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Good morning Chairwoman Brownley, Ranking Member Dunn, and Members of the Subcommittee. Thank you for the opportunity to discuss the VA Emergency Response and All Hazards Emergency Cache (AHEC) program. I am accompanied today by my colleagues from the Veterans Health Administration (VHA): Dr. Larry Mole, the Chief Consultant for Population Health Services; Dr. Steve Steinwandt, the Hines Consolidated Mail Outpatient Pharmacy Director and Emergency Pharmacy Director; and Dr. Paul Kim, Director of VHA Office of Emergency Management.

Introduction

In response to the terror attacks of 9/11, the United States (U.S.) Government took on a herculean task to overhaul homeland security efforts across all sectors of Government. On November 7, 2002, the VA Emergency Preparedness Act of 2002 (Public Law 107-287) became law and began the transformation of VA's preparedness mission. This Act not only enhanced VA's role as part of the Federal response effort aimed at preventing events like 9/11 and the anthrax attacks of 2001, it also served as a catalyst for VA to develop resilient capabilities that would support continuous delivery of services to Veterans in an all hazards environment.

Simultaneously, the Department of Health and Human Services (HHS) was in the process of implementing the Public Health and Bioterrorism Preparedness and Response Act of 2002, which enhanced the viability and capability of the Nation's Strategic National Stockpile (SNS) designed to aid in mitigating the consequences of a Chemical, Biological, Nuclear, or Radiological (CBRN) event or other public health

emergency within the U.S. To complement these efforts, VA, on its own, established the All Hazards Emergency Cache (AHEC) program to bridge the gap until the SNS is operational in the local area impacted by a CBRN event or public health emergency. This capability was primarily designed to preserve VA's health care delivery infrastructure to ensure the continued delivery of services to our Nation's Veterans under the care of their local VA Medical Center (VAMC). AHEC included Medical Countermeasures that were either not stocked in the local VA pharmacy's inventory or quantities that would augment what was on hand to enable a rapid response to a public health emergency or CBRN event.

Today, the mission of the AHEC program remains the same as when it was created. And as a direct result of the VA Office of the Inspector General (OIG) audit dated October 31, 2018, VA continues to implement improvements to increase and ensure the readiness of AHEC to support consequence management operations and ensure the continued delivery of services to our Nation's Veterans.

VA Mission Readiness

The establishment of the AHEC program was just the beginning of the evolution of VA's mission readiness and assurance programs.

One of VA's proudest moments occurred during the 2017 Hurricane response season was when the Department was identified as a major contributor to the overall Federal response while sustaining local VA operations. As a testimony to VA's preparedness and emergency response capabilities, the San Juan VAMC was the only hospital that remained operational throughout the response phase of Hurricane Maria and served as the initial base of operations for several Federal response entities. In partnership with HHS, the Department of Defense, and the Federal Emergency Management Agency, VA evacuated 423 personnel from the Caribbean; cared for over 6,500 personnel at the Manati Federal Medical Station; and provided emergency dialysis support to 76 non-Veteran personnel. To ensure a successful response to Hurricane Maria, VA transported 128 short tons of critical resources and response equipment to Puerto Rico and deployed 1,039 personnel to support both VA and

Federal mission needs. In addition, VA deployed mobile canteen services that provided over 100,000 at-cost meals to disaster survivors and Mobile Vet Centers that provided readjustment counseling services to over 4,500 disaster survivors.

In response to Hurricanes Florence and Michael in 2018, VA again demonstrated its agility to rapidly respond to crisis by establishing Veteran support sites that were one-stop shops for Veteran disaster survivors to receive nutritional, mental health, pharmaceuticals, medical care, and other services to aide in their recovery. The ability to respond with the breadth and depth of capabilities identified above does not happen by accident. This type of response capability is only achievable by having dedicated personnel and long-term investment strategies in response systems that are designed to support day-to-day operations, and during crisis, decisively equip response personnel with the resources necessary to manage the consequences associated with a disaster.

OIG Report on the Emergency Cache Program

VA appreciates the OIG review as it has led to strengthening VA's AHEC program. Since the publication of the report, VA has implemented improvements to the inventory management and internal controls for the All Hazard Emergency Cache program. In response to the OIG recommendations, VA's Emergency Pharmacy Service (EPS) conducted training and aided medical facilities with their first annual wall-to-wall inventory of all cache drugs and supplies. The training provides the foundation for a reliable, efficient, and accurate cache formulary management process. Based on the training, all sites conducted the first enterprise-wide inventory of every facility AHEC. Because of the recent inspections, the individual cache inventories have been reconciled with the master inventory file. Cache sites now receive updated inventory sheets for use during wall-to-wall inventories. Additionally, the agency has developed a SharePoint file folder system for each site in which the existing master inventory file as entered in the software system is sent daily to the folder. Access to the folder is site specific.

Additionally, EPS developed processes to re-label all expired or excess inventory of drugs that are purposefully maintained to respond to drug shortages or for potential

Shelf Life Extension program (SLEP) testing, and to remove and rectify cases of other expired, missing, or excess inventory of drugs. The Department of Defense administers SLEP, a program through which the Food and Drug Administration conducts periodic stability testing of certain drug products to extend the expiration date of such products to help defer their replacement costs in critical federal stockpiles, with the goal of helping to ensure public health preparedness for U.S. military and civilian populations. VHA is coordinating a comprehensive policy that will modernize processes, clearly assign responsibilities among the many program offices with emergency management responsibilities and set requirements that ensure the AHEC program is always mission ready.

VHA provided training on the processes to ensure that expired, excess, incorrect, or missing items discovered during any inventory activity are handled appropriately. Sites were required to remove all expired, excess, and incorrect items from the caches and certify removal. Any items identified as missing are being replaced at affected sites. EPS has sent signage for any items that are expired but purposefully kept in the AHEC because the item is either being tested for SLEP or on national backorder without the availability of a suitable substitute. Sites have certified that signage is appropriately affixed to the expired items. All these requirements will be reviewed by the VHA Office of Emergency Management personnel during their cache inspections.

VHA has assessed the continued use of SLEP in conjunction with stock rotation and returns to a contracted vendor for appropriate disposition from a combined perspective of cost savings and patient safety. The justification to use SLEP varies by Federal agency. VHA participates in SLEP using pharmaceuticals with the following characteristics:

1. Little use in routine care of Veterans;
2. Limited availability from manufacturer; and
3. Excessive replacement cost (>$500,000)

Importantly, all three characteristics must be considered for a given drug since one may outweigh (or minimize) another. For example, an expensive product may not be appropriate for SLEP if the volume normally used by VHA is large enough to permit cost-effective, stock rotation. Using this model, VHA determined that 12

pharmaceuticals should remain in SLEP; 6 for cost versus stock rotation; and 6 others with no clinical use in VHA. There are 13 additional pharmaceuticals that would not qualify for SLEP, most falling under a stock rotation program. SLEP- extended pharmaceuticals should not be used in routine patient care settings. VHA policy will be updated to reflect the appropriate use of SLEP.

The agency conducted a comprehensive assessment and feasibility analysis of drugs that can be readily used in a medical facility operation. EPS, with the oversight of the AHEC Committee, developed criteria for each medication based on the usage patterns of the VA medical facilities, the ability of a medication to be successful in the SLEP program; the availability of the medication through the manufacturers; and replacement cost of the medication. The AHEC Committee approved the assessment and feasibility analysis.

A comprehensive review of VHA Directives 1047(1) *All-Hazards Emergency Cache Program* and 0320.10 *Inspection of VA All-Hazards Emergency Caches by the VHA Office of Emergency Management* is underway which includes an assessment of roles and responsibilities for VHA Central Office program offices and Veterans Integrated Services Networks and field leadership. In December 2018, there was an organizational realignment of 6 program offices in VHA Patient Care Services including Public Health. This realignment was part of VHA Modernization and brought together program offices with similar functions and activities. An Integrated Program Team has been meeting since July 2018 to create the new vision, mission, strategy, and goals for a re-envisioned national Population Health program. One of the eight focus areas of this new program is emergency management. As the VHA Directives mentioned above are revised, responsibilities related to emergency management and Population Health will include clarifying the roles and responsibilities in the AHEC.

Conclusion

We appreciate this opportunity to share our efforts to strengthen VA's preparedness to respond to public health or CBRN emergencies and our continued commitment to develop resilient capabilities to respond to crisis. Our objective is to give

our Nation's Veterans the top-quality care they have earned and deserve, even in an all hazards environment.

Chairwoman Brownley, we appreciate this Subcommittee's continued support and encouragement in identifying and resolving challenges as we find new ways to care for Veterans. This concludes my testimony. My colleagues and I are prepared to respond to any questions you may have.