

ASSESSING VA OVERSIGHT OF DRUG PRESCRIPTION PRACTICES AND PROPER USE OF MEDICAL FACILITIES

FIELD HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

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ASSESSING VA OVERSIGHT OF DRUG PRESCRIPTION PRACTICES AND PROPER USE OF MEDICAL FACILITIES

Friday, May 20, 2016

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

The Subcommittee met, pursuant to notice, at 9:30 a.m., in Old Supreme Court Chambers, State Capital Building, Room 200, 200 East Colfax Avenue, Denver, CO, Hon. Mike Coffman [Chairman of the Subcommittee] presiding.

Present: Representatives Coffman, Lamborn, and Kuster.

OPENING STATEMENT OF MIKE COFFMAN, CHAIRMAN

Mr. COFFMAN. Good morning. This hearing will come to order.

First, I want to welcome Congresswoman Ann Kuster from the State of New Hampshire, Western New Hampshire, New Hampshire's 2nd Congressional District, and Congressman Doug Lamborn with me here from the 5th Congressional District of Colorado.

Good morning. This hearing will come to order. I want to welcome everyone to today's hearing entitled, "Assessing VA Oversight of Drug Prescription Practices and Proper Use of Medical Facilities."

The purpose of this hearing is to address numerous issues related to VA's handling of prescription and oversight practices of controlled substances, as well as its appropriate use of medical facilities to benefit veterans. Particularly during this hearing, we will discuss issues pertaining to quality and access to care, deficiencies in the use of medical and research facilities and the absence of accountability in cases involving misconduct, both in Colorado and across the Nation.

The House Veterans' Affairs Committee has held numerous hearings on the improper prescription practices of VA physicians. In one of those hearings, slides from a video were shown where multiple VA medical employees stated how they were making veterans into drug addicts.

This hearing follows up on our previous concerns in those hearings by looking at VA's internal procedures that likely allow for VA's apparent "prescribe first" mentality and how controlled sub-

stances wind up missing, stolen, or in the hands of the wrong person.

One example of where these internal procedures are going wrong is at the Denver VA Medical Center. The DEA, Drug Enforcement Agency, recently conducted a review of the Denver VAMC—for those of you that don't use acronyms, that is the Veterans Affairs Medical Center—where it found dozens of problems that compromised the safety and legality of the facility's prescription practices. Some of those findings include mailroom employees with related felony convictions with access to controlled substances. This calls into question whether the VA conducts proper background checks prior to hiring. DEA also found that the facility's random drug testing was inadequate.

A wall to wall audit of inventories performed between February and July 2015 found 16 of the 27 medications audited did not balance when comparing receiving, dispensing, and destruction records, and VA pharmacy leadership failed to report theft or loss of controlled substances within DEA time requirements, and in some cases failed to report at all.

In addition to these obvious deficiencies in the Denver VAMC's prescription drug oversight, the facility's maintenance of research facilities also gives cause for concern. For example, numerous pieces of expensive scientific equipment are broken or unused. Further, boxes of patient information, some water damaged, from research studies dating back to 2011 remained stacked up in unsecured rooms during our visit last month. In some cases, research chemicals are also unsecured and unaccounted for within the laboratory.

I look forward to hearing from the VA witnesses that have joined us today in order to get some clarity on these issues. I know that these problems are not confined to the Denver VAMC. So I look forward to discussing other facilities, and how we can help identify systemic problems in order to improve services to our veterans.

With that, I now yield to Ranking Member Kuster for any opening remarks she may have.

OPENING STATEMENT OF ANN M. KUSTER, RANKING MEMBER

Ms. KUSTER. Thank you, Mr. Coffman, and thank you again for the invitation to come here to Denver to talk to you about an important issue that is threatening not only our VA, but our entire country, and that is the issue of opiate use and misuse and the diversion of prescription medication.

This morning we will be examining VA's role in ensuring our prescription drugs are safely controlled in all VA medical facilities. The VA must make sure that it has the right oversight policies in its facilities, and that employees follow the policies and regulations to prevent theft, improper use, and over-prescription of opioids and other controlled substances.

I am concerned about several of the Drug Enforcement Agency's findings in its investigations of the Denver VA Medical Center's handling of prescription medication, and I want to find out what steps have been taken to correct DEA regulation violations. This is one more important step that the VA must take to combat the opioid use and abuse epidemic that is stealing the lives of so many

veterans right here in Colorado, in my home state of New Hampshire, and all across the Nation.

Colorado and New Hampshire share many of the same statistics on opioid abuse. In both of our states, death from drug overdoses are higher than the national average, and death from drug overdoses is now the leading cause of death. You should be pleased that your state has dropped from number two in the Nation down to number 12. In that same timeframe, New Hampshire went from number 24 in the Nation to number three, and you now have a four times greater chance of dying from an opiate drug overdose in New Hampshire than a car accident.

Colorado is 12th in the Nation now for prescription drug misuse. New Hampshire, sadly, has the highest rate of opioid addiction. This is why it is important that we all work together to address this epidemic.

As Members of Congress, just last week we passed 18 bills in the House of Representatives to address the opioid epidemic, and I want to say these were bipartisan bills, and it was a very rare week on Capitol Hill. This included the Jason Simcakoski PROMISE Act, a bill that Congressman Coffman and I championed, which will help improve opioid prescription practices at the VA all across the country.

As a member and founder of the Bipartisan Task Force to Combat the Heroin Epidemic, I have now been named to the bipartisan House and Senate Conference Committee to work out the differences between the House and Senate opioid epidemic legislation. I am committed to working with my colleagues to get these vital life-saving bills passed into law.

Now, the VA must also do its part to ensure proper oversight and to use the resources and best practices it has available to it within the VA, in the community, and through its academic affiliates. I know that the Colorado medical community is actively involved in educating providers on safe prescription of opioids, and that the University of Colorado at Denver's Center for Health, Work and Environment provides guidelines and tools for health care providers to improve chronic pain management, to safely monitor the prescription of opioids, and to prevent opioid use and diversion.

Through its academic affiliation with the University of Colorado's School of Medicine, the Denver VA Medical Center can work to promote best practices for its practitioners and to train our future health care providers on safe prescription practices and alternative treatment for managing chronic pain.

We also will hear this morning about issues concerning facilities and access to care for veterans in this community. I would like to know what Denver is doing to address the increase in patient demand, and if the hospital currently under construction will be adequate to meet the current and future patient demand, to train future residents at the University of Colorado Medical School, and to support important VA-funded research.

I would also like to know what is being done to manage and support VA research currently taking place at VA facilities and through the medical school, and whether VA facilities are being utilized and are adequate to support current efforts.

We will not solve the opioid abuse epidemic in this country, help our veterans affected by the epidemic, or solve the VA's patient access problems without our dedicated and coordinated efforts.

And with that, I thank Mr. Coffman and I yield back.

Order to improve services to our veterans.

Mr. COFFMAN. Thank you, Ranking Member Kuster.

I would like to now introduce our panel. On the panel we have Mr. Ralph Gigliotti. Did I say that right? Mr. Gigliotti, Network Director of VISN 19. He is accompanied by Ms. Sallie Houser-Hanfelder and Dr. Ellen Mangione, the Director and Chief of Staff of the Eastern Colorado Health Care System.

I ask the witnesses to please stand and raise your right hand.

[Witnesses sworn.]

Mr. COFFMAN. Thank you very much. Please be seated.

Let the record reflect that all of the witnesses have answered in the affirmative.

Mr. Gigliotti, you are now recognized for 5 minutes.

OPENING STATEMENT OF RALPH GIGLIOTTI

Mr. GIGLIOTTI. Good morning, Mr. Chairman, Ranking Member Kuster, and Members of the Committee. Thank you for the opportunity to discuss the VA's handling, prescription, oversight practices, and appropriate use of controlled substances at VA facilities.

Oversight and handling of prescription drugs. Questions have arisen regarding pharmacy practices and accountability in VA Eastern Colorado. In the last five years, eight Eastern Colorado VA employees have been disciplined or removed for illegal possession or use of drugs on VA property.

In February 2016, DEA reported findings to the executive leadership team and pharmacy management. Most items were addressed while DEA was on site, which resulted in process changes to ensure the safe handling of pharmaceuticals in VA.

To improve safe pharmacy practices, the VA's Opioid Safety Initiative, OSI, was implemented nationwide in August 2013. Nationally, results of key clinical measures measured by the OSI from July 2012 to March 2016 show a 22 percent reduction in a number of patients receiving opioids; a 37 percent increase in patients on opioids that have had a urine drug screen to help guide treatment decisions; and a 32 percent decrease in overall dosage of opioids in VA. This was all achieved during the time that VA had seen an overall growth of 3 percent in VA outpatient pharmacy service usage. These OSI dashboard metrics indicate the overall trends are moving steadily in a desired direction.

VA Eastern Colorado access. Over the past three fiscal years, VA Eastern Colorado has seen a consistent increase in demand for services, with unique patients increasing by over 13 percent. We have simultaneously increased the supply of health services by 12 percent, but demand has outpaced supply, resulting in longer wait times for our veterans. Despite this, we have made tremendous strides in decreasing the electronic wait list to 543 as of May 2016.

Over the last three fiscal years, our Colorado Springs clinic has seen the most notable increase in workload within our catchment area. On February 4th, 2016, the Office of Inspector General released a report identifying untimely care concerns at this clinic re-

sulting from a complaint received in January 2015. The report also identified areas needing improvement such as scheduling and referral to the Veterans Choice Program.

OIG acknowledged in the same report that we had already executed a number of corrective actions to become compliant with its concerns. These included filling vacancies, hiring new staff and trainers from entry to executive levels, retraining, and practicing continuous quality improvement. We have increasingly relied on care in the community to provide health services to our growing veteran population.

The Denver VA campus. Medical and prosthetic research at the Denver VA campus, including in some temporary buildings, should be moving into its new space at the replacement facility on the Fitzsimmons Campus in Aurora. The project is to replace the current Denver VA facility which was built in 1948. The Army Corps, VA, and Kiewit-Turner are working in close collaboration to complete this new facility. The construction team is dedicated to achieving VA requirements and criteria, while also pursuing cost savings opportunities to maintain the current budget. To ensure that previous challenges are not repeated, we continue to focus on lessons learned over the course of the construction.

In all phases of the construction and activation, the activation team is working in close consultation with our military, veteran, and community stakeholders via regular on-site meetings. The project is currently 67 percent complete.

Sustainable accountability. VA is committed to creating an environment of sustainable accountability in which employees know what is expected of them, and then exceed that. Sustainable accountability means using taxpayer dollars wisely to improve life for our veterans and families. To create this culture, we have taken steps such as changing VA leaders' performance reviews to include veteran-centric outcome objectives, improvements in workforce culture, and focus on ICARE, which will allow VA to address these issues as required.

We have also implemented strong, independent oversight, creating the Office of Accountability Review, and by securing certification in the Office of Special Counsel's Whistleblower Protection Certification Program. The vast majority of VA's 300,000 employees are committed to serving veterans effectively.

Mr. Chairman, this concludes my testimony, and we are prepared to answer any questions that you may have.

[THE PREPARED STATEMENT OF RALPH GIGLIOTTI APPEARS IN THE APPENDIX]

Mr. COFFMAN. Thank you. Your written statement will be entered into the hearing record.

We will now proceed to questioning.

Is there anybody else on the panel to testify at this time?

[No response.]

Mr. COFFMAN. This is to all of you. Chairman Miller wrote a letter to Under Secretary Shulkin last month regarding a VA police report in your facility that showed in 2014 a VA employee was caught during working hours and admitted stealing and using a

Schedule 2 drug, fentanyl. The employee was not disciplined and still works for VA. Can you explain why?

Mr. GIGLIOTTI. I will let Ms. Houser-Hanfelder handle that particular case.

Ms. HOUSER-HANFELDER. Thank you. That employee was disciplined. That employee is on a Last Chance Agreement, and the U.S. Attorney—

Mr. COFFMAN. What was the disciplinary action?

Ms. HOUSER-HANFELDER. It is the Last Chance Agreement that is in the record for the—

Mr. COFFMAN. If you don't get fired for being in the operating room, stealing a powerful narcotic and using it there, if you can't get fired for that, where are the boundaries?

Ms. HOUSER-HANFELDER. There was also prosecution through the court system where they did a preferred statement with her going through rehab and doing community service.

Mr. COFFMAN. But from the VA standpoint, that is not grounds for firing?

Ms. HOUSER-HANFELDER. They did not fire her. We did not fire her. She did disclose some other information to us that enabled us to deal with another employee. But if the question is was she disciplined, she is on a Last Chance Agreement for the continuation of her career, understanding she has no due right processes if she gets an unsatisfactory rating, or if there are any other issues with her.

Mr. COFFMAN. In all cases of drug theft by VA employees, are all subject employees reported to their relevant state licensing board?

Ms. HOUSER-HANFELDER. That depends on the cases. That person does not have a state licensing board. We had no legal rights to report her certification. Each case is on an individual basis as we go through it with our legal counsel.

Mr. COFFMAN. How does VA coordinate with relevant Federal and state law enforcement bodies on issues of pharmaceutical theft from the Department?

Dr. MANGIONE. Thank you, Mr. Chairman. Those are referred immediately to the VA police, to the Office of the Inspector General, and then also to VISN 19 theft and loss report distribution. And in addition, there is a Form 106 which is created and submitted to the DEA, along with an email alerting them to it.

Mr. COFFMAN. Let me—

Mr. GIGLIOTTI. I was going to say, sir, then working with those agencies, the determination would be made in consultation with whether prosecution or not would occur.

Mr. COFFMAN. Mr. Harter is in the audience. His son committed suicide just about a year ago, and this is what Mr. Harter writes: "Towards the end of his junior year at UCCS, University of Colorado at Colorado Springs, in April of last year, he went to the Colorado Springs Lindstrom VA Clinic and told them he was having trouble sleeping, resulting in depression. He is a 50 percent disabled, post-traumatic stress combat veteran, both Iraq and Afghanistan. The clinic didn't schedule him with a doctor. He was seen only by a physician's assistant who documented his condition, prescribed a psychotropic drug"—let's see if I am pronouncing it right—"Venlafaxine, and sent him on his way without any further

follow-up or monitoring. A month later, our son”—and Mr. Harter is saying this—“our son shockingly took his own life.”

This is a drug that requires monitoring. Can you elaborate on this?

Mr. GIGLIOTTI. Dr. Mangione?

Dr. MANGIONE. Our physician’s assistants operate under the direction of a physician and a psychiatrist, in this case Dr. Bill Bain, who is a psychiatrist. Dr. Brian Bain—I am sorry—who is a psychiatrist in the Colorado Springs clinic. We do audits of all the evaluations that are done by our physician’s assistants. And in this case the physician’s assistant followed the procedure appropriately.

What occurred in this particular situation is a bit unclear. It was the intention of the physician’s assistant to have Mr. Harter come back to the clinic within a limited period of time. It is a little bit unclear as to the extent to which Mr. Harter, after this was discussed with the physician’s assistant, wanted to or didn’t want to return. He actually had a history of cancelling a large number of appointments with the clinic. But the intention was that he would come back in the next week for monitoring. He also had a social work appointment as well.

Mr. COFFMAN. What actions were taken when he did not come back?

Dr. MANGIONE. So there are calls typically made out to the particular individual to remind him to come back.

Mr. COFFMAN. Okay. Well, we will be asking for all records related to this particular case.

Congressman Lamborn did an informal field hearing in his district in Colorado Springs, which I attended, where Mr. Harter was able to testify on that, as well as Mrs. Harter, about their son, Noah. I thought it was very compelling and wanted to raise that case to you today, and we will do follow-up on that case, obviously concerned about the loss of his life and the potential loss of other lives if these situations are not corrected.

Congressman Lamborn, you are now recognized.

Oh, I am sorry. This is not a good day for me.

Ranking Member Kuster, you are now recognized for questions.

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

I will have three lines of questioning, and then we will come back?

Mr. COFFMAN. We will come back on a second round.

Ms. KUSTER. Okay. So I am going to start with the prescription medications and your procedures. I also want to get into your pain management, whether you are making any changes around that to decrease the use of opiates. And you mentioned the taxes for Colorado veterans. I would like to briefly touch on that from some previous hearings we have had in Washington.

So if you could help me to understand the corrective actions that have been taken to address the DEA’s finding in its investigation. I am particularly alarmed with the Chair about employee theft, and I understand this Last Chance Agreement. I am wondering if that employee now is subject to drug testing. Is there monitoring that is going on? Just across the board, what are the corrections that are happening?

Because, look, one thing that we have learned, and I have now spent the last year-and-a-half on this issue of the increased use of opioids and, sadly, the substance use disorder and the resulting theft and, in our case in New Hampshire, the growth of heroin and, sadly, the deaths. We have had 420 deaths in one year, and we are a very small state.

So help me to understand. You have this DEA report. What are the corrective actions? Because if your employees are misdirecting heroin or fentanyl or opiates, you have an issue with substance use disorder right in-house, or these materials are being diverted out to what I assume is a very strong market for fentanyl and opiates and everything else, and you have to get on top of it.

So help us to understand that. What are the steps that are being taken?

Dr. MANGIONE. So maybe I should talk about a couple of things and then get into more specifics with your permission, Congresswoman Kuster. There are a number of issues that are already in place. So, for example, when we receive a sealed shipment of a pharmaceutical, there are two people who receive it. One is an independent person separate from the pharmacy, and then a pharmacist. They unseal that cache together.

Ms. KUSTER. I am sorry to interrupt. But as to specifics, do you have cameras now installed in your pharmacy to keep track of any attempted diversion?

Dr. MANGIONE. We are in the process of installing them, but we do not have them yet.

Ms. KUSTER. And what about the tracking? Walk me through the tracking for when the package arrives, who has access to the information, is it electronic or in print, are there passwords being changed on a regular basis.

Dr. MANGIONE. Yes, those are really good points. We discovered it, and fortunately earlier this week, I had an opportunity to speak with some of the other leadership from some of the health facilities around Colorado, and we are very much on the same path. We absolutely have very consistent ways of having two people monitoring—people independent from the pharmacy who are monitoring the drugs coming in and then being recorded.

We in the VA have an electronic system that is called the VISTA Controlled Substance Tracking System, and even though we have all these duplications in the system and two people monitoring, at the end of the day, what really helps us the most are the electronic systems.

So the VISTA system allows us to track any controlled substance into perpetuity. From the minute they arrive, there is an inventory which is created, which is maintained outside of the area of the vault where the medication—

Ms. KUSTER. And is there a reconciliation of that inventory for diversion, for theft and loss and returns?

Dr. MANGIONE. Absolutely. What happens is that that information is uploaded into the vault, and the people in the vault with the cache actually have to reconcile against that particular inventory. Then we complete the loop also with the test to say this what we received, this is what you think was actually sent to us.

And then in the vault there are actually—in the reconciliation every 72 hours independent people, but also two people present at the same time.

Some of the issues that we were cited for by the DEA, I would just like to have an opportunity to explain a couple of those. One issue that has come up is been about—

Mr. COFFMAN. Please move the microphone closer to you.

Dr. MANGIONE [continued]. Okay. Sorry. One of the issues that has come up has to do with the biannual review. This is actually a national issue, because guidance that has been received by VA facilities is that when we do a wall to wall survey, that that actually satisfies the DEA requirements for the biannual review. We weren't doing our survey, but that was not the case. The intention of the biannual review is to review controlled substance inventories throughout the entire facility, whereas the wall to wall, which is required by the VA, is actually just immediately for that particular vault in that particular pharmacy, within the walls of that pharmacy. So if they are using a different denominator to judge whether or not the inventory is consistent, then absolutely, by definition you are going to be finding discrepancies.

Some of the issues that we have found are that, for example, in the course of providing medications that have been returned to us, controlled substances that need to be destroyed, that we ended up putting together the medications that had been originally sent out. I can't tell you exactly what that is, but that is the central—

Mr. GIGLIOTTI. Consolidated mail-out pharmacy.

Dr. MANGIONE [continued]. That is the pharmacy that does mailing out for the facilities. And the medication, even though it is sent out by CMOP, is returned to our pharmacy. So the practice was that we would take those medications, some of them returned by CMOP, and medications that someone might just return to us or whatever, we would put them into the same inventory, and DEA requested that we separate those out.

As far as the number of reports, Form 106, that had been provided to the VA, in fact, we were over-reporting, and we didn't understand that. We had a culture of really trying to have a low threshold for letting anybody know we had discovered a problem. So we did submit a large number of those. At the time they visited us, they pointed out to us that that was, in fact, an error.

One example of an error was that when we had delivered successfully a controlled substance to a veteran, and a veteran had opened it, and then a couple of days later, for example, would report to us that they had not received all of the medication, we actually filed a report with the DEA. But DEA explained to us that once that controlled substance was in the control of a veteran, that we were not responsible for reporting. So that was our error. But again—

Ms. KUSTER. It might be worthwhile for you clinically to keep track of that information even if—I mean, that sounds to me like a veteran who is trying to get additional medication.

Dr. MANGIONE. We absolutely do keep track of that, but it is not required to be put on the form.

Ms. KUSTER. But do you keep track of it internally?

Dr. MANGIONE. Absolutely, because then we can see a trend where this happens two or three times with the same veteran—

Ms. KUSTER. Do you know that one of the mentions in the report was about random drug testing of your pharmacy employees? Do you have random drug testing, and is that something that is happening on an ongoing basis?

Dr. MANGIONE. There are five to 10 individuals randomly drug tested throughout the facility in any particular month. I think we would all agree that we would welcome an increase in that going forward.

Ms. KUSTER. I mean, one of the things, just for my colleagues, we have what is called a special order, but it is when Members of Congress came to the well for one evening for two hours, Republicans and Democrats telling stories, some very personal stories about their constituents, and in some cases family members, and I was impressed. There were several Members of Congress who have a background in pharmacy, and they were very forthcoming that substance use disorder is undiscerning in terms of who it chooses, and that pharmacists and people working in pharmacies are particularly susceptible.

Dr. MANGIONE. One of the other issues that we had is that as of March 1st the VA did require drug testing on anybody who VA is considering employing prior to applying to any particular job category. So it is quite a long list, but it is—

Ms. KUSTER. That was one of the other references that I saw, is that you had some employees, and I think even working with controlled substances, who may have criminal background records related to opiate use or the sale of it.

Dr. MANGIONE. My understanding is that those individuals were contract employees in our mailroom, and that that situation, as far as I understand, has been rectified. But any contractor who is employed, to the extent that we do have contractors, they actually have a full background check.

Ms. KUSTER. And I think what is important to understand is that the mailroom would be, particularly when you are receiving these medications by mail in bulk, and that issue that you pointed out about the returns, everybody all across the country, we are trying to deal with how to safely manage the returns of all this medication.

I will yield back. I want to make sure to give our colleagues a chance, and then we can come back to pain management for a thorough answer. If there is more and you want to submit it for the record, I am sure it will be helpful for our Committee. Thank you.

Mr. COFFMAN. Congressman Lamborn, you are now recognized.

Mr. LAMBORN. Thank you, Mr. Chairman. I want to thank you for your leadership and Chairman Miller, the Full Committee Chairman, of bringing to light some of the problems and issues the VA has had. Sometimes they have stepped forward and addressed them, but other times we are still waiting for an adequate response. But I know it hasn't been for lack of effort on your part and Chairman Miller's part, and all of us on the Committee.

Mr. Gigliotti—I hope I pronounced that correctly—you paint a positive picture of the Lindstrom clinic in Colorado Springs in terms of more capacity and having shorter wait times.

Mr. GIGLIOTTI. A shorter electronic wait list, yes.

Mr. LAMBORN. But as you know, the care they receive after they are admitted is really the crux of the matter. Unfortunately, I still get bad reports in some cases of veterans who are not having satisfactory experiences. Just this week, we heard from a combat veteran who suffers from chronic pain and has a TBI, a traumatic brain injury. Some VA staff characterized this veteran who was seeking treatment as “a drug seeker and a drug addict,” even though the VA substance abuse doctor says that that is not right, that he shouldn’t be determined that way. So it feels like he experienced hostility from some of the VA mental staff, and it was just one of the disappointments in the last 18 months.

We also heard recently from Charlie, a comment from someone who actually worked at the Lindstrom clinic, but he felt like he had to leave because of a poor or even a hostile management environment.

So what are you doing to address the quality of patient care once they actually do receive treatment?

Mr. GIGLIOTTI. Sure, and I will ask Ms. Hanfelder to amplify this. Colorado Springs is one of the fastest growing districts, if you will, in the country. The clinic, we have done some work with our panel sizes so that we are able to see more and more veterans, and I will specifically get to your question. But at the rate of growth that we are seeing, we need to look for ways to expand access points at the site, and the site was selected purposely so that it could be expanded.

So we are now starting the process—sometimes it is a long process—to get an addition to that clinic, and we are also going to be looking at space throughout Colorado Springs to put non-clinical care off of that campus and into more administrative buildings so that the clinic is fully utilized for clinical space.

Why don’t you talk about some of the leadership changes?

Ms. HOUSER-HANFELDER. Sure. Thank you, Congressman Lamborn. Back in the meeting that we had in February where we stepped through the processes that we were working on to improve access, I believe you met the executive leader down in Colorado Springs. He brings a new leadership to that particular clinic. He brings a military background with him, and he has been working diligently on the employee engagement issue.

We need to know when a veteran walks into any of our sites and says he is disrespected or she is disrespected, or they are having problems, because that is not what the expectation is when they are being treated. They are to be treated with respect. Thirty-four percent of our employees are veterans themselves. So we are working diligently on the culture all over our organization, but Nate has really taken it on in Colorado Springs, and we are starting to see that turn. Our patient satisfaction scores are going up, and he is holding people accountable. So when you get those—I know your office sends us those things, we will work on the cases. But we are working with our employees.

If I don’t have engaged employees who are satisfied with their work, I will not have satisfied veterans, and that is our number—I have three priorities as the new director. Access is my number-one priority. Sometimes the priority shifts depending on what day

it is. Number two is getting a replacement facility completed and us in it. And the third one is employee engagement, because we do have some issues with the culture at some of our sites. So we will work on that, and if you will let us know when those cases come up, we will deal with them.

Mr. LAMBORN. Thank you.

Now, let me follow-up lastly, before yielding back to the Chairman, on the tragedy of Noah Harter, who took his life a year ago. Now, his family alleges that he did receive powerful prescription medication to treat depression or the after-effects of being in combat, but he didn't have the therapy or follow-up or counseling from an actual M.D. Are you still doing investigation on that? I think you made reference to an investigation, and what have you found in regard to that?

Dr. MANGIONE. So I would like to say that each suicide is a tragedy, but I can't imagine the loss of a child. So I think that is an incredible tragedy, and I certainly do sympathize with the family.

We actually met with the family several months ago to discuss the care. Dr. Bain was present as well, and I was there too. I am not a psychiatrist, so I don't prescribe Venlafaxine, but Dr. Bain has a great deal of experience with that, and in his review of the case the prescribing of that medication was absolutely appropriate in that circumstance, is my understanding.

What we have also done, though, because it does appear that Noah was lost to follow-up, for whatever reason, is we instituted a situation where when a veteran is about to leave, that there be a return-to-clinic order at the time so that the support staff who are sitting at the front desk before the veteran leaves can confirm with the patient that they will be coming back at a particular time. If the veteran says, well, I may have discussed this with my provider, but the reality is that I am really too busy and I am not going to be coming back for one reason or another, that the support staff will now alert the provider, and the provider will make a call to that veteran, do additional outreach to that individual to say, okay, we really do think you do need to come back in at a particular time.

Mr. LAMBORN. Well, that seems like a very important step. There may be other steps also that should have been done.

Dr. MANGIONE. We know that from an efficiency perspective, when we have the veteran right there, to actually talk with them and make that arrangement to try to follow-up with them on their cell phone or something.

Mr. LAMBORN. Well, I hope there is no sense of blaming the veteran.

Dr. MANGIONE. Absolutely not.

Mr. GIGLIOTTI. Absolutely not.

Dr. MANGIONE. One of the issues that I think is so fascinating, the pain used to be fifth vital sign when I was in training, about how you really have to do away with all sorts of pain, and we as an organization, as well as the country, which was referenced before, about the downside of giving people opiates to control their pain. In fact, we have a researcher who has just received a large grant from the VA to study opiates from the veteran's perspective and what really works for them from their perspective. We as med-

ical providers may have one opinion, but there has been a real dearth of information about what the veteran's perspective is.

Mr. LAMBORN. Thank you, Mr. Chairman. I yield back.

Mr. COFFMAN. We will go into the second round now.

On the case of Noah Harter, was there a formal investigation done with findings of fact as to what occurred?

Dr. MANGIONE. I believe that there was, but my staff can check that for you, if there was a root cause analysis investigation. I can go back and check.

Mr. COFFMAN. So you don't—

Dr. MANGIONE. I believe there was a root cause analysis.

Mr. COFFMAN. Okay. Can I get a copy of that, then? Because if there wasn't one, there should have been one.

Ms. HOUSER-HANFELDER. The root cause analysis is a protected document, so it wouldn't have been released just automatically. We will go back and check to see. There should have been also a peer review done. I am sorry, I don't know the answer.

Mr. COFFMAN. We will put in a formal request.

Ms. HOUSER-HANFELDER. Okay, thank you.

Mr. COFFMAN. We will put in a formal request for that investigation.

Ms. HOUSER-HANFELDER. Okay.

Mr. COFFMAN. And let me say also, you mentioned the issue of drug testing employees, that contract employees who work in the mailroom, you are not drug-testing those, are not required to drug-test those. I am sorry, could somebody clarify that for me?

Ms. HOUSER-HANFELDER. If they are within that series, it is the contractor's responsibility. I do not believe—and we will need to validate this—that it is the VA that drug tests them. It is the contract responsibility, and there was a lapse in that.

Mr. COFFMAN. So we have people with felony drug convictions dealing with drugs in your facility?

Ms. HOUSER-HANFELDER. My understanding is some of them did have that. They were contracted staff. So, yes, we will go back and I will get clarification on that.

Mr. COFFMAN. Who vets the contractors? Who is responsible for vetting contractors, contract staff?

Ms. HOUSER-HANFELDER. Contracting, our contract office.

Mr. GIGLIOTTI. Our contracting staff.

Mr. COFFMAN. So what requirement is put on the contractors, then, on this issue?

Mr. GIGLIOTTI. We have to get the specifics. I don't have them.

Mr. COFFMAN. So you don't know.

Mr. GIGLIOTTI. I don't.

Mr. COFFMAN. You don't know if there is a requirement or if there is not a requirement?

Mr. GIGLIOTTI. I would think—

Mr. COFFMAN. Do you think there ought to be a requirement?

Mr. GIGLIOTTI. Yes.

Mr. COFFMAN. That people with felony drug convictions shouldn't be working in a VA hospital dealing with these controlled substances?

Mr. GIGLIOTTI. In high-risk areas. Yes, I do. I agree.

Ms. HOUSER-HANFELDER. I believe there is.

Mr. GIGLIOTTI. Right. We will have to get you the exact policy.

Mr. COFFMAN. And you are saying that you can attest today that no VA employee is working at your facilities, no employees have felony drug convictions?

Mr. GIGLIOTTI. Of all of our employees?

Mr. COFFMAN. That work in the health care areas.

Mr. GIGLIOTTI. In high-risk areas, there should be no employees—

Mr. COFFMAN. How do you define “high risk”?

Mr. GIGLIOTTI. It would be in this particular case—

Mr. COFFMAN. The one where you had the person shooting up inside the surgery, inside the operating room? You would consider that high risk?

Mr. GIGLIOTTI. That position would—

Mr. COFFMAN. All right, that would be high risk.

Last year, DEA informed the Denver VA of its concerns regarding employees with felony drug convictions handling drugs in the mailroom. Does Denver VA properly conduct all background checks as required?

Ms. HOUSER-HANFELDER. I am going to say yes, but I would like to validate. We do background checks. They are required. We don't do them ourselves. There is law enforcement training. The center does those for us, and that is a requirement when they on-board. Are we 100 percent? I don't know the answer to that. I would need to get back with you.

Mr. COFFMAN. This issue is of grave concern given DEA also identified medications being returned to the Denver VA were not being properly received by a pharmacy for destruction. How is Denver VA addressing this deficiency?

Dr. MANGIONE. Mr. Chairman, I believe that that goes to the issue of the CMOP, and the fact that they were receiving both controlled substances that had been sent out from the CMOP, and that DEA requested that we separate those two out so that there were two different inventories, one where the origin of the controlled substance was CMOP, as opposed to where the origin of the medication was our own pharmacy. I believe that that was what was referred to.

Mr. COFFMAN. I was just concerned that these rules are there for a purpose, and part of it is transparency, to make sure that there are no problems. So you certainly have a great answer in terms of, oh, we were doing it this way, but it was really okay. Was it really okay?

Dr. MANGIONE. No. We have resolved that. We resolved that immediately when it was pointed out to us.

Mr. COFFMAN. Do all facilities in VISN 19 report all cases of pharmaceutical theft or missing mail, obviously containing pharmaceuticals, to the VA central office?

Mr. GIGLIOTTI. The reporting goes—ultimately the reporting does go to central office. Either diversion or theft, or missing, all of that should be reported, yes.

Mr. COFFMAN. Is it?

Mr. GIGLIOTTI. It should be, and we have systems in place. If we are talking an N of 1, I can't say—

Mr. COFFMAN. You can't verify today—

Mr. GIGLIOTTI [continued]. I can't say for 100 percent certainty, but it should be, and if it is not, then that is a matter of accountability.

Mr. COFFMAN. Clearly, you were aware that this question was going to come up. I just can't believe that you didn't go back just to check and say, hey, are we doing this right?

Mr. GIGLIOTTI. We believe we are doing it right, yes.

Mr. COFFMAN. There is a difference between believing and knowing.

Mr. GIGLIOTTI. It is a high-volume issue across a network, and our belief is we are doing it right. We work closely with the local facility. We have a VISN pharmacy person who does announced and unannounced inspections of narcotics, on-site visits, and when issues are found in that process, they are dealt with.

Mr. COFFMAN. Okay. What VA employee, by name, is responsible for preventing drug theft and tracking DEA inspections within VHA?

Mr. GIGLIOTTI. What VA employee, by name—

Mr. COFFMAN. Who is responsible? Who is responsible for preventing drug theft and tracking DEA inspections within VHA in your VISN?

Mr. GIGLIOTTI. In my VISN? Well, ultimately it would be either the chief medical officer, Dr. Lee Anderson, and then under him is our VISN pharmacy coordinator.

Mr. COFFMAN. The VA chief of staff stated to me in a letter dated May 13th that VA reviewed thousands of pages of documentation regarding the AIB in Denver, which he said VA shared with the Committee. While we received the AIB report, we did not receive the evidentiary documentation that Mr. Snyder and previously the Secretary said was provided. Please convey to VA central office that this Subcommittee expects those documents to be provided immediately.

Mr. GIGLIOTTI. I will.

Mr. COFFMAN. Ranking Member Kuster?

Ms. KUSTER. Thank you, Mr. Coffman.

I just want to join my colleagues in my sympathy for the family of Noah Harter.

One step that occurs to me might be happening to your processes when you lose track of a patient coming back, is that I know from personal experience that you can get a medical/social check by the local police, and that maybe you want to add that to your process so that the family can be reassured and families all across the country can be reassured, because obviously, somebody with a 50 percent disability, we are dealing with somebody who is struggling. We have heard testimony in our Committee over and over how hard it is for people coming out of the military, veterans in particular, to acknowledge their challenges and to seek help. Frankly, this is no individual's fault, but the headlines about the VA don't always engender confidence in the process.

So I think maybe adding one more step to the protocol rather than just some telephone call—the reality is none of us answer our telephones anymore. So it may take a face-to-face check, so I would encourage that.

I just want to switch now to the pain management aspect of opiate use and how as the VA nationally we can lead the country in reducing the prescriptions of opiates. That is the most obvious cause of all of these heroin deaths and, in our case, fentanyl and opiates themselves. We have just literally as a country gone on a binge, and you would be shocked to see the chart. We now consume more opiates in the United States, 75 percent of the opiates produced in the world, when our population pales.

So what I wanted to ask very specifically—my Chairman, Mr. Coffman, was kind enough to come to New Hampshire to do a field hearing like this. We had a wonderful witness, Dr. Franklin, Julie Franklin from the White River Junction VA, who is working in a clinic to reduce opiate use with a group of veterans with chronic pain, and she has had fantastic results with acupuncture and yoga and physical therapy, and then the whole mental health therapy, individual therapy, group therapy, to deal with the literal pain, the heart pain and the head pain to go with the physical pain.

They have managed to bring down the use of opiates by 50 percent. If you don't have this kind of clinic, I highly recommend you reach out to her. She is quite extraordinary.

But what are you doing here in Denver? What education and training have Denver VA providers received on safely prescribing and safely reducing the prescription of opiate dosages in the Denver VA?

Dr. MANGIONE. A couple of things. One is that I would say, Congresswoman Kuster, is we actually did reach out to Manchester and to White River Junction, and we offer essentially the same sort of assistance they do. But before I talk about that, I want to talk about a couple of the other activities that we have going on.

One is that we have a very active opiate safety committee in our facility, and they review every prescription which is for greater than 200 morphine milligram equivalents of methadone that is being prescribed. Our goal is to go down next to reviewing everyone who has 100, and then hopefully 90 and 50 after that. We haven't quite gotten to that point yet.

But what happens is—and everybody says, oh, we are going to educate people, and we all know that that is a pretty weak intervention. But what we do is, we actually do follow-up with those individual providers who either have a trend, or now, I think we are down to individual patients who are being put on these higher doses, to say, you know, let's talk about this before you actually proceed with this particular prescription.

Ms. KUSTER. Do you have a procedure for an opiate contract with the patient that includes random drug testing?

Dr. MANGIONE. We do. In fact, we lead the country in urine drug screens. We have a lot of successes.

Ms. KUSTER. I think it is very, very effective. And do you have that type of wraparound care with mental health and therapy and perhaps even acupuncture, yoga, wellness, those types of—

Dr. MANGIONE. All of the above. We have cognitive behavioral therapy, and this goes to Congressman Lamborn's point about—that we need to really understand what the veteran needs and what the veteran wants, because for us to say opiates aren't good for you anymore—which is why we are so thrilled to have this re-

search program now to kind of get the veterans' perspective on the tapering of their opiates.

So we have evidence-based cognitive behavioral therapy, relaxation therapy. We are very engaged with physical therapy because at the end of the day, what we have learned now is that opiates tend to decrease function in individuals, so that doesn't serve anyone. Passive motion is not what we are into right now. It is really trying to have that active engagement, the physical engagement of the individual.

So we do have people who are trained as part of the DoD in both battlefield and in general acupuncture. We also try to target our interventions. So, for example, for migraine headaches we use botox injections, not opiates that affect the entire body. We try to do injections, for example local knee injections, or trigger point injections rather than having more general, but accompanied by physical therapy as well, and yoga, those items that you had mentioned before, and DaVinci, which helps with trigger points and pain, very local and limited. So we try to get away from those more systemic kinds of interventions. My understanding is that we offer everything that those other facilities do.

Ms. KUSTER. Thank you very much.

I will yield back. I just have one more series. Thank you.

Mr. COFFMAN. Do you want to go ahead and do it now, or do you want to come back? It is up to you.

Congressman Lamborn, you are now recognized.

Mr. LAMBORN. Thank you, Mr. Chairman.

Let me ask about the Denver VA research facilities. We see that there is terrible disarray at these research facilities. There is abandoned, unused, broken laboratory equipment everywhere. The sub-zero freezers are not monitored, allowing their contents, such as human blood samples, to spoil. Centrifuges, cell cultures, laser imagers, scales, and other biology equipment costing tens of thousands of dollars are sitting unused. Microscopes costing hundreds of thousands of dollars are not maintained or are not accounted for. Dust-covered computers are commonplace, some containing research data that are piled up.

As I look at these photos, I just sense a real disarray in some of these research facilities. So how do you explain that things have come to this point?

Ms. HOUSER-HANFELDER. I will take that, Congressman Lamborn. We are in the process, thanks to the Congressional delegation of Colorado and the United Veterans of Colorado, of getting ready to move into a new research facility. It is part of the replacement facility, and it has all the new technology, wet labs. Some of the pictures you are seeing here—and I have gone through all of our research facilities. The areas you are seeing that were once wet labs cannot be redone as wet labs. Therefore, we have off-site waivers where many of our researchers are working at the university until we get into our new site.

The disarray, I agree with you. In my walk-through, we have areas that we are staging to get ready to excess equipment. Actually, IT is up in that building. These are secure buildings. This isn't like you walk off the street and you walk into these buildings.

So it is in disarray. We are in the process of considering what needs to be excessed appropriately through our logistics chain, what is going over, what is not going over. The chemicals will all be inventoried for movement.

The research building is going to be one of the first buildings that is handed over to us with a completion date estimated in December now, so we are hoping to get them moved. But we have a lot of lab space that cannot be used for what it was built for many, many, many years ago. It doesn't meet the standards, and that is why we have off-site waivers with the universities that we affiliate with.

So we are in the process of making sure that what is good stays and what is not gets appropriately excessed from our property.

Mr. LAMBORN. Looking at these submissions, it is my understanding that it has been this way for many years. They didn't just happen a few months ago or a few weeks ago. And also, staff tells me that they did walk into some of these buildings and rooms right off this site.

Ms. HOUSER-HANFELDER. All the rooms I went in, you had to have access to them. We had research walking with us to do that. So I will check into that because that is important.

We are also in the process of making sure that our records—and researchers have not until recently had a—how do you get rid of record control for old studies. They now have that. One of our transition activities is every one of our researchers going through their records, because many are still hard copy, to see what, number one, can be destroyed; number two, if they can't be destroyed, where can we secure them, whether that is at NIOSHA or NARA here in Denver that are national repositories, so we don't take up critical space in our new facilities with storage records that you have to maintain for X number of years but don't need to get into.

Mr. LAMBORN. As I look at these photographs, I see that perhaps what you are saying could apply to some things that are going to be transferred to a newer facility and then brought back up to working order. But it looks to me like in other cases, the sorry conditions are allowing things to degenerate into where they become broken and unused and wasted, even though taxpayers invested a lot of money into purchasing that equipment in the first place. If it gets to the point where it is just broken and unused, that is not doing good by the taxpayer.

Ms. HOUSER-HANFELDER. Some of the equipment I saw was very, very old equipment, very research-specific equipment that should have been excessed many years ago. I don't disagree with that. We are going into house cleaning, spring cleaning mode to say, okay, if you have space that you are not using because it is not able to be used, people tend to start storing stuff in it, and we are getting ready to address that with all of our facilities as we transition over to the new building.

It is January 18th is it finished, but there is a lot of work to do before we start transitioning. This will be taken care of.

Mr. LAMBORN. My fear is that some of the expensive equipment, not to mention research or samples, are irretrievably lost, and that would be a tragedy.

Ms. HOUSER-HANFELDER. Yes, sir.

Mr. LAMBORN. Mr. Chairman, I yield back.

Mr. COFFMAN. Thank you.

We will do one more round, a final round of questions.

How does VA coordinate pharmaceutical theft from the mail with relevant Federal and state law enforcement bodies? Can anybody explain that?

Mr. GIGLIOTTI. Sure. When a theft is suspected, our police is engaged. They bring in the Office of the Inspector General, and the Office of the Inspector General will bring in the Drug Enforcement Agency, and then a determination will be made on how to proceed based on the size of the issue involved.

Mr. COFFMAN. So you don't coordinate with any state law enforcement entities?

Mr. GIGLIOTTI. Not that I am aware of, no.

Mr. COFFMAN. Okay. What oversight is in place—

Mr. GIGLIOTTI. Let me add to that, if I could.

Mr. COFFMAN. Sure.

Mr. GIGLIOTTI. Some of our issues are with the delivery. UPS used to be—we had Federal Express before, but UPS, I think we have gone to the United Postal Service in Denver now because there were some theft issues with the company themselves, and that would have been some coordination with state and local law enforcement.

Mr. COFFMAN. Okay. What oversight is in place to ensure that providers are properly prescribing controlled substances? I think we just had the issue with Noah Harter that we mentioned, Mr. Harter being present today. What are we doing to improve that process, and where are we at?

Mr. GIGLIOTTI. I will let Dr. Mangione answer.

Dr. MANGIONE. So we do have the oversight of the Pain Committee, which reviews all of the prescriptions that are over a certain level, 200 morphine milligram equivalents, morphine equivalents. In addition to that, we have as part of our evaluation a system for the physicians every six months, particularly our primary care physicians. We look at what they are prescribing, what the processes are. There is a wonderful software that has been made available by, I believe, VA central office, called The Almanac where we can go in and look at the individual providers and see what their pattern is and what the characteristics of their panel of patients is as far as prescribing.

The other thing that we have done is, we have tried to put some additional safeguards in. So if, in fact, a physician is prescribing, I believe it is 200 morphine milligram equivalents now, that they have to get a second level of approval before they can do that. I imagine my goal as we go forward will be dropping that so that they have to have an approval for 190 and 50 as we go forward, a second level of approval and a case evaluation.

Mr. COFFMAN. Are non-physicians allowed to prescribe drugs? In Mr. Harter's case, his son saw a physician's assistant, and he was able to get a prescription.

Dr. MANGIONE. I don't believe that is a controlled substance, and I don't believe that this—I don't know if I can say this.

Mr. COFFMAN. These are very powerful drugs.

Dr. MANGIONE. My understanding is that that was not the cause.

Mr. COFFMAN. I am sorry. It was not the cause—

Ms. HOUSER-HANFELDER. The question of whether that drug was a narcotic or not is I think at issue. The PA prescribed it—

Dr. MANGIONE. We don't believe that that is a controlled substance.

Mr. COFFMAN. A drug so powerful that it requires monitoring after a patient receives it, a non-physician can prescribe such a drug in this case, leading to suicide? A non-physician can do that under current VA policy?

Dr. MANGIONE. I would ask to be able to follow-up on that.

Mr. COFFMAN. Please, and I will be waiting for that answer.

And does the Eastern Colorado Health Care System use the same prescription drug monitoring program that the State of Colorado uses?

Dr. MANGIONE. Absolutely, and that is another point that I think should really be emphasized. Thank you for bringing that up. We had a culture that really wanted to be able to engage in that quite well before we were able to. My understanding of the reason that we were delayed a little bit is because each state has its own kind of software, and to be able to interface that with the central office software, took a little bit of time for us to do. But as soon as that software was available, I believe within that month, a couple of weeks, we were already participating in that prescription drug monitoring program. I think that is a huge step forward. And we actually contribute, is my understanding, in addition to being able to see what those prescribers in the community—

Mr. GIGLIOTTI. Right, and that includes our Grand Junction facility, too, the entire state.

Mr. COFFMAN. Thank you.

Ranking Member Kuster, you are now recognized.

Ms. KUSTER. Thank you, Mr. Chairman.

And that was part of this promise that the VA Committee passed, that was part of the package of House bills last week that will hope to be in the final package that goes to the President, two things in particular. One is that the VA all across the country use the prescription drug monitoring system; and you are absolutely right, it is difficult because it is state by state and you are relying upon the quality of the data. But I think that is something for your administration to stay on top of, to make sure that your physicians are using that on a regular basis because it will help us to identify sooner in the process people with drug seeking behavior. We will be able to get them the treatment they need and save lives.

Number two, there was a bill in the package that will make the prescription drug monitoring interstate. It may not be quite such a big issue here in Colorado, but in New Hampshire, a small state surrounded by literally Vermont, Massachusetts, Maine, touching the borders of our districts, we need to make sure that we can get that interstate.

I am going to turn my attention to the testimony about access here in Colorado. We have had extensive discussions in our Committee and, in fact, indeed on the House floor about the Aurora project and the delays and the staff blues and the extraordinary cost to taxpayers all across our country. I don't mean to re-litigate that. I know you are all looking forward to getting it open.

But I do need to ask, because the country is watching and waiting, what is your date of opening? What is the total cost of the project? And I am interested in drilling down to the added capacity because of the growth in veterans moving to Colorado or signing up for VA services. Do you know how many beds, how much outpatient? Where are we going to end up? Are we going to be back here in a couple of years talking about access again? So if you could take that one from the top.

Ms. HOUSER-HANFELDER. Let me take a shot at the date of the opening. We know based on—I have meetings every week or every other week with Corps of Engineers and KT, the contractor. They have made a firm commitment that that job will be totally finished January 2018. We have about a six-month ramp-up.

What we are working on now—and I apologize, but I cannot give you a hard date—is, we are working with the Corps with what we call red zone meetings where the Corps is trying to expedite completion of particular buildings early. The issue we are talking about right now—and there is a team I am taking to New Orleans to watch how they are doing their opening of their new facility, and they are taking different parts at different times.

So after we make that trip, have a conversation with Fernando Rivera, who is their director, and look at how they are doing it in order to provide a safe environment while you still have construction going on. I can't give you that date. If I had to give you a date, it would be January 2018 plus six months for activation. It is our goal to start activating that sooner as we get buildings, if we can maintain safe passage into those parts of the building.

Ms. KUSTER. Let me ask it a different way, because I think this has been going on for 10 years or even longer. When do you expect that a veteran will walk through those doors and get some kind of help?

Ms. HOUSER-HANFELDER. We have veterans there now. We have our Life Skills program in the front building, the CVS building. I have to see when they can hand us a building that you can get into. Otherwise I would say it is January 2018 plus six months, which would—

Mr. GIGLIOTTI. June or July.

Ms. HOUSER-HANFELDER [continued]. June or July. July 4th I have heard as a date. It is our goal to get in sooner.

Ms. KUSTER. So two-and-a-half years from now?

Ms. HOUSER-HANFELDER. Yes.

Ms. KUSTER. And what is the total cost? I think our appropriation is \$1.6 billion at this point, billion with a "B".

Mr. GIGLIOTTI. Yes, that has not changed.

Ms. HOUSER-HANFELDER. That has not changed.

Ms. KUSTER. Well, do you expect it to come in higher, lower?

Mr. GIGLIOTTI. I think the expectation is on budget.

Ms. KUSTER. So there are no cost savings from here on out?

Ms. HOUSER-HANFELDER. I don't know. That is a question to go to CFM and to the Corps.

Ms. KUSTER. Okay. And what is the extent of it? How many beds? Inpatient/outpatient programs? How many veterans can you see? I think in the testimony we had, it was a 24 percent increase in one year or something?

Ms. HOUSER-HANFELDER. Right.

Ms. KUSTER. How long is this going to help the vets?

Ms. HOUSER-HANFELDER. Two years.

Ms. KUSTER. A couple of years? After \$1.6 billion, can we get a few years out of this one?

Ms. HOUSER-HANFELDER. With the majority of that increase being in Colorado Springs, the number of beds that we are going to have in it is 148. There is a community living center that was taken out of that building, out of that project. So those 30 beds will not be moving over.

There is a new spinal cord injury center, which is a new program for us. That will be in the new building and be able to serve the veterans of Colorado and the surrounding areas. Right now our veterans go to California for spinal cord treatment for the most part.

Ms. KUSTER. So when will the Denver facility be closing down, and how many beds are being replaced? Is it a net positive, a net increase in beds from the closure of Denver to the opening of Aurora?

Ms. HOUSER-HANFELDER. It is a positive gain for spinal cord injury, otherwise not a gain.

Ms. KUSTER. How many beds are currently in Denver? I am curious if we are getting any net gain. You are saying we are not going to make any dent in the increase—

Ms. HOUSER-HANFELDER. There is not a large net gain of beds.

Mr. GIGLIOTTI. It is a pure replacement other than the spinal cord injury.

Ms. HOUSER-HANFELDER. Right. There is a PTSD component to this that we have right now that was taken out of the—it was never in the project. It is under design right now, and it is one of the leading PTSD programs in the country, inpatient residential programs.

Ms. KUSTER. I know I had some testimony in here or we had something in our records about optometry. You have thousands of people on a wait list, I think it was something like 7,000 people. Are we going to make any gains in optometry? Can veterans expect to get access in optometry or any other field that we are going to start to decrease wait lists and start to see more veterans by building this?

Ms. HOUSER-HANFELDER. Our wait list is down, down tremendously through efficiencies with how we are doing our clinics. We also use the Choice Program. We are one of the top—

Ms. KUSTER. No, I am aware of what the options are. I am trying to focus in here on the taxpayers' extent, the \$1.6 billion, what are we going to get?

Ms. HOUSER-HANFELDER. It is a replacement facility that did not increase capacity very much from how long it has been on the board.

Ms. KUSTER. So what is the rest of the space? How did it get so pricey? What else is there?

Ms. HOUSER-HANFELDER. It is private rooms. Right now if you come into our facility, we don't meet the privacy standards. So it is private rooms. It is rooms that are up to a health care standard that wasn't available in the '40s. So you have much larger—

Ms. KUSTER. What is going to happen to the existing hospital? What happens to the Denver facility?

Mr. GIGLIOTTI. It has not been adjudicated yet. There are an array of options that need to be considered, but no decision has been made yet.

Ms. KUSTER. But is the intention to close it down, or are you going to run two hospitals?

Mr. GIGLIOTTI. No, it would not be—

Ms. HOUSER-HANFELDER. No. The intention is to close it down.

Mr. GIGLIOTTI. Right.

Ms. HOUSER-HANFELDER. Our issue right now, and one that we are dealing with is that because the CLC was taken out of this—

Ms. KUSTER. What is the CLC?

Ms. HOUSER-HANFELDER. I am sorry. Community Living Center.

Mr. GIGLIOTTI. Community Living Center.

Ms. KUSTER. Okay, Community Living Center.

Ms. HOUSER-HANFELDER. The question is—and the PTSD program won't be done at the same time, may not be done at the same time because it is a different construction project—what do you do with those programs in that lapse? That is what we are looking at now.

Ms. KUSTER. So let's just fast forward. Let's take five years. Finally, we have a new facility. What do you expect will happen with the Denver facility? Because I assume there are carrying costs and expenses to the taxpayer for that?

Ms. HOUSER-HANFELDER. Yes. The goal is that we are not in it. There is a whole legal way that—

Mr. GIGLIOTTI. Yes, a GSA process to divest itself of Federal property.

Ms. HOUSER-HANFELDER. There is a lot of interest. If you have been to the facility, the University Hospital used to be behind us. That is almost all down now, and that is a very rich environment for new development. There is also a hospital across the street that has an interest.

Ms. KUSTER. Maybe if we are lucky we can sell it for something.

I am just going to close out my remarks. Colorado, like New Hampshire, is rural, with long distances for veterans to travel. I drove in from the airport. My understanding is your district is out that direction. How are veterans from Denver going to get to this facility, people on fixed income, or from more rural communities? What is the catchment area? How are they going to get there? Because it sounds like we are going to have this lovely Taj Mahal once they get there, but how are they going to get there?

Ms. HOUSER-HANFELDER. The same way they get here. It is only about four miles down the road. It looks like it is further. We have DAV, Disabled American Veteran, transportation system. We had a lot—

Ms. KUSTER. Is there public transportation?

Ms. HOUSER-HANFELDER. There is inside of this large area.

Ms. KUSTER. Say, for example, a vet living in Denver can get to Aurora on public transportation?

Mr. GIGLIOTTI. There is light rail and bus service also.

Ms. HOUSER-HANFELDER. And we will be on the Anschutz Campus, which is where the university is, the Children's Hospital, and

we are working with them to be part of their transportation system from the light rail. The light rail is due to be in place, I believe, in November or December. So there is this whole new—that is a whole new medical complex since 2000.

Ms. KUSTER. Just one last thought, because I keep hearing this in our Committee with every medical center across the country. Please be attentive on your signage for the veterans.

Mr. GIGLIOTTI. Yes.

Ms. KUSTER. It just horrifies me that we would have built this whole thing and they will get there and they will miss their appointment because they can't find where they are going to.

But, thank you very much, and thank you, Mr. Chair, for your leadership and for bringing us out here to Denver on such a gorgeous day.

Mr. COFFMAN. Thank you, Ranking Member Kuster.

Congressman Lamborn, you are now recognized.

Mr. LAMBORN. Thank you, Mr. Chairman. Thanks for having this hearing, as I said earlier.

I am just going to finish up. Many of my questions have already been answered. But what are projections, not here in Denver, but down in Colorado Springs, for the Lindstrom Clinic one year from now or five years from now?

Mr. GIGLIOTTI. It is very important for us to explore and work within our process. The Deputy Secretary, Sloan Gibson, is engaged in this, that we identify space that can be used for comp and pen exams, can be used for non-clinical purposes to free up the current clinic because of the growth being so explosive, to be for clinical care only. And then, it is important that we engage in the process to get an addition that was in the construction of the clinic with the land with great foresight in having the land. Then we would be able to add on to that clinic.

Mr. LAMBORN. Can you add just a little more, either one?

Ms. HOUSER-HANFELDER. On the expansion or the—

Mr. LAMBORN. The post-addition.

Mr. GIGLIOTTI. It is hoped for. We would have to get conceptual approval through the VA process called SCIP and get in that process, and then we get that approval and then we are able to start going into some designs. Designs give us a sense of some of the costs, and then that competes against other projects across the country.

Ms. HOUSER-HANFELDER. And one of the other things we are doing—and Dr. Mangione can probably speak to this—we have a DoD partnership with the Air Force Academy where all of our ambulatory surgery is done actually at the Academy. We are expanding that, and we are expanding specialty care. We have a full-time podiatrist coming on board in July. Not only will he work at the Colorado Springs clinic, he will also get surgery time at the Air Force Academy.

So we are looking at how do we bring in specialty care services, and Nate is doing a fabulous job saying let me tell you what maybe doesn't need to be in this clinical space, and can be moved out, so that we can keep adding specialty care.

We are probably good for one year for primary care growth, and after that, we have a trigger point now that says this is where our

panel sizes are, this is what our, if you will, occupancy of those panels are; what is the trigger for bringing on the next primary care? And, by the way, what does that mean for our specialty care?

Our goal is, we keep veterans in the community they are to get all the care they can get. I-25 is not the easiest route to traverse at any given time between here and Colorado Springs. It is not as bad as 30 in Texas, but close. So we are working on what are the specialty cares we can bring down.

We are also—our veterans need care, and if we can't provide that care, we are partnering in the community in Colorado Springs with providers. We have a meeting coming up in June where HealthNet is going to come in. The providers who provide care to our veterans through Choice are coming to the table, and our staff are coming to the table, as well as veterans, to have this roundtable conversation about how can we make this better, because that is a vital part—40 percent of our Choice case work is in Colorado Springs, although they have 30 percent of the work.

Mr. GIGLIOTTI. Denver is fifth in the country in Choice usage.

Mr. LAMBORN. HealthNet is a very cumbersome access provider, and the system is not seamless right now. We did talk about—it was the focus of the hearing this morning. I am concerned that—I am glad you are having that meeting in June.

Mr. GIGLIOTTI. We are trying a pilot program in our facility in Montana which HealthNet will then vet some schedulers at the facility, and that should help improve the communication between us and them, and that should help the service to the veterans. But it is a pilot program, so we are not sure how it will—

Mr. LAMBORN. And to summarize my initial question, do you have any projections for one year out or five years out for Colorado Springs clinic?

Mr. GIGLIOTTI. So, as Ms. Hanfelder said, primary care in one year should reach its ceiling at the clinic. So it is important for us to buy more space, as much as we can, inside the clinic by getting functions off that are not directly related to care. In five years, we are going to be in a position where we are going to need an addition to meet the demand if the demand continues. We see it all up and down the Front Range. We see it as part of the community, right? Colorado Springs, Denver, it just continues to grow, and veterans are a sizeable percentage of that growth.

Ms. HOUSER-HANFELDER. We also do extended hours, and we do Saturday clinics. So we know that to be good stewards of taxpayers' dollars, my dollars, we need to make sure that the buildings we have are utilized to the capacity that they can, because if they are only open eight hours a day, they sit empty. So we are working and have been fairly successful with the Saturday clinics in Colorado Springs, as well as here in Denver.

Mr. LAMBORN. Mr. Chairman, I yield back.

Mr. COFFMAN. Thank you, Congressman Lamborn.

Let me just say right before the concluding remarks, Congresswoman Kuster raised the issue of the hospital and the cost. Having led the effort in the Congress to strip the VA of its construction management authority to ever build another hospital again and focus on really what your core competencies are, which is providing health care to our veterans and other benefits, it is amazing to

me—and we are still waiting for this administrative investigative board report, the AIB, that to my understanding is finished, but is yet to be released to the public and to the Congress in its entirety. We have a project that, in effect, lost a billion taxpayer dollars where no one who is responsible has been held accountable.

So I think the VA owes that report to the Congress and the American people. It is incredible. I mean, as a combat veteran and as a taxpayer, it is just offensive what occurred in my hometown of Aurora, Colorado. I think there is a GAO report from April of 2013 that says, at that time there were four hospitals that were under construction, that each were hundreds of millions of dollars over budget and years behind schedule, and yet the VA took no action in terms of changing personnel that were responsible for that.

Let me give concluding remarks.

Our thanks to the witnesses. You are now excused.

Today we have had a chance to hear about ongoing problems at medical centers in Colorado and nationwide regarding VA's controlled substance oversight practices, as well as its appropriate use of medical facilities to benefit veterans.

I am troubled by the numerous issues that were identified today, and I look forward to seeing improvement in these areas, both in Denver and across the country, to ensure veterans receive the best health care possible.

I ask unanimous consent that all Members have five legislative days to revise and extend their remarks and include extraneous material.

Without objection, so ordered.

I would like to once again thank all of our witnesses and audience members for joining us in today's conversation.

With that, this hearing is adjourned.

[Whereupon, at 11:02 a.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Ralph Gigliotti

Good morning, Mr. Chairman, Ranking Member Kuster, and Members of the Committee. Thank you for the opportunity to discuss the VA's handling, prescription, oversight practices, and the appropriate use of controlled substances at VA facilities. I am accompanied today by Sallie Houser-Hanfelder, Director, Eastern Colorado Health Care System, and Dr. Ellen Mangione, Chief of Staff, Eastern Colorado Health Care System (ECHCS).

Oversight and Handling of Prescription Drugs

Questions have arisen regarding pharmacy practices and accountability in VA ECHCS. Specific inquiries relate to the results of a Drug Enforcement Administration (DEA) investigation from July 2015, regarding pharmacy discipline practices and prescription and opioid drug management. On July 7, 2015, the DEA issued an administrative warrant and presented on site at the Denver VA medical center with several DEA investigators. The investigators were on site for approximately 3 weeks. In February 2016, DEA reported findings to the Executive Leadership Team and pharmacy management. Many items were addressed verbally while DEA was on site but the DEA investigation remains open.

In the last 5 years, 8 ECHCS VA employees have been disciplined or removed for illegal possession or use of drugs on VA property. Either disciplinary action was taken or the employee resigned from their position.

To improve safe pharmacy practices, the VA Opioid Safety Initiative (OSI) was implemented nationwide in August 2013. The OSI objective is to make the totality of opioid use visible at all levels in the organization. It 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 Morphine Equivalent Daily Dose (MEDD) of opioids. Nationally, results of key clinical metrics for VHA measured by the OSI from Quarter 4 FY 2012 (beginning in July 2012) to Quarter 2 FY 2016 (ending in March 2016) show:

- 151,982 fewer patients receiving opioids (679,376 patients to 527,394 patients, a 22 percent reduction);
- 51,916 fewer patients receiving opioids and benzodiazepines together (122,633 patients to 70,717 patients, a 42 percent reduction);
- 94,045 more patients on opioids that have had a urine drug screen to help guide treatment decisions (160,601 patients to 254,646, a 37 percent increase);
- 122,065 fewer patients on long-term opioid therapy (438,329 to 316,264, a 28 percent reduction);
- The overall dosage of opioids is decreasing in the VA system as 18,883 fewer patients (59,499 patients to 40,616 patients, a 32 percent reduction) are receiving greater than or equal to 100 MEDD; and
- It is important to note that these desired results of OSI have been achieved during a time that VA has seen an overall growth of 136,944 patients (3,959,852 patients to 4,096,796 patients, a 3 percent increase) that have utilized VA outpatient pharmacy services.

The OSI dashboard metrics indicate the overall trends are moving steadily in the desired direction. VA expects this trend to continue as it renews its efforts to promote safe pain management therapies. VA intends to implement safe opioid prescribing training for all prescribers, as the President directed all Federal agencies in his October, 21, 2015, presidential memorandum. To date, 70 percent of prescribers have received training.

VA ECHCS Access

Over the past 3 fiscal years (FY), VA ECHCS has experienced a consistent increase in demand for services. Unique patients receiving services have grown by over 13 percent from 67,070 in April 2014, to 75,896 in April 2016. We have increased the supply of health services over the same time period by 12 percent, completing 571,464 outpatient visits through April 2016, compared to 510,109 through April 2014. High demand has outpaced this increase in supply, resulting in longer wait times for our Veterans in primary care, specialty care, and mental health services. Despite this, VA ECHCS has made tremendous strides in decreasing the electronic wait list (EWL) from a high of 6,817 in January 2016 to 543, as of May 9, 2016.

VA ECHCS has increasingly relied on the community to provide health services to our growing Veteran population. Excluding the Veterans Choice Program, expenditures through the Non-VA Medical Care Program increased by 28 percent from \$112,595,770 in 2014 to \$144,313,630 in 2015. VA ECHCS continues to be in the top five facilities in the nation in the volume of referrals to the Veterans Choice Program. Through March 2016, VA ECHCS has referred 27,716 episodes of care, resulting in 17,251 appointments in the community.

Colorado Springs has seen the most notable increase in workload within the VA ECHCS catchment area over the last 3 FYs. On February 4, 2016, the Office of Inspector General released a report identifying untimely care concerns at the Colorado Springs Outpatient Clinic resulting from a complaint received in January 2015. The report also identified areas, such as scheduling and referrals to the Veterans Choice Program, that needed improvement. The department's Office of the Inspector General acknowledged in the same report that ECHCS had already executed a number of corrective actions to become compliant with their concerns. Actions taken include filling vacancies; hiring new staff and trainers from entry to executive levels; re-training; and practicing continuous quality improvement.

In January 2016, the Electronic Wait List for Primary Care was 807 and Optometry was 4,247. As of May 9, 2016, the combined total is 15. We expect patient wait times to continue decrease over the next 90 days. Other access-challenged services in Colorado Springs include Podiatry, Physical Therapy, and Dental, and wait times in these services have shown significant improvement. Podiatry has opened a second Same-Day Access clinic, while Physical Therapy and Dental wait times have improved as a result of better clinic management and scheduling. As wait times continue to decrease in these services, Veterans will receive prompt access to the care they deserve.

Difficulties in recruiting providers at the Alamosa Community-Based Outpatient Clinic (CBOC) and the recent resignation of the primary physician prompted a review of how best to provide care to the Veteran population in the San Luis Valley. Ongoing recruitments for Alamosa have not been successful due to rurality. By law all Veterans in San Luis Valley are eligible for the Veterans Choice Program because they live more than 40 miles from the nearest VA medical facility. A VA medical facility is defined under the Choice Program as a VA hospital, a CBOC, or a VA health care center, that has at least one full-time primary care physician. Another provider challenge is the resignation of one provider and the impending retirement of another. Recently, VA has identified two potential physician candidates interested in employment at the Alamosa CBOC. However, successful physician recruitment will result in the Veteran population no longer being able to directly opt into Choice because they will no longer reside more than 40 miles from the nearest VA medical facility with a full-time primary care physician. Nevertheless, we will work to ensure continuity of care for those Veterans who have been treated through the Veterans Choice Program in the community.

Denver VA Campus

Medical and prosthetic research currently located on the Denver VA campus, including in some temporary modular buildings, should be moving into its new space at the Replacement Facility on the Fitzsimmons Campus in Aurora, Colorado. The project is to replace the current Denver VA Medical Center which was built in 1948. VA engaged the U.S. Army Corps of Engineers (USACE) and entered into an inter-agency agreement (IAA) with USACE to provide services in support of VA's construction program. VA and USACE utilize this IAA to engage USACE as VA's design and construction agent on our super construction projects over \$100 million in accordance with VA Expiring Authorities Act of 2015 (Public Law 114-58), enacted on September 30, 2015.

The USACE, VA, and Kiewit-Turner are working in close collaboration to complete the construction in Aurora. The construction team is dedicated to meeting the highest possible standard while achieving VA requirements and criteria, while also pursuing cost savings opportunities to maintain the current budget. To ensure that

previous challenges are not repeated and to lead improvements in the management and execution of our capital asset program as we move forward, we will continue to focus on these lessons learned over the course of this construction project:

- Integrated master planning to ensure that the planned acquisition closes the identified gaps in service and corrects facility deficiencies.
- Requiring major medical construction projects to achieve at least 35 percent design prior to cost and schedule information being published and construction funds requested.
- Implementing a deliberate requirements control process, where major acquisition milestones have been identified to review scope and cost changes based on the approved budget and scope.
- Institutionalizing a Project Review Board (PRB) - VA's Office of Acquisition, Logistics, and Construction worked with USACE to establish a PRB for VA that is similar to the structure at the USACE District Offices. The PRB regularly provides management with metrics and insight to indicate if/when the project requires executive input or guidance.
- Using a Project Management Plan - outlines for accomplishing the acquisition from planning to activation to ensure clear communication throughout the project.
- Establishment of VA Activation Office - Ensures the integration of the facility activation into the construction process for timely facility openings.
- Conducting pre-construction reviews - Major construction projects must undergo a "constructability" review by a private construction management firm to review design and engineering factors that facilitate ease of construction and ensure project value.
- Integrating Medical Equipment Planners into the construction project teams - Each major construction project will employ medical equipment planners on the project team from concept design through activation.

The new 148-bed medical center will accommodate inpatient tertiary care and ambulatory care functions. Several renewable energy initiatives are a part of the project, including efforts to achieve LEED certification. In all phases of construction and activation, the Activations Team is working in close consultation with our Military, Veteran and Community stakeholders. VA ECHCS holds regular on-site meetings with the United Veterans Committee of Colorado, as well as executive-level meetings with Paralyzed Veterans of America regarding the new Spinal Cord Injuries and Disorders (SCI-D) unit. As of the end of April 2016, there are approximately 950 Craft construction personnel working onsite. The project is 67percent complete.

Security

Due to undeniably tragic events, other questions have been raised regarding the safety and security of our Veterans and employees. Self-harm and intended injury to others is an unfortunate and rising trend in our global community. Colorado has faced its share of tragedy. VA ECHCS has taken a proactive approach and high-level trainings have been voluntarily scheduled to improve the safety and security of our Veterans and employees.

The VA ECHCS Director requested a security assessment be performed by VA Central Office. The team visited the Denver VA Medical Center, the replacement hospital facility in Aurora, and the outpatient clinics located in Colorado Springs and Golden. At the out-briefing, the team did not identify any significant findings, and was complimentary of the physical security measures in place. VA ECHCS is eagerly waiting to receive the team's written assessment and will rapidly address any findings or recommendations made. VA ECHCS has scheduled the VA Law Enforcement Training Center to provide an employee educational course "Verbal Defense in Healthcare." We anticipate this will help empower our staff with additional skills that they can use to keep people safe during difficult encounters. VA Police and the Emergency Preparedness Coordinator are providing Active Threat Response training and drills throughout the organization.

Sustainable Accountability

VA is committed to creating an environment of sustainable accountability, in which employees know what is expected of them and do it, and then some. Sustainable accountability means VA uses taxpayer dollars wisely and well to improve post-military life for our Veterans and their families. To create this culture, we have taken steps such as changing Senior Executives' and Medical Center Directors' performance reviews to include Veteran-centric outcome objectives. Improvements in workforce culture, with a focus on ICARE values, will allow VA to address issues

as they arise, rather than necessitating employee termination following repeated and/or pervasive poor behavior. VA has also implemented strong independent oversight by establishing the Office of Accountability Review, and by securing certification in OSC's 2302(c) Whistleblower Protection Certification Program, which ensures that Federal agencies meet the statutory obligation to inform their workforce about the rights and remedies available to them under the Whistleblower Protection Enhancement Act and related civil service laws.

Additionally, VA policy states Senior Executives who are the subject of a pending investigation have their performance ratings deferred until the investigation is complete. Any adverse finding is then addressed in the rating itself. VA implemented the expedited Senior Executive removal authority provided by Section 707 of the Veterans Access, Choice, and Accountability Act of 2014, and has thus far used that authority to propose removal of Senior Executives. Furthermore, Federal employees may be terminated for a variety of reasons ranging from absence without leave and inability to maintain performance standards to serious offenses such as falsification of records, misuse of government property, or sexual harassment. The vast majority of VA's more than 300,000 employees are committed to serving Veterans effectively and well. Where performance or conduct issues warrant removal, however, VA takes appropriate action to terminate employment.

Mr. Chairman, this concludes my testimony. My colleagues and I are prepared to answer any questions you, Ranking Member Kuster, or other Members of the Committee may have.

