by recent research, including research conducted within VHA that has shown these therapies to be effective and well-accepted by patients when delivered. VA administrative data indicates that from FY 2011 to FY 2013 psychotherapy telemental health encounters with Veterans with primary diagnosis with PTSD has increased more than 3-fold and during the same time frame, the number of unique Veterans with primary diagnosis of PTSD receiving psychotherapy via telemental health has more than doubled. This is due in part to national VHA efforts to expand the use of telehealth to providing care, particularly to Veterans with PTSD.

In September, an Information Bulletin was distributed to Veterans Integrated Service Network (VISN) leadership that provided guidance on the importance of protected time for the MST Coordinator, ensuring facilities have sufficient capacity to provide MST-related care, and clarification that non-VA (fee basis) care can, and should, be provided when there will be a delay in the facility's ability to meet a Veteran's treatment needs, or if it is otherwise clinically indicated for the MST-related care to be delivered at a non-VA facility. The Information Bulletin also underscored the need to ensure adequate services are available to meet the needs of male Veterans who experienced MST and that these services are provided in a manner that recognizes some of the unique challenges men may face in accessing care and in their recovery more generally. The revised MST Clinical Reminder will include a mental health services referral question, which will streamline access to care for Veterans who express interest in MST-related treatment. In recognition of this, at a national level, MST is clearly defined as an issue of concern for both men and women, in that it has been under the administrative oversight of the national Mental Health Services program office since 2006.

In 2013, VHA concurred with the Office of the Inspector General's recommendation to review existing VHA policy pertaining to authorization of travel for Veterans seeking MST-related treatment at specialized inpatient/residential programs outside of the facilities where they are enrolled. VHA agreed to establish a workgroup to

review the issues and provide recommendations to the Under Secretary for Health. After reviewing current policies, the workgroup confirmed that currently, MST status does not in and of itself qualify Veterans for reimbursement of travel expenses (called Beneficiary Travel) and drafted an initial proposal discussing potential options for addressing this issue. The work group has been directed to conduct further analysis and reach consensus on a recommendation.

Department-Wide Acquisition Reform

The Subcommittee also hosted a number of roundtables to examine the impact Department-wide acquisition reform has had on access and quality of care for Veteran patients and opportunities to improve patient care in addition to the authority to bill and collect from third party health insurance companies. We discussed the processes used to provide non-VA care for Veterans and how billing was conducted following the care being delivered. We also discussed VA standards for claims payment and performance metrics used to track VA results as well as the consolidation of billing and the improvements and efficiencies recognized from the changes.

Since the roundtable discussions, the Department has expanded its use of authorities to acquire care from community health care providers. In January 2014, we successfully launched delivery of healthcare through Patient Centered Community Care (PC3) contracts, beginning a phased deployment across the VA health care system. This new program employs nation-wide contracts to improve Veterans' access to quality health care. These contracts also standardize our referral, authorization and payment processes. Our phased deployment will achieve delivery of health care through PC3 across all VISNs in April of 2014.

VA completed its consolidation of billing through the Consolidated Patient Account Centers (CPAC) in September 2012. This effort was completed ahead of schedule, and has improved the reliability and performance of our billing and collection processes. Since our roundtable discussions we have conducted requests for information through the Federal government procurement system to identify commercial best practices for automation of health care billing systems. This approach was a direct result to the discussions conducted at the roundtable, and it allows our VA team to collect competitive information from numerous firms. We are now processing responses and assessing how best to further develop a solicitation to improve our automation of hospital billing.

Additionally, we met with the Health Subcommittee regarding claims payment timeliness. We have established a nation-wide effort to improve the timeliness of all claims VA pays to providers who provide authorized care to Veterans. We are currently working with our legacy systems and have increased oversight of our claims payment processes. We have partnered with our Department colleagues to develop a fully automated and commercial claims payment system that will enable improved and sustainable performance in our payment processes. This system is in field-testing in one of our networks and will complete development by the end of this calendar year, with a subsequent national roll-out and training for all our claims payment staff by the end of FY 2015.

We have welcomed the involvement from this Subcommittee during our roundtables, which has informed the continued improvements in our administrative processes.

Physician Staffing and Productivity Standards

At last year's hearing, we discussed how VHA was addressing productivity and staffing beginning with Primary Care Services followed by Radiology and Mental Health. We also discussed the complexities associated with measuring productivity in a health care setting. VHA reported in March 2013 that more than 54 percent of its physician workforce had standards in place to measure their productivity and efficiency.

Today, I am pleased to report that we are on target to deliver productivity and staffing standards for all VHA physicians by the end of FY 2014. In October 2013, VHA briefed the OIG on its progress on developing and implementing specialty physician productivity and staffing standards. Based on VHA's briefing, the OIG closed out its "Audit of Physician Staffing Levels for Specialty Care Services," OIG report 11–01827–36, in November of 2013. The work continues and we will not be finished until all physician specialty productivity and staffing standards are complete and ready access to high quality, efficient specialty care is available to our Nations Veterans

Today, I'd like to share with you some of the details of what we have accomplished and assure this Subcommittee of VHA's commitment to the results-oriented approach we have taken in accomplishing the implementation of physician productivity and staffing standards. VHA has adopted an activity-based productivity and

staffing model for specialty physicians. Utilizing an industry accepted Relative Value Unit (RVU)-based model, specialty physician productivity standards have been developed and implemented. In FY 2013, productivity standards for six specialties (dermatology, neurology, gastroenterology, orthopedics, urology, and ophthalmology) were developed, piloted in four VISNs (VISNs (7, 12, 19 & 22)) and then implemented VHA-wide in FY 2013. All VISNs and medical centers were informed of the new productivity standards for the six physician specialties listed above on July 26, 2013. The standards were implemented VHA-wide on September 30, 2013. By the end of March 2014, VHA will have productivity and staffing standards in place for 25 different specialties representing more than 81 percent of its total physician workforce.

A critical component of the productivity and staffing standard implementation is the Specialty Productivity-Access Report & Quadrant (SPARQ) tool that provides an algorithm for the effective management of VHA's specialty physician practices. This tool is designed to assess VHA specialty physician practice business strategies and drive performance improvement in Veteran access to specialty care. This tool was recognized by our OIG colleagues as one of the most important managerial tools developed in support of physician productivity and staffing standards and its ability to go beyond standard implementation to ultimately drive system performance.

The SPARQ tool includes important measures, such as support staff ratios for VHA specialty physicians so as to maximize physician efficiency. The SPARQ tool measures the care team, including advanced practice providers such as Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialists, and their RVU contribution. The SPARQ tool also measures specialty physician value in the form of 'compensation per RVU' so as to demonstrate VHA's ability to be good stewards of public health care resources. Additional views for local medical center and VISN leadership have been added to permit a view of all specialties so that local leaders can make informed decisions about specialty care resources and be accountable for these decisions.

VHA has also undertaken a comprehensive education and communication plan about the specialty physician productivity and staffing standards. VHA has held national calls to actively engage its specialty physician workforce. VHA specialty physicians are committed to demonstrating and improving specialty productivity and access. VHA has also held national calls with its medical center leadership in an effort to clearly communicate the expectations of full implementation of specialty physician productivity and staffing standards. All medical centers have been provided with access to a variety of tools that permit productivity and staffing measurement at the individual physician and specialty practice level. Our national and local specialty leaders have been trained on the business strategies and tools available to assist them in managing their specialty practices with the goal of ready access to quality specialty care for our Veterans.

VA's Pain Management Programs and the Use of Medications to Treat Veterans

At last year's hearing, we discussed how VA is providing comprehensive and patient-centered pain management services to improve the health of Veterans. We also highlighted VA's current pain management strategies, the prevalence and use of opioid therapy to manage chronic pain in Veterans who are potentially at increased risk for a medication-related adverse event such as someone taking a high dose of an opioid at the same time as taking a benzodiazepine medication, the challenges of prescription drug diversion and abuse among Veterans, and the actions VA is taking to improve the management of chronic pain.

Today, we are providing an update on our progress and the on-going challenges that we are working on in order to provide the best care to our deserving Veterans when it comes to managing their pain. This includes the integration of both medications and non-pharmacologic evidence-based strategies.

Veterans enrolled in VA's health care system suffer from higher rates of chronic pain than the general population.[1] Almost 60 percent of Veterans returning from the Middle East and more than 50 percent of Veterans in the entire VA health care system experience some form of chronic pain. Many have survived severe battlefield injuries, resulting in life-long severe pain related to damage to their musculoskeletal system, as well as permanent nerve damage, which can impact their emotional health and brain structures. Many have also incurred head injuries, collectively referred to as traumatic brain injuries (TBI), which can compound psychological injuries such as PTSD. The extent and complexity of these multiple conditions can make

[1] According to a 2010 Institute of Medicine estimate, the rate of chronic pain in the general population is approximately 32 percent.

effective pain management difficult and increase the risk for complications, due to both over-and under-treatment, including overdose and suicide.

In 2011, the Institute of Medicine (IOM) issued their report describing general deficits in the training of U.S. health care professionals in pain management. VA's health care system had identified and broadly responded to these deficits starting in the late 1990s through policy, education and training, clinical monitoring, and the expansion of clinical resources and programs. For instance, VA recognized that in the management of pain, and for mental health problems such as PTSD, that can accompany combat injury related pain, there may be value to non-medication treatment approaches, including evidence-based psychotherapy and complementary and alternative medicine (CAM) approaches such as meditation, animal-assisted therapies and acupuncture. Several of these approaches are in active use and are under ongoing evaluation.

VA recently developed and implemented an Opioid Safety Initiative program to better ensure opioid pain medications are used safely, effectively and judiciously. The basis for this is to make visible the totality of opioid use at all levels, patient, provider and facility, in order to identify high-risk situations. The Opioid Safety Initiative includes key clinical indicators such as the number of unique pharmacy patients dispensed an opioid, unique patients on long-term opioids who receive a urine drug screen, the number of patients receiving an opioid and a benzodiazepine (which puts them at a higher risk of adverse events) and the average dosage per day of opioids such as hydromorphone, methadone, morphine, oxycodone, and oxymorphone. Patients at risk for adverse events from use of opioids are identified through the use of administrative and clinical databases using pre-determined parameters based on published evidence and expert opinion. Several aspects of the Opioid Safety Initiative were underway at the time of the October 10, 2013, hearing and have begun to bear positive results:

- Despite overall growth in the number of Veterans who were dispensed any medication from a VA pharmacy, between the quarter beginning in July 2012 compared to quarter ending in December 2013, 33,142 fewer Veterans received any opioid prescription (including short and long term use) from VA.
- Performing urine drug screens is a useful tool to assist in the clinical management of patients receiving long-term opioid therapy. Between the quarter beginning in July 2012 compared to quarter ending in December 2013, the number of patients on long term opioid therapy who have had at least one urine drug screen increased by 27,783, while the total number of patients on long term opioids decreased by 13,859.
- Whenever clinically feasible, the concomitant use of opioid and benzodiazepine medications should be avoided. Between the quarter beginning in July 2012 compared to quarter ending in December 2013, 10,664 fewer patients were receiving these drugs at the same time.
- Lastly, the average dose of selected opioids has begun to decline slightly in VA, demonstrating that prescribing and consumption behaviors are changing.

These facts signal an important downward trend in VA's prescribing of opioids. VA expects this trend to continue as it renews its efforts to promote safe and effective pharmacologic and non-pharmacologic pain management therapies. Very effective programs yielding significant results have been identified, and are being studied as strong practice leaders.

At the Tampa VA medical center, a safety-focused pain treatment program has been in place since 1988. The goal of the program is to replace the use of opioids for pain management with non-pharmacologic treatments such as behavior therapy, physical therapy, occupational therapy and/or kinesiotherapy. Tampa also has a long-standing process of identifying and conducting clinical reviews of Veterans who have received high morphine equivalent doses. At the Columbus, Ohio VA Outpatient Clinic, a Veteran-centered approach on opioid safety is focused on minimizing short acting opioids. This program has resulted in fewer Veterans on opioids with an 80 percent decrease in short acting opioid doses dispensed.

Current VA Pain Management Strategies

Many Veterans require a combination of strategies for the effective management of pain, including treatment with opioid analgesics, which are known to be effective for at least partially relieving pain caused by many different medical conditions and injuries. VA treatment involves 1) interrupting or moderating the pain signal from peripheral disease/damage (e.g., medications/injections, transcutaneous electrical nerve stimulation (TENS), acupuncture, and stimulation.); 2) supporting structures (e.g., spine) to reduce activation of pain signals (physical therapy and exercise to

build strength and flexibility and help control weight); and 3) help the Veteran cope with pain and learn better self-management strategies (behavioral therapies).

In 2010, the Department of Defense (DoD) and VA jointly published evidence-based Clinical Practice Guidelines (CPG) for the use of chronic opioid therapy in chronic pain available on the internet. Guidelines reserve the use of chronic opioids for patients with moderate to severe pain who have not responded to, or responded only partially to, clinically indicated evidence-based pain management strategies of lower risk, and who also may benefit from a trial of opioids. A toolkit has also been published and widely distributed to assist clinicians in using the Guidelines: (*https://www/qmo.amedd.army.mil* and *http://www.healthquality.va.gov*). VA has also developed and disseminated a patient education resource, entitled "Taking Opioids Responsibly", to increase Veterans' awareness of the risks and benefits of opioid treatment. More recently, the DoD-VA Pain Management Work Group (PMWG) of the VA-DoD Health Executive Council (HEC) has built upon the past work begun with the 2010 CPG and meets monthly to evaluate progress and improve effectiveness of projects focused upon the VA–DoD mission to improve pain management. These include two projects funded in 2013 and well underway: Joint Pain Education and Training Project (JPEP)", and "Tiered Acupuncture Training Across Clinical Settings (ATACS)."

To support a system-wide approach, VA disseminated guidance and tools to providers to communicate long term opioid therapy expectations. Among the tools and guidance are:

a. VA National Pain Management Strategy—VA has established pain management as a national priority. The objective of the strategy is a comprehensive, multicultural, integrated system-wide approach to pain management that reduces pain and suffering and improves quality of life for Veterans experiencing acute and chronic pain. The strategy incorporates care by pain medicine, behavioral health, physical medicine and rehabilitation and other specialty providers to manage complex patients.

b. VHA Pain Management Directive—VA's Pain Management Directive defines and describes policy expectations and responsibilities for the overall National Pain Management Strategy and Stepped Care pain model.

In coordination with DoD, a multi-modality, team-based, stepped care model is being implemented throughout VA. VA and DoD have developed patient and provider educational materials and two Joint Incentive Fund sponsored initiatives are underway.

The Acupuncture Training Across Clinical Settings Project will create access to acupuncture for Veterans and Servicemembers in all clinical settings throughout VA and DoD.

Forty-eight states have implemented Prescription Drug Monitoring Programs (PDMP) as a means to improve the quality of care and prevent the diversion of controlled substances. Two additional states and the District of Columbia have enacted legislation to develop a PDMP or have legislation pending. VA published an Interim Final Rule to allow participation in these programs and is successfully transmitting data from six pilot sites to state PDMPs. The remaining VA facilities are scheduled to begin transmitting data by the end of FY 2014.

Non-pharmacologic Approaches to Treatment of Veterans' Mental Health Problems and Pain Management

The treatment of PTSD in VA follows the evidence-based recommendations of the Joint VA/DoD Clinical Practice Guideline for PTSD, most recently published in 2010 and accessible on the Internet at *http://www.healthquality.va.gov/ptsd/*. The first-line treatments for PTSD are evidence-based trauma focused psychotherapies such as Cognitive Processing Therapy (CPT) or Prolonged Exposure (PE) that have the highest level of evidence (Level A) indicating "a strong recommendation that the intervention is always indicated and acceptable."

In terms of medications, the Guidelines strongly recommend (Level A) selective serotonin reuptake inhibitors or serotonin norepinephrine reuptake inhibitors. To date, VA has provided training in Cognitive Processing Therapy and/or Prolonged Exposure to more than 6,000 VA mental health staff. All VA medical centers provide at least one of these therapies, as required in VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics. According to a 2011 VA survey, 89 percent of VA facilities offered CAM treatments, an increase from 84 percent in 2002. The most common types of CAM provided are meditation (72 percent of VA hospitals); Stress Management/Relaxation Therapy (66 percent); and Guided Imagery (58 percent); acupuncture (41 percent), and yoga (44 percent). The most common uses of CAM are for stress management, anxiety disorder, PTSD, depression, back pain, and wellness-promotion.

The Acupuncture Training Across Clinical Settings Project is now in development to ensure, through standardized training of medical and battlefield acupuncturists, that all Veterans and Servicemembers in all clinical settings throughout VA and DoD have access to appropriate levels of acupuncture. VA has submitted a request for job classification to OPM for the hiring of certified acupuncturists.

VA and DoD combined VA's Health and Information Group survey of CAM modalities with the RAND survey of DoD Innovative Mental Health Programs as the foundation for a joint registry that will provide a record of innovative treatment programs. The combined list now includes over 700 programs and is a substantial initial step toward characterizing and tracking innovative treatment modalities.

Conclusion

As stated earlier, the Department of Veterans Affairs is committed to providing the highest quality care, which our Veterans have earned and deserve. Progress has been made regarding physician staffing and productivity standards, treatment for Veterans who experienced military sexual trauma, pain management programs, and procurement reform, and we will continue to seek improvement as we deliver high quality health care.

We will continue to identify, mitigate, and prevent vulnerabilities within our health care system, wherever we find them, and we will continue to ensure accountability and develop a culture in which accountability principles are clearly stated. And when adverse events do occur, we will identify them, learn from them, improve our systems, and do all we can to prevent these incidents from happening again.

Mr. Chairman, this concludes my testimony. I appreciate the Subcommittee's continued interest in the health and welfare of America's Veterans. At this time, my colleagues and I are prepared to answer your questions.

March 20, 2014
The Honorable Robert A. Petzel, M.D.
Under Secretary for Health
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Dr. Petzel:

Thank you for testifying at the February 26, 2014, Subcommittee on Health oversight hearing entitled, "VA Accountability: Assessing Actions Taken in Response to Subcommittee Oversight."

As a follow-up to that hearing, I request that you respond to the attached questions and provide the requested materials in-full by no later than close of business on Friday, April 25, 2014.

If you have any questions, please contact Christine Hill, Staff Director for the Subcommittee on Health, at *Christine.Hill@mail.house.gov* or by calling (202) 225–9154.

Your timely response to this matter and your commitment to our nation's veterans are both very much appreciated.

Sincerely,

DAN BENISHEK M.D.
Chairman

Questions for the Record From Chairman Dan Benishek M.D.,

1. During the hearing, you stated that, " . . . last year, VA removed 3,000 employees—approximately one percent of its workforce." Please provide the location, position, salary grade, and reason for dismissal for each of the 3,000 employees that the Department removed last year. Please also provide the number of employees that were resigned on threat of discipline last year.

2. During questioning by Representative Wenstrup, you stated that the Department has conducted "several" studies comparing the cost of providing a given medical service through VA to the cost of providing the same service through either Medicare or the private sector. Please provide an electronic copy of such studies.

3. Please provide a copy of the Information Bulletin that was distributed to Veterans Integrated Service Network (VISN) leadership in September 2013 regarding Military Sexual Trauma (MST) Coordinators and describe how the Department intends to measure and track the implementation, utilization, and effect of the Information Bulletin.

4. Please describe how the Department intends to measure and track the implementation, utilization, and effect of the revised MST clinical reminder screening process. Is the Department on track to roll out the revised screening process by the end of fiscal year 2014?

5. Please provide information regarding the number and location of any and all inpatient facilities or programs that exist specifically for the treatment of MST and whether such facilities or programs treat male veterans, female veterans, or both.

6. Please describe the actions the Department is taking to expand access to care for male veterans who have experienced MST.

7. Please provide a copy of the "national educational resources" referenced in the Department's written statement that have been "shifted to clarify the importance of creasing multiple opportunities for disclosure [of MST." What impact are these resources expected to have and how will such impact be tracked and measured?

8. Please provide information regarding the pilot program that Mr. Matkovsky, VA's Assistant Deputy Under Secretary for Health for Administrative Operations, stated the Department was undergoing in VISN 15 and VISN 23 to test an alternate procurement structure for certain high-cost medical equipment. Please include information regarding how the Department intends to measure the outcome of the pilot program.

9. Is the Department still on track to complete the approximately 909 outstanding delivery orders from 2012 by the end of April 2014? If now, why not and when will the outstanding delivery order be filled?

10. Please describe how the Department intends to, " . . . look at the consolidation process and change that as well." What changes are planned for VA's current consolidation process and what is the Department's timeline for full implementation of the planned changes?

11. Please describe the actions that have been taken in the last year to respond to veteran and stakeholder concerns regarding the negative impact of changes to VA's prosthetic procurement process.

12. Please list the "incentive structures" in the Patient Centered Community Care (PC3) program that Mr. Matkovsky mentioned in response to questions regarding PC3 reimbursement rates.

13. What impact does the Department estimate full implementation of PC3 will have on VA's third-party collections?

14. Please provide an update on the request for information (RFI) that the Department released to " . . . identify commercial best practices for automation of health care billing systems . . . " What response has the Department received to the RFI and how and when does the Department intend to incorporate those best practices into VA's third-party collections processes?

15. Please list and briefly describe each of the "many tools" that Dr. Agarwal, VA's Deputy Under Secretary for Health for Policy and Services, testified had been developed to, " . . . assist the local facilities in managing specialty [care] resources appropriately." Please also describe how the Department intends to track the implementation and utilization of these tools and measure the impact they have on veteran access to specialty care services.

16. Please provide information regarding the "comprehensive education and communication plan" that is currently underway regarding specialty physician productivity and staffing standards.

17. VHA Directive 2009–053, which provides pain management policy and implementation procedures, is scheduled to expire on October 31, 2014. Please describe the Department's efforts to-date to prepare to update and reissue this directive and list any and all proposed policy or implementation changes that have been proposed.

18. Please describe the role of the Opioid Safety Initiative within VA's existing pain management programs and provide information regarding how the Department intends to measure and track the Initiative's implementation, utilization, and impact.

19. Please describe that actions, if any, that the Department has taken to ensure that pain management points of contact (POCs) within VA medical facilities regularly communicate with pain management specialists, as appropriate, about veteran patients experiencing acute or chronic pain. Please include any and all guidance that has been sent to the field regarding the referral process from pain management POCs to pain management specialists.

20. During the Subcommittee's October 10, 2013, oversight hearing entitled, "Between Peril and Promise: Facing the Dangers of VA's Skyrocketing Use of Prescription Painkillers to Treat Veterans," a VA witness testified about a VA-wide best practice in pain management called the "Chronic Pain Rehabilitation Program." Please describe what efforts, if any, VA has taken to implement related or similar programs in other VA medical centers and clinics.

21. Please describe the six ongoing pilot programs that are in place to test the Department's initiative regarding state prescription drug monitoring programs, to include information regarding how VA intends to measure the outcome of the pilot programs. Please also elaborate on the Information Technology "limitations" that were referenced in regard to the pilot programs.

22. Please describe the actions, if any, that have been taken to make the VA formulary more consistent with the DoD formulary.

Questions for the Record From Hon. Keith Rothfus

1. On September 9, 2013, you testified at a field hearing in Pittsburgh that VA would delay taking any administrative disciplinary action relating to the systemic failures and mismanagement at the VA Pittsburgh Healthcare System (VAPHS) that resulted in the deaths of at least six veterans due to an outbreak of legionella until the U.S. Justice Department concluded its criminal investigation. Then, on November 21, 2013, the Justice Department announced that it had concluded that investigation and that no criminal charges would be brought. It has now been over three months since that announcement, and the VA has yet to hold anyone at VAPHS accountable. Accordingly, please provide a detailed explanation of what VA has done internally to investigate those responsible for these preventable deaths, what VA has left to be done to conclude that investigation, and a date certain by which the families of the victims and Members of Congress can expect that the VA will take such administrative disciplinary action.

2. On November 26, 2013, following the conclusion of the Justice Department's investigation into the legionella outbreak at VAPHS, Senator Pat Toomey and I sent a letter to Secretary Eric Shinseki requesting information about what administrative disciplinary action the VA planned to take, if any. To date, though, over three months later, neither Senator Toomey nor I have received any response. Can you please explain why the Secretary's office found it acceptable to not send any response to our inquiry? Is this indicative of how VA and the Secretary's office views Congressional inquiries and oversight generally?

3. During the hearing on February 26, 2014, you stated that only one death resulted from the legionella outbreak at VAPHS. Yet, the Centers for Disease Control and Prevention (CDC) found in its investigation that at least 21 veterans were sickened as a result of the outbreak, five of whom died. Moreover, since the CDC released its report, a sixth veteran death has been connected to the outbreak as well. Accordingly, please provide a detailed explanation why VA has concluded, despite the findings of the CDC, that only one death resulted from the outbreak of legionella at VAPHS.

Questions for the Record
Committee on Veterans' Affairs, Subcommittee on Health
U.S. House of Representatives

"VA Accountability: Assessing Actions Taken in Response to Subcommittee Oversight"

February 26, 2014

Questions for the Record from Chairman Dan Benishek, M.D.

Question 1: During the hearing, you stated that, "...last year, VA removed 3,000 employees-approximately one percent of its workforce." Please provide the location, position, salary grade, and reason for dismissal of each of the 3,000 employees that the Department removed last year. Please also provide the number of employees that were resigned on threat of discipline last year.

VA Response: Due to the large amount of data required to fulfill this request, VA continues to work to respond to this question and will follow up with the Committee as soon as possible.

Question 2: During questioning by Representative Wenstrup, you stated that the Department has conducted "several" studies comparing the cost of providing a given medical service through VA to the cost of providing the same service through either Medicare or the private sector. Please provide an electronic copy of the studies.

VA Response:

Studies:

Nugent, G.N., Hendricks, A., Nugent, L.B., Render, M.L. Value for taxpayers' dollars: what VA care would cost at Medicare prices. Medical Care Research and Review 2004; 61, 495-508.

Winkler, SL., Vogel, B., Hoenig, H., Ripley, DC., Wu, S., Fitzgerald, SG., Mann, WC., Reker, DM. Cost, utilization, and policy of provision of assistive technology devices to veterans poststroke by Medicare and VA. Med Care. 2010 Jun;48(6): 558-62.

Nugent, G., Hendricks, A. Estimating private sector values for VA health care: an overview. Medical Care 2003; 41, II2-10.

Note: some recent studies focusing on specific conditions have found that VA costs are greater than private sector health care costs while, noting that VA subjects had higher

rates of comorbidities (e.g., 2012 study on End Stage Renal Disease). An abstract is available at: http://www.ncbi.nlm.nih.gov/pubmed/21945972), and attached below.

Question 3: Please provide a copy of the Information Bulletin that was distributed to Veterans Integrated Service Network (VISN) leadership in September 2013 regarding Military Sexual Trauma (MST) Coordinators and describe how the Department intends to measure and track the implementation, utilization, and effect of the Information Bulletin.

VA Response: A copy of the Information Bulletin is attached. As noted in VA testimony at the February hearing, the intent of this Bulletin was to remind VISN and health care facility leadership of the importance of ensuring that all facilities are in compliance with standing Veterans Health Administration (VHA) policies pertaining to MST. The Bulletin called attention to six policy-related issues. This response will describe the mechanisms in place in VHA to monitor these six areas:

1. *Sufficient protected time for the MST Coordinator role.* The Bulletin reminded leadership of the importance of ensuring that MST Coordinators are given adequate unscheduled time to fulfill the responsibilities of that role. Compliance with this policy will be monitored by periodic site visits to health care facilities conducted by the VHA Office of Mental Health Operations (OMHO). Site visitors conduct extensive interviews with key staff in the facility mental health service, including the MST Coordinator and local mental health leadership, to evaluate the quality of available services, assess compliance with policy, and make recommendations. The interview question template used by site visitors has recently been updated to include a question about whether the MST Coordinator has sufficient protected time.

2. *Sufficient capacity to provide care.* The Bulletin reiterated the requirement that health care facilities provide MST-related treatment services adequate to meet the local demand, and offer options to accommodate Veterans' treatment needs when timely care is not available. This is an area of focus during the OMHO site visits referred to above. Additionally, the MST Support Team in the VHA Mental Health Services office completes an annual report to determine the facility staffing capacity required to meet the mental health needs of Veterans who experienced MST. As noted in testimony, VA has set a benchmark of 0.2 full time equivalent employees (FTEE) per 100 Veterans as the minimum staffing level for MST-related mental health care. In the most recent analysis, 99 percent of VA health care systems were at or above this benchmark. As follow-up, the MST Support Team, in collaboration with OMHO, partnered with mental health stakeholders at the local and VISN levels to develop an action plan to increase the staffing level in the one health care system that fell under the benchmark. The health care system is demonstrating consistent progress on all four action items in quarterly progress reports. OMHO and the MST Support Team currently provide regular support and guidance on an as-needed and at least quarterly basis.

3. *Sensitivity to the needs of all Veterans who have experienced MST.* The Bulletin instructed facilities to ensure that appropriate specialized services are available to meet the treatment needs of both men and women Veterans who experienced MST, and that these services are organized (administratively and physically) in a way that is sensitive to gender-specific concerns. To help ensure compliance, questions specific to this issue have been added to the interview question template used by OMHO during their site visits. The MST Support Team also continues to consult with facility MST Coordinators about treatment service organization on an as-needed basis, which provides a secondary method to ensure MST Coordinators are aware of the need to address this issue.

4. *Shared responsibility and coordination of care.* The Bulletin emphasized the importance of coordinating care across the medical and mental health clinics where MST survivors receive treatment services. Facility MST Coordinators are well-aware of MST survivors' unique range of health care needs, and engage in monitoring, consultation, and staff education as needed to ensure that facility clinics communicate effectively and are providing coordinated services. This is also an area assessed by OMHO during site visits.

5. *Training.* The Bulletin reminded leadership of the need to ensure that all staff receives education and training about MST-related issues appropriate to their role with Veterans. Coordinating local education and training efforts is one of the MST Coordinators' primary duties; they help ensure that facility mental health and primary care providers are completing mandatory MST training and that frontline staff have the knowledge to work sensitively with MST survivors. Additionally, the MST Support Team completes an annual report submitted to Congress that assesses compliance rates with MST mandatory training requirements and helps coordinate follow-up with facilities where compliance falls under the VHA national benchmark of 96 percent. Finally, as noted in testimony, the MST Support Team conducts periodic test calls ("secret shopper calls") to facilities as a check on the training received by frontline staff. Every system is rated based on the ability of frontline staff to connect callers with the MST Coordinator seamlessly and staff members' attention to privacy and sensitivity concerns.

6. *Services provided by trainees.* The Bulletin reiterated national policies with respect to health profession trainees who provide treatment services to MST survivors. The VHA Office of Academic Affiliations (OAA) has program responsibility for national oversight of health profession trainee programs in VHA health care facilities. OAA ensures that facilities follow best practices and are in compliance with national policies with respect to the conduct of treatment services provided by trainees.

Question 4: Please describe how the Department intends to measure and track the implementation, utilization, and effect of the revised MST clinical reminder

screening process. Is the Department on track to roll out the revised screening process by the end of fiscal year 2014?

VA Response: The revised MST Clinical Reminder is on track to be implemented by the end of FY 2014. The revised screening language has been finalized and all support materials are complete. An Information Bulletin detailing facility actions required to prepare for the revision has been sent to all Veterans Integrated Service Network (VISN) Directors, and MST Coordinators and VISN Mental Health Leadership have been briefed on the upcoming revisions.

National release of the revised MST Clinical Reminder will occur after a standard testing process is completed through Office of Information & Technology (OIT). The revised MST Clinical Reminder will be rolled out via a national patch in the electronic medical record system. This is the standard technical process for all updates to the electronic medical record system and ensures uniform implementation in all facilities.

With regard to utilization and effect of the Clinical Reminder data, since FY 2005, VA Mental Health Services' (MHS) national MST Support Team has produced annual reports on the number and percent of Veterans in VHA care screened for MST and those who received MST-related treatment, with results aggregated by gender and by facility. These reports allow for annual monitoring of compliance with national policy regarding universal screening for MST as well as provide VHA with information about the number of Veterans who screen positive for MST.

The addition of the referral question to the Clinical Reminder will now additionally allow VHA to track whether Veterans who request MST-related mental health services are able to access those services. It will also provide data to inform VHA's efforts to establish benchmarks for Veterans' access to MST-related care after screening positive. Veterans who screen positive for MST will vary in their need and interest in MST-related treatment through VHA; without some indication of what percent of Veterans are interested in treatment, it is currently difficult to know the extent to which VA is reaching the subset of Veterans who actually need care.

As such, following implementation of the revised Clinical Reminder, the MST Support Team's annual reports will be expanded to include the number of Veterans who are screened for MST, the number who disclose experiences of MST, and the number who request and access MST-related mental health care. This information will facilitate both local and national monitoring of policy compliance, improve VHA's ability to determine whether expected rates of Veterans are accessing MST-related care, and refine its evaluation of its capacity to provide MST-related care.

Question 5: Please provide information regarding the number and location of any and all inpatients facilities or programs that exist specifically for the treatment of MST and whether such facilities or programs treat male Veterans, female Veterans, or both.

VA Response: VA offers over 240 Mental Health Residential Rehabilitation and Treatment Programs (MH RRTP) with more than 8,000 beds that provide 24-hour

supervision, daily professional and peer services, and comprehensive care addressing medical and mental health concerns and psychosocial needs. These programs provide specialized treatment for substance use disorders, posttraumatic stress disorder, serious mental illness, and other mental health concerns that can be associated with experiences of MST. It is important to note that no MH RRTPs are officially designated as MST treatment programs; rather, programs are defined based on the diagnoses and symptoms for which treatment is provided (for example PTSD Residential Rehabilitation Treatment Programs) with some programs specifically focusing on provision of mental health care related to a Veteran having experienced military sexual trauma.

Information from the FY 2013 Annual Review of MH RRTPs indicate that VA's MH RRTPs provided extensive MST-related services in FY 2013, with 95 percent of programs (228 programs) reporting that they provided MST-related care to Veterans admitted to their residential program either through staff working directly in the program or through engagement with outpatient providers during the residential stay.

MH RRTP programs vary in how they provide care and some Veterans may prefer to receive treatment for MST-related concerns directly within the residential program itself, as opposed to through engagement with outpatient providers during a residential stay. Over half of VHA's MH RRTPs (106 programs) are able to meet this need, as they have staff working in the program that provided treatment for mental health conditions associated with MST during FY 2013. The majority of these programs provided care to both men and women. A list of those programs that provided MST-related care by staff working directly in the program during FY 2013 is attached and includes information on whether care is provided to men only, women only, or both men and women.

Table 1: MH RRTPs that provided MST-related care by staff working directly in the program during FY 2013.

VISN	FACILITY	PROGRAM TYPE	BEDS	GENDER
1	Bedford	DCHV	50	Both
1	Boston	SA RRTP	20	Men Only
1	Brockton	SA RRTP	24	Both
1	Brockton[1]	PTSD RRTP	8	Women Only
1	Brockton	DCHV	46	Both
1	Newington	PTSD RRTP	6	Both
1	White River Junction	SA RRTP	14	Both
2	Batavia	PTSD RRTP (M)	30	Men Only
2	Batavia[1]	PTSD RRTP (W)	6	Women Only
2	Bath	General DOM	187	Both
2	Buffalo	SA RRTP	24	Both

VISN	FACILITY	PROGRAM TYPE	BEDS	GENDER
3	Brooklyn	DOM SA	22	Both
3	Brooklyn	DCHV	50	Both
3	East Orange	SA RRTP	30	Both
3	Lyons[1]	PTSD RRTP (W)	10	Women Only
3	Montrose	DCHV	60	Both
3	Northport	SA RRTP	30	Both
3	Northport	PTSD RRTP	8	Men Only
4	Butler	DOM SA	31	Both
4	Butler	DCHV	25	Both
4	Coatesville*	DOM SA	79	Both
4	Coatesville	DOM PTSD	35	Both
4	Coatesville	DCHV	115	Men Only
4	Wilkes-Barre	SA RRTP	10	Both
5	Baltimore	General PRRTP	10	Both
5	Martinsburg	DOM PTSD	50	Both
5	Martinsburg	General DOM	79	Both
6	Asheville	SA RRTP	18	Both
7	Dublin	DOM SA	30	Both
7	Dublin	DOM PTSD	30	Both
7	Dublin	DCHV	65	Both
7	Tuscaloosa	SA RRTP	21	Both
7	Tuscaloosa	PTSD RRTP	15	Both
7	Tuscaloosa	DCHV	48	Both
8	Bay Pines	PTSD RRTP	14	Both
8	Bay Pines[1]	DOM PTSD	16	Both
8	Bay Pines	DCHV	25	Both
8	Gainesville	SA RRTP	16	Both
8	Miami	SA RRTP	24	Both
8	Miami	PTSD RRTP	16	Both
8	Miami	General PRRTP	18	Both
9	Lexington	SA RRTP	15	Both
9	Lexington	PTSD RRTP	15	Both
9	Louisville	SA RRTP	14	Both
9	Mountain Home	General DOM	135	Both
9	Mountain Home	DCHV	35	Both
10	Cincinnati	PTSD RRTP (M+TBI)	22	Men Only
10	Cincinnati[1]	PTSD RRTP (W)	10	Women Only
10	Cleveland	General PRRTP	20	Both
10	Cleveland	DOM SA	43	Both
10	Cleveland	DOM PTSD	10	Men Only
11	Battle Creek[1]	PTSD RRTP	32	Both
11	Battle Creek	General PRRTP	40	Both
11	Danville	General PRRTP	35	Both
11	Marion IN	SA RRTP	30	Both
12	Madison	SA RRTP	12	Both
12	Milwaukee	DOM SA	45	Both
12	Milwaukee	General DOM	108	Both

VISN	FACILITY	PROGRAM TYPE	BEDS	GENDER
12	North Chicago	PTSD RRTP	26	Both
12	North Chicago	General DOM	39	Both
15	Leavenworth	General DOM	25	Both
15	Leavenworth	DCHV	177	Both
15	Marion IL	General PRRTP	14	Both
15	St. Louis	DCHV	50	Both
16	Biloxi	PTSD RRTP	20	Both
16	Biloxi	General PRRTP	32	Both
16	Jackson	SA RRTP	15	Both
16	Jackson	PTSD RRTP	12	Both
16	Little Rock	DOM PTSD	25	Both
16	Little Rock	General DOM	37	Both
16	Little Rock	DCHV	57	Both
17	Bonham	DOM SA	104	Both
17	Bonham	General DOM	120	Both
17	Dallas	SA RRTP	40	Both
17	Temple[1]	DOM PTSD	8	Women Only
17	Temple	General DOM	262	Both
18	Albuquerque	SA RRTP	24	Both
18	Albuquerque	General PRRTP	16	Both
18	Albuquerque	DCHV	40	Both
18	Phoenix	SA RRTP	20	Men Only
19	Denver	PTSD RRTP	19	Men Only
19	Ft. Harrison	General PRRTP	16	Both
19	Salt Lake City	SA RRTP	15	Both
19	Sheridan	DOM SA	23	Both
19	Sheridan[1]	DOM PTSD	17	Gender Cohort
19	Sheridan	DCHV	45	Both
20	American Lake	DOM SA	24	Both
20	American Lake	DOM PTSD	20	Both
20	Boise	SA RRTP	11	Both
20	Portland	DCHV	26	Both
20	Walla Walla	SA RRTP	28	Both
20	Walla Walla	General DOM	8	Both
20	White City	General DOM	387	Both
20	White City	DCHV	54	Both
21	Honolulu	PTSD RRTP	12	Men Only
21	Palo Alto[1]	PTSD RRTP (M)	40	Men Only
21	Palo Alto[1]	PTSD RRTP (W)	10	Women Only
22	San Diego	SA RRTP	29	Both
22	West LA	DOM SA	62	Both
22	West LA	General DOM	109	Both
22	West LA	DCHV	125	Both
23	Grand Island	SA RRTP	18	Both
23	Hot Springs	DOM PTSD	10	Both
23	Hot Springs	General DOM	40	Both
23	Hot Springs	DCHV	50	Both

VISN	FACILITY	PROGRAM TYPE	BEDS	GENDER
23	St. Cloud	General DOM	148	Both

[1]There is a smaller subset of programs that have been identified (through the MH RRTP Annual Program Review and additional data resources) as providing care primarily for MST-related concerns.

Abbreviations: DCHV: Domiciliary Care for Homeless Veterans; General DOM: General Domiciliary; General PRRTP: General Psychosocial Residential Rehabilitation Treatment Program; DOM PTSD: PTSD Domiciliary; DOM SA: Substance Abuse Domiciliary; SA RRTP: Substance Abuse Residential Rehabilitation Treatment Program; PTSD RRTP: PTSD Residential Rehabilitation Treatment Program; (M): Men Only (W): Women Only; TBI: Traumatic Brain Injury.

Similarly, none of VHA's inpatient mental health programs are officially designated as MST treatment programs. These programs provide treatment to address acute care needs (e.g., psychiatric emergencies and stabilization, medication adjustment) and most would be able to provide MST-related care for any acute needs with which a Veteran might present.

Question 6: Please describe the actions the Department is taking to expand access to care for male Veterans who have experienced MST.

VA Response: VHA is committed to ensuring that appropriate services are available to meet the treatment needs of both men and women Veterans who have experienced MST. With regard to MST-related care to men specifically, VHA monitoring data indicate that efforts to promote male Veterans' engagement in MST-related services have been effective. MST-related outpatient treatment rates among men have increased every year since VA Mental Health Services' national MST Support Team began monitoring them in FY 2007. The number of men receiving MST-related care from VHA has more than doubled in the past seven years (from 16,441 in FY 2007 to 35,378 in FY 2013). During this period, the number of MST-related outpatient visits received by men has increased 235 percent (from 109,679 MST-related health care visits in FY 2007 to 367,412 MST-related health care visits in FY 2013).

As noted in the response to Question #3, the most recent VHA data show that 99 percent of VA health care systems have adequate capacity to provide MST-related care. Complementing these existing resources, VHA's efforts to expand mental health services broadly also may benefit male Veterans who experienced MST. To this end, the VHA Office of Mental Health Operations (OMHO) is developing and implementing a national strategy to expand mental health services via several means. One, by redefining access measures for new and established Veterans receiving mental health care, VHA is approaching its goal of ensuring that all Veterans are able to schedule a mental health visit within 14 days of their desired date. Two, by leveraging telehealth and other technologies, VHA is extending access into rural communities. Three, by investing in provider recruitment, VHA is ensuring that mental health provider staffing levels have increased in recent years to keep pace with Veterans' needs. Finally, by leveraging community partnerships, VHA has successfully initiated a number of pilot programs with community agencies across the country to provide additional mental health resources in areas of need.

The response to Question #3 delineated some of VHA's efforts to ensure that treatment programing and environments are sensitive to the unique needs of male Veterans who experienced MST. In addition, VHA policy strongly encourages facilities to offer Veterans being treated for mental health conditions related to MST the option of being assigned a same-sex mental health provider or an opposite-sex provider if the MST involved a same-sex perpetrator. Additionally, some female and male Veterans may benefit from single-gender treatment environments, to foster their sense of safety, ability to address gender-specific concerns, and strong peer and social support. To accommodate Veterans who do not feel comfortable in mixed-gender treatment settings, many facilities throughout VA have separate programs for men and women. Residential and inpatient programs must have separate sleeping areas for men and women.

Outreach to Veterans to facilitate engagement with care is another critical element to expanding access for male Veterans. VHA outreach materials and efforts reference both men and women and use gender-inclusive language. For example, Internet Web sites such as About Face (available at: www.ptsd.va.gov/apps/AboutFace) and Make the Connection (available at: maketheconnection.net) include video galleries of personal testimonials from male and female Veterans who have experienced MST. Information about men is consistently included in VHA's major MST-related educational offerings, including VHA's mandatory trainings on MST for mental health and primary care providers and the national MST Support Team's monthly training calls.

Question 7: Please provide a copy of the "national educational resources" referenced in the Department's written statement that have been "shifted to clarify the importance of creasing multiple opportunities for disclosure [of MST]." What impact are these resources expected to have and how will such impact be tracked and measured?

VA Response: The MST Support Team's major training resources regarding screening have traditionally included statements such as: "The MST screen only needs to be completed once and is often done by primary care or other medical providers. However, it is good practice to include questions about MST in all mental health intakes as Veterans may be more open to disclosure when meeting with a mental health provider."

. Three new national education resources specific to the Clinical Reminder revision (attached) highlight that with the revised Clinical Reminder, Veterans will be re-assessed for experiences of MST if a Veteran declines the initial screening or if a Veteran has additional military experience following a prior 'no' to the MST Clinical Reminder. These and other existing resources on screening highlight the importance of assessing for MST, even after the Clinical Reminder has been completed. For example, slide 24 of the attached "staff training presentation" reminds providers that:

- Veterans may not feel comfortable disclosing their MST experience during the initial screening.
- Providing additional opportunities for disclosure is important and include:

  - Trauma assessment in mental health clinics as part of a clinician's standard assessment of social and military history.
  - Providers should be knowledgeable about MST and know how to contact the MST Coordinator.
  - Extensive outreach efforts help to ensure Veterans are aware of MST-related care and ways to access that care.
- A provider can alter the reminder response at a later date. For example, the reminder can be changed to 'MST Yes' if a Veteran responds 'no' initially then discloses an MST experience later in treatment.

These materials are intended for use by MST Coordinators in educating providers about the upcoming changes to the Clinical Reminder, as well for use in ongoing staff education, as a complement to existing materials that focus more on the clinical aspects of screening. To support MST Coordinators' training efforts, the MST Support Team's monthly Teleconference Training Series call in February focused on the revised Clinical Reminder; on that call, MST Coordinators were introduced to the Clinical Reminder revision training materials that the MST Support Team would make available and a demonstration was given of how the "staff training presentation" might be presented.

These resources, in conjunction with materials focusing on the clinical aspects of screening, are designed to increase provider knowledge, sensitivity, and skill in screening for experiences of MST and increase the frequency of additional assessment of MST experiences. The final impact of these educational resources is expected to be Veteran disclosure of an MST experience when and with whom they would like to disclose – either during initial completion of the MST Clinical Reminder, or through additional assessment at a later time. As noted in the response to Question #4, the completion of the MST Clinical Reminder and the MST disclosure rate are monitored in the MST Support Team's annual reports.

Question 8: Please provide information regarding the pilot program that Mr. Matkovsky, VA's Assistant Deputy Under Secretary for Health for Administrative Operations, stated the Department was undergoing in VISN 15 and VISN 23 to test an alternate procurement structure for certain high-cost medical equipment. Please include information regarding how the Department intends to measure the outcome of the pilot program.

VA Response: VA is transitioning to a new acquisition process for certain medical imaging modalities. Modalities including Portable X-Ray Units, Portable C-Arms, Ultrasound Systems, Bone Densitometers, and Computed Radiography equipment will be procured through a coordinated process that involves both the VHA Service Area Office (SAO) and VA National Acquisition Center (NAC) contracting offices. The VA NAC will delegate authority to VHA SAO to process delivery orders against base NAC contracts.

We are piloting this new process. The first pilot acquisitions were for VISN 15 in FY2013. Information about these acquisitions is below. This process is being used to acquire Bone Densitometers for VISN 23 in FY2014. This acquisition is in process, with contract award projected in July 2014.

Modality: Portable C-Arms
Quantity: 21

Awarded Price: $3,518,129
Negotiated value added Items (additional warranty, training, trade-in allowance) provided at no charge: $674, 614
Date Acquisition Process Initiated (start market research): June 17, 2013
Date Requirements Package submitted to VHA Contracting Office: July 5, 2013
Date Solicitation Issued: July 22, 2013
Date of Contract Award: September 24, 2013

Modality: Portable X-Ray Units (Digital)
Quantity: 26

Awarded Price: $3,125,375
Negotiated value added Items (additional warranty, training, trade-in allowance) provided at no charge: $872,875
Date Acquisition Process Initiated (start market research): June 3, 2013
Date Requirements Package submitted to VHA Contracting Office: July 5, 2013
Date Solicitation Issued: July 23, 2013
Date of Contract Award: September 23, 2013

We monitor these pilots closely to learn from the processes and outcomes. Considerations that we assess include, but are not limited to: award price versus standard NAC contract price; procurement cycle time; cycle time from identification of need to availability of equipment for patient care; feedback from both internal and external stakeholders.

Question 9: Is the Department still on track to complete the approximately 909 outstanding delivery orders from 2012 by the end of April 2014? If now, why not and when will the outstanding delivery order be filled?

VA Response: The Department is on track to complete approximately 900 delivery orders by the end of April 2014. Evaluation of vendor bids has been completed. Contracting Officers are processing delivery orders.

Question 10: Please describe how the Department intends to "...look at the consolidation process and change that as well." What changes are planned for

VA's current consolidate process and what is the Department's timeline for full implementation of the planned changes?

VA Response: The consolidation process that VA has used to acquire high tech medical imaging equipment is being modified. Some key changes include:

- Utilizing VHA SAO contracting offices to acquire selected (lower cost) imaging equipment;
- Utilizing generic specifications that define required characteristics, rather than using vendor quotes as benchmark requirements;
- Consolidating strategically aligned requirements by VISN, or small groups of VISNs;
- Enhancing communications by leveraging VISN points of contact and including executive leadership;
- Enhancing technical evaluation processes by incorporating Biomedical Engineers and medical staff, and providing them more robust training; and
- Initiating requisitions earlier in each fiscal year.

Many of these process changes have been implemented or partially implemented. Our goal is to continue transition toward these new processes through the balance of FY 2014 and through FY 2015.

Processes are further described below.

Procurement of Lower Cost Imaging Modalities
This grouping of equipment includes the following imaging equipment: portable x-ray machines, mobile C-arms, bone densitometers, Computed Radiography (CR) equipment, and ultrasound machines. Generally, this equipment costs less than $250,000 per unit.

If a VISN plans to procure equipment in one of the low cost modality equipment categories, then the equipment will be purchased by VHA SAO contracting (utilizing the VA NAC's national IDIQ (Indefinite Delivery, Indefinite Quantity) contracts) instead of the VA NAC contracting staff. This was piloted in FY 2013 by VISN 15 with positive outcomes, including a much quicker acquisition cycle and comparable pricing. VISNs that wish to participate in this type of procurement will identify requirements via specifications that describe salient characteristics, rather than citing a specific vendor product or equal. VISNs need to commit funding earlier in the fiscal year (typically by end of March) and the procurement will be completed by the September or the respective fiscal year.

Procurement of High Cost Modalities of Medical Equipment
This grouping of equipment includes (but not limited to) the following imaging modalities: magnetic resonance imaging (MRI) scanners, computed tomography (CT) scanners, PET/CT scanners, nuclear medicine cameras, radiography/fluoroscopy (R/F) rooms, general and digital radiographic equipment, interventional rooms (IR), and cardiac catheterization labs.

If a VISN requires a sufficiently large quantity of one or more of the high cost modalities, then the equipment may be procured by the VA NAC as its own consolidated procurement, separate from the needs of other VISNs/facilities. VISNs that wish to participate in this type of procurement will identify requirements via specifications that describe salient characteristics, rather than citing a specific vendor product or equal. Construction site preparation necessary to accommodate installation of these modalities will be aligned with equipment acquisition and delivery timelines.

Benefits to utilizing this procurement strategy include a shortened acquisition cycle time, comparable pricing, streamlined technical evaluation due to aggregating the same modalities for multiple locations into one procurement, efficiencies of scale, and reduced total cycle time from identification of the need to availability for patient care. This process has been conducted for the New Orleans facility and the Denver facility. It is being conducted in FY 2014 for VISN 22 requirements and VISN 23 requirements.

Enhanced Communications and Process Coordination
Communications regarding medical imaging equipment acquisitions have been streamlined and enhanced. VHA is funneling most communications through points of contacts in its VISN Offices, rather than having the VA NAC communicate directly with 151 individual medical facilities. VHA has more actively engaged Biomedical Engineering personnel to facilitate technical evaluations of the medical equipment with medical staff. Instructions and training have been, and will continue to be, enhanced to help all stakeholders better understand their roles in the acquisition process. Milestones and due dates are regularly communicated through executive leadership.

Internal processes have been evaluated and automated where feasible. For example, Non-Disclosure Agreements are now available on line and submitted electronically, thus expediting the procurement process. We will continue to identify opportunities to automate and streamline processes.

Question 11: Please describe the actions that have been taken in the last year to respond to veteran and stakeholder concerns regarding the negative impact of changes to VA's prosthetic procurement process.

VA Response: VA has not identified a negative impact to Veterans receiving prosthetic appliances and sensory aids, but there have been some delays in vendors receiving payments. To address this, VHA developed a dashboard that tracks the various phases of the procurement process. Weekly reviews are held with Prosthetics and Contracting Offices that have dashboard timelines that are outside the norm. On March 6, 2014, the VHA met with the Paralyzed Veterans of America to demonstrate the dashboard and provide assurance that Veterans would continue to receive timely delivery of prosthetic devices. In addition, VHA has issued VHA Directive 1081, *Procurement Process For Individual Prosthetic Appliances And Sensory Aids Devices Above the Micro-Purchase Threshold.* This VHA Directive defines the procedures for procuring prosthetic

appliances and sensory aids and defines the roles and responsibilities of acquisition team members.

Question 12: Please list the "incentive structures" in the Patient Centered Community Care (PC3) program that Mr. Matkovsky mentioned in response to questions regarding PC3 reimbursement rates.

VA Response: The language provided below was extracted from the PC3 contract and applies to monetary incentives/disincentives for the contracted networks.

Incentive Fee: Upon meeting the minimum performance threshold for all performance objectives, the contractor shall be eligible to receive a monetary incentive for the following Quality Assurance Surveillance Plan (QASP) objectives:

- 1a - Time from receipt of authorization to appointment completion – 30 days or less;
- 2 - Timeliness from completion of the authorized episode of care to return of clinical documentation; Medical documentation for authorized outpatient care submitted within 14 calendar days after completion of initial appointment. Medical documentation for authorized episode of inpatient care submitted within 30 business days after discharge.

- 3 - Timeliness of critical and urgent findings reporting;
(Urgent oral report transmitted to VA within 48 hours of finding. Documentation for critical findings on outpatient imaging or lab testing transmitted to VA by phone within 24 hours of completion of test/evaluation/treatment. Urgent written report transmitted to VA within 48 hours of finding. New diagnosis of cancer reported to VA within 48 hours. Notification within 24 hours if Veteran requires urgent follow-up or additional care during authorized episode of care); and,
- 4 - Network adequacy to enable access. (Urban within 60 minutes of commute time; Rural within 120 minutes of commute time; Highly rural within 240 minutes commute time. When a higher level of care is needed, which is specialized consultative health care, usually for inpatients and in a facility that has personnel and facilities for advanced medical investigation and treatment, such as tertiary referral hospital, e.g. cancer management, neurosurgery, cardiac surgery, plastic surgery, treatment for severe burns, advanced neonatology services, palliative, and other complex medical and surgical interventions: Urban within 120 minutes of commute time; Rural within 240 minutes of commute time; Highly rural within community standard commute time).

If the contract fails to meet these objectives, a monetary disincentive applies. Please note no incentive or disincentive will be applicable from September 2013-April 2014 - implementation period.

The contractors' administrative fee shall be increased (incentive) or decreased (disincentive) by a maximum of three percent of Administrative Services Fee based on

the previous 3-month performance and a weighted average of QASP performance objectives 1a, 2, 3, and 4. The performance objectives shall be weighted as follows:

- Performance Objective 1a at 25 percent
- Performance Objective 2 at 25 percent
- Performance Objective 3 at 35 percent
- Performance Objective 4 at 15 percent

Payments or deductions shall apply to the total amount of completed authorizations and shall be applied according to the methodology below.

Weighted average of QASP Performance Objectives 1a, 2, and 3 for all years and objective 4 beginning in option year 1:

- 3 percent increase for performance greater than or equal to 97.5 percent
- 2 percent increase for performance greater than or equal to 95 percent and less than 97.5 percent
- 1 percent increase for performance greater than or equal to 92.5 percent and less than 95 percent
- No incentive or disincentive for performance greater than 87.5 percent and less than 92.5 percent
- 1 percent decrease for performance greater than 85 percent and less than or equal to 87.5 percent
- 2 percent decrease for performance greater than 82.5 percent and less than or equal to 85 percent
- 3 percent decrease for performance less than or equal to 82.5 percent

QASP Performance Objective 1b (Time from receipt of authorization to appointment completion – 21 days or less) is an enhanced performance objective to encourage contractors to exceed the appointment scheduling standard of 30 calendar days for performance objective 1a (time from receipt of authorization to appointment completion).
In addition to the structure above, and related to Performance Objective 1a, the Contractors' administrative fee shall be increased by one percent (for a maximum possible incentive of four percent in combination with the incentive above) of Administrative Services Fee based on the previous three month performance when meeting the enhanced performance standard for appointment completion as defined.

Question 13: What impact does the Department estimate full implementation of PC3 will have on VA's third-party collections?

VA Response: The full impact of Patient-Centered Community Care (PC3) implementation on third party collections is yet to be seen as the networks are becoming fully operational. Realization of revenue opportunities will depend upon the number of Veterans seeking care for non-service connected conditions who have

billable third party insurance and the treatment is covered under those third party policies.

Based on the revised current cost information available, VA estimates a $14.5 million potential annual impact to revenue based on the following expected impacts of PC3:

- *Increased efficiency of billing timeframes* – As the networks bill VA on a more-timely basis, and the claims are in turn paid more timely, days to bill for Non-VA Care (NVC) should be reduced. This increase in efficiency should lead to realizing collections quicker than in the previous model.
- *Improved revenue* – PC3 is expected to result in increased third party revenue opportunities due to improvements in the scheduling process and reduction in denials related to timely filing. Specifically, patients will be scheduled within 5 days of the referral, and appointment information will be provided to VA medical centers (VAMC) and entered into the scheduling package. This will facilitate Consolidated Patient Account Center (CPAC) precertification efforts, documentation and timely claims submission.

    - The revenue estimate assumes NVC collections per billing ratio (FYTD14 is 40 percent) to improve and align with VA collections to billing ratio which is currently 41 percent.

A	B	C=A*B
Expected Billings ($) from Reduced Days to Bill	FYTD 2014 VA Third Party Collection to Billing Ratio	Estimated Potential Revenue Impact
$35,374,005	41 percent	$14,503,342

VA continues to monitor the NVC process through the full implementation of PC3 to ensure all the efficiencies are realized.

Question 14: Please provide an update on the request for information (RFI) that the Department released to "...identify commercial best practices for automation of health care billing systems..." What response has the Department received to the RFI and how and when does the Department intend to incorporate those best practices into VA's third-party collections processes?

VA Response: VHA Chief Business Office released a Sources Sought notification (solicitation number VA118-14-I-0166) to the public on March 11, 2014. The purpose of the Sources Sought notification was to request information from qualified contractors regarding the development, configuration and implementation of an Automated Billing System (ABS). Along with general company information, the contractors were asked to provide two important pieces of information: 1) a technical capability statement containing a summarized technical approach for implementing a system within VHA;

and 2) a Rough Order of Magnitude (ROM) estimate regarding expected implementation costs.

Responses to the Source Sought notification were due on March 27, 2014. VHA received 11 vendor responses to the solicitation and these responses are still under review by the VHA's Chief Business Office. We expect to use information gathered from the vendor responses for several purposes. First, we will review details of the technical approaches focusing on innovation and commercial best practices conveyed in the responses. All relevant and useful information gleaned from this review will be integrated into CBO's requirements documentation to ensure our planned procurement is based on industry best practices and state-of-the-art functionality. Second, we will analyze the proposed vendor technical approaches in the context of their respective ROM estimates to improve our understating of the planned work breakdown structure and to develop a more accurate Independent Government Cost Estimate (IGCE). Finally, we will work with responding vendors to arrange product demonstrations. This will allow the CBO technical team to observe the vendor solutions first-hand and will allow us to further refine the quality and accuracy of our technical requirements for the planned ABS procurement.

Question 15: Please list and briefly describe each of the "many tools" that Dr. Agarwal, VA's Deputy Under Secretary for Health for Policy and Services, testified had been developed to, "...assist the local facilities in managing specialty [care] resources appropriately." Please also describe how the Department intends to track the implementation and utilization of these tools and measure the impact they have on veteran access to specialty care services.

VA Response: Policy guidance has been provided by the Deputy Undersecretary for Operations and Management (DUSHOM) to the VAMC leadership via Memoranda dated June 26, 2013, and December 16, 2013. These include pathways for review of labor mapping (physicians and support staff), algorithms for interpreting and acting on workload and productivity data, and standards to review productivity in individual specialty group practices with guidelines on acceptable range for productivity by particular specialty based on facility complexity. The Office of Productivity, Efficiency, and Staffing (OPES) is the repository of much of the data for facility use, and has additional guides on analysis. Based on the DUSHOM guidance, those group specialty practices that require action plans be generated by the service/facility are then forwarded to the facility's Veterans Integrated Service Network (VISN) for review. The OPES database allows for longitudinal tracking of the success of services/facility's action plans and this database examines both productivity and access to the group specialty practices at all facilities.

The following reports/databases serve as the key reports available to facilities to assist in managing their Specialty Practices:

Physician Productivity Cube:
The Specialty Physician Productivity Cube (database) contains all VA physicians. The physician workforce accounts for nearly 10 percent of the VHA budget, representing a

significant healthcare resource and resource driver. The Physician Productivity cube contains coded (Current Procedure Terminology (CPT)) detailed information on the professional services delivered by our physician workforce to our Veteran patients at all VA sites. The physician productivity cube assesses the deployment of the physician staff to the missions of clinical care, research, and education as well as administrative responsibilities. It provides an assessment of the distribution of the physician workforce by geography and specialty as well as productivity measurement (Centers for Medicare and Medicaid Services (CMS) work Relative Value Unit (wRVU)/Direct Clinical Full Time Equivalent (FTE)).

Specialty Productivity-Access Report and Quadrant tool (SPARQ):
The Specialty Practice Management Quadrant Tool provides an algorithm for the effective management of VHA's specialty physician staffing and productivity practices. The tool is designed to drive performance improvement in Veteran access to specialty care and effective use of available resources. The SPARQ tool includes measures of: Specialty Specific Non-VA Care expenditures and VA Reliance, Measures of value that include compensation per RVU for total physician salary as well as clinical components, availability of support staff etc. The tool expands into measures of the care team bringing in Advanced Practice Provider (APP=Nurse Practitioners, Physician Assistants, Clinical Nurse Specialists) workload (RVUs). The tool has additional views for local leadership (Chief of Staff, Director, Service Chiefs) included that permit a view of all specialties so that local managers can effectively manage their specialty practice resources.

Specialty Physician Productivity Report:
The report provides detailed productivity by specialty and practice setting (facility complexity level) to be used as benchmarks and may also be used for identification of best practices. This report trends the changes in productivity levels over the previous 5 years and is updated monthly.

Specialty Workforce Report:
The annual Specialty Workforce Report is available to all VHA that provides key information on the specialty physician workforce and is analogous to external benchmarking reports such as Medical Group Management Association (MGMA) and University Health Consortium (UHC) data. Specialty Physician Workforce Reports provide: productivity, per population staffing levels, Associate Provider Staffing, and support staff ratios for sites to effectively manage physician practices.

Productivity Standards and Outlier Report: This report contains observed Specialty Practice productivity levels and identifies sites that are outside of productivity expectations established and communicated to all VHA sites by the DUSHOM. Sites that have been identified as being out of range are required to implement remediation plans.

Question 16: Please provide information regarding the "comprehensive education and communication plan" that is currently underway regarding specialty physician productivity and staffing standards.

VA Response: As part of the Specialty Physician Productivity and Staffing work VHA developed and implemented a comprehensive communication plan. VHA's Office of Productivity, Efficiency and Staffing maintains a VA Intranet site that serves as the main portal of communication and reporting of activities related to Physician Productivity and Staffing. This portal and the reports located at this site are monitored for web hits. For the time period FY 2013 – February 2014 there were 27,268 hits on Physician Productivity Products and Reports. VHA's Office of Productivity, Efficiency and Staffing conducts routine training for managers each Thursday afternoon, and all VISNs and facilities have been provided training on the Physician Productivity Cube.

The DUSHOM has hosted a number of conferences (with VISN Chief Medical Officers and a number of Quality Manager Officers) to review and educate them on the various responsibilities of facilities and VISNs. The Office of the Deputy Under Secretary for Policy and Services held two conferences in August, 2013 which facility Chiefs of Staff attended and which included education as to the implementation of the DUSHOM Memorandum. The Office of the Deputy Under Secretary for Policy and Services, Patient Care Services, has also had a meeting of all Specialty Services National Program Directors, September 2013, which included education and discussion of productivity. Patient Care Services has also had telephone meetings with the Chief of Medicine Field Advisory Committee. The VISN Taskforce which piloted much of this work on productivity has hosted calls with medical and surgical subspecialty service leaders throughout VHA on a regular basis, to educate and gain feedback from the field on the implementation of the DUSHOM Memorandum.

Additionally, the following list provides details of tailored educational sessions that have been provided to these focused groups:

Session:	**Target Audience**
Friday National Hotline X2	Medical Center Executive Leadership
National Open Forum Calls X5	Medical Center Leadership and Providers
CMO/QMO Calls and F-2-F Meetings	VISN Clinical Leadership
Nephrology Field Advisory Committee	Specialty Leadership
Gastroenterology Field Advisory Committee	Specialty Leadership
Orthopedics Field Advisory Committee	Specialty Leadership

Ophthalmology Field Advisory Committee	Specialty Leadership
Urology Field Advisory Committee	Specialty Leadership
Gynecology Field Advisory Committee	Specialty Leadership
Hospitalists Field Advisory Committee	Specialty Leadership
Laboratory and Pathology Workgroup	Specialty Leadership
Anesthesia Field Advisory Committee	Specialty Leadership
Chiefs of Medicine Field Advisory Committee	Specialty Leadership
VISN 1 Chief of Surgery Group	Specialty Leadership
VISN 3 Chief of Surgery Group	Specialty Leadership
VISN 7 Chief of Surgery Group	Specialty Leadership
Systems Redesign Specialty Care Collaborative	Medical Center Leadership and Providers
Local Training on Physician Productivity Cube & SPARQ Tool	Every Thursday by VISN/Medical Center Appointment
Optometry Field Advisory Workgroup	Specialty Leadership
Chiropractic Field Advisory Workgroup	Specialty Leadership
Podiatry Field Advisory Workgroup	Specialty Leadership

Question 17: VHA Directive 2009-053, which provides pain management policy and implementation procedures, is scheduled to expire on October 31, 2014. Please describe the Department's efforts to-date to prepare to update and reissue this directive and list any and all proposed policy or implementation changes that have been proposed.

VA Response: The Department intends to update and reissue Directive 2009-053, *Pain Management*. The National Director for Pain and the Deputy National Director for Pain (Specialty Care Services, Patient Care Services), in collaboration with other experts and offices, are responsible for updating the directive. Specifically, the updated directive will address the following:

1) Implementation of the Opioid Safety Initiative including strategies for training and monitoring of outcomes. (see below)

2) Development of and implementation/dissemination of VHA projects to provide pain management training to its teams of clinicians so that facilities and VISN achieve competency in Stepped Pain Care, as outlined in Directive 2009-053, including all ambulatory settings: in primary care, pain specialty care and pain rehabilitation, including:
    a. The DoD-VA Health Executive Council (HEC) Pain Management Work Group's Joint Investment Fund projects:
        i. The Joint Pain Education and Training Project (JPEP), a "train the trainers" project which is developing a standardized curriculum and training program for pain champions and team who will serve as JPEP Faculty in their roles as teachers of interdisciplinary students, residents, and fellows and clinical staff in all VHA facilities.
        ii. The Tiered Acupuncture Training Across Clinical Settings (ATACS), which is presently identifying and training medical acupuncturists across the VA and DoD who are being trained to teach Battlefield acupuncture to primary care team members throughout the health system.
    b. VHAs Specialty Care Access Network-Extension for Community Healthcare Outcomes (SCAN-ECHO) pain management training program that provides pain management training of primary care providers in rural or relatively inaccessible settings through an "Academic Detailing" model employing a curriculum and longitudinal supervision of clinical cases such as now occurs in residency training programs.
    c. Further development of the Pain Management Mini-Residency program which has been designed, approved and will provide its first training this spring. This program provides:
        i. A course of on-line pain management instruction in the conceptual and knowledge foundation of pain management, followed by;
        ii. An intensive, clinical skill-building in person instructional experience that trains physicians to competencies such as regional pain examinations and office procedures, followed by;
        iii. Longitudinal instruction though virtual networks such as SCAN-ECHO and primary care pain champion conferences.

3) Further clinical studies to establish evidence-based therapies in Integrative Medicine (and behavioral treatment.

4) Development and testing of an efficient, patient-centered, point-of-care, interactive pain assessment system, such as the Pain Assessment Screening Tool and Outcomes Registry, Patient Reported Outcomes Measurement Information System (PASTOR-PROMIS) with the following capabilities:
    a. Provides real-time clinical data pain for decision-support in pain management
    b. Serves to populate a data registry to facilitate the standardization of goal-oriented measurement-based biopsychosocial stepped pain management throughout VHA.

5) Development of the Chronic Care Model project with the Office of Primary Care that includes the following six elements:

Chronic Care Model	
Six Pillars	**Critical Aspects**
Health System	Visible support from all levels of the organization, promote effective improvement strategies aimed at comprehensive systems of change, encourage open and systematic improvement of care, develop care coordination agreements.
Redesign of the Delivery System	Define roles and distribute tasks among team members, use planned interactions to support evidence-based care, provide clinical management services for complex patients, guarantee regular follow-up by the care team.
Use of Decision Support	Embed evidence based guidelines into daily clinical practice to integrate specialist expertise with primary care. These guidelines are shared with patients to encourage participation.
Use of Clinical Information Systems	Provide timely reminders for providers and patients, identify relevant subpopulations for proactive care, faciliate individual patient care planning and share information with patients and providers to coordinate care.
Education and Self Management Skills	Emphasize the patient's central role in managing their care and use effective self management support strategies that include assessment, goal setting, action planning, problem solving and followup.
Access to Community Resources	Encourage patients to participate in effective community programs. For example, a patient may benefit from joining a community based support group to promote self-help strategies.

Question 18: Please describe the role of the Opioid Safety Initiative within VA's existing pain management programs and provide information regarding how the Department intends to measure and track the Initiative's implementation, utilization, and impact.

VA Response: VA recently developed and implemented an Opioid Safety Initiative (OSI) program to ensure opioid pain medications are used safely, effectively and judiciously. The basis for this is to make visible the totality of opioid use at all levels, patient, provider and facility, in order to identify high-risk situations. The OSI includes key clinical indicators such as the number of unique pharmacy patients dispensed an opioid, unique patients on long-term opioids who receive a urine drug screen, the number of patients receiving an opioid and a benzodiazepine (which puts them at a higher risk of adverse events) and the average dosage per day of opioids such as hydromorphone, methadone, morphine, oxycodone, and oxymorphone. Patients at risk for adverse events from use of opioids are identified through the use of administrative and clinical databases using pre-determined parameters based on published evidence

and expert opinion. Several aspects to measure the implementation of the Opioid Safety Initiative upon opioid use were underway at the time of the October 10, 2013, hearing and suggested positive impacts:

- Despite an increase in the number of Veterans who were dispensed any medication from a VA pharmacy, (i.e., all pharmacy users) in October 2012 compared to November 2013, 39,088 fewer Veterans received an opioid prescription from VA during that time period.
- Performing urine drug screens is a useful tool to assist in the clinical management of patients receiving long-term opioid therapy. As of November 2013, urine drug screens were performed on 80,294 more patients than in October 2012.
- Whenever clinically feasible, the concomitant use of opioid and benzodiazepine medications should be avoided. In November 2013, 9,609 fewer patients were receiving these drugs at the same time than in October 2012.
- Lastly, the average dose of selected opioids has begun to decline slightly in VA, demonstrating that prescribing and consumption behaviors are changing.

While these changes may appear to be modest given the size of the VA patient population, they signal an important trend in VA's use of opioids. VA expects this trend to continue as it renews its efforts to promote safe and effective pharmacologic and non-pharmacologic pain management therapies. Very effective programs at several VA facilities yielding significant results have been identified (e.g., Minneapolis, Tampa, and Columbus), and are being studied as best practice leaders.

Question 19: Please describe that actions, if any, that the Department has taken to ensure that pain management points of contact (POCs) within VA medical facilities regularly communicate with pain management specialists, as appropriate, about Veteran patients experiencing acute or chronic pain. Please include any and all guidance that has been sent to the field regarding the referral process from pain management POCs to pain management specialists.

VA Response: Points of contact for Pain Management have been identified at all VA Medical Centers to receive information from VACO offices pertinent to pain. The role of the Pain POCs, at the VISN and at the facility level, is primarily to coordinate efforts in regard to pain management from an administrative side. The Pain POCs are expected to work closely with the Pain Specialists at each facility within the facility Pain Management Committee. However, Pain POCs are not the point of contact for clinical issues regarding individual patients. For Veterans, the POC for their individual pain needs clinically, in regard to evaluation and treatment, is their primary care provider within the Patient Aligned Care Teams (PACT), as necessary, in collaboration with the pain medicine specialty team at the facility. Thus the POCs are not expected to regularly communicate with the clinical providers including pain specialists about specific Veteran patients experiencing acute or chronic pain, in regard to their clinical

management. They may assist, as appropriate, within their administrative capacities. A referral process from pain management POCs (administrative function) to Pain Specialists (clinical function) is not appropriate. A general approach, titled Implementation of the Opioid Safety Initiative (OSI), was forwarded to all POCs. (See attachment).

Implementation of
Opiod Safety Initiativ

Question 20: During the Subcommittee's October 10, 2013, oversight hearing entitled, "Between Peril and Promise: Facing the Dangers of VA's Skyrocketing Use of Prescription Painkillers to Treat Veterans," a VA witness testified about a VA-wide best practice in pain management called the "Chronic Pain Rehabilitation Program." Please describe what efforts, if any, VA has taken to implement related or similar programs in other VA medical centers and clinics.

VA Response: The Under Secretary for Health chartered an Interdisciplinary Pain Management Center Work Group to provide guidance and oversight for VHA's efforts to develop VISN level tertiary care Pain Management Centers. These Centers have the capacity for providing advanced pain medicine diagnostics, surgical and interventional procedures, and in addition provide intensive, integrated chronic pain rehabilitation for Veterans with complex, co-morbid, or treatment refractory conditions.

There are currently ten Commissions for the Accreditation of Healthcare Facilities (CARF)-accredited pain rehabilitation centers in VHA. This includes one Center at the James Haley Veterans Hospital in Tampa, Florida, that is one of only two multidisciplinary pain management centers that has been twice recognized by the American Pain Society as a Clinical Center of Excellence (the other being a program at Stanford University). VHA is in process of greatly expanding access to such Chronic Pain Rehabilitation Centers. Each VISN is expected to have at least one CARF-accredited tertiary, interdisciplinary pain care program no later than September 30, 2014. Some VISNs may have two or more such programs. In addition, there is system-wide education effort ongoing to educate physicians in Primary Care (PACT) and other providers taking care of Veterans with chronic pain conditions about Chronic Pain Rehabilitation approaches and to include components of Chronic Pain Rehabilitation approaches into Primary Care.

Questions 21: Please describe the six ongoing pilot programs that are in place to test the Departments initiative regarding state prescription drug monitoring programs, to include information regarding how VA intends to measure the outcome of the pilot programs. Please also elaborate on the Information Technology "limitations" that were referenced in regard to the pilot programs.

VA Response: VA currently has five test sites that send Veterans' prescription data to state prescription drug monitoring programs on a daily basis. The test sites are located at the following VAMCs: Fayetteville, Arkansas; Muskogee and Oklahoma City, Oklahoma; Durham, North Carolina; Louisville, Kentucky; and Nashville/Murfreesboro, Tennessee.

VA intends to measure the success of the pilot programs by determining the extent to which state prescription drug monitoring programs are able to receive Veterans' prescription drug information. As of March 31, 2014, VA has experienced a successful prescription transfer rate of 100 percent (i.e., 100 percent of the prescription data that is being sent from VA is being received by the state drug monitoring programs at the test sites). If this rate of success continues through the duration of the testing period, VA could release the software nationwide as early as August 2014.

VA's solution is limited to the use of secure File Transfer Protocol (sFTP) and the American Society for Automation in Pharmacy (ASAP) message structure. The use of sFTP is to ensure data transmission is secure between the VA and recipient state. The detail of the ASAP message structure will contain the Patient ID, Patient Name, Address, Date of Birth, Phone Number and Prescription Data. This collected data coming from the VA and other sources is aggregated and access to the data is then controlled by the states via registration to query the state database. This solution is supported by 45 states.

Question 22: Please describe the actions, if any, that have been taken to make the VA formulary more consistent with the DoD formulary.

VA Response: VA and DoD are continuing to work through this issue, and we will follow with this answer in a separate correspondence.

Questions for the Record from Congressman Keith Rothfus

Question 1: On September 9, 2013, you testified at a field hearing in Pittsburgh that VA would delay taking any administrative disciplinary action relating to the systemic failures and mismanagement at the VA Pittsburgh Healthcare System (VAPHS) that resulted in the deaths of at least six veterans due to an outbreak of legionella until the U.S. Justice Department concluded its criminal investigation. Then, on November 21, 2013, the Justice Department announced that it had concluded that investigation and that no criminal charges would be brought. It has now been over three months since that announcement, and the VA has yet to hold anyone at VAPHS accountable. Accordingly, please provide a detailed explanation of what VA has done internally to investigate those responsible for these preventable deaths, what VA has left to be done to conclude that investigation, and a date certain by which the families of the victims and Members of Congress can expect that the VA will take such administrative disciplinary action.

VA Response: VHA Labor Relations/Employee Relations (LR/ER) provides advice and guidance concerning conduct and performance issues that involve VHA senior managers:

- Senior managers include all VHA Senior Executive Service (SES) appointments, Title 38 equivalents and all 38 U.S.C. § 7306 appointees, Associate/Assistant Medical Center Directors, facility Chiefs of Staff and Associate Directors for Patient Care Services/Nurse Executives.
- The LR/ER group also provides this assistance for any GS-15 position or above, or Title 38 equivalent in VA Central Office (VACO) or with direct reporting alignment to VACO.
- VA conducted an organizational assessment of the VA Pittsburgh Healthcare System (VAPHS). The assessment team was asked to review management and oversight controls employed by the VAPHS and VISN 4 surrounding Legionella issues from 2011 to present. The assessment was completed on November 20, 2013.
- Proposed disciplinary actions ranging from reprimands to suspensions have been issued. Final decisions regarding these actions are anticipated very soon. Each employee against whom action is taken has appeal rights, which, if exercised, may modify the final decision. Congressman Rothfus' office will be updated upon final resolution of these matters.

Question 2: On November 26, 2013, following the conclusion of the Justice Department's investigation into the legionella outbreak at VAPHS, Senator Pat Toomey and I sent a letter to Secretary Eric Shinseki requesting information about what administrative disciplinary action the VA planned to take, if any. To date, though, over three months later, neither Senator Toomey nor I have received any response. Can you please explain why the Secretary's office found it acceptable to not send any response to our inquiry? Is this indicative of how VA and the Secretary's office views Congressional inquiries and oversight generally?

VA Response: VA Pittsburgh Healthcare System has extended its condolences to the families of the Veterans with Legionella who died. VA is dedicated to doing whatever it takes to minimize the risk of Legionella and create the safest environment possible for our Nation's Veterans to heal. With the investigation by the U.S. Attorney and VA Office of Inspector General completed, the Veterans Health Administration (VHA) initiated administrative actions related to the outbreak. As is customary, the administrative review was initially paused to avoid interfering with the ongoing investigations. VHA leadership has now initiated actions with careful consideration of the statutory protections and rights of employees, including due process. We are focused on completing this process in a timely manner, consistent with applicable administrative guidelines. When this process is fully complete, VA will provide an update to the Committee. Again, VA is committed to providing the best quality, safe, and effective

health care our Veterans have earned and deserve and extend our condolences to the families of the Veterans with Legionella who died.

Question 3: During the hearing on February 26, 2014, you stated that only one death resulted from the legionella outbreak at VAPHS. Yet, the Centers for Disease Control and Prevention (CDC) found in its investigation that at least 21 veterans were sickened as a result of the outbreak, five of whom died. Moreover, since the CDC released its report, a sixth veteran death has been connected to the outbreak as well. Accordingly, please provide a detailed explanation why VA has concluded, despite the findings of the CDC that only one death resulted from the outbreak of legionella at VAPHS.

VA Response:

VA clarified the erroneous statement in a letter sent to the House Committee on Veterans Affairs, Health Subcommittee, on March 13, 2014. This letter made clear that I made an error when I stated the date of death of one of the patients occurred on July 12, 2012, at the VA Pittsburgh Healthcare System. The date of death was July 4, 2012. Further, of the six deaths discussed at the hearing, VHA is in possession of five death certificates. In the case of the sixth death, the Veteran passed away at a community hospital, and VHA does not currently possess the death certificate. As previously reported, one death was attributed to Legionella pneumonia as the primary cause of death. I based my testimony on the immediate cause of death. However, there was a second patient who had a contributing cause of death listed as Legionella pneumonia on the death certificate, but it was not the primary cause of death. VA extends its condolences to the families of the Veterans affected by acquiring Legionella in our health care system. We are committed to doing whatever it takes to minimize the risk of Legionella and create the safest environment possible for our Nation's Veterans to heal.

Implementation of the Opioid Safety Initiative (OSI)

Veterans Integrated Service Network (VISN) Director Responsibilities VHA Pain Management Directive 2009-053	Date Completed
☐ Implementation of the VHA Pain Management Strategy at the VISN and facility level is evaluated according to performance measures established by the National Pain Management Program Office ☐ Stepped Care Pain Management Model ▪ Step One, Primary Care • Primary care workforce (including behavioral health) • Utilize interdisciplinary teams, supported by primary care Pain Champions, to manage common pain conditions. Relies on system supports, family and patient education programs, collaboration with integrative mental health-primary care teams, and post-deployment programs ▪ Step Two, Secondary Consultation (timely access, defined by urgency of clinical need) • Pain medicine teams • Physical medicine and rehabilitation • Polytrauma programs and teams • Pain psychology • Inpatient pain medicine • Collaboration of pain and palliative care ▪ Step Three, Tertiary, Interdisciplinary Care • Access to VISN and/or facility: o Advanced pain medicine diagnostics and interventions o Commission on Accreditation of Rehabilitation Facilities (CARF) pain rehabilitation programs ☐ Integrated Care/CAM is available or considered as an alternative to chronic opioid monotherapy for routine pain management such as, but not limited to, acupuncture	
VISN OSI Points of Contact (POC)	
☐ Appoint the VISN Chief Medical Officer or designee NOTE: The OSI POC may or may not be the VISN Pain POC as identified in VHA Directive 2009-053 ☐ Appoint at least one licensed prescribing physician from each facility in	

the VISN ☐ Establish a process at the VISN to ensure all POCs have submitted the required data access request forms to gain access to the OSI dashboard ☐ Establish a process at the VISN to review and communicate changes in the POCs to the "VHAPBH PBM BI Question" e-mail group on a quarterly basis. ☐ Develop a plan to transfer the responsibilities of the OSI POC to the VISN Pain POC when the OSI is successfully deployed throughout the VISN. ☐ VISN and Facility POCs have been provided and encouraged to access the link below for Opioid Safety Initiative educational/training materials. https://vaww.cmopnational.va.gov/cmop/PBM/Opioid%20Safety%20Initiative/Forms/AllItems.aspx	
VISN OSI Committees/Reports	
☐ Establish a VISN committee that consists of, but is not limited to, the following individuals: VISN OSI POC, Facility POCs, QMO and a Pain Subject Matter Expert. NOTE: Once the OSI is successfully deployed throughout the VISN, the VISN Pain POC shall chair the OSI committee ☐ Frequency of meetings: At least quarterly ☐ Develop an OSI implementation plan to include measureable goals that focus on: ☐ The OSI dashboard reports • Average dose/day for select opioids • Opioid Utilization over Time • Concomitant use of opioids and benzodiazepines • Patients on Long-Term Opioids who have completed Urine Drug Screens • Education on pain management ☐ Quarterly trend reports from the OSI dashboard will be incorporated into the Network Directors performance evaluation with the DUSHOM ☐ This OSI trend report shall be incorporated into the annual VISN Director's report to DUSHOM on the implementation of the VHA Pain Management Strategy	

Facility Director's Responsibilities VHA Pain Management Directive 2009-053	Date Completed
☐ Implementation of the VHA Pain Management Strategy at the facility level is evaluated according to performance measures established by the National Pain Management Program Office ☐ Stepped Care Pain Management Model	

▪ Step One, Primary Care • Primary care workforce (including behavioral health) • Utilize interdisciplinary teams to manage common pain conditions and relies on system supports, family and patient education programs, collaboration with integrative mental health-primary care teams, and post-deployment programs ▪ Step Two, Secondary Consultation (timely access, defined by urgency of clinical need) • Pain medicine teams • Physical medicine and rehabilitation • Polytrauma programs and teams • Pain psychology • Inpatient pain medicine • Collaboration of pain and palliative care ▪ Step Three, Tertiary, Interdisciplinary Care • Advanced pain medicine diagnostics and interventions—referral or treatment, depending on facility ☐ Integrated Care/CAM is available or considered to chronic opioid monotherapy for routine pain management, such as, but not limited to, acupuncture	
Facility OSI Points of Contact	
☐ Recommend at least one licensed prescribing physician ☐ Ensure all POCs have submitted the required data access request forms to gain access to the OSI dashboard ☐ Establish a process at the facility to review and communicate changes in the POCs to the VISN POC ☐ VISN and Facility POCs have been provided and encouraged to access the link below for Opioid Safety Initiative educational/training materials. https://vaww.cmopnational.va.gov/cmop/PBM/Opioid%20Safety%20Initiative/Forms/AllItems.aspx	
Facility OSI Committees/Reports	
☐ Establish a facility committee that consists of, but is not limited to the following individuals: Facility POCs, Pain Subject matter Experts, Primary Care, Mental Health, Pharmacy, Nursing, Patient Advocate. ☐ Frequency of meetings: At least monthly ☐ Develop an OSI implementation plan to include measureable goals that focus on: ☐ The OSI dashboard reports • Average dose/day for select opioids	

• Opioid Utilization over Time • Concomitant use of opioids and benzodiazepines • Patients on Long-Term Opioids who have completed Urine Drug Screens • Education on pain management ☐ The committee shall provide quarterly trend reports to the facility Chief of Staff on the OSI dashboard report parameters described above ☐ This OSI trend report shall be included into the annual Facility Director's report to the VISN on the implementation of the VHA Pain Management Strategy	

LETTER FROM ROBERT A. PETZEL TO HON. DAN BENISHEK

March 13, 2014
The Honorable Dan Benishek Chairman
Subcommittee on Health Committee on Veterans' Affairs
U.S. House of Representatives Washington, DC 20515

Dear Mr. Chairman:

I have reviewed the February 26, 2014, Committee on Veterans' Affairs, Subcommittee on Health hearing's unofficial transcript. I am writing to clarify responses I gave to questions during the hearing.

First, let me state again that the Department of Veterans Affairs (VA) cares deeply for every Veteran we serve. Our goal is to provide the best quality, safe and effective health care our Veterans have earned and deserve. We take seriously any issue that occurs at any one of the more than 1,700 VA health care points of care across the country.

I would like to clarify that I made an error when I stated the date of death of one of the patients occurred on July 12, 2012, at the VA Pittsburgh Healthcare System. The date of death was July 4, 2012. Further, of the six deaths discussed at the hearing, the Veterans Health Administration (VHA) is in possession of five death certificates. In the case of the sixth death, the Veteran passed away at a community hospital and VHA does not currently possess the death certificate. As previously reported, one death was attributed to Legionella pneumonia as the primary cause of death. I based my testimony on the immediate cause of death. However, there was a second patient who had a contributing cause of death listed as Legionella pneumonia on the death certificate, but it was not the primary cause of death. VA extends its condolences to the families of the Veterans affected by acquiring Legionella in our healthcare system.

We are committed to doing whatever it takes to minimize the risk of Legionella and create the safest environment possible for our nation's Veterans to heal.

Additionally, I would like to clarify a response I gave to a question on three deaths in Atlanta and the Office of the Inspector General (OIG) findings. There were two OIG reports on Atlanta, both published on April 17, 2013. The report titled "Patient Care Issues and Contract Mental Program Mismanagement Atlanta VA Medical Center Decatur, Georgia" (Report 12–02955–178) addresses two deaths that occurred under contract care; a report titled "Mismanagement of Inpatient Mental Health Care Atlanta VA Medical Center Decatur, Georgia" (Report 12–03869–179) addresses one death that occurred at the Atlanta VAMC. When I responded to the question regarding "three deaths" I was referring to deaths mentioned in Report 12–02955–178, not the death at the Atlanta VAMC Inpatient Mental Health Unit. It was my intent to say that the OIG report numbered 12–03869–179 did state that the staff's failure to watch patients may The Honorable Dan Benishek have contributed to the patient's death on the Atlanta VAMC Inpatient Mental Health Unit. VHA recognizes the significance of the tragic events that occurred in Atlanta and has taken action there to improve mental health services for Veterans. VHA's first priority is the delivery of high quality care to our Nation's Veterans including access to quality mental health care.

I request that this letter be made an official part of the record. Thank you for your assistance.

Sincerely,

Julia Brownley,
Ranking Member

DELIVERABLES

Context of Inquiry: On February 26, 2014. Dr. Robert Petzel, Dr. Robert Jesse, Dr. Rajiv Jain, Dr. Madhulika Agarwal and Mr. Phillip Matkovsky testified before the HVAC–Health committee at a hearing titled: "VA Accountability: Assessing Actions Taken in Response to Subcommittee Oversight". There were seven deliverables from the hearing.

Question 1: Please provide the complete list of specialty care services that have not yet implemented productivity standards.

Response: Specialties scheduled for implementation during the 3rd and 4th quarters this year:

- Cardiology

- Pulmonary/Critical Care
- General Surgery
- Physical Medicine and Rehab
- Anesthesiology
- Emergency Medicine
- Laboratory/Pathology
- Geriatrics

Question 2: Please provide an examination of the need for and potential incorporation of whistleblower protections for Veterans reporting military sexual trauma.

Response: As noted by Committee Member Kuster, the Department of Defense is currently reforming policies regarding Servicemembers' protection against retaliation after reporting experiences of military sexual assault. VHA cannot conceive of a scenario where a parallel set of policies in VHA would be necessary.

- Disclosures of MST to a VA staff member would be considered protected health information and thus subject to the provisions of the Health Insurance Portability and Accountability Act (HIPAA). Penalties for unauthorized use of medical record information are already covered under HIPAA and do not need to be duplicated by VA MST-specific whistleblower protections.
- VA does provide care for some active duty Servicemembers or Reservists who later return to active duty. In these cases, VA medical record information may be shared with the Department of Defense. If a disclosure of MST noted in a Servicemember's medical record subsequently led to retaliation against the Servicemember, the transgression would presumably be covered under the Department of Defense's whistleblower protections. Again, there is no need for a parallel set of VA policies.
- Eligibility for VA care is independent of any Department of Defense disciplinary or other proceedings, unless the Veteran was to ultimately receive an Other Than Honorable or Dishonorable discharge. If this discharge were the result of retaliation, this would also presumably be covered by the Department of Defense's whistleblower protections.

Question 3: The Circumstances surrounding the six members of the SES who had "serious disciplinary actions" taken against them over the last two years.

Response: The Department is currently working to provide the circumstances surrounding the six members of the SES who has disciplinary actions taken and will provide this information as soon as possible.

Question 4: Provide a report on MST anonymous callers (Mystery Shopper).

Response: The MST anonymous caller initiative targets a potential barrier to accessing MST-related care: difficulty contacting the MST Coordinator at a VHA health care facility. The initiative was first authorized in June 2010, and four rounds of review have been conducted since at an approximately yearly interval.

During each round, two members of the MHS national MST Support Team—one female and one male—placed calls to the primary switchboard phone number of each facility during normal business hours. Following a standard script, callers asked for assistance in reaching the facility MST Coordinator. Calls were rated based on the ability of operators and other frontline staff (e.g., clinic clerks) to identify the MST Coordinator, the seamlessness of the transfer, and staff members' courtesy and sensitivity to callers' privacy concerns. Each facility was rated as Satisfactory, Marginal, or Unsatisfactory based on results from both calls. All facilities with a Marginal or Unsatisfactory rating received detailed feedback on the calls, and, to date, have submitted action plans to VA Central Office to address the identified issues negatively impacting MST Coordinator accessibility.

The MST Support Team has taken several steps to assist facilities with preparing for the calls and with writing action plans. These include hosting a webinar presentation on the initiative, disseminating tip sheets of strategies on increasing and maintaining accessibility, and consulting with MST Coordinators to problem solve identified barriers.

The initiative has been successful in improving nationwide MST Coordinator accessibility. In Round 4 (Aug–Sep 2013), 83.6% of facilities were judged to have Satisfactory accessibility, 13.6% Marginal, and 2.9% Unsatisfactory. These results represent a nearly 30 percentage point improvement in Satisfactory accessibility and 16 percentage point drop in Unsatisfactory accessibility since Round 1 (Jul–Aug 2010).

Question 5: Provide the FY 2013 Office of Productivity and Efficiency's staffing standard report for MST (measuring the number of MST patients that VA facilities are treating and the staff resources available to treat them);

Response: The Annual Report on Counseling and Treatment for Military Sexual Trauma (MST) for Fiscal Year (FY) 2013 is currently being reviewed and we will provide the report to you as soon as it is available.

Question 5a: Please also provide information paper on the .2 FTE for MST.

Response: Please see below for the methods and results regarding decision to have .2 FTE for MST.

Methods

- The VA MHS MST Support Team completes an annual report to determine the number of trained full time equivalent employees (FTEEs) required to meet the mental health needs of Veterans who have experienced MST, to fulfill the requirements of 38 United States Code, Section 1720D(e). Because MST is associated with a variety of mental health conditions and is treated across multiple outpatient treatment settings, we could not rely solely on the number of providers in a given mental health service line or clinic. Therefore, we relied on methods developed by the VA Office of Productivity, Efficiency, and Staffing (OPES) to quantify workload associated with MST-related mental health care and calculate the effective number of FTEEs associated with this care at each VA Health Care System (HCS). From this we created a metric so that staffing levels could be compared across facilities.
- Each VA HCS varies in the number of Veterans that it serves who have experienced MST and therefore varies in the demand for MST-related mental health care. To enable comparisons across facilities, we calculated a ratio of provider staffing against population size: the total FTEEs providing MST-related mental health care for every 100 Veterans with positive MST screens. It is important to note that not all Veterans with a positive MST screen will want treatment and among those that do request care, the amount of MST-related care required by each Veteran will vary due to the range of mental health conditions associated with MST. But in general, a larger staffing ratio indicates greater staffing and availability of MST-related mental health services.
- We examined the amount of MST-related mental health care that each VA HCS provided and ranked facilities on two indicators: 1) the proportion of Veterans with a positive MST screen who received any MST-related mental health care; and 2) the median number of visits among patients who received MST-related mental health care. We identified health care systems that ranked in the top 25% for both indicators. We then used staffing ratio data from these "high volume" VA health care systems to establish the benchmark.
- The benchmark of 0.2 FTEE per 100 Veterans (or 2 FTEE per 1,000 Veterans) who experienced MST is based on a comparison with these "high volume" VA health care systems. This benchmark is within two standard deviations of the average staffing ratio at high volume health care systems. Even staffing levels that are only a portion of a single FTEE represent portions of workload from several different providers due to the wide range of mental health conditions and clinic settings associated with MST-related mental health care.

Results

- All VA health care systems provide MST-related care to both female and male Veterans and all VA health care systems have mental health providers knowledgeable in the treatment of MST-related mental health conditions. In the most recent analysis, 99 percent of VA health care systems were at or above the established benchmark for MST-related mental health staffing capacity. Over 64,000 Veterans received MST-related mental health care from a VA health care facility. These Veterans received a total of over 693,000 MST-related mental health care visits from over 17,950 individual providers. Not all of those 17,950 individual providers, however, spent all of their clinical hours delivering MST-related mental health care. The care delivered by those providers was equivalent to 580 FTEEs.

Question 6: Provide the committee with information about the VA employees that were held accountable for patient deaths at the Augusta VAMC and the Atlanta VAMC.

Response: Disciplinary actions for Atlanta and Augusta are below:

Disciplinary Actions

Atlanta VAMC

Chief of Staff—Reprimand
Associate Director—Reprimand
Associate Director/Nursing and Patient Care Services—Reprimand
Chief, Mental Health Service Line—Reassigned
Mental Health Inpatient Nurse Manager—Reprimand

Associate Nurse Executive/Mental Health and Geriatrics—Reprimand
Mental Health Inpatient Unit Medical Director—Admonishment
Former Medical Center Director—Retired
Veterans Integrated Service Network (VISN) Chief of Mental Health Services—Retired

Augusta VAMC

Chief of Staff-Received performance Counseling (Voluntarily resigned from position)

Question 7: Please provide the timeline for VHA to contribute to the State Prescription Drug Monitoring Program?

Response: VA participation with State Prescription Drug Monitoring Program is estimated to begin August 2014. This is predicated on a contract award by May 5, 2014, with a contract start shortly after award. The timeline includes achieving Milestone 2 (development enters implementation phase) by May 30, with code changes to other patches and Medication Order Checking Application (MOCHA 2.0) completed, documentation updated, and identification of additional test sites by the end of June. It is expected that this work would enter the national release process near the middle of July with testing and deployment leading to a mid-August completion. The State Drug Monitoring Program patch is dependent on MOCHA 2.0 which will deploy in waves between March 24, 2014 and June 16, 2014, as well as a titration management patch that will start simultaneously with the State Drug Monitoring Program patch. There are potential risks of delays to the August 2014 start date that could arise from dependencies that include contract start date and unforeseen technical issues with states that are not part of the test site process. The VA Office of Information and Technology is responsible for oversight and management of software development and deployment for this program.