VA 2030: A VISION FOR THE FUTURE OF VA

HEARING

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COMMITTEE ON VETERANS' AFFAIRS
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VA 2030: A VISION FOR THE FUTURE OF VA

Wednesday, February 27, 2019

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

The Committee met, pursuant to notice, at 2:00 p.m., in Room 334, Cannon House Office Building, Hon. Mark Takano, presiding.

Present: Representatives Takano, Brownley, Rice, Lamb, Levin, Brindisi, Rose, Pappas, Luria, Lee, Cunningham, Cisneros, Peterson, Sablan, Allred, Underwood, Roe, Bilirakis, Radewagen, Bost, Dunn, Bergman, Banks, Barr, Meuser, Watkins, Roy, Steube.

OPENING STATEMENT OF MARK TAKANO, CHAIRMAN

The CHAIRMAN. Good morning. I want to call this hearing to order.

Mr. Secretary, thank you for joining us today, and I truly appreciate your commitment to your job and to our veterans while you are recovering from foot surgery.

Out of respect and sympathy, I am starting this meeting right on the dot, and I am going to move this hearing along as quickly as possible, so that you can get back to following your doctor's orders to rest and elevate your foot.

Secretary WILKIE. Well, Mr. Chairman, thank you for that. You are too kind. This is the result of decades of athletic mediocrity.

[Laughter.]

Secretary WILKIE. And going to a school where the football dorm is named after Arnold Palmer, which ought to tell you something.

The CHAIRMAN. Okay, all right.

[Laughter.]

The CHAIRMAN. We will discuss that offline here.

I am going to strictly adhere to the 5-minute rule for each Member. And please be cognizant of how much time you have and, if you think you might go over, submit your additional questions for the record.

What I hope to get out of this hearing is to lay the groundwork for a long-term vision for the future of the VA. We all know what we need to do over the next year or two to keep VA functioning, but our aspirational goals should be to envision the perfect VA system and strive toward that, knowing that perfection is never attainable, but we need to establish an ideal and move toward that ideal.

By now I am sure most of you heard me use the term, the phrase, VA 2030. This is the term I will use when describing my vision of the VA; hopefully, an ideal vision of the VA.

My vision is twofold. The VA must be a system that is easy to navigate, easy to enter, with logical responses as veterans' needs change or new needs arise. The second part of my vision is that VA catches up to the changing and new demographics of veterans, and be nimble enough to adapt and respond to those demographic changes.

I often use VA's long-term care programs as an example of VA 2030. Today, there are countless resources to receive assistive care, which is great for veterans; unfortunately, there are countless ways in which veterans can access those services. This makes it confusing for veterans and their loved ones to find the right program to meet their particular needs.

In a perfect world, veterans seeking assist, whether it is with cleaning their house or mowing their lawn, or with greater needs for full-time care in a long-term facility, these veterans should have a single point of entry that evaluates their needs and eligibility for services, so that veterans and their families can make decisions that are right for them. And, as veterans age and their needs change, the care and services provided should adapt to veterans' needs, requiring little effort from the veterans and their families. Using this model, we should be able to remove redundant programs and find gaps in services, while making it easier to navigate VA services.

In the same vein, we must evaluate VA's programs and services to better serve women veterans, the LGBTQ community, and minority veterans. And, with this vision in mind, Ms. Brownley, the Chairman of our Subcommittee on Veterans' Health, Ms. Brownley developed the idea and framework for the Women Veterans Task Force. This task force will examine the current services that are specific to women veterans to see if there is room for improvement. It will also look at programs and services that are meant to serve all veterans, but might need adjustments to better serve men, like prosthetics and mental health care treatments.

This forward-looking process will take trust and a commitment from all involved to work, but we have proven that we have the ability to do it.

VA, Congress, and the VSOs all work together to improve the appeals process. Four years ago, the appeals backlog was enormous and growing. Veterans waited months and years for an answer. Today, thanks to bipartisan cooperation and full involvement with stakeholders, there is a far more efficient process where veterans have the ability to choose which appeal lane works best for them. This model is working to produce more timely decisions that veterans and VSOs are reporting as a large step in the right direction.

For the first time in many years we have a realistic grasp on eliminating the appeals backlog. Mr. Secretary, we have done it before and we can do it again, and I look forward to hearing from you on the areas in which we can quickly make meaningful changes and also areas that might take time, like appeals modernization.

I also look forward to working with Ranking Member Roe and the rest of my colleagues on the Committee to make sure that we meet the audacious goal of VA 2030.

The CHAIRMAN. Before I—well, go ahead. I am going to yield 5 minutes to my friend Dr. Roe for his opening statement.

OPENING STATEMENT OF DAVID P. ROE, RANKING MEMBER

Mr. ROE. Thank you, Chairman Takano, and welcome to all the new Members. I see a lot of new Members on the Committee and we have already had a busy start, so welcome to the Committee.

With the exception of this morning's joint hearing, this is the Committee's first hearing of the 116th, and I applaud you, Chairman, for calling this hearing and for ensuring right out of the gate that our work is forward-thinking.

The Department of Veterans Affairs is at a critical junction. The access and accountability crisis of 2014 brought VA back to the forefront of our national consciousness and ushered in a season of change that has left no facet of VA untouched. Last Congress saw major pieces of legislation enacted to fundamentally transform how VA provides care to veteran patients; how VA makes decisions about modernizing and realigning medical facilities; how VA processes disability claims appeals; how VA recruits and retains medical professionals and support staff; and for how long VA administered the GI Bill benefits; and how employees found responsible for poor performance or misconduct are held accountable.

That is a mouthful what we just did right there, and I want to thank the Members, the returning Members of the Committee for their work on doing this. That is to say nothing of significant strides that were made with respect to electronic health record modernization and interoperability with the Department of Defense. This Congress, our focus will need to remain squarely on how these major initiatives are being implemented, and how VA is preparing for the revolution they represent.

Our work in the last 2 years set the stage for what VA will look like and how VA will function a decade from now. But as the saying goes, and this is one of my favorite philosophers, Yogi Berra, if you don't know where you're going, you might end up someplace else. And it is incumbent on all of us, and especially you, Mr. Secretary, to cast a strong vision on VA's future; to put the right processes and the right people in place to enact that vision, and to remain steady in the face of stumbling blocks and struggles that are inevitable when change of the size and scale we are talking about is concerned.

And I want to note that change will come not just from VA, but from the veterans themselves. In the year 2030, the veteran population will look markedly different than it does today. And, Mr. Chairman, I will look markedly older than I do today, if I make it that far. There will be fewer veterans overall; there will be more veterans who are women and more veterans who are racial minorities. There will also be more veterans living and working in the South and West by 2030 than we see today. These demographic changes are significant, and VA is going to have to start preparing for them now, if the Department stands any chance of being prepared for them tomorrow.

And that is why I believe so strongly in the need for expedited implementation of the Asset and Infrastructure Review portion of the MISSION Act. A rapidly changing veteran population necessitates a rapidly changing VA. The AIR Act was specifically structured to assist VA in making those changes and to ensure that those changes are made through an objective, transparent, fully

data-and-consensus-driven process, rather than by bureaucrats behind closed doors. I urge you in the strongest terms, Mr. Secretary, not to delay the AIR implementation, and to work with this Committee on any legal impediments to swift implementation of AIR. It is perhaps your greatest tool in preparing the VA for 2030.

I want to end with a quick note on information technology before yielding. In the year 2030, if all goes well, the VA will have just finished EHR modernization and will have a seamless health record exchange with DoD. The EHR's development and operational costs will be predictable because VA will have shifted most of them to Cerner, but 11 years is a lifetime in the software industry and the EHR is just one element, albeit a big element, of the VA's overall health IT. We need to stay focused on the ultimate goal: interoperability.

When the Cerner decision was originally announced, I called on Secretary Shulkin to implement the new EHR inside of a world-class interoperability platform, not to build on interoperability functions inside EHR. I believe that even more strongly today. The partnership with Apple and the health app is a great example of interoperability solutions that work just as well today with VA VistA as it will in the future with Cerner. I think VA should incorporate an interoperability strategy in any kind of roadmap for the future, and I look forward to hearing this afternoon about how VA intends to do just that.

Chairman Takano, I thank you again for calling this hearing today, and I yield back my time.

The CHAIRMAN. The gentleman yields back.

Without objection, I am going to recognize the gentleman from California to speak out of order for 30 seconds to introduce a special guest.

Mr. CISNEROS. Well, I just wanted to introduce Sidney Walton. He is in the back there. Sidney lives in North County, San Diego. He is a World War II veteran and today is his 100th birthday.

[Applause.]

[Chorus of Happy Birthday.]

[Applause.]

Mr. CISNEROS. Thank you.

The CHAIRMAN. Thank you.

Mr. CISNEROS. Thank you. It is an honor to have you here. Thank you.

The CHAIRMAN. Well, Sidney, bless you and all of the members of the Greatest Generation for what you have done for our country, but let us get on to the business at hand.

I now recognize myself for—I now recognize the Secretary for his opening statement.

Secretary WILKIE. Well, I was going to take a backseat to you, sir.

[Laughter.]

STATEMENT OF ROBERT L. WILKIE

Secretary WILKIE. Well, thank you, Mr. Chairman and Dr. Roe, and distinguished Members of the Committee.

This is the seventh month that I have been privileged to be part of this wonderful VA team. And I will take speaker's privilege for

less than a minute to introduce myself to this Committee, because we have not had an opportunity in this forum to speak with each other.

I am very proud that General Mattis described me as having been born in khaki diapers; I take that as a great honor. I am the son of a gravely wounded combat soldier from Vietnam; I have had the honor of serving as an officer in two services, the United States Navy and the United States Air Force; and I have been a senior leader in the Department of Defense. I have had no higher honor in my time of public service than to be asked to serve with and for the 20 million veterans of the United States.

Earlier in the year I mentioned that we are no longer on the cusp of transformation, we are in the middle of the most profound transformation in the history of this Department since General Omar Bradley was the head of the Veterans Administration right after World War II.

I am also here to say that part of my pride is that I am a conservative Republican here to praise a Federal workforce. In the last few months, the Department of Veterans Affairs has been the recipient of accolades across the country, pointing out to the dedication, the loyalty, and the efficiency of our workforce. For the first time since the partnership of public service began taking its surveys about the best places in the Federal Government, the Department of Veterans Affairs is no longer 16 out of 17 or 17 out of 17, we are in the top third and moving forward.

In addition, the Annals of Internal Medicine, Dartmouth said last year that the medical care afforded to veterans in our system is as good or better than any in the country.

And, finally, the Journal of the American Medical Association said last year that our wait times are comparable to any in the private sector.

Now, that is a testament to the 370,000 American women and men who have made the choice of making the Department of Veterans Affairs their career.

So I mentioned that we were in the middle of transformation. Last year, the Congress passed the MISSION Act and the President signed it. What the MISSION Act does is present our veterans with more choice, more access, and more availability.

And one thing I will say right at the beginning, I have been told that there are some who believe that the standards we developed were, I believe, arbitrary and capricious. Well, let me say as someone who came up in this institution, primarily in the other body, that I take Article One very seriously.

Section 104 of the MISSION Act says that in order to develop access and availability standards we have to use the metrics that we see laid out in Tricare, in Medicare, and with the 20 largest health care insurance systems in the country. And my goal was to provide our veterans with two things: the kind of service that they were used to in the military when it comes to choice and availability, and to put them on the same playing field as their fellow Americans.

When it also comes to reform, we are talking about, as Dr. Roe said, the development of an electronic health record. No longer will someone like my father, after 30 years of service and terrible

wounds in Vietnam, have to carry around an 800-page paper record. We will begin developing a record that starts the day a young American walks into the military entrance processing station and comes to our VA.

In addition to business transformation, we are—as Ms. Brownley has pointed out in her service on this Committee, we are on the cusp of one of the greatest transformations in the history of our Armed Forces. When my father was commissioned 2 months before the Kennedy Administration began, less than one half of one percent of those in uniform were women. When I stepped down as the Undersecretary of Defense a few months ago, 17 percent of the active force were women, my guess is that will go to 20 percent by 2025. For the Department of Veterans Affairs, that means that right now 10 percent of those we serve are now women. This is not your grandfather's VA anymore. And the symbols that I use to describe the services that we provide is that we serve all of those who have served in uniform.

What we will probably also talk about today are the different crises facing VA that are crises facing the rest of the country: opioid abuse, suicide, and homelessness.

The great tragedy today is that 20 American veterans take their lives every day. The greater tragedy is that 70 percent of those veterans are outside of our Department of Veterans Affairs. Thanks to this Committee and Congress, we now have unprecedented resources to devote to that great American scourge, and I thank you for the support there.

But suicide, homelessness, and opioids are part of a continuum that can lead to tragedy, and VA is changing the way it treats our veterans. If you had told my father 30 years ago that when he came to the VA we would be offering same-day mental health services; to alleviate pain we would not be prescribing opioids in large amounts, but we would be offering an old combat veteran alternative therapies like tai chi and yoga; I probably would have gotten, at modest, in a modest way, a bad look, I might have been hit, but we are changing. We are changing with the climate and we are on the cusp of creating a modern 21st century health care administration.

I will conclude my brief remarks by ending the way I end many of speeches. In my life, I have been taught to look to General Eisenhower for inspiration, and I often remark about a scene on the presidential yacht Williamsburg right after he was inaugurated. He had 40 Korean War veterans on board, some were missing limbs, the rest were terribly disfigured, and he gave them a charge as only a Five Star General of the Army could do, he said you never put your uniform away. You live to remind your fellow Americans why they sleep soundly at night. And I believe that there is no greater charge for the Department of Veterans Affairs than to ensure that we remind our fellow citizens that they sleep soundly at night because of the sacrifices of those who served in uniform, 20 million who live, 9.9 million who use the VA.

And I thank you all for everything you do for America's Warriors and I appreciate your courtesy to me.

Thank you, sir.

[THE PREPARED STATEMENT OF ROBERT L. WILKIE APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Secretary, for your opening remarks, and especially the ending to your remarks.

I want to begin by recognizing myself for 5 minutes, and I want to begin asking you some questions about Blue Water Navy. I want to ask you specifically, will the veterans who served in the Republic of Vietnam, including in its territorial sea, be eligible for VA health care now that the Procopio is the law of the land?

Secretary WILKIE. Well, Mr. Chairman, I won't comment on the merits of the decision, because that is a pre-decisional argument that the Justice Department is still going through, but I will say that, if the decision stands, we are ready to meet the dictates of that decision.

I will also tell you, after discussions with many advocates and those who know much more about this matter than I do, we will probably be coming back to discuss how we expand the resources that we have to address the benefits, and the resources that we need to go back and look at the population that we will have to help.

First of all, we serve about 51,000 Blue Water Navy veterans now who have one of the Agent Orange presumptives, so it is not something that the Department has ignored. But if I as a recovering lawyer look at past jurisprudence, most recent class action decisions by the Supreme Court will tell us that we will have to not only support, rightfully so, those who served in those waters, but we will have to look to their families and their estates. And right now I don't know the number of those who would be impacted by that decision, but I stand ready to meet the dictates of the Court and come back with a briefing to this Committee as to how we will do that.

The CHAIRMAN. Thank you for that answer, Mr. Secretary. But have you or do you intend to recommend to the Solicitor General that Procopio be appealed?

Secretary WILKIE. The only thing that I have said is what I have told you. I have not given them any detailed response other than to say we will follow the dictates of the court and, if we do have that decision in place, we will have to come back to the Congress.

The only other thing I would be truthful in telling you is that I think that there are considerations of that decision that impact the State Department and the Department of Defense that I have no insight into in terms of a court actually changing the definition that has been in place since Thomas Jefferson was Secretary of State as to what is the actual definition of a Nation state. That is the best I can give you when it comes to my advice. But nobody at the Justice Department has asked me for anything more than that.

The CHAIRMAN. So your answer is that you have not recommended an appeal to the Solicitor General?

Secretary WILKIE. No, sir.

The CHAIRMAN. And you will not be? All right. Thank you for that answer.

You announced yesterday at the MilCon VA Subcommittee hearing that you plan to prioritize the initial claims of veterans award-

ed the Purple Heart. I just wanted to endorse this decision and congratulate you for that.

Can you tell us how you will implement this plan and, for example, will you use the DD 214 to make these determinations?

Secretary WILKIE. Absolutely, sir, yes, we will use the DD 214. Now, there are some Purple Heart recipients who are still the victims of that terrible fire in St. Louise in 1974 that wiped out 30, 40, 50, 60 years of Army records. We will do everything we can with the support of the VSOs and DoD when those come to us with those claims and say they have a Purple Heart, to go back and made sure they are made whole.

The CHAIRMAN. How quickly do you expect to get moving on this, about the timing; will implementation start immediately?

Secretary WILKIE. I believe we are going to do that in the next few months. I will contact the Department of Defense and make sure that those who are leaving active service with the Purple Heart are aware of the new regulations, and they put that in their transition package when they depart service, so the new batch of soldiers who have the Purple Heart know that when it comes to claims for their future VA they will have access to the front of the line.

The CHAIRMAN. Thank you, Mr. Secretary.

I am going to yield back the rest of my time and recognize Dr. Roe for 5 minutes.

Mr. ROE. Thank you very much, Mr. Chairman. And we would also like to welcome Mr. Sablan back to the Committee. He is like a bad headache, he just keeps going away and coming back. So, welcome back again.

[Laughter.]

Mr. ROE. Mr. Secretary, very quickly. As I mentioned in opening statement, I believe the Asset and Infrastructure Review component of the MISSION Act is critical to ensuring that the VA is set up to succeed in 2030 and beyond.

What is the status of the market assessments that represent the initial data-gathering stage of the AIR Act?

Secretary WILKIE. Yes, sir. Thank you. And this is also in line with the Chairman's article back in November with Military.com about the movement of the demographics within the VA.

The market assessments were held up after the passage of MISSION in the courts, that is now clear, we have let those contracts. I expect the first phase of the market assessments to be completed in the next few months. I also expect all of the market assessments to be completed in 2020. The Asset and Infrastructure Review Commission under statute is not scheduled to convene until 2022. If we finish in 2020, that is a 2-year lag. I think to meet the expectations of this Committee and the changing world of veterans, we are going to have to come back to the Congress and ask that we move that timeline up, so that the information available to the Asset and Infrastructure Review Commission is fresh, and they won't have to ask to go back in time to fill in the gaps that may have emerged from the time that the market assessment is finished and the time they convene.

Mr. ROE. So is there anything, any support you need from the Committee to begin implementing the AIR Act? That is the other

question, I guess, if you think we should move it up because of that length of time, 2 years.

Secretary WILKIE. Yes, sir. I will say that I will come back to you in the summer after this phase is completed and give you an assessment as to where I think things are and then, if we are on schedule for 2020, then I will ask for that authority.

Mr. ROE. Well, the reason I think this is so critical is that—this is in the private sector too, this is not just the VA, but heads in hospital beds peaked in 1981. So we had more patients actually by count in 1981 than we do today, and yet the population has grown 40 percent. The VA is not immune to that. And the VA and the demographics of the country are shifting where, as we said before, veterans are moving south and west. For example, in California, 10 percent of the homeless veterans live in one county, in LA County, and it is a huge problem. So we see that.

And the VA needs to be more nimble I think in how it is able to move, and I think this asset review is absolutely—we can't keep a thousand buildings under-utilized or not utilized at all and adequately fund the things just we are talking about, the Chairman was talking about, Blue Water Navy and so on.

Would you concur with that?

Secretary WILKIE. Yes, sir, absolutely. This is part of an entire business transformation effort that not only includes the assets of the Department, but the modernization of our business systems, our HR systems, the electronic health record, our supply chain, which I would look forward to coming to the Committee with a focus on that as we discuss how we move forward to the 2030 date. And it is part of an overall revamping of the Department that is long, long overdue.

Mr. ROE. Are your VA medical centers, are the directors or the VISN directors, are they looking at their plot of real estate right now and saying how do we want to look in VISN 1 or 10 in, as the Chairman says, in 10 years or 12 years?

Dr. STONE. Congressman, that is exactly what they are doing. They are looking at not only the demand signal from our veterans in a region, but also the age of the infrastructure. As we sit here today, about 63 percent of our beds are filled; that is not an efficient running system at 63 percent. We must reevaluate the number of beds that we are operating.

In addition, as you are well aware, it is very difficult to assess the quality of the commercial systems around us; they are not as transparent as your VA is. Therefore, being able to cull the information in the first 59 facilities it will be in in the next 3 months in order to do this evaluation is essential.

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

The CHAIRMAN. The gentleman yields back.

I now recognize the gentleman from Pennsylvania, Mr. Lamb, for 5 minutes.

Mr. LAMB. Thank you, Mr. Chairman.

Mr. Secretary, I think you have gotten a lot of questions in recent days about the vacancies in the VA workforce, I understand that is growing. We are now, I think we are getting close to 49,000 at this point, almost 43,000 in VHA; is that your assessment as well?

Secretary WILKIE. Yes, sir, of our authorized and strength, yes.

Mr. LAMB. Right. So we are showing up every day with less than 10 percent—or with more than 10 percent missing of who we could have.

Let me just ask you, I know there are a lot of reasons for that, I know the industry across the board is having some problems recruiting people, are you concerned about the shortage and what are you doing internally to try to fill these positions?

Secretary WILKIE. I will be honest with you, yes, I am concerned. I would not be honest with you if I told you that my focus would be filling 47,000 vacancies. I have to prioritize our efforts as to where we have the most need.

Your service in the Marine Corps will tell you exactly what I am about to say. My first week as the Secretary, I had two senior officials come to me and had two different numbers as to the number of employees we had. And the second, I said, where is your manning document? What's a manning document? As you know from your service, that is a list of the requirements you have, plus the people to meet them. We have none. For the first time, we now have a full-up executive system in place for HR management.

So the focus of my efforts is to fill primary care, women's health, and mental health. We have to compete with the rest of the country, those are the greatest areas. Mental health goes without saying. Women's health, that is because, as I mentioned at the outset, the makeup of our veteran's population has changed dramatically. And primary health because our newer veterans are used to urgent care.

So we are taking the tools that this Committee has provided; relocation, bonus pay, increased salary. I am probably going to come back to you and ask to expand that, so we can reach deeper into those populations.

And Dr. Stone does this on a daily basis.

Mr. LAMB. Sure. Just before you cut in, Dr. Stone, and I will give you the rest of my time to address it, I would like to leave here with a sense of what it is that has helped us so far in the recruitment effort. So it sounds like you are saying bonus pay, increased salary, relocation assistance.

Secretary WILKIE. Absolutely.

Mr. LAMB. You had some success last year in mental health in particular, right, attracting mental health professionals?

Secretary WILKIE. We did. I have not cleared this statement with anyone above my pay grade at the White House, I have had this conversation with General Mattis when he was Secretary, you all have helped us begin to break out of the traditional OPM, industrial age model of compensation, and that is absolutely vital if we are going to continue to serve veterans on all these levels that I just pointed out.

Mr. LAMB. And just one more question before we get to Dr. Stone. Have you received any direction at all from the administration not to fill these vacancies or not to fill some percentage of them? This is for the Secretary.

Secretary WILKIE. Oh, no, sir, not at all. No, no.

Mr. LAMB. Thank you.

Go ahead, Dr. Stone.

Dr. STONE. As you know, American health care and, as you have referenced, Congressman, American health care is a tremendously turbulent labor market. We are growing at 2 to 3 percent a year. We are faced with managing the system without the kind of manning document that we need. We have fielded a commercial, off-the-shelf HR system that is beginning to give us at least the discipline that we can see the openings of authorized and strength, but that doesn't reflect how we are meeting the needs of veterans.

And the best way to look at this is not against the 49,000, but against what our wait times are, and our wait times continue to be reduced across the delivery system and I would encourage you to take a look at those as far as how we are responding to urgent need. Every one of our medical centers today has same-day access to mental health care and has same-day access to primary care.

Mr. LAMB. And not to cut you off, but I do agree with that, the wait times are improving, and I am proud of that and I thank you both for working hard on that.

I also know that we are being told by the workforce, the boots on the ground, the nurses, the staff members, that they are shorthanded, and it is affecting the quality of their work, and it is affecting their own health and, you know, physical condition at the end of the workday. So the shortages are being felt by the people who are there, and I think we all need to work together to address that.

Dr. STONE. Yes, sir.

Secretary WILKIE. And I will just emphasize, and I agree with you, we do compete in that same pool as the private sector and as the military does.

I will also add to what Dr. Stone about wait times. One of the prides I have in coming to you is that in the latest survey of our veterans who are in our system there is an 89-percent satisfaction rate, which tells you that we are getting the quality service. But, as you pointed out, if we don't get the nurses and the doctors the help, that is going to go down.

The CHAIRMAN. The gentleman's time has expired. Let's try to keep our questions within the timeframe.

We have—we are going to be called—we have been called for votes. We are going to have time for one more question before we are going to be having to go vote.

I want to recognize Mr. Bilirakis, the gentleman from Florida, for 5 minutes.

Mr. BILIRAKIS. Thank you, Mr. Chairman. And I appreciate your service, Mr. Secretary.

Mr. Secretary, looking back at the past 10 years, despite an increase in funding, VA's data shows that veterans' suicide rates have not declined, or they haven't significantly declined, that is for sure, but rather, at best, remain steady. With around 20 veterans dying by suicide every day, to me, VA has failed those veterans. And I can understand, and you can elaborate, Mr. Secretary, about the 70 percent, what have you, but the fact is that these are veterans and we need to get to these veterans and get them the care they deserve.

My question is, in 2030, how will VA have worked to eliminate the veteran suicide so, instead of 20 veterans dying every day, we

are down to less than one? And can you elaborate how you expect the broad public health approach VA is taking will achieve better outcomes?

Secretary WILKIE. Yes, sir. I will let Dr. Stone talk about the broad, new public health approach that we have to our individual veterans. I will say, as I said earlier, it is a great national tragedy. Of those 20 veterans who take their own lives every day, two or three are on active duty, two or three are from the Guard and Reserve; the vast majority, I understand from our surveys, are from the Vietnam era. So some of those American warriors have problems that began when Lyndon Johnson was President; I can't cure that, but I can put resources and new thinking into our suicide prevention program.

This year, our budget for suicide prevention is over $200 million. We have on board now the Pentagon's senior expert on suicide as a permanent leader of our suicide prevention efforts. We have even provided your office staffs insight on what you can do if a veteran calls you in distress. We are spreading that out across the country.

We now have same-day mental health services. That is absolutely vital for those veterans who are calling out for our help. We had about 20,000 individual events last year in terms of education and outreach.

The last 2 months of the fiscal year when I became Secretary, I understand there was a GAO report that said $15 million had not been spent on outreach. In the 2 months that I was in charge, I spent 13 out of that $15 million on outreach. We will not let a penny go to waste in that area.

But we are now engaged in a holistic approach and a cry for help also to the greater public. I spent a lot of time in the Pacific and the Pacific Northwest talking to our Native peoples. I went to Alaska to talk to the Alaskan Federation of Natives. More than half of the veterans in Alaska are outside of VA. I asked them to double the number of tribal representatives that they have to help us find those veterans. That same formula applies in Florida, which is the fastest-growing veterans state in the country. I need mayors, I need NGOs, I need churches, because we aren't reaching those 14 out of 20.

And I will let Dr. Stone tell you about the medical approaches that we are taking.

Dr. STONE. The great difficulty that we face is, in spite of the fact that we can identify risk sub-populations within the veteran community, it is reaching them. The 14 deaths a day that occur in veterans not associated with us, not coming to us for care, require a public health approach and a partnership with multiple communities, as well as non-profits to support us.

Let me give you an example of that. Never-activated Guard and Reserve are not considered veterans, they have never been called to Federal service, three a day, of the 14, three a day commit suicide, primarily within former Army Reserve, which account for two of those three, one of three come from the Guard.

In addition, when veterans transition out of service, many of them don't engage us, and an active engagement using our transition assistant programs to try and get them to engage with us should be very helpful in engaging back.

So success in 2030, a public health approach that brings us back into contact with the 14 a day at risk and mitigating that risk.

The CHAIRMAN. The gentleman's time has expired.

I am going to call a recess, so that Members can go vote, but I encourage all Members to return as soon as possible after the final votes, so that we can resume questioning with the Secretary.

[Whereupon, at 3:00 p.m., the Committee recessed, to reconvene at 3:55 p.m., the same day.]

The CHAIRMAN. The Committee will reconvene.

And, Secretary, by unanimous consent, I want to accord you 2 minutes for a point of personal privilege.

Secretary WILKIE. Thank you, sir. I won't take that long. I was remiss when I came in and I saw the picture of Walter Jones, Sr. on the wall, Mr. Jones was a friend of my wife's family in Fayetteville, North Carolina, and I was a close friend of his son and your colleague, late colleague, Walter Jones, Jr. And I issued a statement on behalf of the Department of Veterans Affairs when Congressman Jones passed that the veterans of Eastern North Carolina didn't have a better friend. And I miss him, I miss his friendship, and I thank you for allowing me to mention him, and I appreciate your courtesy.

The CHAIRMAN. Thank you, Mr. Secretary. I also had a chance to get to know Mr. Jones and he will be missed in the Congress.

I now want to recognize for 5 minutes the gentleman from New Hampshire, Mr. Pappas.

Mr. PAPPAS. Well, thank you, Mr. Chair.

I appreciate your patience, Secretary Wilkie.

Secretary WILKIE. Sure.

Mr. PAPPAS. And, you know, I think as has been said for the last several days as we have convened, we are at an important flexion point for the VA. I see that in terms of my own state and the leadership transition that has happened at the Manchester VA in New Hampshire, as well as what is happening across the country. So, thanks for your efforts as part of that and really look forward to the working relationship over the next couple of years.

We talked a little bit before about the workforce, and about some of the challenges that the system faces at recruiting and retaining, and certainly that is a problem across our economy that any medical facility is grappling with right now. I wanted to ask specifically about physician assistants, and I know there has been legislation recently on this.

The VA Choice and Quality Employment Act of 2017 required the implementation of competitive pay for physician assistants to improve recruitment and retention. The omnibus appropriation bill of 2018 also had a provision requiring a pilot program to train military corpsman and medics to become PAs and, upon graduation, work within the VA.

I am wondering if you can give us an update on the implementation of this program.

Dr. STONE. Let me say a couple of things.

Mid-level providers, whether they be nurse practitioners, CRNAs, or physician's assistants, are essential to our delivery system and, therefore, expansion of the utilization and the assurance that we

can use them to the maximum level of their license is essential to the future.

As we implement the additional training of training corpsman or those coming out with advanced skill sets from the services to additional PA—or additional PA skill sets and licensure was included in the laws, as you mentioned, and we are actively working to implement those and to move the funds against those to provide scholarship abilities for it.

And so we look forward to expanding the role of PAs in our delivery system and, as we have talked already, the difficulties in rural areas, PAs can fulfill that, as can our advanced practice nurses.

Mr. PAPPAS. Thank you. I appreciate your response on that and look forward to continuing to provide some oversight on this Committee in terms of the rollout.

In addition to that, I wanted to ask a little bit about the burn pit issue. It has been one that has received the focus of this Committee, it is going to continue to receive the focus over the next term, and I am wondering what changes you would like to see in the VA's burn pit registry to make sure that it is an effective tool to provide compensation and care for veterans who have been exposed.

Secretary WILKIE. Yes, sir. I mentioned at the beginning, I am a son of a combat soldier from Vietnam and I am acutely aware on a personal level of the toll that combat brings, issues like Agent Orange. I actually have the perspective of when I came back to the public sector of having worked with Senator Tillis and Senator Klobuchar to draft the burn pit legislation that eventually became law, the burn pit registry being vital to that, because we don't want to see what happened with Agent Orange happen again.

I am confident that we are getting the number of warriors who were exposed to those burn pits in the numbers that are sufficient, so that when a determination is made as to how to deal with that on a health care level that we will be ready to launch in a way that we weren't ready to launch on Agent Orange back in the '80s and early '90s.

Dr. STONE. The only thing I would add to the Secretary's statement is that the exposure to burn pits seems to cause some sort of very small airway disease and it is very difficult to diagnose. And, although we have large numbers of veterans who have registered as burn pit exposed, we have lesser numbers that have come in and actually gone through health care examinations for us. And we need to do a better job of reaching out to them to bring them into the system, to assure that we are capturing everything we possibly can.

I happen to have had the opportunity early in my training of working Agent Orange clinics. I understand the difficulty that we had at that time. We need to not repeat that fact with burn pit exposure. This all must, however, be based on science and therefore we need access to the veteran to do so.

Mr. PAPPAS. Thank you.

I yield back.

The CHAIRMAN. The gentleman's time has expired.

I now would like to recognize the gentleman from Florida, Dr. Dunn, for 5 minutes.

Mr. DUNN. Thank you very much, Chairman Takano.

And thank you, Secretary Wilkie, for taking the time to be here with us today, I appreciate that. Thank you for your participation.

I want to applaud you on the list of priorities that you have laid out for the clear mission. It makes it easier for our Committee to help you with the tools to accomplish the overall mission that you have of serving our veterans. I also commend your efforts for consulting a number of resources in order to establish best practices, resources from the government, from the private sector organizations, to create the best proposed standards pertaining to wait times and driving times to the VA facilities.

With the specialty care access standards to be finalized soon, can this Committee anticipate that the proposed rules for transplant care, transplant care, will reflect the proposed rule for access in specialty care, or am I mistaken, and the transplant care is built into the specialty rules?

Dr. STONE. It will come separately and within the next few weeks. We originally wrote into the access standards the transplant standards and it became very confusing. We decided to pull back in order to get the access standards out and to begin the debate on access standards, but you will see them within the next few weeks.

And it is absolutely essential for us to get those standards out for transplant. There are many areas of the country where we are the only provider in especially remote areas. We need to get the standards out and allow the debate to occur on them.

Mr. DUNN. If you would like us to weigh in, I have done transplant surgery, I am certainly—I am sure we can find the standards pretty easily and work our way through that with you. So I look forward to working with you on that.

The MISSION Act contained actually two provisions relating to transplant care and the other one was Section 153 that provided the Department with authority to provide living donor transplants, that is something new to the VA. Of course, the Department will not be able to utilize that authority until the rulemaking process is complete, and I understand that to be projected to be sometime around July 2020. We already have veterans that are suffering on the waiting list and it seems like we can do a little faster than that with living—and, again, with the living donors, there is plenty of guidelines on that in all the transplant centers all over the country.

Can we move that forward or can there be an interim rule?

Dr. STONE. Congressman, the counsel would have to judge whether we can do it by interim rule or not, and so I am respectful of that and I have not asked for an interim rule. But you are correct, and we support your position of trying to move this faster. And as we roll out all of these regulations regarding MISSION Act, this is one that has to come quickly forward.

You know, we do over $8 billion worth of end-stage renal disease care inside the VA. The ability to do transplants are essential to transforming the lives of those veterans in end-stage disease.

Mr. DUNN. And many of the transplant centers that the VA has are actually co-located with civilian—great, famous transplant centers that are civilian, and as are other VA hospitals that do not do transplants. And, you know, I assure you that—you know, I have

many friends who are still doing that in that arena who would love to help you and love to help our veterans.

So, with that, I want to thank you both for coming here and sharing your ideas. Secretary Wilkie?

Secretary WILKIE. I agree with Dr. Stone that we need to push this as quickly as possible, but I wanted to thank you too, because the very first event that I did as the Secretary was with you in North Florida and I thank you—

Mr. DUNN. That's right, thank you so much.

Secretary WILKIE [continued].—thank you for your courtesy to me, it was very much appreciated as the new and unknown guy on the block.

Mr. DUNN. Thank you so much, sir.

Mr. Chairman, I—Mr. Chairman—

Mr. LAMB. [Presiding.] You have had a substitution.

Mr. DUNN. I yield back.

Mr. LAMB. Thank you. The gentleman yields back.

The chair recognizes Mr. Levin of California for 5 minutes.

Mr. LEVIN. Thank you, Mr. Chairman, for holding this hearing today.

Thank you, Secretary Wilkie, for joining us. I am hoping that Committee Members have a strong and productive relationship with you this Congress, so that we can achieve as much possible success for our veterans as we can. And I am very honored to be the new chair of the Subcommittee on Economic Opportunity for veterans and represent the district in Southern California with Marine Corps Base Camp Pendleton.

I do want to ask you about some concerns that I have heard surrounding implementation of the Forever GI Bill and the VBA's IT systems as a whole. Both of those issues I think will be a focus this Congress.

Mr. Secretary, in your written testimony you discuss the implementation of Sections 107 and 501 of the Forever GI Bill and you said, and I quote, "By spring 2020, all enrollments will be processed according to the Colmery Act," end quote. And, as I understand it, you will have three or four semesters' worth of claims to reprocess, while also processing the spring 2020 claims. We certainly don't want a repeat of what happened last fall where delays and late payments impacted our student veterans.

I have not seen a detailed plan on how you are going to accomplish this goal, so I ask, what is the VA's plan to make it happen? Are you going to need more staff, bandwidth upgrades, or IT fixes, and are those needs going to be included in the President's budget?

Secretary WILKIE. Thank you, sir. And I will get you the schematic on the way ahead, but let me describe what happened.

My first full day in office was August 1st of last year and it was pretty apparent to me that we were reinforcing a broken system. And I ordered that we go back to the previous system, which pays our recipients what we were paying them at the fiscal year 2018 level. My goal was to make sure that our veterans had something in their pockets.

Now, in terms of the overall difference, we are talking about a cost-of-living increase that was less than 1 percent, but I made the command decision to go back so they had money in their pockets.

Those who might have been overpaid because of bad IT, we are not going to make them pay that back, and those who were not given the entire amount of money they were entitled to, they will be made whole.

The contract for the new system was let out last week. What I put in my formal testimony is accurate, I expect everything to be on schedule and back to the norms set by the GI Bill either at the end of this year or at the beginning of next year. I don't envision any new staff having to be hired, because the IT system, which is being run by a very important, big company, I believe will obviate the need for additional staff, but I will get back to you if there is any change in that.

Mr. LEVIN. I appreciate that, Mr. Secretary.

A different topic. Homelessness among veterans is an issue that is very important to me and it will always be at the forefront of our constituents. It is a big issue in Southern California. Our district encompasses San Diego County and in North San Diego County there are several hundred homeless veterans. We as a Nation have made a log of progress on this issue in the past decade, but we still have a long ways to go and, obviously, if one veteran is homeless, that is one too many.

How does VA plan to work with its partner agencies to address veteran homelessness once the veteran is already in crisis? And also how are we going to identify more veterans at risk for homelessness before they are in crisis, push resources to them early, and identify risk factors during the transition to tailor the transition assistance program to the needs of the individual?

Secretary WILKIE. Thank you, sir. If the chair will indulge me, I am going to probably take more than 45 seconds. And let me start with I think was the saddest observation that I have made in my short time as the VA Secretary and it pertains to Southern California. I was in West Los Angeles at their VA Center and, about 6:00 or 7 o'clock at night, cars started to come into the facility and the people in the cars were not coming out to go to the hospital. I was informed that these were veterans who had jobs, who were contributing to the tax base of Los Angeles County, who were employed, fully employed, but they could not afford a place to live.

I went to the Mayor of Los Angeles, Mayor Garcetti, and said we need to be closer. We do have programs that this Committee and your companion committee dealing with HUD have now fully funded; however, I think we need more VASH vouchers. But I began discussions with the City and County of Los Angeles to allow them to create more transitional housing for us. The problems, as you said, are particularly acute on the West Coast. It was an eye-opener.

One way we are looking at this in terms of long term—and I talked at the beginning of the hearing about a continuum of issues, opioids, homelessness, suicide, and how they come together. We have changed our approach to medical care for those who are at highest risk by taking a whole-health approach, and working with our cities and counties to find people who are outside of our purview and bring them into the system. We have changed the way that we prescribe medicine. We are now looking at more creative ways to partner with the states to create that transitional housing.

Dr. Stone can talk more about the medical side, but we have to look at this in a new way.

When veterans are working and they are making the community better because they are working, we need to expand the aperture on housing. It is Southern California that is the epicenter. I tend to go back again, but I applaud—I have not talked to Governor Newsom, I had a long discussion with Governor Brown before he left, and the Mayor, I am going to talk to the Mayor of San Diego as well. If we got a handle on homelessness in Southern California, the number of homeless veterans in this country would decrease exponentially, that is the epicenter. We will do more.

Mr. LEVIN. Thank you.

Dr. STONE. The only thing I would add to that is a number of our medical centers, probably Washington D.C. has the prototype for it, does recurrent outreaches to the community in which we bring in as many veterans as possible at risk and create a one day in which we do everything we can to try and get them off the street and into our health care systems. A month ago we conducted that at the Washington D.C. VA. Many of us were there for the day working those issues and brought in more than 1,000 veterans from this community, either at risk of homelessness or homeless, in order to bring them an opportunity to improve their lives.

Secretary WILKIE. And I would note that it is not as if America as a whole is not getting a handle on this. About 10 years ago, 400,000 veterans and their families were on the street. It is still too many, it is down to 70, but what I have noticed in my time both as the Undersecretary of Defense and now as the VA Secretary is that we are now seeing different populations, young mothers with families on the street, and that is why I felt it was so important to get to the leaders in Southern California to get us started.

That is not a satisfactory answer, but it is certainly an issue that we need new approaches to.

I apologize for going long.

Mr. LAMB. Thank you, Mr. Levin.

The chair recognizes Mr. Barr from Kentucky for 5 minutes.

Mr. BARR. Thank you, Mr. Chairman, and Ranking Member Roe. Thank you for holding this hearing.

Secretary Wilkie, Dr. Stone, thank you all very much for your service at the Department, your service in the military and continued service to our veterans.

It is probably my highest honor to represent the veterans of the 6th Congressional District in this seat, and it is a big responsibility as well. And we established a Veterans Coalition that is now over 1,000 veterans in the 6th Congressional District of Kentucky, and they do a great job giving our office information and feedback about how we can best serve them.

And, Secretary, you mentioned in your testimony that the VA is now engaged in the greatest transformative period of its history, and I think that is in part largely because of the work that this Congress did in the last Congress passing the VA MISSION Act, and in this Congress we will have the responsibility, the important responsibility of overseeing your Department in the implementation of the MISSION Act.

Mr. Secretary, in your testimony you mentioned the transition from the various programs established under VA Choice to the new, streamlined Veterans Community Care Program. Can you describe how the new Veterans Community Care Program is going to be better for the veterans in the 6th District of Kentucky and around the country?

We know that in January you issued the proposed access standards, so I think our veterans understand what those are, but beyond that, beyond those proposed access standards, what can our veterans expect in terms of the transition from Choice to the new Community Care.

Secretary WILKIE. The first step in creating a modern, 21st century health care administration, when it comes to community care, there were seven different community care programs this Congress—the last Congress culled that down to one, so it is understandable to veterans, to providers, to the local communities. We now have in place the contracts for four regions in the country, the companies that we have the contracts will be able to pay our local hospitals, our small-town doctors, what are they owed; legacy payments will be first. We cannot offer choice, greater choice, unless our small towns are taken care of. Without that, then the system collapses in on itself.

I am particularly cognizant of rural America, not just the great West where we are talking about an expanse of hundreds of hundreds of miles, but also places that I am familiar with having grown up in North Carolina, rural Tennessee, rural Kentucky, rural North Carolina, allowing our veterans when they need it to go to our small-town hospitals.

So consolidating the programs into one, easily understandable, paying our bills, and training our local doctors, nurses, clinics to be part of our greater system. Without that, choice does not work.

The second part of it, and it is the part that is not seen, is the greater business transformation of the Department; HR, supply chain. I have talked about General Mattis. General Mattis and I decided that because we kept reading stories about VA doctors not having the right equipment, and some doctors and nurses having to run across a parking lot to another hospital to get that equipment, we decided that the best thing for us would be to join up with the Defense Logistics Agency and operate a modern supply chain, computerized, programmed supply chain, so that we distribute what we need to our doctors and nurses and medical professionals across the country when the need is there. Without that, we can do all the reforms we want, but if the doctors and the clinics and the hospitals don't have the supplies it doesn't matter.

If Dr. Stone has anything—

Mr. BARR. And, Mr. Secretary, if I could just interject. One kind of snippet of feedback that we are getting from our veterans is the frustration they had with Choice was the additional layer of bureaucracy going through the contractor, and then the medical records getting lost from VA to the contractor, and then finally getting to a community care provider.

In my remaining time, Mr. Chairman, with your indulgence, one final question. And that is, as you know, veterans diagnosed with post-traumatic stress and traumatic brain injury often become iso-

lated and withdrawn as they try to manage their trauma experience. Studies have shown that programs such as adaptive sports help recovering veterans with engagement, independence, and quality of life, which are also important factors in preventing veterans' suicide. As you may know, I represent the horse capital of the world and am particularly aware of the benefits that equine-assisted therapy can have in adaptive sports. And my question is, in what ways is your Department looking to expand adaptive-sports therapies and in particular equine-assisted therapy?

Dr. STONE. We currently have 60 active equine programs across the system. Very effective, as you stated. And, just in recognition of the time, we are actively looking to expand it, as we are all other adaptive sports.

Mr. BARR. Thanks. I look forward to working with you.

I yield back.

The CHAIRMAN. The gentleman's time has expired.

I would like to recognize the gentlelady from Virginia, Ms. Luria.

Ms. LURIA. Thank you, Mr. Secretary, for meeting with us today, and I want to thank you again for the outreach from your office. I know that the new veterans in Congress appreciated the opportunity to meet with you and your staff.

Secretary WILKIE. And I think you got a visit from my daughter today with the Virginia Space Coast Scholars, talking to you about that program in your district.

Ms. LURIA. Well, thank you as well. And also thank you as well for the attention to the growing population of women veterans, and I appreciate you having Dr. Patricia Hayes from the Veterans Health Administration reach out to us as well to address some of those issues in more depth. And through our conversations that we had, we talked specifically about the ways that we can leverage the partnership between the VA and DoD facilities. Furthermore, after that I met with DoD health leadership within my district, and I do think that within Hampton Roads there are additional possibilities to leverage that and I know that it has been successful in other places in the country. So I wanted to thank you for suggesting that and look forward to working with you and your staff on that as well.

As the chair of the Disability Assistance and Memorial Affairs Subcommittee, I wanted to get back to the previous discussion about the Blue Water veterans from earlier in this hearing, and I just wanted to make an additional clarification.

I appreciate your assurance that, if Procopio stands, that you will follow the dictates of the court, but I wanted to further clarify, my understanding is that decision only includes Blue Water veterans for the purposes of VA benefits, but for the purposes of VA health care would you within your discretion as Secretary extend Priority 6 health care for the Blue Water veterans?

Secretary WILKIE. I am going to give you an incomplete answer. I would assume that that would be the case, I don't know legally if—I just don't know.

Dr. STONE. We are making that assumption, but have not had legal clarification of it, but we are actually working our way through trying to understand the scope of services. As the Secretary mentioned in his prior testimony, we are already treating a

portion of that beneficiary population; should the rest come, we are preparing for that.

Ms. LURIA. Okay. So, from your answer, the assumption is we are all moving forward under the assumption that they will receive the health care benefits as well.

Secretary WILKIE. I will ask the lawyers and get you a complete answer.

Ms. LURIA. Okay, I appreciate that. Thank you.

And I yield the remainder of my time. Thank you.

The CHAIRMAN. The gentlewoman yields back.

I would like to now recognize the gentlewoman from American Samoa, Ms. Radewagen for 5 minutes.

Ms. RADEWAGEN. Thank you Chairman Takano and Ranking Member, Dr. Roe.

Welcome Secretary Wilkie. It is great to see you again. When it comes to the future of VA, I am really optimistic. Work is never done, but we have made some great strides forward last year under the leadership of former Chairman Roe. With continuation of that leadership under Chairman Takano, I am sure that we can carry forth with that momentum and I am looking forward to working with VA on the implementation of the VA Mission Act and other bills passed last Congress. And I also look forward to working with my colleagues on unfinished business such as Blue Water Navy.

Mr. Secretary, thank you for your continued commitment to serving our veterans in the territories, especially when it comes to accessibility to health care. I don't have a specific question at this time, per se; instead, I just want to reaffirm that commitment and give you some time to briefly touch on VA's plans regarding Community Care options in the insular areas.

Secretary WILKIE. Thank you, and I will come see you. I have a particular interest in your area of America, but as a part of a larger issue, and that is the people of the Pacific Islands, the people of the Nations of the United States, the mainland participate in the Armed Forces at a rate higher than any other groups in America, highest percentage per capita of Medal of Honor holders, and that is a community that I would like to pay special attention to because of the contributions, but because, also, of the unique challenges that exist in your area—access, distance—also in the continental United States, distance as well in places like Alaska.

The statistic I use is that in a place like Alaska, half of the veterans are outside of the VA. I think the numbers in Samoa and Marianas and Guam are not as high, but they are in the high numbers, and that is something that we have to redress, and I thank you for your courtesy to me.

Ms. RADEWAGEN. Thank you.

Mr. Chairman, I yield back.

The CHAIRMAN. The gentlewoman yields back.

I would now like to recognize the gentlewoman from New York, Ms. Rice.

Ms. RICE. Thank you, Mr. Chairman.

Mr. Secretary, thank you so much for being here and for being patient while we had to go and vote. I want to commend you on all of your efforts that you are making to modernize the VA and there is one area of modernization that I have been working with

Senator Gillibrand on and a lot of the service organizations, and that is to, through the motto of the VA, recognize the contribution of women veterans. The Department, up to this point, has rejected the idea of modernizing the VA motto to be more inclusive of all veterans by stating that, "It is not VA's policy."

The original motto comes from a line from Abraham Lincoln's second inaugural address and we propose to change it very simply to read as follows: To fulfill President Lincoln's promise, to care for those who shall have borne the battle and for their families, caregivers, and survivors.

Now, this is not an issue of political correctness, but more an issue of respect for the over 2 million women veterans in the United States today. And I just wonder if you could give your opinion about what you think. Would you be—until we are able to pass the bill that we are going to reintroduce in this Congress, would you be willing to institute a change to the motto for everyone who works within the VA so that we can recognize the significant contributions of all of our women veterans.

Secretary WILKIE. Yes, ma'am. Let me tell you my philosophy first and then I will address the motto. I mentioned earlier today when referencing Representative Brownley, that my motto is that we serve all veterans. In my prior life as the undersecretary of defense for personnel and readiness, my first directive was to finally give the Department of Defense a policy on military—on sexual harassment and equal opportunity and to revive and modernize our equal opportunity apparatus. That also includes the LGBT community. That is why I am very happy to say that we serve all veterans.

I think you will find that veterans' hospitals are a welcoming place. That we are adjusting and have adjusted to the change in the demographics. I am very proud of that. It doesn't matter who you are or where you are from: You put on the uniform, you are a veteran.

I will tell you philosophically, I am not arrogant enough to say that I want to change Abraham Lincoln's words.

Ms. RICE. Well, I am—

Secretary WILKIE. Let me finish, if you don't mind. Abraham Lincoln, the greatest figure in western civilization, without him, there is no veteran's bureau, veterans department. I am happy with being part of his legacy, but I tell you what our philosophy is: We serve all veterans. And I am not in favor of changing the motto. I let actions speak louder than words—

Ms. RICE. I appreciate that and—

Secretary WILKIE. That is my hardcore feeling.

Ms. RICE. No, I appreciate that. But let me also say that there would, in keeping with President Lincoln's focus on equality for all, I am sure if he were alive today, he would say women should be acknowledged as well, just because they didn't serve back then. But I appreciate your position and I hope someday maybe you will change your opinion on that.

Very quickly, because I am mindful of the time, I—earlier, before the break, you had mentioned efforts that you were making to face the challenge of recruitment retention of the workforce. I just want to speak about the Northport VA, which is just outside of my dis-

trict, but on Long Island. In the past two years alone, they have lost—they have had changeover. They have had four medical center directors, three chiefs of staff, three nursing department directors, and the heads of the human resources department and physical plant have all left the facility. So, that is just an example in one VA just outside of my district.

So, we have to come up with a—and I appreciate the efforts that you are making, but we really have to step it up, because that is just at one VA, that kind of turnover. You can't have any consistency in care with turnover like that.

Secretary WILKIE. I will let Dr. Stone finish that. I want to apologize. I did not mean to cut you off on the previous exchange and I—

Ms. RICE. Oh, no, no, no. I just—it was just the time. Thank you.

Secretary WILKIE [continued].—appreciate your passion and I thank you for letting me speak.

Dr. STONE. The authorities under which we retain our medical center directors limit our pay to about 35 percent of what a medical center director could earn even in a medium-sized city.

Ms. RICE. Yeah.

Dr. STONE. You should expect from us, some proposals that would begin to look at medical center director pay in order for us to retain these great talents. On average, a medical center director earns between a hundred fifty and $180,000. That number is between three hundred and fifty and 600,000 in the commercial space.

Now, that said, 87 percent of our medical center director positions are filled. Why? Because people are connected to the mission and it goes back to your previous comments. People love this mission. That is why we retain nurses at dramatic rates. People are connected to the mission.

Ms. RICE. Thank you. I yield back. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. The gentlelady's time has expired. I now would like to recognize the gentleman from Indiana, Mr. Banks, for 5 minutes.

Mr. BANKS. Thank you, Mr. Chairman.

Mr. Chairman, I would like to challenge you for a moment. I appreciate that you held this hearing today on the future of the VA at 2030 and the data has already been shared many times today, but as you know, we currently have 19 and a half million veterans today. And 2030, the date that we have chosen for the hearing today, a vision for the future of the VA at 2030, we will have a projected 15 and a half million veterans.

But let's look beyond that for a moment, and hopefully sometime in the future, we can have a hearing on the VA at 2045, because that is a date that I circle. A look at that point, we will have, what is forecasted about 12 million veterans, and at that point, it will be the Gulf War generation, the Post-9/11 generation, my generation of veterans. From 19 and a half million veterans today to a projected 12 million veterans at 2045, the VA has no choice but to modernize and become much more different in how it serves our veterans from what it does today. I look forward to that hearing at some point, as well, but I do applaud you on this hearing today,

because looking to the future is an important part of what we do on this Committee.

So, with that, Secretary Wilkie, there is an incredible amount of talk about sinister plots to privatize the VA with really no evidence that that is happening. The real issue that I see is the integration of the military health system. Some amount of integration has to become inevitable when it comes to military health system. The VA is going to need the military population and DoD already needs the veteran patient mix.

MHS Genesis and electronic health record modernization are going to make integration increasingly possible, as I know you agree. So, what are your goals here when it comes to that? What kind of planning is your team doing to make sure that that integration is orderly, beneficial, rather than haphazard?

Secretary WILKIE. You said it: Change management is the key. The answer that I give to a lot of people on the issue of privatization is in line with your remarks. The electronic health record actually keeps Veterans at the center of care. We are in the process—and I will be coming to this Committee hopefully to discuss the final building block in terms of joint program management of this, of the EHRM, which will bring together formally, the Department of Defense and VA in a way that no two large departments have ever come together. So, that is the joint solution in the future.

The other part of this is the demographic change which you just highlighted and which the Chairman highlighted in his article from military.com. I am in the process of standardizing the MOUs for our relationship with our military partners. For instance, Fort Sill, Oklahoma, classic example. VA happened to have more dentists than Fort Sill did. We entered into an arrangement where Fort Sill shared—we shared our dentists with Fort Sill. Fort Sill opened up Reynolds Army Hospital to the VA.

The problem with that paradigm is it really depends on the personalities of the leaders involved, the personality of the medcom commander. We have to eliminate that.

In my hometown Fayetteville, North Carolina, we sit underneath Womack Army Medical Center. The cross-pollination of our resources is absolutely essential if we are going to mitigate extra costs, cut down on administrative overhead and create that modern system. I expect that whomever replaces General Mattis on a permanent basis, I will be in constant discussion with them.

And, you are right, it is actually 2045 that we really need to have our eyes on, because without that increased cooperation between VA and DoD, many of these reforms won't work.

Dr. STONE. I appreciate your perspective. Certainly, America needs a robust medical-care system to deploy with our war fighters and it is deeply troubling when you listen to the potential disassembling of that system, including a potential of 17,000 medics coming out of uniform. That said, the secretary's vision of an interoperable EHR, a combined supply chain, facilitates reduction and risk should you see in the future, the need to bring these systems closer together.

In addition, our polytrauma systems are robust and growing. This is a healthy and growing health care system that we anticipate, even with the reduction in veterans, continued increased de-

pendents of the remaining veterans on the system, the complexity of a lifelong commitment to our veterans, as I stated earlier in our end-stage renal disease are exactly the kind of patients that active-duty military need to sustain their skill sets.

So, we have 1700 academic affiliations today. We look forward to a close and productive relationship with our DoD partners in the future.

Mr. BANKS. Mr. Chairman, my time has expired.

The CHAIRMAN. The gentleman's time has expired. I now recognize the gentleman from California, Mr. Cisneros.

Mr. CISNEROS. Thank you, Mr. Chairman. Thank you, Secretary Wilkie and Dr. Stone for being here and for your testimony today.

Secretary Wilkie, ensuring servicemembers receive the most adequate care and knowledge possible when transitioning from active service to civilian life is of the utmost importance to me. I am most concerned about our transitioning servicemembers falling through our institutional gaps, not aware of the benefit they deserve, and not uplifted in the way we promised.

I think it is great, the work that you are doing on the transition to the health service—electronic health service health records and the integration of the DoD and the VA, but if we are not engaging our servicemembers, as you said, what difference is it really going to make? So, how do we engage our servicemembers so that they know or are aware of the benefits that they have and the medical services that they are entitled to when they leave active-duty service?

Secretary WILKIE. Your question is right on point. I actually have the benefit of having been the undersecretary of defense for personnel and readiness and was able, with the permission of the Secretary of Defense, to put in place the most comprehensive DoD to VA transition program that the Department has ever had in cooperation with the VA. So, we begin educating our servicemembers the year before they tell us that they will be departing on the benefits that they will receive, the future in the VA, but more importantly, given the health issues that we have addressed today, educating them on issues like PTSD, educating them on mental health issues, educating them on the signs for suicide and opioid addiction, educating them for the first time—and this is a VA issue, as well—on financial stability.

One of the things that I was very proud to implement was that, particularly when it comes to our young Marines, most Marines don't spend 20 years in the service; they are out after 6 or 7 because of the operational tempo. They would leave service with nothing in the bank. We now, from the time they enter boot camp are educating them on financial—their financial future and what they can expect and allowing them now to participate in the Thrift Savings Plan, so they leave with something.

So, you are absolutely on target. I think the DoD is in a much better place than it was—and I will let Dr. Stone talk about the health—because that is where we need to continue to make inroads.

Dr. STONE. Trying to get the veteran or soon-to- become veteran to see us—to come to see us is the great difficulty. In the Vietnam-era veteran, we stood up 300 vet centers, which are small store-

fronts mainly with behavioral health and assistance to make it easier to use our systems, in order to come in and to get to yes. We need to evolve the vet centers to make them welcoming places for the Post-9/11 generation and I am quite proud of the role that the leadership at the vet centers is doing in order to do that.

But moving from a cohesive military unit where an individual feels tremendously connected to coming out into a deeply disconnected civilian population creates huge risks for our veterans. And engaging early, engaging often, and then creating ease of transition by whatever means necessary is exactly what we must be doing.

Mr. CISNEROS. You know, I feel too often the emphasis is put on the veteran to go and seek out the support rather than the VA being open to, like, we need you to come in. So, how do we change that scenario?

Dr. STONE. So, let me just say to you that I mentioned earlier the suicide risk amongst Guard and Reserve. The Guard and Reserve leadership has allowed our mobile vet centers to come into their drill weekends to begin to reach out. We are also interacting with human resources command across the services in order to find ways to reach out to more distant, retired, or out-of-uniform personnel.

Secretary WILKIE. And I would say, sir, that we have to rethink and repackage the way we look at military service. I will say whenever I am approached or asked that VA is on one end of the national security continuum. I quoted General Eisenhower at the beginning, I don't think we have made that clear, that we are part of that national security world and what DoD is doing now is something that it probably should have done many decades ago, but now that we are beginning at that end, I think veterans will be much better off.

Mr. CISNEROS. I yield back my time.

The CHAIRMAN. The gentleman yields back. I now recognize the gentleman from Pennsylvania, Mr. Meuser.

Mr. MEUSER. Thank you, Chairman. Thank you, as well, Dr. Roe. Mr. Secretary, thank you very much for being here. Dr. Stone, I really appreciate it. I am finding this very informative and really appreciate your obvious high level of knowledge and dedication to our veterans and Veterans Administration, so thank you.

I come from Pennsylvania, the Ninth Congressional. We are a relatively rural area. We are very fortunately, though, I think the best district in the country. We have got 85,000 veterans. That is unfortunate to have in the district. We are served by the Levittown VA, which tends to rank pretty high; it does very well. The Wilkes Barre VA is right outside my district, but many constituents do go there, and they do a fine job, as well. We do have Fort Indiantown Gap, so we have many military personnel and veterans from that within the district. The Toby Hannah Army Depot is right outside my district. So, it is very much of a military area; many military families are touched by the VA.

The Levittown VA has done a great job. It is really a center to innovation. It has many vets in there on a regular basis, even for social reasons, which is really, really nice. They have done an excellent job in really cultivating, maintaining strong community relationships and that is something, frankly, that I strongly encour-

age, for the local VAs to become part of the community as businesses do and other hospitals, because it really works out for them.

They bring in a lot of state and local officials, primarily—the Levittown VA—the VSOs and such, other non-governmental agencies. So, they really do a nice job.

The veterans there are very satisfied. I would say very satisfied, as it ranks high with the health care services. Now, many do go to more local community doctors for special services closer to where they live and just in response to the proposed 60-minute drive distance, is the VA planning to improve the space-leasing process, because I understand that can be a little cumbersome, so local VA facilities can increase their points of access or is it the idea to contract for care throughout the community or a combination of the two?

Secretary WILKIE. Thank you, sir. I want to say we were talking earlier about the projections in the movement of the veteran's population through 2040. Pennsylvania is a constant in the top 10. So what you said is indicative of the entire state.

You just hit on something that is part of the new way of looking at this. As Dr. Roe has said, we are getting away from the construction of new hospitals. I mean, there have been some in the pipeline. We are getting care that is closer to home. This Congress has afforded us the opportunity to finally close the circle on family caregivers and their support.

Leasing is important. I mentioned Fayetteville, North Carolina—two massive VA facilities in Fayetteville. Two thousand new veterans a month coming into the Fayetteville VA. The new facility is leased. I mean, it is so big that we have golf carts that bring in people from the parking lot. But by leasing it, our people can focus on the needs of the veterans, not cutting the grass and those kinds of daily things that make a building work.

So, that use-mix has to be part of the future, and as Dr. Roe has pointed out, the days—I will say it: The days of us building a four-billion-dollar hospital have to be a thing of the past.

Dr. STONE. We do feel—and I am going to come back to the lifetime commitment we have with the American veteran. There are certain disease processes that are some complex, for instance, prostate cancer, one of the most common cancers in the American male is unusually more aggressive in the American veteran, especially the Vietnam-era veteran. We, therefore, have entered into a relationship with the Prostate Cancer Foundation and The National Cancer Institute in order to provide state-of-the-art germ-cell testing, as well as precision oncology to the 12,000 veterans that we diagnose with prostate cancer each year.

So, we certainly see ourselves buying certain care in the community because it is convenient or it is in a rural area, but those are transactions of health care. We think the full understanding of the American veteran should remain with the veterans' health care system and, especially, in areas like prostate cancer and other solid cancers are things that we ought to be in the center of.

Mr. MEUSER. Chairman, thank you. I yield, but I would look forward to having a continued conversation. I hope that is available. Thank you.

The CHAIRMAN. The gentleman's time has expired.

I now recognize the gentleman from the Northern Mariana Islands, Mr. Sablan.

Mr. SABLAN. Thank you, very much, Mr. Chairman, and Ranking Member Roe, for holding today's hearing looking into the future of the state of Veterans Affairs Department, because for me, I mean, at least we have some luxury of looking into the future, but for me and the veterans that I serve, we are looking at today.

I am from the Northern Mariana Islands, so distant away. I think during Columbus' time, they said that if you travel the ocean then you would come to a cliff. Where I am from is that cliff that goes down. That is how far away.

But, you know, as we look ahead to a vision for the enhancement and care and services, we will deliver our veterans 10 years, 20 years to the future and beyond, I want to call your attention to a particular underserved segment of our veteran population: those living in the U.S. islands, including my district, the Northern Mariana Islands. Our men and women from the islands from long served their country honorably in peacetime and war, throughout history, and across the globe, yet, when they return home after service, they don't have access to a full range of veterans benefits they have earned. When I got into office, we didn't even have a fee-based clinic for our veterans. I made that come to be.

So, what can the VA do now and what does the VA intend to do over the next 10 years to ensure that the veterans in the insular areas are remembered and fully included in the VA's transformation.

Dr. STONE. The remoteness and areas you described so adeptly are challenged in many areas. Yours is certainly unique. We do have clinics on a couple of the islands, but, certainly, areas like Saipan continue to challenge us.

We have contracted with commercial contractors in that area, but continually look forward to the time when we might be able to operate a fully encompassing VA clinic and that the demand will drive that.

In addition to that, the inability to provide specialty care to remote veterans is a continuing challenge resulting in the robust tele-specialty care work across more than 50 specialties that we offer out of both our Hawaii-based system, as well as the rest of the delivery system. That said, there are still times that that veteran must be transported across the ocean in order to get to care.

We have also asked our contractor to provide rotating circuit-rider services across the system, and as we did, the Region 5 and 6 and Alaska and in the Pacific, that will be one of the requirements, is the ability to provide services more robustly to your constituency.

Secretary WILKIE. And I would say, sir, and I mentioned it earlier, and it is something I feel: No community in America serves at a higher percentage. No community in America has a higher percentage of Medal of Honor holders, and I am committed to do everything that we can to make sure that we don't have an underserved population and that the service of your veterans is recognized with the best care that we can give.

Mr. SABLAN. I very much appreciate this. I am going to run out of time, so I will submit some questions, Mr. Secretary, and thank you for that.

My one—if I may, comment on my last comment, during your testimony before the military con—mil-con VA appropriation Subcommittee hearings, I think yesterday, you mentioned plans to visit the Pacific later this year. Trust me, the ship won't fall down that cliff anymore. But I hope your plans include a visit to Northern Marianas so you can meet our veterans and see for yourself, the need to VA care and services in our islands.

And I named an advisory committee, some veterans. You will meet them. You will meet all their veterans, and if you could just come.

Secretary WILKIE. Yes, sir. I believe I will be out with you in May. I think that is right. And what I mentioned yesterday was I was astonished. I was told I was the first VA secretary to visit the big island of Hawaii.

Mr. SABLAN. Well, you will be the first VA secretary to visit.

Secretary WILKIE. And I want to make sure that there are no more firsts. So, I believe that I am on the schedule to come out in May or June.

Mr. SABLAN. Thank you very much.

And I have questions that I will submit for asking. Thank you, I yield back my time.

The CHAIRMAN. The gentleman's time is expired.

I now recognize the gentleman from Kansas, Mr. Watkins, for 5 minutes.

Mr. WATKINS. Thank you, Mr. Chairman. And thank you, Mr. Secretary, and, Dr. Stone, for your leadership, your commitment to veterans, and your professionalism.

I am glad to join this Committee. I look forward to working with you, as well as my democrat and republican colleagues to get you what you need to succeed.

I am going to—I chose—I requested and was granted the opportunity to contribute to your efforts to modernize your technology. And your goals, I believe, will only be met if electronic health records are modernized.

I represent Eastern Kansas, so we have got Topeka, Leavenworth, 55,000 veterans, including myself. I get my medical care at the Topeka VA. And veterans need great quality and access to healthcare and a seamless experience from their active-duty or National Guard Reserves to their veteran experience, and I think EHR is how that is done.

So, we are here to talk VA 2030. So, has the VA yet quantified the goals and benefits expected from the new ERH modernization program, and especially over the long term, so, for example, health outcomes, fewer redundant tests between DoD and VA, greater provider efficiency?

Dr. STONE. I appreciate this question, because it really goes to the heart of this whole modernization effort. The ability to use data for future health outcomes requires the data be accessible and we be able to data mine it, even using artificial intelligence. And when you look out to 2030 or 2040, that data shouldn't wait for me to

be smart enough to ask the question of the data. There should be data mining that moves things forward.

Now, as a physician, I am used to every time I type a medication in for a patient, a pop-up coming up of, oh, by the way, you are allergic to this medicine. The future is that data pop-up ought to include your genetic typing that predicts risks of either disease processes or reactions to medications.

Our million veterans programs have already turned up over 200 medications that are used for other things that may be usable in future hypertension work with veterans. So, the future of this program and the success of it is essential over these ensuing years, and it is mostly about how we will use the data in the future for the benefit of individual veterans.

Mr. WATKINS. Thank you, Dr. Stone.

Mr. Chairman, I yield my time.

The CHAIRMAN. The gentleman yields back.

I now recognize the gentleman from Texas, Mr. Allred for 5 minutes.

Mr. ALLRED. Thank you, Mr. Chairman, and thank you, Mr. Secretary and Dr. Stone for being here and for your excellent, informative answers and for the hard work that I know you are putting in.

I represent Texas and Dallas, Texas, and Texas has the, as you probably know, the second most veterans in the country of any state and we have nearly half a million veterans who live in the North Texas region that are serviced by our VA hospital there, which is one of the largest in the country. I had the opportunity to visit that facility. I saw some incredible work going on there with some dedicated folks. They had wearable robotics that were allowing veterans to walk for the first time in years that I was just blown away by. Great childcare for veterans who come in who have kids and want to have their kids watched while they are getting the service that they need.

But that market is growing extremely rapidly, as with many of the markets that I know we have talked about today; in fact, the estimates that I have seen is that the tenth fastest-growing market is the North Texas region for veterans. And we have some of the problems that go along with that, and the estimate here says that we have a shortage of inpatient beds has resulted in as many as 75 veterans each day waiting for a bed at our local VA.

In an attempt to address that, there is a local hospital that they are trying to acquire in my district, and it would be the only VA facility in the northern part of Dallas, in the northern part of my area, and they are working hard to do that. And this hospital would provide an additional 180 beds for VA patients and as many as 2,000 additional jobs in my district.

And that is a priority for me, and I think Senator Cornyn has also reached out to you about this and I think that there is going to be some bipartisan support for this. And I just wanted to know if you would commit today to working with me and working with us to get this project across the line.

Secretary WILKIE. Let me first start by saying that the projections that we discussed about looking out to 2030 and 2040—and I don't mean this as any slight to the chairman—is that Texas

passes California between 2030 and 2040, in terms of the number of veterans.

Before I let Dr. Stone answer, I have been to Dallas. I have talked to the leadership about the hospital purchase and expansion and I have talked to Senator Cornyn, so you have my commitment to work on that, in light of what is happening in Texas, and I will let Dr. Stone finish.

Dr. STONE. We may be short as much as a million square feet in your market and we can't move fast enough to get this done. This looks like a really exciting opportunity. We had the engineers out looking at that facility. The local leadership has said, Gee, with a coat of paint, we would be ready to go. I want to make sure that that is correct.

In addition, the secretary is advised by a public private-partnership advisor. We have had her out looking at that and engaged in that, as well as, we brought our chief of acquisition, Karen Brazil, into this discussion and her team to see how we could move and make sure that we do it properly. That said, every day, we have the problem of referring people out that we should be able to keep in the system.

So, it is an exciting time and we welcome your partnership in this, but we have got everybody engaged in it and I look forward to engaging you and the secretary as we work our way through this.

Mr. ALLRED. Well, thank you. My office is—we are going to be working with you closely on this. We want to make sure that we can get this across the line, and if there is anything that we can do to help you in that process, you know, I hope you will free to reach out to us. As I said, I think it is a win-win; it is kind of an obvious thing, I think.

Very quickly, I just wanted to touch base with you on veterans' homelessness. I had the honor of working in the Obama Administration in the Department of Housing and Urban Development, and we tried to put a focus on ending veterans' homelessness and putting a significant dent in that. There are some programs that we initiated, and I have seen some news reports saying that in 2017 we had a slight increase in homelessness, 2018, a reduction. I just want to see where we are in terms of work now and what we can do, as a congress, to help you to combat veterans-homelessness.

Secretary WILKIE. Absolutely. The good news is that 10 years ago, there were 400,000 veterans on the street. The bad news is there is still—there are less than 100,000, but that is still bad news.

I have a wonderful relationship with Secretary Carson. I was mentioning earlier my impressions from Southern California, and I will say again, I think the saddest sight that I have seen—and Mr. Chairman, I maybe ask your indulgence—was watching cars coming into West Los Angeles and the veterans in the cars at night, they all had jobs. They all contribute to Los Angeles County. They contribute to the tax base. They are doing what is expected of them and they can't get housing.

In that case, I was very happy to engage with the mayor of Los Angeles, Mayor Garcetti. We have got an understanding of how we are going to increase transitional housing.

The other part of this is what I have seen in terms of the change of homelessness in the homeless population. Different from what I saw in Los Angeles is that we are now seeing more single American women with families who are homeless. So, we have asked for—we will ask for more money, so is HUD, for the transition, for supporting services for families, for homeless, and we need a robust relationship with the localities to help us find those folks.

Mr. ALLRED. Thank you, and thank you, Mr. Chairman, for your indulgence. I yield back.

The CHAIRMAN. The gentleman's time has expired.

And Mr. Secretary, our time together is coming to a close. I thank you for your willingness to answer so many questions and bear with us and we went through our votes. I wanted to say that there is no offense taken about the truth about the number of Texas veterans that we are seeing down the pipeline.

In fact, I am very grateful that Mr. Allred decided to join the Committee; we recruited him. He already serves on two Committees and we knew that we needed representation from Texas on the Committee because of the number of veterans and we wanted to make sure that there was somebody, a point person, that would, you know, advocate for them and advocate for their needs.

Mr. Secretary, I look forward to, you know, working with you. We intend to invite the person that you had mentioned whose—the point person inside your department on veteran suicide. We hope that they will join us at our roundtable.

Secretary WILKIE. Yes, they are coming.

The CHAIRMAN. I hope we can pull together a hearing of some principal folks. My intention is not to inflame the moment. I understand how complicated addressing this issue is. It is complicated and we know the VA has made tremendous strides and has improved its mental health offerings significantly, but there are times when the VA may fall down.

But there are other complexities that we need to solve together as Members of Congress, and I pledge to you and the American people that Dr. Roe and I are going to work together as a team on this issue in combatting veterans' suicide. I want to give Dr. Roe a moment to say a few final words and then we are adjourned.

Mr. ROE. Well, I am sorry Mr. Allred laughed at being from Texas. Tennessee has a history of taking care of Texas and we would have taken care of the vets there or not.

And Dr. Stone, I wanted to thank you for your uplifting comments about Vietnam-era veterans, like myself, that had a more aggressive form of prostate cancer. That leaves me feeling much better since I was treated for that about a year and a half ago, so thank you for uplifting me.

One of the challenges that VA has, and Mr. Allred and all the California folks were all on it, is that the challenges there are—and I just looked it up and the average home price in Los Angeles is $828,000. I have been to West LA and have been through what they are trying to do. They are trying very hard there to help take care of the veteran homelessness. The average lease is $4,000 a month.

The average home price where I live is $148,000 and that is the wealthiest county in my district of 12. So, it gives you an idea

about your money goes a lot further. That may have something to do with why veterans are moving to the South and somewhat to the West.

But there are unique challenges, no question about it, in California, where 10 percent of all the homeless veterans in America live in one county. So, I applaud you for trying to do something there. It is heart-wrenching to see a veteran who served this country who is working for a living out there trying, and cannot live in a home.

I look forward—Mr. Takano—I know, Chairman Takano, you have set a good mark for the Committee. I think we have a lot of to.

Mr. Secretary, Dr. Stone, thank you all both for being here—very forthright—we, again, apologize for having to go vote and leave you all sitting here, but we appreciate the time, the enormous amount of time you spent with us this afternoon, and look forward to working with you all during this Congress, and I yield back.

The CHAIRMAN. Thank you for your courtesy. Thank you very much, both of you.

All Members will have 5 legislative days to revise and extend their remarks and include extraneous materials.

Again, thank you, Secretary Wilkie. I wish you a quick recovery, and this hearing is now adjourned.

[Whereupon, at 5:15 p.m., the Committee was adjourned.]

A P P E N D I X

Prepared Statement of Honorable Robert L. Wilkie

Good afternoon Chairman Takano, Ranking Member Roe≥, and distinguished Members of the Committee. Thank you for the opportunity to testify today on The State of Veterans Affairs. I am accompanied by Dr. Richard Stone, Executive in Charge, Veterans Health Administration (VHA).

I begin by thanking Congress and this Committee for your continued strong support and shared commitment to our nation's Veterans and the Department of Veterans Affairs (VA). In my estimation, two Federal Government departments must rise above partisan politics-the Department of Defense (DoD) and VA. The bipartisan support this Committee provides sustains that proposition.

General Assessment

Veterans and VA staff whom I meet across the country inspire confidence. Since I was sworn in, I have walked my post from Boston to Orlando, from Tampa to Muskogee and San Antonio, from Dallas to Los Angeles and up to Seattle and Anchorage, and across the Pacific to Hawaii-altogether, 35 cities, 26 VA Medical Centers (VAMC), six regional centers, and four national cemeteries. I have seen and talked with great Veterans we serve-and our great employees serving them-in VA medical centers, in polytrauma centers, in Vet Centers, Community Living Centers, State Veterans Homes, and Veteran Treatment Courts where they are getting another chance at success.

Last September I reported to Congress that VA was better for a number of important reasons-Congress's and the Administration's work and support, a more experienced leadership team at all levels that is all on the same page and speaking with a unified voice, and a workforce deeply devoted to caring for Veterans, their families, caregivers, and survivors. Because of that unified effort, VA has accomplished more in the last two years reforming the department and improving care and benefits for our nation's heroes than we have over previous decades.

The state of VA is getting stronger. While we still have a long way to go and enormous amounts of work to be where we need to be serving our nation's Veterans, it is no exaggeration that VA is engaged in the greatest transformative period of its history-truly fundamental transformation that we have not seen since just after World War II when General Omar Bradley headed the VA. And I found it important and reassuring that four previous VA secretaries with a view of the department across nearly two decades are sensing the same and publicly judged that "transformation of the VA health care is being realized after many years of effort . . . ."

We are not "business as usual" in our work fulfilling the President's promise to Veterans. The Partnership for Public Service recently reported VA one of the best places to work in federal government. Dartmouth's Annals of Internal Medicine reported that "VA health care is as good, or better, than any care our American people receive in any part of the country." A new Journal of the American Medical Association (JAMA) study found Veterans' access to VA care "appears to have improved between 2014 and 2017 and appears to have surpassed access in the private sector for 3 of the 4 specialties evaluated." In fact, the third most talked about JAMA article last year reported on VA's work on non-opioid medication pain management.

In short, we are tackling head-on issues affecting Veterans that have lingered for years. We have overhauled the claims and appeals processes so Veterans finally have a simplified system that provides them clear choices and timely decisions. We are implementing the MISSION Act that will give Veterans more choice in healthcare decisions. We are adopting the same electronic health record as DoD to give transitioning Servicemembers a seamless transfer of medical information. We are increasing accountability and protecting whistleblowers with the authorities provided by the Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017. And we are becoming more and more transparent.

Working closely with Congress has been fundamental to these substantive reforms. And we are working hard to keep you informed of progress across the department by providing more information to you, our lawmakers, than at any other time in recent history. And we will continue to do so.

We appreciate and value Congress's important role. With your help and sharp focus on our priorities, we are on the road to becoming the world-class, 21st century healthcare institution and benefits and services resource our country owes them, and they have earned and deserve.

Priorities for VA

Priority 1: Customer Service

Customer service is my prime directive. The delivery of excellent customer service is my responsibility. And it is the responsibility of all VA employees to provide an excellent customer service experience (CX) to Veterans, Servicemembers, their families, caregivers, and survivors when we deliver care, benefits, and memorial services. I am privileged to champion this effort.

Our National Cemetery Administration has long been recognized as the organization with the highest customer satisfaction score in the Nation. That's according to the American Customer Satisfaction Index - ACSI. And that's across all sectors of industry, government, business. We need to work to scope that kind of success across all benefits and services.

That's why I incorporated Customer Experience (CX) into the FY 2018–2024 VA Strategic Plan. Last year, I issued VA's first customer service policy. That policy outlines how VA will achieve excellent customer service along three key pillars: CX Capabilities, CX Governance, and CX Accountability. I am holding all VA executives, managers, supervisors, and employees accountable to foster a climate of customer service excellence. We will be guided by our core VA Values of Integrity, Commitment, Advocacy, Respect, and Excellence (I–CARE). These values define our culture of customer service and help shape our standards of behavior.

Because of VA's leadership in customer experience, our Veterans Experience Office has been designated Lead Agency Partner for the President's Management Agenda (PMA) Cross-Agency Priority (CAP) Goal on Improving Customer Experience across government.

Our goal is to lead the President's work of improving customer experience across Federal agencies and deliver customer service to Veterans we serve that is on par with top private sector companies.

This is not business as usual at VA. We are changing our culture and putting our Veteran customers at the center of our process. To accomplish this goal, we are making investments in Customer Service and we are making bold moves in training and implementing customer experience best practices.

Veterans Experience Office

The Veterans Experience Office (VEO) is my lead organization for achieving our customer service priority and provides the department a core customer experience capability. VEO offers four core customer experience capabilities, including real-time customer experience data, tangible customer experience tools, modern technology, and targeted engagement. VEO deploys customer experience data, technology, tools, and analyzes information and insights collected from Veterans, eligible dependents, caregivers, and survivors. Leaders and providers in the field have real-time Veteran feedback so they can address Veteran concerns immediately and gain program improvement insights quickly. That information helps inform short-term service recovery and long-term program and systems improvements.

Outcomes

In June 2017, VEO deployed VA's first service-level survey to measure the Veteran Experience with VHA's outpatient services. During the first month of the outpatient services surveys, VA's trust score was at 84.7 percent. Since then, the trust score has risen almost every month. In September 2018, the trust score was 86.8 percent. In January 2019, the trust score was 87.9 percent, a 3.2 percent increase since mid-2017.

VEO also administers the quarterly VA–Wide Trust Survey to measure trust across the VA. Since VEO deployed this survey, the VA–Wide Trust has increased from 55 percent in FY 2016 Q2 to 73 percent in FY 2019 Q1. And we are on a steady, positive course. Just since last quarter (FY 2018 Q4), Trust rose three percent from 70 percent to 73 percent, Effectiveness rose two percent from 77 percent to 79 percent, Ease rose one percent from 69 percent to 70 percent, and Emotion rose two percent from 71 percent to 73 percent.

For the first time in many years, VA's overall customer satisfaction rate is on a steady rise. Ninety-two percent of VAMCs have seen Veterans' trust increase because of staff training in patient experience programs like the Red Coat Ambassadors. Our Red Coat Ambassadors wear distinctive red coats and greet, assist, and escort visitors and patients. That is a sign of our work regaining Veterans' trust.

Veterans Signals

VA now employs Veterans Signals. Veterans Signals is a world-class customer service/customer experience (CS/CX) process that aligns VA with the best private sector practices. VA Signals provides VA leaders, decision-makers, and service providers at all levels with near real-time feedback from Veterans, family members, caregivers, and many others. And it provides both quantitative and qualitative information that helps identify opportunities to improve the care and benefits experience and hold ourselves accountable to meeting our Veterans' needs.

Veterans Patient Experience (VA PX)

The PX framework is rooted in research from leading private sector healthcare organizations, high-performing VA healthcare systems, and industry publications, as well as continuing Veteran research using Human Centered Design that outlines Veterans healthcare journeys and identifies the moments that matter most to Veterans, their families, caregivers, and survivors.

The PX framework was designed with seven domains to help align our people (Leadership and Employee Engagement), processes, (Measurement & Improvement, Voice of the Veteran), and culture (Culture, Environment, and Patient Communications) towards the common goal of improving Veterans' patient experience at the VA.

In 2018, VA PX conducted on-site implementation at VA facilities nationwide, including our Own The Moment train-the-trainer sessions and other initiatives to build the enterprise-wide foundation for mature PX programs and strategies at individual facilities. So far, more than 60,000 VA employees have been trained in Own The Moment. As more VA leaders adopt this non-mandatory training, we it will become the definitive customer service workshop at VA, helping provide a consistent Veteran experience across the enterprise.

In 2019, the VA PX program will continue helping VA facilities in their journeys to strategically align towards continuous PX improvement. Through communities of practice, facility-based consultations, and the roll-out of new tools, the VA PX team remains engaged and connected to VHA's mission to provide the best care and the best experiences for our Veterans, families, caregivers, and survivors.

Patient Experience (PX) Symposium

A significant aligning event for consistent, exceptional customer experiences at VA Medical centers was the first annual PX Symposium, hosted by the VEO and the VHA Diffusion of Excellence Initiative in early February. The PX Symposium brought together over 400 leaders in person-more than 5,000 watching online-from every VAMC and Network Office and across VHA to build VA's capacity to establish a uniform, foundational patient experience across the department. The Symposium examined the principles of customer experience and provided practical guidance for understanding experience data and leveraging the Voice of the Veteran through existing surveys and tools, understanding the connection between employee experience and customer experience, developing localized patient improvement plans and prioritizing improvement efforts, and designing practical strategies for successful change management and implementation. We emphasized standardization of certain PX tools across VA that can ensure a consistent, positive experience in the nation's largest healthcare system. Additionally, the Symposium detailed certain planned technology enhancements that will further empower employees in every facility to provide exceptional experiences.

PX Symposium participants returned to their facilities with a concrete understanding of improvement planning. Our leaders are expected to develop fully actionable plans for their Medical Centers, analyze their facility's data and Veteran feedback, and implement best practices from around VA and healthcare industry leaders in the private sector. Action plans will address sustainment and continuous improvement. Medical centers are being challenged to improve internal communications to engage and empower employees and enhance change management efforts.

We owe Veterans every reason to choose VA. The VA PX program will help us get there.

Priority 2: MISSION Act Implementation

More Veterans are choosing VA for their healthcare than ever before.VA is seeing more patients more quickly than ever before. And Veterans are more satisfied with their care than ever before.

Access to Care

Over the past few years, VA has invested heavily in our direct delivery system, leading to reduced wait times for care in VA facilities that currently meet or exceed the quality and timeliness of care provided by the private sector. And VA is improving access across its more than 1,200 facilities even as Veteran participation in VA healthcare continues to increase.

From 2014 through 2018, we saw an increase of 226,000 unique Veterans (a four percent increase). Since 2014, the number of annual appointments for VA care is up by 3.4 million, with over 58 million appointments in VA facilities last fiscal year-620,000 more than the year prior. We have significantly reduced the time to complete an urgent referral to a specialist. In 2014, it took an average of 19.3 days to complete an urgent referral. As of December 2018, that time was down to about 1.5 days-an 89 percent decrease.

Still, our patchwork of seven separate community care programs is a bureaucratic maze that is difficult for Veterans, their families, and VA employees to navigate.

The MISSION Act empowers VA to deliver the quality care and timely service Veterans deserve so we will remain at the center of Veterans' care. And the MISSION Act strengthens VA's internal network and infrastructure so VA can provide Veterans more healthcare access more efficiently.

Transition to the New Veteran Community Care Program

We are building an integrated, holistic system of care that combines the best of VA, our federal partners, academic affiliates, and the private sector.

The Veteran Community Care Program (VCCP) consolidates VA's separate community care programs and will put care in the hands of Veterans and get them the right care at the right time from the right provider. On January 30, 2019, we announced proposed access standards and eligibility conditions that would determine if Veterans are eligible for community care to supplement care they are provided in the VA healthcare system. The proposed regulation for the program (RIN 2900–AQ46) was published in the Federal Register on February 22, 2019, and is open for comments for 30 days from that date.

New Veteran Community Care Program Eligibility Conditions

1. VA does not offer the care or services the veteran requires;

2. VA does not operate a full-service medical facility in the State in which the veteran resides;

3. The veteran was eligible to receive care under the Veterans Choice Program and is eligible to receive care under certain grandfathering provisions;

4. VA is not able to furnish care or services to a veteran in a manner that complies with VA's designated access standards;

5. The veteran and the veteran's referring clinician determine it is in the best medical interest of the veteran to receive care or services from an eligible entity or provider based on consideration of certain criteria that VA would establish; or

6. The veteran is seeking care or services from a VA medical service line that VA has determined is not providing care that complies with VA's standards for quality.

Proposed Access Standards

VA's Proposed Access Standards-proposed for implementation in June 2019-best meet the medical needs of Veterans and will complement existing VA facilities with community providers to give Veterans access to healthcare.

1. **For primary care,** mental health, and non-institutional extended care services, VA is proposing a 30-minute average drive time of the Veteran's residence.

2. **For specialty care,** VA is proposing a 60-minute average drive time of the Veteran's residence.

3. VA is proposing **appointment wait-time standards** of 20 days for primary care, mental healthcare, and non-institutional extended care services and 28 days for specialty care from the date of request with certain exceptions.

	Primary/Mental Health/Non-institutional Extended Care	Specialty Care
Appointment Wait Time	Within 20 Days	Within 28 Days
Drive Time	Within 30 Min	Within 60 Min

VA remains committed to providing care through VA facilities as the primary means for Veterans to receive healthcare, and it will remain the focus of VA's efforts. As a complement to VA's facilities eligible Veterans who cannot receive care within the requirements of these Proposed Access Standards will be offered community care. When Veterans are eligible for care in the community, they may choose to receive care with the eligible community provider, or they may continue to choose to get the care at their VA medical facility.

The Proposed Access Standards are based on analysis of practices and our consultations with Federal agencies-including the DoD, the Department of Health and Human Services, and the Centers for Medicare & Medicaid Services-private sector organizations, and other non-governmental commercial entities. Practices in both the private and public sector formulated our Proposed Access Standards to include appointment wait-time standards and average drive time standards.

VA also published a Notice in the Federal Register seeking public comments, and in July 2018, VA held a public meeting to provide an additional opportunity for public comment.

With VA's proposed Access Standards, the future of VA's healthcare system will lie in the hands of Veterans-exactly where it should be.

In addition, the proposed rule on accessing urgent care (RIN 2900–AQ47) published in the Federal Register on January 31, 2019. This proposed rule would provide eligible Veterans with greater choice to receive certain services when and where they need it. To access this new benefit, Veterans will select a provider in VA's community care network and may be charged a co-payment.

Caregivers

The MISSION Act expands eligibility for VA's Program of Comprehensive Assistance for Family Caregivers under the Caregiver Support Program. Originally, this benefit was only offered to eligible Veterans who incurred or aggravated a serious injury in the line of duty on or after September 11, 2001. The MISSION Act opens the benefit to eligible Veterans and their caregivers from all eras.

The expansion will occur in two phases beginning with Veterans who incurred or aggravated a serious injury in the line of duty on or before May 7, 1975, with further expansion beginning two years after that.

Over the course of the next year, VA will be establishing systems and regulations necessary to expand this program. Caregivers and Veterans can learn about the full range of available support and programs through the Caregivers website or by contacting the Caregiver Support Line toll-free at 1–855–260–3274.

Telehealth

VA is a leader in providing telehealth services. VA achieved more than one million video telehealth visits in FY 2018, a 19 percent increase in video telehealth visits over the prior year. Telehealth is a critical tool to ensure Veterans, especially rural Veterans, can access healthcare when and where they need it. With the support of Congress, VA has an opportunity to continue shaping the future of healthcare with cutting-edge technology providing convenient, accessible, high-quality care to Veterans.

Section 151 of the MISSION Act allows VA to provide even more telehealth services because it authorizes VA providers to practice telehealth at any location in any state, regardless of where the provider is licensed. VA's telehealth program enhances customer service by increasing Veterans' access to VA care, while lessening travel burdens.

In FY 2018, more than 782,000 Veterans (or 13 percent of Veterans obtaining care at VA) had one or more telehealth episodes of care, totaling 2.29 million telehealth episodes of care. Of these 782,000 Veterans using telehealth, 45 percent live in rural areas. VA's major expansion for telehealth and telemental health over the next five years, for both urban and rural Veterans, will focus on care in or near the Veteran's home.

Strengthening VA's Workforce

Under the MISSION Act, VA will have more tools to recruit and retain the best medical providers. Recruitment and retention are critical to ensuring that VA has the right doctors, nurses, clinicians, specialists and technicians to provide the care that Veterans need. VA is establishing new scholarship programs, education debt reduction programs, and bonuses for recruitment, relocation, and retention. We are also starting a pilot scholarship program for Veterans to get medical training in return for serving in a VA hospital or clinic for four years. Peer specialists will be included in patient aligned care teams at VAMCs to promote the use and integration of services for mental health, substance abuse disorder, and behavioral health under the MISSION Act.

Priority 3: Business Transformation

Business transformation is essential if we are to move beyond compartmentalization of the past and empower our employees serving Veterans in the field to provide world-class customer service. This means reforming the systems responsible for claims and appeals, GI Bill benefits, human resources, financial and acquisition management, supply chain management, and construction. The Office of Enterprise Integration (OEI) is charged with coordination and oversight for all these efforts.

Office of Enterprise Integration

The scale and criticality of the initiatives underway at VA require management discipline and strong governance. As part of OEI's coordination and oversight role in VA's business transformation efforts, we have implemented a consistent governance process to review progress against anticipated milestones, timelines, and budget. This process supports continuous alignment with objectives and identifies risks and impediments prior to their realization.

For example, our VA Modernization Board recently initiated a leadership integration forum to synchronize deployment schedules across three major enterprise initiatives: adoption of Defense Medical Logistics Standard Support (DMLSS), financial management business transformation, and our new electronic health record. This forum allowed us to assess the feasibility of a concurrent deployment and identify an alternate course of action. By implementing strong governance and oversight, we are increasing accountability and transparency of our most critical initiatives.

Appeals Modernization

The Veterans Appeals Improvement and Modernization Act of 2017 (AMA) was signed into law on August 23, 2017, and took full effect on February 19, 2019. The Appeals Modernization Act transforms VA's complex and lengthy appeals process into one that is simple, timely, and fair to Veterans and ultimately gives Veterans choice and control over how to handle their claims and appeals. The new appeals process features three decision-review lanes:

1. **Higher-Level Review Lane:** A senior-level claims processor at a VA regional office will conduct a new look at a previous decision based on the evidence of record. Reviewers can overturn previous decisions based on a difference of opinion, or return a decision for correction.

2. **Supplemental Claim Lane:** Veterans can submit new and relevant evidence to support their claim, and a claims processor at a VA regional office will assist in developing evidence.

3. **Appeal Lane:** Veterans who choose to appeal a decision directly to a Veterans Law Judge at the Board of Veterans' Appeals (Board) may request direct review of the evidence the regional office reviewed, submit additional evidence, or have a hearing with a Veterans Law Judge. The Board has a 365-day average processing time goal for appeals in which the Veteran does not submit evidence or request a hearing.

Prior to implementation, the Veterans Benefits Administration (VBA) tested the process using the Rapid Appeals Modernization Program (RAMP). RAMP allowed Veterans with eligible pending disability compensation appeals early participation in the new decision review process.

Since the RAMP's inception in November 2017, more than 69,000 Veterans with over 83,000 appeals have opted into RAMP, and VA has paid almost $214 million in retroactive benefits as of the beginning of February 2019. The Board began adjudicating AMA appeals through VBA's test program on October 1, 2018, and as of February 4, 2019, has dispatched 147 decisions for Veterans in AMA appeals. VBA's RAMP opt-in ended February 15, 2019, just prior to AMA implementation on Feb-

ruary 19, 2019. Any Veteran who opted into RAMP will receive all the benefits of the AMA and will not return to the legacy system.

In addition to focusing on implementation of the Appeals Modernization Act, addressing pending legacy appeals will continue to be a priority for VBA and the Board in FY 2019. VBA's efforts have resulted in appeals actions that have exceeded projections for fiscal year to date 2019. VBA plans to eliminate completely its legacy, non-remand appeals inventory in FY 2020 and significantly reduce its legacy remand inventory in FY 2020.

In FY 2018, the Board decided a record high number of 85,288 decisions, and is on track to meet its FY 2019 goal of 90,050 decisions. The Board and VBA are focused on monitoring the new system, developing and updating information technology, providing training, refining meaningful metrics, and continuing collaboration with stakeholders through implementation and beyond.

Forever GI Bill

Since the passage of the Harry W. Colmery Veterans Educational Assistance Act of 2017 last August, VA has implemented 28 of the law's 34 provisions. Twenty-two of the law's 34 provisions require significant changes to VA information technology systems, and VA has 200 temporary employees in the field to support this additional workload.

Sections 107 and 501 of the bill change the way VA pays monthly housing stipends for GI Bill recipients, and VA is committed to providing a solution that is reliable, efficient and effective. Pending the deployment of a solution, Veterans and schools will continue to receive GI Bill benefit payments as normal. By asking schools to hold fall enrollments through the summer and not meeting the implementation date for the IT solutions of Sections 107 and 501, some beneficiaries experienced delayed and incorrect payments.

In accordance with the Forever GI Bill Housing Payment Fulfillment Act of 2018, VA established a Tiger Team tasked to resolve issues with implementing sections 107 and 501 of the Forever GI Bill. This month we awarded a new contract that we believe will provide the right solution for implementing Sections 107 and 501. By December 2019, we will have Sections 107 and 501 fully implemented. By spring 2020, all enrollments will be processed according to the Colmery Act. We'll recalculate benefits based on where Veterans take classes, and we'll work with schools to make Sections 107 and 501 payments retroactive to the first day of August 2018, the effective date.

The Department is committed to make sure every Post-9/11 GI Bill beneficiary is made whole based on the rates established under the Forever GI Bill rates. And we are actively working to make that happen. We got the word out to Veterans, beneficiaries, schools, VSOs, and other stakeholders that any Veteran who is in a financial hardship due to a late or delayed GI Bill payment should contact us immediately.

In December 2018, we updated the housing rates like we normally would have in August. Those rates were effective for all payments after January 1, 2019. Additionally, we processed over 450,000 rate corrections ensuring any beneficiary who was underpaid from August through December received a check for the difference.

We have completed the spring peak enrollment season without any significant challenges. We worked with schools to get enrollments submitted as quickly as possible.

We appreciate your ongoing support and understanding as we continue to move forward. We're making good progress. And we will keep you informed.

Priority 4: VA/DoD Collaboration

At VA, we are fortunate to have a strong relationship with the DoD. All of our customers come from DoD, and I have made it my focus to ensure we are joined at the hip to provide a seamless experience for Servicemembers leaving the military and coming to VA for healthcare and benefits. We are making progress in a number of mutual areas, including suicide prevention, a new electronic health records system, and modernizing our supply chain. Our collaboration with DoD enables both Departments to reform major systems in an integrated, coordinated manner.

I have made VA and DoD collaboration a priority in VA's strategic plan, with a focus of providing a seamless transition from military service to Veteran status and enabling VA to anticipate needs and provide quality benefits, care, and services. The Joint Executive Committee (JEC) is led by the Deputy Secretary of VA and the DoD Under Secretary of Defense for Personnel and Readiness to oversee these efforts and receive updates at JEC quarterly meetings. Additionally, the JEC Co-Chairs meet bi-weekly to discuss progress on current initiatives, identify potential risks and provide guidance to mitigate those risks.

Joint VA and DoD leadership will publish the VA/DoD Joint Strategic Plan (JSP) for FY 2019–2021 in the next month. The JSP is a critical guidance document that sets longer term goals and objectives for joint efforts.

Here are some specific examples of VA and DoD Collaboration.

Suicide Prevention

Suicide is a national public health issue that affects all Americans, and the health and well-being of our nation's Veterans is VA's top priority. Of the 20 Veterans, active-duty Servicemembers, and non-activated Guard or Reserve members who died by suicide, 14 had not been in our care. That is why we are implementing broad, community-based prevention strategies, driven by data, to connect Veterans outside our system with care and support.

Preventing Veteran suicide requires closer collaboration between VA, DoD, and Department of Homeland Security (DHS). On January 9, 2018, President Trump signed an Executive Order (13822) titled, "Supporting Our Veterans During Their Transition From Uniformed Service to Civilian Life." This Executive Order directs DoD, VA, and the Department of Homeland Security to develop a Joint Action Plan that describes concrete actions to provide access to mental health treatment and suicide prevention resources for transitioning uniformed Servicemembers in the year following their discharge, separation, or retirement.

For Servicemembers and Veterans alike, our collaboration with DoD and DHS is already increasing access to mental health and suicide prevention resources, due in large part to improved integration within VA, especially between the VBA and VHA. VBA and VHA have worked in collaboration with DoD and DHS to engage Servicemembers earlier and more consistently than we have ever done in the past. This engagement includes support to members of the National Guard, Reserves, and Coast Guard.

VA's suicide prevention efforts are guided by our National Strategy for Preventing Veteran Suicide, a long-term plan published in the summer of 2018 that provides a framework for identifying priorities, organizing efforts, and focusing national attention and community resources to prevent suicide among Veterans. It also focuses on adopting a broad public health approach to prevention, with an emphasis on comprehensive, community-based engagement.

However, VA cannot do this alone, and suicide is not solely a mental health issue. As a national problem, Veteran suicide can only be reduced and mitigated through a nationwide community-level approach that begins to solve the problems Veterans face, such as loss of belonging, meaningful employment, and engagement with family, friends, and community.

The National Strategy for Preventing Veteran Suicide provides a blue print for how the nation can help to tackle the critical issue of Veteran suicide and outlines strategic directions and goals that involve implementation of programming across the public health spectrum, including, but not limited to:

- Integrating and coordinating Veteran Suicide Prevention across multiple sectors and settings;
- Developing public-private partnerships and enhancing collaborations across Federal agencies;
- Implementing research informed communication efforts to prevent veteran suicide by changing attitudes knowledge and behaviors;
- Promoting efforts to reduce access to lethal means;
- Implementation of clinical and professional practices for assessing and treating Veterans identified as being at risk for suicidal behaviors; and
- Improvement of the timeliness and usefulness of national surveillance systems relevant to preventing Veteran suicide.

Every day, more than 400 Suicide Prevention Coordinators (SPC) and their teams-located at every VA medical center-connect Veterans with care and educate the community about suicide prevention programs and resources. Through innovative screening and assessment programs such as REACH VET (Recovery Engagement and Coordination for Health-Veterans Enhanced Treatment), VA identifies Veterans who may be at risk for suicide and who may benefit from enhanced care, which can include follow-ups for missed appointments, safety planning, and care plans.

VHA has also expanded its Veterans Crisis Line to three call centers and increased the number of Veterans served by the Readjustment Counseling Service (RCS), which provides services through the 300 Vet Centers, 80 Mobile Vet Centers (MVC), 18 Vet Center Out-Stations, over 990 Community Access Points and the Vet Center Call Center (877–WAR–VETS). In the last two fiscal years, Veterans bene-

fiting from RCS services increased by 31 percent, and Vet Center visits for Veterans, Servicemembers, and families increased by 18 percent.

We are committed to advancing our outreach, prevention, and treatment efforts to further restore the trust of our Veterans and continue to improve access to care and support inside and outside VA.

Electronic Health Record Modernization (EHRM)

We made a historic decision to modernize our electronic health record (EHR) system to provide our nation's Veterans with seamless care as they transition from military service to Veteran status. On May 17, 2018, we awarded a ten-year contract to Cerner to acquire the same EHR solution being deployed by DoD that allows patient data to reside in a single hosting site using a single common system to enable sharing of health information, improve care delivery and coordination, and provide clinicians with data and tools that support patient safety.

To that end, we established our Office of Electronic Health Record Modernization (OEHRM). OEHRM will ensure we successfully prepare for, deploy, and maintain the new EHR solution and the health IT tools dependent upon it. To ensure our new EHR solution is fully interoperable, we are working closely with DoD so Veterans will be able to access their health record wherever they chose to receive healthcare. Specifically, VA and DoD are collaboratively analyzing approaches, processes, organizational designs, governance, and management structures in support of gaining efficiencies and optimizing the use of resources in pursuit of deploying a single, seamless integrated EHR solution.

We are working closely with DoD to synchronize efforts as we deploy and test the new health record in Veterans Integrated Service Network (VISN) 20 in the Pacific Northwest-selected as our first Initial Operating Capability (IOC) site for deployment and testing of the new EHR solution. We are engaging front-line staff and clinicians to identify efficiencies, hone governance, refine configurations, and standardize processes for future locations. We are committed to a timeline that balances risks, patient safety, and user adoption while also working with DoD in providing a more comprehensive, agile, and coordinated management authority to execute requirements and mitigate potential challenges and obstacles.

Throughout this effort, VA will continue to engage front-line staff and clinicians, as it is a fundamental aspect in ensuring we meet the program's goals. We have begun work with the leadership teams in place in the Pacific Northwest. OEHRM has established clinical councils from the field that will develop National workflows and serve as change agents at the local level.

Supply Chain Transformation

VA has embarked on a supply chain transformation program designed to build a lean, efficient supply chain that provides timely access to meaningful data focused on patient and financial outcomes. We are pursuing a holistic modernization effort which will address people, training, processes, data and automated systems. To achieve greater efficiencies by partnering with other Government agencies, VA will strengthen its long-standing relationships with DoD by leveraging expertise to modernize VAs supply chain operations, while allowing the VA to remain fully committed to providing quality healthcare and applying resources where they are most needed.

As we deploy an integrated health record, we are also collaborating with DoD on an enterprise-wide adoption of the Defense Medical Logistics Standard Support (DMLSS) to replace VA's existing logistics and supply chain solution. VA's current system faces numerous challenges and is not equipped to address the complexity of decision-making and integration required across functions, such as acquisition, logistics and construction. The DMLSS solution will ensure that the right products are delivered to the right places at the right time, while providing the best value to the government and taxpayers.

We are piloting DMLSS at James A. Lovell Federal Health Care Center and VA initial EHR sites in Spokane and Seattle to analyze VA enterprise-wide application. We will begin using DMLSS at the James A. Lovell facility in October of this year. This decision leverages a proven system that DoD has developed, tested and implemented. DMLSS and its technical upgrade LogiCole will better enable whole-of-government sourcing and better enable VA to use DoD Medical/Surgical Prime Vendor and other DoD sources, as appropriate, as the source for VA medical materiel. Next month, I will be traveling to the James A. Lovell Federal Health Care Center in Chicago with the Director of the Defense Logistics Agency to inaugurate VA sourcing Medical/Surgical material via the Defense Logistics Agency Electronic Catalog at that facility.

Transition Assistance Program

The annual average unemployment rate for Veterans dropped below four percent in 2017. The annual average veteran unemployment rate in 2018 was 3.5 percent. This is the lowest overall veteran unemployment rate since 2000 (according to data from the Bureau of Labor Statistics). This continues an eight-year trend of declines since 2010, when Veteran unemployment peaked at 8.7 percent. The annual unemployment rate for women Veterans was 3.0 percent in 2018 - the lowest since the data series began (in 2000).

We are proud of our successes collaborating with our Federal agency partners including DoD, the Department of Labor (DOL), and the Small Business Administration to support a seamless transition from military service to civilian life. We acknowledge that no two transitions are the same. So, in collaboration with each other and with other federal partners, we have started embedding transition planning and preparation throughout a Servicemember's military career. As an example of how this collaboration is a true best practice for seamless and integrated federal agency collaboration, we are reaching Service members, their spouses, and other loved ones earlier and more often through additional training called Military Life Cycle (MLC) Modules. VA is now providing nine MLC Modules to engage audiences with DoD/VA benefits, especially during key touchpoints in their military lives (including but not limited to deployments, permanent changes of station, and other major life events). Any active duty Service member, member of the reserve components, military spouse, or other loved one is able and encouraged to participate in the MLC Modules - at any time in their career. These modules are available in-person on installations and delivered by VA TAP Benefits Advisors and online via DoD's Joint Knowledge Online.

We have also enhanced the Transition Assistance Program (TAP) to include a focus on VA benefits and services to ensure transitioning Servicemembers enroll for the benefits and services they have earned. In April 2018 in collaboration with DoD, we revised our TAP curriculum to offer an interactive and engaging experience. The revised curriculum presents VA's Benefits Briefing in succinct modules that educate transitioning Servicemembers on the wide array of VA benefits including healthcare, education, Vocational Rehabilitation & Employment, compensation, life insurance, home loans, as well as an orientation to online benefits portals like eBenefits and MyHealtheVet. The redesigned curriculum gives attending Servicemembers opportunity to complete their VA healthcare application online, facilitated and guided by a VA Benefits Advisor.

At more than 300 installations around the world, VA, DoD, and DOL collaborate to ensure that over 226,000 Servicemembers-and their families-are prepared for and supported during and after their transition from military service. We have a physical presence on these installations, and we can prepare Servicemembers and their families to access their benefits and services. We deliver mandatory VA briefings as well as provide other support and services during TAP, including commander capstone events, individual assistance to transitioning Servicemembers and family members upon request, and, more recently to their caregivers.

To ensure we are supporting Servicemembers at the right time and giving them information they need to make informed decisions, we conduct course assessments that will provide feedback to VA, DOL, and DoD on Veteran outcomes and whether they received useful support and information during their transition journeys. And we have listened to the feedback about the need to better inform and support members of the National Guard and Reserve. VA has revised a TAP briefing tailored specifically for members of the Reserves and National Guard.

We are committed to supporting a seamless transition that includes the economic well-being of the Veteran. VBA recently stood up a new office dedicated to the economic success of our Veterans. Working with all of our partners, we must continue to ensure that low unemployment numbers represent meaningful, gainful employment.

The men and women of our Armed Forces are better trained, better educated, and better prepared for their transition to civilian life than ever before. VA, along with DoD, DOL, and the broader military community, continue to explore ways to reinforce military service as a long-term pathway to economic well-being for transitioning Servicemembers, Veterans, their families, caregivers, and survivors.

Warrior Training Advancement Course (WARTAC)

Since its inception in FY 2014, WARTAC was designed for wounded, ill, and injured Servicemembers to provide them with an opportunity to develop a skill while recuperating or going through the medical board process. WARTAC was expanded to include the full scope of transitioning Servicemembers in FY 2016.

WARTAC is a Skill-Bridge education and employment opportunity for Wounded Warriors and transitioning Servicemembers to receive training to become Veteran Service Representatives (VSRs) and Rating Veteran Service Representatives (RVSRs) in VBA regional office (RO) Veterans Service Centers (VSCs). By taking part in this program, transitioning Servicemembers have an opportunity to continue their service by working for VA as civilians. In addition, WARTAC aligns with VA's Strategic Goal of ensuring Veterans receive timely and integrated care and support that emphasizes their well-being and independence throughout their life journey.

VA partners with DoD under their Career Skills Program which is authorized by the Veterans Opportunity to Work Act, as provided by DoDI 1322.29 in accordance with the authority of 10 U.S. Code § 1143 (e). VA has partnered with 13 military installations throughout the continental United States and Germany. To date, VA has offered employment to 989 WARTAC graduates and is targeted to train 400 Servicemembers during FY 2019.

Additional Priorities

Veterans Homelessness

Significant progress has been made to prevent and end Veteran homelessness. The number of Veterans experiencing homelessness in the United States has declined by nearly half since 2010. On a single night in January 2018, fewer than 40,000 Veterans were experiencing homelessness-5.4 percent fewer than in 2017.

Since 2010, over 700,000 Veterans and their family members have been permanently housed or prevented from becoming homeless. As of December 19, 2018, 69 areas-66 communities and three states-have met the benchmarks and criteria established by the United States Interagency Council on Homelessness, VA, and the Department of Housing and Urban Development to publicly announced an effective end to Veteran homelessness.

Efforts to end Veteran homelessness have greatly expanded the services available to permanently house homeless Veterans and VA offers a wide array of interventions designed to find homeless Veterans, engage them in services, find pathways to permanent housing, and prevent homelessness from occurring.

Opioid Safety & Reduction Efforts

The President recently declared the opioid crisis in our country a public health emergency. Opioid safety and reduction efforts are a department priority, and we have responded with new strategies to rapidly combat this national issue as it affects Veterans. Success requires collaboration among VA leadership and all levels of VA staff-from medical centers to headquarters-Congress, and community partners to ensure we are working with Veterans to achieve positive, life-changing results. The fact that opioid safety, pain care transformation, and treatment of opioid use disorder all contribute to reduction of suicide risk makes these efforts particularly important.

The MISSION Act provides VA clinicians and delegates full access to state prescription drug monitoring programs (PDMPs). With ensuring this unfettered access, VA clinicians can view and analyze a complete prescribing profile of controlled substances, resulting in potentially life-saving medical decisions.

In addition to improving and expanding our participation in state PDMPs, VA is systemically working to change our culture to establish a collaborative approach with Veterans to reduce patient risk by safely and effectively treating their pain while minimizing opioid use.

VA's Opioid Safety Initiative has greatly reduced reliance on opioid medication for pain management, in part by reducing opioid prescribing by more than 50 percent over the past four years. Most of this progress is attributable to reductions in prescribing long-term opioid therapy for newly diagnosed, chronic, non-cancer pain and, instead, utilizing alternative treatments to manage Veteran pain long-term. Alternative treatments can include acupuncture, behavioral therapy, chiropractic care, yoga, and non-opioid medications.

We are committed to providing Veteran-centric, holistic care for the management of pain and for promoting well-being. We are seeing excellent results as sites across the country deploy this "Whole Health" approach. Non-medication treatments work as well and are often better than opioids at controlling non-cancer pain. We want to assure Congress-and Veterans on opioid therapy-that Veterans' medication will not be -decreased or stopped without their knowledge, engagement, and a thoughtful discussion of accessible alternatives. Our goal is to make sure every Veteran has the best function, quality of life, and pain control.

VHA continues to build on the successes of the Opioid Safety Initiative and the already ongoing pain care transformation as a system-wide Pain and Opioid Stew-

ardship Program to comprehensively and efficiently improve opioid prescribing and continue to improve and foster access to high quality pain care. VA is implementing a field-based stewardship program charged with developing processes and procedures to ensure implementation of national policies related to pain management, opioid safety, Overdose Education and Naloxone Distribution (OEND), and Opioid Use Disorder.

We are continuing to expand our OEND program. The OEND program provides the overdose reversal drug naloxone and related education to our patient population free of charge. Additionally, we are ensuring quick access of naloxone to our first responders by having VA Police carry naloxone and ensure naloxone kits are available in AED cabinets.

Along with safer opioid prescribing, we realize it is important to take care of Veterans who may have developed a physical and/or psychological reliance. We are expanding access to medication assisted treatment (MAT) for opioid use disorder. Studies have shown that medication, in conjunction with counseling or psychotherapy and close patient monitoring, is the most effective treatment for opioid use disorder. In addition, we are encouraging our providers to get the required certification so they may prescribe and manage patients on buprenorphine in Primary Care, Pain Clinic, and general mental health settings, not just specialty clinics. In fact, we recently rolled out new training through our Stepped Care for Opioid Use Disorder Train-the-Trainer initiative with which we are training our clinicians.

These are just a few department-wide activities we are implementing as VA's response to the Opioid Crisis. We look forward to continuing to expand our efforts internally with our community providers and more broadly with Congress and the White House Opioid Cabinet.

Women's Health

VA has made significant progress serving women Veterans in recent years. We now provide full services to women Veterans, including comprehensive primary care, gynecology care, maternity care, specialty care, and mental health services. For severely injured Veterans, we also now offer in vitro fertilization services through care in the community and reimbursement of adoption costs.

The number of women Veterans using VHA services has tripled since 2000, growing from nearly 160,000 to over 500,000 today. To accommodate the rapid growth, VHA has expanded services and sites of care across the country. VA now has at least two Women's Heath Primary Care Provider (WH–PCP) at all of VA's healthcare systems. In addition, 91 percent of community-based outpatient clinics (CBOCs) have a WH–PCP in place. VHA now has gynecologists on site at 133 sites and mammography on site at 60 locations.

VHA is in the process of training additional providers so every woman Veteran has an opportunity to receive primary care from a WH–PCP. Since 2008, 5,800 providers have been trained in women's health. In fiscal year 2018, 968 Primary Care and Emergency Care Providers were trained in local and national trainings. VA has also developed a mobile women's health training for rural VA sites to better serve rural women Veterans, who make up 26 percent of women Veterans.

VA is at the forefront of information technology for women's health and is redesigning its electronic medical record to track breast and reproductive healthcare. Quality measures show that women Veterans who receive care from VA are more likely to receive breast cancer and cervical cancer screening than women in private sector healthcare. VA also tracks quality by gender and, unlike some other healthcare systems, has been able to reduce and eliminate gender disparities in important aspects of health screening, prevention, and chronic disease management. We are also factoring care for women Veterans into the design of new VA facilities and using new technologies, including social media, to reach women Veterans and their families. We are proud of our care for women Veterans and are working to increase the trust and knowledge of VA services of women Veterans so they choose VA for benefits and services.

Hiring and Vacancies

VHA's workforce challenges mirror those of the healthcare industry as a whole. There is a national shortage of healthcare professionals, especially physicians and nurses. VA remains fully engaged in a fiercely competitive clinical recruitment market and has increased its number of clinical providers, including hard-to-recruit-and-retain physicians like psychiatrists.

In FY 2018, VA had a net increase of 11,693 employees, including 4,466 in VHA clinical staffing shortage occupations. As of September 30, 2018, VA had an 11 percent vacancy rate. On average-after taking into account VA's average annual turnover rate of 9 percent-VA has an annual growth rate of two to four percent. Accord-

ing to Office of Personnel Management, VA turnover rates compare favorably with other large cabinet-level agencies.

VHA is taking a number of key steps to attract qualified candidates, to include

- Mental Health and other targeted hiring initiatives.
- Leveraging flexible pay ranges resulting in competitive physician salaries.
- Utilization of recruitment/relocation and retention (3Rs) incentives and the Education Debt Reduction Program (EDRP).
- Targeted nationwide recruitment advertising and marketing.
- The "Take A Closer Look at VA" trainee outreach recruitment program.
- Expanding opportunities for telemedicine providers.
- DoD/VA effort to recruit transitioning Servicemembers.
- Exhibiting regularly at key healthcare conferences and job fairs.
- Critical Position Hiring and Vacancies.

Blue Water Navy (BWN)

On January 29, 2019, the US Court of Appeals for the Federal Circuit overturned its 2008 decision on Blue Water Navy. This decision essentially concluded that Congress, by granting a presumption of exposure to herbicides and service connection for certain diseases to Veterans who "served in the Republic of Vietnam," unambiguously included Veterans within the territorial waters. VA estimates indicate that we will receive approximately 61,000 additional disability rating claims in the first year, with a total increase of 268,000 claims over ten years.

Recent legislation from the 115th Congress (H.R. 299) proposed to extend the presumption of Agent Orange exposure to all Veterans who served on ships in the territorial seas of the Republic of Vietnam. VA did not support the legislation because VA is obligated to assess the factual and scientific basis for granting disability compensation for all claims, including those associated with Agent Orange exposure. For Blue Water Navy Veterans who served in the offshore "territorial seas" of the Republic of Vietnam, there is insufficient factual evidence that they were exposed to Agent Orange and insufficient scientific evidence of associated long-term health effects. VA maintains the position that any established presumptions of exposure and/or medical causation should always be supported by sufficient documentation of facts and circumstances, along with scientific and medical evidence about the specific population of affected Veterans.

VBA does not have sufficient resources and infrastructure to process the projected volume of additional BWN claims with the existing inventory and backlog of rating claims while maintaining current timeliness standards.

VA estimated that legislation with a similar impact would have a total cost of $6.7 billion over 10 years ($5.7 billion mandatory; $625 million for healthcare; $349 million discretionary; $8 million IT). Based on updated assumptions, the actual cost is likely to be higher. VA is waiting for various legal decisions to be made, and we are assessing various scenarios that have different timelines, resource requirements, and impacts on claims inventory and timeliness. VA will keep the Committee apprised of potential funding requirements as legal decisions are made.

Conclusion

VA is getting stronger. We have a long way to go. We are making good progress. But we have much work ahead to be where we need to be in serving our nation's Veterans. With your help and sharp focus on our priorities, we are on the road to becoming the world-class, 21st century healthcare institution and benefits and services resource our country owes them, and they have earned and deserve.

Chairman Takano, Ranking Member Roe≥, and distinguished Members of this Committee, thank you for the opportunity to appear before you today to report on The State of VA.

Questions For The Record

House Committee Members to: Department of Veterans Affairs (VA)

Questions for the Record from Congresswoman Brownley

Question 1: In your testimony, you stated: "VA now has at least two Women's Heath Primary Care Provider (WH–PCP) at all of VA's healthcare systems. In addition, 91 percent of community-based outpatient clinics (CBOCs) have a WH–PCP in place. VHA now has gynecologists on site at

133 sites and mammography on site at 60 locations." I am interested in more detail on the locations and availability of these providers and I'm concerned that the number of providers is insufficient. For example, the Greater Los Angeles Healthcare System is the largest integrated healthcare organization in the VA, and it extends from Bakersfield all the way to Los Angeles, and includes Kern County, San Luis Obispo County, Santa Barbara County, Ventura County, and Los Angeles County. Two providers for a system this large is wholly inadequate.

Question 1a: Can you please provide a detailed breakdown of where VA has designated Women's Health Primary Care Providers, gynecologists, and on-site mammography? I am interested in the specific facility-level data for major medical centers, ambulatory care centers, as well as for CBOCs.

VA Response: As of end of Fiscal Year (FY) 2018, VA has at least one designated Women's Health Primary Care Provider (WH–PCP) at 160 of 164 Medical Centers (VAMC) and 790 of 875 Community Based Outpatient Clinics (CBOC). All Health Care Systems (including parent VAMC and associated CBOCs) have at least two WH–PCPs. VA has 223 Gynecologists across 121 Health Care Systems, and onsite mammography at 65 sites. A detailed spreadsheet is attached.

All women Veterans have access to gender specific Primary Care, gynecology, and mammography services. At VA sites that do not have services on site, women are referred for community care that is coordinated by VA.

Local facilities determine whether the provision of on-site breast imaging services versus continued use of community care is the best option. Because of the strict Mammography Quality Standards Act continuing experience requirements, on-site mammography may not be advisable for sites with low numbers of active female enrollees. Therefore, considerations of when to implement breast imaging services include the number of active female enrollees, available space for equipment, and availability of breast imaging staff (radiologists and technologists).

Question 1b: I am also interested in knowing the number of women veterans served at each facility, so that the Committee can better assess patient/provider ratios.

VA Response: The spreadsheet attached in question 1a provides these data. Note: VA data are for women Veterans enrolled in Primary Care.

Question 2: Congress has authorized the construction and/or lease of a number of new VA facilities, including community-based outpatient clinics, which have been approved through the SCIP process.

Question 2a: I request a status update on each Congressionally-authorized project that have not yet been completed, as well as the projected opening date for each facility.

VA Response: All VA-approved projects go through the Strategic Capital Investment Planning process, and the enclosed spreadsheet lists the Congressionally authorized projects. The excel spreadsheet has 3 tabs/sheets: Leases, Majors, and National Cemetery Administration (NCA) Major Construction projects. The planned acceptance dates for leases are projections because the facility acceptance are always contingent on the project award date. NCA projects will not have an Opening date because the vast majority of these projects are cemeteries in operation.

Question for the Record from Congressman Brindisi

Question 1: Secretary Wilkie, I'd like to raise the issue of access to care for our rural veterans. Veterans living in rural communities in my district and across the country rely heavily upon Community Based Outpatient Clinics for primary or routine care. As I know you are aware, the VA has made efforts in recent years to bring primary care closer to where veterans reside. However, VA has recently expressed its intention to close the Bainbridge CBOC in my district and open a new facility in Oneonta, NY.

Question 2: I would fully support opening new clinic, but not at the expense of taking a clinic away.

Question 2a: Secretary Wilkie, as we look toward VA's future, do you agree that we must continue to increase access to community care and ensure rural veterans have access to the care they've earned?

VA Response to Questions 1–2: The Office of Rural Health (ORH) improves access to care for rural Veterans by funding Enterprise Wide Rural Access Initiatives (EWI) in collaboration with Veterans Health Administration (VHA) National Program Offices. This funding ensures system-wide implementation of proven models of care and services tailored to a rural setting. Implementation prioritization at

rural-serving facilities increases access to care and services for Veterans living in rural areas of the United States. In Fiscal Year (FY) 2019, these EWIs will be implemented at 90 percent of VA Medical Centers (VAMC) across all Veterans Integrated Service Networks (VISN). EWI increase access to care for rural Veterans in a number of critical areas, including Primary Care, Specialty Care, Mental Health, Workforce Training and Education, Care Coordination, Health IT Modernization, Research, Innovation, and Transportation.

As we look to the future, we want to ensure we put choice in the hands of the Veteran and provide them access to care where and when they need it. We also want to ensure we have the right mix of providers available for the services all of our Veterans need, and consider the needs of rural Veterans, both in the VA and in the community, in locations that are convenient for Veterans.

Question 3: Secretary Wilkie, we continue to witness a mental health crisis in the veteran community. Since 2001, we have seen veteran suicides increase by over 30 percent. While the VA has done a better job of increasing awareness about veterans mental health and suicide, we continue to see many of our servicemembers returning home struggling with PTSD and other mental health conditions. I'm concerned that VA does not have the resources or strategy in place to tackle this critically important issue.

Question 3a: Secretary Wilkie, how does VA plan on solving the problem of mental health and suicide in the veteran community?

VA Response: VA's suicide prevention efforts are guided by the National Strategy for Preventing Veteran Suicide, a long-term plan published in 2018 that provides a framework for identifying priorities, organizing efforts, and focusing national attention and community resources to prevent suicide among Veterans. The National Strategy for Preventing Veteran Suicide reflects VA's vision for a coordinated national strategy to prevent suicide among all Veterans-one that maintains VA's focus on high-risk individuals in health care settings while adopting a broad public health approach with an emphasis on comprehensive, community-based engagement.

The 14 goals and 43 objectives included in the National Strategy for Preventing Veteran Suicide are meant to work together in a synergistic way to promote wellness, increase protective factors, reduce suicide risk, and facilitate effective mental health treatment and recovery. Suicide prevention is a top priority for VA. This plan offers guidance to VA personnel and stakeholders-including other Federal agencies, state and local governments, health care systems, and community organizations-so that we, as a nation, can reduce suicide rates among Veterans.

The "Executive Order on a National Roadmap to Empower Veterans and End Suicide" was signed on March 5, 2019 by President Trump and is a national call to action to end Veteran suicide. We must work side-by-side with our partners at all levels of government and in the private sector to provide our Veterans with the mental health and suicide prevention services they need.

Primary Care/Patient Aligned Care Teams have also been supporting such collaborative strategies through a series of interdisciplinary trainings, monthly interdisciplinary community of practice calls, active participation in the VA Enterprise Opioid Strategy Team, MISSION Act 134 Prescription Drug Monitoring Group action group, Pain Care Leadership Team, and Stepped Care for Opioid Use Disorder Train the Trainer.

Suicide is a national public health issue that affects communities everywhere. That is why VA has adopted a public health approach to suicide prevention. We are using bundled approaches to prevention that cut across various sectors-faith communities, employers, schools, and health care organizations, for example-to reach Veterans where they live, work, and thrive.

Question 3b: How can we help in this effort?

VA Response: Suicide is a complex issue with no single cause. It is a national public health issue that affects people from all walks of life, not just Veterans, and for a variety of reasons. Suicide is often the result of a complex interaction of risk and protective factors at the individual, community, and societal levels. To prevent Veteran suicide, we must maximize protective factors while minimizing risk factors at all levels, throughout communities nationwide.

We know that an average of approximately 20 Veterans die by suicide each day-this number has remained relatively stable over the last several years. Of those 20, only six have used VA health care in the 2 years prior to their death, while the majority-14-have not. In addition, we know from national data that more than half of Americans who died by suicide in 2016 had no mental health diagnosis at the time of their death. Through the National Strategy for Preventing Veteran Suicide, we

are implementing broad, community-based prevention strategies, driven by data, to connect Veterans outside our system with care and support on national and local facility levels-targeted to the 14 Veterans outside VA care.

Everyone has a role to play in preventing Veteran suicide. We know the care and support that Veterans need often comes before a mental health crisis occurs, and communities may be better equipped to provide these kinds of supports to Veterans and their families. As part of our public health approach to preventing Veteran suicide, we are asking communities and partners to help us reach Veterans before they reach a point of crisis. We know that activities or special interest groups, for example, can boost protective factors against suicide. Communities can foster an environment where Veterans can find connection and camaraderie, achieve a sense of purpose, bolster their coping skills, and live a healthy lifestyle.

While there is still a lot we can learn about suicide, there are some things that we know for sure: suicide is preventable, treatment works, and there is hope.

Question 4: 14 of the roughly 22 veterans who commit suicide every day on average never sought or received care from the VA. While this is a daunting statistic, I think it clearly shows that we need to do a better job of reaching out to our veterans during and after their separation from service to make sure they are aware of the services that are available to them. I know we can do a better job of outreach and suicide prevention. Secretary Wilkie, how do you view the VA's role in conducting proactive outreach to veterans to help them understand that there are programs within the VA that can help them through mental health issues?

VA Response: Every death by suicide is a tragedy, and we will not relent in our efforts to connect Veterans who are experiencing an emotional or mental health crisis with lifesaving support. That's why VA has made it a top priority to prevent suicide among the 20 million Veterans nationwide. To ensure that all Veterans, their families, and caregivers have access to lifesaving resources and support, VA is continually broadening its outreach efforts to deliver important messages and educate Veterans where they live, work, and thrive.

Guided by the National Strategy for Preventing Veteran Suicide, VA is using a comprehensive outreach approach across many different communications channels. This approach considers the fact that only about 30 percent of Veterans use VA health care-underscoring the need for innovative ways to connect Veterans and their loved ones to resources and information. Some of VA's outreach efforts include:

- **Earned media:** Working directly with media organizations enables VA to disseminate information about resources and articles on new developments.
- **Events:** Hosting tables at resource fairs gives VA an opportunity to connect face-to-face with Veterans who might not directly reach out to VA, providing them valuable information about benefits, employment, and resources.
- **Social media:** By using social media platforms such as Facebook and Twitter, we can directly connect with the public and respond to their questions through forums such as Facebook Live events.
- **Public Service Announcements (PSA):** VA has produced and distributed numerous inspiring PSAs that air on television networks nationwide. For example, the recent "Facing the Challenge" PSA highlights the importance of having an open conversation with people in your life who may be going through a difficult time.
- **Paid media:** Using a combination of digital advertising and traditional advertising on billboards and in print, VA educates people about the ways they can help the Veterans in their lives through the #BeThere campaign and other suicide prevention resources for supporting Veterans.
- **Partnerships:** Relationships with organizations and government agencies that regularly interact with Veteran populations help educate and engage communities and share valuable resources, such as our S.A.V.E. training developed in collaboration with the PsychArmor Institute.
- **Suicide Prevention Month Campaign:** Every September, this annual observance is an invaluable opportunity for VA to collaborate with partner organizations to help people recognize suicide risk factors and encourage everyone to "Be There" for Veterans.

In March, we started promoting our Be There campaign through billboards. Through a partnership with PSA Advertising, VA will gain access to available billboard placements across the country. At the launch of this effort, VA will place ads in the top 100 largest markets to promote both Be There and the Veterans Crisis Line. VA will also roll out market- and audience-specific advertisements to reach target populations in communities beyond the largest markets. Using data on rel-

evant topics such as firearm ownership, opioid use, Veteran population density and more, VA will identify messages that reflect each community's specific challenges and potential risk factors and feature Veterans who mirror the local population.

VA also promotes our Make the Connection campaign. Make the Connection is VA's premier digital mental health literacy and anti-stigma program, which highlights Veterans' true and inspiring stories of mental health recovery and connects Veterans and their family members with local, mental health resources. More than 600 videos from Veterans of all eras, genders, and backgrounds are at the heart of the campaign. The program was founded to encourage Veterans and their families to seek mental health services (if necessary), educate Veterans and their families about the signs and symptoms of mental health issues, and to promote help-seeking behavior in Veterans and the general public.

Through this all-embracing approach, VA can equip health care providers, caregivers, and Veterans' family members and friends with the information and materials they need to identify and support Veterans who may be at risk. Although VA is continuously making strides in connecting Veterans with the support they need, this work is far from done. Over the next several years, VA is redoubling its efforts to reach Veterans in rural areas, increasing support for recently transitioned Veterans, and expanding campaigns and partnerships at the state and local levels.

Question 5: Secretary Wilkie, as you know, we've seen the harm that long-term opioid use and therapy can cause veterans, and recent studies have shown that veterans are twice as likely to die of opioid related overdoses. I recognize that the VA has a unique challenge in caring for patients who live with chronic pain often resulting from their service. However, I think it's important that we work to find ways to reduce the number opioid prescriptions by offering alternative therapies that can help our veterans manage their pain without the risk of addiction.

Question 5a: Secretary Wilkie, can you outline the VA's current efforts to identify and offer alternative pain management therapies?

VA Response: As a preliminary point of clarification, we generally now use the terms "complementary" or "integrative" to describe this category of therapies rather than "alternative." This is to make completely clear that we do not endorse using these therapies to the exclusion of evidence-based conventional approaches, but rather in addition to and in support of them.

Substantial progress has been made in building infrastructure to support increased access to Complementary and Integrative Health (CIH) services for Veterans with pain and other conditions. On May 19, 2017, Veterans Health Administration (VHA) Directive 1137 was approved, establishing internal policy regarding the provision of CIH approaches. The current list of approved CIH approaches covered by the Veterans Medical Benefits package includes acupuncture, meditation, yoga, tai chi/qi gong, biofeedback, hypnosis, guided imagery, and massage as covered benefits if appropriate as part of the Veteran's care plan. Chiropractic care was previously approved for use at VA in 2004 so was not included in this list, and its use across the VA continues to increase. Chiropractic care has been shown to correlate with decreased opioid use in Veteran and general populations, and currently over 110 VA facilities operate on-station chiropractic clinics. The availability of CIH approaches in VA has also continued to grow as the infrastructure (including policy, qualifications standards, tracking/coding/billing mechanisms, position descriptions, etc.) has been developed to support the ability to deliver, manage, and track these services. Most notable is the recently approved qualification standard for massage therapists, which will allow licensed and certified massage therapists to be hired across the VHA for the first time, and a qualification standard for licensed acupuncturist which was approved in February 2018 which will greatly improve in house delivery of acupuncture. In FY 2018, there were 181,961 total acupuncture encounters (a 20-percent increase from FY 2017) and 131,547 unique Veterans receiving acupuncture (a 60-percent increase from FY 2017) across the enterprise.

In addition, VHA has trained over 2,400 battlefield acupuncture (BFA) providers and has 78 active BFA instructors. BFA is a limited acupuncture protocol applied just to the ears designed to relieve acute and chronic pain. Standards have also been developed for facilities to use in identifying staff properly trained to deliver each of the CIH approaches, and CIH Skills Training programs are being developed to increase capacity of VA staff to deliver these in the future.

Additionally, CIH Champions from facilities across the country have been identified and included on Veterans Integrated Service Networks (VISN) Pain Management Committees to support inclusion of CIH approaches as a routine part of pain management. This group meets monthly with the Office of Patient Centered Care and Cultural Transformation/10NE Integrative Health Coordinating Center to dis-

cuss VISN-level best practices and concerns and to gain new information related to CIH to take back to their VISNs. The Integrative Health Coordinating Center is also working closely with VHA Office of Community Care to develop standards and protocols for the delivery of CIH services in the community where necessary.

Section 933 of the Comprehensive Addiction and Recovery Act of 2016 (CARA) requires demonstration projects on integrating the delivery of CIH services with other health care services provided by VA for Veterans with mental health conditions, chronic pain, and other chronic conditions. Rather than just adding these approaches into primary care, CIH approaches are delivered through a Whole Health System. This approach improves access and reduces the burden on Primary Care. Whole Health is an approach to health care that empowers and equips people to take charge of their health, well-being, and to live their life to the fullest, and is the primary delivery vehicle through which Veterans can access CIH services.

The Whole Health System includes three components 1) Empower: The Pathway-in partnership with peers, empowers Veterans to explore mission, aspiration, and purpose and begin personal health planning; 2) Equip: Well-being Programs equip Veterans with self-care tools, skill-building, and support. Services may include proactive CIH approaches such as yoga, tai chi, or mindfulness. 3) Treat: Whole Health Clinical Care -in VA, the community, or both, clinicians are trained in Whole Health and incorporate CIH approaches based on the Veterans personalized health plan. VA staff has been working with Veterans around the country to bring elements of this Whole Health approach to life. In conjunction with the requirements of CARA, VA began implementation of the full Whole Health System in 18 Flagship Facilities in the beginning of FY 2018, the first wave of facilities in the national deployment of Whole Health. Flagship facility implementation of the Whole Health System will proceed over a 3-year period (FY 2018 - FY 2020) and is supported by a well-proven collaborative model which drives large scale organizational change.

The Whole Health approach is well-integrated with the VA Opioid Safety Initiative (OSI) and the National Pain Program's Stepped Care Model, both of which emphasize redesigning pain care with a focus on non-pharmacological approaches, self-care, skill building, and support. Preliminary data show a decrease in opioid prescription costs among Veterans with two or more Whole Health encounters; we continue to focus on the mitigation of opioid overuse as a priority goal for the Whole Health initiative.

An important delivery strategy is making Whole Health and CIH for pain and other conditions available via telehealth and we have made significant progress in this area. In FY 2017, 770 Whole Health/CIH Encounters were offered to 160 unique Veterans at 9 VAMCs across VHA. In FY 2018, 4,354 Whole Health/CIH encounters have been offered to 1,004 unique Veterans via Telehealth at approximately 26 VAMCs across VHA. We continue to see significant growth in utilization of Whole Health through telehealth in FY 2019 to date as well.

In addition, the VA Whole Health Education Program provides education and skills-based practice on Whole Health and CIH approaches; to date over 20,000 VA staff have participated in one or more Whole Health education offerings. One example of the many educational opportunities is Whole Health for Pain and Suffering: this 2-day course teaches evidence-informed, safe, and effective non-pharmaceutical approaches to pain care. Participants learn how mind-body approaches and self-management can support coping and wellbeing for people with pain, including acupuncture, dietary supplements, and manual therapies. Clinician self-care, burnout prevention, and enhancing resilience are also emphasized. To date, 1,274 VA staff have completed the Whole Health for Pain and Suffering course, with an additional 704 projected to attend through the end of FY 2019.

Along with identifying the challenges and successes of CIH implementation at VA facilities, our research partners from VA Health Services Research and Development Service continue to examine many patient-reported health outcomes, clinical outcomes, and Veteran satisfaction measures in their comprehensive study of the flagship sites. We will be able to better understand the health outcomes as well as cost impact upon conclusion of their evaluation efforts.

Question 5b: How does VA plan to build upon these efforts over the next decade?

VA Response: We plan to continue to expand Veteran access to complementary and integrative approaches for pain through all of our successful strategies to date, including infrastructure development, hiring of CIH providers, telehealth, community care coordination, education, and research.

One specific example, in 2018, the Office of Patient Centered Care and Cultural Transformation adopted the Institute for Healthcare Improvement Learning Collaborative model and launched the first Learning Collaborative for the 18 Whole

Health flagship facilities to support the delivery and implementation of the Whole Health System. To further support national deployment, The Whole Health Learning Collaborative Two: Driving Cultural Transformation begins in the Spring of 2019 and will support 36 more facilities in continuing to accelerate Whole Health delivery and innovation across VA. On March 12, 2019, guidance from the Office of the Deputy Under Secretary for Health and Operations Management was distributed requesting that each VISN identify two additional sites to help further Whole Health deployment in their VISN. Teams from each of the participating sites will join three face-to-face meetings during the 18-month collaborative, as well as monthly calls and virtual meetings as part of this Learning Collaborative process.

Telehealth modalities are continuing to grow to facilitate a smoother Provider and Veteran experience of Whole Health and CIH. The most recent innovation is VA Video Connect modality, which is popular among both group and one-on-one TeleWholeHealth encounters such as Telecoaching, Tele-facilitated Groups, and TeleWholeHealth Clinical Care encounters. With this modality, Veterans can access their Health Coach or Provider from anywhere they have an Internet connection. The provider and Veteran enter a virtual medical room where they can complete the encounter.

We are also planning for continued growth in our education program, which is critical to expanding access to CIH services for pain. We have trained 60 VA clinical faculty across the country to date to teach the Whole Health curriculum as a means to scale implementation. This coming year, we will train an additional 40 field-based faculty to continue this expansion. In addition, we anticipate continued increase in the hiring of CIH providers across the VA to provide pain treatment options. For example, we expect on-station chiropractic clinics at a minimum of 50 percent of all VAMCs in each VISN by December 2021.

VA is also committed to expanding its research efforts in the area of CIH and Whole Health for pain. In 2016 VA Health Services Research & Development held a state-of-the-art conference on non-pharmacological approaches to chronic pain. This conference convened VA researchers and clinical experts to identify which CIH and other non-pharmacological approaches had sufficient evidence to be provided across the system and which require further research. Based on the findings of this conference, the VA Office and Research and Development will continue to support research on the use of this type of approaches for the management of pain conditions.

Questions for the Record from Congressman Pappas

Question 1: Contracting: In the first district of New Hampshire, one of the biggest problems facing VA and providing quality care to veterans has been the contracting process. Even when VA wants to expand, and identifies available facilities or opportunities for expansion, the contracting process is so convoluted and bogged down in bureaucracy, that these projects end up being delayed by months, if not years. At the end of the day, this just hurts our veterans, since we can't offer them all the services and support that we'd like to.

Question 1a: I'm curious to know if you're aware of these issues, and if so, what you're doing to fix it?

VA Response: The Department of Veterans Affairs (VA) acknowledges issues, and we're working to improve coordination and control for better, faster delivery of VA health care facilities. Specifically, requirements development through internal approvals, VA Medical Centers to Veterans Integrated Service Networks to the Strategic Capital Investment Planning process, can take too long. VA is reviewing our processes to ensure engagement on proposed solutions earlier in the process to help conclude more quickly on the most effective acquisition strategies and improved internal approval processes.

In addition to internal VA processes, the authorization processes for major leases can be cumbersome. For larger leases, authorization must be obtained from two VA authorizing committees and two General Services Administration authorizing committees. Internally, VA is working to ensure we coordinate the timing of what we submit for future fiscal years so parallel reviews can be enabled versus sequential, as happens today.

Question 1b: And if not, can I have your commitment that you will investigate and work towards finding a solution?

VA Response: Yes; VA is aware and diligently working toward solutions as expressed above in question 1a.

Question 2: Physician Assistants: As you may know, PAs were identified by the VA IG in 2015 as a critical occupation. The VA Choice and Quality Employment Act of 2017 required the implementation of competitive pay for Physician Assistants, to improve recruitment and retention. The Omnibus Appropriations Bill of 2018 also had a provision requiring a pilot program to train military corpsmen and medics to become PAs and upon graduation work within the VA.

Question 2a: Can you provide a detailed update, noting specific dates, on the implementation of both programs?

VA Response: VA is working to implement the competitive pay for Physician Assistants (PAs). It is a multipronged lengthy process. VA is working with Defense Finance and Accounting Service regarding the system changes that must take effect prior to implementation. VA anticipates implementation by December 2019 if no unforeseen issues arise.

The purpose of the new pilot program is to provide educational assistance to certain former members of the Armed Forces for education and training as VA PAs. The Veterans Health Administration (VHA) has taken multiple steps to ensure timeliness in the development phase including working to develop required regulations that will allow VHA to move forward in initiating the pilot process. The entire effort (rulemaking and planning phase activities) is expected to take approximately 18 months. Therefore, the implementation of the pilot program is expected in 2021.

In the meantime, VA is using the Health Professional Scholarship Program to create a pipeline of newly graduated PAs to fill critical vacancies with an emphasis on selection of Veterans.

Question 2b: Additionally, what is the Department's position on Full Practicing Authority pertaining to Physician Assistants?

VA Response: Over the past several years, VHA has made efforts to promote full practice authority in several contexts, notably telehealth and certain nursing specialties, because Full Practice Authority (FPA) is consistent with our mission as a national, integrated health care system. However, the issue of FPA, whether for PAs or any other group, does not come without serious ramifications, and the potential impacts on care delivery to Veterans must be carefully considered. VHA is currently reviewing our options from both legal and policy perspectives. Due to the complexity of the issues presented, we cannot offer a timeline at this time, and cannot say for certain whether we will provide FPA to PAs. We note that, unlike the vast majority of medical providers and practitioners employed by VA, PAs are not subject to a national licensing requirement, which further complicates the question of developing appropriate expectations and standards of practice.

Questions for the Record from Congressman Peterson

Question 1: Mr. Secretary, I have two new, skilled-nursing veterans home project proposals in my district that will greatly benefit underserved rural veterans. One is in Bemidji, MN, and the other is in Montevideo, MN. These communities have been preparing for more than ten years to build these homes, and the state has secured significant funding for the projects, too. Once the state of Minnesota submits an application for each home, will you and your department be willing to provide me with updates on your review progress of these applications?

VA Response: VA's State Veterans Home Program received applications for three new homes from the Minnesota Department of Veterans Affairs on March 25, 2019. The applications have been reviewed and approved for listing on the Fiscal Year (FY) 2020 priority list.

Question 2: Mr. Secretary, in regard to veterans home applications, I have heard concerns that there is a significant time lag between a state being made aware that federal construction grants have been approved, and when the state receives a completed Memorandum of Agreement from the VA. This can make it difficult for states to plan ahead. Will you commit to accelerating the timeline between when a grant decision is made by the VA and when a state receives a completed Memorandum of Agreement?

VA Response: VA is currently looking for ways to streamline the application process and will work within the program's regulation to find improvements.

Question 3: Mr. Secretary, along those lines, when can we expect to see the VA State Home Construction Grants Priority List for Fiscal Year 2019?

VA Response: The FY 2019 VA State Home Construction Priority List was released to Congressional members, and the Governors and State Directors Offices, on March 22, 2019.

Question 4: Toxic Wounds of War: Mr. Secretary, when I travel my district I hear devastating stories from veterans and their families who are suffering from medical complications associated with exposure to Agent Orange. One of my priorities on this committee is to advocate for veterans who are suffering from terrible diseases that the medical community associates with Agent Orange, burn pits, and others. Will you commit to working with me and help veterans receive the health care they need for diseases associated with their service?

VA Response: VA is fully committed to working with you to help Veterans who have been exposed to toxic environmental chemicals and who may now be injured or sick as a result. To do this effectively requires high-quality research. VA uses its own original research as well as partnering with the Department of Defense (DoD) and/or academia. There are currently over 40 active studies that are ongoing. Many current research studies focus on Airborne Hazards. VA also relies on scholarly consensus reports from the independent National Academy of Science Engineering and Medicine (NAS) (formerly the Institute of Medicine).

The National Academy volumes supported and commissioned by Congress cover deployment-related environmental exposure topics. These subjects include the 11 volumes of the Agent Orange Updates, 11 volumes of the Gulf War series, and consensus reports regarding Airborne Hazards. Special volumes cover a wide variety of topics such as: concerns for intergenerational effects of deployment, vaccines, antimalarials, fuels, infectious disease, among others. NAS has just started to work on Volume 12 titled Respiratory Health Effects of Airborne hazards exposures in the Southwest Asia Theater of Operations. The full report is expected in October 2020.

The monthly Deployment Health Working Group meeting coordinates and synchronizes VA and DoD efforts for a wide variety of deployment-related environmental exposure concerns. VA takes a whole-of-government approach, actively partnering with not only DoD, but the Environmental Protection Agency, the Agency for Toxic Substance Disease Registry, and other agencies to establish best practices for exposure monitoring and research efforts.

The VA War-Related Illness and Injury Study Center-at three sites-assists with hard-to-diagnose illnesses as well as the development of treatment plans that are unique to the Veteran when necessary.

VA has six active registries which include: Airborne Hazard and Open Burn Pit Registry, Agent Orange, Gulf War, Ionizing Radiation, Toxic Embedded Fragments, and Depleted Uranium. These registries are all still active and collecting information that can result in information to improve Veterans' health.

The future of exposure monitoring and care of Servicemembers and Veterans is improving. DoD and VA have jointly developed a program called the Individual Longitudinal Exposure Record (ILER). Currently in its pilot phase, this effort will match a Servicemember with a location and any exposure monitoring information. This will occur throughout the Servicemember's career. This record will be available for VA to improve clinical care, research, and claims submissions. It will also be a key component of the new Electronic Health Record. VA is committed to working with Congress to provide the best for our Veterans.

Questions for the Record from Congressman Sablan

Question 1: As we look ahead to a vision for the enhancements in care and services we will deliver our veterans ten years into the future and beyond, I want to call your attention to a particularly underserved segment of our veteran population: those living in the U.S. insular areas, including my district, the Northern Mariana Islands. Our men and women from the islands have served our country honorably, in peacetime and war, throughout history and across the globe. Yet when they return home after service, they do not have access to the full range of veterans benefits they have earned.

Question 1a: What can the VA do, now what does the VA intend to do over the next decade, to ensure that they are remembered, and fully included, in the VA's transformation?

VA Response: VA Pacific Islands Health Care System (VAPIHCS) will continually assess and analyze changing levels of medical care demand from enrolled Veterans throughout the Commonwealth of the Northern Marianas Islands (CNMI) and tailor a combined VA/community health care partnered system involving the merits

of both to meet Veterans' needs. Recommendations from two recent studies, a feasibility study by a non-VA contractor (2019) and the Government Accountability Office (2018), are also involved in the analysis. VA leadership will continue to make visits to the CNMI and discuss with Veterans, health care providers, and elected officials, the programs and services projected and receptivity to needs expressed by these stakeholders. Recent expansions of telehealth capability to the Tinian and Rota islands will be further developed as needs arise.

VA will continue to deliver benefits to Veterans who have honorably served our Nation. This includes delivering benefits to all Veterans, within and outside of the United States, in a timely and accurate manner.

Veterans on CNMI are entitled to the full range of benefits that all other eligible Veterans are entitled to. The Veterans Benefits Administration (VBA) is committed to reaching Veterans, survivors, and their family members residing in remote or underserved areas, so they may be well informed of the various benefits and services to which they are entitled. VBA is responsible for distributing more than $100 billion in benefits to Veterans and their families annually and has made significant accomplishments over the past few years in providing these benefits, including improving claims processing and revamping the pre-discharge program for transitioning Servicemembers. Increasing outreach is one of the ways VA is improving Veterans' access to VA benefits and services, which we will continue to do over the next decade.

The Honolulu Regional Office (RO) serves Veterans in Hawaii and the Western Pacific U.S. territories of Guam and American Samoa, as well as CNMI (Saipan, Tinian, and Rota) by providing them the benefits they have earned in a manner that honors their service. The RO works closely with VAPIHCS' Outreach Clinic on Saipan to assist Veterans as well. VBA benefit counselors provide quarterly outreach/itinerant visits, subject to available funding.

Question 2: The VA MISSION Act included my language requiring the department to report on the VA's ability to provide hospital care, medical, mental health, and geriatric services to veterans living in the territories and a study of the feasibility of establishing a VA medical facility in the Northern Marianas, the only territory without one. The report is due March 3.

Question 2a: Will the VA submit the report on time?

VA Response: The report was submitted on March 20, 2019.

Question 3: In previous statements on the MISSION Act, you stated that to successfully implement the legislation, we must engage stakeholders at all levels.

Question 3a: What efforts have been made or are being made to engage veterans in the territories in the process?

VA Response: VAPIHCS is very involved in the implementation of various programs and key steps related to the provisions of the MISSION Act. Developing the new Veterans Community Care Program and a network of accessible, high quality non-VA medical providers is one such aspect. Communications about the various MISSION Act-related programs and projects are being managed by VA Central Office.

VA is working to engage and educate Veterans across each era and geographic location on MISSION Act, including within VAPIHCS. VAPIHCS leadership are working closely with local Veterans Service Organizations and other stakeholders and are seeking their assistance in amplifying Veteran engagement in the territories.

Question 4: The Northern Marianas was hit by two typhoons last year. One of those, Super Typhoon Yutu, was the strongest storm to hit the United States in 84 years. In the aftermath of these disasters, the VA provided the VA Disaster Assistance pamphlet for distribution among our veterans. Unfortunately, most of the programs and services listed are NOT, I repeat, are NOT directly available or even apply to veterans in the Northern Marianas. You can imagine the reaction from our veterans in learning of yet another way the VA fails to consider their needs. With the support of former Ranking Member Walz, your staff agreed to update or create a pamphlet that accurately reflects the assistance available to veterans in the territories, and the Northern Marianas specifically.

Question 4a: When can I expect to have the pamphlet?

VA Response: The Department developed the brochure and placemat to educate VA employees and external stakeholders of VA benefits that may be used to assist

Veterans during disasters across a diverse set of physical locations. These documents are high-level, universal tools summarizing potentially applicable Veterans Health Administration, VBA, and National Cemetery Administration programs for Veterans before, during, and after disasters across the country.

(DISASTER RELIEF TO VETERANS BROCHURE (Upon Request)
(DISASTER ASSISTANCE FOR VETERANS PLACEMENT (Upon Request)

Question 4b: How will the VA improve disaster assistance services to veteran in the territories?

VA Response: VHA's Office of Emergency Management (OEM) in coordination and partnership with VHA's Telemedicine Program and Clinical Operations are training and equipping Telehealth Emergency Management teams to deploy during disasters and set up Telehealth capabilities to bridge the gap between available clinicians and distance. As we develop this capability and technology, VA can begin clinical disaster operations within 24 hours of the area being deemed safe. VHA OEM is currently exploring deployable power generation and satellite technology that will support the Telehealth capabilities.

Question 5: The Veterans Evaluation Services (VES) is under contract with the VA to schedule and conduct examinations required by the VA for Compensation and Pension Claims or Separation Exams filed by veterans in my district. According to VES, they utilize a network of private facilities and civilian providers certified by the VA to conduct these exams.

Question 5a: Please provide a list of the private facilities and civilian providers certified by the VA to conduct the Compensation and Pension Claims or Separation Exams in the Northern Marianas, Guam, and American Samoa.

VA Response: The following is a listing of the civilian providers and their private facility locations in the Northern Marianas, Guam, and American Samoa:

Doctor Name	Exam Location
ALVAREZ ANN M	396 CHALAN SAN ANTONIO TAMUNING, GU 96913.
ALVAREZ ANN M	263 VIETNAM VETERANS HIGHWAY, TAMUNING, GU 96913.
ANAND BHAVANA C	MAIN RD, OTTOVILLE, PAGO PAGO, AMERICAN SAMOA 96799.
ANAND CHAITANYA	MAIN RD, OTTOVILLE, PAGO PAGO, AMERICAN SAMOA 96799.
AVERBUCH ILYA M	263 VIETNAM VETERANS HIGHWAY, TAMUNING, GU 96913.
BRADY WILLIAM F	396 CHALAN SAN ANTONIO TAMUNING, GU 96913.
BRADY WILLIAM F	MAIN RD, OTTOVILLE, PAGO PAGO, AMERICAN SAMOA 96799.
BRAM–MOSTYN AVRAM A	263 VIETNAM VETERANS HIGHWAY, TAMUNING, GU 96913.
BRAM–MOSTYN AVRAM A	MAIN RD, OTTOVILLE, PAGO PAGO, AMERICAN SAMOA 96799.
CASTILLANO JESSE A	396 CHALAN SAN ANTONIO TAMUNING, GU 96913.
CAUGHRON STEPHEN C	263 VIETNAM VETERANS HIGHWAY, TAMUNING, GU 96913.
CHARLTON WESLEY W	633 GOVERNOR CARLOS G CAMACHO RD, ST. LUCY'S EYE CLINIC, TAMUNING, GU.
COLSKY LIANE C	396 CHALAN SAN ANTONIO TAMUNING, GU 96913.
COLSKY LIANE C	MAIN RD, OTTOVILLE, PAGO PAGO, AMERICAN SAMOA 96799.
COLSKY LIANE C	202 HILTON RD HILTON GUAM RESORT & SPA, TAMUNING, GUAM 96913.
DAVIS DWIGHT	396 CHALAN SAN ANTONIO TAMUNING, GU 96913.

Doctor Name	Exam Location
DEBENEDICTIS MARJORIE F	633 GOVERNOR CARLOS G CAMACHO RD, ST. LUCY'S EYE CLINIC, TAMUNING, GU.
FAZIO RACHEL L	MAIN RD, OTTOVILLE, PAGO PAGO, AMERICAN SAMOA 96799.
GIORGIO BERNARD W	396 CHALAN SAN ANTONIO TAMUNING, GU 96913.
GIORGIO BERNARD W	263 VIETNAM VETERANS HIGHWAY, TAMUNING, GU 96913.
GRIFFITH CEABERT J	396 CHALAN SAN ANTONIO TAMUNING, GU 96913.
GRIFFITH CEABERT J	263 VIETNAM VETERANS HIGHWAY, TAMUNING, GU 96913.
GRIFFITH CEABERT J	MAIN RD, OTTOVILLE, PAGO PAGO, AMERICAN SAMOA 96799.
HERD DAVID A	MAIN RD, OTTOVILLE, PAGO PAGO, AMERICAN SAMOA 96799.
HOLLAND MARIAN C	396 CHALAN SAN ANTONIO TAMUNING, GU 96913.
HOLLAND MARIAN C	SUITE 6C, KIM'S BUILDING MIDDLE RD, GUALO RAI, SAIPAN 96950.
HUSSAIN FAIZ	396 CHALAN SAN ANTONIO TAMUNING, GU 96913.
HUSSAIN FAIZ	263 VIETNAM VETERANS HIGHWAY, TAMUNING, GU 96913.
HUSSAIN FAIZ	202 HILTON RD HILTON GUAM RESORT & SPA, TAMUNING, GUAM 96913.
HUTCHINSON AARON J	396 CHALAN SAN ANTONIO TAMUNING, GU 96913.
HUTCHINSON AARON J	263 VIETNAM VETERANS HIGHWAY, TAMUNING, GU 96913.
HUTCHINSON AARON J	MAIN RD, OTTOVILLE, PAGO PAGO, AMERICAN SAMOA 96799.
KALLINGAL GEORGE K	1201 ROUTE 16, BARRIGADA, GU.
KEW YVONNE	263 VIETNAM VETERANS HIGHWAY, TAMUNING, GU 96913.
KOROI NIKASIO P	LBJ TROPICAL MEDICAL CENTER, FAGAALU, PAGO PAGO, AS.
KRUM, JR. NELSON C	MIDDLE ROAD GUALO RAI, PARADISE DENTAL CENTER, SAIPAN, MP.
LAGATIANA LARRY	LBJ TROPICAL MEDICAL CENTER, FAGAALU, PAGO PAGO, AS.
LIEBERMAN DANIEL	396 CHALAN SAN ANTONIO TAMUNING, GU 96913.
LIEBERMAN DANIEL	263 VIETNAM VETERANS HIGHWAY, TAMUNING, GU 96913.
LIEBERMAN DANIEL	MAIN RD, OTTOVILLE, PAGO PAGO, AMERICAN SAMOA 96799.
LIMBO NEIL Z	222 CHALAN SANTO PAPA JUAN PAPA DOS, SUITE 203, HAGATNA, GU.
LLOYD SEAN D	263 VIETNAM VETERANS HIGHWAY, TAMUNING, GU 96913.
MALONE RICKY D	263 VIETNAM VETERANS HIGHWAY, TAMUNING, GU 96913.
MALONE RICKY D	MAIN RD, OTTOVILLE, PAGO PAGO, AMERICAN SAMOA 96799.
MANGLONA JANNA W	222 CHALAN SANTO PAPA JUAN PAPA DOS, SUITE 203, HAGATNA, GU.
MANGLONA JANNA W	238 ARCHBISHOP FC FLORES ST, DNA BUILDING, HAGATNA, GU.
MANGLONA JANNA W	SUITE 6C, KIM'S BUILDING MIDDLE RD, GUALO RAI, SAIPAN 96950.
MCCUTCHAN JUETA B	MAIN RD, OTTOVILLE, PAGO PAGO, AMERICAN SAMOA 96799.

Doctor Name	Exam Location
MEMINGER EUGIA L	396 CHALAN SAN ANTONIO TAMUNING, GU 96913.
MENKES ALEXANDER L	396 CHALAN SAN ANTONIO TAMUNING, GU 96913.
MOBLEY KAREN J	263 VIETNAM VETERANS HIGHWAY, TAMUNING, GU 96913.
MORGAN MARGARET AMBER	263 VIETNAM VETERANS HIGHWAY, TAMUNING, GU 96913.
MORGAN MARGARET AMBER	MAIN RD, OTTOVILLE, PAGO PAGO, AMERICAN SAMOA 96799.
MORGAN MARGARET AMBER	633 GOV CARLOS CAMACHO RD GUAM RADIOLOGY CONSULTANTS TAMUNING 96913.
MORRIS PETER D	396 CHALAN SAN ANTONIO TAMUNING, GU 96913.
PENTECOST JEFFREY O	263 VIETNAM VETERANS HIGHWAY, TAMUNING, GU 96913.
PETAIA–STEFFANY LALOASI M	4779 HIGHWAY 1, MY VISION EYE CLINIC, TAFUNA, AMERICAN SAMOA.
PIETRAFITTA JOSEPH J	396 CHALAN SAN ANTONIO TAMUNING, GU 96913.
ROSSEAU GAIL L	396 CHALAN SAN ANTONIO TAMUNING, GU 96913.
SAELUA FAAFETAI	NUU'ULI RD 5799, PAGO PAGO, AMERICAN SAMOA 96799.
SIATUU BENJAMIN D	LBJ TROPICAL MEDICAL CENTER, FAGAALU, PAGO PAGO, AMERICAN SAMOA 96799.
SICIARZ KRISTOF	396 CHALAN SAN ANTONIO TAMUNING, GU 96913.
STEARNS ANTHONY R	BEACH RD, GARAPAN MARIANAS MEDICAL CENTER, SAIPAN, MP.
TOFAEONO VICTOR T	MAIN RD, OTTOVILLE, PAGO PAGO, AMERICAN SAMOA 96799.
TRIOLO DENNIS J	545 CHALAN SAN ANTONIO SUITE 305, AUDIOLOGICAL ASSOCIATES, TAMUNING, GU.
TUCKER NATALIA S	396 CHALAN SAN ANTONIO TAMUNING, GU 96913.
WAGNER RICHARD L	263 VIETNAM VETERANS HIGHWAY, TAMUNING, GU 96913.
WAGNER RICHARD L	MAIN RD, OTTOVILLE, PAGO PAGO, AMERICAN SAMOA 96799.
WIJAYAGUNARATNE PRIYANTHA S	263 VIETNAM VETERANS HIGHWAY, TAMUNING, GU 96913.
ZIEBER DAVID A	222 CHALAN SANTO PAPA, SUITE 203, HAGATNA, GU.
ZIEBER DAVID A	222 CHALAN SANTO PAPA HAGATNA, GU.
ZIEBER DAVID A	633 GOV CARLOS CAMACHO RD GUAM RADIOLOGY CONSULTANTS TAMUNING 96913.
ZUEHLS JOHANNA J	396 CHALAN SAN ANTONIO TAMUNING, GU 96913.

Question 5b: Please list the private facilities and civilian providers to whom veterans in the Pacific insular areas have been referred for such exams, and the number of veterans from each Pacific insular area referred to each facility and provider over the last 5 years for those exams.

VA Response: The following provides the number of Veterans from the Pacific insular areas referred to each provider and facility over the last 5 years for those exams. Please note that some exam locations reflect the closest location to the Vet-

eran at the time of referral of the examination even though the Veteran's permanent location was in a Pacific insular area:

Veteran's Referred Per Provider Per Year

PROVIDER	2014	2015	2016	2017	2018	2019	Grand Total
ALVAREZ ANN M				77	52	1	130
ANAND BHAVANA C				4		4	
ANAND CHAITANYA					13		13
ANDRLIK KAILA R					2		2
AVERBUCH ILYA M				206		26	
BERRY AUTUMN M					1		1
BLANK MARCIA S					1		1
BRADY WILLIAM F					55	29	84
BRAM–MOSTYN AVRAM A				27			27
CASTILLANO JESSE A						20	20
CAUGHRON STEPHEN C				41		1	42
CHARLTON WESLEY W				15	82	15	112
CHEE PERCIVAL H				1			1
CHUN DAHYUN					1		1
COLSKY LIANE C					45		45
DAVIS DWIGHT						33	33
DEBENEDICTIS MARJORIE F	5		7	28	2	1	43
ENCARNACION RUBEN L					2		2
FAZIO RACHEL L					8	11	19
GANN MICHAEL K					1		1
GAUEN NALANI E					1		1
GIORGIO BERNARD W				29	25		54
GONZALES–ANTEOJO GENEROSE L					2		2
GRIFFITH CEABERT J				25	52		77
GRIMM EMILY A					1	2	3
HARRIS ELIZABETH A					2		2
HERD DAVID A					56		56
HESSON JESSICA E					1		1
HOLLAND MARIAN C						32	32
HUSSAIN FAIZ				46	66	2	114

Veteran's Referred Per Provider Per Year—Continued

PROVIDER	2014	2015	2016	2017	2018	2019	Grand Total
HUTCHINGS WALTER S			1				1
HUTCHINSON AARON J				30	63	6	99
JACKSON DANETTE P					1		1
KALLINGAL GEORGE K	11	5	59	155	165	40	435
KEW YVONNE				2			2
KHALIL JOSEPH N					1		1
KOROI NIKASIO P				1			1
KRUM, JR. NELSON C					1		1
LAGATIANA LARRY				6	97	15	118
LIEBERMAN DANIEL				34	6		40
LIMBO NEIL Z				7	5	1	13
LLOYD SEAN D					28		28
LLOYD (INT'L) SEAN D					15		15
MALONE RICKY D					38		38
MANGLONA JANNA W	41	6	161	354	141		703
MCCUTCHAN JUETA B				16			16
MEMINGER EUGIA L						11	11
MENKES ALEXANDER L						39	39
MILNER FLOYD E					1		1
MIRANDA RHODORA P					1		1
MOBLEY KAREN J					6		6
MORGAN MARGARET AMBER				74	30		104
MORRIS PETER D					72		72
ORLEY JORDAN S					1		1
PADGETT AMBER N					1		1
PARK JINSENG					1		1
PASCUAL DANILO L					2		2
PEARSON SEAN P					1		1
PENTECOST JEFFREY O					45		45
PETAIA–STEFFANY LALOASI M					12	4	16
PIETRAFITTA JOSEPH J					25		25
ROSS ANN S					1		1

Veteran's Referred Per Provider Per Year—Continued

PROVIDER	2014	2015	2016	2017	2018	2019	Grand Total
ROSSEAU GAIL L						7	7
SAELUA FAAFETAI	5						5
SEALE STUART A					1		1
SEDGH JOHN					1		1
SIATUU BENJAMIN D				4			4
SICIARZ KRISTOF					52		52
STEARNS ANTHONY R	2						2
THOMPSON MALIA L					4		4
TOFAEONO VICTOR T	12	5	19	122	63	13	234
TRIOLO DENNIS J					76	30	106
TUCKER NATALIA S					29	1	30
VILLALON MELISSA A					2		2
WAGNER RICHARD L				98	15	7	120
WIJAYAGUNARATNE PRIYANTHA S					4		4
WILLIAMS ALICE					1		1
WILLIAMS PAUL C					1		1
WRIGHT GRIGGSBY H					1		1
YOO SHINYOUNG					1		1
ZIEBER DAVID A	14			89	90	16	209
ZUEHLS JOHANNA J					20		20
Grand Total	**90**	**16**	**247**	**1307**	**1596**	**337**	**3593**

Veteran's Referred Per Facility Per Year

Exam Location	2014	2015	2016	2017	2018	2019	Grand Total
103 V.A. RUFINO ST, LEGASPI VILLAGE, MEDICAL TOWERS MAKATI, MAKATI CITY, PH					2		2
1180 N TOWN CENTER DR, STE 100, LAS VEGAS, NV					1		1
1201 N DECATUR BLVD STE110, LAS VEGAS, NV 89108					2		2
1201 ROUTE 16, BARRIGADA, GU	11	5	59	155	165	40	435
130 MARVIN ROAD SOUTHEAST, SUITE 142, LACEY, WA					1		1

Veteran's Referred Per Facility Per Year—Continued

Exam Location	2014	2015	2016	2017	2018	2019	Grand Total
1300 WEST 155TH ST, STE 107, GARDENA, CA					1		1
1350 S KING ST, SUITE 325, HONOLULU, HI					2		2
1505 W AVENUE J, SUITE 201, LANCASTER, CA					1		1
202 HILTON RD, HILTON GUAM RESORT & SPA, TAMUNING, GUAM 96913					16	1	17
222 CHALAN SANTO PAPA #304, REFLECTION DENTAL, HAGATNA, GU				7	5	1	13
222 CHALAN SANTO PAPA , SUITE 203, HAGATNA, GU					1		1
222 CHALAN SANTO PAPA JUAN PAPA DOS, SUITE 203, HAGATNA, GU	41	6	161	354	36		598
222 CHALAN SANTO PAPA STE 203 HAGATNA GU 96910	14			11			25
238 ARCHBISHOP FC FLORES ST, DNA BUILDING, HAGATNA, GU					91		91
263 VIETNAM VETERANS HIGHWAY, TAMUNING, GU 96913				382	186	2	570
3/F MERCURY DRUG BUILDING, GLORIETTA 3 AYALA CENTE, PATIENT FIRST MEDICAL CENTER, MAKATI CITY, PH					2	2	
3096 RIVERSIDE DR, STE D, MACON, GA			1				1
313 TEHERAN–RO, KANGNAM–GU, 2ND FLOOR SUNGJI HEIGHTS 1 BUILDING, SEOUL, KO					1	1	
33 JONGNO 1(il)-GA JONGNO–GU Seoul, KO 03159					1		1
34616 11TH PLACE S, SUITE 3–1, FEDERAL WAY, WA					1		1
396 CHALAN SAN ANTONIO TAMUNING, GU 96913					456	146	602
4747 KILAUEA AVE, STE 108, HONOLULU, HI					4		4
4779 HIGHWAY 1, MY VISION EYE CLINIC, TAFUNA, AS					12	4	16
4870 WEST CLARK RD YPSILANTI, MI 48197					1		1
50 SOUTH BERETANIA STREET, SUITE C116, HONOLULU, HI				1			1

Veteran's Referred Per Facility Per Year—Continued

Exam Location	2014	2015	2016	2017	2018	2019	Grand Total
500 ALA MOANA BLVD STE 400 BLDG 7, HONULULU, HI 96813					2		2
545 CHALAN SAN ANTONIO SUITE 305, AUDIOLOGICAL ASSOCIATES, TAMUNING, GU					76	30	106
615 PIIKOI STREET, SUITE 511, HONOLULU, HI					2		2
633 GOV CARLOS CAMACHO RD TAMUNING, GU 96913				106	89	16	211
633 GOVERNOR CARLOS G CAMACHO RD, ST. LUCY'S EYE CLINIC, TAMUNING, GU	5		7	43	84	16	155
7001 INDIANA AVENUE, SUITE 12, RIVERSIDE, CA					1		1
7424 BRIDGEPORT WAY W LAKEWOOD, WA 98499					1		1
7525 CUSTER RD W, LAKEWOOD, WA					1		1
888 KAPIOLANI BLVD # 1905 HONOLULU, HI 96813					1	2	3
9005 S PECOS ROAD, SUITE 2520, HENDERSON, NV					1		1
94–1221 KA UKA BLVD, SUITE B205, WAIPAHU, HONOLULU, HI 96797				1			1
970 N KALAHEO AVE, SUITE C315, KAILUA, HI 96734					1		1
98–1247 KAAHUMANU ST, HI, 96701–5311					3		3
98–1247 KAAHUMANU ST, SUITE 116, AIEA, HI					3		3
BEACH RD, GARAPAN MARIANAS MEDICAL CENTER, SAIPAN, MP	2						2
CONGRESSIONAL AVE, CIRCLE C MALL, URBAN HEALTH MEDICA, QUEZON CITY, PH					1		1
LBJ TROPICAL MEDICAL CENTER, FAGAALU, PAGO PAGO, AS				11	97	15	123
MAIN RD, OTTOVILLE, PAGO PAGO, AMERICAN SAMOA 96799	12	5	19	236	225	59	556
MAPO–GU DOHWA–DONG 560, DOKMAKRO 320, SUITE 1504, SEOUL, KO					1		1
MIDDLE ROAD GUALO RAI, PARADISE DENTAL CENTER, SAIPAN, MP					1		1

Veteran's Referred Per Facility Per Year—Continued

Exam Location	2014	2015	2016	2017	2018	2019	Grand Total
MYEONGDONG 9 GA GIL, JUNG–GU, #12, SEOUL, KO					1		1
NINOY AQUINO AVE CLARKFREEPORT, MABALACAT, PH 2010					1		1
NINOY AQUINO AVE, CLARK FREEPORT, OUR LADY OF MT. CARMEL MEDICAL CENTER, MABALACAT, PH					2		2
NUU'ULI RD 5799, PAGO PAGO, AS	5						5
STE 6C KIM'S BUILDING MIDDLE RD, GUALO RAI, SAIPAN, MP 96950					14	5	19
Grand Total	**90**	**16**	**247**	**1307**	**1596**	**337**	**3593**

Question 6: During your testimony before the MilCon-VA Appropriations Subcommittee hearing yesterday, you mentioned plans to visit the Pacific later this year. I hope your plans include a visit to the Northern Marianas so you can meet our veterans and hear for yourself the importance of making direct VA care and services more accessible to them.

Question 6a: Are you able to confirm whether or not your travel plans include a visit to the Northern Mariana Islands?

VA Response: Due to the nature of the Secretary's position, long term projections for travel opportunities can be unpredictable, but at this time the Secretary still does plan on visiting CNMI, should his schedule permit. Once more details regarding Secretary travel become more available, the travel team will be in contact with your office.

Questions for the Record from Congressman Barr

Question 1: From the Secretary's testimony: The MISSION Act expands eligibility for VA's Program of Comprehensive Assistance for Family Caregivers under the Caregiver Support Program. Originally, this benefit was only offered to eligible Veterans who incurred or aggravated a serious injury in the line of duty on or after September 11, 2001. The MISSION Act opens the benefit to eligible Veterans and their caregivers from all eras.

The expansion will occur in two phases beginning with Veterans who incurred or aggravated a serious injury in the line of duty on or before May 7, 1975, with further expansion beginning two years after that.

Over the course of the next year, VA will be establishing systems and regulations necessary to expand this program.

I met with veterans from my district this week and while thankful for the expansion of the Comprehensive Assistance for Family Caregivers Program to pre-9/11 veterans, they noted that issues with the development of the program's IT system may be contributing to delays in implementing program's expansion.

Question 1a: Can you speak on how the IT system is being developed in relation to the Comprehensive Assistance for Family Caregivers Program?

VA Response: The first phase of expansion of the Program of Comprehensive Assistance for Family Caregivers (PCAFC) cannot begin until the Department of Veterans Affairs (VA) certifies to Congress that VA has fully implemented the information technology (IT) system required by section 162(a) of the VA MISSION Act of 2018. VA has determined that a commercial-off-the-shelf solution is the most efficient, effective, and sustainable solution for the Caregiver IT needs and is actively moving forward with implementation of that solution. The scope of this effort includes replacing the functionality in the prior system, migrating data, integrating with VA services, and updating legacy systems. These efforts are incremental and agile in nature, and VA looks forward to updating Congress on our progress.

Question 1b: How can we in Congress further help the VA to ensure this expansion is being efficiently and effectively rolled out for our pre 9/11 veterans?

VA Response: VA appreciates the commitment of Congress to support improvements to and expansion of PCAFC. In order to be successful, we must ensure we have an IT system capable of supporting the administrative and oversight needs of PCAFC, clearly defined regulations to guide implementation, and adequate funding to support delivery of supports and services available under PCAFC including sufficient staffing at the national and local medical center levels. VA is diligently working to address each of these areas and is engaging Veterans Service Organizations and other stakeholders to ensure robust feedback during this transformation. VA welcomes any additional stakeholder feedback Congress may be willing to share.

Question 2: From Secretary Wilkie's testimony: The number of women Veterans using VHA services has tripled since 2000, growing from nearly 160,000 to over 500,000 today. To accommodate the rapid growth, VHA has expanded services and sites of care across the country. VA now has at least two Women's Heath Primary Care Provider (WH–PCP) at all of VA's healthcare systems. VHA is in the process of training additional providers so every woman Veteran has an opportunity to receive primary care from a WH–PCP.

Mr. Secretary, I commend you and the VA for investing in the care for women veterans, a growing and important segment of the veteran population. These providers are essential to making sure female veterans get the care they deserve. As you may know, unfortunately women are significantly more at risk of being victims of military sexual assault while serving on active duty. According to the findings of the Department of Veterans Affairs' National Screening Program, nearly 1 in 4 women and 1 in 100 men reported that they have been victims of military sexual assault during their time serving in the military.

Are the WH–PCP's being trained and properly equipped by the VHA to appropriately address the needs of female military sexual trauma (MST) survivors?

VA Response: VA's Women's Health Mini-Residency Primary Care curricula provides training for those who care for Military Sexual Trauma (MST) survivors. Providers are trained how to sensitively screen for MST and to facilitate patient access to appropriate resources. Primary Care teams are also educated how to conduct gender-specific exams for those with a history of MST and the impact MST may have on ongoing health concerns. The Emergency Care Mini-Residency training also equips teams to care for Veterans who experienced acute sexual assault and MST.