

**NOMINATION OF HON. DAVID J. SHULKIN, M.D.,
TO BE SECRETARY, U.S. DEPARTMENT OF
VETERANS AFFAIRS**

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

UNITED STATES SENATE

ONE HUNDRED FIFTEENTH CONGRESS

FIRST SESSION

FEBRUARY 1, 2017

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**NOMINATION OF HON. DAVID J. SHULKIN,
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OF VETERANS AFFAIRS**

WEDNESDAY, FEBRUARY 1, 2017

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 2:50 p.m., in room 106, Dirksen Senate Office Building, Hon. Johnny Isakson, Chairman of the Committee, presiding.

Present: Senators Isakson, Moran, Boozman, Heller, Cassidy, Rounds, Tillis, Sullivan, Tester, Murray, Sanders, Brown, Blumenthal, Hirono, and Manchin.

**HON. JOHNNY ISAKSON, CHAIRMAN,
U.S. SENATOR FROM GEORGIA**

Chairman ISAKSON. We are in the midst of what may be as many as five votes on the floor, and in order to keep the Committee moving quickly and have this hearing over with as expeditiously but as thoroughly as possible, we are going to start off in a little bit different order. I will introduce Senator Toomey from Pennsylvania to make an introduction of Dr. Shulkin. Then we will have an opening statement by the Ranking Member, an opening statement by myself, and then we will begin to go to the hearing with the Members present.

Is that satisfactory with everybody? Is that OK with you, Jon? Senator TESTER. You bet.

Chairman ISAKSON. With that being the case, I introduce the distinguished Senator from Pennsylvania for the purposes of remarks about the Secretary-to-be.

**STATEMENT OF HON. PATRICK J. TOOMEY,
U.S. SENATOR FROM PENNSYLVANIA**

Senator TOOMEY. Thank you very much Chairman Isakson, Ranking Member, Tester, Members of the Committee. I appreciate this opportunity to briefly introduce Dr. Shulkin before the Committee.

You know, Washington, D.C., has long been a city that focuses a lot on titles. When Dr. Shulkin arrived in Washington to help take charge and reform a troubled Veterans Health Administration, he got a new title. He was "Honorable" Under Secretary of the Veterans Administration. Yet there is another title which I

think is more important to him, and by which he is very well-known in Pennsylvania, and that is doctor.

Despite the challenges which he has faced, and with which he has been entrusted, he has never forgotten his focus on medicine and his focus on serving others. As a fellow Pennsylvanian, it is an honor for me to be able to introduce him to this Committee today.

You know, Pennsylvania has a very large number of veterans, nearly a million across our commonwealth. We have eight VA medical centers, 31 VA community-based outreach clinics. I have said many times, our veterans should be first in line for the best quality health care in America.

In Pennsylvania and across our country in recent years, that has not always been the case, but in recent years the VA and Congress have worked to address some of the challenges and issues, and we have made progress.

There is more work to be done. It is my hope that after confirmation, Dr. Shulkin will be leading that charge. I think he is the right man for this moment.

He has got a very, very impressive and distinguished background. He is a graduate of the Medical College of Pennsylvania, now part of Drexel. He did his residency and fellowship at the University of Pittsburgh. He ended up back in Philadelphia at the University of Pennsylvania, where he played numerous roles, working his way up to become Chief Medical Officer and Chief Quality Officer for the University of Pennsylvania Health System. Dr. Shulkin then went on to Temple, then Drexel, managing those schools' hospitals in various capacities. He then left for New York and became the President of the Beth Israel Medical Center. He later became President of the Morristown Medical Center, which is part of the Atlantic Health System.

In 2015, Dr. Shulkin got the call that the VA needed his experience to help address some of the problems that we were facing there, and as the Committee knows, in 2014 the VA was embroiled in major scandals. Well, despite the difficult circumstances, Dr. Shulkin agreed to accept the position, accept the challenges, and he was confirmed by the Senate without objection. He then began to fix the implementation of the Choice Act, which had significant problems.

Last week, Dr. Shulkin and I met and had a very constructive, great conversation about many things, including the ongoing implementation challenges of the Choice Act. I was very, very impressed with his extensive knowledge and his insights. I think those—that knowledge and insights have been forged by a career as a top administration in some of the Nation's largest hospital systems, but it is also informed by his personal experience as a physician, which I think is invaluable.

I look forward to continuing our work together to help our Nation's veterans. It is an honor for me to be able to introduce Dr. David Shulkin to the Veterans' Affairs Committee today. He is a great Pennsylvanian. I believe he will be a great leader of this essential organization.

I thank you very much Mr. Chairman and Ranking Member Tester.

Chairman ISAKSON. Senator Toomey, thank you very much for being here. I know your time is tight and I appreciate your remarks about Dr. Shulkin. I appreciate all the work you have done to help the Veterans' Affairs Committee. You will be excused. We will not hold it against you because you have got to vote; so do we.

Senator TOOMEY. Thank you very much.

Chairman ISAKSON. Thank you.

Dr. Shulkin, we are going to have brief remarks by me, then the Ranking Member, then it will be your turn at the microphone.

**OPENING STATEMENT OF HON. JOHNNY ISAKSON, CHAIRMAN,
U.S. SENATOR FROM GEORGIA**

Chairman ISAKSON. I want to tell everybody about the first time I met Dr. Shulkin. It was on a Delta airplane, flying to Washington, DC, where I have met most of the people I know in my life, it seems like, between Georgia while coming to Washington, DC. I had just come from a meeting in my office with an anesthesiologist in Georgia, who had a concern and a question about the VA and anesthesiology and nurse anesthetists and all those types of things—a complicated issue, which is not the most important part.

The important part is that Dr. Shulkin recognized me and came over and gave me his card and said, "I am David Shulkin." I said, "Well, I know who you are. We are going to have you before the Committee pretty soon." He said, "Yeah. On Tuesday." That is when we had his confirmation hearing as Under Secretary.

I said, "Well, I will tell you what. Let me give you this card that I just received in my office from this anesthesiologist who has a concern with VA and anesthesia. Would you call him if you get a chance?"

I got to the office the next morning. Dr. Shulkin had not only called him but he had called him and spent about 3 hours on the phone with him, and when I got to the office I had a call from Dr. Shulkin to let me know he had talked to him, plus a call from the doctor to tell me how satisfied he was that Dr. Shulkin cared enough to call him.

That is what I look for. That is the tender, loving care that we look for in all executives that is rarely ever there, and in a job like veterans' health care, that type of service and attitude is important. I also want to remind Dr. Shulkin of what he did that day, and that was my first day I knew if I could cast a good vote for him, I would.

Now, let me just make these remarks, because all of the Members are going to have a lot of questions later on, and I know Sen. Tester is going to make remarks after I do.

It is very important that we complete the task of getting open accessibility to our veterans to health care, but we make everybody understand we are not about privatizing health care for veterans. We are about making health care more available to veterans through implementation of the private sector with the Veterans Administration. We do not want to privatize it; we want to empower it.

Further, we know that we still have wait times far too long on appeals. If we have one goal after getting Choice fixed, if we have one goal we have got to have, that is to get the wait time on ap-

peals down, and I mean way down. I think it is doable if we, on the Committee, do our job, working with the appropriators, and if the VA does its job in telling us what it really needs to do to speed up that process, whatever it might be. I am committed to accomplishing those two things in this 2-year term on the Committee.

With that said, I am really lucky, as a Chairman, to have had a great Ranking Member in Richard Blumenthal the last 2 years. He helped the whole Committee unanimously pass through the U.S. Senate the Jeff Miller and Richard Blumenthal Veterans Health Care and Benefits Improvement Act last year, the last day of the session before Christmas. We made a lot of steps forward, but we did not make the ones we needed to, we did not make all of them.

Now Jon Tester will replace Richard Blumenthal as Ranking Member, so I still am blessed to have the best Ranking Member I could possibly have. He is a good friend. He cares about veterans. I enjoy working with him a lot. With that said I will introduce Sen. Jon Tester of Montana.

**OPENING STATEMENT OF HON. JON TESTER, RANKING
MEMBER, U.S. SENATOR FROM MONTANA**

Senator TESTER. Well, thank you, Chairman Isakson. I look forward to working with you, too. You are very kind. Thank you.

Dr. Shulkin, welcome to this Committee.

Dr. SHULKIN. Thank you.

Senator TESTER. As you may have noticed, you are operating on a little bigger stage than what you operated on before, in more ways than one.

I appreciate you accepting the responsibility that comes with the duties of the Secretary of the Department of Veterans Affairs. It is my hope, and I believe the hope of this Committee, that you are up to this task. The way in which you answer our questions today will help many of us make that final determination.

Amidst an impressive career as a health care executive in the private sector, you were brought into the VA about 18 months ago to help transform the administration and delivery of veterans' health care. The wait time scandals that arose from Phoenix, back in 2014, were something that none of us could tolerate.

After Secretary Robert McDonald took the helm of the Department, a number of senior leaders were replaced and a number of transformational reforms were initiated, many of which you were a part of. Meanwhile, Congress, in a rare demonstration of bipartisanship, enacted the Veterans Access, Choice and Accountability Act of 2014. This legislation sought to bolster the capacity of the VA to better directly serve veterans, and to expand veterans' access to community care when the VA was incapable of providing that care in a timely manner. Now, 2½ years later, the VA is confronted with looming and dramatic funding shortfalls and a so-called Choice Program that, at least in Montana, has only left veterans with the choice of waiting longer for care or not getting it at all.

Just a couple of weeks ago, a veteran from Helena, MT, wrote me: "Trying to get a cardiologist and working with the Choice Program was one of the most stressful parts of my heart attack incident. It took 19 days from the time the Choice Program was con-

tacted with my urgent case for me to get to the specialist. I was concerned the entire time that I was going to have a heart attack while I was waiting.”

This is unacceptable. I can share dozens of similar stories, from frustrated veterans, family members, and even front-line VA employees in Montana, not to mention community providers in my State and across the country that continue to drop out of the Choice Program because of the bureaucracy involved and the time it takes to get reimbursed through this program.

Look, I get it. Some of it is how that law was written, and some—actually, a lot in my State—is on the part of the third-party administrator. But, a lot also has to fall on the VA, and as the head of the Veterans Health Administration for the last 2 years, a lot of that responsibility falls directly with you.

We often look at the numbers and the statistics up here, to try to determine whether a program or an agency is effective, but behind every statistic, behind every number is a person and a story. And the story I hear every time I go back to Montana, which is almost every weekend, is that the Choice Program is making a difficult problem even worse.

The VA has endorsed an effort to simply extend the life of that program, but I will tell you, if anyone wants to extend the life of that program, without also taking the steps needed to make it work better for veterans, you are going to have to go through me. And I will oppose you every step of the way. I relayed that message to you during our last conversation in my office. It is my understanding that we are on the same page. I appreciate you being up-front about that.

I also know that you will be fighting a war on multiple fronts. While trying to carry out the Department’s mission, you will have to deal with a Congress that has not proven itself to be the most productive or cooperative partner. You will have to deal with the new President, who has taken some public positions on everything from privatization to personal opinions about the VA workforce that are in stark contrast to the positions that you have taken.

Sooner than later you will come to a crossroads. You will have to choose whether to pursue what you think is best for veterans or what the President tells you is best for veterans. I want you to succeed. It is critically important. But, there was a reason it took so long to find someone to sit in your chair here today.

In a conversation with VSO representatives a couple of weeks ago, Bob Wallace, the VFW Executive Director, described Bob McDonald’s job, your predecessor, as trying to turn around the Titanic in a bathtub, in as little time as possible.

Under Secretary McDonald’s leadership there is no question that VA has made some meaningful and tangible progress on critical priorities like connecting more veterans to care, ending veterans’ homelessness, and getting the disability claims backlogged under control. Though the overall veteran population has decreased in recent years, more and more veterans are enrolled in VA health care and are receiving critical benefits like disability compensation or educational benefits.

As we move forward, more veterans will come out of the shadows. The veteran population will age, and their already complex

medical conditions will become even more complex. These folks will turn to the VA and it is critical that you earn their trust by demonstrating that you can meet their needs in not only a timely but a thorough manner.

So, the question of the day is whether you can build upon VA's successes and continue delivering for veterans and their families, while also taking steps to address the systemic and chronic challenges that impede the Department's ability to carry out its mission.

In short, I hope you are up for the job. We need to know that you are the right person to lead this department at a critical time, because there is far too much at stake.

I look forward to this discussion today and I want to thank you again for your willingness to serve on behalf of our Nation's veterans and their families.

Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Tester. I appreciate your service and I appreciate your thorough opening statement.

Now we are getting ready to see what a Congressional shuffle is all about. We had our second vote called. You saw a couple of Members leave to go over. They will come back so I can go over and replace them. We are going to go back and forth and play ping pong for about an hour and one-half. That is not to diminish a single question that we need to ask, and if we have to pause for a minute to get everybody back, we will do that, Dr. Shulkin.

Dr. Shulkin, would you please stand and raise your right hand?

Do you solemnly swear or affirm that the testimony you are about to give before the Senate Veterans' Affairs Committee is the truth, will be the truth, the whole truth, and nothing but the truth, so help you God?

Dr. SHULKIN. I do.

Chairman ISAKSON. Thank you. You may be seated.

You are welcome to have the floor for 5 minutes or so, a little more if you want it, and if you have got any family members or anyone you want to introduce in the audience, please do so.

STATEMENT OF HON. DAVID J. SHULKIN, M.D., NOMINEE TO BE SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. SHULKIN. OK. Well, Chairman Isakson, thank you for your remarks, and Ranking Member Tester, thank you for your remarks, and to all the distinguished Members of the Committee, and everyone here who joined us who cares deeply about veterans, I want to thank you for being here today.

I have gotten to know all of you over the past 18 months, and I have a great respect for this Committee and the work you do. I happen to think it is the best committee in the Senate. It works in a bipartisan way on the behalf of veterans.

It has been a privilege to serve as the Under Secretary for Health for the past 18 months, and it is my highest professional honor to be considered for the Secretary of Veterans Affairs.

I am also grateful to my wife, who is here today, Dr. Merle Bari, somewhere—that way. OK. We met in medical school. We have been married for 29 years. It has been her continuous support and encouragement during my first confirmation process, and now, al-

most 2 years later, when we started that, her commitment to veterans that has really inspired me. My two children, Danny and Jenny, are probably watching too, and I think all of you know our jobs are really family affairs.

Our country's sacred obligation to fully honor our commitments to our veterans is deeply personal to me. I was born on an Army base. My father was an Army psychiatrist—he is probably watching too. Both grandfathers were Army veterans, and my paternal grandfather served as the Chief Pharmacist at the VA hospital in Madison, WI.

As a young doctor I trained in several VA hospitals. I view my service at VA as a duty to give back to the men and women who secured the uniquely American freedoms and opportunities we all enjoy because of the sacrifices they made.

I came to VA at a time of crisis, when it was clear that veterans were not getting timely access to high-quality health care they deserved. I soon discovered that it was years of ineffective systems and deficiencies in workplace culture that led to these problems. I concluded it would take years to fix these problems, but because veterans' lives were at stake, there was no time to waste. That is why I focused on meeting the most urgent health care needs of our veterans first, and reorganized our approach to reflect that.

As a result, we have dramatically reduced the number of people waiting for urgent care. The VA now has same-day services in primary care and mental health at all of our medical centers, to make sure veterans get the urgent care they need, when they need it most.

Over the past 18 months, I have had the opportunity to travel across the country to hear directly from veterans, their service organizations, and stakeholders about their concerns with VA. I appreciate both the candor of these conversations and the overwhelming support and commitment I have received from so many in improving VA. The opportunity to spend with and learn about the needs of the veterans we serve was the best preparation I could have had for this nomination.

VA has been working hard to act more as an integrated enterprise, and toward that end I have worked closely with my colleagues in Veterans Benefit Administration and the National Cemetery Administration. I understand that veterans see us as one VA and not as three separate administrations. Creating a seamless experience for veterans accessing benefits and services is critical to fulfilling our mission. If confirmed, I would build upon my foundational understanding of these issues to accelerate change across all three administrations.

VA is a unique national resource that is worth saving, and I am committed to doing just that. One thing I want to be especially clear on is that VA has many dedicated employees across the country, and our veterans tell us just that every day. It is unfortunate that a few employees who have deviated from the values we hold so dear have been able to tarnish the reputation of so many who have dedicated their lives to serving those who have served.

There should be no doubt that if confirmed as Secretary, I will seek major reform and a transformation of VA. There will be far greater accountability, dramatically improved access, responsive-

ness and expanded care options, but the Department of Veterans Affairs will not be privatized under my watch. If confirmed, I intend to build a system that puts veterans first and allows them to get the best possible health care wherever it may be, in VA or in the community.

I have demonstrated my commitment to moving care into the community where it makes sense for the veteran. When I began my tenure as Under Secretary for Health, 21 percent of care was delivered in the community, but today that figure stands at 31 percent. But, veterans tell us that even with the ability to seek care in the community, they want VA services. Of the more than 1 million veterans who took advantage of the Choice Program, only 5,000 have sought care solely in the community. The rest used both VA and the community.

Should I be confirmed, I intend to build an integrated system of care that would strengthen services within VA that are essential for veteran well-being, and use services in the community that can serve veterans with better outcomes and value to the taxpayer. We will need to work closely together to extend and reform the Choice Program to ensure veterans are able to seek the care in the community they need.

We have made significant progress in suicide prevention, including hiring more mental health professionals, implementing a predictive tool to identify those at the greatest risk, and fixing the Veterans Crisis Line so it better serves our veterans. We must also continue our progress in addressing the unique needs of women veterans by expanding women's health services and ensuring our facilities are welcoming to women. I also want to recognize the importance of supporting the efforts of families and caregivers who are involved in the care of our veterans.

We have to continue our work to eliminate the disability claims backlog, and we need legislation that would allow us to reform the outdated appeals process. We must continue the progress we have made in reducing veterans' homelessness, and modernize our IT systems to improve our services and efficiencies. We have to address infrastructure issues and take a closer look at facilities that no longer serve a useful purpose. We must explore expansion of public-private partnerships rather than continue to build medical centers that have large cost overruns and take too long to build.

With the support of the Members of this Committee and others in Congress, veterans and their service organizations, the dedicated employees of VA, and the American people, we can fulfill President Lincoln's promise and our sacred mission "to care for him"—and now for her—"who shall have borne the battle." There is no nobler mission or higher calling for me, and it would be my distinct honor and privilege to lead this effort. Our veterans deserve the very best, and with your support, I am confident we will succeed.

Thank you and I look forward to your questions.

[The prepared statement of Dr. Shulkin follows:]

PREPARED STATEMENT OF DR. DAVID SHULKIN, NOMINEE TO BE SECRETARY, U.S.
DEPARTMENT OF VETERANS AFFAIRS

Chairman Isakson, Ranking Member Tester, Distinguished Members of the Committee on Veterans' Affairs, and everyone here today who cares deeply about our Veterans: Thank you for the opportunity to address you. I have gotten to know

many of you over the past 18 months, and I have great respect for this Committee and the work you do. It has been a privilege to serve as Under Secretary for Health over the past 18 months. It is my highest professional honor to be nominated for consideration as the next Secretary of Veterans Affairs.

I'm grateful to have my wife, Dr. Merle Bari, with me here today. We met in medical school and have been married for 29 years. Her continuous encouragement and support since my first confirmation process almost two years ago, as well as her commitment to our Veterans, have inspired me.

Our country's sacred obligation to fully honor our commitments to our Veterans is deeply personal to me. I was born on an Army base. My father was an Army psychiatrist, both grandfathers were Army Veterans, and my paternal grandfather served as Chief Pharmacist at the VA hospital in Madison, Wisconsin. As a young doctor, I trained in VA hospitals. I view my VA service as a duty to give back to the men and women who secured the uniquely American freedoms and opportunities we all enjoy because of the sacrifices they made. I came to VA during a time of crisis, when it was clear Veterans were not getting the timely access to high-quality health care they deserved. I soon discovered that years of ineffective systems and deficiencies in workplace culture had led to these problems. I concluded it would take years to fix the problems, but because Veterans' lives were at stake, there was no time to waste. That is why I focused on meeting the most urgent health care needs of our Veterans first, and reorganized our approach to reflect that. As a result, we've dramatically reduced the number of people waiting for urgent care. The VA now has same-day services in primary care and mental health at all our medical centers to make sure our Veterans get the urgent care they need, when they need it most.

Over the past 18 months, I have had the opportunity to travel across the country hearing directly from Veterans, service organizations, and stakeholders about their concerns with VA. I appreciate both the candor of these conversations and the overwhelming support and commitment I have received from so many for improving VA. The opportunity to spend time with and learn about the needs of the Veterans we serve was the best preparation I could have had for this nomination.

VA has been working hard to act more as an integrated enterprise, and toward that end, I have worked closely with my colleagues in VBA and NCA. I understand that Veterans see us as one VA and not three separate administrations. Creating a seamless experience for Veterans accessing benefits and services is critical to fulfilling our mission. If confirmed, I would build on my foundational understanding of these issues to accelerate change across all three administrations.

VA is a unique national resource that is worth saving, and I am committed to doing just that. One thing I want to be especially clear on is that VA has many dedicated employees across the country, and our Veterans tell us that every day. It is unfortunate that a few employees who deviated from the values we hold so dear have been able to tarnish the reputation of so many who have dedicated their lives to serving those who have served.

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With the support of the Members of this Committee and others in Congress, Veterans and their service organizations, the dedicated employees of VA, and the American people, we can fulfill President Lincoln's promise and our sacred mission "to care for him who shall have borne the battle." There is no nobler mission or higher calling for me, and it would be my distinct honor and privilege to lead this effort. Our Veterans deserve the very best, and with your support, I am confident we will succeed. Thank you and I look forward to your questions.

RESPONSE TO PREHEARING QUESTIONS SUBMITTED BY HON. JOHNNY ISAKSON TO HON. DAVID J. SHULKIN, M.D., NOMINEE TO BE SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. Dr. Shulkin, after serving at the Department of Veterans Affairs (VA) for about 20 months, what do you see as the most significant challenges facing VA and what would be your highest priorities if confirmed as Secretary?

Response. Our most significant challenge will be to address the systemic challenges that face VA. Over the past 18 months that I have served as USH we have been focused on addressing the acute issues that VA inexperienced with the crisis in access and the erosion of confidence with the American people. We have made real progress, and have turned the corner in numerous areas. However, it is now time to address the systemic issues that are required in business transformation.

My highest priority would be to work with the Administration and Congress to develop a sustainable plan for VA's transformation. This would involve working together to create a true integrated network of care, a system supported by an engaged workforce and modern technology solutions, and accountable for improving outcomes and efficiencies.

Specifically, I would target improvements to ease of the use of our services by decreasing non value added rules and regulations, implement industry best practices that lead to improved quality and efficiencies. I also want to accelerate our efforts in suicide prevention, homelessness, women's healthcare, continue to decrease the claims backlog and work on appeals modernization.

Question 2. Dr. Shulkin, would you please detail what experiences you have had while serving as Under Secretary for Health that you believe have helped prepare you for this broader role at VA?

Response. Most significant in preparing for the role of SECVA has been the opportunity to visit, spend time listening and learning about the needs of the veterans we serve. During my 18 months as USH I have seen firsthand the unique services and programs that VA offers to Veterans. As a practicing VA physician, I have been able to use and see the systems our clinician rely upon to treat Veterans. With this opportunity, I have learned what works and what needs to be changed. I have also seen all too often where we have fallen short of the trust and confidence that veterans has placed in us

VA has been working hard to act more as an integrated enterprise and in doing so I have worked closely with my colleagues in VBA, NCA and the Board of Veterans Appeals. I understand that veterans see us all as one VA and not separate administrations and therefore having a seamless experience is critical to us fulfilling our mission. During my time as USH, I have been able to contribute to efforts that improve services to veterans who utilize VBA and NCA. If confirmed, I would build upon my foundational understanding of these issues to accelerate change in all three administrations.

Question 3. Since 2010, veteran homelessness has decreased by 47 percent. If confirmed, how do you intend to continue to prioritize efforts to prevent and end veteran homelessness?

Response. While these statistics indicate tremendous progress in ending Veteran homelessness and that the efforts of VA and its partners are producing successful outcomes for many Veterans, more must be done to accelerate progress. No one entity can end homelessness among Veterans alone. To achieve this goal, we need con-

tinued urgency and commitment from leaders in every community. There has been unprecedented support from the Administration, Congress, and state and local leaders to provide both the funding and human resources needed to end Veteran homelessness and much of our progress has come from the VA's collaboration with community leaders focusing efforts on the implementation of evidence based proven practices that are reducing homelessness among Veterans. But we know that ending Veteran homelessness is not a single event in time; rather, it is a deliberate effort made to achieve the goal, and continued follow-up efforts to make sure that progress toward achieving the goal is maintained.

We must continue our commitment to our efforts around rapid rehousing and permanent supportive housing for Veterans who fall into homelessness so that their homelessness is rare, brief, and nonrecurring. The ultimate goal is to make sure that every Veteran has permanent, sustainable housing with access to high-quality health care and other supportive services and that Veteran homelessness in the future is prevented whenever possible.

But housing Veterans is not the end of the journey. These Veterans, especially Veterans who have experienced chronic homelessness, need ongoing intervention and case management. Therefore, we must commit to continue to fully support our homeless programs such as HUD-VASH and Supportive Services for Veteran Families (SSVF) and the current efforts to transform our homeless Grant and Per Diem (GPD) program. These programs provide data driven essential services designed to support Veterans with obtaining and maintaining housing stability. With our full commitment to stay the course that has proven successful to date, we can and will end Veteran homelessness and provide the blueprint for solving all homelessness.

Question 4. Legislation was enacted last fall to authorize VA to implement its master plan for the West Los Angeles campus. This new model for the campus, with a focus on housing and supportive services for veterans, could become a model for future VA campuses. If confirmed, how would you safeguard against mismanagement, which has occurred in the past, and ensure the master plan is implemented in a transparent, responsible way that best serves veterans and that will be an example for other VA campuses?

Response. In September 2016, Congress passed the West Los Angeles Leasing Act of 2016, which is historic legislation essential to VA's ongoing effort to revitalize the West Los Angeles campus. Through such legislation, VA envisions providing approximately 1,200 permanent supportive housing units and Veteran focused services on the campus, particularly for homeless, severely disabled, aging, and female Veteran populations. Within the next 30 days, we plan to execute the first Enhanced-Use Lease agreement for the campus, which will provide approximately 55 new housing units for Veterans.

Enactment of this legislation was based on unprecedented collaboration and cooperation between the Department, Congress, Veteran Service Organizations, the community, and other stakeholders. Our ultimate goal is to fully revitalize the campus, so that it is both a 21st Century facility that provides convenient healthcare, benefits, and services, and serves a home for our Veterans and their families. As noted in the framework Draft Master Plan that Secretary Bob McDonald publicly announced in January 2016, VA is working to ensure that future third-party land-use agreements are Veteran focused and provide fair market value, from both a monetary and in-kind consideration standpoint.

Currently, the West Los Angeles Leasing Act of 2016 requires VA to notify Congress 45 days before entering or renewing any leases or sharing agreement on the campus. The bill also requires VA to provide annual reports to Congress for the leases and sharing agreements carried out at West LA. In that regard, we have instituted a process where all proposed land-use agreements undergo thorough review of subject matter experts at both the medical center and VA headquarters, before approval and execution. And as required under the legislation, any revenues generated from such agreements will remain on campus, to maintain and renovate facilities to serve Veterans of greater Los Angeles. Additionally, the legislation expressly prohibits VA from disposing of any of the land at West LA. We are also required to submit annual audits to Congress, for any leases and Sharing Agreements executed on the campus.

Through this process, VA has recently executed new agreements with our local medical affiliate, the University of California at Los Angeles, as well as the Brentwood School, and the city of Los Angeles. These agreements are part of our overall intent, to create irreversible momentum in a collaborative and transparent manner, where the campus is used consistent with the principles of the 1888 deed, which conveyed the property to the United States.

We have established a new Community Veteran Engagement Board for the campus, where pertinent Veteran organizations and representatives will meet regularly,

to discuss any and all matters of interest regarding our mission and operation of serving Veterans on the campus; to include the framework Master Plan and campus development.

A number of efforts are underway to support the implementation of the framework Draft Master Plan. In October, 2016, VA hired Concourse Federal Group (CFG) to assist with project management. CFG and their team of subject matter experts provide daily, on the ground support to VA for campus optimization and utilization, land use matters, and external communications. In December 2016, we also formed a VA Integrated Project Team, to begin the next phase of working to finalize the master plan for the campus. Experts from pertinent offices such as VHA; VA's Office Of Construction And Facilities Management; Office Of Asset Enterprise Management, Office of General Counsel, and the Office of the Secretary, will be working in unison, to ensure that the next steps such as environmental, historic, traffic, and utilities due diligence, occurs in an open and inclusive process. VA will continue to hold town hall and public hearing events, to enable us to receive valuable input from Veterans, Veteran service organizations, our community partners, and local neighbors. Through this process, we envision a campus that includes not just permanent supportive housing units for Veterans and their families, but complimentary services to promote Veteran wellness, education, vocational training, rehabilitation, and peer interaction.

We are also working with local philanthropists, specifically a 501(c)(3) entity known as the "1887 Fund," to allow them to raise funds and provide donated expertise to restore the historic Wadsworth Chapel, and other landmark historic facilities on the campus.

In coordination with the Los Angeles National Cemetery, we are working to commence the planned columbarium expansion project at the campus, to provide up to 10,000 new niches for Veterans wishing for the campus to serve as their final resting place.

We are also pleased to advise that the campus is under new leadership. In February 2016, Ann Brown was appointed to serve as the Medical Center Director at West LA. Before coming to the campus, she served as the Director at the Jesse Brown VA Medical Center in Chicago, Illinois. Before that, she was the Director in Martinsburg, West Virginia; the Acting Deputy Network Director for VISN 9; the Associate Director for Operations in Nashville, Tennessee, and the VISN 23 Business Office Manager in Lincoln, Nebraska. Through her leadership and during her brief tenure, the West LA campus now has a new Acting Associate Director, a Chief of Staff, an Associate Director for Patient Care Services, and an Assistant Director. We look forward to Ann continuing to build her team at the campus, to successfully carry out the charge we have for her and other VA personnel, which is to continue to put Veterans at the center of everything we do.

Our sustained focus, commitment, and collaboration with the Department of Housing & Urban Development, the Department of Labor, local housing authorities, the former plaintiffs to the West LA litigation, local philanthropists, Veteran stakeholders, and the local community, has resulted in a 57% decline in Veteran homelessness in greater Los Angeles, since 2011. We know that in order to end Veteran homelessness nationwide, we must end it in Greater LA. Through our continued and collective efforts, I am confident that West LA will become a 21st-century, state-of-the-art model for other campuses nationwide, and make us all proud as we continue to serve and honor our nations Veterans.

Question 5. Women constitute an ever-growing segment of the Armed Forces and, consequently, the overall veteran population. What do you see as the primary challenges to appropriately treating and serving women veterans in VA facilities?

Response. The primary challenges to caring for women Veterans in VA facilities include: ensuring providers are well-trained to provide women's health services, ensuring an open and welcoming culture, including environment of care/facility issues, and outreaching to women Veterans prevent suicide.

Access

- Since 2014, VA has made tremendous strides in providing enhanced services and access for women.
 - 100% of medical centers and 90% of Community Based Outpatient Clinics have Designated Women's Health Providers
 - 130 VA medical centers have gynecology services on-site
 - VA tracks quality by gender and has reduced or eliminated several key disparities
 - o On some important quality measures, VA is better than the private sector (breast and cervical cancer screening)

- To meet increasing demand, VA needs to hire and train additional Designated Women's Health Providers per year.
 - Convincing VA providers to train in Womens Health is difficult due to:
 - (1) increased provider workload;
 - (2) few incentives for those who have been seeing only men for decades.
 - Recruiting external providers is difficult due to:
 - (1) shrinking national workforce of Primary Care physicians;
 - (2) persistent perception of limited opportunity to care for women in VA settings.

Culture

- VA is now engaged in an enterprise-wide effort to ensure its language, practice, and culture is inclusive of women Veterans.
- A 2015 national survey of women Veterans showed high satisfaction for those in VA care, perceived lack of Womens Health services among those not in VA care.
- VA has launched multiple campaigns aimed at inclusivity and recognition for women Veterans.

Suicide Among Women Veterans

In 2014, an average of 20 Veterans died by suicide each day. Six of the 20 were users of VHA services.

- Between 2001 and 2014:
 - The age-adjusted rate of suicide climbed much more rapidly for women Veterans than for women in the civilian population.
 - The rate of suicide for women Veterans in VA care, however, climbed more slowly than did the rate for those not using VA services.

VA's Office for Suicide Prevention partners with organizations to target services to women Veterans and ensures all outreach materials are inclusive.

Question 6. In response to the mismanagement and cost overruns at the new Denver VA Medical Center, Congress mandated that all major construction projects over \$100 million be managed by the US Army Corps of Engineers. Additionally, VA made numerous changes to its policies and procedures for major construction projects. If confirmed, would you make it a priority to continue these and additional reform efforts to ensure that VA major construction projects are on budget and on schedule?

Response. VA's Office of Construction & Facilities Management (CFM) is responsible planning, designing, constructing and acquiring major facilities, and setting design and construction standards. VA recognizes that there is a need for continued improvement in the management of its major construction program and for adopting best practices to avoid cost overruns and lengthy delays encountered on some recent major projects.

Since 2014, VA has put in place sound construction management processes based on best practices from private industry and other Federal agencies including recommendations from the Government Accountability Office, VA's Office of Inspector General, and the US Army Corps of Engineers (USACE). VA has also partnered with, and embarked on process improvements based on recommendations from construction industry partners such as the National Institute of Building Sciences and the Associated General Contractors of America. The following improvements were put in place to ensure future success in the major construction program:

- Incorporating integrated master planning to ensure projects address gaps and meet agency goals;
- Requiring major medical construction projects to achieve at least 35% design prior to establishing cost and schedule estimates or requesting funds;
- Implementing rigorous requirements control and change management processes, and structured decisionmaking at key acquisition milestones;
- Using a Project Management Plan for delivery—from planning to activation—to ensure clear communication throughout the life of every project;
- Conducting pre-construction reviews of major construction projects throughout the design, to evaluate design and engineering factors and ensure constructability within given budget and schedule parameters;
- Integrating Medical Equipment Planners into construction project teams from concept through activation; and
- Putting in place metrics tools that will help monitor and manage performance and identify and mitigate emerging risks on large projects.

By accepting and incorporating best practices and recommendations from these organizations, CFM has been on a path of continuous improvement with the goal of achieving successful execution of our major construction projects.

Additionally, VA and USACE have a long history of working together to advance VA's facility construction program and share best practices. VA has engaged USACE to support our non-recurring maintenance and minor construction programs at more than 70 of our medical centers and national cemeteries across the enterprise. In December 2014, VA entered into an agreement to transition the Denver project to USACE for completion. Since then, VA has entered into agreements with USACE that now include VA utilizing USACE as Construction Agent on several major construction projects. This partnership continues to develop and mature, and the two agencies are working together to ensure the success of those partnered projects.

VA continues to address concerns from Congress and other entities and will continue to work to ensure the VA construction program is delivering quality, sustainable facilities on-time and on-budget into the future. VA is also interested in improving the planning and execution of its entire capital program to better address its aging infrastructure and meet the needs of Veterans with state-of-the art facilities and services

Question 7. What do you see as the role of this Committee in conducting oversight regarding VA and what steps would you take to ensure that the Committee is promptly notified of any emerging trends, issues, or developments at VA?

Response. The Committee's responsibility to the American public is to provide oversight of the Veterans Administration on all Veterans affairs issues to include budget, health care, benefits and cemetery affairs. If confirmed, I would seek to increase communication and collaboration with the Committee and its members and reduce the internal barriers that delay our responses and partnership with SVAC. I would also seek to make available my senior leaders and subject matter experts to answer your questions and be a resource that you need to do your job.

Since joining the VA as Under Secretary, I have worked to provide quality and timely responses that meets the needs of the Committee. I will ensure that we notify your committee of concerning issues, trends and developments in a timely manner. We will continue our work on decreasing case work response time and ensure that you have the information you need to provide oversight necessary.

Question 8. The National Cemetery Administration (NCA) has repeatedly earned the highest customer satisfaction score among the private or public sectors, yet the American Customer Satisfaction Index ranked the Department of Veterans Affairs third last in customer satisfaction among Federal agencies for 2015. What factors set NCA so far apart from the rest of VA and how would you leverage their best practices to improve customer satisfaction across the rest of the department?

Response. NCA continues to perform at a high level and builds its customer service culture around VA's core values, ICARE-Integrity, Commitment, Advocacy, Respect, and Excellence. In 2016, NCA received the highest ranking for any organization-public or private-on the American Customer Satisfaction Index (ACSI). With an index score of 96, NCA scored 28 points higher than the aggregate Federal Government score of 68. The following is a brief overview of the key processes underlying NCA's high customer satisfaction ratings.

1. Commitment from top leadership to be the best.
2. Define Excellence using input from all levels of the organization.
 - a. NCA has established a formal Organization and Assessment (OAI) program to assess performance and the overall organizational health of National Cemeteries, Memorial Service Networks (MSNs), and Central Office components. Using Malcolm Baldrige National Quality Award criteria as a management framework, it enables NCA to document, track, monitor, and report progress toward successful achievement of NCA Operational Standards and Measures in the key cemetery operational areas of interments, grounds maintenance, headstone/marker operations, equipment maintenance, facility, maintenance, and safety.
 - b. NCA applies OAI to each organizational entity annually and records performance as a scorecard.
 - c. Long Range Plan (FY 2016–2021) developed which focuses on five specific goals that will enhance service to Veterans and their families.
3. Train employees on how excellence is defined and provide tools to succeed.
 - a. Conduct front-line training at NCA's National Training Center in St. Louis
 - i. 48-week Cemetery Director intern program
 - ii. Cemetery Caretaker training
4. Hold employees and management accountable.
 - a. Cascade performance expectations in performance plans.
5. Establish continuous customer feedback loop and adjust OAI surveys.
 - a. Quarterly Customer Satisfaction Surveys
 - b. Refresh operational standards and measures based on feedback

- i. Annual Lessons Learned Conference
- ii. Communities of Practice website
- 6. Commitment to employing Veterans.
 - a. Workforce embodies the culture of Veterans serving Veterans
 - i. Almost 75% of NCA employees are Veterans
 - ii. Over 28% are disabled Veterans

The Veterans Health Administration (VHA) does, in fact, utilize the American Customer Satisfaction Index (ACSI) to understand how Veterans who have used VA healthcare services rate their customer experience, and compares that experience with that of private sector hospitals. For over a decade, VHA ACSI scores have outpaced that of the private sector (see Table 1 below). Many factors undoubtedly influence those scores—but certainly the high quality of VHA services along with their affordably are powerful drivers. But VHA is not content to rely solely on the ACSI to judge its performance, and we believe that the best way to compare ourselves is not with other Federal agencies, but rather, the U.S. health care system at large. Across private hospitals, physician groups, and plans in this Nation, the principal measure of patient experience is the Consumer Assessment of Health Providers and Systems (CAHPS) survey, which VA administers using an outside contractor. Our CAHPS surveys indicate VHA does have more work to do in the area of Access, although other areas, such as Comprehensiveness of Care, i.e., care for Veterans that focuses on all of their needs and preferences are, in fact, superior.

Regarding best practices, while I was Under Secretary, I commissioned the Diffusion of Excellence initiative as an endeavor that focuses on achieving consistency of best practices throughout the VHA. During my first few months in office, I visited a number of facilities that had very unique ways of engaging both veterans and the employees who served them—even in sites that struggled to perform overall. I knew that if we identified the practices that worked best for veterans—both clinical and business-related—that we would be able to improve customer satisfaction throughout the system.

The Diffusion model has not only identified over 100 best practices within VHA alone for improving the veteran experience—it actually provides a framework that allows us to replicate those change efforts in other areas throughout the system.

As of today, these best practices have been replicated over 300 times across different sites in the system. The Diffusion model has gained traction, and is featured in an article that I wrote for the Journal of the American Medical Association, published just a couple of weeks ago.

In addition, a major enabler of establishing and spreading these best practices is an electronic platform (called the Diffusion Hub) that not only helps with implementing methodologies—it also provides a library of tool kits for specific solutions that we would like to see everywhere. This platform not only includes projects within VHA—but projects that originated out of NCA and VBA, for spread in other administrations as appropriate. As of now, there are already several best practices in customer engagement that NCA has contributed to this platform through Secretary McDonald’s Leaders Developing Leaders (LDL) initiative.

Table 1: VHA Trends in the American Customer Satisfaction Index

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
VHA Inpatients	83	84	83	85	84	85	85	84	84	81	86
VHA Outpatients	80	82	83	81	83	82	83	82	82	79	80
Private Sector Hospitals	71	74	77	75	77	73	76	76	78	76	74

Table 2: VA comparisons on Consumer Assessment of Health Providers and Systems (adjusted for differences in age, education, and health status)

CAHPS Composite	VA vs. Private Sector
Access (based on % always getting care when needed)	6 points lower than private sector
Communication	About the same
Provider Discusses Medical Decisions	About the same
Self-Management Support	About the same
Comprehensiveness (attending to mental and emotional health as well as physical health).	6 points higher than private sector
Office Staff	About the same

Question 9. The Veterans Choice Program, created by section 101 of Public Law 113–146, the Veterans Access, Choice and Accountability Act of 2014, would expire

August 7, 2017, without Congressional action. Going forward, how do you envision expanding veterans' access to non-VA care while preserving within the Veterans Health Administration (VHA) the care and services VHA performs well?

Response. One of the most critical needs facing our Veterans is access to community care. VA's long-term vision for the future state is delivering timely, high-quality community care. It will make it easier for Veterans to access community care and easier for community providers to work with VA.

Our goal is to deliver community care that is easy to understand, simple to administer, and meets the needs of Veterans and their families, community providers, and VA Staff. VA has developed a long-term strategy as a starting point that allows for a balance between community care and care in the VA, purchasing community care when VA does not provide the service or cannot provide it when clinically needed. VA needs local market assessments to determine the availability of care both in the VA and in the community to ensure the appropriate mix of care.

We are making immediate improvements today, while seeking longer-term solutions. Together with Congress's support and funding, VA will continue working to streamline and transform VA Community Care to improve the community care experience.

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

Question 10. Dr. Shulkin, what is your view on the role of the Secretary of Veterans Affairs? If confirmed, would you seek to be an independent advocate for veterans or would you be the executor of the Administration's policies relating to veterans?

Response. The Secretary of VA is responsible to ensure that our Nation's veterans receive the highest level of service and care that we can provide. The Secretary also serves to ensure that the President and Congress' policies and laws are carried out to the best of their ability. If confirmed, as Secretary, I would work tirelessly to see that these objectives are fulfilled. As Secretary, if confirmed, I would be a strong and independent advocate for veterans and for policies that would support the interests of veterans. Once laws and policies are put in place, the Secretary should serve to ensure that these are carried out to the best of his or her ability.

Question 11. Dr. Shulkin, what are your top three goals as Secretary of Veterans Affairs?

Response. If confirmed, my top goals as Secretary would be:

- 1) To ensure that the right people are in place to serve veterans, whether that be senior management or front line staff.
- 2) To ensure that the right resources, tools, and systems are in place to deliver these services to our veterans
- 3) To ensure that veterans are receiving the highest quality and character of services that they have earned and deserve.

Question 12. Dr. Shulkin, after serving nearly two years as Under Secretary for Health, how will you broaden your focus for VHA to the entire organization? What do you foresee as your biggest challenge in that endeavor?

Response. If confirmed, my goal for VA is to work as a seamless organization to meet the needs of our veterans. From a veterans perspective, they do not care if their services come from VHA, VBA, or NCA, but rather they care their issues are being addressed. The real strength of VA comes from the ability to meet physical, social, economic, and the holistic needs of the veteran.

VA has been working hard to act more as an integrated enterprise and in doing so I have worked closely with my colleagues in VBA, NCA and the Board of Appeals. I understand that veterans see us all as one VA and not separate administrations and therefore having a seamless experience is critical to us fulfilling our mission. During my time as USH I have been able to contribute to efforts that improve services to veterans who utilize VBA and NCA. If confirmed, I would build upon my foundational understanding of critical issues to accelerate changes in all three administrations and implement a singular veteran centric service model for VA.

The largest challenge to working as an integrated enterprise is the ability to accelerate our journey to be a veteran centric organization and to challenge the status quo.

Question 13. Dr. Shulkin, one of the Secretary's major roles on an annual basis is developing and then defending VA's budget for a given year. Please explain your role in this endeavor under Secretary McDonald.

Response. My role was to develop, submit and defend the budget for VA's Medical Care appropriations—the Medical Services, Medical Community Care, Medical Support and Compliance, and Medical Facilities accounts, as well as for the Medical and Prosthetic Research appropriation.

The VA Medical Care budget is largely driven by the VA Enrollee Health Care Model, an actuarial model that estimates demand for health care services for the more than nine million Veterans enrolled with VA.

One of our challenges in developing this budget is that many Veterans have multiple options for health care, including Medicare, TRICARE, and employer health insurance.

We estimate that enrolled Veterans get a little more than one third of their total health care from the VA; however, this demand level can change rapidly based on economic conditions and availability of VA services.

We have seen steady growth in Veteran reliance on VA health care over the last several years, and anticipate that trend will continue in the future.

In addition to the modeled amounts, we developed estimates for other significant requirements, including:

- State Home programs
- Homeless prevention programs
- Readjustment Counseling Services (Vet Centers)
- Non-Recurring Maintenance for VA's aging health care facilities
- Activation of new health care facilities (initial outfitting of equipment, furniture and supplies, and new staff when applicable)
- Medical information technology support requirements, including VistA Evolution
- CHAMPVA and related programs (Spina Bifida, Foreign Medical Program, and Children of Women Vietnam Veterans)
- Caregivers support programs
- Indian Health Service agreements
- Health care services for Veterans exposed to toxic water at Camp Lejeune
- Medical and Prosthetic Research programs

a. Do you anticipate working within the limits established by the Office of Management and Budget or going to the President to advocate for the level of funding that is needed to fully fund the Department in the coming year?

Response. It is essential that the Secretary be a strong advocate for the resources that are required to do the job of serving our country's veterans. It is also essential that the Secretary ensure that those resources that are allocated are spent in an efficient and effective manner.

As I know you understand, the Office of Management and Budget must balance the needs of all Federal Government agencies against the total annual budgetary resources established by Congress. Therefore, increases in the VA budget may need to come at the expense of other agencies.

Question 14. Dr. Shulkin, if confirmed, what will be your plan to work with employee unions? Do you believe they play an important role in bridging communication between VA employees and management?

Response. As the USH, I have seen the value in working to engage with the employee unions and there have also been challenges. The five national unions within the VA represent approximately 285,000 VA employees. VA has also negotiated master collective bargaining agreements with four of the national unions. Therefore, engaging with the unions, including bargaining on some policies that change employees' conditions of employment, is not only a statutory or contractual requirement, but when done effectively it creates a labor-management environment that enhances VA's ability to communicate our policies and initiatives to our employees.

Question 15. Dr. Shulkin, what is your view on the role of whistleblowers? If confirmed, will you encourage whistleblowing by the Department's employees?

Response. I support the Whistleblower Protection Act of 1989. VA has established a Whistleblower Protection Program that ensures employees, contractors, and grantees who disclose allegations of serious wrongdoing or gross mismanagement are free from fear of reprisal for their disclosures. If confirmed, will you encourage whistleblowing by the Department's employees? Yes. Leaders are responsible for establishing a workplace atmosphere in which employees are comfortable highlighting and sharing their successes—as well as identifying areas in which we can improve. Whether that means notifying managers and supervisors of isolated gaps or bringing attention to larger, systemic issues that impede excellence, it is important that all employees are encouraged to report deficiencies in care or services we provide to Veterans. Relatively simple issues that front-line staff may be aware of can grow

into significantly larger problems if left unresolved. In the most serious cases, these problems can lead to and encourage improper and unethical actions.

Across VA, I expect workplace environments that enable full participation of employees. I expect employees to bring to the attention of their managers and supervisors shortcomings in the delivery of our services to Veterans or any perceived violations of law or official wrongdoing—including gross waste, fraud, or abuse of authority. And I will make clear that intimidation or retaliation against whistleblowers—or any employee who raises a hand to identify a legitimate problem, make a suggestion, or report what may be a violation of law—is absolutely unacceptable. I will not tolerate it. Protecting employees from reprisal is a moral obligation of VA leaders, a statutory obligation, and a priority for this Department. We will take prompt action to hold accountable those engaged in conduct identified as reprisal for whistleblowing, and that action includes appropriate disciplinary action.

Question 16. Last Congress, this Committee considered a number of legislative proposals that would have provided the Department with authority to sanction employees—both general schedule and Senior Executives—that is not available to other Federal agencies. Do you believe that, in order to best manage the Department's workforce, it needs expedited firing authority that would reduce an employee's right to appeal?

Response. What we need is an employee discipline and appeal process that provides enough due process to pass constitutional muster but allows us to take action faster than we can under the current process and affords more deference to the Agency's decisions than Merit Systems Protection Board judges often do. Ideally we'd like to see an overall reform of employee discipline and appeals rules throughout the Federal Government, not something that singles out VA employees for harsher treatment than their peers in other agencies, because we want to be able to attract and retain good people from all over rather than lose them to other agencies. We'd like to see a change in the agency's burden of proof on appeal to the MSPB, so we can sustain our actions based on substantial evidence rather than the higher and harder-to-prove preponderant evidence standard that applies today. That small change would allow us to take discipline more expeditiously and sustain our well-founded actions on appeal.

Question 17. Dr. Shulkin, have you spoken to the President-elect about your vision for the rest of the leadership team at VA? What is that vision?

Response. Yes, I have spoken to President Trump about my vision for the leadership team at VA. We seek to fill our leadership positions with people that have outstanding values and ethics, people that are passionate about serving veterans, people with superb experience and competence, and people who understand the needs of veterans.

Question 18. Dr. Shulkin, will you commit to quarterly meetings to update this Committee on progress the Department has made on recommendations from OIG, GAO, OSC, and other investigative reports? Who is responsible within VA for tracking and ensuring that these recommendations are implemented?

Response. Yes, I will commit to these quarterly updates. Each Administration is responsible for tracking and ensuring recommendations are implemented. If confirmed I would ask that the Office of Congressional and Legislative Affairs be responsible for communicating the recommendations from these reports and the resulting actions taken by VA to comply with these recommendations.

Question 19. Dr. Shulkin, the President-elect's vision to reform VA included the following statement, "Ensure our veterans get the care they need wherever and whenever they need it. No more long drives. No more waiting backlogs. No more excessive red tape. Just the care and support they earned with their service to our country." If confirmed, how will you achieve this vision—do you have more specifics on the President's 10-Point plan for reforming and modernizing VA for the 21st Century?

Response. If confirmed, I will immediately begin working to define the options that would work toward the improvements in VA that the President, Congress, and the American public seeks. In terms of the 10 point plan, I am still studying the various proposals and options that have been laid out by the President.

Question 20. Secretary McDonald has been lauded by Veterans Service Organizations and military service organizations for his attentiveness to their concerns.

a. Please describe your past VSO and MSO interactions.

Response. My interactions with Veteran Service Organizations (VSOs) and Military Service Organizations (MSOs) have been very positive and collaborative in nature. I have met with the Big 6 VSOs (Disabled American Veterans, The American Legion, Veterans of Foreign Wars, Paralyzed Veterans of America, AMVETS and Vietnam Veterans of America) as well as Iraq and Afghanistan Veterans of America

(IAVA) on a monthly basis to share best practices and proactively address major VSO issues. Senior VA leaders have also met with the Post-9/11 VSO Groups: Got Your Six, Team Rubicon, Team Red, White and Blue (RWB), Student Veterans of America, Travis Manion Foundation and many MSOs such as Military Officers Association of America (MOAA) and Fleet Reserve Association (FRA) to build coalitions and address Veteran issues as well. VA Leaders have traveled to the major conventions and annual meetings and met individually with each of the VSO groups on a routine and reoccurring basis to solicit feedback and opportunities that VA can take to improve services for Veterans. On the local level, VA medical center facilities meet with our VSO partners on a monthly basis to capture feedback and improve the care and delivery of health care services to Veterans in the community.

Some of the initiatives that we have worked closely with MSOs/VSOs included MyVA Transformation, MyVA Access and Suicide Prevention. A direct measure of the improvement that we have made with our MSO/VSO partners is with rebuilding trust. Nearly 60 percent of Veterans surveyed in June 2016 “trust VA to fulfill our country’s commitment to Veterans” which is up from 47 percent in December 2015.

b. Please give specific examples of how you anticipate involving the VSOs and MSOs.

Response. We expect the same level of partnership and engagement with our VSOs/MSOs colleagues to continue as we work to continue the progress/momentum that we have gained with MyVA Transformation.

Question 21. Dr. Shulkin, will you commit to making data public, including the Monday morning workload report and wait times by medical facility?

Response. I am a strong believer of transparency of data. I am committed to making public our wait times by medical facility and our patient satisfaction scores related to access by facility. I am not familiar with the workload report, but if confirmed would be willing to consider looking at this suggestion.

Question 22. Dr. Shulkin, if confirmed, will you direct your agency to timely and fully respond to all reasonable Freedom of Information Act requests submitted by the American people?

Response. Yes, as stated earlier I believe in transparency.

Question 23. Dr. Shulkin, will you commit to sharing with committee staff VA organizational charts, for the administrations and staff offices, which include names and contact information, so that staff can get timely answers to concerns?

Response. Yes

Question 24. Dr. Shulkin, as you know, RAND recently reported that VA health care is as good or better than health care provided by the private sector. After nearly two years as Under Secretary of Health at VA, do you agree with this finding? Please explain.

Response. Statements related to the comparison of quality between VA and the private sector has been studied by numerous independent research groups. These research finding speak for themselves. My interpretation of these studies is that clearly in some areas, VA outperforms the private sector. Areas of superior performance generally include the comprehensive nature of VA care and include measures related to health screening, primary care, outpatient measures, safety and behavioral health. However, there are other areas of healthcare performance where VHA lags. If confirmed as Secretary, I would continue to focus my efforts on improving the quality and safety of VA healthcare, and continue to pursue improvement efforts utilizing private sector benchmarks.

Question 25. Many veterans, especially those with complicated health issues, rely upon the specialized services of the VHA. Many of these services, like spinal cord injury, blind rehabilitation, and prosthetics, are not widely available in the private sector. In an era of declining budgets and decentralization of funds, please describe your views on VA’s responsibility to maintain capacity in these programs. What is your perspective on the future of VA specialized services (spinal cord injury, polytrauma, blinded rehabilitation, mental health)?

Response. With regard to mental health care, VA comprises an unparalleled system of comprehensive treatments and integrated services to meet the needs of each Veteran and the family members who support the Veteran’s care. These services support Veteran resilience, identify and treat mental health conditions at their earliest onset, address acute mental health crises, and provide recovery-oriented treatments. VA provides a continuum of forward-looking outpatient, residential, and inpatient mental health services across the country. In FY 2016, more than 1.6 million Veterans received specialized mental health treatment from VA; This number has risen each year from over 900,000 in FY 2006. VHA provides mental health care integrated within its Primary Care clinics at VHA medical centers and large and very large community clinics with 15% more Veterans receiving Primary Care Men-

tal Health Integration services in 2016 than in 2014. The integration of mental health services into primary care settings is designed in part to help overcome some Veterans' reservations about seeking mental health services. It also provides an opportunity to deliver mental health services to those who may otherwise not seek them and to identify, prevent, and treat mental health conditions at the earliest opportunity. Through the Measurement Based Care in Mental Health Initiative, VA is working toward the nationwide implementation of measurement based care (MBC). Fifty-eight champion sites, representing 18 Veterans Integrated Service Networks, have been selected to help develop and refine the infrastructure for this implementation. With MBC, Veterans assess their wellness through a standardized set of questions, with the resulting data then used to individualize and enhance their mental health care. To our knowledge VA is the largest mental health system implementing MBC.

A key VHA strategic principle is to ensure access, continuity, and quality for special emphasis and vulnerable populations in VHA, such as Veterans with spinal cord injuries and disorders (SCI/D), where VHA has expertise not found in the community. VA provides world class care to Veterans with SCI/D so they can achieve the highest possible health, independence, quality of life, and productivity throughout life.

A unique strength of the VA SCI/D System of Care, not found elsewhere in the private sector, is that the full continuum of care is provided to Veterans with SCI/D throughout life. This includes rehabilitation, acute care, ongoing primary care, preventive care (including comprehensive annual evaluations), lifelong medical management, outpatient care, home care, telehealth, respite care, long-term care, and end of life care. That care is coordinated through a hub and spokes model; similar coordination is not available outside of the VA.

There is no better place for Veterans with an SCI/D to get care than one of the 24 regional VA SCI/D Centers, where care is provided through highly dedicated and committed teams of knowledgeable and skilled professionals from different disciplines. In addition, VA facilities without an SCI Center have trained SCI/D teams that work closely with SCI Centers to deliver primary and limited specialty care. This hub and spoke model of care provides integrated and coordinated regional and local care throughout the US. Geographical access is further enhanced by dedicated SCI/D home care and telehealth programs. There are unique dedicated SCI/D long-term care units in VA that are not available anywhere else in the country. There are superior critical services provided in VA, such as prosthetics, bowel and bladder care, ventilator care, Home Improvement and Structural Modifications (HISA) grants, and travel.

In 2000, a report "VA Spinal Cord Injury and Disorders: A Comparison of Program Data Collected Across Four Modes of Care" demonstrated that the VA SCI/D System of Care was more comprehensive and offered superior resources, care, and training as compared with other large SCI Systems of Care in the U.S. and in Europe. Analyses of outcome data collected since then show that VA provides care that meets or exceeds internal and external benchmarks in all areas, including outcomes related to quality of life. Over the past 20 years, studies, surveys, anecdotal evidence, and behavior have demonstrated that Veterans with SCI/D highly value VA care.

- A will maintain our commitment to ensure these Veterans receive the specialized services they need. Such services are not widely available in the private sector—if at all.
- VA has established programs and systems of care to maintain and ensure the provision of lifelong specialized care and services for these severely disabled Veterans
- VA's systems of care for Polytrauma/Traumatic Brain Injury (TBI), Amputation, Spinal Cord Injury and Disorders, and Blind Rehabilitation are strong:
 - Specialized services are provided across tiered networks of specialty rehabilitation centers that serve as regional referral centers for acute inpatient rehabilitation for severe injuries.
 - Ongoing care and services are provided for Veterans in VA facilities with specialized interdisciplinary teams closer to the Veteran's home community.
- These VA programs uphold the highest standards of rehabilitation, such as CARF (Commission on Accreditation of Rehabilitation Facilities) accreditation for inpatient rehabilitation facilities, and participating in HHS 'Model Systems' for VA's TBI and SCI programs (consortium of premiere private and academic rehabilitation centers).
- VA is further committed to ensuring Veterans continue to receive the prosthetic items and services they need. In FY 2016, VA expended \$2.8 Billion to provide 20 million medical items, prosthetic devices and items to 3.3 million Veterans.

- With regard to mental health care, VA comprises an unparalleled system of comprehensive treatments and integrated services to meet the needs of each Veteran and the family members who support the Veteran's care.
- These services support Veteran resilience, identify and treat mental health conditions at their earliest onset, address acute mental health crises, and provide recovery-oriented treatments.
- VA is committed to ensuring continuing access to a full spectrum of mental health care for our Veterans.

Question 26. VHA has made undeniable progress over the past two years in integrating more community care into the VA health care system. Do you believe that a veteran's primary care clinician should continue to be part of the VA system or can s/he be any clinician a veteran chooses?

Response: VA has developed a model of personalized, proactive, primary care for Veterans. It provides a comprehensive approach to caring for the Veteran. Every Veteran is assigned to a primary care provider when they begin participating in VA health care to ensure their care is coordinated. This approach is critical to ensuring the Veterans health. However, in many parts of the country, Veterans live too far or face other obstacles in getting to the VA for their primary care. If Veterans receive primary care in the community, VA needs to ensure that all of the care is coordinated and the provider quality is the same or better than the VA.

Question 27. As we have discussed on numerous occasions, the roll-out and execution of the Veterans Choice Program in Montana and many other states has been nothing short of a disaster. In fact, the same issues have remained largely unresolved for two years and have left veterans, community providers and VA employees frustrated and angry. As many of these issues remain the responsibility of the Third Party Administrators in Choice, what are you going to do to hold them accountable for a continued failure to meet the terms of their contract, and to meet the basic expectations of veterans? Do you continue to believe that VA becoming the primary payer of Choice for all veterans and community care spending flexibility are critical to ensuring that the Choice program operates as intended?

Response. The VA uses several strategies to evaluate contractor performance and imposes penalties on contractors when they fail to meet the terms of their contracts. The Quality Assurance Surveillance Plan (QASP) is a recurring assessment of contractor performance throughout the term of the contract. When contractors fail to meet the metrics established in the QASPs, letters of correction and financial penalties, also called equitable adjustments, are assessed against the contractor. Equitable adjustments have been, and will continue to be, used to move the contractor toward meeting the metrics outlined in the contract.

Congress can assist in simplifying the claims processes through a change in the law that makes the VA the primary payer. This change would lead to greater efficiencies in claims submission by our community providers and subsequent payment by our contracting partners. This change would also eliminate the labor intensive process of identifying and communicating other insurance coverage on the front end. A transition back to VA being primary payer should be a relatively smooth transition since the original framework of our Consolidated Patient Account Centers (CPAC) was built upon this premise. This change will allow our CPACs to operate as originally designed by recouping costs from third-party payers after care has been rendered.

Question 28. Dr. Shulkin, the Commission on Care rejected the idea of granting veterans who use the VA unfettered choice in seeking care outside of the VA. Do you agree with this position, or do you believe that a veteran who is eligible for VA health care ought to be provided with a voucher to seek care wherever s/he chooses, with VA footing the bill?

Response. My belief is that every veteran that relies upon VHA for their healthcare must have access to the best quality healthcare in a timeframe that meets their clinical needs. We must utilize care within the VA and outside the VA to meet this objective. In terms of total unfettered access, I think given the models considered by the Commission and the subsequent economic modeling done by their economists, that the Commission came up with the reasonable conclusions. However, if confirmed, I would plan to explore different options that would allow veterans greater choice while maintaining the unique character and services of VHA. These proposals will require additional analysis before they can be fully considered.

Question 29. Dr. Shulkin, are you in favor of the Commission on Care recommendation that would grant veterans with other-than-honorable administrative discharges eligibility to access VA health care on at least a temporary basis?

Response. If confirmed, I would take a serious look at such a proposal and confer with both the White House and Congress about ways that we might address this population.

a. Have you spoken to President-elect Trump about how he intends to handle services for veterans in need who have bad paper discharges?

Response. No

Question 30. President-elect Trump's plan for veterans talks about embedding satellite VA clinics within other health care facilities in rural and other underserved areas. With existing government acquisition, leasing, and contracting laws, how do you intend to make this happen quickly?

Response. The Department has various means for providing care or embedding "clinics" in affiliates or other healthcare facilities to provide healthcare for Veterans in rural and other underserved areas:

VA providers only—VA provides healthcare out of non-VA's healthcare sites through the sharing of staff/resources, not real property. This is a similar model to how VA partnered with the Department of Defense (DOD) to do exit exams. A VA doctor would perform exams in a DOD facility, but VA would not have real property interest in the site, it would be purely resource sharing.

Real Estate Solutions—VA could utilize tools such as revocable licenses and permits as quick, short-term real estate agreements to occupy third-party space for VA providers. Such agreements do not have to be competitively sourced but can only provide a interim solution—up to 5 years in certain circumstances but typically much shorter. For any type of long-term, presence, VA would acquire space from a third party through leasing. With current competitive requirements, it may take longer to go through the process. VA would lease a portion of space and staff it with VA personnel as a standard clinic. The competitive procurement process would dictate the final location from within a VA specified geographic area, but requirements could be written to help narrow down the scope. This issue could be streamlined with legislative changes to allow sole source leasing with affiliates and state and local governments. In that case, it would still be a lease, but could be non-competitive if it were with an affiliate location or applicable local government.

Question 31. Dr. Shulkin, do you intend to modify Secretary McDonald's *MyVA* priorities or "breakthrough initiatives?"

Response. The *MyVA* priorities were established through consultations with VA management and staff, veterans service organizations, community groups and The *MyVA* advisory Committee. Progress has been made in many of these areas and in some cases the goals have been achieved. If confirmed as Secretary, I would continue progress in those areas where progress is still needed, establish new and bold goals for other priority areas, and continue to consult with veterans and the organizations that represent their interest to modify and evolve these initiatives.

Question 32. In your opinion, what more do you believe needs to be done to improve personnel recruitment and retention at VA health care facilities?

Response. VHA is continually striving to improve personnel recruitment and retention at VA health care facilities, and has a robust and multi-pronged approach to recruitment. Local facilities have in-house human resources departments, as well as nurse recruiters, who reach out to and coordinate with applicants on a local level, including outreach to nearby training programs and hosting open houses when needed to facilitate hiring. Facilities also produce job advertisements in local, state and national publications, journals, newspapers, radio advertisements, hold local career/job fairs, and attend local and regional job fairs. VHA also has a National Recruitment Program (NRP), 100 percent staffed by Veterans, that employs private sector best practices to fill VHA's top five most critical clinical and executive positions.

Our major challenge is the unnecessary hiring complexity caused by VA having three different hiring authorities. As Secretary, I'd like to continue to explore with the Congress establishing an Alternative Human Resources (HR) System for VA, converting VA to Title 38. Additionally, for our clinicians, a single Federal credentialing system, coupled with national reciprocity for credentialing, would greatly improve our ability to hire and retain clinicians, improve the hiring process from the applicant's perspective, and allow us to more easily deploy our clinicians to meet surge needs as the may arise across VHA.

Finally, the prudent use of recruitment, retention and relocation incentives has been an important tool for VHA hiring and retention. Removing these incentives from the CARA award caps would restore our ability to appropriately deploy these important flexibilities to improve our ability to compete with the private sector.

Question 33. There has been increasing pressure in recent years for VA to contract for services in local—especially rural—communities where VA facilities are not

easily accessible. Mental health is one area of particular emphasis in this regard. What do you believe is VA's responsibility for meeting the needs, including mental health needs, of rural veterans? If confirmed, what emphasis would you place on this issue?

Response.

- VHA is committed to meeting the health care needs, including mental health, of all Veterans, regardless of where they live.
- Rural Veterans deserve a special focus as they have a higher risk of suicide than Veterans in urban areas.
- Other challenges of rural Veterans include:
 - Provider shortages
 - Geographic barriers
 - Lack of transportation options
 - Rural community hospital closures
- VHA is taking steps to address mental health provider shortages in rural areas by establishing regional telemental health hubs
- In 2016 VHA established four regional telemental health (TMH) hubs to enhance Veteran access to mental health care for Veterans residing in rural areas
 - The four hubs are in South Carolina, Utah, Pennsylvania, and Washington-Oregon area.
 - Six additional hubs are planned to come online in 2017.
 - This will extend mental health services to up to 200 sites of care where more mental health capacity is needed.
- VHA has also expanded capacity to serve rural Veterans at home, issuing tablets for the delivery of care, including mental health, to nearly 3,000 Veterans.
- Standardized training on suicide prevention guidelines in face-to-face clinical settings and during telephone contacts specifically for clinicians who work with rural Veterans
- Integrating evidence-based practices and existing VA programs (e.g., suicide risk management in primary care, crisis support, firearm safety, and the Home-Based Mental Health Evaluation program) into a comprehensive portfolio of best practices to prevent rural Veteran suicides.
- We recognize there are workforce shortages in rural areas and will continue to pursue strategies to meet these workforce gaps, including:
 - Expanded scope of practice for advanced practice registered nurses
 - Expanding workforce training programs in rural VA locations
 - Leveraging the VA ECHO (Extension for Community Health Outcomes) program to ensure primary care providers in rural sites can access specialty training and consultation
 - Hiring of highly trained Veteran combat medics and corpsmen

Question 34. What is the appropriate level of oversight and responsibility that VA has for the care veterans receive from community providers?

Response. VA needs to ensure we provide a full network of care, including appropriate quality in the network. The Request for Proposal (RFP) that was released on December 28, 2015 includes requirements for the networks to be accredited and for providers to be credentialed. The contractor must establish a variety of quality, network adequacy, patient experience and operational efficiency plans. There are over 20 in total that will be required as part of the contract. In addition, VA will establish certain quality measures to be included based on industry standards. A Quality and Patient Safety Model and Framework was created to establish the baseline for moving to a value-based model of care, based on the Institute of Medicine (IOM). These measures will move the VA forward in ensuring appropriate quality when community care is provided.

Question 35. Female veterans are the fastest growing population in the VA today and will continue to grow over the next several years. The President-elect has stated his intent to better meet the needs of female veterans, which I support.

a. During your time at VA, what have you done to improve the physical and mental health care access, quality of care, and address privacy, security, as well as the transition for female veterans?

Response.

Physical and Mental Health Care Access

- Since 2014, VA has made tremendous strides in providing enhanced services and access for women.
 - 100% of medical centers and 90% of Community Based Outpatient Clinics have Designated Women's Health Providers
 - 130 VA medical centers have gynecology services on-site

- VA offers a full continuum of gender-sensitive mental health services to women Veterans
- VA has deployed large scale initiatives to train current VA physicians on Women’s Health core curricula and priority topics, including Mental Health
- All Primary Care and Mental Health providers are also trained in the care of Veterans who have experienced Military Sexual Trauma

Quality of Care

- VA tracks quality by gender and has reduced or eliminated several key disparities
- On some important quality measures, VA is better than the private sector (breast and cervical cancer screening)

Privacy and Security

- VHA has committed to ensuring all facilities meet Privacy Standards—to include physical and auditory privacy—and to increasing the accountability of facilities to follow these standards.
- By policy, all Veterans’ personalized health information is protected with the same level of privacy and security regardless of gender.
- VA’s focus also goes beyond physical security to ensure the entire experience of women Veterans is positive.
- VA has launched multiple campaigns aimed at recognizing the service of women Veterans and is now launching an even more direct effort to increase civility and respect through the “End Harassment” campaign.

b. Will the President-elect’s desire to “fully equip” every VA hospital with women’s health services bump other projects for the SCIP list to achieve this goal?

Response. For the past several years, one of VHA’s goals has been to incorporate women’s health into various aspects of our capital initiatives. Just a few of our numerous examples include dedicating a women’s health exam room into the PACT design model; converting existing multi-bed inpatient rooms to single bed inpatient rooms; updating VA’s Women’s Health Design Standard and Guide for separate women’s clinics; and including a women’s health sub-criteria in the Strategic Capital Investment Planning (SCIP) scoring process to increase points for any capital initiative focusing on women’s health.

In addition, in the SCIP 2018 cycle, VHA narrowed the first year capital initiative focus to only include leases and projects under the following umbrellas: Women’s Health, Inpatient Medical/Surgical Bed Conversion to Single Beds, Primary Care and Outpatient Mental Health, Safety, and Infrastructure. The impact of this focus for first year projects and leases resulted in approximately a 1/3 reduction in capital initiatives compared between the SCIP 2017 cycle final list and SCIP 2018’s preliminary list. This allowed women’s health type projects and leases to better compete for limited construction and leasing funding.

VHA plans to continue this narrowed focus with the same categories for the SCIP 2019 cycle in an effort to continue to support VHA’s goals, which includes converting existing deficient space and/or adding more space, resulting in state-of-the-art, modern environments for VA to provide women’s health.

Question 36. During your time at VA, what have you specifically done to reduce the number of veteran suicides? What do you still hope to accomplish if confirmed as Secretary?

Response. Accomplished:

- Convened a Call to Action on Preventing Veteran Suicide in February 2016— included Congressional members, Federal partners, non-profits, VSOs, survivors of suicide prevention; led to recommendations that have been implemented throughout VA and communities
- Completed most comprehensive analysis of Veteran suicide to date: “Suicide Among Veterans and Other Americans”—examining more than 55 million Veteran records from 1979 to 2014 from all 50 states and 4 territories.
- Convened several public-private partnership strategic planning sessions to seek input and dialog about our partnership strategy.
- Signed Memoranda of Agreement with Johnson & Johnson, Give an Hour, Bristol Myers Squibb Foundation, IBM, Wounded Warrior Project, Psych Armor, and Project Hero expanding the reach of VA mental health programing.
- Developed and implemented REACH VET (Recovery Engagement and Coordination for Health—Veterans Enhanced Treatment), to identify and intervene with Veterans who are at a statistically elevated risk for suicide and other adverse outcomes.
- Designated the month of September for Suicide Prevention Awareness and led “Be There” campaign across Federal, VSO, and corporate partners.

- Elevated VA's suicide prevention efforts and redirected resources, and personnel to create a new Office for Suicide Prevention to reach across entire department and lead a comprehensive strategy on suicide prevention

In Progress

- Implement state-of-the-art best practices for risk assessment, treatment, crisis management and quality improvement for VHA users in all clinics that treat Veterans at elevated risk.
- Continue to deploy comprehensive solutions, including targeted screening, risk assessment, predictive analytics, outreach, and innovative programming to identify Veterans at elevated risk and offer care as appropriate.
- Enhance enterprise-wide awareness and training of all staff (clinical and non-clinical) in recognition and intervention for Veterans at risk for suicide.
- Ensure ease of Veteran experience and quality of clinical care in VCL-Suicide Prevention Coordinator care continuum. Expand programming of Suicide Prevention Coordinators (SPCs) based on identified areas of need.
- Execute a public-private partnership program to increase coordination of available suicide prevention resources for Veterans not enrolled in VA.
- Expand existing outreach campaigns to target highest-risk Veterans and increase overall reach.
- Create new and update existing IT infrastructure to provide rapid access to data that inform suicide prevention effort
- Develop data-sharing strategies specific to Veteran suicides to engage our Federal, non-profit, and corporate partners to work together on better understanding Veteran suicide

Question 37. Veteran homelessness decreased by 47 percent between 2010 and 2016, largely due to funding from Congress and the hard work of local communities, yet on any given night, nearly 40,000 veterans remain homeless. Ensuring veterans have permanent housing is incredibly important.

Response. While there has been tremendous progress in ending Veteran homelessness and the efforts of VA and its partners are producing successful outcomes for many Veterans, there is still work to be done to ensure that no Veteran is without a place to call home. We know that ending Veteran homelessness is not a single event in time; rather, it is a deliberate effort made to achieve the goal, and continued follow-up efforts to make sure that progress toward achieving the goal is maintained. We must continue our commitment to our efforts around rapid rehousing and permanent supportive housing for Veterans who fall into homelessness so that their homelessness is rare, brief, and nonrecurring. The ultimate goal is to make sure that every Veteran has permanent, sustainable housing with access to high-quality health care and other supportive services and that Veteran homelessness in the future is prevented whenever possible.

While several states and nearly 40 communities have met the Federal benchmarks and criteria for ending veteran homelessness, I have heard from communities that have reached the goal earlier that maintaining a system that can rapidly house newly homeless veterans takes nearly the same level of effort and resources as housing unsheltered veterans to meet the goals. Even as the number of unsheltered veterans decreases, will you commit to evaluating resource needs based on existing populations and projections as you consider budget proposals for these programs?

a. If confirmed, will you commit to ensuring that this work remains a priority at VA?

Response. I am committed to ending Veteran homelessness and if confirmed it will remain a priority at the VA.

Question 38. According to the VA's National Center on Homelessness Among Veterans, the fastest growing subpopulations of homeless veterans are female veterans and those who have deployed to Afghanistan and Iraq under OEF/OIF/OND in the last decade and a half. What will you do to ensure that VA homelessness programs address the needs of these specific groups?

Response. Last year, the National Center on Homelessness Among Veterans conducted a study to look at population projections of Veterans likely to either be a risk of or actually become homeless and access VA care over the next 10 years. Women Veterans and Veterans who had served in the OEF/OIF era were identified as two subpopulations projected to grow in number while those older than age 55 were projected to decline. It should be noted that even with this growth, the majority of homeless Veterans is still projected to be predominantly single and male (85-90% in 2025). The National Center has commissioned two subsequent studies to map both current need profiles of homeless women Veterans served within VA and outcomes associated with different program utilization patterns. We expect to have results from these studies within the next six months which will be essential to accu-

rately mapping where we need to strategically direct resources to address this projected demand. At this time, we do feel that current VHA program capacity, particularly in the Supportive Services for Veterans and Families (SSVF) and HUD-VASH programs which provide the bulk of services for women Veterans who are homeless or at-risk for homelessness, is sufficient to support these projections for at least the near term.

Question 39. Over the last 15 years, Congress has worked to improve health care, benefits, and care coordination for our most seriously wounded, ill and injured servicemembers, veterans, and their caregivers/family members to ensure a seamless transition between the DOD and VA systems and to provide continuity in care and services. How do you plan to strengthen collaboration and cooperation between these two agencies and improve upon the existing health and benefit systems?

Response.

- VA, in partnership with DOD, has taken significant steps to address the transition of seriously wounded, ill and injured Servicemembers and Veterans. We will continue to build on this work by:

- Leveraging the VA/DOD Interagency Care Coordination Committee (IC3), a subcommittee under the VA/DOD Joint Executive Committee, was formed to improve care coordination and reduce transition gaps.

- Enhancing care coordination through the Lead Coordinator role who serves as the primary point of contact for Servicemembers and Veterans and their caregivers during recovery and transition between DOD and VA;

- Community of Practice—connecting the DOD and VA clinical and non-clinical case managers of recovering Servicemembers and Veterans enabling collaboration and best practices to be shared;

- Implementing Interagency Comprehensive Care Plans—serves as a single, interoperable, individualized plan that assists managing the patient's goals thus reducing the need to retell their story as they transition and relocate. We will work to establish an IT solution for the Interagency Comprehensive Plan.

- Enhancing health information exchange:

- A Veteran's complete health history is critical to providing seamless, high-quality integrated care and benefits.

- Today, more than 220,000 VA health care and benefits professionals have access to Joint Legacy Viewer, which VA and DOD clinicians can use to access the health records of Veterans and Active Duty and Reserve Servicemembers

- We are currently deploying EHMP (Electronic Health Management Platform) which will integrate health data from VA, DOD, and community care partners into a customizable interface that provides a holistic view of each Veteran's health records.

- Disability claim filing pathways: (not sure this is the right place, but including here just in case)

- VA and DOD are dedicated to improving the processes for individuals in the IDES and Separating Servicemember (SSM) disability claim filing pathways.

- The Service Treatment Record (STR) is the common data information source critical to support both claimant groups.

- Efforts are actively underway to ensure the STR can be electronically transferred from the DOD to VA systems, relieving the need for the Servicemember to hand-carry their records to VBA for claim support.

- VA and DOD have re-engineered the Separating Servicemember claims workflow and it will be piloted by DOD and VA facilities in the National Capital area starting in March 2017.

Question 40. Accurate forecasting of usage of veterans benefits is essential in planning for resources to administer those benefits. If confirmed, what would you do to ensure that VA provides accurate and timely forecasts of the need for additional staffing resources so that Congress is able to appropriate resources in a timely manner?

Response. A workforce analysis is the foundation of any good workforce plan as it directly aligns the organization's needs with outcomes. VBA's workforce analysis is an ongoing effort, and as new data becomes available (such as the Veterans Benefits Management System (VBMS) transactional-level data and National Work Queue (NWQ) post-implementation data), it is incorporated in VBA's Resource Allocation Model (RAM) which is a systematic approach to distributing field resources each fiscal year.

The RAM utilizes a weighted model to assign compensation and pension Full Time Equivalent (FTE) resources based on regional office (RO) workload, including rating inventory; and rating, non-rating, and appeal receipts. The RAM incorporates several variables to accurately align with VBA's transformation to a paperless, elec-

tronic environment, where receipts can be assigned and managed at the national level. These variables include station efficiency (claims completed per FTE), quality, and RO capacity.

VBA leaders use the model as a guide, making adjustments for special circumstances or missions performed by individual ROs. Special missions include:

- the Appeals Management Office (AMO),
- Benefits Delivery at Discharge (BDD) sites,
- Integrated Disability Evaluation System (IDES) processing sites,
- Quick Start processing locations,
- National Call Centers (NCCs),
- foreign claims processing locations,
- radiation processing locations,
- Camp Lejeune Contaminated Water (CLCW) processing locations, and
- Pension Management Centers (PMCs).

With the exploration and analysis of future workload management functionality, VBA will work closely with DOD to collaborate on drawdown estimates and aggregate demographics of forces so VA has an early picture of the Veteran population profile. Data will be assessed at a more granular level to understand employee production and prioritize the integration of additional enhancements in the NWQ. VBA submits its annual Staffing Levels report to Congress in late March, detailing the staffing levels at each RO.

Question 41. The current appeals process for veterans benefits is broken. More than 450,000 appeals are pending. The current appeals process is complex, inefficient, and confusing. Most importantly, it no longer serves veterans and their families. In 2016, VA worked with eleven VSO and non-VSO stakeholders to create a framework to reform the appeals process. Do you support reforming the current appeals process? If confirmed, will you prioritize reforming the current appeals process? Do you support the 2016 framework as described above?

Response. I fully support reforming the current appeals process. Comprehensive reform is necessary to replace the current lengthy, complex, confusing VA appeals process with a new appeals framework that makes sense for Veterans, their advocates, VA, and stakeholders. This reform is crucial to enable VA to provide the best service to Veterans and, if confirmed, I will prioritize reforming the current appeals process.

I support the framework developed collaboratively by VA and a wide spectrum of stakeholder groups in 2016. I believe that the engagement of the organizations that participated in development of the new framework ultimately led to a stronger proposal, as we were able to incorporate their feedback and experience having helped Veterans through the complex appeals process.

The current VA appeals process takes too long. Appeals have no defined endpoint or timeframe and require continuous evidence gathering and re-adjudication. On average Veterans are waiting 3 years for a resolution on their appeal. For cases that reach the Board of Veteran's Appeals (Board), Veterans are waiting on average 6 years and thousands of Veterans are waiting much longer. The current appeals process is also too complex. Veterans do not understand the process, it contains too many steps and it is very challenging to explain to Veterans. Additionally, accountability does not rest with one appellate body; rather, jurisdiction over appeals is split between the Veterans Benefits Administration (VBA) and the Board.

The new framework, which I fully support, steps away from an appeals process that tries to do many unrelated things inside a single process and replaces it with differentiated lanes, which give Veterans clear options after receiving an initial decision on a claim. For a claim decision originating in VBA, for example, one lane would be for review of the same evidence by a higher-level claims adjudicator in VBA; one lane would be for submitting new and relevant evidence with a supplemental claim to VBA; and one lane would be the appeals lane for seeking review by a Veterans Law Judge at the Board. In this last lane, intermediate and duplicative steps currently required by statute to receive Board review, such as the Statement of the Case and the Substantive Appeal, would be eliminated. Furthermore, hearing and non-hearing options at the Board would be handled on separate dockets so these distinctly different types of work can be better managed. As a result of this new design, the agency of original jurisdiction (AOJ), such as VBA, would be the claims adjudication agency within VA, and the Board would be the appeals agency.

This new design would contain a mechanism to correct any duty to assist errors by the AOJ. If the higher-level claims adjudicator or Board discovers an error in the duty to assist that occurred before the AOJ decision being reviewed, the claim would be returned to the AOJ for correction unless the claim could be granted in full. However, the Secretary's duty to assist would not apply to the lane in which

a Veteran requests higher-level review by the AOJ or review on appeal to the Board. The duty to assist would, however, continue to apply whenever the Veteran initiated a new claim or supplemental claim.

This disentanglement of process would be enabled by one crucial innovation. In order to make sure that no lane becomes a trap for any Veteran who misunderstands the process or experiences changed circumstances, a Veteran who is not fully satisfied with the result of any lane would have 1 year to seek further review while preserving an effective date for benefits based upon the original filing date of the claim. For example, a Veteran could go straight from an initial AOJ decision on a claim to an appeal to the Board. If the Board decision was not favorable, but it helped the Veteran understand what evidence was needed to support the claim, then the Veteran would have 1 year to submit new and relevant evidence to the AOJ in a supplemental claim without fearing an effective-date penalty for choosing to go to the Board first.

To fully enable this process and provide the appeals experience that Veterans deserve, VBA, which receives the vast majority of appeals, would modify its claims decisions notices to ensure they are clearer and more detailed. This information would allow Veterans and their representatives to make informed choices about whether to file a supplemental claim with the AOJ, seek a higher-level review of the initial decision within the AOJ, or appeal to the Board.

The new framework would not only improve the experience of Veterans and deliver more timely results, but it would also improve quality. By having a higher-level review lane within the VBA claims process and a non-hearing option lane at the Board, both reviewing only the record considered by the initial claims adjudicator, the output of those reviews would provide a feedback mechanism for targeted training and improved quality in VBA.

The legislation should be enacted now. It has wide stakeholder support and the longer we wait to enact the Appeals Reform legislation more and more appeals will enter the current, broken system. The status quo is not acceptable for our Nation's Veterans and taxpayers. The new framework will provide much needed comprehensive reform to modernize the VA appeals process and provide Veterans a decision on their appeal that is timely, transparent, and fair.

Question 42. There was a recent Congressional Budget Office report released that suggested that significant savings could be realized in VA compensation expenditures by streamlining who is considered service-connected. Of particular note, the report suggests that a number of presumptive conditions, such as Multiple Sclerosis, should not in fact be presumptively considered for service-connection. Do you support the recommendations offered by CBO targeting service-connected disabled veterans compensation?

Response. This recommendation would alter the fundamental principles of the VA disability compensation program, specifically the definition of "line of duty" as it relates to determining service-connection for diseases or injuries related to military service. While this principle has been debated and studied over the years, VA still believes and Congress has historically maintained support for the current definition of line of duty. That is, servicemembers who contract any injury or illness while on duty or on authorized leave, that is not the result of willful misconduct or drug and alcohol abuse, are entitled to service-connection for such conditions. The basic premise is that Servicemembers are on duty 24 hours a day, seven days a week and such individuals are subject to the Uniform Code of Military Justice at all times and in all places, including while on leave. VA believes that the government should continue to support those who have made enormous sacrifices and answered the call to defend their country by maintaining the current definition of line of duty.

Additionally, VA does not support eliminating the presumption of service-connection for certain conditions such as Multiple Sclerosis. The establishment of presumptive disabilities is based on extensive medical evidence and sound scientific research which identifies certain medical conditions that manifest years after the Veteran's exposure. VA believes these individuals are justly considered for service-connected benefits as it relates to these conditions.

Question 43. VA's FY 2017 budget request for major and minor construction of \$1.025 billion is a significant decrease from FY 2016 request of \$1.675 billion. The Department testified that it was taking a "strategic pause" regarding construction awaiting the report by the Commission on Care. Now that the report has been published, what do you think the Department should do to modernize and replace its aging and substandard facilities?

Response. In FY 2017 the Department did not request funding for any new construction projects. Instead, VA's FY 2017 budget request focused on fixing what we have by directing resources to fund the continuation or completion of minor con-

struction and non-recurring maintenance (NRM) projects initiated in prior fiscal years.

The reason for not funding any new projects was because VA was waiting to receive the recommendations from the Commission on Care (which we received in July to determine if resources would need to be reallocated or requested to implement infrastructure strategies accordingly. In addition, VA wanted to ensure maximum future flexibility by not committing to a long term solution prior to the release of the report.

In August 2016, the President and VA responded to the Commission's report. The Department agreed that the Commission's facilities recommendations were critical to enable a successful transformation of VA's healthcare system to an integrated network to serve Veterans. VA stated that a strong suite of capital planning programs, tools, and resources would be needed to be able to fully realize the benefits and Veteran outcomes expected from implementing an integrated healthcare network.

Currently, VA is working toward the goal of high performing networks that take into account current and expected future services by developing a structure to integrate community care and VA-provided healthcare on a market by market basis. The Department kicked-off an effort with private sector healthcare experts to design an approach for integrated healthcare delivery decisions based on Veteran population, demand, internal capacity, and external public and private sector health care resources and capacity. Once the approach is validated, tested, piloted, and deployed nationwide, a national infrastructure realignment strategy will be developed accordingly to establish an objective process to appropriately realign VA's capital infrastructure. Through this process, VA will also identify the resources, tools, and authorities that are needed to enable the divestiture of assets and to streamline capital project execution. VA is committed to pursuing the appropriate capital resources to serve Veterans and ensure that a successful realignment strategy is implemented.

Question 44. VA's vocational rehabilitation and employment program is one of the smallest, yet most important, programs within the Department. It is the linchpin for helping veterans who incur service-connected disabilities achieve a fulfilling and gainful future. I am deeply committed to making sure that this program lives up to its full potential, especially when individuals who have sustained serious injuries in combat are concerned.

What are your thoughts on the role that vocational rehabilitation plays in terms of the total rehabilitation of an individual recovering from severe combat-related injuries and on how VA's current efforts might be improved?

Response. "What are your thoughts on the role that vocational rehabilitation plays in terms of the total rehabilitation of an individual recovering from severe combat-related injuries":

- The Vocational Rehabilitation and Employment (VR&E) program provides comprehensive services and assistance to enable Veterans and Servicemembers with service-connected disabilities to include physical, cognitive, mental, and emotional disabilities as well as an employment handicap to prepare for, find, and maintain suitable employment. For Veterans with service-connected disabilities so severe that they cannot immediately consider work, the VR&E program offers services to improve their ability to live as independently as possible in their homes and communities. Nearly one quarter or more of VR&E participants recently studied, by cohort, have a primary rating for Post-Traumatic Stress Disorder (PTSD). (VR&E Longitudinal Study Annual Report 2016, 2015). VR&E participants in the longitudinal study also reflect an average disability rating of 60%; participants have a range of physical and emotional barriers and disabilities.

- VR&E's service delivery model works to best support Veterans where Veterans are located. VR&E employs over 1,000 professional Vocational Rehabilitation Counselors (VRCs) and Employment Coordinators (EC). These personnel provide services to Veterans and transitioning Servicemembers through a network of over 350 locations. VR&E's service delivery model include operations at 56 regional offices (ROs); the National Capital Region Benefits Office; approximately 142 out-based offices; 71 Integrated Disability Evaluation System (IDES) installations and 94 VetSuccess on Campus (VSOC) schools/sites. VR&E is also able to provide individualized services based on the Veteran or Servicemember's unique individualized needs.

- VR&E has two special missions focused on reaching critical populations via targeted outreach and support—IDES and VSOC. VR&E actively collaborates with the Department of Defense to provide VR&E services to Servicemembers through the IDES program. Vocational Rehabilitation Counselors are located on 71 military installations and work directly with transitioning Servicemembers to provide VR&E services. VR&E is committed to ensuring that the needs of seriously injured Vet-

erans and Servicemembers are met in a timely manner by providing priority processing of applications for these populations. Automatic entitlement to VR&E services for wounded, ill and injured Servicemembers, a provision of Public Law 110-181(NDAA; Congress has renewed annually), allows for streamlined support and assistance for this critical population. Veteran Success on Campus (VSOC) Counselors provide on-campus access to VA benefits and services/support for 78,000 Veteran students on 94 campuses across the country.

Response. "How could VA's current efforts be improved"

- As part of ongoing VR&E Transformation, VR&E has several initiatives currently in development to improve service delivery to Veteran clients. VR&E Service is currently developing a new case management system and process that will be fully electronic and paperless, with planned pilot/deployment in FY 2017. VR&E also deployed tele-counseling Nation-wide in 2015, and continues to work to increase the use of this enabling technology to better serve both Veterans and their counselors. VR&E is also working on initiatives to streamline administrative processing and support for VR&E in the VR&E program.

- To continue to better understand the VR&E population, VR&E continues to execute the congressionally mandated 20-year VR&E Longitudinal Study of Veterans who began their VR&E programs in 2010, 2012, and 2014. Reports are submitted to Congress annually on the long-term benefits of participating in the VR&E program. The study allows VR&E to continuously analyze trends among participants receiving services, and respond with initiatives that improve and adapt services to their changing needs.

Question 45. VA granted the presumption of service-connection for conditions associated with exposure to Agent Orange to recipients of the Vietnam Service Medal until 2002 when criteria was restricted to those who had "boots on the ground." What are your views on granting the presumption of service-connection to veterans who served in the bays, harbors, and territorial seas?

Response. VA honors the service and dedication of U.S. Navy and Coast Guard Veterans who served aboard ships on the offshore waters of Vietnam. However, current laws are intended to compensate Veterans for Agent Orange exposure related diseases when there was an actual potential for such exposure. That potential existed for Veterans who served within the land boundaries of Vietnam, including its inland waterways, where Agent Orange use occurred.

The United States Court of Appeals for the Federal Circuit upheld this definition in *Haas v. Peake* (2008). Available evidence does not support such potential exposure existed for service aboard ships operating on Vietnam's open water bays, harbors, and territorial seas. The distinction is based on the fact that aerial spraying of Agent Orange and other tactical herbicides over Vietnam was used to destroy enemy food crops, reveal enemy positions by defoliating jungle and riverbank cover, and create vegetation-free security zones around military bases. No such use of Agent Orange occurred over the offshore waters of Vietnam.

To better understand possible Agent Orange exposure among Navy Vietnam Veterans, VA tasked the National Academies of Science (NAS) with investigating and determining whether there were any potential routes of exposure, such as through aerial spray drift or sea water contamination from river water runoff. The NAS report, *Blue Water Navy Vietnam Veterans and Agent Orange Exposure* (2011), determined that there was insufficient evidence to confirm that these potential routes resulted in any significant exposure. U.S. Navy and Coast Guard activity during the Vietnam War involved large open water ships conducting operations off the coast of Vietnam [often referred to as the "Blue Water Navy"] and smaller vessels conducting operations on the inland bays and river system of Vietnam [often referred to as the "Brown Water Navy"]. Some Blue Water ships temporarily entered Vietnam's inland waterways to conduct naval gunfire support of ground operations or to deliver supplies.

Although there is insufficient scientific evidence to grant a blanket presumption of Agent Orange exposure for all U.S. Navy Vietnam Veterans, VA has a liberal policy of presuming exposure for all Veterans who served aboard Brown Water vessels operating on Vietnam's inland waterways and for those Veterans serving aboard Blue Water ships that temporarily entered the inland waterways. Additionally, if evidence shows that a Blue Water ship off the Vietnam coast sent crew members ashore for duty or visitation, any Veteran on the ship at that time will receive the presumption of exposure if they state that they personally went ashore. The Veterans Benefits Administration (VBA) maintains a list of ships that entered Vietnam's inland waterways or otherwise sent crew members ashore for duty or visitation. This list is based on evidence found in ship histories or deck logs, which are received from the Department of Defense's Army and Joint Services Records Research Center (JSRRC) or other credible sources. The list is available online and can

be quickly updated by VBA's Compensation Service to reflect the most up-to-date research.

Question 46. VA currently uses the criteria of 170,000 un-served veterans within a 75-mile radius for purposes of establishing new national cemeteries. In the past, the Senate has supported this standard and has authorized new cemeteries based upon VA's recommendations. Do you believe this should continue to be the standard practice? In the absence of a VA recommendation, do you believe Congress should legislate the location of new national cemeteries?

Do you believe this should continue to be the standard practice?

Response. VA changed the criteria used to establish new national cemeteries in FY 2011. The current standard, which was approved by Congress, reduced the Veteran population threshold required to build a new national cemetery from 170,000 to 80,000 within a 75-mile radius. As a result of this change, VA will construct 5 new national cemeteries designed to serve over 550,000 Veterans.

In addition, VA established burial access policies in 2011 and 2013 that will allow for construction of five Columbarium-only national cemeteries in certain urban locations where time and distance barriers make it difficult for Veterans to use the existing national cemeteries. VA will also establish a national cemetery presence in eight rural areas where the Veteran population is less than 25,000 within a 75-mile service area. The proposal targets those states in which: 1) there is no open national cemetery within the state; and 2) areas within the state are not currently served by a state Veterans cemetery or a national cemetery in another state.

In the absence of a VA recommendation, do you believe Congress should legislate the location of new national cemeteries?

Response. VA opposes any legislative action that would direct the location of a national cemetery. The placement of national cemeteries is based on objective criteria that address the maximum number of unserved Veterans in a given area. This approach has been very successful. To date, 91.7% of the total Veteran population—approximately 20 million Veterans—has convenient access to a burial option. When all planned national and state Veteran cemeteries currently in queue are opened, 95% of the Veteran population will be served.

Question 47. What is the future of VHA's electronic health record?

Response. The future of VHA's electronic health record (EHR) is a modern system that improves health outcomes for Veterans on a platform that can seamlessly adopt technological advances.

VA is carefully considering the future of VistA. In the context of current budgetary constraints, we are evaluating all options from adopting a commercial off the shelf (COTS) EHR to retaining an enhanced and standardized VistA. We are actively gathering key information and expert feedback, and recruiting a Chief Health Informatics Officer with extensive commercial EHR experience to help VHA craft an informed EHR strategy within the first 100 days of the new Administration. The goal is to make a decision that will best serve Veteran's needs.

OI&T has been working in partnership with VHA to develop the foundation for a modern health platform—the Digital Health Platform (DHP). This new initiative successfully completed a proof-of-concept. Over time, this approach will address the interoperability and integration challenges for Veterans by integrating information gathered from mobile applications, devices, wearable technology, along with data from Veterans' VA, military and commercial electronic health records in real-time.

We are not waiting for a decision to enhance the care Veterans are receiving today. Interoperability between VA and DOD is better today than at any point in the history of the Departments with the deployment of the Joint Legacy Viewer (JLV). JLV is not a vision for the future or a plan on paper. JLV is available to all clinicians in every VA facility in the country. It is a web based user interface that provides the clinician an intuitive interface to display DOD and VA healthcare data on a single screen. Providers from a variety of specialties have provided positive feedback and user stories are proving that we are successfully sharing information seamlessly between the departments. We have also invested in a longer term interoperability solution known as the Enterprise Health Management Platform (eHMP).

eHMP builds on the interoperability success of JLV, and is a modern web based user-interface that will improve access to health information by integrating health data from VA, DOD, and community care partners into a customizable interface that provides a holistic view of each Veteran's health records. A version of eHMP has been installed at 130 sites.

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

Question 48. In response to question 11, you note that you are still studying the various proposals and options that have been laid out by the President. At this point, how would you recommend fleshing out his plan?

Response. If confirmed as Secretary, I would immediately engage with the Administration to discuss ways to implement the President's plan. It is my understanding that the transition team has formulated some approaches already, but these have not yet been shared with me, as I have not yet been confirmed. If confirmed, I would then engage with both the Senate and House as well as others such as Veteran Service Organizations to gain their perspectives and suggestions for improving healthcare to veterans. I have gone on record about my belief that we must develop an integrated system of care, utilizing what is best about VA and best from the private sector. My commitment in this process is to be open to new ideas and approaches as long as they improve access and quality of care for veterans. I would ensure that any solutions that I would recommend for consideration would be consistent with my values to support policy that is in the best interest of our veterans and advances our system toward higher levels of performance.

Question 49. In response to question 12, you note that VA will expect the same level of partnership and engagement with the VSOs and MSOs to continue the progress/momentum that VA has gained with the MyVA Transformation. Can you please provide specific examples of the partnership and engagement you anticipate having with the VSOs and MSOs? For example, will you continue to have monthly meetings with the groups outlined in your response?

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

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

Question 50. With regard to question 20, can you please clarify what options you are considering in order to provide veterans with greater choice than they have now?

Response. The Choice program has been essential for VA to have made improvements in access to care. However, we have learned that the program as it currently exists is too complex and as a result is not working well enough for many veterans. We must fix this. Furthermore, in designing a healthcare system, it would not be my recommendation to use mileage and wait times as the criteria for determining eligibility. My goal is to design a system that is both easier to use and supports greater choice for our veterans. However, we must do this in a way that ensures that veterans are receiving high quality care and that is affordable to the taxpayer. If confirmed, I would present several specific options on how to achieve these goals by improving upon the design of our current Choice system and in recommending alternative eligibility criteria to mileage and wait times. I would not want to prematurely offer specifics on these proposals at this time as I believe they must first be studied and modeled and appropriate input from stakeholders must be obtained before these are discussed in a public forum.

Question 51. With regard to question 25, can you please provide what emphasis you would place on meeting the needs, including mental health needs, of rural veterans?

Response. I am committed to meeting the health care needs of all Veterans, regardless of where they live. Rural Veterans face unique challenges in accessing care and it would be my priority to refine telehealth, community care, and home health options as a means of providing these Veterans access to health care when and where they need it.

Question 52. With regard to question 27, can you please reference what you have done, during your tenure at VA, to improve the physical and mental health care ac-

cess, quality of care, and address privacy, security, as well as the transition for female veterans?

Response. During my tenure as Undersecretary for Health, VHA committed to ensuring all facilities met Privacy Standards—to include physical and auditory privacy—and to increasing the accountability of facilities to follow these standards. VHA created a policy to ensure that personalized health information is protected with the same level of privacy and security regardless of gender. We also launched multiple campaigns aimed at recognizing the service of women Veterans and will be soon launching an even more direct effort to increase civility and respect through the “End Harassment” campaign.

Question 53. In response to question 34, can you please clarify your personal belief?

Response. My read of the statutory language at title 38 U.S.C. section 105 leads me to the conclusion that any disability resulting from injury incurred in or aggravated by service shall be service-connected. There is no requirement of causation. This conclusion has been reviewed by Federal courts and found to be accurate.

At times, both the Congress and VA have established presumptions of service connection for certain disabilities and diseases that are shown by sound scientific and/or medical evidence to have resulted from exposure to a contaminant while in service or, in the case of amyotrophic lateral sclerosis (ALS), service itself. All such disabilities are covered unless it is a result of willful misconduct or an abuse of alcohol or drugs. Multiple sclerosis is one example of this type of disease.

Question 54. In response to question 35, please describe what you believe the Department should do to modernize and replace its aging and substandard facilities.

Response. As stated in VA’s FY 2017 Budget Request, based on the current mission, the Department has an identified need of approximately \$41 to \$50 billion to close critical performance gaps in the areas of safety, security, utilization, access, seismic safety, facility condition, space, parking, and energy. Once the Department develops and implements its integrated healthcare delivery model, a national infrastructure realignment strategy will be developed to align VA’s infrastructure to match the approach to provide care to Veterans. At that time, VA will determine what inpatient and outpatient facilities are needed, as well as what renovation/construction is needed to implement the realignment. Depending on the realignment, a significant portion of the \$41 to \$50 billion infrastructure gap will still need to be addressed through renovation or replacement. This effort will require a combination of substantial investment in VA-owned and operated infrastructure and disposal/reuse of unneeded facilities. This effort will require a combination of substantial investment in VA-owned and operated infrastructure and disposal/reuse of unneeded facilities and continued reliance on care in the community.

Question 55. In your response to question 39, you note that VA is actively “gathering key information and expert feedback” to help VHA craft an informed EHR strategy within the first 100 days of the Administration. You note that you are recruiting a Chief Health Informatics Officer to help in this effort. How will the hiring freeze impact the recruitment of the Chief Health Informatics Officer?

Response. I have had discussions with the White House on the hiring freeze, at this time those discussions have centered on ensuring that we are able to hire for positions that require direct patient care. If confirmed, I will evaluate other positions to see if others would require a request an exception to the freeze.

Question 56. With regard to question 13, given the level of depth provided in other areas of this questionnaire on issues and items not currently within your direct purview of Under Secretary of Health, can you please review the tracking mechanism of disability claims production widely-known as the Monday Morning Workload Report and respond to whether under your leadership you would continue to make public this report?

Response. Yes, The Monday Morning Workload Report is a public report. It is our transparent communication to share with the public how VA is performing in our mission to deliver benefits to our Nation’s Veterans.

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

Question 57. Dr. Shulkin, how would you describe the culture and functionality of the highest echelon in the VA Central Office? What changes would you make in the VA Central Office? Please be specific and candid.

Response. Over the past 18 months as Under Secretary of Health, I have come to understand the issues involving VA management and organization of our Central Office. While I have made several important organizational changes, I made a deliberate decision not to undergo large scale organizational changes, I wanted the organization to focus on addressing our wait time issues and other organizational priorities that I had established. Organizational change is important, but it can also be very distracting, and I wanted the organization to know our top priority was to address the clinical needs of our veterans. Also during my tenure as Under Secretary, I named 20 new senior leaders to my top 22 management positions. Each leader has been instructed to assess their organization and to present their assessments. We have begun a formal organizational review and assessment. If confirmed, I am prepared to make the necessary changes at VACO and the field to ensure more efficient and effective operations. Specifically I plan to address the separation between policy and operations at VACO which has resulted in duplicative and sometimes confusing direction to the field.

Question 58. Dr. Shulkin, what distinguishes you from the current VA leadership team? Do you plan to lead and manage the VA differently than the current VA leadership team? What are the differences? Please be specific.

Response. The Secretary of VA is responsible for ensuring that our nations veterans receive the highest level of service and care that we can provide. The Secretary also serves to ensure that the President and Congress' policies and laws are carried out as intended to the best of their ability. If confirmed, as Secretary, I would work tirelessly to see that these objectives are fulfilled.

With a new Administration and Congress, we have the opportunity to address systemic issues that have not been fully addressed in the last Administration. If confirmed, I would seek to work collaboratively with the new Administration, Congress, and Veteran organizations to implement systemic changes for VA that would improve service, quality and value. Given that there will be new leadership in place at the White House, Congress, and VA, this will be different than the last Administration. The mandate from the country to do better for our veterans is clear and now is the time to take on the tough issues and propose bold solutions. I am ready for this opportunity and challenge.

Question 59. Dr. Shulkin, once the replacement for a new Undersecretary of the Veterans Health Administration (VHA) has been identified, what are the top three priorities that individual should consider in this position overseeing the VHA? What are the biggest challenges facing the VHA?

Response. As Under Secretary for Health, I established five priorities for VHA. I firmly believe that these priorities are critical to the continued improvement of VHA. These five priorities were 1) Improve Access to Care, 2) Improve employee engagement and filling VA management vacancies, 3) Implementing industry best practices, 4) Developing an integrated network of care between VA and community care, and 5) Enhancing trust among veterans.

My instructions to a new Under Secretary for Health will be to prioritize Quality. Quality involves three important components of care: access, clinical outcomes, and service levels. Specifically with the focus on quality, we want to accelerate efforts in suicide prevention and treatment of behavioral health conditions, and women's healthcare.

Question 60. How many rural VA facilities have you visited? Please identify the locations.

Response I have visited a number of rural facilities: Dublin, Georgia; Augusta Maine; Bangor Maine, Caribou Maine, and Lebanon, Pennsylvania. In addition I conducted a number of listening sessions in Alaska during my visit there in 2015. I also practice internal medicine, via telehealth, in Grants Pass Oregon, which is a rural area that has a shortage of primary care physicians.

Question 61. How many VA employees are currently on administrative leave? Of those currently on administrative leave, how much has the VA exhausted on their salaries while they have been on administrative leave and unable to fulfill the duties for which they were hired?

Response. Attached for your review are the personnel actions as of 12/16/2016.

[Privileged and Confidential for use by US Government only, which cannot be printed in the public record.]

Question 62. Dr. Shulkin, in your experience in the VA Central Office, are there VA employees you believe are toxic, corrosive or indifferent to VA culture reform? If so, would you remove some or none of these individuals from the VA? If so, what authorities do you possess and would utilize to remove these individuals from the VA? If you believe you do not have the authority to remove them, explain why. If

you believe you need additional authority to remove them, explain in detail the authority you believe is required.

Response. Yes, I believe that there are employees that have deviated from the values that are essential for us to serve veterans. As Secretary, I would work to remove these employees from our workforce. The process to remove employees is currently too long and too cumbersome. While it is essential that there is due process, I would seek the authority to remove these individuals in a more expedited manner.

Question 63. Please provide information regarding the Office of General Counsel, to include: FY09-FY 2017 funding levels, full-time personnel and their duty station, and job descriptions for the positions within the Office of General Counsel. Please also describe and explain the breadth of the Office of General Counsel's work and advisement. If the Office of General Counsel advises you take a position or make a decision that is counter to President-elect Trump's positions and commitments to reform the VA, will you follow the advisement of the Office of General Counsel? Is the Secretary of the VA required by law to execute the position or decision advised by the Office of General Counsel? Explain options available to the Secretary of the VA to take a position or make a decision counter to the advisement of the Office of General Counsel.

Response. OGC's annual budget of approximately \$114M (\$94M BA, \$20M RA) supports +/- 700 FTE. Roughly 400 of OGC's personnel work in the District Chief Counsel Offices that provide legal support to VA's Medical Centers, Regional Offices, National Cemeteries, and other field operations; approximately 85 represent the Department in litigation before the US Court of Appeals for Veterans Claims; and the balance are assigned to VA Central Office and provide subject-matter-specific legal support to VA leadership on all issues arising from VA policies and programs, including information law, personnel law, procurement law, real estate law, Veterans' benefits law, torts and administrative law. The OGC workforce includes approximately 480 attorneys and 220 non-attorneys, including paralegals, legal assistants, and other administrative staff.

OGC's authorizing statute, 38 U.S.C. §311, provides for the appointment of a General Counsel by the President, with the advice and consent of the Senate, to serve as the chief legal officer of the Department and to provide legal assistance to the Secretary concerning the programs and policies of the Department. OGC's authorizing regulations, provided in 38 CFR Part 14, provide that the General Counsel is responsible to the Secretary for the following:

(a) All litigation arising in, or out of, the activities of the Department of Veterans Affairs or involving any employee thereof in his or her official capacity.

(b) All interpretative legal advice involving construction or application of laws, including statutes, regulations, and decisions as well as common law.

(c) All legal services, advice and assistance required to implement any law administered by the Department of Veterans Affairs.

(d) All delegations of authority and professional guidance required to meet these responsibilities.

(e) Maintenance of a system of field offices capable of providing legal advice and assistance to all Department of Veterans Affairs field installations and acting for the General Counsel as provided by Department of Veterans Affairs Regulations and instructions, or as directed by the General Counsel in special cases. This includes cooperation with U.S. Attorneys in all civil and criminal cases pertaining to the Department of Veterans Affairs and reporting to the U.S. Attorneys, as authorized, or to the General Counsel, or both, criminal matters coming to the attention of the Regional Counsel.

(f) Other matters assigned.

OGC provides advice and counsel to the Secretary and other VA officials regarding the legal framework within which those officials may act. Because actions taken in contravention of applicable laws may put the Department at unnecessary risk of litigation or other adverse outcomes, OGC endeavors to provide an analysis of available options rather than to simply advise for or against a single course of action. OGC strives to give useful, practical advice, couched in terms of "yes, if . . ." rather than "no, because." This approach generally avoids putting the Secretary in the position of having to choose between carrying out the President's agenda and complying with the law. As Secretary, I intend to work with my General Counsel to identify legally defensible means of accomplishing the reforms to which the President-elect has committed for the benefit of Veterans and taxpayers.

Question 64. If the VA Inspector General (IG) provides a report with findings of wrongdoing and criminal action, do you intend to notify Congress prior to or in tandem with the disclosure of the IG's report? In detail, please explain the authorities and actions you will execute to hold accountable the employees identified in the IG's

report. Regarding similar instances under the leadership of Secretary McDonald, he refused to execute and utilize authorities provided to him. Do you intend to break with this precedent and use the authorities granted to the Secretary of Veterans Affairs?

Response. With respect to utilizing the statutory authorities for employee accountability that are at my disposal, I am aware that the expedited Senior Executive removal authority contained within the Veterans' Access, Choice, and Accountability Act of 2014 has come under question in the courts and may be found to be unconstitutional. Because the Choice Act authority supplemented rather than replaced other, more defensible authorities for holding employees accountable, Secretary McDonald chose to use the other authorities rather than the Choice Act once the constitutional issue became clear. We do still have a number of options for holding employees accountable, including traditional processes under Title 5 and Title 38 and the expedited process that came with the Choice Act. As frustrating as it is for me as a leader and for Congress as an authorizing body to see that authority challenged, it really doesn't serve Veterans or taxpayers well if we take an action that we know we'll have trouble defending in court. So while I will consider all of the authorities at my disposal to hold misbehaving and under-performing employees accountable, I will approach each case with an eye toward ensuring that the action taken will withstand appeal.

Question 65. In July 2015, the VA requested authorities from Congress to transfer \$3.5 billion from the Choice Program to fund a shortfall in non-VA health care. Despite knowledge of such a debt as early as February 2015, VA officials waited until July to disclose the situation, providing a one-month notice of the potential lapse in health care for veterans due to insufficient funds. Do you agree with the VA's strategy to leave Congress little time to assess and address the \$3.5 billion shortfall? If not, please explain how this situation should have been handled? If a shortfall scenario were to occur again as some have insinuated, what can we expect you to do differently from previous VA leadership?

Response.

- VA's budget plan early in FY 2015 was based on the Choice Program being operational more quickly than what was ultimately possible and a higher anticipated use by Veterans of Choice Program funds. VA pushed forward with plans for providing Care in the Community as part of the effort to improve Veterans access to care. The planned increase in workload was not able to be supported within the Choice Program operations established at that time. As a result, VA's non-Choice Care in the Community program's increased execution was at a rate that exceeded the 2015 plan. Program execution visibility was hampered by limitations of the financial management systems as well as the uncertainty of the program's cost in 2015 from both unreported obligations and over-obligations associated with medical authorizations.

- Regrettably, the process to clearly define the specific shortfall required more time than would have been preferred and significantly shortened the response time made available to the Congress. Secretary McDonald was made aware of the shortfall in May 2015 when VA staff confirmed there would be funding shortfalls in Care in the Community. Congress was informed in briefings in June and July that the non-Choice Care in the Community account was executing at a rate well beyond the 2015 funded plan.

- In June 23, 2015 letters to the Committees on Veterans Affairs and the Appropriations Committees and subcommittees, VA requested authority to use available Choice Act funding and to transfer existing funds from other medical programs to address the shortfall in non-Choice Community Care requirements.

- VA requested Congressional flexibility to use section 802 funds on a limited authority basis in the amount of \$2.5 billion as the estimated cost exceeding the Care in the Community 2015 budget and use \$500 million for Hepatitis C treatments. VA could also make a \$348.5 million transfer from Medical Facilities to the Medical Services account for Community Care, all totaling \$3.48 billion.

- Congressional action provided VA the authority to use up to \$3.3485 billion of Choice Act funds to meet the shortfall in the non-Choice Care in the Community FY 2015 budget.

What is different now?

- Significant advancements have been made in refining processes for the utilization of Choice Program funds.

- VHA is completing monthly Financial Management System—Fee Basis Claims System (FMS-FBCS) reconciliations that are certified by VISN directors and Chief Financial Officers.

- For FY 2017, VA requested and received a separate appropriation for Community Care which will improve transparency and Congressional oversight.
- The FY 2017 appropriation provided VA with new authority to transfer funds to the Medical Community Care account from other VA discretionary accounts.
- VA is in the process of modernizing the Financial Management System, which along with improvements in methods and processes in the various automation systems that feed into the financial management system, will give VA senior management the ability to more easily identify this type of problem in the future.
- A congressional action that would assist VA is legislative language allowing VA to record the costs of Care in the Community at the time of payment, like some other Federal agencies, as opposed to the current practice requiring funds to be obligated at the time of authorization for care.

The planning and budget execution review processes that are now in place, will provide the necessary early warning of any similar funding issues and will allow for possible internal corrections. Additionally, I will be provided with the necessary information regarding the development of such an issue and will inform the Congress of it in a much more responsive manner.

Question 66. If the Senate Veterans' Affairs Committee requests the presence of VA employees to testify regarding a matter that was investigated by the Inspector General, will you make those personnel available to testify? Would you refuse to make VA employees available and advise they invoke their Fifth Amendment right against self-incrimination as Deputy Secretary Sloan Gibson did with several VA employees that the IG found were manipulating the VA system regarding relocation and financially benefited. Would you have made these employees available to testify before the House Veterans' Affairs Committee? What would you have done in this specific situation?

Response. I am committed to sharing information about VA policies, programs and activities with the oversight committees. The issue sometimes is one of timing: would testimony before the Committee during an active IG investigation potentially compromise a criminal proceeding, or violate an individual witness's Constitutional right against self-incrimination? We have to balance those competing interests in an effort to do the right thing in each case.

In the VBA relocation cases, it is my understanding that those employees retained private attorneys who advised them to invoke their Fifth Amendment rights. The Fifth Amendment right against self-incrimination is personal to individuals, not subject to invocation or waiver by one's employer, including the Deputy Secretary.

The problem in that case was timing. At the time that the employees' testimony was requested, the IG had referred the case to the Department of Justice for possible criminal prosecution, and DOJ had not yet determined whether it would take the case. As a result, HVAC's demand for those employees' testimony on the same issues that had been referred for potential criminal prosecution posed a real—not hypothetical—threat to their constitutional right against self-incrimination. In the interest of providing the Committee the information it needed, the Deputy Secretary asked the Committee to defer the hearing until after DOJ disposed of the case so the employees' Fifth Amendment rights would not be implicated. When the Committee declined to postpone the hearing, the employees invoked their right against self-incrimination.

Question 67. How do you define unusual and excessive burden as it relates to the clause within the Choice Act? Do you consider it is an unusual and/or excessive burden for an 80 year old veteran without a vehicle to arrange transportation for a 200 mile drive to receive a shingles shot at a VA hospital facility? In this specific case, would you permit this veteran access to a shingles shot in his community by utilizing the unusual and excessive burden clause in Choice?

Response. As defined in the Veterans Access, Choice and Accountability Act (VACAA), the Unusual or Excessive burden provision is for a Veteran who resides 40 miles or less from the closest VA medical facility and the Veteran faces an unusual or excessive burden in accessing such a facility. If the Veteran lives 200 miles from the closest VA medical facility, they would be able to use the Choice program for all of their care under the distance provision of VACAA. If the Veteran lived 40 miles or less from the closest VA medical facility and has a medical condition that impacts his ability to travel to that facility, the Veteran would be eligible to receive all of their care through VACAA. The Unusual or Excessive burden provision did not account for transportation issues in making a determination regarding eligibility. The Unusual and Excessive burden provision does not take into account the availability of services in local market. VA believes that eligibility requirements should allow for the use of community care in instances where clinicians have determined there is need and VA cannot provide the service or provide the service timely.

Question 68. Do you believe the Choice Program should be extended? Should the criteria for eligibility be altered? Do you have recommendations to improve Choice? If so, please provide a summary.

Response. Yes, VA would recommend that the Choice Act be amended to make full expenditure of the Choice Fund the sole basis for the expiration of the Veterans Choice Program (VCP) while utilizing existing eligibility criteria. This change would serve as an interim measure while Congress continues to consider VA's long term plans as well as the recommendations of the Commission on Care.

VA's long term plan would consolidate all of its community care programs (both VCP and other programs, since VCP is only about 25% of total community care) into a single program that meets the needs of Veterans, their families, and community providers. This new program would clarify eligibility requirements, build on existing infrastructure to develop a high-performing network, streamline clinical and business processes, and implement continuum of care coordination services. This new program will provide enrolled Veterans increased flexibility, greater choice and faster access to health care in the community.

VA has also identified several shorter-term legislative measures that offer immediate improvement for VCP. Those proposals include making VA the primary payer for VCP. We urge Congress to enact those changes, as well as adjust the termination provisions in the Choice Act. Addressing the sunset date issue in the coming weeks will accomplish three significant objectives that VA believes all stakeholders can agree on: 1) allowing Veterans to benefit from every dollar already appropriated by Congress to improve Veterans' access to care; 2) providing the new 115th Congress, the new incoming Administration, and Veteran stakeholders more time to chart the course for the future of community care, including ensuring the financial resources are available to carry out that course; and 3) time for VA to work with Congress and stakeholders to ensure a smooth transition with minimal disruption for Veterans moving from VCP to VA's new consolidated community care program.

Question 69. Do you consider front-line medical facility positions, including direct patient care positions, to be positions that are low risk and do not require a heightened sensitivity level to conduct an investigation and/or criminal background check? Do you believe the policies within 5 CFR 731 that govern suitability of covered positions in the VA provides sufficient guidance and specific direction to determine whether an individual is "favorable" to hire and should be in contact with veterans? What would you change in the VA credentialing process, please be specific, to better protect veterans from individuals who may cause them harm

Response. Provision of high-quality, safe patient care is the foremost mission of the VA. A critical component of providing safe care is the hiring and appointing of qualified healthcare providers. This begins before the provider is offered a position through the intense onboarding process.

The onboarding process is comprised of many steps which are all in place to ensure the applicants have the qualifications to meet VA standards and perform the duties for which they are being hired. The onboarding process includes the Human Resource process of investigating background to reveal criminal convictions, civil judgments, and exclusions from participation in Federal and State Health Care Programs, qualifications and basic eligibility determination, interviews, reference checks, and at minimum, a National Agency Check with Written Inquiry (NACI) level background investigation.

Another distinct and separate component of the onboarding process is the credentialing and privileging of the provider. This is an extensive process in which the training, education, work history, clinical references, and licensure are primary source verified. During the credentialing process the National Practitioner Data Bank (NPDB) is queried as well as the Federation of State Medical Boards (FSMB) (for physicians) to identify any licensure actions, medical malpractice payments, adverse clinical privileges actions, health care-related criminal convictions and civil judgments and exclusions from participation in Federal or state health care programs. Licensed Independent Practitioners, such as physicians and dentists, are also enrolled in the NPDB's continuous query program and FSMB's Disciplinary

Alert Service so that the facility is instantly notified if any report is made by any entity (VA or non-VA) to either organization so that immediate action can be taken as necessary.

VA utilizes an electronic credentialing software platform, VetPro, in which the primary source verified credentials for over 300,000 licensed, registered, or certified healthcare provider are stored and maintained. These files are easily shared and transferred between VA facilities to expedite the credentialing process for providers who move within the agency. The sharing of these files also assists in ensuring providers who have had substantiated clinical care concerns do not easily move

throughout the system as their VA clinical history is available to anyone with access to their file.

The selecting official at the facility level has all of this information to review and consider when making a decision of whether or not to hire the provider and if they are a good fit for the patient care needs of the facility.

Once hired, all Licensed Independent Practitioners are continuously monitored through a Focused Professional Practice Evaluation process and then through an Ongoing Professional Practice Evaluation process. These are screening tools (required for any Joint Commission Accredited facility) used to evaluate all providers who have been granted privileges and to proactively identify quality of care issues.

VA is committed to the thorough vetting of all providers who will treat our patients and we will continue to provide education, guidance, and tools to help the leaders at the VHA facilities make informed hiring decisions. VA meets and exceeds the Joint Commission accreditation standards for credentialing of healthcare providers that are utilized by healthcare organizations throughout the country.

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

Question 70. What steps will you take to establish a fully interoperable record-sharing system between the Department of Defense and the Department of Veterans Affairs, and to move beyond the use of the Joint Legacy Viewer to trade screenshots of records?

Response. In accordance with requirements in the FY 2014 National Defense Authorization Act, DOD and VA were required to be interoperable by December 2016. This was certified ahead of schedule on April 8, 2016.

- The DOD/VA Joint Legacy Viewer (JLV) is a clinical application that provides an integrated, chronological display of the complete longitudinal health record from DOD, VA, and Community Care providers in a customizable viewer.

- JLV is not a “screenshot” sharing technology. It uses and displays (near real-time) computable data that can be organized as each user requires for their current and future workflow needs.

- JLV shows all patient data, regardless of the source (VA, DOD, community partners) in one place.

- Veterans Benefits Administration (VBA) offices use JLV to expedite benefit claim processing, and other staff from Office of Inspector General (OIG), Office of Medical Legal Affairs (OMLA), and Office of General Counsel (OGC).

Today, more than 228,000 VA health care and benefits professionals have access to JLV and have used it to view more than 2 Million Veteran records. A preliminary VHA review found that patients reported 14% higher customer satisfaction when providers were using JLV because they were more familiar with their medical history.

Next steps in interoperability—eHMP:

- JLV has been a critical first step in connecting VA and DOD health systems with a read-only application, however, it is limited in its functionality.

- VA has developed Enterprise Health Management Platform (eHMP) which will deliver urgently-needed clinical functionality, while incorporating all of the data interoperability achieved with JLV.

- Through eHMP (which is a platform and not an EHR), clinicians will have a powerful Google-type record search that encompasses VA, DOD, and Community partners, as well as the ability to write notes, order laboratory tests, and communicate with improved tracking to ensure follow through on tasks.

- VA has deployed the initial version of eHMP (version 1.2) across the entire VHA enterprise.

- By “sitting” on top of the VA’s 130 separate VistA EHR’s, eHMP can maintain a consistent user interface while the supporting EHR systems underneath are modernized and/or changed.

Question 71. Do you support overturning the decades-old ban on allowing VA to cover the costs associated with in vitro fertilization and other assisted reproductive technology services?

Response. VA’s goal is to restore and improve the quality of life for Veterans in accordance with evidence based medical standards and to the greatest extent the law will permit.

- In the past, IVF has been legislatively excluded from the medical benefits package.

- Recent passage of Pub. L. 114–223 enables VA to provide counseling and treatment using Assisted Reproductive Technologies (ART), including IVF to Veterans (and their respective spouse) with a service-connected (SC) condition that renders them unable to have children without the use of fertility treatment.

- VA subsequently amended its regulation with publication of an interim final rule on January 19, 2017 that authorizes the same. VA will provide ART treatment, including IVF, to these affected Veterans and spouses.

- VA estimates that nearly 400 total Veterans will be provided ART (including IVF) treatment over the remainder of this fiscal year and FY 2017.

Note: The most common single cause of battle injuries is explosive devices (36.3%). Such trauma frequently results in genito-urinary injuries. For example, 1 in 5 warriors were evacuated from Operation Enduring Freedom combat in October 2011 with a genito-urinary injury.

Question 72. What is your assessment of VA's protections against retaliation for reporting sexual assault within the VA system?

Response. VA's protections against retaliation for reporting sexual assault within the VA system is deeply rooted in its commitment to creating a culture, embedded in our mission and core values, which engages and inspires employees to their highest possible level of performance and conduct.

Sexual harassment in the workplace is prohibited by law, and sexual assault is a serious form of sexual harassment. Reporting sexual harassment (or harassment on the basis of race, color, religion, national origin or age) is an activity that is protected by law. Retaliation against any individual for reporting such conduct is prohibited. VA managers at the highest and lowest level and employees are prohibited by law from retaliating against any employee for reporting sexual assault. There are consequences for engaging in such behavior.

In VA's Office of Resolution Management, there is an enterprise-wide Anti-Harassment Office (AHO), which provides centralized tracking, monitoring and reporting to proactively respond to all allegations of harassment. The AHO ensures that all harassment allegations are reported to VA leadership. Such a report outlines prompt corrective measures taken to decrease harassing behavior in the workplace. The AHO is committed to establishing transparency and accountability at every level of employment.

VA has also established enterprise-wide anti-harassment policies and procedures to ensure that an allegation of harassment, including sexual assault and retaliation for reporting sexual assault, receives a prompt, thorough and impartial investigation; and that VA takes immediate and appropriate corrective action when it determines that harassment has occurred.

By doing this, VA can proactively prevent harassing conduct before it becomes severe or pervasive. The EEO complaint process is also designed to make individuals whole for discrimination, that has already occurred, through damage awards and equitable relief, and to prevent the recurrence of the unlawful discriminatory conduct. While the EEO complaint process does not require an agency to discipline its employees, VA through the AHO, requires that immediate and appropriate corrective actions are taken to eliminate harassing conduct regardless of whether the conduct violates the law or whether an employee pursues an EEO complaint. The AHO focuses solely on whatever action is necessary to promptly bring the harassment to an end or to prevent it from occurring at all.

An employee who believes that he or she has been subjected to harassing conduct, for reporting sexual assault or for any other reason, can report the matter to his or her immediate supervisor (or second-line supervisor if the immediate supervisor is the alleged harasser); to the Anti-Harassment Coordinator (AHC) for his or her specific office; or to the AHO. Employees who witness potential harassment are encouraged to report it. Supervisors or managers who are notified of harassment or witness potential harassment are required to report it immediately, and also to assess the situation immediately in consultation with the AHO or AHC.

All reports of hostile or abusive conduct and related information is maintained on a confidential basis to the greatest extent possible. The identity of the employee alleging violations of the Anti-Harassment Policy will be kept confidential except as necessary to conduct an appropriate inquiry into the alleged violations or when otherwise required by law. Anonymous allegations of harassment will also be investigated and monitored to the fullest extent possible.

VA is dedicated to protecting its employees from retaliation for reporting sexual assault and all other unlawful discrimination, and VA has in place an effective mechanism and policy to ensure that our employees are protected. For the sake of everyone, including the Veterans we serve, we want to provide a safe working environment for every VA employee.

Question 73. Do you support expanding the caregivers program to cover caregivers of veterans from all eras? What is your assessment of the program as it stands and how can it be further streamlined and improved?

Response.

- The Caregivers and Veterans Omnibus Healthcare Services Act of 2010 allows VA to provide services to qualified family caregivers of eligible Post-9/11 Veterans who incurred or aggravated a serious injury in the line of duty, including a monthly stipend paid directly to designated primary family caregiver, and coverage under CHAMPVA if eligible.

- VA has developed multiple public/private partnerships in support of family caregivers of Veterans to provide training, education, and support to caregivers of Veterans of all eras.

- The Caregiver Support Program is currently involved in program review and evaluation with VA researchers to evaluate the short-term impacts of the Program of Comprehensive Assistance for Family Caregivers (PCAFC) and the Program of General Caregiver Support Services by assessing the impact of current programming on the health and well-being of Veterans and caregivers. This work is ongoing and will impact current as well as future programming.

- According to RAND's report "Hidden Heroes," the needs of family caregivers of Pre 9/11 Veterans are different than the Program of Comprehensive Assistance for Family Caregivers provides.

- Based on current budget models, VA estimates the annual cost of expansion to be approximately \$3 billion annually.

- I would support providing equitable programming for caregivers of Veterans, regardless of the Veteran's era of service or the reason why the Veteran requires assistance from a family caregiver. I would welcome collaboration with Congress to make enhancements, including legislative changes, to the current program which may allow for expansion to caregivers of Veterans from eras.

Question 74. What is your assessment of the program as it stands and how can it be further streamlined and improved?

- As it stands, the Program of Comprehensive Assistance has provided services to more than 30,000 family caregivers of Veterans, far exceeding the original vision.

- Despite the attention focused on the Post-9/11 Program, VA has very successfully implemented many other services and supports to family caregivers who do not qualify for the Comprehensive Assistance Program, including multiple trainings, peer support, and a very active telephone support line.

- 350 Full Time Caregiver Support Coordinators at medical centers across country

- 4,000 caregivers of Veterans of all eras have completed self-care training

- Active peer support mentoring program, telephone education groups, on-line trainings

- Caregiver Support Line has received more than 276,000 calls, continuing to average more than 250 calls per day

- The legislation could be improved. One specific example is the use of the word "injured," in the Law, which excludes caregivers of Veterans with ALS, MS, and other debilitating illnesses.

- Another idea for improvement may be focusing the caregiver support for aging Veterans in need of home-based care which may help delay long-term institutional care.

Question 75. With the policy change last year to open all military professions to women and to allow transgender individuals to serve, what steps must VA undertake to ensure the system is prepared to handle an increasingly diverse veteran population?

Response.

- VA must continue education and training of providers

- VHA's LGBT (LGBT), Health Program, Women's Health, Center for Women Veterans, Center for Minority Veterans, and Office of Health Equity have led national campaigns to raise awareness about the healthcare needs of lesbian, gay, bisexual and transgender women, African Americans, and rural Veterans.

- The VHA LGBT Health Program has developed fact sheets for Veterans and providers on LGBT Veteran health care available here: (http://www.patientcare.va.gov/LGBT/VA_LGBT_Outreach.asp)

- VHA strongly supports training for providers so they can have tools to deliver clinically and culturally competent care for our diverse group of Veterans.

- The VHA LGBT Health Program has developed and promoted several clinical trainings for providers in sexual health, transgender healthcare, as well as les-

bian, gay, and bisexual Veteran healthcare (http://www.patientcare.va.gov/LGBT/LGBT_Veteran_Training.asp).

- A national transgender e-consultation program and a transgender SCAN-ECHO program has been implemented. To date, 55 interdisciplinary healthcare teams encompassing nearly 400 providers have been trained
- The VHA LGBT Health Program has been working with Pentagon officials about training military healthcare providers in transgender care utilizing the VA model.

- In 2016, VA established an LGBT Veteran Care Coordinator at every facility. These Coordinators help train local staff and ensure that the facility provides appropriate clinical services for LGBT Veterans.

- A demographic field for Self-Identified Gender Identity (expected Feb 2017) in the electronic health record will help providers and staff better communicate with a diverse veteran population.

Question 76. What benefits has VA seen from its Child Care Pilot Program and what steps could be taken to permanently establish this program at VA facilities around the country?

Response. The Caregivers Act of 2010 required a Child Care Pilot program be established in at least three VISNs over two years. The VHA sites selected were:

- Buffalo, New York; opened 10/2011
- Northport, NY; opened 4/2012
- American Lake-Puget Sound (American Lake), Washington; (9/2012)
- Dallas, TX became an additional pilot site in 3/2013

The four pilots have continued to provide child care services with congressional authority extensions, most recently the Department of Veterans Affairs Expiring Authorities Act of 2016, authorizing services through December 31, 2017.

- VHA is not able to conclusively demonstrate a relationship between use of the child care pilot sites and impact on no-show rates

- However, despite limited data, Veterans did voice this service improved access to their appointments.

- The pilot program is highly successful based on Veteran satisfaction with child care provided and allowed Veterans greater access to appointments.

- While women Veterans are the most frequent users, it is notable that male Veterans users also use the service.

- VA is on record as asking for permissive authority legislation. There is no legal authority to expand the pilots or to add additional childcare in VA.

- In order to expand the program, Congress would need to enact legislation granting permanent discretionary authority to the Secretary to provide child care assistance for Veterans accessing health care at facilities. The Secretary's authority should include the ability to establish the types of child care providers to participate in this program, the scope of child care assistance, and the location of child care services.

Question 77. The Integrated Disability Evaluation System (IDES) integrates the Department of Defense (DOD) and Department of Veterans Affairs (VA) disability systems to improve and expedite processing of servicemembers through the disability evaluation system.

a. What is your assessment of the need to further streamline and improve the IDES?

Response. The Integrated Disability Evaluation System (IDES) is a joint DOD/VA Program that can certainly be presented as a success story of integrated, inter departmental cooperation. This program is designed to assist the DOD in determining whether wounded, ill, or injured Servicemembers (SMs) are fit for continued military service or if found unfit by the DOD, separate or retire the SM for their service-connected disability. IDES further showcases the unified efforts of DOD and VA working together to ensure all medically required evaluations, medical supportive services and full VA entitlements are made available to SMs found to be unfit. From the Program's Initial Operating Capabilities (IOC) to date, over 190,061 Servicemembers have been processed via the IDES Program. In FY 2016, the IDES program averaged approximately 2453 cases per month. By continuing to provide this expeditious, yet comprehensive level of service to our SMs participating in the IDES Program, potential opportunities for continued improvement and streamlining include:

- Ongoing early identification and thorough evaluation by DOD of SMs that may not meet the retention standards established by their specific military service.

- Offering enrollment in VA Healthcare to all IDES Program participants as a mechanism for maintaining uninterrupted access/healthcare coverage post separation from military service.

SMs approaching normal separations/discharge or retirement from the service may also be eligible for VA benefits. These SMs may apply for VA benefits and compensation after they have separated from the service or may file a claim for VA compensation and benefits while still in the service by participating in the VA's Benefits Delivery at Discharge (BDD) or the Quick Start Program.

BDD allows a Servicemember to submit a claim for disability compensation 60 to 180 days prior to separation, retirement, or release from active duty or demobilization. BDD can help the SM receive VA disability benefits sooner, with a goal of within 60 days after release or discharge

- *Separation Health Assessment (SHA) Initiative.* Although part of the BDD Program, VA and DOD commenced an initiative in 2013 that further assists SMs by allowing them to choose which Department (DOD or the VA) will conduct their final separation from service examination. If a SM chooses to have their SHA examination performed by the VA, they must file a claim for benefits no later than 90 days prior to their scheduled separation. Once completed, the examination results are provided to the DOD, who in turn will review and accept the examination results as the final separation from service examination. The goal of this initiative is to provide VA disability benefits to the SM within 60 days after release or discharge.

- Quick Start allows a Servicemember to submit a claim for disability compensation 1 to 59 days prior to separation, retirement, or release from active duty or demobilization. By submitting a disability compensation claim before discharge makes it possible to receive VA disability benefits as soon as possible after separation, retirement, or demobilization. SMs with 1–59 days remaining on active duty or full time Reserve or National Guard service, or SMs who do not meet the Benefits Delivery at Discharge (BDD) criteria requiring availability for all examinations prior to discharge, may apply through Quick Start.

b. If confirmed, how would you work with the DOD Secretary to ensure both DOD and VA ensure that veterans move smoothly through the multi-step disability evaluation process?

Response. Our approach would include continued holistic reviews of the IDES program, specifically focusing on a more robust feedback process from current and former participants of IDES and their families to ascertain:

- Transition improvements that can be made to the Program. Conduct a comprehensive review of all phases of the program and re-evaluate the challenges faced by both the SMs and their supporting chain of commands to remove or modify administrative processes identified as “very challenging” by Program participants and commanders alike.
- Review current services, programs and assistance provided by both the VA and DOD with a specific focus on the families of separating SMs, to better prepare them for their spouse's transition from military service.

RESPONSE TO PREHEARING QUESTIONS SUBMITTED BY HON. BERNARD SANDERS TO HON. DAVID J. SHULKIN, M.D., NOMINEE TO BE SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 78. Dr. Shulkin, as Under Secretary for Health, you stated to Virginia's Daily Press that privatization “would be a terrible mistake, a terrible direction for veterans and for the country, to essentially systematically implement recommendations that would lead to the end of the VA health-care system.” As Secretary of the Department of Veterans Affairs, would you continue to oppose efforts to reduce the Federal role in providing health care services to veterans?

Response. I have consistently stated my support for an integrated system of care for veterans. I wrote about this in my New England Journal of Medicine article in 2016. This integrated network would support and enhance services that are essential to veterans within the VA that either cannot be readily found in the private sector. The integrated system would also utilize care in the community that may be more accessible or higher quality of care than found in the VA. It is my firm belief that this integrated system of care will provide the best outcome for our veterans and the best value for taxpayers. Each community has different needs and capabilities and therefore such a system will require local needs assessments. Nationally, VA currently utilizes 31% of its' care in the community, demonstrating that we are able to both support a strong VA and work effectively with community providers.

I also believe that the VA health care system is essential to fulfilling our commitment to our Nation's veterans. All of my efforts would be directed to making our system work better on behalf of our veterans. I do believe that with thoughtful and proactive planning we can enhance and strengthen services, and eliminate waste and duplication by accelerating our efforts through an integrated system of care that serves veterans.

Question 79. In respect to the Choice Program, I hear two main concerns from Vermont veterans. First, is that there are delays in third party administrator (TPA) authorizations for care, which have led to critical medical appointments being delayed or missed entirely. Second, miscommunications between VA and the TPA on authorizations and billing have led to multiple Vermont veterans being sent to collections by local health care providers. As Secretary, how would you address these issues to ensure veterans get the care they need when they need it, without their credit being adversely impacted?

Response. VHA is committed to ensuring that all Veterans have timely access to care. In June 2016, the Office of Community Care implemented a contract modification to improve the appointing requirements and processes for Veterans

Choice Program services. In accordance with the modification, the initial appointment for an episode of care must be scheduled within five (5) business days of the contractor's receipt of a 10-0386 "VHA Choice Approval for Medical Care" form (or similar VA-generated request), all applicable clinical documentation, and the Veteran has opted in for VCP. The appointment must take place within 30 calendar days of the initial scheduling unless the desired appointment date is otherwise noted on the referral.

VHA continues to work with the contractors and VA staff to ensure clear and concise communication is the utmost importance to for our Veterans to have timely access to care. The Office of Community Care has worked on the development and modifications of the VHA form 10-0386 to make the request for care clear and concise for our Veterans. The form has several mandated fields that require VA staff members to ensure the request has all the pertinent information needed for the contractors to provide the best care to our Veterans.

VA understands that any situation resulting in delayed payments or accumulation of debt due to inappropriately billed claims is stressful for Veterans and unacceptable. We are working hard to correct these errors and offer assistance to our Veterans immediately.

We were able to pull the following data specific to VISN 1 and Vermont: In the past 90 days (Oct-Dec 2016), Community Care received a total of 139 Adverse Credit Reporting (ACR) requests for VISN 1.

Question 80. Treatment courts can play an important role in ensuring veterans with histories of substance misuse get a second chance. What do you see as VA's role in ensuring veterans can benefit from these programs?

Response. Incarceration as an adult male is the most powerful predictor of homelessness. VA services for justice-involved Veterans are therefore provided through two dedicated national programs, both prevention-oriented components of VA's Homeless Programs: Health Care for Reentry Veterans (HCRV) and Veterans Justice Outreach (VJO). Known collectively as the Veterans Justice Programs (VJP), HCRV and VJO facilitate access to needed VA health care and other services for Veterans at all stages of the criminal justice process, from initial contact with law enforcement through community reentry following extended incarceration.

VJO Specialists serve Veterans at earlier stages of the criminal justice process, with a three-pronged focus on outreach to community law enforcement, jails, and courts. All VJO Specialists must be licensed independent clinicians, and the vast majority are social workers. Differences (in size, structure, openness to outside partnerships and to treatment-based criminal justice interventions, etc.) between local criminal justice systems, as well as the partnership-driven nature of the work, mean that the VJO program can look significantly different from one location to the next. VJO Specialists at each VAMC work with Veterans in the local criminal courts (including but not limited to the Veterans Treatment Courts, or VTCs), conduct outreach in local jails, and engage with local law enforcement by delivering VA-focused training sessions and other informational presentations.

VA supports VTCs through the participation of its VJO Specialists as members of VTC treatment teams, and through the health care services it provides to Veteran defendants, most of whom would otherwise receive care at county expense. The Specialists assess Veteran defendants' treatment needs, assist as needed with the VA eligibility and enrollment process, link Veterans with appropriate VA treatment services, and (with the Veterans' permission) provide regular updates to the court on their progress in treatment. The VJO Specialists' (and VA's) role in a VTC is lim-

ited to the treatment-related aspects of the court process; although VA eligibility may be a court-imposed requirement for admission, VA does not decide which Veteran defendants should be admitted to a VTC or define the level of offenses (e.g., misdemeanor vs. felony) that a VTC will accept. VJO Specialists work closely with justice system partners as they plan new VTCs, informing the partners about VA services that would be available to Veterans defendants locally or regionally. However, as with all VJO-related services, the Specialists do not advocate specifically for the use a particular model or set numerical targets for desired VTC growth, but instead encourage communities to plan proactively to meet the needs of justice involved Veterans using approaches that best fit local circumstances. VA also does not provide grant funding or other financial support to VTCs or other Veteran-focused courts.

Question 81. It can sometimes be challenging for rural veterans, like those in my home state of Vermont, to have all their health care needs met. Under your leadership, how would VA maximize its telehealth capabilities to ensure rural veterans can assess quality VA-provided care closer to—or even in—their home?

Response. Telehealth is a key component of the strategy to address access issues, especially in rural areas where it can be difficult to hire providers.

- VA is expanding services through enterprise-wide initiatives, including by the expansion of Primary Care, Tele-Mental Health, and specialty care hubs that each service many sites of care.

- In Fiscal Year 2016, VA provided more than 2 million Telehealth visits to over 700,000 Veterans across more than 50 specialties.

- Approximately 315,000 of these Veterans were located in rural areas, including approximately 1,500 in rural areas of Vermont.

- While most Veterans currently access Telehealth services in their local VA Community-Based Outpatient Clinic, VA's Veteran-centric approach has led the Department to pursue expansion of services directly into Veterans' homes.

- VA Video Connect, VA's home Telehealth program, provided more than 39,000 encounters direct to Veterans' homes last year, of which over 40% were rural.

- For Veterans without an Internet-connected device at home, VA has implemented a system to provide tablets for home Telehealth use.

- As VA works to expand established Telehealth services, the Office of Rural Health and Office of Connected Care also partner with clinical program offices to foster innovative Telehealth programs that specifically increase access for rural Veterans.

- In FY 2016, rural Telehealth programs provided care to over 85,000 Veterans in remote areas across the country. This number is expected to increase to the hundreds of thousands in FY 2017.

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

Question 82. As of December 31, 2016, there were over 450,000 cases pending in VA's appeals system. Last year, Secretary McDonald convened a group of stakeholders including VSOs to attend a multi-day event to collaborate on how to fix the VA appeals system. Department of Veterans Affairs Appeals Modernization Act of 2016, which I introduced last Congress put the results of that collaboration into legislation and the Disabled American Veterans, the American Legion, the Veterans of Foreign Wars, the Paralyzed Veterans of America, AMVETS, the Military Officers Association of America, the National Association of County Veterans Service Officers, and the National Association of State Directors of Veterans Affairs supported the legislation.

Do you support the reforms contained in that legislation as a path forward for improving the appeals process, if not, why not, and how would you reform the process?

Response. I fully support reforming the current appeals process. Comprehensive reform is necessary to replace the current lengthy, complex, confusing VA appeals process with a new appeals framework that makes sense for Veterans, their advocates, VA, and stakeholders. This reform is crucial to enable VA to provide the best service to Veterans and, if confirmed, I will prioritize reforming the current appeals process.

I support the framework developed collaboratively by VA and a wide spectrum of stakeholder groups in 2016. I believe that the engagement of the organizations that participated in development of the new framework ultimately led to a stronger pro-

posal, as we were able to incorporate their feedback and experience having helped Veterans through the complex appeals process.

The current VA appeals process takes too long. Appeals have no defined endpoint or timeframe and require continuous evidence gathering and re-adjudication. On average Veterans are waiting 3 years for a resolution on their appeal. For cases that reach the Board of Veteran's Appeals (Board), Veterans are waiting on average 6 years and thousands of Veterans are waiting much longer. The current appeals process is also too complex. Veterans do not understand the process, it contains too many steps and it is very challenging to explain to Veterans. Additionally, accountability does not rest with one appellate body; rather, jurisdiction over appeals is split between the Veterans Benefits Administration (VBA) and the Board.

The new framework, which I fully support, steps away from an appeals process that tries to do many unrelated things inside a single process and replaces it with differentiated lanes, which give Veterans clear options after receiving an initial decision on a claim. For a claim decision originating in VBA, for example, one lane would be for review of the same evidence by a higher-level claims adjudicator in VBA; one lane would be for submitting new and relevant evidence with a supplemental claim to VBA; and one lane would be the appeals lane for seeking review by a Veterans Law Judge at the Board. In this last lane, intermediate and duplicative steps currently required by statute to receive Board review, such as the Statement of the Case and the Substantive Appeal, would be eliminated. Furthermore, hearing and non-hearing options at the Board would be handled on separate dockets so these distinctly different types of work can be better managed. As a result of this new design, the agency of original jurisdiction (AOJ), such as VBA, would be the claims adjudication agency within VA, and the Board would be the appeals agency.

This new design would contain a mechanism to correct any duty to assist errors by the AOJ. If the higher-level claims adjudicator or Board discovers an error in the duty to assist that occurred before the AOJ decision being reviewed, the claim would be returned to the AOJ for correction unless the claim could be granted in full. However, the Secretary's duty to assist would not apply to the lane in which a Veteran requests higher-level review by the AOJ or review on appeal to the Board. The duty to assist would, however, continue to apply whenever the Veteran initiated a new claim or supplemental claim.

This disentanglement of process would be enabled by one crucial innovation. In order to make sure that no lane becomes a trap for any Veteran who misunderstands the process or experiences changed circumstances, a Veteran who is not fully satisfied with the result of any lane would have 1 year to seek further review while preserving an effective date for benefits based upon the original filing date of the claim. For example, a Veteran could go straight from an initial AOJ decision on a claim to an appeal to the Board. If the Board decision was not favorable, but it helped the Veteran understand what evidence was needed to support the claim, then the Veteran would have 1 year to submit new and relevant evidence to the AOJ in a supplemental claim without fearing an effective-date penalty for choosing to go to the Board first.

To fully enable this process and provide the appeals experience that Veterans deserve, VBA, which receives the vast majority of appeals, would modify its claims decisions notices to ensure they are clearer and more detailed. This information would allow Veterans and their representatives to make informed choices about whether to file a supplemental claim with the AOJ, seek a higher-level review of the initial decision within the AOJ, or appeal to the Board.

The new framework would not only improve the experience of Veterans and deliver more timely results, but it would also improve quality. By having a higher-level review lane within the VBA claims process and a non-hearing option lane at the Board, both reviewing only the record considered by the initial claims adjudicator, the output of those reviews would provide a feedback mechanism for targeted training and improved quality in VBA.

The legislation should be enacted now. It has wide stakeholder support and the longer we wait to enact the Appeals Reform legislation more and more appeals will enter the current, broken system. The status quo is not acceptable for our Nation's Veterans and taxpayers. The new framework will provide much needed comprehensive reform to modernize the VA appeals process and provide Veterans a decision on their appeal that is timely, transparent, and fair.

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

Question 83. As a result of the Veterans Access, Choice and Accountability Act of 2014, veterans have been charged fees for seeking care in the community through the Choice Program. In some cases these fees have been turned over to collection agencies, putting the veteran's credit score and sometimes livelihood at risk. Under your direction what steps will the VA take to ensure that veterans have a clean financial bill of health?

Response. The Choice Act requires VA to be secondary payer when a Veteran receives community care for a non-service-connected condition and has other health insurance (OHI). In these cases Veterans are responsible for their co-pay or deductible as part of their participation with their OHI.

There have been cases when the delayed payment to the community care provider is inappropriately billed to the Veteran directly. The Choice contracts clearly identify billing timeframes for the Choice contractors and VA. The contractors have 30 days to pay a submitted claim or to deny the claim with an explanation of additional information needed to process. VA has 14 days to pay the contractors—this is a new addition to the contract in order to address the backlog of payments.

VA understands that any situation resulting in delayed payments or accumulation of debt due to inappropriately billed claims is stressful for Veterans and unacceptable. We are working hard to correct these errors and offer assistance to our Veterans immediately.

a. Additionally, I hear concerns from medical providers who have had reimbursements delayed by the VA for months. This has caused providers to stop taking veterans, many of whom live in rural areas and are in need of care. Under your direction, what steps will the VA take to improve reimbursements rates for care in the community?

Response. Currently there are no reports of providers refusing to see Veterans as a result of non-payment from VA. We have however received reports of providers who are refusing to see Veterans because of non-payment from the third party contractors. We are 100% current with Choice payments to the TPAs and have been for over 4 weeks.

In February 2016, the Office of Community Care created the Provider Rapid response Team. The purpose of this team is to quickly respond to any issue with provider payment or anything else that might affect Veteran's access to care in the community. This team liaises directly with leadership with the contractors to quickly and effectively solve provider issues.

Question 84. The Diffusion of Best Practices initiative has shown promise in standardizing veterans' care and experience at VA medical facilities. If confirmed as VA Secretary, what is your vision for continuing to build on that process?

Response. Diffusion of Excellence is an initiative that carried out one of my major priorities as Under Secretary: achieving consistency of best practices across the system. In your home state, Cleveland has a simple but impactful best practice that involves non-clinical employees spending time with veterans throughout their journey through the hospital: with this program, employees not only witness the experience of veterans firsthand, but they also get to know the veterans more closely and hear their stories throughout their service.

If confirmed I would ask Dr. Elnahal and his team to build the Diffusion of Excellence initiative out for the entirety of VA. This is an easier endeavor than it might seem: throughout the last 18 months, hundreds of best practices have been compiled with an online information sharing tool called the Diffusion Hub, which included many projects commissioned over the last year at VBA and NCA during a major leadership development initiative. We will establish a similar performance improvement and governance framework for the entirety of VA, and strategically target areas where we need the most improvement.

Appendix: Diffusion Activities occurring in Ohio:

Current Diffusion Efforts Impacting Your Veteran Constituents



Will also leverage model for private sector best practices, which will offer Ohio facilities even more options.



Practices Submitted from Ohio Facilities for November 2016 USH Shark Tank Competition

- Twenty-Nine Practices were submitted from five facilities
- Eight were selected as Semifinalists, and one was designated a Gold Status Practice

	Women Veterans Ladies Night Event	Veteran Experience
Chillicothe VAMC	Bike Share Project	Veteran Experience
	Nurse First	Care Coordination
	RPIE NVCC Emergency Consult	Care Coordination
	Veteran Orientation	Veteran Experience
	Systems Redesign Approach	Access
Cleveland VAMC	ALS System of Care to improve access, address unique patient needs, and improve delivery of care	Access
	Veterans Engagement: Reconnecting Employees with America's Heroes (Implementing sites: VISN 17)	Employee Engagement



Question 85. In your current role, you continue to hold medical appointments with veterans. Why is that important to you and what have you learned from that experience that would enhance your ability to lead VA?

Response. During my career as a healthcare executive I have always maintained an active practice of internal medicine. I have found it is the best way for me to

remain connected to the mission of helping those in need and in learning how systems of care actually work. Being a practicing physician also allows me to understand and communicate better with our staff and to understand how the system allows them, or fails them in their job to care for veterans. Practicing medicine at the VA, in both New York City and via telehealth in Grants Pass Oregon, has allowed me to better understand the needs of the veterans that we serve and how our system of care is different than what I have experienced in the private sector. It has given me firsthand knowledge of the integrated nature of our system, that provides not just physical care, but also addresses the social, psychological and economic needs of our veterans. I've also come to appreciate the specialized services offered by VA such as prosthetics and adaptive sports programs that are essential to the well being of many of the veterans that we have the honor of serving.

Question 86. With each new generation of warfighters confronts issues of exposure to toxic and hazardous materials during service. Will you commit to addressing the full scope of health issues faced by veterans and their families as the result of exposure to things like Agent Orange, burn pits, or nuclear material?

Response. The Department of Veterans Affairs (VA) honors the national service and sacrifice of our Veterans and is committed to providing compensation and health care benefits for disabilities that were incurred or aggravated by that service. This includes any disability resulting from exposure to environmental toxins or hazardous materials.

VA regulations and policies have long addressed environmental exposure issues that include World War II-era radiation from atomic bomb use and testing; Vietnam-era Agent Orange herbicide use; Gulf War desert particulate matter and burn pit toxins; and Camp Lejeune contaminated water during the 1950s–1980s.

Specifically, these regulations govern and address benefits for:

(1) Radiation exposure-related disabilities and for participation in radiation-risk activities and exposure to ionizing radiation;

(2) Diseases associated with exposure to Agent Orange herbicide for those Veterans who served in or visited Vietnam, or on its inland waterways, between January 9, 1962 and May 7, 1975; for service in a military unit operating on the Korean demilitarized zone between April 1, 1968 and August 31, 1971; for regular and repeated contact with a post-Vietnam C-123 aircraft used for aerial spraying of Agent Orange in Vietnam; and for involvement with testing, storage, transport, or other use of Agent Orange;

(3) Disability patterns associated with service in the Southwest Asian Persian Gulf War theater. These include undiagnosed illnesses and diagnosable medically unexplained chronic multi-symptom illnesses, as well as certain infectious diseases. In addition, our regulations also provide benefits for other diagnosable conditions associated with burn pit and Southwest Asia desert hazards; and

(4) Disabilities associated with service at the US Marine Corps' Camp Lejeune, NC, based on evidence of exposure to contaminated water from the mid-1950s to the mid-1980s. Free health care is already available for certain associated diseases and a VA regulation is pending that would provide presumptive service connection for eight diseases.

VA will continue to work with the Department of Defense to monitor and respond to any indication of toxic or hazardous environmental exposures experienced by Veterans during their military service and provide benefits for any resulting disabilities.

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

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

Response. There is no doubt that if the hiring freeze were to continue for an indefinite period of time that we would begin to see a real degradation of service levels of Veterans I would be specifically concerned that if there was a delay in new enrollments for benefits that access to healthcare may be impacted, which would be

unacceptable. As I mentioned in my hearing I have spoken to the Acting Under Secretary for Benefits, Thomas Murphy. He is prioritizing new enrollments and will inform the Secretary if significant changes occur as a result of attrition that may be impacting service levels. If there is a significant change in the number of days that Veterans are waiting for benefits the Acting Secretary of VA would address this with the White House and request an exemption from the hiring freeze. Currently, VBA is in the process of submitting an exemption request to permit the hiring of direct labor occupations to ensure reduced impact on VBA's ability to serve Veterans.

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

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

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

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

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

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

Response. The goals of the VistA Evolution program are improving the efficiency and quality of Veterans' health care by modernizing VA's health information systems; increasing data interoperability with DOD and private sector care partners; reducing the time it takes to deploy new health information management capabilities; and continuing to provide safe, efficient health care IT tools to VA medical providers so they can continue to deliver Veteran-centric, team-based, and quality-driven care. The VistA Evolution Program manages the development of what is known as VistA 4 which is a collection of approximately 60 projects and initiatives focused on VA's interoperability efforts with DOD and the private sector; the flagship Enter-

prise Health Management Platform (eHMP) and Joint Legacy Viewer (JLV) projects and other projects. Among many achievements, the work of the VistA Evolution Program has enabled VA to certify to Congress, together with Department of Defense (DOD), that VA had met the FY 2014 National Defense Authorization Act (NDAA) interoperability standards.

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

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

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

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

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

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

Response. Secretary McDonald entered VA in 2014 at a time of crisis. His leadership allowed VA to begin a path of recovery and he was able to lay the foundation for the transformation of VA. As such, yes I believe that Secretary McDonald was both effective and successful. My vision of transformation and reform can build upon the good work that Secretary McDonald began. I do believe that for VA to be successful we must now begin to address some of the long term systems problems that VA faces. First is our need to act as an integrated enterprise both within our three separate administrations and across the country. This will allow us to take advantage of VA's economies of scale and also begin to deliver a more consistent experience for our Veterans. We must also modernize many of our systems that have been long neglected. We must address the need for greater integration of our services between VA and the private sector and other Federal entities, whether this relates to healthcare or to building and maintaining our current infrastructure and facilities. This action will take dedicated focus by our leadership but I believe can be accomplished and will result in meaningful improvements for our Veterans.

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

Response. VA is undergoing one of the most ambitious Department-wide initiatives to transform its workplace culture in its history, known as *MyVA*. The *MyVA* initiative is predicated on five foundational strategies, one of which is Improving the

Employee Experience. This core strategy is aimed at fundamentally changing the VA culture to focus on two key and inextricably linked goals: improving leadership and increasing employee engagement in every corner of the Department. To that end, we have implemented a new ILEAD campaign that promotes leadership development for leaders at every level, characterized by principle-based leadership and demonstrated through “servant leader” behavior. These two powerful concepts shift the emphasis from self-serving behaviors and blindly following bureaucratic rules, to behaving in ways that put principles first, and service to others as the driving force. With respect to employee engagement, I will rely on feedback from our employees through the OPM Federal Employees Viewpoint Survey and the VA All Employee Survey. As a result of these surveys I am committed to:

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

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

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

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

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

Response. I have several concerns about section 247.

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

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

mandate and the expertise to investigate many of the concerns that VA whistleblowers raise.

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

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

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

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

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

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

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

Response. I will rely on the support and counsel of our Office of Tribal Government Relations (OTGR) to coordinate the agency's tribal consultation efforts, and to ensure both the Secretary and other senior VA leadership are engaged in communicating and working with tribal leaders as part of the enduring government to gov-

ernment relationship that exists between the United States and Indian tribes. We also rely on OTGR to assist the VA enterprise with cultivating informed, trusting relationships with tribal leaders, national intertribal organizations and service providers to identify opportunities for sharing of resources and pursuing partnerships that ensure access to care for our Veterans living within or near tribal communities.

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

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

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

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

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

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

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

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

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

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

National Recruiters routinely post VHA practice opportunities on career sites such as www.vacareers.gov.

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

Response. Yes

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

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

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

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

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

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

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

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

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

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

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

Response.

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

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

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

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

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

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

Response. Our goal is to provide all eligible Veterans with access to an integrated, high-performing network that allows Veterans to achieve the best health outcomes and patient experiences possible. This network takes the best of VA and the best of the private sector and combines them together. Today, 80% of Veterans already have a choice between VA and private sector care as they have other health insurance options. Last year 1/3 of all of our appointments were in the community, up from 20% less than two years ago. The Commission on Care considered a few options and rejected the idea of unfettered choice. Given what they were considering I do agree with their decisionmaking. However, if confirmed as Secretary I would consider a number of new alternatives to a system restricting care based upon wait times and mileage. I believe that there are new models that need to be considered that are clinically based and that maximizes the strengths of VA and the private-sector, is mindful of taxpayer dollars, and puts the Veteran at the center of decision-making. I would welcome the opportunity to work with you further to ensure that we consider all of the options available to us to ensure that Veterans are getting the care that they need.

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

Response. If confirmed, I would commit to using the regulatory authority available to the Secretary to ensure that Veterans with other than honorable discharges

are getting access to care. In the situation where we need legislative change I would work with both the White House and Congress about ways that we can address this population.

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

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

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

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

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

some targeted expansion in training in rural and highly rural facilities. VA had the first accredited Psychology residency program in the state of Alaska. In FY 2016, VA awarded eighteen pre-degree Licensed Professional Mental Health Counselor internship positions to seven VA medical centers. For FY 2017, VA awarded 3 pre-degree Marriage and Family Therapist internship positions at one site.

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

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

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

Question 29. On February 2, 2017, the VA filed a “Notice of Inquiry” in the *Federal Register* to “request information and comments from interested parties to help inform VA’s development” of a quality and safety policy for providers of modification services under the Automobile Adaptive Equipment program. However, the Act requires that the Secretary develop this comprehensive policy in “consultation” with different stakeholders, including the National Highway Transportation Safety Administration, and industry representatives.

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

Response. Yes, VA fully intends to comply with establishing this program in consultation with stakeholders and AAE entities across the national and state level, and public sector. VA has already been in contact with many of these stakeholders, and in doing so has discovered a number of entities with established quality and safety programs related to automobile adaptive equipment. Given the short suspense to implement this comprehensive program and supporting policy, and in order

to be as broadly inclusive as possible, VA issued this public notice to expeditiously gather information from across all entities. Once this information is coalesced, VA will be fully informed about, and will have identified, all stakeholders for subsequent extensive consultation. This plan will then be presented in proposed regulation to all for review/public comment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Response. At the time VA contracted with the National Academy of Medicine (NAM) for both Gulf War & Health, Volume 11 and Veterans & Agent Orange, Volume 11, VA subject matter experts (SMEs) were well aware of Congress' upcoming legislative requirement and wrote the two contracts accordingly—to have major focus on intergenerational health effects. With the final passage and signing into law of the Toxic Exposure Research Act, VA SMEs took further steps to discuss with NAM staff each of these two contracts and the exact language of the Act to ensure that NAM would be able to deliver reports which met the explicit requirements of Congress. On 12 January, 2017 VA SMEs took the additional step of discussing with the seated NAM ad hoc committee for Gulf War & Health, Volume 11 both the charge to the Committee (from the contract) and the language from the Act. VA SMEs will do the same with the NAM ad hoc committee for Veterans & Agent Orange, Volume 11 in March 2017. Both of these NAM reports are due to be completed in early 2019. Both of these reports, but especially Gulf War & Health, Volume 11, will have broad applicability to all Veteran cohorts and their descendants.

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

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

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

mittee. Both committees will address the key elements of the Toxic Exposure Research Act.

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

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

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

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

Response. While VA appreciates the focus on improving employment services for Veterans by consolidating various programs, we do not support the creation of a separate Veterans Economic Opportunities Administration (VEOA). The current Veterans Benefits Administration (VBA) structure reflects the Under Secretary for Benefits' overall responsibility for Veterans benefit programs, including compensation, pension, survivors' benefits, VR&E, educational assistance, home loan guaranty, and insurance. A separate Administration for economic opportunity programs would negatively impact Veterans and would result in a redundancy of management support services. Additional staff would be required to support the administrative and management functions for the new administration which would be at the expense of direct FTE associated with the delivery of benefits, which would reduce support to Veterans. In 2011, the Office of Economic Opportunity (OEO) was established in VBA under the authority of the Under Secretary of Benefits to directly oversee Education Service, VR&E Service, Loan Guaranty Service, and Economic and Employment Initiatives. We believe there is currently an appropriate management structure in which there is internal collaboration among these program offices to oversee Veteran programs related to economic opportunities. We are concerned that dividing the benefit programs between two Administrations will result in a redundancy of management support services and add an administrative burden.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

stating, “Antidepressant medications have been shown to increase the risk of suicidal thinking and behavior.”

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

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

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

- *Animal Assisted Therapy* programs where Veterans are part of the training process for service dogs, particularly around socialization of the service dogs in different settings
 - Socialization of the dog in crowds, on elevators, in public places, etc. necessitates the Veteran involved in the training to be in these settings
 - Allow the Veteran to apply coping strategies learned in therapy to real-life situations while training the dog
 - Gives the Veteran a sense of purpose and ‘giving back’ to others since the dogs are ultimately paired with another Veteran with a physical disability
 - Several programs across the country; program at Palo Alto has been in place almost 9 years with many success stories
- *Mental Health Mobility Impairment Service Dog Initiative* where Veterans with substantial mobility limitation secondary to a mental health condition are eligible for the veterinary health benefit
 - Evaluation by a multidisciplinary team, including a mental health clinician, determines that a service dog is the optimum intervention to overcome or mitigate the mobility limitation
 - Mobility limitation may include difficulty navigating public spaces, completing the activities of daily life such as shopping in a grocery store, and coming into the clinic for appointments
 - Center for Compassionate Innovation, Mental Health, and Prosthetics and Sensory Aid Services are teaming up to evaluate quality of life and satisfaction outcomes from 100 Veterans under this initiative
 - 7 Veterans have been approved for the veterinary benefit, 4 have dogs and 3 are in the process of being paired with a service dog, and 20 are going through the evaluation process with their multidisciplinary teams
- *PTSD Service Dog Study*
 - Recruitment is at greater than 80%; recruitment anticipated to be completed by spring
 - Fully staffed with all dog trainers (on board). Two per study site at three study sites equal six (6) trainers. A seventh trainer serves as the supervisor

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

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

During the last 18 months, VA and other Federal research funding agencies have worked together to address the mental health needs of Veterans through the National Research Action Plan (NRAP), developed in response to President Obama's

Executive Order 13625. The plan outlines the vision for PTSD, TBI, and suicide prevention research and describes requirements intended to help the agencies successfully reach important research goals over the next few years.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Initiatives like this have been proven successful in efforts such as the Digital Health Platform (DHP) proof of concept, which utilized the public private partnership construct with an academic partner. DHP is a first-of-its-kind public-private partnership that will redefine the concept of "interoperability." DHP is a cloud-based platform. It is not hampered by software updates and changing technology. It is flexible and open. DHP already works with existing health platforms such as VistA, Cerner, Epic, and more. Future developments can be sourced industry wide.

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

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

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

and total cost incurred by the Federal Government. Please furnish this data and if there is no method by which the VA has tracked and collected this data, please explain why and how intend to furnish this data.

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

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

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

Factors	Mitigation Plan
Increasing Demand/Lack of Providers and Clinic Staff.	<ul style="list-style-type: none"> • Active recruitment of health care providers and clinic staff—VA increased provider and nursing staffing by approximately 12% over the past two years • Granting full practice authority for Advanced Practice Nurses • Increase use of telehealth for Primary Care and Mental Health • Use of community care resources when unable to recruit providers • Increased use of extended clinic hours
Inefficiencies in clinic practices.	<ul style="list-style-type: none"> • Implemented Clinic Practice Management Program across VA—in this program all facilities have at least one group practice manager to oversee and optimize administrative clinic activities • Validating clinic grids to achieve optimal clinic capacity • Focus on improving productivity—increased productivity by 16% over past two years • Developed strategies for reducing “no show” rates, and redesigning clinic space • Implemented standardized face to face Clinic Clerk Training for optimal scheduling of patients • The above efforts have resulted in an increase in 12,000 appointments daily in 2016 when compared to 2014

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

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

Yet, the VA is again pursuing what appears to be a VA solution to scheduling software with VSE. This is concerning, when there are many commercially available, proven and affordable off-the-shelf solutions. Even more concerning is at the

hearing yesterday you also referenced an additional VA scheduling tool, called MASS. I am very concerned the VA is moving forward with multiple scheduling tools, at great cost, without giving adequate thought to commercially available solutions, interoperability and effectiveness. An even greater, overarching concern is the scheduling solutions you describe did not mention how they would integrate into an even larger EHR transition. Lack of preparation and the absence of a coordinated strategy are what led to the disjointed IT architecture VA has now.

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

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

VSE

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

MASS

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

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

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

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

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

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

Response. The intent of the RFI is to conduct market research and ensure that VA is in a position to gather the best information on commercial-off-the-shelf (COTS) solutions that will meet the requirements specified in the legislation. In addition, the RFI provides VA with the information to determine if the procurement must be set aside for competition among Veteran-owned-small-businesses (VOSB) in

compliance with the June 16, 2016, U.S. Supreme Court decision regarding *Kingdomware Technologies, Inc. v. United States* (Kingdomware) case.

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

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

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

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

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

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

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

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

In order to enhance our clinical practice standardization, VA will leverage the Enterprise Health Management Platform (eHMP), which is now deployed and in pilot testing throughout the VA system. It provides a structured interface for standardization of clinical processes and can be utilized with our current legacy systems or a commercial EHR.

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

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

TOXIC EXPOSURE

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

The VA currently continues to exclude these bays and harbors from the definition of inland waters. We all agree the rivers were contaminated and rivers run into the harbors and bays. Maritime traffic and anchoring kept that area in a state of flux and the Institute of Medicine has also confirmed a plausible pathway for the dioxin to have entered the shipboard potable water system via the shipboard distillation

system, which actually enriched the dioxin. Will you be taking action to restore benefits to these veterans?"

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

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

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

TELEMEDICINE

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

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

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

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

VA LEASES

Question 53. As you know, Congress has not, through a regular process, authorized Department of Veterans Affairs (VA) major medical facility leases since a 2012 change in budgetary scoring of these leases by the Congressional Budget Office (CBO). This change in budgetary scoring has resulted in VA major medical facility leases receiving large, up-front spending scores, despite the fact that actual spending would not increase. This issue has prevented Congress from authorizing two

dozen major medical facility leases in 15 states, including in Virginia and North Carolina, states with some of the fastest growing populations in the Nation. If confirmed as Secretary of Veterans Affairs, what are your plans to address this problem? How can we, as elected officials, better assist VA in finding a solution to the lease authorization issue?

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

COMMUNITY CARE NETWORK RFP

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

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

- a. Expanding the number of urgent/emergent drugs available.
- b. In comparison to approximately 75 existing regional and local first fill contracts, the urgent/emergent drugs available under the CCN is in some cases a reduction but in many cases it is an expansion.
- c. Eliminating the out-of-pocket costs Veterans must now pay for their PC3 and Choice urgent/emergent prescriptions.
- d. Eliminating the need for Veterans to seek reimbursement from VA for PC3 and Choice urgent/emergent prescriptions.
- e. Ensuring continuity of care by making urgently needed medications not listed on the CCN drug list to be available via a prior authorization process.
- f. This feature is not currently available uniformly across the VA system.
- g. The changes to non-VA prescription fulfillment processes were developed with significant input from field-based VA pharmacists who were charged with improving access, patient safety and the customer experience. VA's formulary management process is dynamic, updated continuously to meet the needs of Veterans and the evolving health system. In the unlikely event the changes result in disruption of services to Veterans, VA has the ability to modify the process to avoid the disruptions.

FASTER CARE FOR VETERANS ACT

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

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

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

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

THE VA AND CERTIFIED REGISTERED NURSE ANESTHETISTS

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

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

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

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

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

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

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

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

TRAUMATIC BRAIN INJURY AND POST-TRAUMATIC STRESS

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

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

Psychopharmacology Initiative). I stand committed to work with the best within VA and synergize our efforts with researchers across the country and around the world to meet the health needs of our Nation's Veterans.

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

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

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

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

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

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

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

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

When I came to VA 18 months ago, the biggest issue I believe we faced was access to care for our Veterans. However, from the way that VA was approaching access I did not believe that we could develop an effective solution to the problems we faced. I, therefore, instructed our team to reduce our clinicians' way of ordering consults from 31 different ways to just 2 ways: either routine or urgent. That allowed us to see which Veterans needed care the most. It also allowed us to focus

our efforts on these urgent health care needs. Once we did that, we went to our second idea—that is to have national access stand downs. This was a mandatory event that occurred in every single medical center to focus the entire staff on reducing urgent care needs. This effort is described in an article I wrote, <http://catalyst.nejm.org/va-stand-down-resolved-56000-plus-urgent-care-consults/>.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Central to the effort was establishing a new list of medical supplies and equipment to be purchased through a centralized system, using one of four regional "prime vendors." This list, or formulary, includes over seven thousand items and continues to expand, as have the number of facilities using this list. The modernization effort centralizes purchasing authority, streamlines ordering, tracking and procurement of equipment and supplies by providing an efficient, just-in-time distribution process. It also enables VA to leverage its scale to order items at a negotiated rate to avoid costs.

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

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

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

are properly accredited, VA will be able to provide this same service to their organizations as well.

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

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

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

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

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

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

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

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

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

"The third instance was revealed to have impacted my husbands' benefits claim directly. We received a copy of his Disability Benefits Questionnaires which contained medical history of another veteran that had been erroneously inserted into my husband's claim. This other veteran is older and had been seen at a VA for dizziness which my husband now suffers from as well. However, this medical appointment date was 1986 when my husband was just a freshman in high-school and did not suffer dizziness until his Traumatic Brain Injury (TBI) sustained while performing USAF work duties in Plattsburgh, NY in 1990. This 1986 VA visit was cited as the reason for denying his C & P rating increase claim in 2014. An appeal was

filed in a timely manner and the second rating doctor reviewed this rating file and used the original rating doctor's decision as the reason to also deny the benefit rating increase claim. Neither of these doctors referred James for follow up evaluation of TBI related issues."

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Question 80. I am asking this question on behalf of my constituent, Capt. Trevor Sayer. “I am a USMC Captain retiring this summer. I am retiring from a joint command in Arizona, and begin my terminal leave in March. The VA pre-discharge claims enrollment program (BDD) allows active duty to submit claims 120 days out. However, if you are leaving the state in which you file before the claim is processed and your appointment for your initial medical exams are not made in time then the claim has to start over in the new state. Now in my case, I am in Arizona and going home to Ketchikan. I could start my claim now in Arizona but I am told it could delay processing by months because the claim would need to be transferred to Alaska then arrangements for me to fly from Ketchikan to a VA med center in Anchorage would need to be made in order to do initial medical screenings. There simply isn’t time within this 120 day window to do all the evaluations in AZ before I depart. The alternative being to forego terminal leave in order to do medical screening prior to going to Alaska or wait till I get home to Ketchikan and submit a fully developed claim once my retirement is effective thus eliminating the benefit of the pre-discharge program. What if the VA had a mobile outreach program in Alaska?”

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

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

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

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

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

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

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

Response. For some data from the Electronic Health Record (e.g., lab test results), information becomes available within My HealthVet three calendar days after it has been verified. This delay enables the provider to communicate with the patient if needed, for example to discuss an abnormal test result. The example you provided of an echocardiogram is something that is not currently sent to My HealthVet, but is something we are working on for the future.

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

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

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

to them. As part of plan to improve and consolidate community care programs, the variation in emergency care would also be addressed.

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

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

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

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

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

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

Question 87. I am asking this question on behalf of my constituents. "There appears to be some pretty significant delays in the referral management office to get referral appointments. We believe that part of the problem is a lack of sufficient personal for referral management offices to handle and swiftly process those referrals outside of the VA to a specialist. If a specialist is seen (like a pulmonary doctor)

and refers to another specialist (thoracic surgeon), we have to go back to the VA referral process system again into a holding pattern to get the request from the specialist that requested we see another specialist or series of tests that results in further delays. And we have to wait for the primary nurse practitioner to approve it before we can even get to the other specialist who is a doctor. We also find that we have to make routine phone calls to follow up on those actions, like the ‘squeaky wheel gets greased first.’”

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

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

VA PUGET SOUND HEALTH CARE SYSTEM

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

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

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

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

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

IMPACT OF HIRING FREEZE

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

For example, data from VA Portland Health Care System, which provides benefits and treatment to veterans in Washington State, shows that on average they processed more than 500 claims for beneficiary travel program every business day in 2016. As a result of this high volume, the travel reimbursement claims processing time is backlogged to about six weeks for most claims and up to eight weeks or more

for complex claims. Portland VA had hoped to address this backlog by hiring additional staff for their Veterans Transportation Program. Unfortunately, although the authorized number of staff for the VTP was raised to nine employees, the hiring freeze has blocked this VA from hiring the staff it needs to quickly provide this important benefit to our veterans.

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

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

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

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

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

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

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

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

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

UNDER OTHER THAN HONORABLE DISCHARGES

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

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

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

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

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

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

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

PAIN MANAGEMENT

Question 92. The VA, with Committee oversight and support, has taken important steps to improve pain management throughout the VA system. These include implementation of a “step care” model that matches appropriate therapies to the unique needs of individual patients, particularly for veterans with complex chronic pain problems of long, sometimes lifelong, duration. There has also been collaboration with the Department of Defense to allow servicemembers transitioning to VA care to have their pain management coordinated across the systems. Furthermore, VA researchers have worked with the National Institute of Health and other research partners on new treatments, particularly those that could be alternatives to the use of opioids for chronic pain. Despite progress, a lot remains to be done.

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

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

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

Response. In response to Section 932 of the Comprehensive Addiction and Recovery Act (CARA), passed in July 2016, the VHA has developed an ambitious plan to expand research, education, and clinical delivery of complementary and integrative health approaches for pain management as well as mental health and overall well-being over the coming three years. On the clinical side, the Integrative Health Coordinating Center in the Office of Patient Centered Care & Cultural Transformation is working to make the evidence-based CIH approaches—including acupuncture, chiropractic, yoga, tai chi, meditation, and massage—more widely available to Veterans nationally. Our commitment is that every medical center will offer at least

two of these therapies routinely for Veterans with pain, and one “flagship” site in each VISN will offer the entire range of therapies. Our new Community Care contract will also make these complementary therapies available to Veterans in the community if they are not available through the medical center.

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

VETERANS ABILITY TO RAISE CONCERNS

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

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

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

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

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

Response. Yes.

BREMERTON CBOC

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

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

Response. The VISN 20 Network Director during an update call with your staff on February 2, 2017, committed to seeking clinical space in a non-VHA healthcare facility into which could be placed an additional PACT Team to increase primary care while work to relocate the Bremerton CBOC is completed. VA has already iden-

tified two possible locations: one at the new Harrison Hospital in Silverdale; a second in the Franciscan Medical Building in Port Orchard. Opening an additional PACT team at a satellite location in the Bremerton area is contingent on our ability to timely recruit the PACT medical team professionals required to provide this service. In the meantime, all new Veterans seeking enrollment for Primary Care Services in the Kitsap County area are offered the option to enroll with a Choice primary care provider. There are approximately 153 Primary Care Choice providers in Kitsap County—sufficient to provide the primary care needs of our Veterans in the Bremerton area.

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

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

ACCESS TO WOMEN'S HEALTH IN RURAL AREAS

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

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

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

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

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

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

CAREGIVERS

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

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

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

IMPACT OF INCREASED MILITARY

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

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

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

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

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

HOMELESSNESS

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

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

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

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

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

EDUCATION

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

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

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

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

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

Response. Yes

Question 102. Last year, the Department of Education worked with the Department of Veterans Affairs to publish full estimates on the amount and percentage

of VA and DOD funding that is received by institutions of higher education from each Federal educational program, including Post-9/11 GI Bill benefits and Military Tuition Assistance. I had been pressing for some time for this data to become publicly available as a useful tool to know which institutions have a healthy level of outside, non-Federal investment.

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

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

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

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

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

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

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

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

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

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

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

LGBTQ

Question 105. When Vice President Mike Pence was running for Congress in 2000, his website included multiple statements that are shamefully discriminatory against the LGBTQ community. In addition to opposing gay marriage and anti-discrimination laws that protect LGBTQ individuals, a section of his website included a statement that has been interpreted as an endorsement of conversion therapy, a discredited practice that falsely purports to change a person’s sexual orientation or gender identity. While Vice President Pence has denied this accusation, I remain deeply concerned about this Administration’s treatment of LGBTQ individuals.

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

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

Response. I am committed to diversity and inclusion in both patient care and the VA workforce. In fact, VA is among the leaders in the Federal Government in the area of LGBT protections. With respect to Veteran patient care, on July 1, 2014, VHA issued a policy memorandum ensuring that all our LGBT Veteran patients receive quality and respectful patient care, “in an environment and culture that is informed, welcoming, and empowering for the LGBT Veterans and families whom we serve.” The specific guidance on care for transgender Veterans can be found in VHA Directive 2013–003: Providing Health Care for Transgender and Intersex Veterans. VHA also established an Office of Health Equity to address the different and specific health care needs of diverse populations, including the LGBT community. To ensure that these services are delivered by culturally competent health care providers, VA has had a longstanding commitment and explicit policy protecting all of its employees from discrimination and harassment on the basis of gender identity

and sexual orientation, long before these protections became embedded in Federal policy or law. We complement these policy protections with mandatory and elective EEO, cultural competency and unconscious bias training in the area of LGBT awareness for all our employees, including health care providers and supervisors. The VA is close to issuing a Transgender Employee Workplace Transition Guidance as a resource for our employees to address these issues appropriately and sensitively in the VA workplace; I will ensure this gets published. I commit to you that VA will continue to support these and other protections for our LGBTQ Veterans and employees.

ACA

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

- As Republicans rush to rip apart the civilian healthcare system by repeal, increase uncompensated care at rural hospitals, threaten to gut Medicaid and take away the guarantee of full coverage under Medicare, what conversations have you been a part of to ensure no veterans lose health insurance?
- During your confirmation hearing you said that VA will do all it can to care for all veterans; could you provide specific answers to how, if confirmed, you will handle a possible increase in the number of veterans seeking VA care if they lose coverage through ACA repeal?

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

SEXUAL ASSAULT

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

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

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

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

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

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

MEDICAL LEGAL PARTNERSHIPS

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

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

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

- VHA Directive 2011-034 encourages VA medical centers to make space available for legal services providers to assist veterans. Approximately 120 legal pro bono clinics staffed by outside legal providers are currently given space to operate in VA centers. Do you commit to keeping VHA Directive 2011-034 in place? What additional steps will you take to ensure veterans have access to legal services, to support existing MLPs, and to create new partnerships between health facilities and legal service providers?

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

CERTIFIED REGISTERED NURSE ANESTHETISTS

Question 110. In your response to pre-hearing questions, you recognized workforce shortages at VA and promised to continue pursuing strategies to meet such gaps, which included expanding the scope of practice for advanced practice registered nurses. On December 14, 2016, VA issued the final rule providing full practice authority for advanced practice registered nurses with an effective date of January 13, 2017. However, the final rule excluded Certified Registered Nurse Anesthetists (CRNAs) from receiving full practice authority, which the draft rule did not. This is despite supportive evidence in favor of full practice authority for CRNAs in research journals and recommendations from numerous independent entities, including the Commission on Care. Additionally, the exclusion of CRNAs from the VA

final rule is inconsistent with the full practice authorities that exist in other Federal health care systems in the military and the Indian Health Service. I understand that VA's rationale behind excluding CRNAs from the final rule was that there is no shortage of anesthesia providers in the VA system. However, a RAND study commissioned by this Committee published in 2015 found that a lack of anesthesia services and support directly affects VA's ability to provide care. It seems like the research evidence, recommendations from independent entities, and policies of Federal health systems outside VA should have been sufficient to include CRNAs in the final rule, which I fully support.

- Can you please provide a comprehensive explanation as to how you came to the conclusion you did, including fully identifying and explaining the criteria you used for providing APRN full practice authority and how this criteria was applied equitably across the four APRN categories?

- Will you commit to revisiting VA's rule on nursing full practice authority to further assess whether CRNAs should be included if confirmed?

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

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

SMOKING

Question 111. As a physician, I'm sure you know that smoking poses a significant threat to the health of our veterans, in addition to costing the VA healthcare system billions of dollars every year. You may also be aware that over half of current smokers (57%) report that they had tried quitting within the past year and, according to the Centers for Disease Control and Prevention, as of 2010 nearly 70% of adult smokers wanted to quit.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Question 113. How will you implement the Career Ready Student Veterans Act, legislation aimed at blocking GI Bill benefits going to programs that, due to low-quality or lack of accreditation, do not result in veteran-graduates earning state certifications and licenses?

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

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

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

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

b. Do you believe that when VA and other Federal entities designate that an institution of higher education displays signs of instability? If so, what is your plan to

communicate to student veterans when an institution shows such potential, as ITT Tech and Corinthian Colleges did prior to their closing?

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

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

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

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

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

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

Question 117. Last December, ProPublica and The Virginian-Pilot issued a report, based on data gathered from VA's Agent Orange Registry, which assess that children born to servicemembers who had self-reported Agent Orange exposure during or after the Vietnam War were 34 percent more likely to have a birth defect than children born to servicemembers who had not self-reported exposure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Response. Yes. The Jeff Miller and Richard Blumenthal Veterans Health Care Act and Benefits Improvement Act of 2016, Public Law 114-315, was signed into law on December 16, 2016. Section 701 of this Act expands the eligibility to participate in the GPD program to persons fleeing domestic violence and interpersonal violence. VHA is working to incorporate the statutory changes as they relate to eligibility under the GPD program as quickly as possible following the standard agency protocols for inclusion of new statutory elements and notification to the field. Additionally, Our HUD-VASH regulations further define homeless as any individual or family who is fleeing or is attempting to flee domestic violence, dating violence, sexual

assault, stalking, or other dangerous or life-threatening conditions in the individual's or family's current housing situation, including where the health and safety of children is jeopardized and who have no other residence and lack the resources or support networks to obtain other permanent housing.

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

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

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

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

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

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

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

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

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

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

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

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

PATIENT SAFETY

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

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

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

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

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

INFORMATION TECHNOLOGY AND INTEROPERABILITY

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

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

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

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

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

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

Response. I believe that progress has been made but we need to do much better. The Veterans Health Administration and the Office of Information & Technology

continue to collaborate as partners in improving the Health Information Technology (HIT) at VA. Through this partnership, VHA has received a number of critical improvements to HIT at VA while recognizing that our work together is ongoing so as to keep pace with the needs of VA's medical providers serving Veterans as well as putting modern HIT tools in the hands of Veterans.

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

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

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

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

BAD PAPER DISCHARGES

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

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

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

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

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

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

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

Pursuant to the Administrative Procedure Act, rulemaking requires time for public notice and comment, as well as Office of Management and Budget (OMB) review.

VA anticipates publishing a proposed rule to update 38 CFR 3.12 by the end of calendar year 2017.

LONG-TERM CARE

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

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

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

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

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

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

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

VHA will continue to implement effective strategies based on measuring Veteran need for increased access to HCBS, creating an appropriate balance of HCBS and

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

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

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

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

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

CAREGIVERS SUPPORTS

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

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

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

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

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

APPEALS LEGISLATION

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

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

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

AGENT ORANGE AND THE DMZ

Question 128. In March 2016, I wrote to then Secretary Bob McDonald regarding the qualifying period for the presumption policy related to Agent Orange Exposure to all veterans who served in the Korean Demilitarized Zone (DMZ). In May 2016,

Secretary McDonald responded indicating that VA would consult with the Department of Defense (DOD) about whether veterans were exposed to a herbicide agent in or near the DMZ prior to April 1, 1968.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The development and maintenance of successful Telemedicine services rely on the coordinated efforts of information technology, telehealth, engineering, and clinical provider staff as well as the availability of a robust information technology network, modern equipment, and a supportive legal and policy environment.

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

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

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

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

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

Response. VBA makes every effort to work claims in a timely manner. We recognize that some pending claims require additional time to process to ensure VA meets its legal obligations to assist Veterans in the development of their claims. Complex claims (involving multiple body systems or a high number of claimed contentions) do tend to take longer as VA considers additional evidence and/or new medical conditions throughout the claims process. Additionally, late evidence or new

contentions stop the momentum made in processing the claim, since they usually require a new round of evidence-gathering, medical examinations, and analysis, thus prolonging the determination of a decision. VBA is focused on resolving specific rating claims—our oldest claims, fully developed claims, and special interest claims (homeless, extreme financial hardship, former prisoners of war, terminally ill, etc.). Based on claim characteristics that make a claim more complex as well as VA's responsibility to help Veterans develop their claims, VA expects some claims to take longer than 125 days. One of VBA's published strategic targets is to reduce the disability rating claims backlog to less than 10 percent of the total rating inventory by FY 2021.

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

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

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

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

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

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

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

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

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

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

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

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

- *Comprehensiveness*: Includes full continuum of service availability for women;
- *Choice*: Considers treatment modality (e.g., mixed-gender, women-only service options);
- *Competency (of clinician)*: Addresses women's unique treatment needs; and
- *Innovation*: Provides creative options and settings for subgroups of women, especially when caseloads of women are small.

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

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

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

Response. By an "integrated" model, I am referring to a system that integrates the best of what the VA offers Veterans and the best of what the private sector can offer together. A successful VA system would be more than just the intersection of

VA and the private sector but it would have additional value added for Veterans. By using VA's considerable capabilities in care coordination, case management, and quality oversight, VA can make sure that Veterans receive an integrated experience and do not have the gaps in care that too many Americans experience in the our health care system. I believe such an integrated model of care can provide our Veterans with healthcare outcomes that will be the best care available anywhere. Please see my article that I published in the New England Journal of Medicine where I described this model for the country. [www. nejm.org/doi/full/10.1056/NEJMp160](http://www.nejm.org/doi/full/10.1056/NEJMp160)

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

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

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

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

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

Question 142. Both Healthnet and TriWest have a footprint in West Virginia and my office has received complaints about the inability to reach a representative by phone and the lengthy approval process. Lengthy approval times often lead to a financial burden on the veteran and their family. Please elaborate on what VA is currently doing and what you envision VA will do when contracting with third party administrators in the future?

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

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

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

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

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

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

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

Other Elements in Mitigation Plan

Factors	Mitigation Plan
Increasing Demand/Lack of Providers and Clinic Staff.	<ul style="list-style-type: none"> • Active recruitment of health care providers and clinic staff—VA increased provider and nursing staffing by approximately 12% over the past two years • Granting full practice authority for Advanced Practice Nurses • Increase use of telehealth for Primary Care and Mental Health • Use of community care resources when unable to recruit providers • Increased use of extended clinic hours
Inefficiencies in clinic practices.	<ul style="list-style-type: none"> • Implemented Clinic Practice Management Program across VA—in this program all facilities have at least one group practice manager to oversee and optimize administrative clinic activities • Validating clinic grids to achieve optimal clinic capacity • Focus on improving productivity—increased productivity by 16% over past two years • Developed strategies for reducing “no show” rates, and re-designing clinic space • Implemented standardized face to face Clinic Clerk Training for optimal scheduling of patients • The above efforts have resulted in an increase in 12,000 appointments daily in 2016 when compared to 2014

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

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

Question 145. With VA’s expertise on substance abuse and the Department’s robust Office of Research and Development, I believe that you are well equipped to be on the forefront of alterative pain therapy research for the entire country. Please

elaborate on how you will increase the number of alternative treatments for pain management. What investments will you make and are there authorities you need from Congress?

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

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

Response. Employees want to work in an environment where they have the tools and resources they need to be able to serve their patients. As a health care executive this is what the type of environment I strive to have for our staff and their patients. Employees want a place that has systems that work, co-workers that are well trained and supported, and a culture of respect. If confirmed as Secretary, I would work hard to have a work environment that supports our staff and allows them to do their best for our Veterans. Part of what is needed is to be able to support, retain, and recognize those employees that share the organization's values and are high performers and to be able to remove those that have strayed from these values. When people are allowed to remain in the workplace, despite poor performance or bad behavior, it is demoralizing to all employees.

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

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

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

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

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

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

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

evaluation process, to include accessibility to Veteran's benefits and system and procedural enhancements to improve the timeliness and quality of rating decisions.

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

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

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

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

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

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

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

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

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

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

sistants, and Clinical Pharmacists). Full staffing, a full array of services, and enhanced availability across the Nation are key components of VA's Mental Health Access improvement plan.

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

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

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

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

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

[The Committee questionnaire for Presidential nominees from David J. Shulkin, M.D., submitted twice, follows:]

**QUESTIONNAIRE
FOR PRESIDENTIAL NOMINEES
115th Congress**

PART I: ALL OF THE INFORMATION IN THIS PART WILL BE MADE PUBLIC

1. Basic Biographical Information

Please provide the following information.

<i>Position to Which You Have Been Nominated</i>	
<u>Name of Position</u>	<u>Date of Nomination</u>
Secretary, Veterans Affairs	January 11, 2017

<i>Current Legal Name</i>			
<u>First Name</u>	<u>Middle Name</u>	<u>Last Name</u>	<u>Suffix</u>
David	Jonathan	Shulkin	

<i>Addresses</i>					
<u>Residential Address</u> (do not include street address)			<u>Office Address</u> (include street address)		
			Street: 810 Vermont Avenue		
City: Gladwyne	State: PA	Zip: 19035	City: Washington	State: DC	Zip: 20420

<i>Other Names Used</i>						
<u>First Name</u>	<u>Middle Name</u>	<u>Last Name</u>	<u>Suffix</u>	<small>Check if Multiple Name</small>	<u>Name Used From</u> (Month/Year) (Check box if estimate)	<u>Name Used To</u> (Month/Year) (Check box if estimate)
					Est <input type="checkbox"/>	Est <input type="checkbox"/>
					Est <input type="checkbox"/>	Est <input type="checkbox"/>

<i>Birth Year and Place</i>	
Year of Birth (Do not include month and day)	Place of Birth
1959	Highland Park, IL

<i>Marital Status</i>	
Check All That Describe Your Current Situation:	
Never Married <input type="checkbox"/>	Married XXX <input checked="" type="checkbox"/>
Separated <input type="checkbox"/>	Annulled <input type="checkbox"/>
Divorced <input type="checkbox"/>	Widowed <input type="checkbox"/>

<i>Spouse's Name (current spouse only)</i>			
<u>Spouse's First Name</u>	<u>Spouse's Middle Name</u>	<u>Spouse's Last Name</u>	<u>Spouse's Suffix</u>
Merle	Mindy	Shulkin	

<i>Spouse's Other Names Used (current spouse only)</i>						
<u>First Name</u>	<u>Middle Name</u>	<u>Last Name</u>	<u>Suffix</u>	<u>Check If Maiden Name</u>	<u>Name Used From</u> (Month/Year) (Check box if estimate)	<u>Name Used To</u> (Month/Year) (Check box if estimate)
Merle	Mindy	Bari		x	1960 Est <input type="checkbox"/>	present Est <input type="checkbox"/>
					Est <input type="checkbox"/>	Est <input type="checkbox"/>

<i>Children's Names (if over 18)</i>			
First Name	Middle Name	Last Name	Suffix
Daniel	Bari	Shulkin	
Jennifer	Laurie	Shulkin	

2. Education

List all post-secondary schools attended.

<u>Name of School</u>	<u>Type of School</u> (vocational/technical/trade school, college/university/military college, correspondence/distance/extension/online school)	<u>Date Began School</u> (month/year) (check box if estimate)	<u>Date Ended School</u> (month/year) (check box if estimate) (check "present!" box if still in school)	<u>Degree</u>	<u>Date Awarded</u>
Hampshire College	College	Est September 1977	Est Present January 1982 <input type="checkbox"/>	BA	January 1982
Medical College of Pennsylvania (Now Drexel School of Medicine)	Medical School	Est September 1982	Est Present May 1986 <input type="checkbox"/> <input type="checkbox"/>	MD	June 1986
Yale University School of Medicine	First Year of Residency	Est July 1986 <input type="checkbox"/>	Est Present June 1987 <input type="checkbox"/> <input type="checkbox"/>		
University of Pittsburgh, Presbyterian Medical Center	Internal Medicine Residency (years 2 and 3)	Est July 1987 <input type="checkbox"/>	Est Present June 1989 <input type="checkbox"/> <input type="checkbox"/>		
University of Pittsburgh General Medicine Fellowship	General Medicine Fellowship	July 1989	December 1990		
Robert Wood Johnson Foundation	Fellow	July 1990	December 1991		

3. Employment

(A) List all of your employment activities, including unemployment and self-employment. If the employment activity was military duty, list separate employment activity periods to show each change of military duty station. Do not list employment before your 18th birthday unless to provide a minimum of two years of employment history.

<u>Type of Employment</u> (Active Military Duty Station, National Guard/Reserve, USPHS Commissioned Corps, Other federal employment, State Government (Non-federal Employment), Self-employment, Unemployment, Federal Contractor, Non-Government Employment (excluding self-employment), Other	<u>Name of Your Employer/Assigned Duty Station</u>	<u>Most Recent Position Title/Rank</u>	<u>Location</u> (City and State only)	<u>Date Employment Began</u> (month/year) (check box if estimate)	<u>Date Employment Ended</u> (month/year) (check box if estimate) (check "present" box if still employed)
Government	US Department of Veterans Affairs	Under Secretary for Health	Washington DC	July 2015 Est <input type="checkbox"/>	Est Present Present
Private – non Government	Morristown Medical Center	President, Morristown Medical Center President, Accountable Care Organization, Vice President Atlantic Health System	Morristown, NJ	January 2010 Est <input type="checkbox"/>	July 2015 Est <input type="checkbox"/>
Private – Non Government	Kennedy Health System	Consulting Role – Interim Chief Medical Officer	Voorhees, NJ	April 2009 Est <input type="checkbox"/>	January 2010 Est <input type="checkbox"/>
Private – Non Government	Beth Israel Medical Center	President and CEO	New York, New York	July 2005 Est <input type="checkbox"/>	April 2009 Est <input type="checkbox"/>
Private – Non Government	Temple University Hospital	Chief Medical Officer	Philadelphia, PA	March 2004 Est <input type="checkbox"/>	July 2005 Est <input type="checkbox"/>
Private – Non Government	Drexel University School of Medicine	Chief Quality Officer	Philadelphia, PA	July 2002	March 2004
Private – Non Government	DoctorQuality, Inc	Chairman and CEO	Conshohocken, PA	November 1999	July 2002
Private – Non Government	University of Pennsylvania/ University of Pennsylvania Health System	Chief Medical Officer/Chief Quality Officer/ Senior Executive Managed Care and Contracting and Operations	Philadelphia, PA	December 1998	December 1999

Private – Non Government	University of Pennsylvania/ University of Pennsylvania Health System	Chief Medical Officer/ Chief Quality Officer	Philadelphia, PA	February 1996	November 1998
Private – Non Government	University of Pennsylvania Hospitals	Chief Medical Officer	Philadelphia, PA	February 1993	November 1997
Private – Non Government	Hospital of the University of Pennsylvania	Direct of Clinical Outcome Assessment and Quality Management	Philadelphia, PA	January 1992	January 1993
Private – Non Government	Robert Wood Johnson Foundation	Fellow	Washington, DC	July 1990	December 1991

(B) List any advisory, consultative, honorary or other part-time service or positions with federal, state, or local governments, not listed elsewhere.

<u>Name of Government Entity</u>	<u>Name of Position</u>	<u>Date Service Began</u> (month/year) (check box if estimate)	<u>Date Service Ended</u> (month/year) (check box if estimate) (check "present" box if still serving)
Institute of Medicine	Advisory Committee Member (Committee to Advise HCFA Administrator on Peer Review Evaluation Plan)	1993 Est <input type="checkbox"/>	1994 Est <input type="checkbox"/> Present <input type="checkbox"/>
Center for Medicare and Medicaid Services	Advisory Committee Member (Committee on Quality)	2004 Est <input type="checkbox"/>	2004 Est <input type="checkbox"/> Present <input type="checkbox"/>
Agency for Healthcare Research and Quality	External Advisory Board Member – University of Rochester – Safety in Neurologic Event Surveillance	2004 Est <input type="checkbox"/>	2004 Est <input type="checkbox"/> Present <input type="checkbox"/>

4. Honors and Awards

List all scholarships, fellowships, honorary degrees, civilian service citations, military medals, academic or professional honors, honorary society memberships and any other special recognition for outstanding service or achievement.

- *Eugene Baum Memorial Prize for Scholastic Excellence, Medical College of Pennsylvania- 1986*
- *Medical Journalism Award, awarded by Sandoz Pharmaceuticals for the Physicians for Research in Cost-Effectiveness (PRICE) Newsletter excellence in design and editorial content- 1989*
- *A MA/Burroughs Welcome Leadership Award for Community Services- 1988-1989*

- *Top Philadelphians Under 40- Philadelphia Business Journal - 1994*
- *Healthcare Hero's Award- Philadelphia Business Journal Awarded for Accomplishments in the Philadelphia Healthcare Community- 1994*
- *100 People to Watch- Business Philadelphia- 1994*
- *Quality Recognition Award- Philadelphia Chamber of Commerce -Awarded for Quality Improvement Efforts- 1995*
- *Quality Recognition Award- Philadelphia Chamber of Commerce- Awarded for Quality Improvement Efforts- 1996*
- *PACE/Delaware Valley Quality Recognition Award- 1997*
- *Up and Comers Healthcare Leaders for the Next Century- Modern Healthcare- 1997*
- *Fellow- American College of Physicians- 1998*
- *Alfred Stengel Health System Champion Award, University of Pennsylvania Health System- 1998*
- *Alpha Omega Alpha Honorary Society (Lifetime) - 1998*
- *What Works Award (for Disease Management) - Health Technology Magazine- 1998*
- *International Emerging Leaders Award- Healthcare Forum/Korn Ferry- 1998*
- *Innovation Leadership Award- Temple University Health System- 2005*
- *Medical Humanitarian Leadership Award- Biku Cholim- New York - 2006 18.*
- *Modern Healthcare, - Up and Comers-Ten Years Later- Star of the Class- 2007*
- *Community Services Award- United Jewish Services Lower East Side NY 2007*
- *100 Most Powerful People in Healthcare in America- Modern Healthcare- 2008*
- *Latino Health Community Services Award- NY, NY 2008*
- *Fifty Most Powerful Physician Executives- Modern Healthcare- 2008, 2009, 2011*

- *Rosef Joseph Community Medical Award- Council of Jewish Organizations. New York, NY, 2009*
- *Top Physician Leaders of Hospitals, Annual Listing, The Health Review- 2009*
- *Top Physician Leaders of Hospitals and Health Systems-Becker's Hospital Review- 20 12-2 103*
- *Maimonides Humanitarian Award- New Jersey Health Professionals Division Israel Bonds-2013*
- *Power Top 50 in Healthcare- New Jersey Biz- 20 14*
- *100 Physician Leaders in Healthcare- Becker"s Hospital Review- 2014*
- *American Cancer Society- Annual Honoree, 2014*
- *Digital Transformations, CEO of the Year, JiveWorld16, 2016*
- *50 Most Influential Physician Executives, Modern Healthcare, 2016*
- *Doctor of Humane Letters, Honorary Degree, Pace University, New York, NY*
- *Honorary Degree, Thomas Jefferson University School of Medicine, Philadelphia, PA*
- *Distinguished Alumnus Award, Drexel University*

5. Memberships

List all memberships that you have held in professional, social, business, fraternal, scholarly, civic, or charitable organizations in the last ten years.

Unless relevant to your nomination, you do NOT need to include memberships in charitable organizations available to the public as a result of a tax deductible donation of \$1,000 or less, Parent-Teacher Associations or other organizations connected to schools attended by your children, athletic clubs or teams, automobile support organizations (such as AAA), discounts clubs (such as Groupon or Sam's Club), or affinity memberships/consumer clubs (such as frequent flyer memberships).

<u>Name of Organization</u>	<u>Dates of Your Membership</u> (You may approximate)	<u>Position(s) Held</u>
American Medical Association	1988-1990, Resident Member 2010 – Present, Member	Chair Resident Physicians Section of Pennsylvania Medical Society and AMA member

American College of Physicians	1997 – Present, Member 1998 – Present, Fellow	Fellow and Member
New Jersey Council of Teach Hospitals	2013- 2015	Chair of Board
Morris County Business Chamber	2012-2015	Executive Cabinet Member
American Hospital Association	2009-2014	Regional Policy Committee Member
NY Academy of Medicine	2008-2010	Member
Northeast Business Group on Health	2008-2010 and 2013- March 2015	Member
Patient Safety Officer Society	2002-2009	President
Union Square Partnership	2005-2006	Board Member
Vistage CEO Group	2007-2015	Member

6. Political Activity

(A) Have you ever been a candidate for or been elected or appointed to a political office?
NO

<u>Name of Office</u>	<u>Elected/Appointed/ Candidate Only</u>	<u>Year(s) Election Held or Appointment Made</u>	<u>Term of Service (if applicable)</u>

(B) List any offices held in or services rendered to a political party or election committee during the last ten years that you have not listed elsewhere.

<u>Name of Party/Election Committee</u>	<u>Office/Services Rendered</u>	<u>Responsibilities</u>	<u>Dates of Service</u>
None			

(C) Itemize all individual political contributions of \$200 or more that you have made in the past five years to any individual, campaign organization, political party, political action committee, or similar entity. Please list each individual contribution and not the total amount contributed to the person or entity during the year.

<u>Name of Recipient</u>	<u>Amount</u>	<u>Year of Contribution</u>
Menendez for Senate	\$1000	2012
Pallone for Congress	\$250	2014
Assemblyman Singer of NJ	\$300	2014

7. Publications

List the titles, publishers and dates of books, articles, reports or other published materials that you have written, including articles published on the Internet.

<u>Title</u>	<u>Publisher</u>	<u>Date(s) of Publication</u>
Shulkin D, Zuckerman B. Spectrofluorometric analysis of the effect of centrophenoxine on Lipofuscin accumulations in the Nematode, Caenorhabditis elegans	Journal of the American Aging Association	1982;19:181
Shulkin D, Tripoli L, Abell T. Lues Maligna in a patient with Human Immunodeficiency Virus Infection	American Journal of Medicine	1988;85:425
Shulkin D, Levey J. Thyrotoxic periodic paralysis in a patient taking Acetazolamide.	The American Journal of Medical Sciences	1989;297:5:337
Bari M, Shulkin D., E. Abell Precocious Ulcerative Syphilis and Human Immunodeficiency Virus Infection	Journal of the American Academy of Dermatology	1989;266:3000-3003
Shulkin D, Escarce J, Enarson C, Eisenberg J The Impact of the Medicare fee schedule on An academic department of medicine.	Journal of the American Medical Association	1991;266:3000-3003
Resenstein, A Shulkin, D Medical staff cooperation in controlling health care costs: the pros and cons of influencing physician behavior.	Health Care Strategic Management	1991;6: 14-16
Eisenberg, J Shulkin, D Payment reform : what are the prospects for internal medicine.	Annals of Internal Medicine	1991; 115:493-494

<p>Shulkin, D</p> <p>Fox, K</p> <p>Stadtmover, E</p> <p>Guidelines for Prophylactic platelet Transfusions: Need for a concurrent outcomes management System.</p>	<p>Quality Review Bulletin</p>	<p>1992;18:477-479</p>
<p>Shulkin, D</p> <p>Kronhaus, A</p> <p>Nash, D</p> <p>Management training of physicians: the privately financed fellowship.</p>	<p>Academic Medicine</p>	<p>1992;67:266-70</p>
<p>Shulkin, D</p> <p>Nash, D</p> <p>The Impact of Managed Care Formularies on the Cost and Quality of Care: a Survey of Physician Attitudes</p>	<p>Journal of Research in Pharmaceutical Economics</p>	<p>1992;4(2) :31 -42</p>
<p>Shulkin, D</p> <p>Kinosian, B</p> <p>Blick, H</p> <p>Daly, J</p> <p>Eisenberg, J</p> <p>The economic impact of infections: an analysis of hospital costs and charges in surgical oncology patients.</p>	<p>Archives of Surgery</p>	<p>1993;128:449-452</p>

<p>Shulkin, D Lieverman, J Morganroth, J Schwartz, J.S. Use of Claims Data for Determining the Appropriateness of Ambulatory Cardiac Monitoring</p>	<p>American Journal of Cardiology</p>	<p>1993;7 1 :749-750</p>
<p>Shulkin, D Kinosian, B Glick, H Puschett, C Daly, J Sirio, C Explaining Cost Variations in Clinical Trials Using Severity of Illness Measures</p>	<p>Clinical Performance and High Quality Healthcare</p>	<p>1993;1(3):134-137</p>
<p>Shulkin, D Rennie, D Goin, J Patterns of authorship among chairman of medicine</p>	<p>Academic Medicine</p>	<p>1993;68(9):688-692</p>
<p>Shulkin, D Otten, J The patient focus walk-through assessment tool: an instrument to supplement patient satisfaction data.</p>	<p>American Journal of Medical Quality</p>	<p>1993;8(2):68-71</p>

Shulkin, D Cooper, W Reasons for Rising Administrative Costs.	Annals of Internal Medicine	1993;119:74-78
Shulkin, D The July phenomenon revisited: Are hospital complication Associated with new house staff?	American Journal of Medical Quality	1995;10(1):14-17
Shulkin, D Brennan P.J. The Cost of Caring for Patient with Tuberculosis	Journal of Infection Control	1995;23(1): 1-4
Shulkin, D Black, F Weiss, K Erban, S Innovations in Patient Care; Changing Clinical Practice and Improving Quality	The Journal of Quality Improvement	1995;2(8):376-393
Shulkin, D Brailer, D Using Quality Indicators to Develop and Automated Measure of Adverse Events	International Journal Technology Management- Special Publication on the Role of Management of Technology in Clinical and Administrative Healthcare Delivery	1995;32-37
Shulkin, D Ratki, T	Journal of Clinical Outcomes Management	1996;(3):39-48

Matuszewski, K Model Guidelines for the Pre-operative Evaluation of Patients Undergoing Elective Surgery		
Shulkin, D Hillman, A Care for Homeless: a Practical Solution to an Academic Problem	Journal of Health and Social Policy	1996;7(4): 1-9
Shulkin, D Harris, M Coordinating Initiatives in Critical Pathways and Information System	Quality Management in Health Care	1996;4(2):37-41
Shulkin, D Ferniany, W The Effect of Developing Patient Compendiums for Pathways on Patient Satisfaction	American Journal of Medical Quality	1996;11(1):43-45
Shulkin, D Quality Management in an Academic Integrated Delivery System: the Case of the University of Pennsylvania Health System.	International Journal for Quality in Health Care	1997;9(3): 171-176.
Shulkin, D Bernard, D.B. The Media versus Managed Health Care: Are we Seeing a	Archives of Internal Medicine	1998;158:2109-2111

Full Court Press?		
Shulkin, D Why Quality Improvement Efforts Fail and What You can Do About it.	American Journal of Medical Quality	2000: 15(2):49-53
Shulkin, D Vjota, D Maskantani, S The Health Partners Payer-Provider Model Creating Accountability for Implementing Best-Practices (Disease Management)	American Journal of Managed Care	2000:1:13-15
Shulkin, D King, ES Moyer, DV Courturie, MJ Gaughan, JP Getting Doctors to Report Errors: The DISCLOSE Study.	Joint Commission Journal of Quality and Patient Safety	2006: 17(6):291-300
Shulkin, D King, ES Moyer, DV Courturie, MJ Gaughan, JP Getting Doctors to Report	Journal of Hospital Medicine	2006;1(5):296-305

Errors: The DISCLOSE Study.		
Shulkin, D Using a Market Model to Track Advances in Patient Safety	Joint Commission Journal of Quality and Patient Safety	2003:29(3):146-151
Shulkin, D Like Night and Day- Shedding Light on Off- Hours Care.	New England Journal of Medicine	2008:358:2091-2093
Shulkin, D Safety Assessing Hospital Safety on Nights and Weekends: The SWAN Tool	Journal of Patient Safety	2009 5(2):75-78
Shulkin, D Leitman, IM Levin, R Sivarprasad, L Saralukulasingam, CJ Bernard, DS Friedmann, P Quality and Financial Outcomes from Gainsharing for Inpatient Admissions: A Three Year Experience.	Journal of Hospital Medicine	2010(59):50 1-507
Shulkin, D Jewell, KE Alexandrov, AW Impact of Systems of Care and Blood Pressure Management on	Journal of Population Health Management	2011 ; 14(6):267-75

Stroke Outcomes		
Shulkin, D Mashchak-Carey, B Schutta, MH Schwartz, S Joshi, M Bernard, D Successful Implementation of a Comprehensive Diabetes Disease Management Program in an Academic Health System	Disease Management	1999;2(1-2):43-50.
Shulkin, D Nash, D Comite, F Loepkee, R VanCleave, B Kane, B Christianson, J Pousma, D Measurement of the Impact of Winoma Health Online	Disease Management	2001;4(1):15-18
Shulkin, D Using a Market Model to track Advances in Patient Safety	Journal of Quality and Safety	2003;29(3):146-51
Shulkin, D PRIDE in Accountable Care	Journal of Population Health Management	2011;14:211-14.

Shulkin, D Building an Accountable Care Organization for All the Wrong Reasons.	Mayo Clinic Proceedings	2012;87(8):721-722
Shulkin, D Reinventing the Pharmacy and Therapeutics Committee	Pharmacy and Therapeutics	2012;37(1 1):623-649
Shulkin, D, T. O'Keefe, D. Visconi, A. Robinson, AS Rooke, W. Neigher Eliminating Visiting Hour Restrictions in Hospitals	Journal of Healthcare Quality	2014;36(6):54-57
Shulkin, D Shulkin, MW Shulkin, DJ A Story of Three Generations in Healthcare	Virtual Mentor	2013:July 1, 15(7):61 1-614
Shulkin, D The Role of Allergists in ACO's.	Annals of Allergy and Immunology	July 15, 2013
Shulkin D Beyond the VA Crisis- Transforming into a High Performance Network	New England Journal of Medicine-	2016;374(11):1003-5
Shulkin D Why VA Healthcare is Different	Federal Practitioner	2016 May Issue
Shulkin D How the VA's Stand Down Resolved 56,000 Plus Urgent-Care Consults	New England Journal of Medicine Catalyst	April 14, 2016 Catalyst.nejm.com

Shulkin D Califf, RM Robb, MS Bindman, AV Transforming Evidence Generation to Support Health and Healthcare Decisions	New England Journal of Medicine	375(24):2395-2400 December 15, 2016
Shulkin D VA needs skilled healthcare leaders to speed system reforms	Modern Healthcare	January 2, 2016
Shulkin D VA Voluntary Service Celebrates 70 Years	Veterans' Choices	2016;64(1):2
Shulkin D VA is Saving Lives Everyday	Omaha World-Herald	October 10, 2016
Shulkin D How VA's Million Veteran Program Will Advance the National Movement Toward Precision Medicine	Bloomberg News Blog	2016
Shulkin D From Resident to Patient	Resident and Staff Physician	1988; <u>34</u> :10-15
Shulkin D Variation in Medical Care: Cookbook medicine for the 90s?	Forum in Internal Medicine	1989;2:2-5
Shulkin D The high cost of health care: a model of over-regulation	Bulletin of the Delaware County Medical Society	1990; <u>101</u> (70):10:17-22
Shulkin D Cost controversies: a patient with syncope	Hospital Physician	1990; <u>26</u> (4):51-59

8. Public Statements

(A) List any testimony, official statements or other communications relating to matters of public policy that you have issued or provided or that others presented on your behalf to public bodies or officials.

- *Nomination Hearing of David Shulkin 5/5/15*
- *Alaska Field Hearing 8/25/15*
- *A Call for System-Wide Change: Evaluating the Independent Assessment of the Veterans Health Administration 10/7/15 (accompanied by Shulkin)*
- *Choice Consolidation: Assessing VA's Plan to Improve Care in the Community 11/18/15 (accompanied by Shulkin)*
- *Senate - Consolidating Non-VA Care Programs – 12/2/15 (accompanied by Shulkin)*
- *Phoenix Field Hearing 12/14/15*
- *Senate – VA's Transformation Strategy: Examining the Plan to Modernize VA 1/21/16 (accompanied by Shulkin)*
- *Lost Opportunities for Veterans: An Examination of VA's Technology Transfer Program 2/3/16*
- *U.S. Department of Veterans Affairs Budget Request for FY 17 2/10/16 (accompanied by Shulkin)*
- *Senate FY 17 and 18 Advance Appropriations Hearings 2/23/16 (accompanied by Shulkin)*
- *House Appropriations Committee 3/2/16*
- *Senate Committee on Appropriations FY17 and 18 advance appropriations 3/3/16*
- *Senate Appropriations – 3/10/16*
- *Evaluating VA IT: Scheduling Modernization and Choice Consolidation 4/14/16*
- *A Continued Assessment of Delays in Veterans' Access to Health Care 4/19/16*
- *Senate- VA Hearing on Information Technology 6/22/2016*
- *Senate – The Future of the VA: Examining the Commission on Care Report and VA's Response 9/14/16 (accompanied by Shulkin)*

(B) List any speeches or talks delivered by you, including commencement speeches, remarks, lectures, panel discussions, conferences, political speeches, and question-and-answer sessions. Include the dates and places where such speeches or talks were given. See Attachment B

(C) List all interviews you have given to newspapers, magazines or other publications, and radio or television stations (including the dates of such interviews). See Attachment C

David Shulkin M.D.

Attachment B- Lectures, Speeches, Presentations

Lectures by Invitation:

1981	Centrophenoxine and the Aging Nematode, American Aging Association Annual Meeting, New York, NY
1988	Ulcerative Syphilis and Acquired Immunodeficiency Syndrome, Regional Meeting of the American College of Physicians, Philadelphia, PA
1989	Variation in Medical Care. University of Pittsburgh School of Medicine, Pittsburgh, PA
1990	Medical Costs: Are Doctors Responding Appropriately? Altoona Hospital, Grand Rounds, Altoona, PA
1990	Seeing the Way to Cost-Effective Eye Care. Excel Foundation Conference on Eye Care, Delivery, New York,
1991	Ethical Issues Facing Medicine. The Philadelphia Center, Philadelphia, PA
1991	Economic Imperatives in an Ambulatory Care Program. Department of Environmental and Community Medicine, Robert Wood Johnson Medical School, New Brunswick, NJ
1991	Quality Care in a Cost-Conscious Environment. The Medical College of Pennsylvania, Philadelphia, PA
1991	Preparing Physicians for the 21st Century: Integrating Educational Approaches to Cost and Quality in Graduate Medical Education. York Hospital, York, PA
1991	Physician Opportunities Outside the Traditional Boundaries. The Medical College of Pennsylvania, Philadelphia, PA
1991	Efficient Utilization of the Hospital Laboratory. Grand Rounds, Children's Hospital of Philadelphia, Philadelphia
1991	Appropriate Use of Biotechnology. Health Dimensions, Washington, DC

- 1991 Panel: Cost-Effective Workup of a Solitary Pulmonary Nodule. Cooper University Medical Center, Camden NJ
- 1991 The Medicare Fee Schedule, American Academic Medical Center Consortium Annual Meeting, Philadelphia
- 1991 Changes in Physician Payment Reform, Robert Wood Johnson Foundation Clinical Scholars Program National Meeting, Ft. Lauderdale, FL
- 1991 Cost-Effectiveness of an Enteral Feeding Product, Society of General Internal Medicine Annual Meeting, Washington, DC
- 1991 Medical Costs: A New Perspective - Issues in Medicine for the Primary Care Physician. St. Margaret's Hospital, Pittsburgh, PA
- 1991 Rising Costs: The Role of the Medical Practitioner. Healthcare Financial Management Educational Foundation, Washington, DC
- 1991 Impact of the Medicare Fee Schedule on an Academic Department of Medicine. Society of General Internal Medicine Annual Meeting, Washington, DC
- 1992 The Burden of Caring for the Homeless in Academic Medical Centers Annual Meeting. Society for General Internal Medicine, Washington DC
- 1992 Administrative Costs in Hospitals. American Federation of Clinical Research Annual Meeting, Baltimore, MD
- 1992 Explaining Cost Variations Using Severity of Illness Measures. Society of General Internal Medicine Annual Meeting, Washington, DC
- 1992 Financial Incentives and Physician Behavior. Senior Management Seminar, The Wharton School
- 1992 Economic Considerations of Smoking Cessation. New York, NY
- 1992 An Approach to Outcomes Management. American Society for Medical Quality, Hershey, PA
- 1992 Continuous Quality Improvement. American Society for Statistical Control, Philadelphia, PA

- 1992 Implementing an Outcomes Management System. Taylor Hospital, Chester, PA
- 1992 Physician Participation in Quality Assessment and Measurement. Riddle Memorial Hospital, Media, PA
- 1992 Outcomes Management in the 90's. Grand Rounds, Medical College of Pennsylvania, Philadelphia, PA
- 1992 Upcoming Trends in Outcomes Measurement. Senior Management, Medicare/Blue Shield, Camp Hill, PA
- 1992 Comparing Quality Measurement in Industry and Health Care. American Society for Quality Control, Philadelphia
- 1993 General Internists and the Transition to Continuous Quality Improvement. Society of General Internal Medicine Annual Meeting, Washington, DC
- 1993 Profiling Physician Behavior. Address to the Managed Care Congress, Regional Meeting, New York, NY
- 1993 External Monitoring of Quality Care, Council of Teaching Hospitals, Emergency Medicine Directors, Philadelphia, PA
- 1993 Managed Care in the 1990's. Keynote Talk, Hospital Association of Pennsylvania Annual Meeting, Hershey, PA
- 1993 Health Care Reform: Impact on the Hospital Worker, American Society Healthcare Employees, Delaware Valley Chapter, Philadelphia, PA
- 1993 Physician Involvement in Continuous Quality Improvement, Riddle Hospital, Media, PA
- 1993 The Changing Face of Patient Education. Fifth Annual Directors Conference, Schering Managed Care, Charleston,
- 1993 Outcomes Management and Health Care Reform. Pennsylvania Society of Hospital Pharmacists, Norristown, PA
- 1993 Physician Involvement in Quality of Care Assessment. Grand Rounds, Medical College Hospitals, Bucks County Campus, Bucks County, PA
- 1993 Quality Improvement in the Ambulatory Setting, Prudential Health Care Forum on Quality, Horsham, PA
- 1993 Quality Improvement and Outcomes Research in Infection

- Control. Annual Meeting of the Association for Practitioners in Infection Control, Philadelphia, PA
- 1993 Using Clinical Outcomes Data to Improve Pharmaceutical Quality. Central Pennsylvania Association, Hospital Pharmacy, Philadelphia, PA
- 1993 Benchmarking Clinical Outcomes. Prudential Insurance Company of America, Corporate Headquarters, Horsham, PA
- 1993 Health Care Financing and Clinical Care. Medical College of Pennsylvania, Philadelphia, PA
- 1993 Outcomes Measurement and Management. The National Managed Health Care Congress, Washington DC
- 1993 The Physician's Role in Pharmaceutical Cost Control. American Society of Hospital Pharmacists, Atlanta, GA
- 1993 The Impact of Outcomes Research on Medical Education. The Medical College of Pennsylvania, Philadelphia, PA
- 1993 Impact of Outcomes Research on the Pharmaceutical Industry. Regional Conference, Philadelphia, PA
- 1993 Developing Agendas for Physicians in Quality Improvement. Delaware Valley Quality Assurance Professionals, Plymouth Meeting, PA
- 1993 How Physicians Will Respond to Cost Containment. Medical Data International, Washington DC
- 1993 Pharmacoeconomic Factors Involved in the Treatment of Acute Hypertension. American Society of Hospital Pharmacists, Atlanta, GA
- 1993 Impact of Outcomes Management on Surgical Practice. American College of Surgeons, Eastern Chapter, Allentown, PA
- 1993 Managed Care: Visions for the 21st Century. Hospital Association of Pennsylvania, Hershey, PA
- 1993 Peer Ratings and Physician Performance. Northeast Regional Managed Health Care Congress, New York, NY
- 1994 A Strategy to Improve Patient Satisfaction Using Clinical Pathways to Clarify Patient Expectations. Academy for Health Services Marketing, San Diego, CA

- 1994 Comparison of Clinical Pharmacists and Infectious Disease Fellow Based Antibiotic Restriction Programs at a University Hospital. Infectious Disease Society of America, Orlando, FL
- 1994 Administrative Positions as a Career Option Society for General Internal Medicine, Washington, DC
- 1994 Developing Physician Leadership Skills in a Changing Environment, Pennsylvania Medical Society Education and Trust Corporation, Harrisburg, PA
- 1994 Incidence of Sepsis Syndrome in Academic Medical Centers. ICAAC Poster Presentation, Orlando, FL
- 1994 Innovations in Patient Care. Association Health Services Research, San Diego, CA
- 1994 Quality Management Initiatives. Council of Teaching Hospitals, Rochester, NY
- 1994 Applications of Critical Pathways. Academic Medical Center Consortium, Boston, MA
- 1994 Health Care Agenda for the 90's. Brigham and Women's Hospital, Boston, MA
- 1994 Public Accountability of Medicine. Children's Hospital of Pennsylvania, Philadelphia, PA
- 1994 Quality Assessment and Outcomes Management. Fourth Annual Critical Care Symposium, Lehigh Valley Medical Hospital, Allentown, PA
- 1994 Evaluating the Outcomes of Epilepsy. Pfizer, Inc., Chicago, IL
- 1994 The Impact of Outcomes Data on the Pharmaceutical Industry. Cytogen, Inc., Princeton, NJ
- 1994 Use of Outcomes Data in Cardiovascular Diseases. National Registry for Myocardial Infarcts. Naples, FL
- 1994 Critical Pathways and Case Management. Rose Medical Center, Park City, UT
- 1994 Improving Quality Assessment and Health Care Reform, Rose Medical Center, Park City, UT
- 1994 Health Reform in American Medicine. Rotary Club of Whales, Medical College of Pennsylvania, Philadelphia, PA

- 1994 Pharmacoeconomics a Quality of Life Studies. Institute for International Research. Philadelphia, PA
- 1994 Clinical and Financial Outcomes: Important Concepts Applicable to Institutional Health Care. Hospital Pharmacy Advisory Board, Chicago, IL
- 1994 Outcomes Assessment in Surgery. Surgical Grand Rounds, St. Lukes Hospital, Bethlehem, PA
- 1994 Outcomes Management in Medical Education. Grand Rounds, Fitzgerald Mercy Medical Center. Darby, PA
- 1994 The New Therapies: Who Will Foot the Bill in the New Health Care Climate? Therapeutic Options in Neurology, Philadelphia, PA
- 1994 Developing Integrated Delivery Systems. Jersey Shore Medical Center, St. Simmons Island, GA
- 1994 Responses from the Pharmaceutical Industry in a Captiated Environment. Bristol-Myers Squibb Leadership, Absecon, NJ
- 1994 Strategic Planning for Managed Care Environments. St. Joseph's Hospital, Sea Isle, GA
- 1994 Use of Quality Measures. Academic Medical Center Consortium. Boston, MA
- 1994 Improving Cost-Effective Clinical Decision Making. The Institute for Physician Leadership. Hershey, PA
- 1994 Managing Information in a Managed Care Environment. Pennsylvania Medical Society, Pittsburgh, PA
- 1994 Paying for Quality in Managed Care. The Northeast Managed Healthcare Congress, New York, NY
- 1994 Challenges for Academic Medical Centers. Health Policy Institute, Thomas Jefferson University, Philadelphia, PA
- 1994 Clinical Outcomes and Pharmacoeconomics. Pennsylvania Society of Hospital Pharmacists, Philadelphia, PA
- 1994 Disease Management for the Pharmaceutical Industry. Bristol-Myers Squibb Company, Tarrytown, NY
- 1994 Physician Leadership in the Quality Debate. President's Forum, American Medical Association, Washington DC

- 1994 Information Management in Quality of Care. Pennsylvania Medical Society, West Conshohocken, PA
- 1995 Physician Involvement in Resource Management. Albert Einstein Medical Center, Montefiore Medical Center, Bronx, NY
- 1995 Managing Health Care in the Rural Environment. Armstrong County Memorial Hospital, Kittanning, PA
- 1995 Outcomes Management. The Johnson and Johnson Wharton Fellows Program, Bryn Mawr, PA
- 1995 Quality Improvement Efforts, Philadelphia Chamber of Commerce Annual Banquet, Philadelphia, PA
- 1995 Quality Measurement and Providers, Regional Leadership Conference, Blue Cross of Western Pennsylvania, Pittsburgh, PA
- 1995 Case Management: The Link to Outcomes Management. National Case Management Conference, The Medical College of Pennsylvania, Philadelphia, PA
- 1995 Disease Management Systems. Scientific Advisory Meeting Merck and Co. Plymouth Meeting, PA
- 1995 Models of Multi disciplinary Care. Annual Meeting of the Pennsylvania Respiratory Care Society, Philadelphia, PA
- 1995 Improving Efficiency in a Managed Care Environment. Grand Rounds, Doylestown Hospital, Doylestown, PA
- 1995 Network Development in Managed Care Environments. Wyoming Valley Health Care System, Grand Rounds, Wilkes-Barre, PA
- 1995 Clinical Benchmarking. University Hospital Consortium, Philadelphia, PA
- 1995 Improving Clinical Decision Making. American Medical Association Annual Meeting, Chicago, IL
- 1995 Measuring Hospital Quality: Current Realities and Future Goals. Health Services Research in Radiology, Philadelphia,
- 1995 Physician Leadership in Guideline Development. National Conference Integrating Economics, Product Selection of Clinical Pathways, Boston, MA

- 1995 Outcomes Measurement and Disease Management. Turner/White Communications, New York, NY
- 1995 Redesigning the Hospitals Approach to Quality Measurement. Brandywine Hospital, Brandywine, PA
- 1995 Open Versus Closed Formularies. Pharmaceutical Manufacturers Association Education and Research Institute, Philadelphia, PA
- 1995 Dealing with the Onslaught of Measures; lessons from a survivor. University of Massachusetts Medical Center, Westborough, MA
- 1995 Demonstrating Best Practices in Academic Medical Centers. Association of Academic Medical Centers Annual Meeting, Washington, D.C.
- 1995 Comparing the Length of Ventilation on CABG Patients Pre/Post Weaning Pathway. Respiratory Care Association, Orlando, FL
- 1996 UPHS First Annual Disease Management Forum (Course Director), Philadelphia, PA
- 1996 Developing a Managed Care Curriculum for Physician Educators. Society for General Internal Medicine Annual Meeting, Washington, DC.
- 1996 Critical Pathways. Jersey Shore Medical Center, Abescon, NJ
- 1996 Partnership with Managed Care Organizations, Institute for International Research, Washington, DC
- 1996 Disease Management: New Research Realities. BIO Council of Biotechnology Centers Meeting, Philadelphia, PA
- 1996 Managed Care: Is the Boy Crying Wolf Again? Children's Hospital of Philadelphia, Philadelphia, PA
- 1996 Quality Care in Managed Care Medicine. Riddle Memorial Hospital, Media, PA
- 1996 Developing Integrated Delivery Systems, Advisory Board Company, Washington, DC

- 1996 Automating Pathways to Analyze Variance. Third National Healthcare Conference on Performance Improvement, Washington, DC
- 1997 Developing Quality Management Programs. York Hospital Board Retreat, Washington, DC
- 1997 Physician Leadership Skills in the Year 2000. York Hospital Medical Staff, York, PA
- 1997 Developing Integrated Healthcare. Palmetto General Hospital Retreat, Marco Island, FL
- 1997 Health Promotion and Disease Prevention. Bryn Mawr, PA
- 1997 Predictive Model for Resource Allocation. Academic Medicine and Managed Care Forum, Washington, DC
- 1997 Balancing Healthcare Costs, Quality and Access Center for Clinical Quality Evaluation. Vienna, VA.
- 1997 Information System Technology and Improving Healthcare. Scottsdale Institute. Scottsdale, AZ.
- 1997 Role of Pharmacists in Leading Healthcare Systems - Keynote Address. American Society of Health System Pharmacists, Washington, DC
- 1997 Merging Hospitals and Leading Change. Pennsylvania Hospital Leadership Retreat. Bryn Mawr, PA
- 1997 Managing Quality in Health Care: An international Comparison - Moderator. Insead, Fontainebleau, France
- 1997 Emerging Roles for Internists, Society for General Internal Medicine. Washington, DC.
- 1997 Outcomes in Obesity Management. Obesity Leadership Conference, Naples, FL
- 1997 Managing Care in a Integrated Delivery Systems, Annual Meeting of the American Medical College, Washington, DC.
- 1997 National Quality Award Presentation, National Committee for Quality Assurance, Washington DC.
- 1998 Cost-Effectiveness and the Community-Based Physician, Grand Rounds. Holy Redeemer Health System, Bucks County, PA.

- 1998 Managed Care Principles in Practice. John Hopkins University, Baltimore, MD.
- 1998 Creating New Standards for Excellence. Robert Wood Johnson Medical School, New Brunswick, NJ.
- 1998 Going Beyond Competition in Medicine. Alpha Omega Alpha Honorary Society, Philadelphia, PA.
- 1998 Seven Trends that will Change American Healthcare. Carilion Health System, Roanoke, VA.
- 1998 Addressing the Needs of the Elderly American Geriatrics Society, Philadelphia, PA
- 1998 Managing Risk. The New Healthcare Marketplace Conference, University of Syracuse, Syracuse, NY.
- 1998 Corporate Partnerships – Essential Principles for Success. Abbott Pharmaceuticals, Philadelphia, PA.
- 1998 Preparing for the Future in Managing Patient Care: Keynote address. Louisiana State University Medical Center, Second Annual Disease Management Forum, Baton Rouge, LA
- 1998 Pursuing Excellence in Healthcare. Ministry Healthcare Leadership Conference, Kohler, WI.
- 1998 Partnerships between Academic Medicine and For-Profit Companies, Merck, Company, West Point, PA.
- 1998 Designing and Implementing Strategies for Improvement. National Physician Leadership Forum, VHA, Inc. Dallas, TX.
- 1998 Leadership Issues in Turbulent Times. Society for Chief Medical Officers, San Francisco, CA.
- 1998 Prioritizing Issues for Physician Leaders. The Chief Medical Officers Forum. The Wharton School, Philadelphia PA.
- 1998 Health System Development and Implementation. The Ernest A. Codman Award. Joint Commission of Accrediting Organizations, Chicago, IL.
- 1998 Disease Management Programs for the Chronically Ill. Zeneca Managed Care Symposium, Palm Beach, FL.
- 1998 Leading Change in Academic Systems. Harvard School of Public Health, Boston, MA.

- 1998 Bringing Disease Management to a National Level. VHA Shareholders Forum, Dallas TX.
- 1998 The State of the Chief Medical Officer Role. The Wharton School, Philadelphia, PA.
- 1998 Preparing for the Future in Managing Patient Care. Louisiana State University Second Annual Disease Management Forum, Baton Rouge, LA.
- 1998 Good Medicine Done Right: Improving Healthcare through Disease Management. Institute for Healthcare Improvement Annual Meeting, Orlando, FL.
- 1999 Creating Economic Value in Hospitals. Hospital Council of Western Pennsylvania, Pittsburgh, PA.
- 1999 Technology Assessment. Chief Medical Officer Forum. The Wharton School, Philadelphia, PA.
- 1999 Technology, Costs, and quality. HBSI National Forum. Washington, DC.
- 1999 Redesigning Clinical Care for Better Outcomes. Physician Leadership and Management Program. Chicago, IL.
- 1999 Ushering in the New Age of Care Management and Medical Informatics. Sisters of Joseph's Physician Leadership Forum. Dearborn, MI.
- 1999 Seven Trends That Will Change American Healthcare
T Greater Philadelphia Chamber of Commerce, Philadelphia, PA
- 1999 The VHA Leadership Award – Awardee
Presentation. VHA Ntl Meeting, Orlando, FL.
- 1999 Redesigning Managed Care's Future in Academic
Delivery Systems. Greater Phila Health Alliance,
Philadelphia, PA
- 1999 Revisiting the Role of Community and Academic Hospitals
Grand Rounds., Holy Redeemer Health System, Huntington, PA
- 1999 The Role of Biotechnology in Managed Care.
Amgen Leadership Conference, Los Angeles, CA
- 1999 Delivering the Message About HealthCare. American
Writers Association. Philadelphia, PA

- 1999 Conflict and Change: How Quality Enters the Coverage Decision ECRI, Plymouth Meeting, PA
- 1999 Partnering for Profit Through Quality Management. American College of Medical Quality, Atlanta, Georgia
- 2000 Will Quality Ever Drive the Healthcare Industry? APIDM, Philadelphia, PA
- 2000 Entering the Internet Era in Healthcare. Healthcare Management Program. The Wharton School. Philadelphia, PA
- 2000 Understanding Economics of Quality Improvement. Institute of Medicine -Effect of Financing Policies on Quality Improvement, Washington DC.
- 2000 Patient Safety Issues and Reporting of Errors. Hospital Association of Pennsylvania, Harrisburgh, PA
- 2000 Strategies to Conquer Quality. National Committee for Quality Assurance, Washington, DC
- 2000 New Internet Initiatives to Change the Medical Marketplace. KEPRO, Harrisburg, PA
- 2000 Physician Leadership on the Net. York Hospital Strategic Board Retreat York, PA
- 2000 Internet Internet Strategies for Quality. American College of Medical Quality. Annual Meeting. Dallas, TX
- 2000 Enhancing Plan and Provider Relationships. Medical Alliance, Burlington, VT
- 2000 Medical Error Reduction in a Changing Healthcare Environment Consortia Health Plans, Chicago, Ill.
- 2000 Leadership in a Challenging Environment Borgess Health System, Grand Rapids, MI
- 2001 Employee Choices in Health Care Selection Delaware Valley HealthCare Coalition, Bucks County PA

- 2001 Clinical and Administrative Integration of Benefit Selection
First Benefits Conference, Conshohocken, PA
- 2001 Where have all of the ehealth companies gone?
Thomas Jefferson University, Philadelphia PA
- 2001 The Business Case for Quality, Pittsburgh Business Group
on Health, Pittsburgh, PA
- 2001 What Matters to Consumers? Washington Business
Group on Health, Washington, DC
- 2001 Patient Safety – The Employers Role
MidWest Business Group on Health, Chicago, IL
- 2001 Consumer Oriented Health Care- Cerner Corporation
Kansas City, MO
- 2001 Patient Safety- What Managed Care and Providers Can
Do Together? National Managed Care Congress,
Atlanta, GA
- 2001 What Patients Want- Consumers in Healthcare
MidWest Business Group on Health, Chicago, IL
- 2001 Providers Reactions to Intention to Treat Quality Data.
HCN, Milwaukee Wisconsin.
- 2001 Where have all of the Healthcare Leaders Gone?
Greater Philadelphia Health Care Assembly, Medical
College of Pennsylvania, Philadelphia, PA
- 2001 Will There Be a Marketplace for Quality? Frankford
Health System Philadelphia, PA
- 2001 Keynote: Information Systems in Patient Safety –
Hospital Information Management Regional Meeting-
Lankenau Hospital, Wynnewood, PA
- 2001 Making Medicine Work. Mid Atlantic Venture Fair,
Philadelphia, PA
- 2001 Economic Parameters in Health Services, WEMBA,
Wharton School, Philadelphia, PA
- 2001 Technology and the Role of the Peer Review

- Organization Third Annual KePRO Conference,
Harrisburg, PA
- 2002 Return on Investment of Quality Care. Robert Wood
Johnson Foundation Clinical Scholars Program. Yale
University School of Medicine, New Haven, CT
- 2002 Technology's Return on Investment in Healthcare
Widner University, West Chester, PA
- 2002 Defined Contributions in Health Care- The National
Managed Care Congress- Baltimore, MD
- 2002 Regulations and Policy Changes. Evanston
Northwestern Hospital Foundation, Chicago, Ill.
- 2002 Accountability and Safety. Maryland Hospital
Association Keynote. Baltimore, MD
- 2002 Guidelines and Quality of Care- Main Line Health
Cardiology Division, Conshohocken, PA
- 2002 Information Technology for Payers, Physicians, and
Patients Health Insurers Association of America
(HIAA), Chicago Ill.
- 2002 Making Healthcare Safer. American College of
Healthcare Executives- Wilmington, DE
- 2002 Outcomes Workshop- Making Healthcare Better
Second Annual Outcomes Management Seminar
Northwestern Memorial Hospital, Chicago, IL
- 2002 Finding Successful Strategies to Change Physician
Behavior. Pharmaceutical Marketing Congress
Philadelphia, PA
- 2002 The Market Model for Patient Safety.
The Wharton Healthcare Conference
Philadelphia, PA
- 2002 Lessons for Quality Improvement Organizations
Board Retreat, WVMI, Inc. Farmington, PA

- 2002 Patient Safety Lessons for Providers, Employers, and Consumers- Wisconsin Health Care Forum, Madison, WI
- 2003 Patient Safety Officers Training, Harvard University, Boston, MA
- 2003 Quality of Care Perspectives- National Quality Colloquium, Boston, MA
- 2003 Organ Transplantation- Improving the Processes of Care, Gift of Life, Lafayette Hill, PA
- 2003 Organizational Dynamics in Health Organizations Traverse City, Michigan
- 2003 Where Rubber Meets the Road- Practical Applications of Patient Safety- West Virginia Medical Institute Board of Trustees, West Sulfur Springs, WV
- 2003 Leading Change for Patient Safety- American Board of Utilization Review and Quality Assurance Annual Meeting, Orlando, Florida
- 2004 Changing Physician Behavior: Lessons for the Pharmaceutical Industry. Healthcare Marketing Council New York, NY
- 2004 Quality Improvement Organizations: Role of Managed Care Plans- Quality Insights of Pennsylvania, Keynote Harrisburg, PA
- 2004 Patient Safety Advances- Morristown Memorial Hospital Grand Rounds- Morristown, N.J.
- 2004 Quality Report Cards- Delaware Valley Hospital Council- Philadelphia, PA
- 2004 Reducing Infection Rates. Keynote- Infectious Disease Outcomes Congress, Harrisburgh, PA
- 2004 Evidence Based Patient Safety Practices- American College of Obstetrics and Gynecology Annual Conference, Philadelphia, PA

- 2004 Ambulatory Patient Safety Practices, National Patient Safety Forum, Boston, MA
- 2004 Plans and Providers Collaboration Strategies for Improving Quality, National Managed Care Congress Washington, DC
- 2004 Recent Initiatives in Medical Error Reduction, Quality Colloquium, Harvard University, Boston, MA
- 2004 Physician Performance Measurement: A National Perspective, Care Science Conference, Philadelphia, PA
- 2004 Healthcare Improvements In the Past Year. Board of Trustees Annual Meeting, West Virginia Medical Institute, Roanoke, VA
- 2004 Evidence Based Medicine: Reducing Variation in Clinical Practice- Third Annual Campaign in Quality St. Lukes Healthcare, Utica, NY
- 2004 Industrial Techniques to Improve Healthcare Efficiency Delaware Valley Healthcare Professional Society- Keynote- Philadelphia, PA
- 2004 Patient Safety Innovations for Hospitals and Physicians West Virginia Hospital Association, Chareleston, WV
- 2004 Management Perspectives on Health Care. Temple University Health Care Alumni Association, Philadelphia, PA
- 2005 Team Work and Communication Strategies to Reduce Injury. School of Physical Therapy, Temple University
- 2005 Rapid Response Teams and Systems Approaches to Reducing Errors, New Jersey Hospital Association Princeton, NJ
- 2005 Disease Management in the Hospital Setting Disease Management Society, National Meeting Philadelphia, PA
- 2005 New Developments in Safety. Harvard Colloquim on Quality. Boston, MA

- 2006 Rapid Response Teams- Greater New York Hospital Association Keynote Speaker- Pelham, NY
- 2006 Quality: A View from the CEO's Office FOJP Annual Conference, New York, NY
- 2007 Leadership and Diversity in Healthcare. Greater New York Hospital Association. Baruch College, NY, NY
- 2007 Exploring Integrative Approaches to Healthcare. Urban Zen Initiative. Donna Karan Foundation, NY, NY
- 2007 Translating Best Practices from the Mainland. Keynote Speech- Schneider Regional Medical Center St. Thomas, US Virgin Islands
- 2008 Running a Hospital in the Big Apple Aish International, New York, NY
- 2008 Leading Quality from the CEO's Office Quality Colloquium at Harvard, Boston, MA
- 2009 Challenges for Healthcare Leaders. Keynote New Jersey Hospital Association Annual Meeting Princeton, NJ
- 2009 Pay for Performance Systems- The State of the Union New York Business Group on Health, New York
- 2009 Health Care Payment Reform in the US- American College of Physicians National Meeting- Meet the Professor Session- Philadelphia, PA
- 2009 Accountable Care Organizations. Kennedy Health System Board- Voorhees NJ
- 2009 Health Care Reform: Implications for Providers Delaware Valley Health Executives- Thomas Jefferson University, Philadelphia, PA
- 2009 Physician Leadership Models in University Based Hospital Structures- UMDNJ-Kennedy System Board Retreat, Atlantic City, NJ

- 2009 Changing Models of Healthcare Delivery- Federation
Medical Executive 1st Annual Lecture, Philadelphia,
PA
- 2009 Economic Changes in the Healthcare Industry
Gerson Lehman Executive Forum New York, NY
- 2010 Stroke and Blood Pressure Management (Moderator)
Short Hills, NJ
- 2010 Implications of Health Reform for Health Care
Leadership- Keynote Address to the 13th Annual
Institute for Clinical Systems Improvement and
Institute for Healthcare Improvement Meeting
St Paul, Minnesota
- 2010 Evidence Based Practice- Panel Discussion
ICSI/IHI, St. Paul, MN
- 2009 Innovation in Healthcare, Farleigh Dickenson
School of Business- Innovation Summit, Madison, NJ
- 2011 Impact of Health Reform on Foundations
Morristown, NJ
- 2010 Implications of Health Reform on Long Term Care
Keynote Talk- Care One National Meeting
Meadowlands, NJ
- 2011 Homeland Security Issues in Healthcare
Summit on Resilience, PACE University
New York, NY
- 2012 Contemporary Concepts in Healthcare Services
Keynote Speaker- Bracco Diagnostics
Princeton, NJ
- 2012 Implications of Health Care Reform
Kean University, Union NJ

- 2012 Where Healthcare is Heading- Panel Presentation
Quest Diagnostics, National Conference
Parsippany, New Jersey
- 2103 Value Based Purchasing and Episodes of Care
Rutgers University Bowers Conference
New Brunswick, NJ
- 2013 Implications of Federal Health Reform
Northeast Business Group on Health, Annual
Meeting, New York, New York
- 2012 The Future of Emergency Medicine
American College of Emergency Physicians
New Brunswick, NJ
- 2013 Accountable Care and the Vascular Surgeon
New Jersey Society of Vascular Surgeons Belleville,
NJ
- 2013 Advanced in Technology and Innovation
ACG Conference, Boston, MA
- 2013 Technologic Advancements in Medicine
Morgan Stanley Healthcare Conference
New York, New York
- 2013 International Lessons in Running Hospitals
Lainaido Hospital, Netanya, Israel \
- 2013 Innovations in Healthcare Models of Care
Mid-Jersey Chamber of Commerce
New Brunswick, NJ
- 2013 Accountable Care Models: Implications on
Post Acute Care. Alvarez and Marsal Annual
Conference Kiawah Island, SC
- 2013 :Lessons from an ACO Delivery System
Princeton Club, New York, NY
- 2013 Value Based Purchasing in Oncology.
Northeast Business Group on Health Symposium
Jersey City, NJ

- 2013 Accountable Care Sustainability
Marwood Lecture New York, NY
- 2014 Eliminating Disparities in Vulnerable Populations
Symposium on Population Health
St. Elizabeths College, Madison NJ
- 2014 Accountable Care Delivery Systems and Care
Coordination- Rutgers University Pharmacy
Conference Somerset, NJ
- 2014 A CEO's Lessons from Running Hospitals
Rutgers University, School of Social Science and
Health, Newark NJ
- 2015 Impact of Provider Reimbursement Systems on
Pharmaceutical Development: Panel Discussion
Research and Development Summit- Miami, FL
- 2015 Consumerism and Health Insurance: Panel Discussion
Morris County Chamber of Commerce, Morristown NJ
- 2015 Impact of Provider Reimbursement Systems on
Pharmaceutical Development: Panel Discussion-
R and D Summit- Miami, Florida
- 2016 Systemic Improvements in Healthcare
Paralyzed Veterans of America
Arlington, VA
- 2016 Innovations in Medicine
Lake Nona Impact Forum
Orlando, FL
- 2016 Quality of Care Keynote
American College of Medical Quality Annual Meeting
Washington DC
- 2016 Building the Big Data Economy. Panel
Discussion Bloomberg News – Newseum
Washington DC

2016	Transforming VA Healthcare Using Telehealth Keynote: American Telehealth Association Minneapolis, MN
2016	Giving Back through Public Service Commencement Keynote, PACE University New York, NY
2016	Technology and Medical Advances New Jersey Tech Council Keynote Newark, NJ
2016	Decisions for Healthcare Leaders Commencement Keynote, Thomas Jefferson University School of Medicine, Philadelphia, PA
2016	Precision Medicine and Research for Veterans LaunchPad Milken Foundation National Press Club, Washington DC
2016	Adapt or Die- Invisible Wounds of War Bush Institute, Dallas Tx
2016	Interagency Innovation- Department of Defense Collaborations- National Defense University Washington DC
2016	Veteran Well Being: Preventing Suicide National Press Club Washington DC
2015	American Legion Annual Conference Future of Veterans Affairs, Baltimore MD
2015	Paralyzed Veterans of America Centers of Excellence, Jacksonville Fl
2015	Keynote: Ending Homelessness Among Veterans Congressional Black Caucus, Washington DC
2015	American Council for Technology and Industry Advisory Council – Working with the Private Sector, Washington, DC
2015	Using Information Technology to Advance America’s Healthcare Priorities. Department of Defense/VA and Government HIT Summit Alexandria, Virginia

- 2015 Academic Medicine and the Veterans Affairs: The Impact on American Medicine- AAMC Annual Meeting Council of Deans- Baltimore, MD
- 2015 Federal Healthcare and Implications for the Future
Keynote: AMSUS- The Society for Federal Health Professionals. San Antonio, Texas
- 2015 Technology Applications to the Veterans Healthcare System
Keynote: AFCEA International Bethesda, MD
- 2015 Inoperability and Integrated Care. Federal Healthcare Executive Forum. Washington, DC
- 2016 Future Models of VA Care. Paralyzed Veterans of America Arlington, VA
- 2016 Addressing the Needs of Veterans, Disabled Veterans of America, Crystal City, VA
- 2016 Innovation in Government. Lake Nona Impact Forum Orlando, Florida
- 2016 Innovation in the VA Health System
American College of Healthcare Executives Annual Session, Chicago, IL
- 2016 Federal Models of Caring for Patients National Association of Community Health Centers Washington, DC
- 2016 VA Healthcare. Commission on Care Washington, DC
- 2016 Research in Veterans Brain Health
VA Brain Trust Summit, Wash DC
- 2011 Strategic Future of VA
VA Strategic Summit
Washington DC
- 2016 VA Care vs. Private Sector Care
VA Healthcare 2016, Pentagon City, VA

- 2016 VA's Role in Medical Education
Resident Fellows Section
American Medical Association, Chicago IL
- 2016 Advances in Mental Health
White House Summit on Making Healthcare Better
White House, Washington DC
- 2016 What's Next for VA?
Keeping the Promise Conference
Washington DC
- 2016 Addiction and Healing: Forum with
Senators Booker and Menendez
and the Surgeon General
Livingston, NJ
- 2016 Re-inventing Veterans Health care
Disabled American Veterans Annual Conference
Atlanta, GA
- 2016 Progress at the Veterans Health Administration
Veterans Foreign Wars, Annual Meeting
Charlotte, NC
- 2016 Rehabilitation in Disabled Veterans. Paralyzed
Veterans of America- Keynote Orlando, FL
- 2016 Best Practices in Veterans Care
International Veterans Conference
Seoul, South Korea
- 2016 Advances in Care of CNS Disorders
Cohen Veterans Network
Washington DC
- 2016 Advancing Veterans Health Care
American Legion National Conference
Cincinnati OH
- 2016 Blind Rehabilitation Care
Blind Veterans of America National Meeting
Milwaukee, WI

2016	Developments in Veterans Healthcare Potomac Officers Society Tysons Corner, Virginia
2016	Pharmaceutical Best Practices Wisconsin Society of Pharmacists Keynote Wisconsin Dells, WI
2016	Suicide Prevention. White House Summit on Suicide. White House
2016	Caregiving in Home Settings Elizabeth Dole Foundation – Hidden Heroes Washington DC
2016	Precision Medicine Association of Academic Health Centers Washington DC
2016	Military Wellness Initiative United State Congress Center Washington DC
2016	Predictive Analytics creating Breakthroughs US News and World Report Futures Conference Washington, DC
2016	International Health Technology Presentation to the Crown Prince and Princess of Denmark Washington, DC

Lectures at University of Pennsylvania:

1991	Health Economics. Governors School of Business, University of Pennsylvania, Philadelphia, PA
1993	Measuring Quality Outcomes in Managed Care, University of Pennsylvania Center for Professional Development, Conshohocken, PA

- 1993 Organizational Incentives for Quality in the Hospital Environment. Sixth Annual Managed Care Health Care Senior Executive Education Program, The Wharton School, Philadelphia, PA
- 1993 International Implications of Outcomes Management. Leonard Davis Institute of Health Economics, Helsinki Program in Health Economics, Philadelphia, PA
- 1993 Managed Care and Outcomes Assessment, University of Pennsylvania Continuing Education Series. Conshohocken, PA
- 1994 Improving Quality in Health Care. The Wharton Annual Healthcare Conference. The Wharton School, Philadelphia, PA
- 1994 Measuring Quality in Health Care. Grand Rounds, Hospital of the University of Pennsylvania, Philadelphia, PA
- 1994 Managing Cost and Quality in Health Care, Wharton Executive Management Program, Philadelphia, PA
- 1994 Health Services Research in Radiology and Surgery. Department of Radiology, Sheraton Hotel, Philadelphia, PA
- 1995 Strategic Planning for Physician Executives, Management Development Program, The Wharton School, Philadelphia, PA
- 1995 Rethinking Outcomes Management. Wyeth Ayerst Program in Management for Chairs of Medicine. The Wharton School, Philadelphia, PA
- 1995 Using Outcomes to Improve Efficiency in Drug Utilization: Management Program for Pharmacists. The Wharton School, Philadelphia, PA
- 1995 Outcomes Management. The Johnson and Johnson Wharton Fellows Program, Bryn Mawr, PA

- 1995 Measuring Hospital Quality: Current Realities and Future Goals. Health Service Research in Radiology, Philadelphia, PA
- 1996 Re-engineering Health Care. University of Pennsylvania Health System Planning Group, Bryn Mawr, PA
- 1996 Quality Measurement at the University of Pennsylvania. American-France Summit in Health Economics. Leonard Davis Institute of Health Economics, Philadelphia, PA
- 1996 Getting Physicians Involved in Managed Care (moderator). Clinical Performance Improvement Round table. The Wharton School, Philadelphia, PA
- 1996 Pasmire Lecture - The Cycle of Life (moderator). Presbyterian Medical Center, Philadelphia, PA
- 1996 Outcomes Management. Association of Gynecologic Oncology Leadership Program. The Wharton School, Philadelphia, PA
- 1997 Impact of Managed Care of Plastic Surgery. Division of Plastic Surgery. University of Pennsylvania, Philadelphia, PA
- 1997 Leading Into the Future of Anesthesia. Department of Anesthesia. Hospital of the University of Pennsylvania, Philadelphia, PA
- 1997 The Future of Health Care. Penn Business Students in Medicine, Philadelphia, PA
- 1997 Health Promotion and Disease Prevention, UPHS, Bryn Mawr, PA
- 1997 Financing Healthcare, Medical Management Conference, Presbyterian Medical Center, Philadelphia, PA
- 1997 Addressing Healthcare Productivity, Medical Management Conference, Hospital of the University of Pennsylvania, Philadelphia, PA

- 1997 Disease Management under Managed Care. Institute on Aging, Philadelphia, PA
- 1997 Managing Risk, Grand Rounds Department of Medicine, Hospital of the University of Pennsylvania, Philadelphia, PA
- 1998 Managing Clinical Performance: Creating Competitive Advantage, The Wharton School Impact Conference, Philadelphia, PA
- 1998 Disease Management as an Industry., The Wharton School, Philadelphia, PA
- 1998 Health Care Management, Japan Quality Assurance Institute, Philadelphia, PA
- 1998 The Seven Trends That Will Change Healthcare. Keynote speaker: Pennsylvania Hospital Leadership Retreat, Bryn Mawr, PA
- 1999 Quality and Managed Care. Institute of Medicine, Healthcare Conference for Congressional Staff. Philadelphia, PA
- 1999 Graduate Medical Education's Changing Face, Medical Management Conference, Presbyterian Medical Center, Philadelphia, PA

Lectures at Drexel University School of Medicine

- 2002 Teaching Resident and Students about Quality Directors of Medical Education, Queen Lane Campus
- 2003 Best Practice Standards for Physicians
Drexel University Physicians
- 2003 Preventing Medical Liability Through Clinical Best Practices, Queen Lane Campus

Lectures at Temple University School of Medicine

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| 2004 | Innovations in Medicine- Medicine Grand Rounds
Philadelphia, PA |
| 2004 | Improving Safety in Surgical Practices- Surgery Grand
Rounds, Philadelphia, PA |
| 2004 | Pediatric Best Practices- Pediatric Grand Rounds
Temple University Children's Hospital, Philadelphia
PA |
| 2004 | Communication Practices Impacting Outcomes.
Psychiatry Grand Rounds, Temple University
Hospital, Philadelphia, PA |

Lectures at Beth Israel Medical Center

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| 2006 | Diabetes Disease Management
Endocrinology Grand Rounds, NY,NY |
| 2006 | Primary Care Practices in Urban Settings
Family Medicine Grand Rounds, NY, NY |
| 2007 | Patient Centered Care-Progress in the Past 50 Years
Medicine Grand Rounds, NY, NY |
| 2009 | Learning from China's Healthcare System
Operations Forum, NY, NY |
| 2013 | Medical Best Practices. Medicine Grand Rounds, NY |
| 2013 | Clinical Practices for Medicine Grand Rounds,
Obstetrics and Gynecology, New York, NY |

Lectures at Atlantic Health

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| 2010 | Understanding Where Healthcare is Going
Grand Rounds Medicine and Surgery – Morristown, NJ |
| 2011 | Leadership Roles for Physician Executives- Physician |

- 2013 The Affordable Care Act
Surgery Grand Rounds, Morristown NJ
- 2013 Technology in the Changing Healthcare Environment
Advanced Physician Leadership Academy

David Shulkin M.D.

Attachment C- Interviews, Radio, Magazines

Press Quotes

- Diabetes Control in Aisle 3- Modern Healthcare April 20, 1998
- Does Standardization Equal Quality? Physicians News Digest April 1998
- UPHS Puts Quality Plan in Place: Will it Pay Off- Return on Quality Report- March 15, 1998
- Preventive Measures- Penn Health August 1997
- Asthma Disease Management Program Links Health Professionals – Drug Topics Magazine August 18, 1997
- Healthcare Leaders for the Next Century- Modern Healthcare September 15, 1997
- Physicians Rate HUP Services- HUPdate- October 1997
- UPHS and Pharmacare Team up on Program for Asthma- Disease Management News October 10, 1997
- UPHS: 82.9% of Risk Members will be in DM programs- Disease Management News October 25, 1997
- Monitoring Asthma Patient Compliance- Healthcare Business Digest Volume 2(9) September 1997
- Mismanged Care? US News and World Report November 24, 1997
- Transplant Survival is greatly Improved- Philadelphia Inquirer December 13, 1997
- Managed Care gathers the power of data Philadelphia Inquirer December 14, 1997
- For Better Health Info on the Net- Philadelphia Business Journal March 17-23 2000
- Quality of Care and Coverage- ERCI Conference Spotlights- The American Journal of Managed Care January 2000 page 126-129
- Physician Advocates Quality Medicine as Best Path to Successful Practice- The Quality Indicator April 2001 pages 1-5.
- Recognizing Quality- Modern Healthcare February 2, 1998, page 31.
- Health System wins Major National Award- Daily Pennsylvanian February 4, 1998
- UPHS Develops DM Partnerships with CHI, Aetna. US Healthcare- Disease Management News January 25, 1998
- National Quality Award given to Penn System- Philadelphia Business Journal February 13-19 1998
- Feds could pay HUP not to train residents- Daily Pennsylvanian October 8, 1997
- 50 Most Influential Physician Executives- Modern Healthcare May 9, 2011
- Atlantic Health System and Continuum Health Alliance Announce Collaboration- Alternative Press September 7, 2011
- Aetna Considers Carving out Specialized Care Agreements- Philadelphia Business Journal February 20-26 1998
- TakingbigRisk.com Modern Healthcare February 21, 2000 page 37-41.

- Shulkin, Bernard Start Internet DM Related Services Company- Disease Management News Volume 5(4) 1999 page 1.
- Strategic Physician Recruiting- Health Leaders March 2012
- Hospitals, Docs are assuming leadership in majority of ACO Governance structures- ACO Business News Volume 3(3) March 2012
- Up and Comers Yearbook- Class of 1997- Supplement to Modern Healthcare September 17, 2007
- Doctors and Health Plans: Can They Possibly Get Along? Medical Practice Bulletin Volume 1, 1999
- Payers expand quality incentives – Physicians News Digest November 2003
- Health Experts Look Beyond HMOs for Better Approach- Wall Street Journal March 3, 2003
- Quality Improvements needed in healthcare Observer Dispatch June 3, 1999
- Good news: The doctor really will see you now. Philadelphia Inquirer July 20, 1997
- University Program sets standards in care- Daily Pennsylvanian January 25, 1999
- Consultation about costs needed- Medical World News- June 26, 1989
- After Dot-com experience, Doctor Returns to 1st Love. Philadelphia Business Journal August 16-22 2002
- New professional society launches Patient Safety Officer Society- Formulary March 2002 Volume 37 page 1
- Penn Health strikes online deal with VHA. Philadelphia Business Journal October 9-15 1998
- Making the Grade- Wall Street Journal- October 19, 1998
- Physicians Wary of JCAHO Rules on Medical Errors- Physician Financial News- Volume 19, September 15, 2001
- University of Pennsylvania Hospital Extends DM System- The Quality Letter December 1998
- Taking the pulse of Medicine – Philadelphia Inquirer November 6, 2000
- Triple Crown Healthier- Pennsylvania Current February 25, 1999
- Technicality Costs Hospitals 20 M- Philadelphia Business Journal May 15-21 1998.
- Medication Error cut in area- Philadelphia Inquirer January 6, 2005
- Voyage to the Web- Philly Tech October 2000 Cover Story
- HUP Ranked among nations best hospitals- July 15, 1999
- Financially Press UPHS seeks outside funding of DM programs- Disease Management News July 25, 1999
- Beeper users sent back to phone age. Philadelphia Inquirer May 21, 1998
- Bypass Mortality Rates Fall – Philadelphia Inquirer
- Karpas Center Celebrates 25 Years on First Ave- Town and Village October 5, 2006
- Accountable Care Organizations- New Jersey Business 933:8214 2014
- ACO Pioneers- :Q and A with Leaders from the Nebraska Medical Center and Atlantic Health: Beckers Hospital Review- March 20, 2011
- A Long Legal Battle Looms as Hospitals Fight Closure- The New York Sun Mary 7, 2007
- The Quality Quagmire- Managed Healthcare News Volume 17(1):January 2001

- Charity care puts hospitals in need of a transfusion- Philadelphia Inquirer March 29, 1998
- Affordable Care Act: Prescription for Change in NJ Healthcare NJ Spotlight June 18, 2012
- Making the Grade- Wall Street Journal October 19, 1998
- A Hospital CEOs Secrets to Good Healthcare Prevention Magazine March 14, 2009
- How to Tell Your Doctor to Wash his Hands: The Nice Way for Patients to Get Tough- Bottom Line Personal Volume 30(15) August 1, 2009
- An ACO- What's That? Hospital and Health Networks Daily July 18, 2012
- Quote of the Day- AIS's Health Business Daily- April 2, 2012
- A new tool to compare hospital performance- Philly.com November 4, 2011
- Readmissions up but deaths down- Philadelphia Inquirer- September 29, 2006
- Ailing Health Care System Finds Reform a Salve, Not Cure- All The Business Edge of Morris County February 2011 Issue 2 No 3.
- Finding a Way to Ask Doctors Tough Questions- Wall Street Journal March 4, 2009
- In Morristown, Changing the Industry's silo mentality- NJ Biz October 7 2013
- The high-deductible Trap Modern Healthcare June 22, 2013
- Shulkin to Chair Board of NJ Council of Teaching Hospitals- Morristown Patch January 7, 2013
- Hospitals may take hit over cliff deal- Star Ledger January 4, 2013
- Accountable Care Organizations- MD Advisor Fall 2012
- Schedules for Medicare fees are studied- Philadelphia Business Journal December 9-15 1991
- Beth Israel Medical Center recruiting 50 bilingual Asian staff to enhance its services to the Chinese community- Sing Tai Newspaper August 11, 2005
- Beth Israel Kings Highway to welcome new President- Daily Bulletin of Brooklyn July 29 2005
- Doctors at Teaching Hospitals face pay cuts, study says- Philadelphia Inquirer December 4, 1991
- ACOs and Market Share: Could care Coordination Drive Monopolization? Becker's Hospital Review- November 7, 2013
- Reform Update- ACO Executives say experience rocky, but informative , Modern Healthcare January 8, 2014
- Healthcare reform put into action- Star Ledger 933(7650) 2013
- 24 hour Visitation? AARC Times 933(7743).
- Throwing Out a Net For Good Health Care. Philadelphia Inquirer April 16, 2000
- Changing the State of Today's Healthcare Quality and Safety. FOJP Focus Volume 3 Winter 2007
- Providers and Businesses Begin Addressing the Healthcare Elephant in the Room Morris County Chamber of Commerce Business Edge August 2012
- New Jersey Hospital Launches Storefront Modeled on Apple Genius Bar- Medcity News 12/3/14

- New Jersey Hospital sets up an on-site Digital Health Store – MobiHealth News January 15, 2015
- Do Hospitals Need Genius Bar-Like Services – Hospitals and Health Networks January 15, 2015
- Technology Stores Added to Health System Offerings- Hospitals and Health Networks February 10, 2015
- Hospital Taps Mobile Tech to Connect with Patients- Daily Record 12/8/14
- Tech Support at the Hospital? Morristown Medical Center Says, “Why Not?”- Healthcare Design 1/29/15
- New Jersey Hospital Launches Health Center Modeled on Apple’s Genius Bar PSFK.com 12/15/14
- Hospital opens Apple-Style Genius Bar for Healthcare – Advisory.com 12/15/14
- What one hospital learned from the Apple Store. Healthioutcomes.com 12/11/14
- Health Management? There’s an APP for that and Morristown’s Hospital Store Will Make it Work for You. NJBiz, 12/17/14

Media Interviews:

- Frankie Boyer Health Radio Show- Visiting Hours are Never Over- March 2014
- WLTW New York Radio interview with Nina Dei Rio on visiting hours- March 2014
- How to Choose a Good Doctor- Radio Jim Bohannon show
- Market Watch Looking for a New Doctor? Its kind of like dating. WLTW New York
- Health Leaders Magazine (Philip Betbeze) 7-2-15
- The Year in VA and Military Medicine (John Gresham) 9/15
- New Executives at VA - Fed News Radio (Emily Kopp) 9/15
- USA Today interview for Veterans Day special edition supplemental published Nov 2015 interviews took place in September 2015
- VA Vacancies –NBC News (Rich Gardella) 10/7/15
- Veterans Day Special Supplemental (Reporter – USA Today) 11/2015
- Interview with Pitt Med Alumni Magazine (Nick Keppler) 11/2015
- Fed News Radio (Emily Kopp) November 2015
- Federal Practitioner (Q and A with no reporter listed)
<http://www.mdedge.com/fedprac/article/106300/new-view-va> December 2015
- AZ Central, “VA Inspectors reject blame for delayed disciplining of Phoenix Executives (Dennis Wagner) 12/15
- Federal Practitioner Profile Dr. Shulkin’s January 2016 (no reporter listed -
<http://www.mdedge.com/fedprac/article/105039/new-va-under-secretary-health-focuses-access-employee-engagement>
- The Military Advantage Blog (Tom Philpott) March, 2016
- Bloomberg – USH was a panel participant at this Newseum event: PUSHING THE BOUNDARIES OF HEALTHCARE INNOVATION: Personalized Care and Cancer Treatment In the Age of Big Data 04/2016
- Advisory.com (Eric Larsen) 5/2016
- USA Today, access to care and wait times (Donovan Slack) 5/2016

- Philadelphia Inquirer (Sam Wood) 5/2016
- Washington Post and Bloomberg (Reporters: The Washington Post -Laurie McGinley and Bloomberg - Justin Sink, Forbes Mathew Herper). 06/2016
- White House Moonshot – Dr. Shulkin did a mini satellite media tour in which he did 6 back to back telephone interviews on Moonshot . (Leo Shane – Military Times)
- USA Today and Associated Press (Multiple Reporters) 07/2016
- USA Today, NYT, Etc – Media Avail at roundtable discussion to announce results of largest analyses of Veteran Suicide – 07/2016
- Gannett News (Keith Ryzewicz) 07/2016
- Year in VA & Military Medicine Magazine (Charles Oldham) 8/29/16
- NPR interview on VACAA Hiring Initiative (Quil Lawrence) 9/28/2016
- DC VA Medical Center site visit by Crowned Prince Fredrik of Denmark – USH interviewed by Danish TV on VA's future strategic vision. 9/29/16
- ReachMD/iHeart Radio Interview (Program hosts Mark Masselli and Margaret Flinter) 10/6/16
- The Business of Government Hour (Michael J. Keegan, host) 10-6-16
- USA Today (Reporter Donovan Slack / Exclusive: VA shuffles managers, declares 'new leadership') 10-18-16
- U.S. News & World Report (Michael Schroeder) 12/16
- USA Today interview (Donovan Slack) Exclusive: Internal documents detail secret VA quality ratings, 12/16
- NPR on Choice Hiring (Quil Lawrence) 12/16

9. Agreements or Arrangements

XX See OGE Form 278. (If, for your nomination, you have completed an OGE Form 278 Executive Branch Personnel Public Financial Disclosure Report, you may check the box here to complete this section and then proceed to the next section.)

As of the date of filing your OGE Form 278, report your agreements or arrangements for: (1) continuing participation in an employee benefit plan (e.g. pension, 401k, deferred compensation); (2) continuation of payment by a former employer (including severance payments); (3) leaves of absence; and (4) future employment.

Provide information regarding any agreements or arrangements you have concerning (1) future employment; (2) a leave of absence during your period of Government service; (3) continuation of payments by a former employer other than the United States Government; and (4) continuing participation in an employee welfare or benefit plan maintained by a former employer other than United States Government retirement benefits.

<u>Status and Terms of Any Agreement or Arrangement</u>	<u>Parties</u>	<u>Date</u> (month/year)
None		

10. Lobbying

In the past ten years, have you registered as a lobbyist? If so, please indicate the state, federal, or local bodies with which you have registered (e.g., House, Senate, California Secretary of State).

- None

11. Testifying Before the Congress

(A) Do you agree to appear and testify before any duly constituted committee of the Congress upon the request of such Committee?

Yes

[Letters from the Office of Government Ethics follows:]

UNITED STATES OFFICE OF
GOVERNMENT ETHICS



JAN 27 2017

The Honorable Johnny Isakson
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

In accordance with the Ethics in Government Act of 1978, I enclose a copy of the financial disclosure report filed by David J. Shulkin, who has been nominated by President Trump for the position of Secretary, Department of Veterans Affairs.

We have reviewed the report and have obtained advice from the agency concerning any possible conflict in light of its functions and the nominee's proposed duties. Also enclosed is an ethics agreement outlining the actions that the nominee will undertake to avoid conflicts of interest. Unless a date for compliance is indicated in the ethics agreement, the nominee must fully comply within three months of confirmation with any action specified in the ethics agreement.

Based thereon, we believe that this nominee is in compliance with applicable laws and regulations governing conflicts of interest.

Sincerely,

A handwritten signature in black ink that reads "Walter M. Shaub, Jr." in a cursive style.

Walter M. Shaub, Jr.
Director

Enclosures

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DEPARTMENT OF VETERANS AFFAIRS
Designated Agency Ethics Official

February 1, 2017

Walter M. Shaub, Jr.
Director
Office of Government Ethics
Suite 500
1201 New York Avenue, N.W.
Washington, D.C. 20005-3917

Dear Director Shaub:

I am enclosing a supplement to the ethics agreement that David J. Shulkin signed on January 27, 2017. Based on my review of the ethics commitment made in this supplement, it is my opinion that there will be no unresolved conflicts between his financial interests and the duties that he will be expected to perform as Secretary.

Sincerely yours,

A handwritten signature in black ink, appearing to read "Mark Jaynes".

Mark Jaynes
Alternate Designated Agency Ethics Official/
Deputy Chief Counsel

Enclosure

UNITED STATES OFFICE OF
GOVERNMENT ETHICS

February 2, 2017

The Honorable Johnny Isakson
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

By letter dated January 27, 2017, the Office of Government Ethics (OGE) transmitted to the Committee the financial disclosure report and ethics agreement of David J. Shulkin in connection with his nomination for the position of Secretary, Department of Veterans Affairs. Enclosed are a letter from the Department of Veterans Affairs and a letter from Dr. Shulkin supplementing Dr. Shulkin's ethics agreement.

We have reviewed this additional submission and have also obtained advice from the Department of Veterans Affairs concerning any possible conflict in light of its functions and Dr. Shulkin's proposed duties. Based on the information provided, OGE continues to believe that Dr. Shulkin is in compliance with applicable laws and regulations governing conflicts of interest.

Sincerely,
**WALTER
SHAUB**

Walter M. Shaub, Jr.
Director

Digitally signed by WALTER SHAUB
DN: c=US, o=U.S. Government, ou=Office of
Government Ethics, cn=WALTER SHAUB,
#9.23.32.1922616611001.1.0520100504655
Date: 2017.02.02 14:50:18 -0500

Enclosures

[Letters from David J. Shulkin, M.D., to the Office of General Counsel, U.S. Department of Veterans Affairs:]

January 27, 2017

Ms. Tammy L. Kennedy
Chief Counsel and
Designated Agency Ethics Official
U.S. Department of Veterans Affairs
Washington, D.C. 20420

Dear Ms. Kennedy,

The purpose of this letter is to describe the steps that I will take to avoid any actual or apparent conflict of interest in the event that I am confirmed for the position of Secretary of the U.S. Department of Veterans Affairs.

As required by 18 U.S.C. § 208(a), I will not participate personally and substantially in any particular matter in which I know that I have a financial interest directly and predictably affected by the matter, or in which I know that a person whose interests are imputed to me has a financial interest directly and predictably affected by the matter, unless I first obtain a written waiver, pursuant to 18 U.S.C. § 208(b)(1), or qualify for a regulatory exemption, pursuant to 18 U.S.C. § 208(b)(2). I understand that the interests of the following persons are imputed to me: any spouse or minor child of mine; any general partner of a partnership in which I am a limited or general partner; any organization in which I serve as officer, director, trustee, general partner or employee; and any person or organization with which I am negotiating or have an arrangement concerning prospective employment.

I received a severance payment from Atlantic Health System on July 2, 2015. Until July 3, 2017, I will not participate personally and substantially in any particular matter involving specific parties in which I know Atlantic Health System, or its hospitals, is a party or represents a party, unless I first receive a written waiver pursuant to 5 C.F.R. § 2635.503(c).

My spouse owns a medical practice, Merle Bari MD and Associates Inc. I will not participate personally and substantially in any particular matter that to my knowledge has a direct and predictable effect on the financial interests of Merle Bari MD and Associates Inc., unless I first obtain a written waiver pursuant to 18 U.S.C. § 208(b)(1).

I have been advised that the duties of the position of Secretary may involve particular matters affecting the financial interests of the following entities: ImaCor, Inc., Control Rad Inc., SpectraMD, Inc., and Electrocore, Inc. The Department has determined that it is not necessary at this time for me to divest my interests in these entities because the likelihood that my duties will involve any such matter is remote. Accordingly, with regard to each of these entities, I will not participate personally and

Ms. Tammy Kennedy
Page 2

substantially in any particular matter that to my knowledge has a direct and predictable effect on the financial interests of the entity for as long as I own it, unless I first obtain a written waiver, pursuant to 18 U.S.C. § 208(b)(1), or qualify for a regulatory exemption, pursuant to 18 U.S.C. § 208(b)(2).

I have an agreement with Hutchinson Biofilm Medical Solutions Ltd. that entitles me to receive a grant of stock options from the company if, at any time in the future, the company issues stock options. I will not participate personally and substantially in any particular matter that to my knowledge has a direct and predictable effect on the financial interests of Hutchinson Biofilm Medical Solutions Ltd., unless I first obtain a written waiver, pursuant to 18 U.S.C. § 208(b)(1), or qualify for a regulatory exemption, pursuant to 18 U.S.C. § 208(b)(2).

I will divest my interests in the following entities within 90 days of my confirmation: Amazon, Bank of America, Citigroup Inc., JP Morgan Chase, Morgan Stanley, Wells Fargo, and M&T Bank Corp. With regard to each of these entities, I will not participate personally and substantially in any particular matter that to my knowledge has a direct and predictable effect on the financial interests of the entity until I have divested it, unless I first obtain a written waiver, pursuant to 18 U.S.C. § 208(b)(1), or qualify for a regulatory exemption, pursuant to 18 U.S.C. § 208(b)(2).

I understand that I may be eligible to request a Certificate of Divestiture for qualifying assets and that a Certificate of Divestiture is effective only if obtained prior to divestiture. Regardless of whether I receive a Certificate of Divestiture, I will ensure that all divestitures discussed in this agreement occur within the agreed upon timeframes and that all proceeds are invested in non-conflicting assets.

I have been advised that this ethics agreement will be posted publicly, consistent with 5 U.S.C. § 552, on the website of the U.S. Office of Government Ethics with ethics agreements of other Presidential nominees who file public financial disclosure reports.

Sincerely,

A handwritten signature in dark ink, appearing to read "D. Shulkin", with a horizontal line extending to the right.

David Shulkin

February 1, 2017

Ms. Tammy L. Kennedy
Chief Counsel and
Designated Agency Ethics Official
U.S. Department of Veterans Affairs
Washington, D.C. 20420

Dear Ms. Kennedy:

The purpose of this letter is to supplement my ethics agreement signed on January 27, 2017. The following information supplements my ethics agreement:

I understand that as an appointee I will be required to sign the Ethics Pledge required under the Executive Order dated January 28, 2017 ("Ethics Commitments by Executive Branch Appointees") and that I will be bound by the requirements and restrictions therein in addition to the commitments I made in the ethics agreement I signed on January 27, 2017.

I have been advised that this supplement to my ethics agreement will be posted publicly, consistent with 5 U.S.C. § 552, on the website of the U.S. Office of Government Ethics with ethics agreements of other Presidential nominees who file public financial disclosure reports.

Sincerely,



David J. Shulkin

Chairman ISAKSON. We appreciate your service and your testimony.

For the Members' purposes, we are going to have at least two rounds of questions. We are going to make sure everybody has plenty of time to ask. We have a little bit of a gymnastics that is going on right now, so we will make sure everybody has time.

I would like for every member of the VSOs or the VSO representatives who are in the audience to please stand. The Veterans of Foreign Wars. [Applause.]

I want you all to understand something. You are the reason we are here. We are not the reason you are here. You are the reason we are here, to make sure we get the VA working as well as we can, as efficient as we can, and we thank you for your service to the country.

Now, I am going to ask Dr. Cassidy to come up and take my place in the chair until either Senator Moran gets back or I get back, and we will go back and forth, and my staff will tell you who to call on next. We will try our best to go Democrat, Republican, Democrat, Republican.

If you all do not mind, I am going to turn it over to Dr. Cassidy. Senator CASSIDY [presiding]. OK.
Senator Sullivan.

**HON. DAN SULLIVAN,
U.S. SENATOR FROM ALASKA**

Senator SULLIVAN. Thank you, Mr. Chairman and Dr. Shulkin. Welcome. Congratulations. I very much appreciate your service, your desire to continue to serve. I appreciate your family's service. I know it is a team effort and thank you.

You know, Alaska, my State, we have more vets per capita than any State in the country, and I appreciate very much your continued commitment, or your commitment as the Under Secretary, to come up to Alaska. I think you and I—it is safe to say we had a memorable trip up there. We met with hundreds of Alaskan veterans. I think you saw the deep patriotism that is embedded in the heart of every one of my constituents, the toughness, but also a lot of the unique challenges which you have been working with us on. I very much appreciate it.

Let me begin by trying to get a few commitments that relate to that. You came up as part of your Under Secretary confirmation process to the State, but if confirmed, can I get a commitment from you to come back to Alaska, and for you and I to spend some time, not only in the urban areas but some of the more very, very rural parts of the State, where, again, we have veterans all over?

Dr. SHULKIN. Senator, we had a very good trip and there is nothing I would enjoy more than doing it again with you.

Senator SULLIVAN. Great. I take it that is a yes.

Dr. SHULKIN. Yes.

Senator SULLIVAN. Great.

If confirmed, will you continue to work on the Alaska Pilot Program, which you initiated, in part, because of our trip together, which worked on addressing some of the unique challenges? I want to commend you for your focus on that, but as you know we still have work to do. Will you commit to me, if confirmed, to continue to work on those unique challenges that we have in the State?

Dr. SHULKIN. Well, Senator, first of all, I want to thank you, because you have been tireless in insisting that we get the program working. So, many of the pilots that we began, that are now spread throughout the country, actually started in Alaska, and I think we have demonstrated that it is now working better because of many of the initiatives that you started.

Senator SULLIVAN. Well, it is a team effort.

Dr. SHULKIN. Yes.

Senator SULLIVAN. I am glad that you and I worked together on these, and I want to continue to do that if you are confirmed.

You know, speaking of a team effort, you and I have had the opportunity, particularly on a lot of plane flights and things in Alaska, and hearings and office visits, to talk about a lot of issues, Alaska-related, national-related.

One of the things I did for this confirmation process was I reached out directly to the veterans in my State, and said, "Hey, what questions would you want to ask the incoming Secretary?" So, as you can imagine, we had dozens of responses, which I am going to relay a few here. The ones that we do not have time to discuss in the hearing we will submit for the record.

The first one meant a lot to me. It is from an Alaska veteran by the name of Bob Thoms. Cajun Bob is his nickname. He lives in

the Mat-Su Valley. This is somebody who has bled for his country. This is a Marine who has received six Purple Hearts, Silver Star, he was on the cover of Life magazine during the Battle of Hue City, Vietnam veteran. He is a hero among us.

I am sure a lot of the veterans in the audience can relate to this. He indicated, you know, an interest, certainly, in the issue, but still a deep distrust of VA. He is nervous that your appointment as Secretary is going to be more of the same, because, as you know, there has been promises and promises and promises, generations of promises. His focus has been where people are not held accountable and veterans are stuck in a system that works against them and not for them.

His question regarding your nomination, and vets like him, is he said he was hoping for someone who—and forgive the language here; it is a Marine—would kick ass and take names with regard to being the Secretary.

How can you assure veterans like Cajun Bob and others, not only in Alaska but throughout the country, that some of the big focuses that President Trump has talked about, on really shaking up the VA, are going to happen under your watch, when, to be honest, you have been part of the outgoing administration? This concern was a common theme from a lot of the questions we received. If you can answer that I would be very appreciative, and I know Cajun Bob would too.

Dr. SHULKIN. Well, first of all, I think when you and I go back to Alaska we should go meet with Cajun Bob. I think he would love that.

Senator SULLIVAN. You would love that.

Dr. SHULKIN. Yes.

Senator SULLIVAN. I would love that.

Dr. SHULKIN. Yes, and we will ask him how we are doing.

But, look. I think what Cajun Bob is saying is really important. If you do not have trust in the group that is empowered to take care of you and provide you services, you cannot do your job very well. So, —

Senator SULLIVAN. Do you think the VA has trust right now?

Dr. SHULKIN. I think that trust was eroded, particularly with the wait time crisis in April 2014, and many people lost trust. We know, when we first began to measure this last year, our trust level with veterans was at 41 percent. Today it is at 61 percent. So, I think that we are slowly regaining trust, but we have a long way to go.

What I would say to Cajun Bob is that, look, I approach things first as a doctor, and as a doctor I know no matter how smart I think I am, or if I, you know, did the best in my medical school class, if my patient does not trust me, they are not going to listen to what I have to say, then I am not going to be able to help them. So, I think that is very important.

As a health care executive, I look at our system in VA and I say if we do not have a modern system that is responsive to our veterans' needs, that we cannot perform our function. One of the things that I think most people would tell you about me is I do not have a lot of patience, and I am going to be serious about making

these changes and regaining that trust. If I do not do it, I should be held accountable and you should replace me.

Senator SULLIVAN. Thank you. Thank you, Mr. Chairman.

Senator CASSIDY. Ranking Member Tester.

Senator TESTER. Yes. Thank you, Senator.

When you interviewed for this job, and had to visit with the President, and you agreed to take the job, were there any conditions attached?

Dr. SHULKIN. I did have a chance to speak to President Trump, President-Elect at that time, about this position, and what we spoke about, he asked me several questions. He said, "Tell me what is your view on what is happening in VA now—"

Senator TESTER. OK.

Dr. SHULKIN [continuing]. "What you think needs to be done and what are the things that have to essentially occur?"

Senator TESTER. Yep.

Dr. SHULKIN. We shared the common vision that we have to do a lot better for our veterans.

Senator TESTER. Gotcha.

Dr. SHULKIN. We did not have specific preconditions in this job, and he knows that I would follow my values and do what I think needs to be done.

Senator TESTER. So, there were no conditions attached?

Dr. SHULKIN. There were no conditions.

Senator TESTER. Did you talk about privatization at all?

Dr. SHULKIN. Yes, we did.

Senator TESTER. What was his definition of privatization and what is yours? Are they the same?

Dr. SHULKIN. Well, I did not ask him his definition. I told him what I thought needed to happen, and—

Senator TESTER. Tell me what that definition is.

Dr. SHULKIN. What I told him is that I am a strong advocate for the VA, that the services that are available in VA are not available in the private sector, and that my view of where VA needs to go is an integrated system of care—

Senator TESTER. OK.

Dr. SHULKIN [continuing]. Taking the best of VA and the best in the community, and that is what I would work toward.

Senator TESTER. OK. You have mentioned before that the wait time or the mileage is what you would use. So, give me your definition. If I am a veteran and I have got a problem—say I have a cold—and I want to go to my local doc. Are you going to let me do that, or are you going to say, "No. Go to the nearest VA facility," if there is one down the block?

Dr. SHULKIN. Well, I think there are two parts to your question, because it is really the key issue. How do you design a health care system that works for veterans? I would not have designed it based upon mileage and on wait time.

Senator TESTER. OK. That is fine.

Dr. SHULKIN. OK? I would design it based upon clinical need. What we really want to do is make sure that the veteran can get to the services that they need in health care in a timely fashion. That is why I focused on urgent care issues. That is why there is

now primary care, same-day access and mental care—mental health same-day access in every VA across the country.

For somebody who needs to see their doctor that day, they should be seen. If they cannot be seen in the VA, they should be seen in their community.

Senator TESTER. That goes for any condition? If they cannot be seen that day—so of the docs in a hospital or a CBOC are booked up and somebody comes in and has the flu, if they cannot get in you send them to the doc—send them to local hospital or local clinic?

Dr. SHULKIN. Senator, what I am talking about is a clinical definition of urgent care.

Senator TESTER. OK. Gotcha.

Dr. SHULKIN. I do not want any veteran in this country—

Senator TESTER. That is—the urgent care—

Dr. SHULKIN [continuing]. In harm.

Senator TESTER. Yeah, I gotcha.

Dr. SHULKIN. OK? For a cold, OK, now you are—

Senator TESTER. That is—

Dr. SHULKIN [continuing]. Getting a doctor's advice—

Senator TESTER. Yeah, yeah.

Dr. SHULKIN [continuing]. We may be able to help you over the telephone through telehealth, et cetera.

Senator TESTER. OK. That is fine.

So, can you talk a little bit about the Choice Program and what has—because, I mean, that has kind of been your baby, right? Can you tell me why a veteran, for example, in Plentywood, MT, would be on a telehealth screen to a doc within a clinic or CBOC, and that doc tells that veteran that he needs a chest x-ray, and then they have to go through the VA to get confirmation that that chest x-ray actually is going to be taken care of the by the VA, and 2 weeks later that person gets a chest x-ray?

Dr. SHULKIN. Yeah. I cannot tell you that that makes any sense. What we did in the Choice Program was we added a layer of additional administrative complexity, where instead of the VA being able to help the veteran, as they always did, you now had to go through a third-party administrator. That led to a delay in care, in many cases, too many cases.

Senator TESTER. Yeah.

Dr. SHULKIN. You have been describing a few already.

Senator TESTER. Yeah.

Dr. SHULKIN. We need to take that layer of complexity out. The VA needs to take back the customer service—

Senator TESTER. OK.

Dr. SHULKIN [continuing]. And the scheduling.

Senator TESTER. Excuse me, because I framed it wrong. I am not even talking about the ones who go to the Choice Program. I am talking about the ones that have VA care, where a VA doc looks at them and says, "You need an x-ray," yet it takes 2 weeks to get that x-ray. This is in a private facility, by the way, that is contracted with the VA, and it takes 2 weeks to get the x-ray done. I mean, that makes no sense whatsoever.

Dr. SHULKIN. It makes no sense whatsoever.

Senator TESTER. What can we do to fix it?

Dr. SHULKIN. Well, what we have to do is, first of all, we do know the Choice Program has added complexity. If what you are saying is there is a delay in getting contracted care—right?

Senator TESTER. Right.

Dr. SHULKIN. When a doctor orders an x-ray, there should not be a lot of intermediary steps there. We should be able to go directly and be able to get that x-ray.

Senator TESTER. I gotcha. What can be done to fix it, though? Then I will kick it off—

Dr. SHULKIN. Well—

Senator TESTER [continuing]. Because I am out of time.

Dr. SHULKIN [continuing]. We are going to remove the bureaucracy in between, because there is no benefit to that 2-week delay.

Senator TESTER. We will get to Choice on the next round. Thank you, Mr. Chairman.

Senator CASSIDY. Yes.

Next is Senator Rounds.

**HON. MIKE ROUNDS,
U.S. SENATOR FROM SOUTH DAKOTA**

Senator ROUNDS. Thank you, Mr. Chairman.

Dr. Shulkin, first let me begin by just saying that I appreciated the opportunity to visit with you in my office the other day. I shared with you then that I appreciated the way that you came into the VA. You are one of the guys that came in when—even in the campaigns they were not talking about Washington as a swamp yet. They were talking about the fact that—and on several occasions, with Mr. McDonald, Secretary McDonald, we talked about the fact that you two guys came in knowing that you were in the middle of something that you had to fix. It was at a time in which you had a billion-dollar overcost or an overrun on one single hospital in Colorado, yet you guys came in, and you came in with the intent of fixing and making things better for veterans, and I appreciate that.

At the same time, I want to just touch on a couple of issues that you and I have talked about in the past, that I want to get into a little bit more today, as we said we would during that meeting in my office.

First of all, the Black Hills VA system in Hot Springs, SD, where, as you know, there is a host of individuals there that have—for literally since that town was created—serviced veterans in in-treatment facilities. They have also made it very clear that they want to continue that. As a matter of fact, they are one of your five-star facilities in the United States.

Secretary McDonald had suggested some significant changes there. In our meeting the other day, you indicated a willingness to take a look at finding something that will work for the community of Hot Springs in their desire to serve veterans. Would you expand on that a little bit, and once again just commit that you will take a second look at it and see what we can do to make this work, for the veterans, to make it better for them, in that whole area? It is not just South Dakota. It is Wyoming. It is Colorado. It is Nebraska as well.

Dr. SHULKIN. Yeah. I think it was the afternoon after we met, I already had a chance to get on the phone with the VISN director and the facilities director out in that area, and I had them go through their rationale about how they got to their decisionmaking. I had some additional questions, much like you, and I appreciate you bringing those to my attention.

We are going to re-look at this. There were actually a couple of options on the table, all that I can understand how they got to where they got to, but I think that there are some additional questions. So, I have begun the process of looking at that and will get back to you and discuss with you about what some of those options are. I actually want to get your thoughts on how we can serve the veterans in that area best.

Senator ROUNDS. Very good. I think the veterans in that area, and most certainly the community of Hot Springs, as I say, that community came into existence, really, to serve veterans, and it is one of the oldest in the United States. I appreciate that and your interest in working with us.

The second item is one that I think is probably a little less comfortable in discussing, and that is the Emergency Care Fairness Act, that was passed by this Congress in 2009, and signed by the President in 2010. What this was, for the benefit of folks out there that may not understand it, this basically said that if a veteran ends up going to an emergency room, even if they wanted to go to a VA center, if the emergency care was delivered at a non-VA facility, the VA would pick up the cost of that emergency room treatment.

Shortly after that occurred, rules were revised within VA that did exactly the opposite, indicating that they would act as a secondary payer only. Even with veterans who have Medicare, any deductibles or copays, the VA has said, "Sorry. That is a secondary payment and we are not responsible for it." So, they have not made any of those payments. In fact, I think the total costs on that are into the billions of dollars now, which are on the backs of veterans.

Now, Congress' intent was pretty clear and, in fact, not only has there been one court case on it, which went in favor of the veterans, there has now been an appeals case, which ruled that VA is wrong. In fact, let me just quote this to you—

Dr. SHULKIN. Mm-hmm.

Senator ROUNDS [continuing]. This is the way that it comes up. This is in the case of *Staab v. McDonald* which says, "And the VA needs to find a way to pay for it."

So, let me just lay this out for you. This particular product is one in which the court said the VA is wrong, and the VA needs to pay these copays and deductibles for those facilities that are outside of a VA facility, which was the direction from Congress.

Now that is two court cases right in a row. My understanding is that you have had a chance to take a look at this.

Dr. SHULKIN. Mm-hmm.

Senator ROUNDS. The reason why it came to my attention is we had two different times in which there were requests to hotline bills in the Senate, suggesting unanimous consent items that would have reversed that law, which would have taken VA out of paying

literally billions of dollars, and it would have dumped it on the backs of veterans, after the fact.

Now, we stopped both of them.

Dr. SHULKIN. Mm-hmm.

Senator ROUNDS. What I would like to know, sir, is your opinion on the bill and where you see us going from here, with getting that resolved.

Dr. SHULKIN. Yeah. Well, right now my opinion does not matter because this is law. The judges have ruled, and you have accurately described the situation. I have instructed VA to start putting together—and they are doing this now—the regulations that it is going to take to be able to start paying these bills, these emergency room bills, and every day that we delay, veterans are being put in the middle, and that is really unfair to them.

Senator ROUNDS. Dr. Shulkin, here is the reason why people get discouraged with this. This is exactly the conversation that you and I had, and that was my understanding. Yet just today, in my office, I received a letter. I was surprised to receive a letter from the VA, in reply to our letter, which we had sent in asking the VA to reconsider their position. In today's letter it stated that the current status of the bill is still active, on appeal, and requires an opening brief to be submitted on February 6, 2017—

Dr. SHULKIN. Yes.

Senator ROUNDS [continuing]. Indicating they continue to do battle on this in the courts.

Dr. SHULKIN. Let me clarify our position.

Senator ROUNDS. OK.

Dr. SHULKIN. I have already said—your facts are correct. This is law and we are moving forward to start paying these bills. However, VA does not believe that the court interpreted the statute correctly. So, the Department of Justice—and this is since you and I had a chance to meet—has just decided to accept the appeal. So, the Department of Justice will appeal this, and we will see what happens.

In the meantime, I am not going to allow veterans to be put in the middle, like we have been continuing to do. We are going to move forward and we will do it with speed, to make sure that we start paying these bills as soon as we possibly can. But, there will be—the Department of Justice has decided to take up this case.

Senator ROUNDS. Just for the record, I understand—I know that I am going over my time, Mr. Chairman, but this is in terms of more than \$3 billion, and in some cases estimated at more than \$10 billion of debt which veterans will have if the VA does not pay it. Dr. Shulkin, you do not have the money in your budget. Are you prepared to ask this Congress for the appropriate funds to get the bill paid if—

Dr. SHULKIN. Well, I will try to be brief as well. The concern that VA has—having said we are moving in the direction that I think you are comfortable with—the concern is this is a new interpretation of a benefit for veterans who have other health insurance and who are not service-connected. If we do not get additional funds authorized, that money will come from the services that we provide today to veterans, and they will have less health care available.

So, yes, we will come to you and ask you to help support, with additional funding, this new benefit if it is not overturned in an appeal by the Department of Justice.

Senator ROUNDS. Let me note that it was a benefit that was directed by Congress—

Dr. SHULKIN. Yes.

Senator ROUNDS [continuing]. In 2009, and signed into law in 2010.

Dr. SHULKIN. You are correct, sir.

Senator ROUNDS. Thank you, sir.

Dr. SHULKIN. Yes.

Senator ROUNDS. Appreciate it.

Senator CASSIDY. Senator Sanders.

HON. BERNARD SANDERS, U.S. SENATOR FROM VERMONT

Senator SANDERS. Thank you, Mr. Chairman, and Dr. Shulkin, thanks for dropping in the other day and thanks for being here. Thanks for all the veterans and veterans' organizations for being here.

Let me just jump into a couple of issues. There is an effort, and probably being led by the Koch brothers, to privatize virtually every government agency. Will you oppose the privatization of the VA?

Dr. SHULKIN. I have been clear. I am opposed to the privatization of the VA.

Senator SANDERS. Let me pick up on a point that Senator Rounds just made a moment ago and broaden it a little bit.

No agency of government can do its job unless it has an adequate budget. Will you be 100 percent honest in coming before this Committee and telling us what the needs are of the VA, in terms of making sure that every veteran in this country who goes to VA has the quality care that he or she needs?

Dr. SHULKIN. Senator Sanders, I see that as one of the primary responsibilities of a Secretary. I absolutely will do that.

Senator SANDERS. So, you do understand that there will be pressure on you; that, generally, administrations, no matter what they may be, try to tell heads of agencies to tamp down on their requests. But, what I think is needed is, speaking for, I hope, the whole Committee, is that we want you to ask for what you need.

Dr. SHULKIN. Yeah. I have not been in Washington as long as you, but in my short time I have already figured out exactly what you are saying. Yes, I will commit to that.

Senator SANDERS. Thank you.

In our chat the other day, you told me something that I did not know—I did not know and I do not know that other Members of the Committee know, so, correct me if I am wrong. You told me that there are now 45,000 vacancies just in VA health, not to mention other parts of the system. Is that correct?

Dr. SHULKIN. There are 47,230 vacancies now throughout VA.

Senator SANDERS. Throughout VA.

Dr. SHULKIN. Throughout VA. Most are in health.

Senator SANDERS. OK.

Dr. SHULKIN. Not all.

Senator SANDERS. I have to believe that with that number of vacancies that has an impact on the quality of care and the timeliness of care that veterans receive.

Dr. SHULKIN. We believe it does.

Senator SANDERS. Do you have the resources now to fill those vacancies?

Dr. SHULKIN. Yes. Yes. Our budget—every position that we are recruiting for—those are active recruitments—has a budget associated with it. Yes, sir.

Senator SANDERS. As I understand it, President Trump's freeze on Federal hires will not impact you?

Dr. SHULKIN. I have been very pleased that after the freeze memo came out we went immediately back to the White House and said that this would impact us, and we got an exception for all of the positions that are critical related to health and safety. I feel very comfortable with that. Of the 47,230 that we are actively recruiting for, about 37,000 right now are excepted.

Senator SANDERS. OK.

There is no question, I think primarily for political reasons, the VA has been beaten up a whole lot in recent years, by politicians, by the news agencies, and so forth. That is not to say that the VA does not have serious problems, but it does say that our entire health care system has serious problems, not just the VA.

Now, when I was Chair of this Committee, we had a meeting right in this room, right at that table. We had the leadership of every major veterans' organization in the country, where I asked a pretty simple question. It was, "If and when people get into the system, understanding there are unacceptable waits to get in, but once they get into the system, do you believe that the quality of care that veterans are receiving is good?"

What I will not forget, and I want to ask you that same question, is, without exception, every leader of every major veterans' organization, from The American Legion, VFW, DAV, on down, said once people get into the system, by and large the quality of care is good, very good, excellent. What do you think?

Dr. SHULKIN. Well, even more important than what I think, there have been numerous independent studies by academic centers and other groups that have studied this, and consistently they have found that the quality of VA care, particularly when it relates to mental health, primary care measures, screening measures, safety measures, quality measures in general, is actually superior in the VA system to the average of the private health care system. I do want to add, though, that does not mean that we are perfect. About 5 to 6 percent of our hospitals in the VA system are actually below where they need to be.

Senator SANDERS. That is a fair point. But, let me just reiterate that for the benefit of all three of us who are here—

[Laughter.]

Senator SANDERS [continuing]. Which is, every person here wants the VA to do better. I do not think there is a partisan division on that.

Dr. SHULKIN. Yes.

Senator SANDERS. But, I think it is also important that before we go beating up VA every day, run to CNN or all the newspapers,

anyone, saying VA is terrible, that we understand—and you correct me if I am misreading this—there was a recent report that came out in RAND—

Dr. SHULKIN. Yes.

Senator SANDERS [continuing]. Which is an independent think tank, which I think was actually commissioned by legislation that we passed.

This is what it said; and tell me if you agree with the quote. “In a tally of 83 different measures, covering a variety of types of care, including safety and effectiveness of treatment, the quality of VA health care exceeded that of non-VA care.” End of quote.

Do you think that is a valid—

Dr. SHULKIN. I read the same study you did and I think that has been shown by other groups as well.

Senator SANDERS. Just on one issue, in terms of mental health, that I hope, Mr. Chairman, we can work on. Right now, if a veteran needs mental health care from VA, as I understand it, he or she can get that care, but amazingly enough, he cannot bring in his wife or girlfriend or spouse or whatever it may be. I am not quite sure how you treat an individual without bringing family members in.

Is that something you think we should—I know that is the case by law now. Is that something we might want to look at?

Dr. SHULKIN. Well, I think what we do know is when we send a soldier off to battle, we are sending the whole family off, and so often many of these issues that are so difficult to deal with have to be dealt with in the family unit, which is very important. I do think that if our goal is—and I know it is our shared goal, to be able to help treat and address this issue—we need to think about different ways of doing that, and including the family as part of that, I think, is going to be an important way to find solutions.

Senator SANDERS. Mr. Chairman, I would hope that we could work together on that issue.

Chairman ISAKSON [presiding]. We certainly will. And we are going to work at sticking to 5 minutes so we can have enough rounds to get everything in.

Thank you, Senator Sanders.

Before I rotate the turn, because Senator Tillis is going to be next, let me just ask this. Dr. Shulkin, do you know of any health care systems in the country that have more than 6.5 million patients and 314,000 personnel?

Dr. SHULKIN. I am not aware of one, sir.

Chairman ISAKSON. Is not that the right numbers for the VA?

Dr. SHULKIN. Yes.

Chairman ISAKSON. So, in answer to your question, we have got 314,000 personnel delivering medical services to 6.5 million veterans. Those are the biggest numbers in the country. You are going to have a slip-up every now and then.

Yet, there are good stories out there. We are going to do two things. We are going to fix the slip-ups—you know, no more terrible stories like finding maggots in somebody’s wound or things like that, which are sensationalized. Senator Tester and I have talked about making statements on the floor about every 2 weeks, telling the good stories of the VA, so you better be having some.

If there are bad stories, we want to tell those too, including how we have corrected them, so we dispel what is happening right now, where the media is just making a story out of anything that comes out of VA.

With that said, Senator Tillis, you are in charge.

Senator TILLIS. Well, thank you, Mr. Chair.

Chairman ISAKSON. For 5 minutes.

HON. THOM TILLIS, U.S. SENATOR FROM NORTH CAROLINA

Senator TILLIS. Oh. First off, just for those of you out here, all the Members on this VA Committee are interested in this hearing. They happen to be playing the dance that we are doing right now. I, for one, am missing a vote right now, and I have asked them to go ahead and call the vote so they can get to the next one, so that I could have this discussion.

Dr. Shulkin, and Mr. Chair, I do not even know if this is allowed within the rules, so I will not do it, but I am just curious, with the number of VSOs who stood up here, I would be really curious if they were willing to do this without a request from me. How many of them would raise their hand to the idea of we want to completely and utterly privatize the VA? [Pause.]

I did not break the rules but it seems to me that there are not a whole lot of people who are behind this. I know that you are not.

Dr. SHULKIN. Right.

Senator TILLIS. The reason that I mention that is I am tired of some of the suggestions by Members of Congress who say that there is some plot out there, or agenda, to do it. It is simply not true.

We need to get Choice to work. We have had discussions about that. We have to recognize that 30 to 40 percent of all VA care comes from non-VA providers. Then, we just need to get it right, so the brick-and-mortar presence is exactly where it needs to be to provide the best care to the veteran.

Anyone in this body who tells you that there is a movement afoot to privatize the VA has either been mislead or they are trying to mislead you, and I am not going to be a part of that, nor am I going to stand for it.

I think you are great. I have already told you I am going to vote for your confirmation. You have done a great job in your current capacity. You have got about as many friends in Alaska as polar bears. I am glad to hear that. [Laughter.]

You have been down to North Carolina.

Dr. SHULKIN. Yes.

Senator TILLIS. I like the idea that the Administration showed wisdom in bringing somebody in who has a bird's-eye view of the transformation plan. A lot of what Secretary McDonald was trying to accomplish makes sense. Some of it we can make better. I know that I have your commitment to follow through and build on those 12 breakthrough priorities, putting pressure on Congress to take action, which we have not yet, to enable you to actually execute those priorities.

Are you going to come before this body and commit to me that you will be shooting straight with us, to say for us to get the work done so that you can fulfill a commitment to transform the VA?

Dr. SHULKIN. Yes. Absolutely. First of all, your involvement in helping us, and along with—

Senator TILLIS. Senator Tester.

Dr. SHULKIN [continuing]. Senator Tester as well, we really appreciate. I could not agree with you more. There is a lot of very, very good work that has been done that we want to build upon, but as Secretary, it would be my job to make sure that you allow me to have the tools and the resources and the authority to be able to get this work done, to make the progress that we need to make. And I expect to be held accountable if you give me that authority and I am not getting the job done.

Senator TILLIS. Thank you. I also meant to mention that I have thoroughly enjoyed having Senator Tester over in our office, talking with the VA over the last year. He has shown up every time. We have had great discussion and I look forward to, with the Chair's indulgence, of allowing us to continue to do that with you all.

Two things I want to get to very quickly. One, as close to a yes-no answer would be great. The Community Care RFP, or request for proposal, that was issued in December—I think December 28—in some ways some people are viewing that as kind of a midnight rule that we would have liked to have spent some time talking under the new Administration about the priorities of that RFP. What are your plans, as Secretary, with this RFP?

Dr. SHULKIN. We have instructed a group, in the next 2 weeks, to give us their assessment on whether this RFP has enough flexibility to allow us to do the types of transformation that we need to do or whether we need to take a pause. So, in 2 weeks we are going to have an answer to that.

Senator TILLIS. We would like to get that report as soon as possible—

Dr. SHULKIN. Yes.

Senator TILLIS [continuing]. Because, obviously, this may or may not fall under things that we could do with a resolution of disapproval. I do not think that is productive. We would make sure—I would like to make sure that our Members are consulted and those who may not be familiar with it know the implications of your assessment.

The last thing that I want to talk about, we spoke about in my office earlier. We need to have you come back and tell the Congress when we are the main reason why you cannot do what you want to do. We need to have some frank discussions about limits that we are placing on you. I shared with you, in my office, a situation where the VA were making a good decision to consolidate a presence in very close proximity and you were not allowed to do something that would have improved the care and access in an area that I went to visit.

I hope I have your commitment to come before this body and say, "We will do this because you have told us to, but it is at the expense of an improved level of access and care," wherever that may be. I think we cannot have it both ways. We cannot constrain what, in your best judgment, is the best way to serve veterans and then come up here and quietly prevent you from doing that.

Do I have your commitment to have that open dialog with us?

Dr. SHULKIN. Absolutely. I think if we continue the status quo, that is not going to get us where we need to go.

Senator TILLIS. Unless we want to put a mirror down there at the witness stand and blame us for suboptimizing what we can do for the veterans.

Then, a part of that also has to be making the tough decisions about the inventory of brick-and-mortar presences that no longer make sense. We have got to make sure that the focus is on the veteran. It is not on a job or two here and there, which is important but it is not near as important as making sure that we have optimized our presence and our footprint in every State in the Nation.

Thank you. I look forward to working with you.

Dr. SHULKIN. Thank you, Senator.

Chairman ISAKSON. I am sorry. We will go to Senator Boozman and then Senator Brown.

Senator BROWN. No. We are not going back and forth, Mr. Chairman.

Chairman ISAKSON. Well, I am trying to do, time-wise, the best I can, and some we are doubling up, in some cases. I will make sure you have plenty of time.

Senator BROWN. Thank you, Mr. Chairman.

HON. JOHN BOOZMAN, U.S. SENATOR FROM ARKANSAS

Senator BOOZMAN. Thank you, Mr. Chairman.

The Choice has really been very effective in Arkansas. Alone, over 4,500 community providers are providing veterans with quality care, with close to 13,000 individual veterans being served between July 2015 and November 2016. That is really a good story and we really do appreciate the efforts, and I know you have been right in the middle of that.

The IG report that came out, you know, talked about cumbersome authorization and scheduling. Can you talk a little bit about both of those things, and really, in particular, the scheduling aspect? That is something that I know, with your background, you are very, very familiar with—

Dr. SHULKIN. Mm-hmm.

Senator BOOZMAN [continuing]. It is a solvable problem. Can you talk a little bit about how we do a better job of getting that done?

Dr. SHULKIN. Senator, the two things on the IG report, on Choice and on scheduling. Is that correct?

Senator BOOZMAN. Yes, sir.

Dr. SHULKIN. OK. The IG report, which just recently came out on the Choice Program, covered a time period from November 2014 to September 2015, and it described, I think accurately, a program that was in disarray. Since then, we have made, with your help, four changes to the law, 50 contract modifications. We have completely changed the ability, so now VA employees can make out-bound calls. We have changed the episode from 60 days to a year.

We have made this a much, much different program than it is today, and we can see the result. More veterans are able to schedule appointments. We now have over a million Choice appointments that have been scheduled by veterans, which is a good thing—or a million veterans have used the Choice Program; 6 million appointments.

In terms of scheduling, we still have not given our employees the right tools to be able to do their job well. They are using what I would call old blue DOS screens to schedule, and I do not know how they even do their job. Thank God they are so good at what they do.

We need to give them new tools. I have asked, and we are moving forward with a commercial scheduling product for scheduling. It is called MASS. We also have an internal scheduling program. We call it—because everything has an acronym in VA—called VSE. That will be ready for a decision on February 10, whether it is a go, no-go. It is deployed to about 10 sites where it is being tested by our employees, and we are going to make a decision on that as well.

So, the bottom line is we need a new scheduling system. We have known that for years. We are finally going to do it.

Senator BOOZMAN. Good. Very good.

One thing that has come up, I know that, you know, we have struggled forever with the process disability compensation claims, to try and get those done in a timely manner. I have been on the Committee now for—in the House and the Senate for 15 or 16 years, and this is something that just has always been a problem. I know that you have worked on it really hard and the numbers have come down. That is a good thing.

Particularly, the backlog to receive medical disability exams, and I think at one time it was 600,000.

Dr. SHULKIN. Mm-hmm.

Senator BOOZMAN. We are down now to closer to 60,000, and moving in the right direction.

I guess recently we have redone the contracts and things?

Dr. SHULKIN. Mm-hmm.

Senator BOOZMAN. There is some concern that, you know, the people that did such a good job getting it in this situation. We have got new folks coming in and there is concern that they do not have the resources to actually, in a timely fashion, get set up and get the job done.

What we do not want to do is get ourselves back in the situation of having the—can you just talk about that and kind of talk about the concerns?

Dr. SHULKIN. I think you are correct. We have decided to take on a new contract, to outsource a contract to a vendor. We awarded that. That was protested by two companies that did not win the award. The GAO actually took a look at our process and said that VA did things correctly. But, this is now being considered through a court process, and we heard today that we are likely to hear back on that protest through the courts in June.

Until then, we have a bridge contract. I spoke to our Acting Under Secretary today, our Acting Under Secretary of Benefits, who assures me that veterans are getting the C&P exams that they need, that we are not seeing a delay, because we are able to use the bridge contract as well as those clinicians who work in VHA.

So, we have to wait until June and we will see what the resolution is through the courts.

Senator BOOZMAN. Very good. One further thing, and then we are running out of time.

You are a private sector guy. You have run all kinds of operations, been very, very successful. You have had the ability, in those entities, to hold people accountable. Can you talk a little bit about what you need to do and what tools we need to give you? Marco Rubio has a bill.

Dr. SHULKIN. Mm-hmm.

Senator BOOZMAN. Others have bills.

Dr. SHULKIN. Mm-hmm.

Senator BOOZMAN. Tell us a little bit about that. That is just a basic component of running a—

Dr. SHULKIN. Absolutely. When I talk about the tools that a Secretary needs to do their job, a basic function of any chief executive is to be able to get the right people working in the organization, and those that do stray from the values that we hold have to leave the organization. We do not currently have that right on either side, so I see this as a dual-pronged process.

For those employees that really do not belong in the organization, the Secretary needs the ability to be able to remove them. We have—we were given expedited authority to remove employees through the Choice Act, which you gave us. Unfortunately, it was determined to be unconstitutional, and now the Department of Justice did not choose to go and to defend that.

So, we are going to need new tools, and I am going to need to come back to you, and we need to figure out a way that we can make what you wanted to happen work better and make it constitutional.

On the other side, a Secretary also needs the ability to retain, reward, and recruit those types of employees that we all want serving veterans, and we have been hampered in our ability to use the tools that we once had to be able to retain and recruit the very, very best. And, fortunately, the vast majority of our employees are people that we are all proud of. I am proud to work with them, I am going to stand behind them as Secretary, and I want the tools that we can make sure that we have the very best people in this country serving our veterans.

Senator BOOZMAN. Good. Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Boozman.

Senator Brown.

HON. SHERROD BROWN, U.S. SENATOR FROM OHIO

Senator BROWN. Thank you, Mr. Chairman. Thanks, Dr. Shulkin. It is nice to see you again. I enjoyed our conversation.

First, Senator Tillis talked about the paranoia, it seems like, on their side of the aisle, that the people at the VA might want to privatize. Well, the fact is the President has talked about privatization. The fact is the President spoke out against changing Medicare: voucherizing, privatizing, raising the retirement age, the eligibility age; and then is trying to put a Secretary of Health and Human Services in who has devoted his Congressional career to privatizing, voucherizing, raising the eligibility age.

So, I think it is important that all the VSOs here represented, all the people that care about veterans, all the people on both sides of the aisle here that think the VA should remain a public system with the Choice Act, understanding it not be privatized, continue

to speak out. That is why I am pleased that Dr. Shulkin has said that in response to Senator Tillis and that Dr. Shulkin has said to me, privately, and to many others, that he will absolutely resist privatization.

I am also concerned because I know the President has advisors, paid and unpaid, who are pushing him hard on privatization of the VA, so it is important that we all be vigilant.

That is, anyway, all I wanted to say there.

The hiring freeze, you spoke about it yesterday. I am concerned about the hiring freeze, what it does to the 400,000 pending disability compensation and pension claims at the VBA. I wanted you to just answer yes or no, because of us getting back for votes and all. You are committed, I assume, to VBA processing claims quickly, speeding that up? Yes or no.

Dr. SHULKIN. Yes.

Senator BROWN. How many vacancies exist at VBA for claims processing?

Dr. SHULKIN. I do not have the specific number. There are 47,230 across VA. We have an exception for 37,000. VBA is not part of that exception, so I spoke to the Acting Under Secretary today, who has assured me he has metrics on what is happening to these claims. If we are seeing a big concern with that, I do plan on going back and addressing that.

The problem is without getting your benefits you cannot get access to health care, so these two are connected.

Senator BROWN. Well, they are connected, too, in the sense that the President's freeze, while there are exemptions, the understanding is the exceptions do not include human resource specialists. I do not know how you hire enough medical professionals. I hope that you will go back to the White House and explain this, from fruits to nuts, so they understand what damage this is doing to processing those claims and elsewhere in the VA system.

Dr. SHULKIN. I do plan on that.

Senator BROWN. Thank you.

I want to talk briefly about something. In Dayton, last December, the Secretary signed a memorandum of agreement with the city of Dayton, OH, and local organizations, to establish VA's History, Research and National Heritage Center. You are familiar with this MOA?

Dr. SHULKIN. Yes.

Senator BROWN. I need your commitment to fully implement it. This project has taken longer than it should have, almost 7 years. Please review it and begin implementation as quickly as possible.

Dr. SHULKIN. It is a terrific program. Yes, sir.

Senator BROWN. Thank you. Thanks. It means a lot to that community.

Last question. In my State, in Ohio, 11 million people, 25,000 veterans, 12,000 of their family members gained coverage because of the Affordable Care Act, because of Obamacare, either the federally run exchange or Medicaid expansion. I want your support to guarantee health care for our Nation's veterans and their families, including those that would be harmed by an ACA repeal.

Dr. SHULKIN. Well, that is why the VA is here, and that is our mission. So, we will do everything that we can, if there is an influx of veterans into our system. Yes, sir.

Senator BROWN. Does that mean that you will use your seat in the Cabinet, as you sit around the table with perhaps Secretary Price and the President of the United States and the Vice President of the United States, all who have campaigned on repealing the Affordable Care Act? Does that mean you will use your seat at the Cabinet table to push back on the Administration's attempts to limit access to care for all of them, including those 25,000 veterans?

Dr. SHULKIN. Senator, if I am confirmed, my sole focus is going to be on making sure that veterans' needs are met and on veterans getting the services that they need. That is going to be my role in the Cabinet. I see that as a very important responsibility, and I am going to speak up on behalf of veterans.

Senator BROWN. OK. Thank you for the way you said that. My fear is that if the Affordable Care Act is repealed, 22 million people lose their coverage. There is no plan that anybody has come up with yet to replace it. I care about all 22 million of those. I especially care, as I know you do, about the 25,000 veterans and 12,000 family members who would also lose coverage if that is done. So, I ask you to speak out, as difficult as it might be when you may be the only one in the room speaking out, not just for primarily those veterans but how they will fall through the cracks if they do not really replace the repeal of the Affordable Care Act.

Dr. SHULKIN. I appreciate that.

Senator BROWN. Thank you.

Chairman ISAKSON. Just for a clarification, the repeal of the Affordable Care Act would not affect a veteran, because the Veterans Administration is open for business and operated by the VA.

Senator BROWN. Mr. Chairman, respectfully, the ACA did insure 25,000 veterans and 12,000 family members that were not insured prior to the ACA, because they fell through the cracks at the VA.

Chairman ISAKSON. But, we have made clear there is no privatization of the VA and there is no diminishing of the VA. We are not going to do that, nor are we going to take away any of their valuable current holders. [Pause.]

We have a fourth vote and then a fifth vote, which is coming up, and I am going to make both of those votes. I am going to ask Senator Rounds to fill in for me as Chair. Senator Manchin—have you asked questions yet, Senator Manchin?

Senator MANCHIN. No sir.

Chairman ISAKSON. Well, what we will do, if that is OK with—are you ready? Do you want to ask yours now, Dan?

Senator SULLIVAN. If that is OK, Mr. Chairman.

Chairman ISAKSON. Dan has got to go back, and you have got—I will go with Dan and then you. [Pause.]

OK. Well, I think we can get both of them in before the last vote is over. I will make sure—the cloakroom is looking for you, so we will hold it open. [Pause.]

Senator Sullivan, come forward. Oh, go ahead, Senator Rounds.

Senator SULLIVAN. Thank you, Mr. Chairman, and my good friend from West Virginia, thank you.

Dr. Shulkin, you know, you were talking about accountability, which you and I have had that discussion, and you have already had a lot of questions on that. The authority that was provided you in the Choice Act, you welcome that, do you not?

Dr. SHULKIN. Yes.

Senator SULLIVAN. So, you mentioned it was determined it was unconstitutional—just—I believe a court determined it was unconstitutional. Did not the Justice Department say it was unconstitutional?

Dr. SHULKIN. My understanding of this, and I am not a lawyer—I know you are, so I am on dangerous grounds—

[Laughter.]

Dr. SHULKIN [continuing]. My understanding is a court did determine—

Senator SULLIVAN. OK.

Dr. SHULKIN [continuing]. That this was unconstitutional. The Department of Justice failed to accept our request to appeal that, so we were pretty much stuck and we were overturned.

Senator SULLIVAN. OK. Well, we want to work with you because I think that is a bipartisan area of agreement that the trust that you were talking about, with regard to our veterans, is undermined when you have these stories. I am not saying—as you know, most of the VA officials do a great job and really care about the veterans community that they serve. But, there have been some reports, I think very legitimate reports, where there has been malfeasance and actions that deserved to be punished or relieved. When that does not happen, it undermines the trust from our veterans.

I think that is a bipartisan commitment. We all want to work with you on that, to restore that authority, make it constitutional, of course.

Dr. SHULKIN. Yes.

Senator SULLIVAN. But, I had my doubts on where that was.

Let me go back again to another veteran constituent asked about how will the VA increase its presence in isolated communities and communities that are very rural? What are your ideas for that? And a related question, in Alaska, do you see the Alaska Tribal Health System playing an important role in that area with regard to Alaska Native veterans, or non-Native veterans?

Dr. SHULKIN. Yeah. I see our ability to address the health care professional shortage in rural areas in three ways. First, and most important, to work with the community providers, as we have been doing, particularly in rural areas. In the case of Alaska, working with the tribal consortiums and the Indian Health Service has been absolutely critical, and I am pleased to say we just signed a 2.5 year extension to make sure that there is continuity of care for our veterans, and using them.

Senator SULLIVAN. Thank you for that. I know that was a focus.

Dr. SHULKIN. Right. So, that is number 1.

Number 2 is, we have to use technology in areas where we are not able to recruit all the health care professionals we need. Most people do not realize, nobody in this country is using telehealth technology the way that the VA is. We did 2.1 million telehealth visits last year. That was 700,000 veterans. Nobody comes close, and we are doing it terrifically.

I actually practice medicine, from here in Washington to Grants Pass, OR, where I take care of patients using telehealth. I can tell you, I was skeptical, but it works well, and the patients like it, too.

Third is, we do need these tools to recruit and to use, frankly, financial incentives to get health care professionals to areas that we need them to care for veterans, because we are competing against the community, like in Mat-Su Valley, which you and I were talking about, we have been 2 years without a primary care doctor, and that is just not acceptable.

Senator SULLIVAN. We want to work with you. Again, I think that is an area of bipartisan concern. Getting a doctor out in the Mat-Su Valley in Alaska is going to be very important, and I appreciate your commitment on that.

Let me ask my final question, the broader issue that, again, I know the Chairman talked about in his opening remarks. But, what is your plan to tackle the current backlog and the process as it relates to appeals, because as you know, that has been a big challenge. There are some appeals that have been hanging out there for years—5, 6, 7, 8, 9, 10 years.

Dr. SHULKIN. Right. The appeals process is broken. The system was designed in 1933, and every now and then you have to update it, and we are way past that. We need an appeals modernization act, I think, that several people—I know Senator Blumenthal, Senator Rubio has proposed legislation. We will not fix this problem without legislation to fix it.

Let me just update you on a few figures. The average appeal in the board is 6 years. We have one appeal that is now going on beyond 30 years, and the reason is you can constantly add new evidence at any point in the process and it starts over.

So, this process needs to be fixed. We are really fortunate that Members of Congress, the VA, and our veteran service organizations lock themselves in a room until we came up with a solution that we think works, and that is now pending before you. We hope it is reintroduced into this Congress and we hope that you will pass it.

Senator SULLIVAN. Thank you. Thank you, Mr. Chairman, and Dr. Shulkin, I look forward to your swift confirmation.

Dr. SHULKIN. Thank you.

Senator SULLIVAN. Thank you again for your willingness to serve.

Senator ROUNDS [presiding]. Senator Manchin.

HON. JOE MANCHIN III, U.S. SENATOR FROM WEST VIRGINIA

Senator MANCHIN. Thank you, Mr. Chairman, and thank you, Dr. Shulkin, for being here and also for being willing to serve. You have done a great job in the year and one-half you have been there and I appreciate very much your service.

I want to thank you, basically, for working as you did, well, trying to make the changes we needed to make. I think we are on a positive role there and a positive movement.

Second, I would like to invite you to come to West Virginia and see our facility. I do not know if people know this but, you know, we are one of the most patriotic States with more veterans than most any. Out of 1,800,000 people that live in my State, 9.2 percent

are veterans. Almost 10 percent of my population are veterans, which is unbelievable.

With that, my concern, as you know, has been with opioid addiction.

Dr. SHULKIN. Yes.

Senator MANCHIN. Not just in my State, but nationwide there has been an epidemic. It is also within veterans. In my veteran corps it has been very detrimental to them.

A story ran in the *Wall Street Journal* that said 66,000 veterans were treated for substance abuse disorder just in the last fiscal year—66,000. It detailed that there is a shortage of VA in-patient, residential rehab beds, and that the VA often relies on non-VA facilities to treat addicted veterans. To give you an example of how under-bedded we are, under-supplied for the needs that we have, there are only 906 VA in-patient drug rehab beds nationwide—only 906 for a population which is in desperate need.

With that, Congressman Price, who has been considered for DHHS, has not committed to the funding that would support these types of rehab centers, that would help people get off of these prescription and lethal drugs. I did not know what your thought was, because right now you do not have the ability to pick up without the private sector support. If the Affordable Care Act goes down, we are dead. If he does not make a commitment from DHHS, we are dead again, and then you do not have the ability or the funding mechanism to pick up the slack.

So, I do not know how you feel about that, just to get your input. I am not trying to put you on the spot, but what do you make of this and how does this addiction—how are we doing on the addiction fight?

Dr. SHULKIN. This is an area, opioid addiction, that I am very proud that VA recognized, frankly, before the rest of the country did; recognized it as a crisis and began to take action. In 2009, VA put a comprehensive program in place. It is why, while the rest of the country has seen opioid use go up, we have seen a 22 percent reduction since 2010. We are doing things that, quite frankly, we think are working and that the rest of the country can learn from.

It does not mean, as you are suggesting, that we do not have to do more and that we should not do more. But, our work in making patients sign informed consents, our work in taking back medications that they are not using, in academic detailing, where we are teaching our doctors about the appropriate way, when to use opioids and when not to, our use of complementary care, so that we use alternatives to pain management—these are the things that are working, because what we know works best is to not start a patient, do not allow them to get addicted, which is going to help. But, for those that are there, we know that substance abuse is a big issue among veterans. We have to get them the right treatment.

Senator MANCHIN. You and I have met now—I appreciate you coming to the office and the conversation we had was quite enlightening. We talked about something that I found out was a problem, I found out through the VAs, and especially with the addiction problem. A lot of the hospitals have told me that if an addicted person comes and they do not get what they ask for—and they usually

know exactly what they want, not what is prescribed for them but what they want—they will call their Congressman or Senator and complain about bad treatment they are receiving, which puts you all on alert that you are not getting satisfactory services from that clinic, whether it be one of my CBOCs or whether it is going to be one of my hospitals.

What I have asked for—and I do not know how the other committees feel about this—but what I asked for is that when it comes to dispersing opiates, the addictive opiates that are killing people right and left, including our veterans, that the hospitals and dispensing from the VA should not be—should not be calculated in that chain of satisfaction, basically because they are not getting the pill they want. Everything else, yes, we know if they are not getting the service. But on that one there, that puts them, and puts our hospital systems basically in the position to where they get reimbursements, you know, basically cut and severed if they do not get good, high ratings from their patients. An addicted person is not going to give you a good, complimentary evaluation if they do not get what they want. It just makes common sense. You all, I hope, have the ability to do that, or I hope you would look into that.

Dr. SHULKIN. Yeah. Look, even if we get scored poorly, we are going to do the right thing for the veteran, and that is most important. But, I do appreciate you bringing this up as an issue.

I spoke this morning to Dr. Clancy, who heads up our quality area, who is responsible for this scoring, and she has said that we can actually calculate our scores without those questions in it, so we can do it with and without—

Senator MANCHIN. Right.

Dr. SHULKIN [continuing]. And actually learn about what you are talking about.

Senator MANCHIN. You would lead the charge nationwide and it would be a great help for the society.

I want to thank you for the job you have done in the VA, because you all have turned it around. It is moving in the right direction. A lot more needs to be done, but my veterans appreciate it very much. Thank you, sir.

Dr. SHULKIN. Thank you.

Senator ROUNDS. Senator Cassidy.

HON. BILL CASSIDY, U.S. SENATOR FROM LOUISIANA

Senator CASSIDY. Dr. Shulkin, nice to see you.

Dr. SHULKIN. Nice to see you.

Senator CASSIDY. Again, I have always—since you started I have admired the work you have done and the commitment you have made.

I did not forget, you and I, in a private conversation, I mentioned a physician colleague in the VA who said that some of the research positions are not going to young clinician researchers. So, for the record, he did say I could connect you, give you his name.

Dr. SHULKIN. Great.

Senator CASSIDY. We will communicate that to your staff.

Dr. SHULKIN. Excellent. Thank you.

Senator CASSIDY. Now, Senator Manchin just brought up the problem of opioid addiction. My concern is that we hide problems by speaking of a mean. You have decreased opioid addiction by 22 percent. That is system-wide. You are a big system. I bet you there are some hospitals where it has actually increased—increased despite a recognition of the problem.

Dr. SHULKIN. Mm-hmm.

Senator CASSIDY. So, you are saying yes, which I take as an agreement.

Dr. SHULKIN. Yes.

Senator CASSIDY. How do we know which facilities are bad apples—

Dr. SHULKIN. Mm-hmm.

Senator CASSIDY [continuing]. If, since 2010, despite the mean going down, we know, therefore, some going up are really going up, that their weighting, still, the mean goes down? What specific interventions are being done in those facilities, and how quickly do you identify—you see the set of questions I am going after?

Dr. SHULKIN. We not only have the data by facility, like you are suggesting, we actually have it by prescriber, and that is one of the reasons why we have been able to drive down the use. Every prescriber gets their prescribing use compared to other prescribers in the VA system, and then we mandated—it is not a voluntary or optional process—academic detailing, which means that everybody needs to be able to sit down with their prescribing, with an advance teacher, and sit down and talk about what they could be doing better.

Senator CASSIDY. Are there physicians, or prescribers, who have been outliers on the upside—they are not oncologists, they are not pain doctors, so we do not think they have a reason to be prescribing a lot—

Dr. SHULKIN. Yes.

Senator CASSIDY [continuing]. Rather they are just—I am suspecting you have some that continue to be outliers on the upside.

Dr. SHULKIN. We do.

Senator CASSIDY. Now, if you can identify them, what is being done?

Dr. SHULKIN. Well—

Senator CASSIDY. Since this has been going on since 2010—

Dr. SHULKIN. Yes.

Senator CASSIDY [continuing]. You know, it is not so much we are going to detail them because clearly they continue to prescribe.

Dr. SHULKIN. Right. Right. As you know, from being a practicing physician, when you get this type of data, there are processes on how to do that, and this is not bureaucratic. This is what happens in every hospital across the United States. We tend to use a peer review process, where you get to sit down with your colleagues, who also practice, and have to explain why you are continuing to practice that way. If the explanation is not good, they actually can be de-credentialed and de-privileged with their ability to see—

Senator CASSIDY. Now in the past year—

Dr. SHULKIN. Yeah.

Senator CASSIDY [continuing]. How many physicians have been de-credentialed for overprescribing opioids?

Dr. SHULKIN. I am not aware of any, specifically.

Senator CASSIDY. How many physicians would be two standard deviations above the mean, in terms of—not an oncologist, not a pain doctor—

Dr. SHULKIN. Yeah.

Senator CASSIDY [continuing]. How many would be two standard deviations above the mean, in terms of prescribing?

Dr. SHULKIN. I am not familiar enough that I want to start giving you wrong information, but I suspect, just because I think you and I have been doing this long enough, that there are some. I do think that addressing that issue, that the VA really has begun to do this, through its medical staff and its chiefs of staff, but I do not have specific numbers for you.

Senator CASSIDY. Yeah, I get that, and there is a specificity here. On the other hand, you can hide a lot of stuff within speaking about the mean.

Dr. SHULKIN. Absolutely.

Senator CASSIDY. Now, I think, and I typically find that 5 percent of every group you ought to take out back and dispose of. Right? Not Senators, of course. [Laughter.]

Not on this side of the aisle. [Laughter.]

That said, I think I spoke to Dr. Clancy when I first joined the Senate, about the specificity, and was told, yes, you can go that specifically.

Dr. SHULKIN. Yes.

Senator CASSIDY. The fact that you still have those two standard deviations above suggests to me that this process of academic detailing and peer review is either too cumbersome, too fenced around with protections, or something, but there are still veterans getting addicted because of inappropriate prescribing.

Dr. SHULKIN. I am sure—in everything that we are doing, I am sure we can do this better, and we will take this back and take a look at it. But overall—and you are right, we are talking about means, and I agree with your statistical analysis here—but overall, we are actually doing things that many in America have not begun to do. We have begun to write this up and speak about it at national conferences, and we think there is a lot to learn from it. That does not mean that we cannot do it better, and we will look at this.

Senator CASSIDY. And although I am frustrated, I will return to where I started. I appreciate the good work you and many of the physicians have done. We wish to support you. But I will, when you come back, continue to ask about the specificity.

Dr. SHULKIN. Right.

Senator CASSIDY. To what degree are we using data analytics to specify those prescribers who really are outliers, and really probably should not be allowed to prescribe narcotics?

Dr. SHULKIN. OK. Very good. Thank you.

Senator ROUNDS. Senator Blumenthal.

**HON. RICHARD BLUMENTHAL,
U.S. SENATOR FROM CONNECTICUT**

Senator BLUMENTHAL. Thank you, Senator Rounds. I want to begin where Senator Cassidy finished, first to thank you for your

service. You have done great work so far in your present position. You have brought new leadership and vision to an agency that needs it. I also look forward to your coming back here, as Senator Cassidy has alluded to. You have been extraordinarily accessible and responsive to all of us, I feel, and I want to thank you for that.

Particularly for me, we had a productive conversation yesterday, and you committed to helping me with a number of issues in Connecticut, including getting us Wi-Fi in our facilities, most especially West Haven, where I have been working, and working, and working to accomplish that end, and billing problems in Connecticut that are impacting some veterans when the VA fails to pay a provider, and a number of other areas where you have been extremely responsive. So, I thank you for that very good beginning.

I would like to ask you, first of all, on an issue that we discussed yesterday, the appeals reform. I think you and I agree that this measure is extraordinarily necessary because claims have been delayed and backlogged and gridlocked for far too long, and the appeals process needs to be better strengthened with resources and streamlined. Would you agree?

Dr. SHULKIN. Yeah, and, Senator, while you were probably doing your fourth or fifth vote, we recognized and thanked you for your leadership in introducing into the last Congress, and hope that you will reintroduce it. We desperately need appeals modernization and this issue will not get fixed without it.

Senator BLUMENTHAL. I plan to champion it again. Thank you for your support.

The American Legion included, in its legislative priorities—and I thank them for doing so—the need to protect student veterans from predatory schools.

Dr. SHULKIN. Yes.

Senator BLUMENTHAL. In 2016, the Yale Law School issued a report entitled “VA’s Failure to Protect Veterans From Deceptive Recruiting Practices,” which showed that the VA is not complying with 38 U.S. Code 3696, which requires the disapproval of GI Bill funding when the VA finds that colleges have engaged in deceptive and misleading college recruiting.

This topic is very close to my heart, having two sons who have served, and knowing many, many student veterans. If confirmed, will you commit to cracking down on colleges that are essentially lying to our veterans, and cheating them and the taxpayers out of veterans’ hard-earned GI Bill support, including by using all resources and authorities available to you, as the head of the VA, as well as working with other Federal agencies to crack down on these abuses?

Dr. SHULKIN. Yes, Senator. This situation that you described would not be tolerable to me, and absolutely, I would commit to that.

Senator BLUMENTHAL. I would pledge to you my total and complete support, at whatever level, in whatever way that I can help.

Dr. SHULKIN. Mm-hmm.

Senator BLUMENTHAL. I want to second what I think is Senator Murray’s cause here. She has been such a champion of IVF treatment for veterans, and I hope that you will lend your complete support to that program as well.

Dr. SHULKIN. Yeah. On January 19th, this became a final interim rule, so we are moving ahead with coverage for service-connected IVF treatment. It is absolutely—it is long overdue.

Senator BLUMENTHAL. Great. And in light of your own medical background, I am sure you appreciate the need and importance of this program.

And finally, because my time is running out and we have one more vote, a 2015 report from the Veterans Education Success Fund found that 20 percent of 300 GI Bill-approved programs, in licensed occupations, left the graduates ineligible to work.

In the last Congress we joined in a bipartisan, bicameral effort to unanimously pass the Miller and Blumenthal Veterans Health Care and Benefits Improvement Act. One component was the Career-Ready Student Veterans Act, which requires the VA to disapprove GI Bill benefits for programs that lack the appropriate accreditation for graduates to earn State licenses and certification. It sounds highly technical but in the real world can have a tremendous impact on enabling our veterans to get to work, and I hope that you will commit to rapidly implementing this important bill.

Dr. SHULKIN. Yes. Thank you for your leadership on that.

Senator BLUMENTHAL. Thank you. I very much appreciate your leadership and I look forward to working with you.

Dr. SHULKIN. Thank you, Senator.

Senator BLUMENTHAL. Thank you.

Chairman ISAKSON [presiding]. Senator Blumenthal, you were not here at the beginning of the testimony and I wanted you to know I bragged about you and appreciated very much your leadership last year in co-chairing the Committee with me, leading to the stuff we passed at the end of the session. I just wanted to acknowledge that publicly.

Senator BLUMENTHAL. Thank you. Well, I appreciate that, Mr. Chairman, and I was proud to be among your supporting cast. Thank you.

Chairman ISAKSON. Well, any time the Committee can pass out a bill 15–0, something is going right, and we appreciate your help.

Senator BLUMENTHAL. Thank you.

Chairman ISAKSON. OK. Who is going to interpret these notes for me? Are you next, Mike?

Senator Rounds, and thank you Senator Rounds for filling in for me.

Senator ROUNDS. Thank you, Mr. Chairman. I would like to talk about the Choice Act, and just reconfirm your thoughts about some directions we have got to go.

Last year, this Committee passed out an amendment to the Choice Act which would have made the VA the primary, rather than the secondary, payer in the Choice Act, which would clear up a whole lot of stuff out there. Would you commit, once again, your support to moving this from secondary payer to primary payer in the Veterans Choice Act?

Dr. SHULKIN. Yeah. Senator, I think the way that we are using the term “primary payer,” absolutely. We want to take the veteran away from being caught in the middle and then being caught in this credit swap. I want to make sure that when we write this that we write it correctly, because we do not want to add to the expense

of the Choice Act. We want to use our funds most judiciously, and to the benefit of the taxpayers and veterans.

So, yes, we think we need to do it differently. As you know, in Community Care, VA is the primary payer. In Choice, we are the secondary payer. It makes no sense to have two different ways of paying bills for the same veterans. So, we want to get it to one program that makes sense. I think you and I would describe that as primary payer, but there is some technical language in there I want to make sure is in the bill.

Senator ROUNDS. But the idea would be that, under the Choice Program, when a VA goes to their physician, following the rules, that the VA would pick up the bill, and then if there was other insurance, the VA would then go back and—

Dr. SHULKIN. That is the exact idea.

Senator ROUNDS. OK.

Dr. SHULKIN. Yes.

Senator ROUNDS. Second item. With regard to the costs involved, I just want to hear your thoughts on this. In some of the work that we have done, we find some rather disturbing costs involved in the administration, not just of the Choice Act, but really the cost of administering the claims process.

Dr. SHULKIN. Yeah.

Senator ROUNDS. Let me just lay out what we are finding. Now, the VA's average cost to process one claim is approximately 10 times the cost of a TRICARE claim—10 times. VA/VHA, not just the Veterans Choice Act but VA current programs, \$15.91 per claim. Now compare that with TRICARE at \$1.50 per claim for paper, or \$0.40 per claim for electronic. Even Medicare, at \$0.80 per claim.

We have got to have a better way of delivering that administrative service because that is money that, right now, rather than going into veterans' care is going into administrative thing that is clearly out of date, and out of proportion with what the rest of the industry is going to.

Would you like to share a little bit about—I mean, you have seen it now for a couple of years.

Dr. SHULKIN. Yes.

Senator ROUNDS. And I know you are aware of it. Can you talk a little about how you see your vision—

Dr. SHULKIN. Yeah.

Senator ROUNDS [continuing]. And how we start to address this?

Dr. SHULKIN. Certainly our goal is to get the administrative costs down to as low as possible. Our RFP that we had talked about earlier is redefining the way that a third-party administrator's role would be, and the idea would be to get the administrative costs down. That is the objective.

The numbers that you are talking about, when the Choice Program got stood up, and so we were just enrolling patients, the administrative costs were astronomical, because we were building a brand new administrative infrastructure and using third parties to do that, and so the administrative costs were sky high. Since May 2016, our administrative costs in the Choice Program are now 10 percent. That is not bad, compared to industry managed care standards. We think we can do better than that.

TRICARE, the comparison you made, has been up and running for years and years, so, you know, the comparisons were not exactly equal. Your observation about that any cost that goes to administration is not going to benefit directly a veteran, that is what we want to get as small as possible.

Senator ROUNDS. Very good. Thank you, Mr. Chairman. I will yield back my time.

Chairman ISAKSON. Thank you again for filling in while I was out.

Before I introduce Senator Murray, for the benefit of everybody at the dais now, we are going to hold the record open until 6 p.m. tomorrow for you to submit any questions after the hearing you want to submit. Dr. Shulkin, we are going to ask you have them answered by 6 p.m. next Monday. We want to get you confirmed, unless you have a bad answer to any of those questions.

Dr. SHULKIN. You do know it is Super Bowl Sunday, right?

Chairman ISAKSON. I have got the Falcons pin on right here. OK. [Laughter.]

But on Monday, it is Shulkin Monday. It may be the Falcons on Sunday but it is still—

[Laughter.]

Chairman ISAKSON. OK. OK. Unless you plan on doing some celebrating that we did not want to know about. [Laughter.]

I am aware, and since you asked, the Falcons are playing on Sunday at 6:30 p.m., Fox television. [Laughter.]

It is going to be Tom Brady today. [Laughter.]

We are finally going to get him one of these days.

Senator Murray.

HON. PATTY MURRAY, U.S. SENATOR FROM WASHINGTON

Senator MURRAY. Thank you very much, Chairman Isakson, and to our Ranking Member, Senator Tester.

I want to recognize all the VSOs here. It is an amazing turnout and it shows how much you care about this nomination and this department, and I appreciate that.

Dr. Shulkin, welcome. We had a chance to talk yesterday about what I think needs to be done to provide better care for all of our military families, and you know where I stand on a lot of things, from privatization to the urgent need to improve access to care.

You also know that I believe the problems at VA are not always about money, but about the need for strong leadership, so I want to get right to my questions, since I know my time is limited here, since I know the Chairman does want to go to a game on Sunday.

Chairman ISAKSON. If Sunday is the deadline, it is Monday. [Laughter.]

Senator MURRAY. Dr. Shulkin, I think Senator Blumenthal asked about this, but after a very long fight Congress finally passed a bipartisan provision to give the VA legal authority to cover IVF for veterans and their spouses through fiscal year 2018. Despite some technical holdups, I have been assured that the VA will implement this consistent with the intent of that law, but I am very concerned that the Trump Administration, in some reckless attempt to just reverse regulations, will prevent that from happening.

I wanted to ask you specifically, do I have your assurance, yes or no, that veterans and their spouses will have access to this service through fiscal year 2018?

Dr. SHULKIN. Yes. It was an interim final rule on January 19. Done.

Senator MURRAY. OK. And can I count on your continued support for access to IVF for those veterans?

Dr. SHULKIN. Yes.

Senator MURRAY. Great. Dr. Shulkin, President Trump last week issued a hiring freeze on Federal workers, which does affect the agency you may lead, as well as more than 800 positions at VA facilities in my home State of Washington. Now I know the VA has responded with some exemptions, to try and make sure care is not compromised, but there are still open positions.

Do you agree with the President's hiring freeze, which is now affecting those open positions at the VA?

Dr. SHULKIN. Senator, the most important thing to me is that we have the resources to hire the people that we need to take care of our veterans, and we have requested that from the White House and we have gotten that. So, the openings, we have 37,000 positions exempted right now that we are actively recruiting for, and that we desperately want to fill. I am very comfortable with where we are at this point.

Senator MURRAY. OK. Well, are you going to make sure the President understands that this freeze is actually counter-productive at the VA?

Dr. SHULKIN. Everything that we have asked for from the administration right now has been granted, so I feel comfortable that we have what we need. I do commit that if confirmed as Secretary, I would be a tireless advocate to ask the President for everything that we need to make sure that our veterans are getting both the health care and services that they deserve and that I would be here to protect, because if I am Secretary I am going to have their back.

Senator MURRAY. OK. We will hold you to that.

Now, I have heard from a lot of veterans in my State and across the country who are actually outraged by President Trump's executive order that unfairly banned refugees from Muslim-majority countries and created a religious test as to how Federal agencies treat Americans, their families, and those seeking a better life here in the United States. I stand with them, and I believe what Republicans and President Trump are doing is un-American and unconstitutional.

Can you assure me that as VA Secretary under this administration that when pressed by President Trump to carry out an unconstitutional act, such as denying medical services and benefits, or making a hiring decision based on race, ethnicity, or religion, that you will never withhold care or treat a veteran different as a result of their ethnicity or religion?

Dr. SHULKIN. Senator, look. I very, very much value the way that this Committee works, which is in a bipartisan way. Our total focus is on veterans. As Secretary of VA, if I am confirmed, my sole focus is going to be on making sure that every veteran who has earned the right to be cared for as a veteran, through VA, gets that, regardless of anything, and nothing will get in the way of giv-

ing a veteran the services that they deserve and the health care that they need, and the other services. So, that would be——

Senator MURRAY. Including ethnicity and religion?

Dr. SHULKIN. Veterans are not religions and Democrats and Republicans, they all bleed red, and as far as I am concerned they are all the same. They all deserve the same exact access to services and health care.

Senator MURRAY. OK. Well, President Trump also said that he is going to conduct a wide-scale investigation of voting issues pertaining to the recent Presidential election, despite the fact there is no evidence of voter fraud. And now, as you know, veterans and servicemembers are often registered in multiple States, which alone is, by the way, not a crime unless the individual actually votes in multiple States.

I am very concerned that this misguided effort could lead to veterans and servicemembers being stripped from voter roles in every jurisdiction they are registered in, which is especially egregious given, of course, their service to our country.

As Secretary, what are you going to do to make sure veterans, servicemembers, and their families do not have their rights robbed by this process?

Dr. SHULKIN. I do not know that the issue related to voters' rights and some of the things that you are describing are in the purview of the Secretary of the VA, but certainly everything that is in the purview of the Secretary of the VA that I can do to advocate on behalf of veterans, I am going to make sure that I do.

Senator MURRAY. Well, I appreciate that. Well, I hope that when you hear the President make a wide-scale whatever, that he seems to be doing, that you remind him that veterans also are impacted by this. When he says that he is going to go after voter fraud across the country, as I said, many of our veterans and their families are registered, by virtue of their service in several States. They are not voting in two different States or three different States, but they are registered so they can participate as citizens.

I expect you to stand up and remind the President, when he makes these broad, wide-range executive actions, that veterans have to be thought about in that process.

Dr. SHULKIN. Yes.

Senator MURRAY. Thank you.

Chairman ISAKSON. I just want to inject, as kind of an after—not an afterthought but a primary thought, that we have so many foreign nationals who fight in our military. I think 15 percent of our military is made up of people who are foreign nationals who are here on permits.

Diego Rincon of Colombia was the first lost Georgian who lost his life in Iraq. His portrait hangs over my desk in my office, and he volunteered for the United States military, to later become a citizen. And our military has had a great open policy for recruiting both domestic American citizens as well as overseas citizens of other countries who have come here to become U.S. citizens.

We have a tremendous commitment to any of those people, regardless of where they are from or who they are. If they sign for us to fight and risk their lives, they deserve every benefit unfettered that we promise them when they sign up, and we are going

to always see to it that is the case. I am sure Dr. Shulkin will, and I will too.

Dr. SHULKIN. Yes.

Chairman ISAKSON. With that said—let us see, did Jerry come back? Have you asked any questions yet?

Senator MORAN. I have not.

Chairman ISAKSON. OK. Who—and we just had Patty.

Have you asked any questions yet? Have you got time to wait for him?

Senator MORAN. Mm-hmm.

Chairman ISAKSON. Dean Heller.

HON. DEAN HELLER, U.S. SENATOR FROM NEVADA

Senator HELLER. Mr. Chairman, thank you, and to the new Ranking Member, I look forward to working with both of you.

Dr. Shulkin, congratulations.

Dr. SHULKIN. Thank you.

Senator HELLER. I am pleased for you and your family and those that are perhaps watching today's hearing. I appreciate the visit you made to my office yesterday, where we talked about some numbers and some statistics that were important to me. I told you I may bring them up in today's hearing, so here we are. I want to thank all the VSOs and all those that are in attendance today for sharing and expressing your concern for this particular position, which is important to all of us.

I want to compare some of the numbers of today when it comes to backlog claims, and I apologize if this has been a topic discussed prior to me getting in here, but the backlog claims today versus December 2013.

Today, we have a 28 percent backlog, about 1,235 to be exact, versus December 2013 it was 67 percent. So, you can see that we have made some progress and I appreciate the men and women back in Nevada that are working for us and doing a great job back there to reduce this backlog.

Today, the total pending claims is 4,416 versus in 2013, which was 6,622. The problem, of course, is in the appeals. We talked about this a little bit. Today, it is 2,731 versus 2013, where it was 1,140. That is a 140 percent increase since 2013.

As you know, as we have pushed on the—and staff back in Nevada have pushed on this backlog claims for pending claims. Obviously the problem is that we are now seeing these appeals balloon.

Dr. SHULKIN. Yes.

Senator HELLER. What process? What process do you see in the near future that will address these appeals?

Dr. SHULKIN. Senator, first of all, thank you for recognizing the tremendous progress that the benefits team has done. This has been—

Senator HELLER. They have done a great job.

Dr. SHULKIN [continuing]. An example of modernization of VA that has taken the numbers down dramatically—

Senator HELLER. Yes.

Dr. SHULKIN [continuing]. Nationally from over 700,000 to today, about 80- or 90,000, and we are going to do better than that by the end of the year.

Senator HELLER. Good. Glad to hear that.

Dr. SHULKIN. But, in the appeals process, we have no hopes without a modernization act being passed through Congress to fix the appeals process. It is a broken process. It will not get better without your help, and we certainly hope that you and your colleagues will pass a modernization act this year.

Senator HELLER. The average days to complete now are 124 days versus where it was in 2013. In Nevada, at least, it was 433—

Dr. SHULKIN. Mm-hmm.

Senator HELLER [continuing]. Almost 434 days. So, you can see that there is some real progress there. I just want our veterans to know, back in the State of Nevada, how hard that office is working, the men and women that are committed to our veterans to make sure that they do get these benefits and services that they need.

I would like to talk about doctor shortages for just a moment. We have, in the State of Nevada, felt a real impact. Nevada ranks 47th in the Nation for physicians per capita, and 48th for nurses. And as you know, on top of that the VA is competing with the private sector for hiring.

Given your experience, especially in running hospitals, what recruitment or retention efforts and initiatives will you be pushing to ensure that we get high-quality medical professionals joining and staying at the VA?

Dr. SHULKIN. Well, recruitment is our key issue, and I want people to know that working at the VA is a tremendous privilege. I see patients in the VA and I am proud to work with the men and women that serve in the VA. People read about all the bad press and the media events, and they say, “Well, I may not want to work there,” but I can tell you, when they come they see an environment that really is an extraordinary place to work. I want people to come.

When you have given us the tools, like the Choice Act, we have hired 18,800 net new staff because of the authorization that you gave us. I hope, as Secretary, if I am confirmed, that you give me the ability to recruit and retain even further. So, when the CARA legislation passed, inadvertently, I believe, or at least I hope, our recruitment dollars were put into the CARA performance awards. So, it actually removed a tool that we used in the past to recruit and retain the very, very best, and I would like to have the ability to have what we had before, which is the dollars available to do what you are talking about.

Senator HELLER. Doctor, just—

Dr. SHULKIN. Yes.

Senator HELLER [continuing]. Because I am short on time—

Dr. SHULKIN. Yep.

Senator HELLER [continuing]. Can you give me your opinion on medical scribes, and do you believe that they will help these VA physicians and their workloads?

Dr. SHULKIN. We are looking at the medical scribe issue. The private sector has used it very successfully and we are starting some pilots in that. That is something that I think has some promise.

Senator HELLER. How about more doctors in rural areas?

Dr. SHULKIN. We need them, and we need to expand our graduate medical education programs in these rural areas. We would like to do that as well.

Senator HELLER. Thank you. Mr. Chairman, my time is out.

Chairman ISAKSON. Thank you, Senator Heller. We will go to Ms. Hirono and then to Jerry Moran.

HON. MAZIE K. HIRONO, U.S. SENATOR FROM HAWAII

Senator HIRONO. Thank you very much. It is good to see you again. I enjoyed the opportunity to talk with you and, in fact, just to reiterate, when I met with you I mentioned that three aspects of VA Administration that I am particularly interested in, and you committed to working with me on all of them, one is, of course, to improve access to health care for veterans and also to the various programs that support veterans. The second is to improve the communication between VA and the veterans, and the third is to smooth the transition from—for the veterans when they leave active service status.

So, how we implement all of these areas are what we will be going forward on, should you be confirmed.

I did have a question that I hope—a series of questions that I think should elicit very short answers from you. The first is that I was informed that there is a tool called the Blue Button—

Dr. SHULKIN. Yes.

Senator HIRONO [continuing]. That was born out of a veterans'—VA to empower patients with direct access to their medical data contained in the My Health, whatever—

Dr. SHULKIN. My Healthy Vet.

Senator HIRONO. Yes. OK—personal health record portal. Will you promise to support the ongoing development of the Blue Button tool and consider allowing more functions beyond viewing and downloading one's records?

Dr. SHULKIN. I will be brief. I think you are right. This was a success, the Blue Button, easily to download your EMR. We do have a digital services team that is looking at ways to be able to expand capabilities.

Senator HIRONO. Great. I have a number of questions relating to the care that they should receive. I know that you are aware of the bill that Senator Joni Ernst and I introduced. She introduced it. I am the lead Democratic cosponsor on veteran e-health and telemedicine, and I would like you to reiterate, for the record, that you believe that this is a very good thing, it would provide more avenues for care for especially our veterans who live in rural areas, and that you will work very closely, particularly to overcome some objections by the American Medical Association.

Dr. SHULKIN. Yeah. As I discussed with you, this bill is something that I strongly support, and we need this to take care of our veterans, particularly in our rural areas. I really hope that you will re-introduce that, and I will do everything possible to help support that bill.

Senator HIRONO. And, of course, we would like the Chair to be on board also.

Another care question. The VA is currently collaborating on a pilot basis with pharmacies to provide walk-in services for common

health care issues. The VA has a contract with CVS, which is everywhere, including in Hawaii. I think it would be a good thing if you would be willing to look at expanding the VA's collaboration with pharmacies to provide walk-in services, which would be so much more convenient for our veterans than to have to go to a VA facility.

Dr. SHULKIN. Yeah. This started with our Palo Alto VA and I would agree with you. It has been a successful pilot. We are looking at expanding but we will probably need to do that through an RFP to make sure that the process of giving out a contract is fair and complies with Federal rules.

Senator HIRONO. Another—this has to do with survivor claims. In the Veterans Health Care and Benefits Improvement Act, there was a provision to automate the survivor claims process, to just speed up the process, and I just would want to make sure that the implementation of this provision is occurring, so that the claims—claimants can get what they should be getting without going through all kinds of unnecessary hoops.

Dr. SHULKIN. Yeah. Senator, I agree, this is important to do. I do not have a specific timeline but I would be glad to get back to you with that.

Senator HIRONO. Thank you.

Well, this goes to construction of facilities, because we still—the CBOCs are very important and there are a number of these facilities that are in the pipeline, including one in Hawaii, the Advanced Leeward Outpatient Healthcare Access Clinic, and State Veterans Home on Oahu. I would want to work with you to make sure that these projects are moving along, because they are already on the list of projects to build.

Dr. SHULKIN. I would be glad to do that.

Senator HIRONO. Then very specifically, we passed the Filipino Veterans Equity Compensation Fund and there are still some claims being made to the fund, and some of these veterans are having a hard time with providing all of the kind of records that they need. Some of the records have been destroyed, et cetera, and we would really want to work with you as World War II Filipino veterans are dying on a daily basis, and I will want to work with you so you can facilitate the decisions to support these veterans with just claims.

Dr. SHULKIN. Yes. You and I discussed that and I am supportive of doing what we can to get people who have earned the benefits the benefits that they deserve.

Senator HIRONO. Thank you. Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Hirono. I appreciate your input and your questions.

We will go to Senator Moran, followed by Senator Tester, followed by Senator Boozman.

Senator Moran.

HON. JERRY MORAN, U.S. SENATOR FROM KANSAS

Senator MORAN. Mr. Chairman, thank you very much. Dr. Shulkin, welcome to the Committee. Welcome back to the Committee. I congratulate you and your wife on your nomination and look forward to hearing your testimony today.

Let me start by saying that we had a fine conversation in our office. I am looking for assurance that the VA is going to be different than it has been, in a more—this may sound provincial, about Congress, but a couple of things that have troubled me about the VA. One is that the outreach to Members of Congress, responsiveness, our ability to get VA attention on case work and individual veterans problems, in my view, has been miserable, and you assured me that things are going to change, and I assume if I asked you that question you would be politically adept enough to say yes again today. But the reality is, in my view, the VA is failing not just Congress but veterans that we are elected to serve and try very hard to care for.

Another example of the VA's lack of concern for Congress is it seems to me, in way too many instances, perhaps all, in legislation that we passed, the VA then narrows the scope of that legislation, thwarting congressional intent. I just sat here listening to you testify and was thinking about three instances, just in the Choice Act. Remember the early days of 40 miles in which it was as the crow flies. That is a way to deny veterans benefits that Congress intended for them to have—ultimately corrected, that is a good thing, but interesting to me that is where the VA started.

The full-time position. What is the definition of a facility, and particularly as a CBOC, we tried to redefine what a CBOC is, based upon a full-time position. The VA then narrows it—not 40 hours as most of us would expect a full-time position to be, but something less than that. Again, thwarting the efforts of Congress, the intent of Congress to serve our veterans.

The one that you and I talked most about in my office, which I am hoping that you have some good news, is the opportunity for us to correct this issue of unusual and excessive burden in which we indicated that you can go—you can have Choice, but then you narrowed it by—you, the VA—narrowed it by limiting the necessary procedures, the procedures that then qualified. Again, narrowing the opportunity for veterans to be served by Choice. And just three instances I thought, sitting here listening to your testimony.

Any chance you can tell me good news, that you have looked at that and—

Dr. SHULKIN. Yeah. Senator, I can give you good news on that, that I believe—and I appreciate you and your staff pointing this out to us—those were meant to be examples. I think the field took them literally, that these are the only five conditions. So, we have gone out now, nationally, and clarified that, to give the flexibility that you need.

But let me make the comment. This is complex business when we are making laws and implementing them. These examples are going to continue to come up. My commitment to you, if I am confirmed as Secretary, is we have to have these types of conversations and this type of communication, because you are hearing from constituents and you have information, and we need to get back to you in a timely fashion. That is why I am committed to that. Because we are going to continue to have these differences in interpretations. But in the end, we both want what is best for veterans,

and I believe we will come up with the right solutions, like in this example where I just gave you good news.

Senator MORAN. That is good news, and I appreciate that, assuming that we then see a result.

Dr. SHULKIN. Yes.

Senator MORAN. In many instances in which the VA assures us that they have solved a problem, you get out to Kansas and nobody in the VISN or nobody in the hospital—

Dr. SHULKIN. Right.

Senator MORAN [continuing]. Knows any change. Your work is fully cut out for you, even when you make a decision that is advantageous to veterans.

I am thinking about what you just said. We are going to have these kind of discussions—that is true. You are going to implement laws, but it does seem to me that in too many instances the goal has been to narrow the scope. I mean, the VA ought to be looking for ways to expand the opportunities, not narrow them. So, I hope your attitude and approach changes from what I saw in the past.

I also asked you—and I do not think this happened so I do not think you can deliver good news—I asked you to have conversations with the VSOs—American Legion, VFW, Vietnam Veterans, and folks who are very interested in talking to you—and again, I would encourage you in this setting to do so, if you become confirmed or whether you become confirmed.

Dr. SHULKIN. Yeah. You know, I think I have told you, but if not, I am absolutely clear, on the record, that the VSOs are—have been an absolute valued and treasured resource to me as a voice for veterans. I consider my relationships with them absolutely critical to the success of what I currently do, and certainly critical to the success of a Secretary. I meet with them on a regular basis. I e-mail with them. I take phone calls. My staff does too, so that commitment is absolutely there. If we need to do it more than we are doing it, then we will do it more than we are doing it.

Senator MORAN. I notice that President Trump, his words on Choice were—President Trump says, “Ensure our veterans get the care they need, wherever and whenever they need it. No more long drives. No more waiting. No backlogs. No more excessive red tape. Just care and support they earned with their service to our country.” And in regard to accountability, something I have yet to raise this morning, “Fire the corrupt, incompetent VA executives who let our veterans down. Use the power of the presidency to remove and discipline the Federal employees and managers who have violated the public trust, and failed to carry out the duties on behalf of our veterans.”

I assume you are, as a nominee, you are supportive of both President Trump’s statements. I would ask you, just on a—how would you grade yourself? If you come to this Committee 6 months from now, what would be the scorecard by which we could determine or I could determine whether you have met the goals of your service as the Secretary of the department?

Dr. SHULKIN. Well, we can talk about what the right time to come back and do that is, but, listen, there is only one goal that is important to me. Ask the veterans what they think of the services that they are getting, and what their trust level is of us, in

terms of being able to deliver that. That is the most important outcome. We can define metrics on how to do that, but this is an organization—I think this is really what you have been saying all along—that has to be veteran-centric. That is the only reason we exist. That is the only reason why you have a Secretary, to make sure that they are advocating on behalf of them.

So, let us ask them and let us see if we are doing a better job.

Senator MORAN. Well, that is fine.

Mr. Chairman, I will conclude with this. Dr. Shulkin, you have the advantage of having served in the VA for 18, 20 months.

Dr. SHULKIN. Mm-hmm.

Senator MORAN. It is also a disadvantage because I put you on a higher platform as somebody who cannot use the excuses, “I am going to go out and ask veterans what they need.” You know the problems, and there ought not be a significant learning curve. Yours is not about conducting a town hall meeting and learning from veterans what the problems are. In my view, you have the ability, the background, to actually solve the problems.

So, from my perspective, the answer to this question will not be “we are still conducting a survey,” and I do not think that is what you are saying. My point, in a sense, is to compliment you for your experience, but also to say that I think more is expected of you as a result of that experience.

Dr. SHULKIN. Yeah. Senator, you are not going to hear me asking for a learning curve. If you are moving toward confirmation, I hope you do it swiftly, because I am eager not to waste another day. I want to get on with this. I think the veterans deserve it. I think our employees deserve us building a system that meets their needs, so that they can serve veterans better, and there is not going to be a day wasted.

Senator MORAN. Thank you, Doctor. Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Moran. We will go to Senator Boozman.

Senator BOOZMAN. Thank you, Mr. Chairman. I will be brief. We appreciate, again, you being here, and I had a very, very good visit with you in the office.

I was going to ask you a question about the opioids that we talked about in the office, but instead of that, something that is related to that is we also talked about me being very supportive of the VA’s adaptive sports programs, which I think should be expanded. Right now we have the big programs, but to expand them to the smaller communities, the smaller regions, in the sense that if we do those kind of things, then we will lessen the opioid problems and some of these other things that we are experiencing as a result of veterans just being in really difficult situations, where they need to get their minds off of things and into something positive.

Can you tell us, are there plans to expand the program, perhaps on a smaller scale, to include these areas? And what constraints do you see in expanding the programs on the local and community level?

Dr. SHULKIN. Yeah.

Senator BOOZMAN. How can we help?

Dr. SHULKIN. I did not appreciate the importance of adaptive sports until I came to the VA, because, frankly, I have never been part of a health system that even thought about this as part of health care and well-being. But when I got into the mountains of Aspen with 400 veterans, and got them part of getting them out of their wheelchairs onto the mountains, it transformed my view of how we can help people.

So, the stories that you talk about, about getting people off of medications, people who are suicidal, to regain a joy in their life and to start living again, were inspirational.

I did it again this summer in San Diego with surfing with veterans. I had never surfed before. A pretty incredible experience.

So, I am a big, big believer, because I have seen this. We need to do more of it. We need to get into the smaller communities. I am not looking for additional monies from the Federal Government. What I am looking to do is to get sponsors, corporate sponsors, which we have so many of. There are probably some in the room today and our VSOs, like DAV, who supports our efforts, and many of the other VSOs. I am looking for us to have other people see how vital this is in transforming people's lives. They are going to want to be part of it, once they experience it.

Senator BOOZMAN. Very good. Thank you, Mr. Chairman.

Chairman ISAKSON. Senator Tester.

Senator TESTER. Thank you, Mr. Chairman. We have had some issues with third-party administrators in the State. You are aware of it. What can we do to hold them more accountable for their contractual obligations to the VA and to the taxpayer and to the veterans?

Dr. SHULKIN. Yep. I think it is called competition, Senator. When we brought the Choice Program up, we only had two bidders for the Choice Program, and we accepted both of them. And now that we are going out for an RFP, this is going to be a much, much better competition. We already have interest from many more vendors. Frankly, this is going to be an open process, and those who can deliver on doing the better job are going to win the contracts.

Senator TESTER. Well, to my knowledge there was only one that bid on Montana. And I will tell you that they have taken some things, they have embedded some people, they supposedly increased their call center, but they still do not know Montana.

Is there any thought of having the VA be the administrator for that Choice Program?

Dr. SHULKIN. The redesign in the Choice Program that we are going to come back to you with allows the VA to do the things that it does well, which is dealing with veterans, doing customer service, making sure the veterans' needs are met. We outsourced that in the Choice Program and we learned that was a mistake. We are not going to do that again.

But, on the other hand, VA is not good at many of these managed care functions, claims processing, and some of the network adequacy that you have to maintain. So, what we want to do is make the decision based upon what makes sense for the veterans, what needs to be in VA, and what needs to be done by private industry. We believe we can find that balance.

Senator TESTER. Yeah. I will just tell you, from my perspective, the VA might not be good, and may have room for improvement, and they do, but the third-party administrators are worse, truthfully, at least in our case.

So, I would like to cut to the chase. There is a lady from Billings that said—she wrote me a note and said, “What can David Shulkin do to ensure that all service men and women coming home from overseas duty get the medical attention they need, including mental health care?”

Dr. SHULKIN. Well, you know, we have to do a couple of things. The most important is access, and that has been our focus. That is why if you go to Billings you are going to find same-day services in mental health. But, we need more mental health professionals, which we are seeking to hire more mental health professionals. And we need to use our technology, like tele-mental health, that we are using for 336,000 veterans today. We need to continue to expand that. We have just established national hubs—ten national hubs of tele-mental health, so we can reach areas like Billings, that may not have the number of health care professionals it needs.

So, we have a lot more to do but we think we are headed in the right direction, and we are committed, and we are not going to rest until we meet everyone who is returning to have their needs met.

Senator TESTER. OK. You come from the health care side.

Dr. SHULKIN. Mm-hmm.

Senator TESTER. OK? There has been some concern by some folks who are paying attention that the VBA side may suffer with you as Secretary of the VA. I am just being flat honest. You have commented about the freeze, and you did—and I congratulate you on that—get them to unfreeze, for the most part, the health care folks. But you still have a backlog on veterans’ benefits.

What is your intention to do there? Is this not a manpower issue?

Dr. SHULKIN. Yeah. First of all, it was not just health care that we got exempted. The National Cemetery too—

Senator TESTER. OK.

Dr. SHULKIN [continuing]. Because it is very important to be able to get people—

Senator TESTER. Gotcha.

Dr. SHULKIN [continuing]. The proper burial.

Senator TESTER. Thank you for that.

Dr. SHULKIN. What I firmly believe is, what I have learned over the 18 months, we are one VA, and you do not get health care if you cannot get benefits. And benefits is not going to suffer if I am confirmed as Secretary, because it is important to veterans and we have to focus on it.

The issue of a 90-day freeze, I am working with our current Under Secretary, Tom Murphy—

Senator TESTER. Yes.

Dr. SHULKIN [continuing]. That if this really starts to impact our ability to get veterans benefits, that is something I am willing to address with the administration.

I am not going to forget about it. I am going to advocate for what veterans need.

Senator TESTER. Over the course of the campaign, President Trump has said that the VA is a disaster, the most corrupt agency in the United States. Do you agree with that?

Dr. SHULKIN. The President and I spoke about where the VA needs to go, and that is where we focused all of our attention. I did not talk to him about his past comments, but he and I agree, absolutely, firmly aligned, that we need to do a lot better for our veterans. We agreed upon that moving forward, that the Secretary's role is going to be to get those changes made.

Senator TESTER. How do you feel about the workforce in the VA?

Dr. SHULKIN. I feel we have such a tremendous workforce. I am so proud of our employees. Just bear with me 1 second, because, you know, I just cannot stop thinking about this. When I was in St. Louis, I actually made a visit with Senator McCaskill—we visited the VA. They asked me to meet an employee, one of our employees, though she did not want to really talk to me because she was very humble.

But what they told me about her is, the week before there was a veteran who had come 3 hours to his appointment in St. Louis, and they kept him waiting, so he missed his bus home. So, she is walking out to go home, with her coat, she sees this veteran in the waiting room, and she says, "Can I help you?" and he says, "Well, I missed my bus. I have nowhere to go. I do not know St. Louis. I am worried about staying here overnight." She said, "I will drive you home." He said, "It is 3 hours." She said, "Let's go," and she drove him home.

These are our employees. These are the people that people do not hear about. They are there, not for the money. They are there despite the bad press. They are there because they are passionate about helping veterans. Thirty-five percent of our employees are veterans themselves. These are the best people in health care, and I am proud to serve with them.

Senator TESTER. Do you believe that beating the hell out of the entire VA workforce is productive?

Dr. SHULKIN. Beating them up?

Senator TESTER. Yeah.

Dr. SHULKIN. Oh, I think it is destructive. I think it has hurt our ability to recruit. It has demoralized our workforce. It demoralizes those of us who are trying to improve it, and it has got to stop. I appreciate the Chairman and you both helping us with that.

Senator TESTER. VA job applications are down by about one-third. Is that correct?

Dr. SHULKIN. Even more, at the height of the crisis, they were down 78 percent. We are getting back.

Senator TESTER. Do you think that is part of the reason they are down by a third, because it has come in vogue to beat the hell out of the VA?

Dr. SHULKIN. A big part of the reason.

Senator TESTER. All right. A couple more questions, if I might. We would love to have you come out to Montana, for a number of reasons. We have got some great employees out there too. And make no mistake about it: the ones that are bad, we need to get rid of and get them out of the system. There is no doubt about that. But I will you there are some tremendous people out there.

I am wondering if you could find it to come to our great State, which has 10 percent of the population of veterans, second-highest only to Sullivan's State, of veterans. So, we can take a look at what is out there and take a look at the distances and visit with some of the veterans and the staff.

Dr. SHULKIN. Well, after I go to Alaska and West Virginia, apparently——

Senator TESTER. We are kind of on the way to both of those places.

Dr. SHULKIN. There you go. [Laughter.]

I will meet you there.

Senator TESTER. It is good.

Senator MORAN. Kansas is on the way, too.

Senator TESTER. All right.

I will present some questions for the record, but in closing, Mr. Chairman, I will tell you that I was not as prepared for this meeting as I should have been; and I will tell you why. These lights are bright and the beam comes down and hits off of Paul Rieckhoff's head——

[Laughter.]

Senator TESTER [continuing]. And increases the intensity, where I can hardly see David Shulkin. I am telling you, it is tough.

Chairman ISAKSON. I thought that was a halo. [Laughter.]

Thank you very much, Mr. Tester. I appreciate everything, Jon. As Ranking Member, I am looking forward to a great year, and I think we have already shared the common goals that I am going to talk about in just a second, but before I do, Jerry Moran has another question.

Senator MORAN. I did say one. I will ask three real quickly. Is that the same as one?

Chairman ISAKSON. No. It is three times as many. [Laughter.]

Senator MORAN. First of all, I was pleased to hear something you said, Dr. Shulkin. I think it was in response to the Senator from Montana's questions. We introduced legislation in the past, Senate Bill 1463, and it is corresponding with exactly what you said. Our goal was to get rid of the 40 miles—the issue we face is that people cannot use Choice because the VA has come up with reasons why they cannot, and we want them to be able to use Choice. So, it is whether the service is available——

Dr. SHULKIN. Yeah.

Senator MORAN [continuing]. Not whether there is a facility.

Dr. SHULKIN. I understand.

Senator MORAN. You said that, and that is the nature of how I think we improve choice, is to make certain that, again—colonoscopy is an example I use, and a shingles shot is easy. A guy wants a shingles shot at home, the VA says, "No, you cannot do that. You live within 40 miles of a CBOC," and the veteran says, "Oh, no, no. That is fine. I have called them. They do not do shingles shots." The VA's answer is, "It does not matter. There is a facility within 40 miles."

Dr. SHULKIN. Right.

Senator MORAN. Those are things we can get rid of, and you indicated that in your response to Mr. Tester, and I appreciate that.

Second, the authorities—you have responded to a letter of mine. Since the Chairman is critiquing the time, I would say I would still welcome an answer to this question. What authorities do you not have—what specific authority do you need to discharge the kind of people that Jon Tester just said we need to get rid of? And the example that we used with you, and the letter you responded to me, is the physician assistant who committed sexual acts against PTSD patients at Fort Leavenworth, the hospital, and he was allowed to retire. That has those victims of those crimes wondering, how did the VA let this happen in the first place, but second, why would not this person be fired instead of retired? And we still do not know the answer of what has transpired there, and I do not know that you will tell me that today, but I am still anxious in knowing.

Dr. SHULKIN. Yeah. Yeah. I look forward to working with you on that, because I do not want to be overseeing an agency that allows that to continue to happen.

Senator MORAN. And the final thing I would say—Mr. Chairman, I am anxious to help you in any way I can as we try to make certain that the VA does its job well, to support these Secretary and the employees at the VA. I look forward to working with you as the Chairman of MILCON/VA Appropriations Subcommittee to see that good things happen. And you can convince me that money is the issue, but first of all convince me that we are using the money that we get today in the very best way and we will be an ally.

Dr. SHULKIN. I agree. Thank you, Senator.

Senator MORAN. Thank you.

Chairman ISAKSON. Thank you, Senator Moran. We are going to close—I am going to close out. I have not asked any of my questions yet and I have three or four to ask. But I want to make—for the record and for all the staff, for all the Members of the Committee, we are going to hold open the Committee records until tomorrow at 6 p.m. for any questions that any member feels they need to ask. They will have until six o'clock tomorrow night to submit those to us. Dr. Shulkin will be able to watch the Falcons beat the Patriots on Sunday, and then get his answers in by Monday at 6 p.m. Is that fair enough?

Dr. SHULKIN. That is good.

Chairman ISAKSON. I am doing everything I can. I think you can see the Committee has been dedicated to this hearing. We have not had any of the monkey business, or whatever you want to call it, that we have heard going on at some of the other committees. We want to work this thing through, have your confirmation vote taken so you can get back to helping veterans and getting that done. So, be sure you get your answers back as quick as you can.

Dr. SHULKIN. We will.

Chairman ISAKSON. We will finish our FBI review sometime before Monday is over, so we will have everything done. Hopefully we will be able to have a vote on confirmation, up or down, at the end of next week.

Is that too soon? Did I say something wrong? We can do it by then, could we not?

STAFF. Yeah.

Chairman ISAKSON. For once I was right. That is great. I usually get that wrong.

Let me just say this. Dr. Shulkin, you have heard from Jon Tester, you have heard from Mr. Moran, you have heard from a number of the other members about Choice, and you have heard from me, and we have talked an awful lot about it. Choice needs to work, and it needs to be a real choice. It is the veteran's choice, not the VA's choice, or not the private sector's choice. We need to see to it that there are not limitations on who can go to a doctor in the private sector, that if they go to a doctor in the private sector we have accountability in the system to ensure the doctor does what they should.

Second, we need to make sure that the rate that we pay does not have a differential in it. Right now, if I am not mistaken, there are doctors getting different levels of pay that are doing care in the community. Is that right?

Dr. SHULKIN. Yes. Depending upon the geography and whether it is a rural area or not, yes.

Chairman ISAKSON. But it should be the Medicare rate, I think—is that right?

Dr. SHULKIN. Yes, in most parts of the country.

Chairman ISAKSON. If it is rural, is there a special dispensation for rural?

Dr. SHULKIN. Exactly.

Chairman ISAKSON. As long as it is because of the mileage, the distance, or whatever, that is fine. But we do not need competition in metro areas—

Dr. SHULKIN. Right.

Chairman ISAKSON [continuing]. Where services are available, by reimbursing different levels of rates to doctors. It should be the same and it should be the Medicare rate.

Dr. SHULKIN. Yes.

Chairman ISAKSON. Am I right that in 2016, there were 2 million more veterans' appointments served at the VA than there were the previous year?

Dr. SHULKIN. 2.1 million. Yes, sir.

Chairman ISAKSON. I think some—Choice contributed to that.

Dr. SHULKIN. Oh, absolutely.

Chairman ISAKSON. It contributed to that by having more available places for veterans to get an appointment in a timely fashion.

Dr. SHULKIN. Yes.

Chairman ISAKSON. I do not consider that—that was an increased cost of operation for the VA that only because the VA was being utilized, when before, they were not costing as much because they could not give the service—

Dr. SHULKIN. Right.

Chairman ISAKSON [continuing]. Because we did not have enough personnel.

So, for all this—wherever the people are that do the models back at CBO, that we have to base our legislation on, and we get our letters on, they need to understand that when they saw the amounts—the cost that went up, it was because veterans finally were getting the benefits they were supposed to get from their service. It was not an increase in the cost of the benefits. Is that right?

Dr. SHULKIN. I agree with that.

Chairman ISAKSON. And the more—the better the Choice Program works, in terms of easy access and not so much paperwork, the less it is going to cost the Federal Government to run the Veterans Administration and the less pressure it is going to be on the VA to have office buildings, hospitals, and facilities, because we will have a utilization of private sector which has those things, which will help lower the pressure on the VA.

Dr. SHULKIN. Yeah.

Chairman ISAKSON. The Denver hospital is the perfect example. The first challenge I tackled when I became Chairman was to find out we had a 1 billion—that is 1 billion with a B—dollar cost overrun in the construction of the Denver hospital. We went out to the hospital, Senator Blumenthal and I. Were you with us on that trip?

Senator TESTER. I was not.

Chairman ISAKSON. We got there and when we opened Pandora's Box, which we did, we had a hospital that was 43 percent funded, 57 percent unfunded, and nobody knew what to do.

Now, with the help of the entire Senate, Senator Blumenthal and I and the Committee, we got the money to finish that hospital, and part of it is now completed, as I understand. Part of it is now completed.

The overrun is not \$1 billion but it is pretty close, and when you get to something like that, you cannot just not finish it. You have got to finish it. But if you should not be starting it, you should not have started it either, and I think with Choice working the way it should, with good management of the VA, we will lessen the pressure on the VA to build hospitals and buildings, and raise the amount of money that is available for VA to provide services to veterans. And I think that is the perfect system you can have, because that is where I want the money going.

Dr. SHULKIN. Yeah.

Chairman ISAKSON. I want to see to it the veterans getting the benefits that they have earned by serving their country.

Last, and most importantly, I am sick and tired of turning on Fox television and CNN and whoever it is—I do not want to discriminate—all of them, I mean, whatever you call them. Every morning I get up at six o'clock to do my exercises, and I turn on my television set, and there is rarely a week goes by that at least one morning, and sometimes more, somebody has got a story about maggots being found in the wound of a veteran in a hospital, or drugs being dispensed in the wrong way to a veteran, almost like it is candy, or somebody doing something that just does not make any sense at all—Phoenix being the poster child for that all happening, by the way, I might add.

I want to be a part of a news-free VA that only is making news because of the good things it is doing, not the few isolated bad things that happen. But those things should not happen, and the things I quoted were things that actually have happened in recent months. And I want to work with you and work with Jon Tester and work with the Committee to tell the good stories of the Veterans Administration on health care on the floor of the Senate, and in the travels that we will make in the next 2 years.

But I want to make sure you commit to me that, when you have situations like this pop up, you will quickly tackle them, you will

quickly respond to them, and you will do everything you can within your power to see to it the people responsible for it are reprimanded to the extent you have the ability to do that. Will you promise me that?

Dr. SHULKIN. You have my commitment, Senator.

Chairman ISAKSON. Now, with me saying that, the last thing I want to say is this. When Richard and I worked so hard on the—and Jon, and everybody did last year—we got to the accountability portion, where we wanted to be able to fire people, and because of the Merit Systems Protection Board and a lot of other limitations, that could not be done.

There are a lot of people who think that the Merit Systems Protection Board and some of the employee protections that exist in the government are there to keep them from getting fired and give them protection to do their job, but a lot of them it gives them cover not to do as much of a job as they want to—not a lot, but a few. We want to—I want to see if we can work through this year to find a way with labor, with our different interests from the two different parties, and everybody else will say, “Is not there some way that Dr. David Shulkin could let his agency set goals, be tested, but his agency be monitored? And if there is someone—if there is someone—that does not respond to the goals that are set for them, does not respond to the care we want them delivering, that there is a way to then have a disciplinary action that brings about accountability.”

I would like to see you—help you do that. It may not be reinstatement of the Merit Systems Protection Board. It may not be anything that I have talked about. But, there is some way we have got to give you the tools that you need to run an agency of 314,000 employees, and 6.5 million beneficiaries in the Veterans Administration.

Dr. SHULKIN. Yes. I agree, sir.

Chairman ISAKSON. We will all work with you to try to do that. We do not want to fire anybody. We do not want to privatize the VA. We do not want to fire anybody. We do not want any of the stories that are going on to go around. But, we do want to start looking to solve the problems at the VA and see to it what it is to the public, what it is to us, and that is the best health care delivery system it could be for our veterans.

With that said, do you have anything else to say, Jon? Jon, do you have anything else?

Senator TESTER. No. The only thing I would like to say, Johnny, is thank you. David, we look forward to working together to make this confirmation happen as quickly as you can get your stuff in. I also wanted to thank you for being here today, David, and putting yourself up for this position.

Dr. SHULKIN. Thank you. Thank you very much.

Chairman ISAKSON. Questions for the record need to be in the office of the Committee by tomorrow night at 6 p.m. Answers from Dr. Shulkin, they need to be 24 hours after the Falcons win the game against the Patriots, which is Monday. [Laughter.]

We appreciate your time. We appreciate your testimony—

Dr. SHULKIN. Thank you.

Chairman ISAKSON [continuing]. And we appreciate your service to the country.

Dr. SHULKIN. Thank you.

Chairman ISAKSON. This hearing is adjourned.

[Whereupon, at 5:16 p.m., the Committee was adjourned.]

A P P E N D I X

LETTER FROM HON. ROBERT P. CASEY, JR., U.S. SENATOR FROM PENNSYLVANIA

ROBERT P. CASEY, JR.
U.S. SENATOR FROM PENNSYLVANIA
OFFICE OF THE CLERK
U.S. SENATE
WASHINGTON, D.C. 20510

United States Senate
WASHINGTON, D.C. 20510

February 1, 2017

The Honorable Johnny Isakson
Chairman
Senate Committee on Veterans' Affairs
412 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Jon Tester
Ranking Member
Senate Committee on Veterans' Affairs
412 Russell Senate Office Building
Washington, D.C. 20510

Dear Chairman Isakson and Ranking Member Tester:

I write to express my support for the nomination of Dr. David Shulkin, a fellow Pennsylvanian, to be the Secretary of Veterans Affairs. I regret that I cannot attend the hearing today due to scheduling conflicts to voice my support for Dr. Shulkin in person.

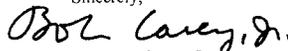
Dr. Shulkin will bring significant experience to this office. He has extensive experience as a physician and hospital administrator for more than twenty years. As VA Under Secretary of Health, Dr. Shulkin has proven his ability to lead the largest integrated health system in the United States and his willingness to make changes needed to improve the VA.

As Under Secretary of Health, Dr. Shulkin demonstrated his ability to drive positive and necessary reform at the VA. There is still much more work to be done - from ending the disability claims and appeals backlog to increasing access to the best mental health care. It is clear that the challenges facing the VA are enormous.

It is crucial that the VA Secretary is committed and passionate about taking care of our Veterans. Our Veterans and their families have sacrificed greatly for our country, and they deserve nothing less than the highest quality care and services that they have earned.

I support Dr. Shulkin, and I urge his confirmation. I look forward to working with him in this important role.

Sincerely,



Robert P. Casey, Jr.
United States Senator

PREPARED STATEMENT OF REP. TIM WALZ, RANKING MEMBER, U.S. HOUSE
COMMITTEE ON VETERANS' AFFAIRS

**Ranking Member Tim Walz
Committee on Veterans' Affairs
United States House of Representatives
Statement for the Record on the Nomination of Dr. David J. Shulkin
Secretary of the Department of Veterans Affairs
February 1, 2017**

Mr. Chairman, I want to thank you for the opportunity to share the perspective of House Democrats both on Dr. Shulkin's nomination and our priorities in the 115th Congress.

Serving our veterans as well as they have served us is one of the most bipartisan issues in Congress. As such, we have an incredible opportunity to work together to improve the lives of our nation's veterans. I know Chairman Isakson, Chairman Roe, Ranking Member Tester and I all share a common vision: to transform the VA to deliver care and benefits efficiently and effectively for every single American veteran.

Implementing that vision will be Dr. Shulkin's responsibility. Dr. Shulkin's distinguished career speaks for itself—running some of the largest health care systems in the nation, delivering quality health care and supporting groundbreaking medical research. In the 114th Congress, I had the privilege of working with Dr. Shulkin in his current role as Under Secretary of Health at the Department. I know him to be a true and passionate advocate for veterans, and I am pleased his nomination is being considered today. I believe his clear-eyed recognition of the challenges we face will serve him well as we move forward.

Over the past several years, every Member of Congress has fielded concerns from veterans, their families and loved ones about access to care and benefits. Our committees and the VA have done important work to improving our veterans' experience. Make no mistake, we still have work to do, and House Democrats are eager to roll up our sleeves and continue that work. As we move forward, we will continue to work diligently on both sides of the aisle to hold the VA accountable when needed and focus on our shared desired outcome: that no veteran is left behind.

Below are some of the specific priorities House Democrats will be focused on in the days ahead:

Access to Care

Over 9 million veterans rely on the VA every day for their healthcare needs and service-connected and specialty care. From traumatic brain injury, to post-traumatic stress, to diseases caused by toxic exposures, to women veterans' access to care, VA doctors, nurses, and medical support staff perform miracles every day. That being said, it is incumbent on us in Congress and this Administration to ensure that each of them have the tools necessary to provide quality and timely care. As we consider short- and long-term care solutions in the 115th Congress, we must acknowledge that public-private partnerships and non-VA care will continue to play a critical role in years to come.

VA Choice Program

Congress authorized the Choice Program under the Veterans Access, Choice and Accountability Act of 2014, P.L. 113-146 in response to a nationwide systemic VA patient access crisis. We need the VA to move towards a more integrated, permanent community care program that can respond to demands and needs for each city, region and state across the country. We need to decrease wait times and continue to deliver quality services to veterans and their families. The Choice Program has provided success in some areas, but in others, including my own district, we have experienced significant challenges that are unacceptable. As we work together to consolidate non-VA care, it is my hope that Congress and Dr. Shulkin work together to ensure the Department has the authority, budget, staff and provider and care networks in place to better coordinate care as the veteran population continues to age and more servicemembers transition home.

President's Memorandum on the Federal Hiring Freeze

The President's Memorandum on the federal hiring freeze issued on January 23, 2017 will harm veterans by leaving them without access to the critical care and services they deserve. Our nation's veterans have already sacrificed enough. They should never be asked to bear the brunt of this freeze. Whether it's a veteran applying for a job at another federal agency or scheduling a procedure at a VA hospital, this freeze will be felt across the country. Any partial lift or cherry-picked exempted positions is unacceptable. One in three people hired by the federal government is a veteran and this is nothing less than a burden and strain on the everyday lives of our men and women who served. Senator Tester and I teamed up to lead a letter to President Trump from our colleagues calling for the full lift of the freeze. As we move forward, Dr. Shulkin's assistance in identifying how this is impacting veterans and vacant positions still unfilled at the Department will be enormously helpful in advocating for veterans.

Mental Health

I look forward to continuing our bipartisan work to ensure that veterans receive the mental health care and services they deserve. Many of our nation's heroes return home only to face a completely new, internal war. We owe it to those who put their life on the line for our freedom to fight with them as they heal their invisible wounds. Chairman Roe and I founded the Invisible Wounds Caucus in the House prior to our leadership posts with our respective committees and so this an issue we feel strongly about across the House Veterans' Affairs Committee.

Dr. Shulkin and the new Administration have a moral obligation to improve the availability of mental health providers, mental health care and wrap-around services in every region and network as VA's data continues to show drastic and horrifying shortage. This is nothing short of a crisis and it is a bipartisan issue we must address today.

Economic Security

Our goal as a nation is to provide those who serve with the opportunity to achieve the American Dream; to utilize their skills, support their families, and have passion for their work. Make no mistake about it, employing a veteran is not only morally right, it makes sense economically as well. Veterans provide employers with a strong, skilled, and dedicated workforce. Put simply, veterans know how to get the job done. The veterans working in my office exemplify this every day and I'm proud to spearhead this bipartisan mission with my colleagues. I encourage Dr. Shulkin to continue the work of the previous Administration on bolstering the service-to-career pipeline and continue its partnership with the Department of Labor VETS. Whether it's protecting the Post 9/11 GI bill or improving the tuition assistance programs for transitioning servicemembers, I hope Dr. Shulkin and this Administration will work with House Democrats on these moral obligations to each veteran.

Affordable Care Act

As we explore short and long-term solutions for VA and non-VA care, we must take into consideration any potential impacts of repealing The Affordable Care Act. With over 22 million veterans in our country, only 9 million are enrolled in the VA. The millions of veterans who do not use VA or only use VA as a part of their health care needs is a critical component of our nation's care system. Since 2013, the ACA has reduced the number of uninsured elderly veterans by an estimated 42 percent according to the National Health Interview Survey. While the ACA has brought tremendous opportunity throughout our nation, we must recognize that increased access to care in some parts of the country does not translate into all. As both committees continue our work on the long-term implications of the Choice Program and coordinating care in the community, I urge Dr. Shulkin and the Department to take seriously the pending health care challenges ahead for our veterans and their families in the months to come beyond the VA.

I appreciate the opportunity to share our thoughts and perspective today. I have optimism and confidence we can move forward together in a direction that truly improves the lives of veterans for generations to come.

LETTER FROM LAURA THEVENOT, CHIEF EXECUTIVE OFFICER, AMERICAN SOCIETY FOR RADIATION ONCOLOGY



AS RO
AMERICAN SOCIETY FOR RADIATION ONCOLOGY

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January 24, 2017

The Honorable Johnny Isakson
Chair
Senate Veterans' Affairs Committee
United States Senate
Washington DC, 20510

The Honorable Jon Tester
Ranking Member
Senate Veterans' Affairs Committee
United States Senate
Washington DC, 20510

Dear Chairman Isakson and Ranking Member Tester:

Brave Americans who have served in our nation's military and have been diagnosed with cancer should never have to worry about timely access to the best available cancer care. Radiation therapy is one of the three major treatments for cancer along with surgery and chemotherapy. In recent years, there have been substantial clinical and technical advances in radiation oncology, resulting in new regimens with increased survival and improved quality of life.

The American Society for Radiation Oncology (ASTRO) is deeply committed to improving the quality of cancer care for our Veterans and all Americans, and strongly supports the nomination of David Shulkin, MD, to be Secretary of the Department of Veterans Affairs (VA). We believe that Dr. Shulkin's experience as VA undersecretary and as a physician executive uniquely qualifies him to accelerate necessary reforms to improve quality in the VA health system.

Under the new administration, ASTRO's experts in cancer treatment and research look forward to continuing our work with the VA, including our partnership with the VA's National Radiation Oncology Program, which oversees the development and execution of radiation therapy within the VA, on the [Radiation Oncology Practice Assessment \(ROPA\) program](#). ROPA will provide radiation oncologists at the VA with comprehensive feedback reports that show how each of their patients' diagnoses, treatments and treatment outcomes compare with national standards. Combined with the traditional cancer outcome measures of recurrence and survival, this assessment allows oncologists to see how changes in their clinical practice impact the success of each veteran's cancer treatment.

The ROPA program abstracts data from the VA's electronic medical record system into detailed feedback reports provided to VA radiation oncologists. Disease site-specific experts from ASTRO completed the first phase of the project in August 2016 by identifying quality measures for prostate and lung cancer patients.

Approximately 60 percent of cancer patients receive radiation therapy, including the brave men and women treated through the VA. ASTRO looks forward to working with Dr. Shulkin on ROPA and other opportunities to improve the quality of radiation oncology care among veterans and all cancer patients.

American Society for Radiation Oncology
January 24, 2017
Page 2

We urge swift Senate confirmation of Dr. Shulkin, and we look forward to working with him in this important role.

Sincerely,



Laura Thevenot
Chief Executive Officer

CC: The Honorable Phil Roe
Chair
House Veterans' Affairs Committee

The Honorable Tim Walz
Ranking Member
House Veterans' Affairs Committee

ASTRO is the largest radiation oncology society in the world, with 10,000 members practicing in both hospitals and community based centers who specialize in treating patients with radiation therapies. As the leading organization in radiation oncology, biology, and physics, the Society is dedicated to the advancement of the practice of radiation oncology by promoting excellence in patient care, providing opportunities for educational and professional development, promoting research and disseminating research results, and representing radiation oncology in a rapidly evolving health care environment.

LETTER FROM WILLIAM J. RAUSCH, EXECUTIVE DIRECTOR, GOT YOUR 6



January 31, 2017

The Honorable Johnny Isakson
U.S. Senate
412 Russell Senate Building
Washington, D.C. 20510-6050
(202) 224-9126

The Honorable Jon Tester
U.S. Senate
582A Hart Senate Office Building
Washington, DC 20510
(202) 224-2074

Dear Chairman Isakson and Ranking Member Tester,

In the military, "got your six" means "I've got your back." As a coalition, Got Your 6 works to integrate that commitment of support into popular culture, engage veterans and civilians together to foster understanding and empower veterans to lead in their communities. Got Your 6 knows that veterans leave the military seeking new challenges and we fight to ensure there are opportunities for them to continue their service while receiving the care and support they need.

We believe that when the Department of Veterans Affairs is successful, veterans are successful. That's why during Dr. David Shulkin's time as VA Under Secretary Health, Got Your 6 worked closely with him to reform VA while putting veterans first. Over that time, Dr. Shulkin helped propel VA along a transformational path that sets the current administration up for success. While Dr. Shulkin does not have our shared experience of military service, he has demonstrated his unwavering commitment of serving our veterans and our nation through his work at the VA.

Dr. Shulkin understands the needs of veterans and our desire to transform VA into a model agency. We look forward to working with Dr. Shulkin, his staff, and the entire Trump Administration to ensure that the reforms that have taken place over the last two years move forward and that veterans are continued to be put first. We proudly support his nomination and hope for a swift confirmation to become the ninth United States Secretary of Veterans Affairs.

Sincerely,

A handwritten signature in black ink, appearing to read 'WJ Rausch'.

William J. Rausch
Executive Director
Got Your 6

LETTER FROM RANDY REEVES, PRESIDENT, THE NATIONAL ASSOCIATION OF STATE
DIRECTORS OF VETERANS AFFAIRS, INC. (NASDVA)



*The National Association of State
Directors of Veterans Affairs, Inc.*

January 29, 2017

The Honorable Johnny Isakson
Chairman
The United States Senate Committee on Veterans Affairs
Russell Senate Building, Room 412
Washington, D.C. 20510

RE: Confirmation of Dr. David Shulkin as Secretary of Veterans Affairs

Dear Chairman Isakson:

On behalf of the National Association of State Directors of Veterans Affairs (NASDVA), thank you for the continued dedication and work of the Senate Committee on Veterans Affairs to ensure the best possible service and care for America's Veterans. We sincerely appreciate the willingness you have consistently shown in listening and giving kind consideration to NASDVA's ideas, concerns and recommendations for our Veterans.

We ask for the speedy confirmation of Dr. David Shulkin as Secretary, U.S. Department of Veterans Affairs (VA). As we all know, Dr. Shulkin is an accomplished physician and leader in healthcare. Most importantly, I think, he has been an important leader in the team that has effected the largest (positive) transformation in VA's history. We can all agree there is still work ahead and we are confident that David Shulkin will be a great leader for VA, serve our Veterans well and continue the MyVA Transformation.

NASDVA, through its member States, is second only to VA in the amount of direct service and care it provides to America's Veterans and we continue to be a formal partner with VA with one single purpose of serving our Veterans. We pledge our support and continued partnership to work, to the fullest extent possible, with Dr. Shulkin and his team to continue VA's transformation and to serve America's Veterans. I am

Sincerely,

Randy Reeves
President

Copy: The Honorable Jon Tester
Ranking Member
The United States Senate Committee on Veterans Affairs

NASDVA, Inc., 107 S. West Street, #570, Alexandria, VA 22314