DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

June 5, 2020

In Reply Refer To: 001B
FOIA Request: 19-09094-F

Austin R. Evers & Maureen Rasheed
Executive Director
American Oversight
foia@americanoversight.org

Dear Austin Evers and Maureen Rasheed,

This is the Tenth Partial Initial Agency Decision (IAD) to your Freedom of Information Act (FOIA) request to the Office of the Secretary, U.S. Dept. of Veterans Affairs (OSVA) dated July 11, 2019, referred to this FOIA office on July 2, 2019, and assigned FOIA tracking number **19-09094-F.** You requested, as you phrase it:
"All emails sent or received by former Secretary David Shulkin or former Chief of Staff and Acting Secretary Peter O'Rourke on any personal, non-governmental, or nonofficial email account regarding official agency business.
[. . .]
Please provide all responsive records from November 9, 2016, through March 28, 2018."

Tenth Partial IAD & Reasonable Searches Dated 8/2/19
On August 2, 2019, OSVA received approximately twenty-two thousand (22,000) pages of emails from David Shulkin working on VA business on his aol.com and gmail.com email accounts, in which Mr. Shulkin did **not** copy a VA employee. OSVA now releases to you two thousand three hundred eighty-three (2,383) pages, Bates-numbered 7531-10031. Ninety-nine (99) pages of Transition documents between those Bates-numbers were non-responsive, as unrelated to the VA or VA business.

OSVA releases partial email addresses of Laurie Perlmutter (lperl), Marc Sherman (mbs), Bruce Moskowitz (brucem), whereas redacting their email addresses would not identify them as the recipients or senders. OSVA releases the names of Marc Sherman's associates Michael Zinner, Terry Fadem, Clifford Ko, and Kurt Heyssel, as well as Perlmutter associate Marisol Garcia. OSVA releases names of RFP panelists Amy Cooper, Stan Huff, Stephanie Reel, Jon Manis, Karson, Ed Marx, Frank Opelka, Aneesh Chopra, Cris Ross, Carla Smith, Ryan Howells, Paul Sutton, and Kenneth Mandi. VA elects to release the names and VA contact information of VA Senior Executives. VA also releases photographs of the VA Secretary, as well as public photographs.

After reviewing you two thousand three hundred eighty-three (2,383) pages, Bates-numbered 7531-10031, OSVA redacts some information with FOIA Exemptions 2, 4, 5, and 6. 5 U.S.C. § 552(b)(2) exempts from disclosure information "related solely to the internal personnel rules and practices of an agency." In this instance, the redacted information relates solely to internal personnel rules and practices of unsuccessful VA applicants applying for or considering VA positions, or VA employees resigning from the VA. The redacted information includes unsuccessful or withdrawn applicants' personal statements, past employers, jobs, duties, descriptions, locations, education, certifications, accomplishments, security clearances, training, awards, references, publications, research projects, and research grants. Redacted information

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also includes filled-in information from federal applicants submitted on SF-86, security clearance forms, FBI forms, and Presidential appointment forms, including attachments. Redacted information also includes details of Scott Blackburn's resignation.

5 U.S.C. § 552(b)(4) exempts from disclosure "trade secrets and commercial or financial information obtained from a person and privileged or confidential." "Where commercial or financial information is both customarily and actually treated as private by its owner and provided to the government under an assurance of privacy, the information is "confidential" within Exemption 4's meaning." Food Marketing Inst. v. Argus Media, No. 18-481, at *2 (U.S. June 24, 2019). Redacted information includes details of multiple proposals (including from Apple, Moskowitz's legal consultation, NGLPRQ, and a Bergen proposal to the New Jersey government), proposed technical approaches, teaming or partnership agreements, assessment methodology, labor rates, all of which the VA never accepted. Redacted information also includes copyrighted GCAAR forms, a Harvard journal article, and McKinsey and Company's leadership assessments. Such information is marked confidential, and offerors (such as Apple, Moskowitz's legal consultation, NGLPRQ, Bergen, and McKinsey and Company) typically treat such as commercially private information or having received an assurance of privacy from the VA.

Exemption 5 protects interagency or intra-agency memorandums or letters that would not be available by law to a party other than an agency in litigation with the agency. The presidential communications privilege protects agency communications to or from the President or his advisers. OSVA redacted communications between VA employees and White House Counsel or advisors. Loving v. DOD, 550 F.3d 32, 37-38 (D.C. Cir. 2008) (Exemption 5 "incorporates" Presidential Communications Privilege, which protects "'communications directly involving and documents actually viewed by the President,' as well as documents 'solicited and received' by the President or his 'immediate White House advisers'" (internal citations omitted)); Berman v. CIA, 378 F. Supp. 2d 1209, 1219-20 (E.D. Cal. 2005) (same), aff'd on other grounds, 501 F.3d 1136 (9th Cir. 2007); Judicial Watch, Inc. v. DOJ, 365 F.3d 1108, 1110 n.1 (D.C. Cir. 2004) ("embrac[ing] the definitional analysis set forth" in In re Sealed Case, 121 F.3d 729, 749-50, 752 (D.C. Cir. 1997), protecting documents covered by Presidential Communications Privilege); Amnesty Int'l USA v. CIA, 728 F. Supp. 2d 479, 522 (S.D.N.Y. 2010) ("all twenty documents reflect or memorialize communications between senior presidential advisers and other United States government officials and are therefore properly withheld"). Out of fifteen thousand three hundred forty-two (15,342) released to you, OSVA redacted information per the presidential communications privilege on only eighty-one (81) pages.

5 U.S.C. § 552(b)(5) exempts from required disclosure "inter-agency or intra-agency memorandums or letters which would not be available by law to a party other than an agency in litigation with the agency." Under the attorney-client privilege, the VA redacts portions of records, emails, and communications between VA employees and attorneys relating to proposed language for a Request for Proposal procurement. Under the work product privilege, the VA redacts paraphrases of VA attorney-client communication relating to proposed language for a Request for Proposal procurement. The release of this information would impede the ability of VA employees and attorneys, as well as amongst VA employees who paragraphed VA attorney-client communication, to speak openly and frankly about legal issues concerning procurements. The release of this information would also compromise the VA's legal positions for any potential procurement lawsuits.

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FOIA Exemption 5 also permits an agency to withhold material reflecting the thoughts, opinions, and recommendations of federal officials reviewing an issue. Under the deliberative process privilege and FOIA Exemption 5, OSVA redacts internal government deliberations, thoughts, opinions, recommendations, and solutions from federal employees and consultants reviewing in their professional capacities: VA programs, potential responses to news inquiries, talking points, a proposed Executive Order, unsubstantiated allegations, a VA OIG complaint details, proposed language for a Request for Proposal, a Columbia University professor's proposal on addressing veteran mental health, VA telehealth proposals, draft phone agendas, and a McKinsey and Company's leadership assessment. The information contained in the responsive records is both predecisional and deliberative because it reflects preliminary opinions, proposed solutions, recommendations on VA programs, potential responses to news inquiries, talking points, a proposed Executive Order, unsubstantiated allegations, a VA OIG complaint details, proposed language for a Request for Proposal, a Columbia University professor's proposal on addressing veteran mental health, VA telehealth proposals, draft phone agendas, and a McKinsey and Company's leadership assessment, which do not reflect VA's final decision. Exposure of premature discussions before a final decision is made could create undue public confusion. The release of the redacted information would negatively impact the ability of federal employees and consultants to openly and frankly consider issues amongst themselves when deliberating, discussing, reviewing, proposing changes to, and making recommendations on: VA programs, potential responses to news inquiries, talking points, a proposed Executive Order, unsubstantiated allegations, a VA OIG complaint details, proposed language for a Request for Proposal, a Columbia University professor's proposal on addressing veteran mental health, VA telehealth proposals, draft phone agendas, and a McKinsey and Company's leadership assessment. The information reveals the thoughts, deliberations, and opinions that, if released, would have a chilling effect on the ability of federal officials to discuss, opine, recommend or be forthcoming about the agency's issues which require full and frank assessment. Here, the disclosure of the withheld information is likely to compromise the integrity of this deliberative, decision-making, or investigation process. Moreover, the predecisional character of a document is not altered by the passage of time. Bruscino v. BOP, No. 94-1955, 1995 WL 444406 at *5 (D.D. C. May 15, 1995), aff'd in part, No. 95-5212, 1996 WL 393101 (D.C. Cir. June 24, 1996); Bruscino v. BOP, No. 94-1955, 1995 WL 444406 at *5 (D.D. C. May 15, 1995), aff'd in part, No. 95-5212, 1996 WL 393101 (D.C. Cir. June 24, 1996); Access Reports v. DOJ, 926 F.2d 1192, 1196-97 (D.C. Cir. 1991) ("talking points" memoranda are predecisional); ACLU v. DHS, 738 F. Supp. 2d 93, 112 (D.D.C. 2010) ("'talking points' are predecisional . . . the document itself suggests that a public statement was anticipated at the time of its creation, and given that no official statement has yet been made, the talking points remain ripe recommendations that are ready for adoption or rejection by the Department"); Sec. Fin. Life Ins. Co., No. 03-102-SBC, 2005 WL 839543, at *11 (D.D.C. Apr. 12, 2005) ("The undisputed evidence establishes that these [talking points] are deliberative."); Judicial Watch, Inc. v. U.S. Dep't of Commerce, 337 F. Supp. 2d 146, 174 (D.D.C. 2004) (protecting "talking points" and recommendations on how to answer questions); St. Louis Sewer Dist., No. 10-2103, at *18 (E.D. Mo. Mar. 2, 2012) (protecting e-mail communications, "press releases, talking points and 'Q & A,'" drafts, and briefing materials); Citizens for Responsibility & Ethics in Wash. v. DHS, 514 F. Supp. 2d 36, 44 (D.D.C. 2007) (protecting briefing materials concerning Hurricane Katrina response including proposed "solutions and approaches"); Judicial Watch, Inc. v. DOE, 310 F. Supp. 2d 271, 317 (D.D.C. 2004) (protecting briefing materials for Secretary of the Interior), aff'd in part, rev'd in part on other grounds & remanded, 412 F.3d 125, 133 (D.C. Cir. 2005); Klunzinger v. IRS, 27 F. Supp. 2d 1015, 1026 (W.D. 1998) (protecting paper to brief commissioner for meeting); Thompson v. Dep't of the Navy, No. 95-347, 1997 WL 527344, at *4 (D.D.C. Aug. 18, 1997) (protecting materials to brief senior officials responding to media inquiries, as "disclosure of

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materials reflecting the process by which the Navy formulates its policy concerning statements to and interactions with the press" could stifle frank communication within the agency), aff'd, No. 97-5292, 1998 WL 202253, at *1 (D.C. Cir. Mar. 11, 1998) (per curiam); Williams v. DOJ, 556 F. Supp. 63, 65 (D.D.C. 1982) (protecting "briefing papers prepared for the Attorney General prior to an appearance before a congressional committee").

5 U.S.C. § 552(b)(6) exempts from required disclosure "personnel and medical files and similar files the disclosure of which would constitute a clearly unwarranted invasion of personal privacy." FOIA Exemption 6 permits VA to withhold a document or information within a document if disclosure of the information, either by itself or in conjunction with other information available to either the public or the FOIA requester, would result in an unwarranted invasion of an individual's personal privacy without contributing significantly to the public's understanding of the activities of the federal government. Specifically, the information being withheld, as indicated on the enclosed documents, under FOIA Exemption 6, consists of names, identities, photographs, email addresses, phone numbers, cellular numbers, facsimile numbers, unsuccessful resume application details, medical details, photographs, and personal details unrelated to the VA of: federal employees, Congressional employees, federal contractors, veterans, federal applicants, private citizens, and their family members. Federal employees, Congressional employees, federal contractors, veterans, federal applicants, private citizens, and their family members retain a significant privacy interest under certain circumstances, such as in instances where the release of their information could represent a threat to their well-being, harassment, or their ability to function within their sphere of employment. The federal employees, Congressional employees, federal contractors, veterans, federal applicants, private citizens, and their family members whose information is at issue have a substantial privacy interest in their personal information. In weighing the private versus the public interest, we find that there is no public interest in knowing the names, identities, email addresses, phone numbers, cellular numbers, facsimile numbers, resume application details, medical details, photographs, and personal details unrelated to the VA of: federal employees, Congressional employees, federal contractors, unsuccessful federal applicants, veterans, private citizens, and their family members. The coverage of FOIA Exemption 6 is absolute unless the FOIA requester can demonstrate a countervailing public interest in the requested information by demonstrating that the FOIA requester is in a position to provide the requested information to members of the general public and that the information requested contributes significantly to the public's understanding of the activities of the Federal government. Additionally, the requester must demonstrate how the public's need to understand the information significantly outweighs the privacy interest of the person to whom the information pertains. Upon consideration of the records, I have not been able to identify a countervailing public interest of sufficient magnitude to outweigh the privacy interest of the individuals whose names are redacted. The protected information has been redacted and (b)(6) inserted. "Withholding a telephone number or e-mail address, alone, is not sufficient to protect that [privacy] interest; alternate means of contacting and harassing these employees would be readily discoverable on the Internet if this court ordered their names disclosed." Long v. Immigration & Customs Enf't, 2017 U.S. Dist. LEXIS 160719 (D.C. Cir. 2017).

Out of the twenty-two thousand (22,000) pages, OSVA released fifteen thousand three hundred forty-two (15,342) pages, some redacted, to you. About six thousand five hundred (6,500) pages predate November 9, 2016 and, thus, are non-responsive to your FOIA request. One hundred one (101) pages of Transition documents were unrelated to the VA or VA business and, thus, are not agency records. Thirty (30) pages of Shulkin's solely personal details were unrelated to the VA and, thus, not agency records. Of the released fifteen thousand three

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hundred forty-two (15,342) pages, some redacted, to you, six thousand sixty-four (6,064) pages relate to three (3) informal advisors.

Previous Partial Initial Agency Decisions

On June 2, 2020, OSVA released to you two thousand five hundred thirteen (2,513) pages, Bates-numbered 5001-7530 redacted with FOIA Exemptions 2, 4, 5, and 6. On May 5, 2020, OSVA released to you six hundred eighty-nine (689) pages, Bates-numbered 19304-20000 redacted with FOIA Exemptions 5 and 6.

On April 7, 2020, OSVA released one thousand nine hundred seventy-nine (1,979) pages, Bates-numbered 20001-21985 redacted with FOIA Exemptions 4, 5, and 6. On March 24, 2020, OSVA released to you two thousand three hundred seventy (2,370) pages, Bates-numbered 21639-21985 and 5001-7037, redacted with FOIA Exemptions 2, 4, 5, 6, and 7. On March 17, 2020, OSVA released to you two thousand three hundred eighteen (2,318) pages, Bates-numbered 19304-21634, redacted with FOIA Exemptions 4, 5, and 6.

On March 10, 2020, OSVA released you two thousand two hundred seventy-four (2,774) pages, non-consecutively Bates-numbered 15140-19303, redacted with FOIA Exemptions 2, 4, 5, and 6. One thousand eight hundred twenty-nine (1,829) pages between those Bates-numbers predated November 9, 2016 and were, thus, non-responsive to your FOIA request. Thirty (30) pages between those Bates-numbers were unrelated to the VA and, thus, not agency records.

On February 3, 2020, OSVA released one thousand nine hundred fifty-four (1,954) pages, Bates-numbered 1659-3638, redacted with FOIA Exemptions 2, 4, 5, and 6. On January 14, 2020, OSVA released seven hundred six (706) pages, Bates-numbered 950-1658, redacted with FOIA Exemptions 2, 5, and 6.

On January 6, 2020, OSVA released to you five hundred forty-three (543) pages, non-consecutively Bates-numbered 10033-11500, redacted with FOIA Exemptions 5 and 6. The other four thousand two hundred seventy-nine (4,279) pages, within pages Bates-numbered 10033-14999, predated November 9, 2016 and, thus, are non-responsive to your FOIA request. On January 6, 2020, OSVA also re-released to you nine hundred forty-nine (949) pages, Bates-numbered 1-949, previously released to you on November 21, 2019, but with fewer redactions.

Approximate 30,800 Pages of Emails Received on or About 12/23/19

On or about December 23, 2019, Mr. Shulkin submitted approximately thirty thousand eight hundred (30,800) pages of emails in which he copied a VA email address. About sixteen thousand four hundred (16,400) pages predate November 9, 2016, and thus, are non-responsive to your FOIA request, with about fourteen thousand four hundred (14,400) left to review.

From a sample size of one thousand eighty-one (1,081) emails totaling three thousand nine hundred twenty-nine (3,929) pages, Shulkin did **not** copy, forward, or send to his VA email address, seven hundred nine (709) emails totaling two thousand four hundred thirty-nine (2,439). Of the remaining fourteen thousand four hundred (14,400) pages left to review, we estimate seven thousand two hundred (7,200) pages in which Shulkin copied, forwarded, or sent to his VA email address, and seven thousand two hundred (7,200) pages in which Shulkin did **not** copy, forward, or send to his VA email address.

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For your past FOIA request **18-07426-F**, OSVA has released to you all of Shulkin's aol and gmail emails, possibly redacted, in which Shulkin directly communicated with the three (3) informal advisors and copied, forwarded, or sent to his VA email address. For your FOIA request **18-11960-F**, OSVA has produced and will continue to produce all of Shulkin's aol and gmail emails referencing the three (3) informal advisors and copying or sending emails to his VA email address.

OSVA will process the seven thousand two hundred (7,200) pages in which Shulkin did **not** copy, forward, or send to his VA email address as responsive to this FOIA request.

FOIA Mediation

As part of the 2007 FOIA amendments, the Office of Government Information Services (OGIS) was created to offer mediation services to resolve disputes between FOIA requesters and Federal agencies as a non-exclusive alternative to litigation. Using OGIS services does not affect your right to pursue litigation. Under the provisions of the FOIA Improvement Act of 2016, the following contact information is provided to assist FOIA requesters in resolving disputes:

VA Central Office FOIA Public Liaison:
Name: Doloras Johnson
Email Address: vacofoiaservice@va.gov

Office of Government Information Services (OGIS)
Email Address: ogis@nara.gov
Fax: 202-741-5769
Mailing address:
National Archives and Records Administration
8601 Adelphi Road
College Park, MD 20740-6001

FOIA Appeal

This concludes OSVA's Tenth Partial IAD to request **19-09094-F**. Please be advised that should you desire to do so, you may appeal the determination made in this response to:

Office of General Counsel (024)
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

If you should choose to file an appeal, please include a copy of this letter with your written appeal and clearly indicate the basis for your disagreement with the determination set forth in this response. Please be advised that in accordance with VA's implementing FOIA regulations at 38 C.F.R. § 1.559, your appeal must be postmarked no later than ninety (90) days of the date of this letter.

Sincerely,

Richard Ha, JD, CIPP/G
OSVA FOIA Officer

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Attachments – Redacted two thousand three hundred eighty-three (2,383)

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Message

From: Marc Sherman [mbs(b) (6) gmail.com]
Sent: 2/19/2017 4:03:08 PM
To: David shulkin [Drshulkin@aol.com]
CC: Ike Perlmutter [(@frenchangel59.com]; Bruce Moskowitz [brucem(b) (6) mac.com]
Subject: Re: a great idea on telehealth

I have some thoughts on this Executive Order (EO) you proposed, with the caveat that I am not a constitutional lawyer. Please also know that I am providing these thoughts to spur the discussion **so the solution can be chosen with as much likelihood of success as possible**, not to stifle it or the need to clear implement telemedicine.

It seems to me that an EO to allow telemedicine to be conducted by a doctor **from one VA facility to a doctor at another VA** facility is no problem. Although, do you really need an EO for that? It seems you could do that without an EO. I wonder if an EO from a doctor at a VA facility to a doctor at a private facility would carry the day. I predict that it will challenged by the states. I am not suggesting that the states win that challenge, but I do think it will be controversial, time consuming and take focus away. Any reaction or further thoughts? Also, what other EOs could advance the ball faster?

On Fri, Feb 17, 2017 at 9:01 PM, David shulkin <Drshulkin@aol.com> wrote:
Ike- here is one additional action item to consider- an executive order from POTUS to expand access for veterans by giving VA the ability to do telemedicine across state lines- it would be a big help.

Just an idea

David

DRAFT

Executive Order to allow VA Doctors Freedom to Deliver Telehealth care to Veterans

Many of our Veterans currently have to travel hundreds of miles to see their VA doctor. Red tape is keeping our VA physicians from using technology, in the form of telemedicine, to care for our Veterans using their mobile phone or computers.

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered as follows:

A Department of Veterans Affairs health care professional may practice the health care profession of the health care professional at any location in any State, regardless of where such health care professional or the patient is located, when the health care professional is using telemedicine to provide treatment to an individual.

Department health care professional' means a health care professional who is--

(A) authorized by the Secretary to provide health care under this chapter; and

(B) is appointed by the Department under title 5 or title 38, United States Code.

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The health care professional would be required to adhere to all quality standards relating to the provision of telemedicine in accordance with applicable policies of the Department; and would be required to have an active, current, full, and unrestricted license, registration, or certification in a State to practice the health care profession of the health care professional. **VA providers who are covered by the Federal Tort Claims Act when caring for patients in person would similarly be covered when delivering care via telemedicine to a patient no matter where the provider or patient is located.**

VA providers who meet the above requirements, and who are also participating in and checking their state PDMP, would also be exempt from conducting at least 1 in-person medical examination with a patient before prescribing them a controlled substance, which currently requires veterans to travel hundreds of miles to a VA facility in order to receive needed care.

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Message

From: Bruce Moskowitz [brucem(b) (6) mac.com]
Sent: 2/18/2017 12:58:52 PM
To: David shulkin [Drshulkin@aol.com]
CC: Ike Perlmutter [(@frenchangel59.com]; Marc Sherman [mbs(b) (6) gmail.com]
Subject: Re: a great idea on telehealth

Very important.

Sent from my iPad
Bruce Moskowitz M.D.

On Feb 17, 2017, at 9:01 PM, David shulkin <Drshulkin@aol.com> wrote:

> Ike- here is one additional action item to consider- an executive order from POTUS to expand access for veterans by giving VA the ability to do telemedicine across state lines- it would be a big help.
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> Just an idea
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The health care professional would be required to adhere to all quality standards relating to the provision of telemedicine in accordance with applicable policies of the Department; and would be required to have an active, current, full, and unrestricted license, registration, or certification in a State to practice the health care profession of the health care professional. **VA providers who are covered**

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VA providers who meet the above requirements, and who are also participating in and checking their state PDMP, would also be exempt from conducting at least 1 in-person medical examination with a patient before prescribing them a controlled substance, which currently requires veterans to travel hundreds of miles to a VA facility in order to receive needed care.

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 2/18/2017 12:44:06 PM
To: Jennifer Lee [(b) (6) @gmail.com]
Subject: Re: a great idea on telehealth

Ill see him next week

Ill try to call

Sent from my iPhone

On Feb 18, 2017, at 7:03 AM, Jennifer Lee <(b) (6) @gmail.com> wrote:

> No problem. Will put it together for you.
> When do you need it by? Will you see POTUS next week?
>
> Also am wondering if you have a few minutes for a quick call some time this weekend (not urgent) but a few things I have been thinking since the news yesterday and how I can help us move quickly on suicide, etc.
>
> Thank you
> Jen
>
> On Feb 18, 2017 6:51 AM, "David shulkin" <Drshulkin@aol.com> wrote:
> A background memo would also be helpful
>
> Sent from my iPhone
>
> On Feb 17, 2017, at 11:17 PM, Jennifer Lee <(b) (6) @gmail.com> wrote:
>
> > Oh! Well that would certainly be fastest!
> >
> > I was going to get Darin or Jake to tap their WH staff contacts and float a draft so they can start working it. Not sure how much vetting they do-- I helped with the Obama mental health EO in 2012 which had considerable vetting but am guessing that we could move faster w this. Just in case, it still might save time for me to work in parallel with staff?
> >
> > Do you need a memo or more background for POTUS? I can provide a more polished draft if it would help.
> >
> > On Feb 17, 2017 9:49 PM, "David shulkin" <Drshulkin@aol.com> wrote:
> > How would you plan to move forward?
> >
> > I would bring to Potus- what are you thinking?
> >
> > Sent from my iPhone

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On Feb 17, 2017, at 9:32 PM, Jennifer Lee <(b) (6) @gmail.com> wrote:

Great! So okay for me to move forward?

I will move fast to get this done quickly if okay with you

On Feb 17, 2017 9:10 PM, "David shulkin" <Drshulkin@aol.com> wrote:
Perfect

Sent from my iPhone

On Feb 17, 2017, at 8:22 PM, Jennifer Lee (b) (6) @gmail.com> wrote:

I just drafted this for now and can get you better language, but just wanted to give you an idea...

The key issue we are having is clarified by the

(b) (5)

(b) (5)

(b) (5)

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(b) (5) [redacted]

[redacted]

[redacted]

[redacted]

(b) (5) [redacted]

On Fri, Feb 17, 2017 at 5:25 PM, David shulkin <Drshulkin@aol.com> wrote:
Tell me what it would say specifically

Sent from my iPhone

> On Feb 17, 2017, at 4:57 PM, Jennifer Lee (b) (6) [redacted]@gmail.com> wrote:
>
> Would the President be willing to do an (b) (5) [redacted]

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(b) (5)
(b) (5)
[redacted]
> I can explain more on the phone if you like.
>
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>
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Message

From: Jennifer Lee [(b) (6) @gmail.com]
Sent: 2/18/2017 12:03:48 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: a great idea on telehealth

No problem. Will put it together for you.
When do you need it by? Will you see POTUS next week?

Also am wondering if you have a few minutes for a quick call some time this weekend (not urgent) but a few things I have been thinking since the news yesterday and how I can help us move quickly on suicide, etc.

Thank you
Jen

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> [redacted]
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> (b) (5)
>
> [redacted]

AMERICAN OVERSIGHT

(b) (5) [redacted]

On Fri, Feb 17, 2017 at 5:25 PM, David shulkin <Drshulkin@aol.com> wrote:
Tell me what it would say specifically

Sent from my iPhone

> On Feb 17, 2017, at 4:57 PM, Jennifer Lee (b) (6) [redacted]@gmail.com> wrote:
>
> Would the President be willing to do an (b) (5) [redacted]

> I can explain more on the phone if you like.
>
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>

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 2/18/2017 11:51:20 AM
To: Jennifer Lee [(b) (6) @gmail.com]
Subject: Re: a great idea on telehealth

A background memo would also be helpful

Sent from my iPhone

On Feb 17, 2017, at 11:17 PM, Jennifer Lee <(b) (6) @gmail.com> wrote:

> Oh! Well that would certainly be fastest!
>
> I was going to get Darin or Jake to tap their WH staff contacts and float a draft so they can start working it. Not sure how much vetting they do-- I helped with the Obama mental health EO in 2012 which had considerable vetting but am guessing that we could move faster w this. Just in case, it still might save time for me to work in parallel with staff?
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On Feb 17, 2017 9:49 PM, "David shulkin" <Drshulkin@aol.com> wrote:

> How would you plan to move forward?
>
> I would bring to Potus- what are you thinking?
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> Sent from my iPhone
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AMERICAN OVERSIGHT

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[redacted]

(b) (5)

[redacted]

(b) (5)

[redacted]

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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 2/18/2017 4:23:34 AM
To: Jennifer Lee [(b) (6) @gmail.com]
Subject: Re: a great idea on telehealth

Better polished is good

Sent from my iPhone

On Feb 17, 2017, at 11:17 PM, Jennifer Lee <(b) (6) @gmail.com> wrote:

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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 2/18/2017 2:49:11 AM
To: Jennifer Lee [(b) (6) @gmail.com]
Subject: Re: a great idea on telehealth

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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 2/18/2017 2:10:15 AM
To: Jennifer Lee [(b) (6) @gmail.com]
Subject: Re: a great idea on telehealth

Perfect

Sent from my iPhone

On Feb 17, 2017, at 8:22 PM, Jennifer Lee <(b) (6) @gmail.com> wrote:

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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 2/18/2017 2:01:03 AM
To: Ike Perlmutter [(b) (6)@frenchangel59.com]
CC: Marc Sherman [mbs(b) (6) gmail.com]; Bruce Moskowitz [brucem(b) (6) mac.com]
Subject: Fwd: a great idea on telehealth

Ike- here is one additional action item to consider- an executive order from POTUS to expand access for veterans by giving VA the ability to do telemedicine across state lines- it would be a big help.

Just an idea

David

DRAFT

Executive Order to allow VA Doctors Freedom to Deliver Telehealth care to Veterans

Many of our Veterans currently have to travel hundreds of miles to see their VA doctor. Red tape is keeping our VA physicians from using technology, in the form of telemedicine, to care for our Veterans using their mobile phone or computers.

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered as follows:

A Department of Veterans Affairs health care professional may practice the health care profession of the health care professional at any location in any State, regardless of where such health care professional or the patient is located, when the health care professional is using telemedicine to provide treatment to an individual.

Department health care professional' means a health care professional who is--

(A) authorized by the Secretary to provide health care under this chapter; and

(B) is appointed by the Department under title 5 or title 38, United States Code.

The health care professional would be required to adhere to all quality standards relating to the provision of telemedicine in accordance with applicable policies of the Department; and would be required to have an active, current, full, and unrestricted license, registration, or certification in a State to practice the health care profession of the health care professional. **VA providers who are covered by the Federal Tort Claims Act when caring for patients in person would similarly be covered when delivering care via telemedicine to a patient no matter where the provider or patient is located.**

VA providers who meet the above requirements, and who are also participating in and checking their state PDMP, would also be exempt from conducting at least 1 in-person medical examination with a patient before prescribing them a controlled substance, which currently requires veterans to travel hundreds of miles to a VA facility in order to receive needed care.

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Message

From: Jennifer Lee [(b) (6) @gmail.com]
Sent: 2/18/2017 1:22:29 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: a great idea on telehealth

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AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 2/17/2017 10:25:53 PM
To: Jennifer Lee [(b) (6) @gmail.com]
Subject: Re: a great idea on telehealth

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Sent from my iPhone

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AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 3/3/2017 11:35:24 AM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: Your recent appt with the VA

I acknowlege and thank them

You cant possibly speak to everyone who wants your time

Sent from my iPhone

On Mar 3, 2017, at 6:13 AM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:

> Not sure how he found out- but obviously the word seems to have spread. This is the cardiologist at Newton who started with us in the ACO.
>
> I will need advice from you on how to navigate all these requests which I am sure I am bound to get- to be polite but practical and still encouraging.
>
> ---
>
> **From:** (b) (6) <(b) (6) @aol.com>
> **Sent:** Thursday, March 2, 2017 8:09 PM
> **To:** (b) (6) @hotmail.com; (b) (6) @atlantichealth.org
> **Subject:** Your recent appt with the VA
>
> Dear Poonam,
>
> I wanted to congratulate you on your appointment to the Veteran's Administration. You will certainly be an asset to David Shulkin and his team. As a twelve year NAVY veteran I am very pleased to know that such a well qualified and forward thinking team will lead the VA health system.
>
> I enjoyed working with you during the formation of the Atlantic Health ACO. The ACO has been very successful, no doubt your insight and direction played a major role, In our prior meetings we frequently discussed methods,sometimes novel, but always pragmatic to more efficiently deliver patient centered healthcare. One of my current roles is as the cardiology director for a local skilled nursing facility. I round two hours per week with an ANP, and nearly always by early recognition and intervention, prevent a readmission. We are currently developing a CHF pathway/protocol to optimize patient management at our SNF. I am always looking to improve outcomes and to add value to healthcare.
>
> I have worked as an advisor to a healthcare technology business, RV Healthcare Analytics. The CEO is a lifelong friend and one of the former founders/owners of a healthcare contract management firm Meditract. This platform served one in every four hospitals in the US, Their current platform is a Value Enhancement Program for hospitals/hospital systems. The technology analyzes the complete spectrum of hospital based healthcare delivery. This

AMERICAN OVERSIGHT

platform also provides the tools to implement and execute programatic changes in hospital operations. The goal to maximize efficiency and reduce costs, without sacrificing quality. This technology could also be adapted to a large outpatient system as well.

I truly believe that this has the potential to significantly improve the efficiency and delivery of healthcare to our veterans. I also believe that it represents an example of disruptive innovation in the healthcare field. I understand that you must be very busy, but I would love the opportunity to discuss this further. Hope to hear from you soon.

Best personal regards,

(b) (6)

[redacted] MD, FACC

cell (b) (6)
office (b) (6)

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 3/3/2017 11:13:39 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Fw: Your recent appt with the VA

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(b)

AMERICAN OVERSIGHT

(b) (6) MD, FACC

cell (b) (6)
office (b) (6)

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 2/20/2017 10:38:49 PM
To: Marc Sherman [mbs(b) (6) gmail.com]
CC: IP [@frenchangel59.com]; Bruce Moskowitz [brucem(b) (6) mac.com]
Subject: Re: Document for the President

I think its excellent

David

Sent from my iPhone

> On Feb 20, 2017, at 5:24 PM, Marc Sherman <mbs(b) (6) mail.com> wrote:
>
> David
>
> I prepared a document for Ike to share with the President which summarizes and combines the "Transformation Plan" and the "Messaging Plan." All of the information is a culmination of the discussions we have had over the past several weeks as well as the refinements made over the past few days. I wanted to make sure you saw it and are comfortable. Let me or Ike know if you have any concerns, but I hope you find it true to our discussions and your vision. Keep in mind that page one attempts to put mountains of information onto one page so attention is not lost.
>
> Best
>
> Marc
> <VA plan to POTUS 022017 v2.docx>

AMERICAN OVERSIGHT

Message

From: Marc Sherman [mbs(b) (6) gmail.com]
Sent: 2/20/2017 10:24:44 PM
To: David shulkin [drshulkin@aol.com]; IP [@frenchangel59.com]; Bruce Moskowitz [brucem(b) (6) mac.com]
Subject: Document for the President
Attachments: VA plan to POTUS 022017 v2.docx

David

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Best

Marc

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Department of Veterans Affairs

Transformation Plan

1. **PHYSICAL INFRASTRUCTURE** -
    - Freeze construction , assess the need of each property, identify underutilized facilities, Integrate property or dispose
2. **IT TRANSFORMATION**
    - Freeze software development,
    - Collaborate with tech companies to develop/ implement best of class IT
    - Build and begin to implement IT strategy and integrated system that markedly improves appointment scheduling, billing, electronic health record, quality of care.
    - Coordinate with DOD for integrated medical record system and improved flow of medical record information
3. **ACCESS TO CARE**
    - Expand private public partnerships for easy access to care, specialty physicians and more choice for veterans
        - Expand CHOICE program – eliminate 40/30 limitations and extend Medicare payment plan
        - Partnership with Academic Medical Centers – This will provide support for the tremendous shortage of medical professionals at the VA and supplement knowledge and talent for quality of care improvement.
        - Longer-term partnership with select community hospitals in rural communities
    - Develop Telemedicine and Telehealth program (provides immediate access)
    - Create zero suicide initiative
    - Partner with existing private VA service clinics to integrate additional expertise/capability into the VA Care Delivery Network
4. **BENEFITS**
    - Revised benefit process
        - paperless (digitized) system,
        - reduced claims processing time by two weeks
        - revised system of disability ratings
5. **ADMINISTRATIVE**
    - Establish program to identify and eliminate waste, fraud and abuse
    - Congressional changes for Accountability to allow the Secretary to remove bad employees and would help to retain and recruit high quality staff
    - Install White House Hotline
    - Create VA office of modernization
    - Implement central purchasing
    - Review existing and proposed material contracts for renewal or termination
    - Improve VA leadership talent pool
    - Create a new set quality measures to mirror the private sector quality measurement process

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POTUS MESSAGING PLAN

OBJECTIVE	DESCRIPTION	FORMAT	DATE	100 DAY MESSAGE
Improve Access to Care	Enhance digital healthcare delivery – permit VA doctors to provide telehealth services to veterans using digital and telecommunications technology	**POTUS EXECUTIVE ORDER**	Early March	Provide Improved Access to remote veterans who are waiting for care-through use of technology and best doctors
Provide modern and efficient facilities for veterans	Announce a private-public partnership model in Omaha Nebraska to build an ambulatory care facility instead of an unneeded hospital facility using 10% of the money allocated and private funds to build the rest	POTUS Announcement	Early March	Stop business as usual and start to show how private sector practices can benefit veterans and taxpayers – the approach will ensure "best use of taxpayer dollars" and afford convenient, timely access for veterans to the highest quality health care.
Give veterans more choice for selecting their care	Seeking swift action by Congress to authorize legislation for expanding Choice options for veterans to be signed immediately by the President	POTUS Announcement	Before March 7th	Congress needs to act both to extend the current Choice program which ends August 7th but also to offer legislation for a better program for veterans
Eliminate Fraud and Abuse	President directs the Secretary to establish a special advisor reporting to the Secretary to ensure aggressive action to identify fraud and abuse	POTUS Announcement	Early March	Part of his 10 point plan to address this issue

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Make VA employees accountable	Encourage Congress to work with Secretary of VA to get meaningful Accountability reform passed and he would sign immediately	POTUS Announcement	House planning on passing a bill March 14th	Allows the Secretary to remove bad employees and would help to retain and recruit high quality staff
Be more responsive to Veteran issues and problem resolution	Install the White House/VA Hotline	POTUS to announce the date of the hotline	MAY announcement of June 2017 Implementation	We've put a system in place to ensure that problems are addressed in timely fashion; that those responsible for decision making have the information/context to formulate timely solutions in response.
Create closer collaboration between VA and DOD	President to direct the SecDef and SecVA to present him with recommendations within 120 days for improved flow of medical record information and for better transitioning from service to VA	POTUS Announcement	June 1st	May address the medical records issue by providing a mechanism for VA to use the DOD electronic medical records contract and therefore avoid a lengthy contracting process

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SECRETARY MESSAGING PLAN

OBJECTIVE	DESCRIPTION	FORMAT	DATE	100 DAY MESSAGE
Get decisions sooner to veterans on benefits	VA Benefits is going paperless and automating its systems	SecVA Announcement	March	Part of our benefits modernizations approach
Modernize our IT systems	Work to replace our current older systems. Work with tech industry to find solutions for our veterans	SecVA Announcement	July 1at	Build and begin to implement IT strategy that markedly improves appointment scheduling, billing, electronic health record, quality of care.
Zero Suicide Approach to Mental Health	Launch an aggressive new approach for suicide prevention	SECVA Announcement	April	
Appeals Modernization To reduce the time waiting for appeal decisions	Encourage Congress to adopt VA Appeal legislation	SECVA Messaging	March	
Improve the Choice program	Begin veteran listening sessions around the country to hear what veterans want and reach out to strategic partners like the Cohen Veteran network	SECVA Messaging	March	
Make VA more efficient for better service to veterans	Work on organizational restructuring through the VA Modernization office and announce plans	SECVA Messaging	June	

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	for supply chain and contract management improvements			
Bring new talent to help lead VA	Announcement cooperation with leading AMC's and professional organizations	SECVA Announcement	May	Improve the leadership, talent pool, bringing more seasoned, strategic talent to key positions to advance the VA Build a companion strategy that "brings Dr. Shulkin to the 365K employees" – provide forums for him to engage the entire VA; and motivate, engage top leadership, then cascade those conversations to subsets of the organizational structure

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Message

From: David Shulkin [drshulkin@aol.com]
Sent: 2/5/2017 5:51:31 PM
To: (b) (6) [redacted]@gmail.com
BCC: vacodjs1@va.gov
Subject: to do list
Attachments: feb6todo.docx

Can we review this list of to-dos on monday?

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TOPIC	Higher Priority	INVITEE	NOTES
Department Governance and Organizational Structure and 100 day plan	X	Bob Snyder	PAS positions for David White and Jake , Modernization PEO, CFO Realignment
(b) (6)		Strategic Partnerships	
MyVA	X	Scott Blackburn	Discuss 100 day plan and MyVA committee composition, LDL, Modernization PEO
Meet with Tiger Team on RFP	X	Greg Giddens , Jake and Full Team	
Budget Submission for 18		Mark Yow and Ed Murray and who they want to bring	
VBA Team		Tom Murphy and who he wants to bring	Distribute 100 day plan
IT Team		Rob Thomas and who he wants	100 day plan and discuss the IT PMO contract
Community Care Team		Baligh and his team	100 day plan and primary payer status page 22
WH Hotline	X	Bob Snyder, Jake and whoever we need to bring	Get an update on the plans
OCLA		Chris Occonnor	Update on legislative activities HVAC Choice Hearing
Upcoming Talks	X	(b) (6) (and Speechwriters?)	Need to begin to prepare upcoming speeches – February 14 State Homes – DAV feb 26
Individual meetings with Beachhead team	X	I need to meet with each f0r 30 minutes except for Daren and Jake	General introductions
Digital Services Team		??	What are they working on?
Facilities		Stella, Ed and others?	Review book with empty and underutilized

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) @gmail.com]
Sent: 2/20/2017 1:09:31 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Re: Plan

March Potus announcements may can happen at one press conference, after a vso listening session. That's why they are grouped together.

On Feb 19, 2017 7:27 PM, "(b) (6) <(b) (6) @gmail.com> wrote:

Sir. I took what you sent today, and Friday, added some of your travel and events to give you a sense where you could make some of these announcements. This is a larger working document.

Will print the document you sent today, Friday and add this to the prints.

Suggestions:

Ex. Announce Digitization - at first or second RO visit

Ex. Announce working with tech industry on specifics with Apple at the Data Palooza.

(b) (6)

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) @gmail.com]
Sent: 2/20/2017 12:27:38 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Plan
Attachments: Secretary's Priorities 100 Day Plan - accountable.docx

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(b) (6)

AMERICAN OVERSIGHT

100 Day Action Plan

DATE TO LAUNCH	INITIATIVE	DESCRIPTION	ACCOUNTABLE OFFICE	FORMAT
February	Freeze new Major Construction	No new starts for major construction	OALC – Gideon's, Fiotes	
March	Get Decisions Sooner on Benefits- Digitalization	Secretary to Announce First VA Regional Office has gone paperless- on the way to entire system being paperless	VBA – Murphy	SecVA Announcement
March 2, 2017	Site Visit	Secretary will visit the Regional Office and Indianapolis VAMC		*potentially announce digitization campaign there or before
March	Improve Access to Care	Allow for VA doctors nationwide to provide telehealth services into Veterans Homes and mobile phones. Allow A doctors to manage pain better through Telehealth		POTUS EO
March	Provide Modern and Efficient facilities for Veterans	Announce 40M dollars raised in new model for ambulatory service facilities in Omaha NE	SP – (b) (b) (6)	POTUS Announcement Stopping business as usual and show how private sector practices can benefit Veterans and Tax Payers
March	Give Veterans More Choice	Seeking swift action by Congress to authorize legislation for expanding choice options to be sign immediately by the Presidents		POTUS Announcement

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March	Eliminate Fraud and Abuse	President directs Secretary to establish a special advisor reporting to the Secretary to ensure aggressive action (Utilize Technology for audit and identification of Fraud and Abuse)	OSVA	POTUS Announcement, Apart of the 10 Point Plan
March	Accountability	Encourage Congress to work with Secretary to get meaningful Accountability reform passed to be signed immediately Legislation for VA Accountability to be introduced March 14th by House	GC – Flanz, OCLA – O'Connor	POTUS Announcement (Remove poor employees and recruit and retain top talent)
March 8, 2017	HVAC Hearing	Secretary will be the lead witness for the HVAC Choice Hearing		*what good news do flood the press with before the hearing
March	Veteran Listening Sessions	Begin national listening sessions on Choice to ensure that the system in the future is veteran centric (Reaching out to partners like the Cohen Network)	VHA - Yehia	*do we do this before the hearing or after.
March 9, 2017	R&D Leadership Summit	Secretary will participate on panel with top Executives from Pharmaceutical Companies		
March 10, 2017	Site Visit	Secretary will visit Cemetery and Miami VAMC		
March	Benefits- Agent Orange	Secretary to announce 3 new presumptive conditions for exposure to Agent Orange	VBA – Murphy, OPP - Tran	SecVA Announcement (do we save this for an RO or before ACHE)

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March	Reduce Claims Processing Time	VA will launch a new process for reducing claims processing time for benefits by two weeks	VBA – Murphy	
March 11, 2017	Current Advances in Cardio Vascular Care	Secretary will present "Caring for American Veterans" in King of Prussia, PA		
March 13, 2017	National League of Cities			
March 15, 2017	Hill Vets			
March 16, 2017	Rabbinical College of America	Secretary will receive an Honorary Doctoral Degree in Newark New Jersey		
March	Rationalize VA Infrastructure	Prioritize underutilized facilities and identify the process for making recommendations for consolidation	SA – Selnick, OALC - Fiotes	
March	Appeals Modernization	Encourage congress to pass appeals legislation	BVA – Spickler, OCLA – O'Connor	SecVA Messaging
March 22, 2017	AFGE	Secretary will attend the Semi-Annual Labor Mgt Relations Meeting		
March 25, 2017	Medal of Honor Day	Secretary will participate in Medal of Honor Day at the White House		
March 28, 2017	Chiefs if Staff and Nurse Executives	Secretary will speak at the Chief of Staffs and Nurse Executives Conference in Baltimore		
March 29, 2017	Site Visit	Secretary will visit the Hines/Jesse Brown/North Chicago/ Cemetery and or RO		

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March 30, 2017	ACHE	Secretary will be the keynote speaker at VA DAY in Chicago		*Do you talk about Physician Ambassador Program there and Quality Metrics
March	Physician Volunteer Workforce	Secretary will announce the Physician Ambassador program for physicians to volunteer services to help veterans at VA's nationwide	VHA – Alaigh, (b) (6)	*Announce at ACHE
March	Zero Suicide Imitative	Launch the Secretary's Zero Suicide Initiative that will include the recruitment of 1000 mental health personnel, pursuing auto-enrollment from DOD to VA, immediate tele-mental health access, and a National Advisory Board of experts and families reporting to the Secretary	VHA – Lee	
April 3, 2017	Delaware Veterans Summit	Secretary will speak at the Delaware Veterans Summit with Senator Carper		
April 4-5 2017	MVAC	Secretary will host MVAC in Washington, DC		
April 6, 2017	Wonder Warrior Soldier Ride	Secretary will participate in the Wounded Warrior Solder Ride at the White House		
April 13, 2017	Site Visit	Secretary will visit the Cleveland VAMC/RO		
April	Expand Mental Health Coverage	Secretary will issue a directive to expand mental health treatment access to	VHA – Alaigh, Lee	

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		veterans with other than honorable discharges	VBA – Murphy	
April	Quality	VA will release a new set of measures to easily compare VA to private sector quality to improve transparency	VHA – Alaigh, Clancu	
April	VA/DOD Cooperation with IT Infrastructure Sharing	The President will direct VA and DOD Secretaries to present a plan for greater collaboration in sharing medical records	VHA – Alaigh, Lee OIT - Thomas	
April 18, 2017	Studer Group and CEO Forum	Secretary will speak at the Studer CEO Forum in Washington DC		
April 25, 2017	Senior Leader Summit	Secretary will host a VA Senior Leader Summit		
April	Tech Initiative	VA will announce technology partnerships with leading companies to promote high tech solutions to veterans	OSVA	*Announce at Data Palooza
April 27, 2017	Health Data Palooza	Secretary will be the Key Note Speaker at the Health Data Palooza		*Announce Tech Initiative
April	Improved Benefits Decisions	A revised system of ratings of disabilities will be released	VBA – Murphy	
April 29, 2017	White House Correspondents Dinner	Secretary will attend the White House Correspondence Dinner		
May 4, 2017	Heroes of Military Medicine	Secretary will attend the Heroes of Military Medicine and present an award of to a Medal of Honor Recipient		

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May	Bring New Talent to Help VA	Announcement Cooperation with leading AMC's		SecVA Announcement
May 8, 2017	Site Visit	Secretary will visit the Northport VAMC		
May 9, 2017	NYC Film Festival	Secretary will speak with NY Film Festival		
May 24, 2017	GI Film Festival	Secretary will speak at the GI Film Festival		
May 25, 2017	Site Visit	Secretary will visit the Northport VAMC		
March	VA Reorganization	In order to better serve veterans and improve value to taxpayers, VA will establish an Office of Modernization to reduce unnecessary layers and administrative offices	OSVA	
June	White House Hotline	A new WH hotline will be launched to handle veteran issues	OSVA - Davis	
June	Veteran Choice	Proposal will be presented to POTUS and we will work with Congress for removal of the 40/30 rule and to have a system that provides veterans with greater choice, access, and quality	VHA – Alaigh , Yehia	
June 9, 2017	Site Visit	Secretary will visit the Palo Alto VAMC		
June 1, 2017	Create closer Collaboration between DOD and VA	President to Direct SecDef and SecVA to present him with him recommendations in 120 days for improved flow of medical records and from service member to Veteran transition		POTUS Announcement *consider

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				announcing claims analytics
June 23, 2017	US Mayors Conference	Secretary will speak at the Annual US Conference of Mayors in Miami Florida		
July 17, 2017	Wheelchair Games	Secretary will attend the National Wheelchair games in Cincinnatic, Ohio		
June	Information Technology	Work to replace IT infrastructure. Work with Tech Industry to find solutions for Veterans	OIT - Thomas	SecVA Announcement

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 6/10/2017 12:30:51 PM
To: Drshulkin@aol.com
Subject: Probably

(b) and I are discussing- we will probably going to do Sweden and Norway before heading to Belgium that week

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 2/9/2017 5:10:00 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re:

bummer and i am missing it all

From: David shulkin <Drshulkin@aol.com>
Sent: Thursday, February 9, 2017 12:06 PM
To: Poonam Alaigh
Subject: Re:

Best day yet- lots of ideas for a major change agenda - ill share next week

Sent from my iPhone

> On Feb 9, 2017, at 11:35 AM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:
>
> How is NLC going- hopefully not looking for Poonam
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 2/9/2017 5:06:31 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re:

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Sent from my iPhone

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AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6)@hotmail.com]
Sent: 2/9/2017 4:35:19 PM
To: David Shulkin [drshulkin@aol.com]

How is NLC going- hopefully not looking for Poonam

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 2/1/2017 12:01:15 AM
To: Bruce Moskowitz [brucem(b) (6) mac.com]
CC: (b) (6) [(b) (6) 1@jhmi.edu]; (b) (6) M.D. (b) (6) @mayo.edu]; (b) (6) [(b) @mayo.edu]; (b) (6) partners.org; (b) (6) ccf.org; (b) (6) kp.org; IP [(@frenchangel59.com]; lper(b) @gmail.com; mbs(b) (6) gmail.com
Subject: Re: Agenda

Looks excellent

Thanks

David

Sent from my iPhone

> On Jan 31, 2017, at 5:38 PM, Bruce Moskowitz <brucem(b) (6) mac.com> wrote:
>
> Please review and if any comments or additions we need the feedback by 8:00 am tomorrow so that we may share the final version with the White House. Thank you.
>
> <VA AC Mtg Agenda 02xx17 v3.pdf>
>
>
>
> Sent from my iPad
> Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [brucem(b) (6) mac.com]
Sent: 1/31/2017 10:38:42 PM
To: (b) (6) [(b) (6) @jhmi.edu]; (b) (6) M.D(b) (6) @mayo.edu]; (b) (6) [(b) @mayo.edu]; (b) (6) partners.org; (b) (6) ccf.org; (b) (6) kp.org; drshulkin@aol.com
CC: IP [@frenchangel59.com]; lper(b) @gmail.com; mbs(b) (6) gmail.com
Subject: Agenda
Attachments: VA AC Mtg Agenda 02xx17 v3.pdf; Untitled attachment 15191.txt

Please review and if any comments or additions we need the feedback by 8:00 am tomorrow so that we may share the final version with the White House. Thank you.

AMERICAN OVERSIGHT

AGENDA
VETERANS ADMINISTRATION ADVISORY COMMITTEE

XXXXXXX, FEBRUARY XX, 2017 | XXTIME EST

Attendees:

David Shulkin
(b) (6)
(b) (6)

Bruce Moskowitz
(b) (6)
Ike Perlmutter

Laurie Perlmutter
(b) (6)
Marc Sherman

(b) (6)
(b) (6)

(b) (6) (representing the White House)

1. **Introductions and Purpose**
2. **Discussion Items - Potential Issues / Potential Solutions**
   a. Underutilized facilities- case example blackhills
   b. IT: issues related to cloud based system vs cots
   c. Public Relations Strategy
   d. Supply Chain
   e. Shared Services vs. local control
   f. Community Care RFP / Community based healthcare and payment
   g. Physician Shortage (See detail in Appendix A)
   h. Telemedicine
   i. 40/30 rule
   j. Increase mental health professionals
   k. Homelessness
   l. Job training and jobs
   m. Implementation
   n. A veterans' advocate program
   o. A veteran's patient portal
   p. Fraud Waste & Abuse [https://www.va.gov/oig/publications/press-releases.asp]
   q. Research and NIH
   r. Veterans' family issues
3. **Obstacles**
   a. Physician shortage
   b. Role / impact of Capitol Hill / Regulatory Environment / Existing Regulations
   c. Civil Service system
   d. Redirection of funds
   e. Others
4. **Role of the White House**
5. **Timing**
6. **Role / impact of outside Veterans' Service Organizations**
   [https://en.wikipedia.org/wiki/List_of_veterans_organizations#United_States]
7. **Role / impact of Veterans' Advisory Committees [25 existing committees]**
8. **Immediate Crisis Steps**
   a. Hire a top executive to help Dr. Shulkin implement and execute his plans.
   b. Retain a top Public Relations firm who specializes in crisis management.

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c. Divest or repurpose all underutilized real estate.
d. Identify the centers that are not providing high quality treatment and care, have no patients, and are losing money.
e. Immediate freeze on all planned CAPEX for the future projects.
f. Review any contracts that were signed in last 13 months. If they are not in line with our broader strategy and do not benefit the VA we should not renew.

9. Immediate Systemic Improvement

a. Establish Fellowship Program
b. Centralize all procurement for all VA hospitals
c. IT (Electronic Records)

10. Immediate Veterans' Service Improvement

a. Eliminate the "40/30 rule".
b. Establish community healthcare alternatives and payment mechanism.
c. Establish a program that can help veterans [post-treatment] locate jobs.
d. Systemic restructuring to improve Patient care
e. Physician and nursing retention
f. Veterans'' Employment & reentry programs & initiatives
[http://heroesworkhere.disney.com]

11. Action Steps

Appendix A (Physician Shortage)

1. Bruce Moskowitz met with the leadership of the American College of Surgeons and the American College of Physicians to ask for their assistance, two organizations that include private sector members who are board certified. They have the resources to immediately ask members to open up their practices to veterans. However, we would need to get rid of the 40/ 30 rule, the overly burdensome paperwork and the current inability to share records. They are willing to accept Medicare rates which is below what they usually see patients for.

2. The hiring process for physicians and nurse practitioners needs to be restructured. It takes on average three to six months. The process needs to be streamlined by adopting the Kaiser Permanente approach.

3. The VA System should institute telemedicine in multiple ways. David and Bruce have first-hand experience of how patient care and outcomes can vastly improve through telemedicine. In addition, it improves the VA's ability to provide immediate care and follow-up care. Some of the institutions represented on the committee have the platforms already in place to do this.

4. The lack of medical training slots after graduating medical school is going to create a shortage of 250,000 physicians in the private sector in the very near future. This is under the jurisdiction of Dr. Price (Health and Human services). We need to look at a plan that opens up slots (whether it is NYU or any other medical center) that in return provides Veteran Care.

5. Finally, the inducement for joining the VA for new graduates (even with a shift to the private sector we will need physicians who are committed to spending their careers taking care of Veterans) will only occur if they are allowed to also do research that eventually may create a licensed product and share the rewards. David and Bruce will seek the assistance of someone that is recognized as the best in technology transfer. We cannot be competitive without this. Even physicians in the private sector who assist with care of the Veteran need this opportunity.

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Sent from my iPad
Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/29/2017 8:44:05 PM
To: (b) (6) @davmail.org
BCC: Poonam Alaigh [(b) (6) @hotmail.com]

(b) (6) as i get ready for my hearing this week I was reflecting upon all of the support Ive hd over the past two months and you were top of mind.

I just wanted to thank you

David

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [brucem(b) (6) mac.com]
Sent: 5/31/2017 4:41:22 PM
To: (b) (6) [(b) (6) apple.com]
CC: (b) (6) [(b) (6) @apple.com]; (b) (6) [(b) (6) @apple.com]; (b) (6) [(b) (6) @apple.com]; rob.thomas2@va.gov; David Shulkin [drshulkin@aol.com]; Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: next steps on VA project

The individual, the Secretary David Shulkin, is assigning to head the VA contingent is the CIO Rob Thomas who I CC'd. Mr. Perlmutter who is in direct contact with Mr. (b) has asked me to coordinate who is presenting which agenda item from those on our side of the call including those from the academic centers and the VA. Since I am responsible to keep our side focused on as getting as much done prior to the call as possible your approach is on target. Mr. Perlmutter and I would hope that the call can reflect what the academic partners pointed out; that we can use existing technology at the academic centers so we do not have to reinvent the wheel. We also need an NDA for the group at responsive health who are part of Mount Sinai and if I need to sign an NDA let me know. Thank you

Sent from my iPad
Bruce Moskowitz M.D.

On May 31, 2017, at 12:16 PM, (b) (6) [t(b) (6) apple.com> wrote:

> Bruce,
> Thanks very much for organizing the call last Friday. Here is what we plan as next steps:
> We have draft NDAs for the five medical centers ready, and we will send directly to the contacts on the conference call last week to try to get them in place as soon as possible.
> The Apple technical team wants to speak or meet with the VA so that they can obtain information they need to plan and answer the type of questions the five medical centers were asking on the conference call. We will set that up, again as soon as possible.
> Once the NDAs are signed and we have been able to refine how Apple would like to approach the project, we can set up another conference call with the medical centers where Apple can participate. The goal on that call would be to dive deeper into the specifics of the work and set the agenda for getting the work done. Ideally, this can all happen before the June 14th call so we can have real progress to report.
> Of course we will copy you on all emails. Please let me know if you have questions.
> Thanks,
>
> (b) (6) Vice President for Public Policy, Americas • Apple • (b) (6)

AMERICAN OVERSIGHT

Message

From: L Perl [(b) (6) @gmail.com]
Sent: 1/25/2017 12:48:46 PM
To: (b) (6) kp.org
CC: David shulkin [drshulkin@aol.com]; Bruce Moskowitz [brucem(b) (6) mac.com]; IKE [(@frenchangel59.com]; Marc Sherman [mbs(b) (6) gmail.com]
Subject: Welcome-- from Laurie Perlmutter

Mr. (b) (6)

I want to welcome you to our Advisory Committee and deeply thank you for your participation. This is absolutely fantastic news.

We are passionate about improving the treatment, care, and lives of our veterans - and very much look forward to working closely with you to achieve these goals.

Thank you again.

My Best,

Laurie Perlmutter

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6)@hotmail.com]
Sent: 3/26/2017 11:11:19 PM
To: David Shulkin [drshulkin@aol.com]
Subject: hopefully you will get a kick out of what I sent you on whatsapp

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 2/24/2017 11:15:31 AM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: [EXTERNAL] Meeting date.....Wednesday March 8/ 2pm.....

Ill be traveling in florida that day
I think more important is to have your supply chain leader there

Sent from my iPhone

On Feb 23, 2017, at 7:41 PM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:

> So will your office coordinate or mine - better if yours with the right attendees
>
> Sent from my iPad
>
> On Feb 23, 2017, at 7:36 PM, David shulkin <Drshulkin@aol.com> wrote:
>
> > Yes i spoke to them yesterday- lets meet with them
> >
> > Sent from my iPhone
> >
> > On Feb 23, 2017, at 7:33 PM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:
> >
> > > What is this about? Should I/we meet- purpose?
> > >
> > > Sent from my iPad
> > >
> > > Begin forwarded message:
> > >
> > > **From:** "Alaigh, Poonam, M.D." <Poonam.Alaigh@va.gov>
> > > **Date:** February 23, 2017 at 7:26:55 PM EST
> > > **To:** 'Poonam Alaigh' <(b) (6) @hotmail.com>
> > > **Subject: FW: [EXTERNAL] Meeting date.....Wednesday March 8/ 2pm.....**
> > >
> > > Sent with Good (www.good.com)
> > >
> > > -----Original Message-----
> > > **From:** (b) (6)
> > > **Sent:** Thursday, February 23, 2017 12:39 PM Central Standard Time
> > > **To:** Alaigh, Poonam, M.D.
> > > **Cc:** (b) (6) (b) (6) (VHACO)

AMERICAN OVERSIGHT

Subject: RE: [EXTERNAL] Meeting date.....Wednesday March 8/ 2pm.....

Poonam,

As per morning meeting, we are to send items through you, not directly to 10th floor.

Follow up from last night's email below: Found out this morning from email PDUSH staff had for Dr. Stone from GNYHA Ventures, that (b) (6) (GNYHA) and colleagues met with David previously in early November, and as follow up were supposed to set up a meeting with Dr. Stone and whomever he wished to invite regarding supply chain. I have been attending supply chain meetings for Rich. Meeting invite went out earlier today for 3/8 to small group working on supply chain. My office asked for an agenda to review what they planned to cover.

What was received was the memo above which was also sent directly to David from (b) in an email:

David...as requested, we put together a draft discussion document/work plan for your review. Not at all being presumptuous, but wanted to give you our complete thought process. We wrote this from the "voice" of VHA.....would appreciate any feedback before the March 8 meeting so we can meet your objectives.

We want to help you in any and every way....

(b)

(b) (6)

President

GNYHA Ventures, Inc.

AMERICAN OVERSIGHT

As you can see this memo covers much MORE than supply chain and they even mention a sole source contract (per Vivieca prohibitive by law). How do you want us to handle this?

(b)

From: (b) (6)
Sent: Wednesday, February 22, 2017 7:22 PM
To: Alaigh, Poonam, M.D.
Subject: FW: [EXTERNAL] Meeting date.....Wednesday March 8/ 2pm.....

Sent with Good (www.good.com)

-----Original Message-----
From: (b) (6)
Sent: Wednesday, February 22, 2017 07:18 PM Eastern Standard Time
To: Shulkin, David J., MD
Cc: (b) (6) (VHACO)
Subject: RE: [EXTERNAL] Meeting date.....Wednesday March 8/ 2pm.....

David, I don't have that meeting on my calendar. Not sure what it is. Will check with (b) (6) to see if she knows what this is, if it was on Rich's calendar.

(b)

Sent with Good (www.good.com)

-----Original Message-----
From: Shulkin, David J., MD
Sent: Wednesday, February 22, 2017 06:59 PM Eastern Standard Time
To: (b) (6)
Cc: Alaigh, Poonam, M.D.
Subject: FW: [EXTERNAL] Meeting

AMERICAN OVERSIGHT

date.....Wednesday March 8/ 2pm.....

(b) do you have an agenda planned for this meeting?

Sent with Good (www.good.com)

-----Original Message-----
From: (b) (6) [(b) (6) @GNYHA.org]
Sent: Wednesday, February 22, 2017 04:58 PM Eastern Standard Time
To: Shulkin, David J., MD
Subject: [EXTERNAL] Meeting
date.....Wednesday March 8/ 2pm.....

(b) (6)

President

GNYHA Ventures, Inc.

Executive Vice President, Administration

Greater New York Hospital Association

555 West 57th Street, 15th Floor | New York, NY 10019

T (b) (6) C (b) (6)
E (b) (6) @gnyha.org

<VA Memo V2 (3).docx>

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 2/24/2017 12:41:53 AM
To: David shulkin [Drshulkin@aol.com]
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Sent from my iPad

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> > **From:** "Alaigh, Poonam, M.D." <Poonam.Alaigh@va.gov>
> > **Date:** February 23, 2017 at 7:26:55 PM EST
> > **To:** 'Poonam Alaigh' <(b) (6) @hotmail.com>
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AMERICAN OVERSIGHT

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(b)

(b) (6)

President

GNYHA Ventures, Inc

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To: Alaigh, Poonam, M.D.
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AMERICAN OVERSIGHT

Sent with Good (www.good.com)

-----Original Message-----
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(b)

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-----Original Message-----
From: (b) (6) [(b) (6) @GNYHA.org]
Sent: Wednesday, February 22, 2017 04:58 PM Eastern Standard Time
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Subject: [EXTERNAL] Meeting date.....Wednesday March 8/ 2pm.....

AMERICAN OVERSIGHT

(b) (6)

President

GNYHA Ventures, Inc.

Executive Vice President, Administration

Greater New York Hospital Association

555 West 57th Street, 15th Floor | New York, NY 10019

T (b) (6) C (b) (6) E (b) (6) @gnyha.org

<VA Memo V2 (3).docx>

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 2/24/2017 12:36:04 AM
To: Poonam Alaigh [(b) (6)@hotmail.com]
Subject: Re: [EXTERNAL] Meeting date.....Wednesday March 8/ 2pm.....

Yes i spoke to them yesterday- lets meet with them

Sent from my iPhone

On Feb 23, 2017, at 7:33 PM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:

> What is this about? Should I/we meet- purpose?
>
> Sent from my iPad
>
> Begin forwarded message:
>
> **From:** "Alaigh, Poonam, M.D." <Poonam.Alaigh@va.gov>
> **Date:** February 23, 2017 at 7:26:55 PM EST
> **To:** 'Poonam Alaigh' <(b) (6) @hotmail.com>
> **Subject: FW: [EXTERNAL] Meeting date.....Wednesday March 8/ 2pm.....**
>
> Sent with Good (www.good.com)
>
> -----Original Message-----
> **From:** (b) (6)
> **Sent:** Thursday, February 23, 2017 12:39 PM Central Standard Time
> **To:** Alaigh, Poonam, M.D.
> **Cc:** (b) (6) (b) (6) (VHACO)
> **Subject:** RE: [EXTERNAL] Meeting date.....Wednesday March 8/ 2pm.....
>
> Poonam,
>
> As per morning meeting, we are to send items through you, not directly to 10th floor.
>
> Follow up from last night's email below: Found out this morning from email PDUSH staff had for Dr. Stone from GNYHA Ventures, that (b) (6) (GNYHA) and colleagues met with David previously in early November, and as follow up were supposed to set up a meeting with Dr. Stone and whomever he wished to invite regarding supply chain. I have been attending supply chain meetings for Rich. Meeting invite went out earlier today for 3/8 to small group working on supply chain. My office asked for an agenda to review what they planned to cover.

AMERICAN OVERSIGHT

What was received was the memo above which was also sent directly to David from (b) (b) an email:

David...as requested, we put together a draft discussion document/work plan for your review. Not at all being presumptuous, but wanted to give you our complete thought process. We wrote this from the "voice" of VHA.....would appreciate any feedback before the March 8 meeting so we can meet your objectives.

We want to help you in any and every way....

(b)

(b) (6)

President

GNYHA Ventures, Inc.

As you can see this memo covers much MORE than supply chain and they even mention a sole source contract (per Vivieca prohibitive by law). How do you want us to handle this?

(b)

From: (b) (6)
Sent: Wednesday, February 22, 2017 7:22 PM
To: Alaigh, Poonam, M.D.
Subject: FW: [EXTERNAL] Meeting date.....Wednesday March 8/ 2pm.....

Sent with Good (www.good.com)

-----Original Message-----
From: (b) (6)
Sent: Wednesday, February 22, 2017 07:18 PM Eastern Standard Time
To: Shulkin, David J., MD

AMERICAN OVERSIGHT

Cc: (b) (6) (VHACO)
Subject: RE: [EXTERNAL] Meeting date.....Wednesday March 8/ 2pm.....

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(b)

Sent with Good (www.good.com)

-----Original Message-----
From: Shulkin, David J., MD
Sent: Wednesday, February 22, 2017 06:59 PM Eastern Standard Time
To: (b) (6)
Cc: Alaigh, Poonam, M.D.
Subject: FW: [EXTERNAL] Meeting date.....Wednesday March 8/ 2pm.....

(b) do you have an agenda planned for this meeting?

Sent with Good (www.good.com)

-----Original Message-----
From: (b) (6) [(b) (6) @GNYHA.org]
Sent: Wednesday, February 22, 2017 04:58 PM Eastern Standard Time
To: Shulkin, David J., MD
Subject: [EXTERNAL] Meeting date.....Wednesday March 8/ 2pm.....

(b) (6)

President

GNYHA Ventures, Inc.

Executive Vice President, Administration

Greater New York Hospital Association

555 West 57th Street, 15th Floor | New York, NY 10019

AMERICAN OVERSIGHT

T (b) (6) C (b) (6) E (b) (6) @gnyha.org

<VA Memo V2 (3).docx>

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6)@hotmail.com]
Sent: 2/24/2017 12:33:59 AM
To: David shulkin [drshulkin@aol.com]
Subject: Fwd: [EXTERNAL] Meeting date.....Wednesday March 8/ 2pm.....
Attachments: VA Memo V2 (3).docx

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Sent from my iPad

Begin forwarded message:

From: "Alaigh, Poonam, M.D." <Poonam.Alaigh@va.gov>
Date: February 23, 2017 at 7:26:55 PM EST
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President

GNYHA Ventures, Inc.

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555 West 57th Street, 15th Floor | New York, NY 10019

T (b) (6) C (b) (6) E (b) (6) @gnyha.org

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Draft Thought Agenda for March 8th Meeting with Premier/GNYHA (from VHA Perspective)

Background
The Veterans Health Administration (VHA) in recent years has gone through major changes to improve the care for our Veterans. Our Department holds one of the biggest repositories of healthcare data both in individual VA Medical Centers and also within the VistA Electronic Healthcare Record. Through this we are at a pivotal time on how we can use this data to improve and make healthcare more efficient for our veterans, while also saving cost for the taxpayer. This memo will outline some preliminary next steps for VHA to take to start this process.

Memorandum
VA would like to execute a strategic five-year partnership through a sole source contract to complete a comprehensive analysis of VHA and develop a corresponding strategy and implementation plan on how best utilize the commercial market's as well as VA's existing tools, solutions and methodologies to make VHA care delivery more efficient and cost effective for our Veterans. This contract would provide senior advisory services across all aspects of healthcare delivery. Please see below for the three proposed stages.

Stage One: Comprehensive Assessment of VHA: Full assessment of the VHA enterprise and VISN/facility level and where they stand on the items below (with a comparison to commercial systems in the same region). This will include map and gap and compilation of best practices.

a. Access to care issues
b. Supply chain and formulary
c. Opioid Management
d. Infection Control
e. Chronic Disease Management
f. Labor Effectiveness, Optimization of Staffing
g. Workflow and Business Function Optimization and Improvement

Stage Two: Alignment of Tools, Solutions and Methodologies: Building on prior assessment and working closely with the Office of Information and Technology, identify where technology or leading methodologies should be implemented with a focus on Commercial off the Shelf Products. This would require assessment of current tools and capabilities, requirements generation, market analysis and tool implementation and deployment strategy. Areas of focus would be:

a. A centralized repository to warehouse all VA Data
b. Centralized data platform for data analytics, dashboards and report generation focused on increased access, decrease cost and improved quality
c. Labor and Costing tools to improve facility level operation efficiency and optimization
d. Supply chain tools to align purchasing for the VA to drive cost savings.

Stage Three: Define Strategy for Health Reliability Organization to centralize population health and care delivery improvement efforts. This organization will also set benchmarks on an annual basis down to each VA medical center.

Conclusion
Identify and contract with a partner to serve the VA immediately to begin executing this memo

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Message

From: (b) (6) [(b) (6) @comcast.net]
Sent: 2/1/2017 6:22:52 PM
To: (b) (6) (b) (6) @ptt.gov]
CC: David shulkin [drshulkin@aol.com]; (b) (6) @gmail.com; Vivieca Simpson [(b) (6) @gmail.com]
Subject: Fwd: VA HEC and Dr. Shulkin

(b) (6)

Sending to you here with editorial comment. Please reach out to this guy and send him the statement you sent when Dr. Shulkin was nominated. This reporter is very close to one of our whistleblowers in Atlanta and is an annoyance. Let's provide nothing further than what you have done already. Once confirmed, we can determine next steps and how to engage him.

(b) (6)

Begin forwarded message:

From: "(b) (6) <(b) (6) @va.gov>
Date: February 1, 2017 at 1:03:11 PM EST
To: "(b) (6) (b) (6) @va.gov>, "(b) (6) <(b) (6) @va.gov>
Cc: "Hutton, James" <James.Hutton@va.gov>, '(b) (6) <(b) (6) @comcast.net>
Subject: RE: VA HEC and Dr. Shulkin

Got it.

(b) (6)
Director of Communications for Policy and Services
Veterans Health Administration
U.S. Department of Veterans Affairs
810 Vermont Avenue, N.W.
Washington, D.C. 20420
Direct (b) (6)
Cell: (b) (6)

-----Original Message-----
From: (b) (6)
Sent: Wednesday, February 01, 2017 12:59 PM Eastern Standard Time
To: (b) (6) (b) (6)
Cc: Hutton, James; (b) (6)
Subject: FW: VA HEC and Dr. Shulkin

(b) (6)

Please see below from Brad Schrade. He emailed close to 4:00 yesterday while James and I were in a meeting but went ahead and posted his blog.

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See at: http://investigations.blog.ajc.com/2017/02/01/incoming-va-secretary-needs-to-fix-new-problems-at-veterans-enrollment-office-whistleblower-says/

The last line simply says, " An email to VA's press office in Washington on Tuesday was not immediately returned."

I realize nothing can happen today on this, but if we can send something in the next day or so, I'll ask Brad to update his story/blog.

I'm including (b) (6) because he's worked the HEC issues rather extensively, but thought you all might have something in the can that was done for Dr. Shulkin.

(b) (6)

-----Original Message-----
From: Hutton, James
Sent: Wednesday, February 01, 2017 12:35 PM
To: (b) (6)
Cc: (b) (6)
Subject: FW: VA HEC and Dr. Shulkin

Below is the note from Brad.

James Hutton

Deputy Assistant Secretary (Acting)

Office of Public Affairs

Department of Veterans Affairs

810 Vermont Ave, NW

AMERICAN OVERSIGHT

Washington, D.C. 20420

Office: 202-461-7558

Email: james.hutton@va.gov

Twitter: @jehutton

VA on Facebook . Twitter . YouTube . Flickr . Blog

-----Original Message-----

From: Schrade, Brad (CMG-Atlanta) [mailto(b) (6) @ajc.com]

Sent: Tuesday, January 31, 2017 3:50 PM

To: Hutton, James

Cc: (b) (6)

Subject: [EXTERNAL] VA HEC and Dr. Shulkin

James or (b) (6)

Can one of you call me regarding Dr. Shulkin and the HEC in Atlanta? WE are publishing something about his visit to the HEC in August 2015 and want to get a comment about his plans to fix ongoing problems at the facility.

Thanks,

Brad Schrade

AJC

(b) (6)

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 2/17/2017 3:49:10 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: Booker office

No

Sent from my iPhone

> On Feb 17, 2017, at 8:30 AM, Poonam Alaigh <(b) (6) n@hotmail.com> wrote:
>
> I am having lunch with (b) from Booker office today- anything I need to bring up from your perspective
>
> Sent from my iPhone

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Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 2/17/2017 1:30:50 PM
To: drshulkin@aol.com
Subject: Booker office

I am having lunch with (b) from Booker office today- anything I need to bring up from your perspective

Sent from my iPhone

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Message

From: Poonam Alaigh [(b) (6)@hotmail.com]
Sent: 1/27/2017 9:11:13 PM
To: David shulkin [drshulkin@aol.com]
Subject: More from (b)

Sent from my iPad

Begin forwarded message:

From: (b) (6) <(b) (6)@normandyrealty.com>
Date: January 27, 2017 at 4:03:36 PM EST
To: Poonam Alaigh <(b) (6)@hotmail.com>
Subject: Re: Great seeing you

Great..step by step..:)

(b) (6)
Founder and Partner
Normandy Real Estate Partners
D: (b) (6)
Original Message
From: Poonam Alaigh
Sent: Friday, January 27, 2017 4:02 PM
To: (b) (6)
Subject: Re: Great seeing you

He definitely thought is was valuable and a good starting point around exploring various possibilities- the question that is still unresolved is whether there could be a collaboration established between all the key stakeholders to include Google, IBM, Microsoft, Amazon etc to establish a VA specific technology solution that could be expeditiously and flawlessly executed to deliver high quality and timely services in a veteran centric manner - we can discuss more when we meet. Overall, he was extremely pleased

Sent from my iPhone

On Jan 27, 2017, at 3:52 PM, (b) (6)
<(b) (6)@normandyrealty.com> wrote:

Poon

By the way, did you think David liked the overall mtg?

(b)

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(b) (6)

Founder and Partner

Normandy Real Estate Partners

D: (b) (6)

Original Message

From: Poonam Alaigh

Sent: Friday, January 27, 2017 2:59 PM

To: (b) (6)

Subject: Re: Great seeing you

Will do and look forward to connecting with (b) thanks and safe travels

Sent from my iPhone

> On Jan 27, 2017, at 10:57 AM, (b) (6) <(b) (6) @normandyrealty.com> wrote:
>
> Poonam
>
> Great to see you in DC yesterday !
>
> Hopefully our (b) (6) Apple meeting lays the ground work to help David and our Veterans.
>
> (b) (6) of Apple (former EPA Commissioner understands the DC environment very well) and is an Outstanding person, and someone who I have great confidence in to help collaborate for David.
>
> Yes, definitely come visit me in Morristown.
>
> I am copying my associate (b) (6) on this email.
>
> Next week and following week I will be out of USA (south America), but back Feb 13 and balance of month.
>
> Best always
>
> (b)
>
> -----Original Message-----
>
> From: Poonam Alaigh [mailto:(b) (6) @hotmail.com]
>
> Sent: Friday, January 27, 2017 6:01 AM
>
> To: (b) (6)
>
> Subject: Great seeing you

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It was great seeing you yesterday. I am in DC more and more now in terms of time, commitment and scope of responsibilities. I am still at Morristown though winding down the end of next month, so let's catch up soon in NJ.

Safe travels back and hopefully the trip was fruitful on many different fronts.

Sent from my iPad

This email has been sent for the sole use of the intended recipient(s). The message content and any attachments may contain confidential or proprietary information. If you are not the intended recipient, do not review, copy or distribute, please contact the sender immediately, and delete all copies of this email and any attachments. Thank you.

This email has been sent for the sole use of the intended recipient(s). The message content and any attachments may contain confidential or proprietary information. If you are not the intended recipient, do not review, copy or distribute, please contact the sender immediately, and delete all copies of this email and any attachments. Thank you.

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/5/2017 1:58:34 AM
To: Bruce Moskowitz [brucem(b) (6) mac.com]
CC: Poonam Alaigh [(b) (6) @hotmail.com]; Ike Perlmutter [@frenchangel59.com]
Subject: Re: Yes Access Website Launch

Thanks Bruce

Sent from my iPhone

On Apr 4, 2017, at 9:54 PM, Bruce Moskowitz <brucem(b) (6) mac.com> wrote:

> I will forward to them thank you
>
> Sent from my iPhone
>
> On Apr 4, 2017, at 9:38 PM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:
>
> > Bruce- we are ready to present to the Academic Affiliates now- so let us know how you propose for us to proceed.
> >
> > ---
> >
> > **From:** Bruce Moskowitz <brucem(b) (6) mac.com>
> > **Sent:** Tuesday, April 4, 2017 9:50 AM
> > **To:** David shulkin
> > **Cc:** Ike Perlmutter; Poonam Alaigh
> > **Subject:** Re: Yes Access Website Launch
> >
> > This is transformational you and your team should take great pride in developing this as the most important step towards quality of care. When can I show this to our academic partners? They will be of great importance to providing there input to the press.
> >
> > Sent from my iPad
> > Bruce Moskowitz M.D.
> >
> > On Apr 4, 2017, at 9:40 AM, David shulkin <Drshulkin@aol.com> wrote:
> >
> > > **Bruce- attached is a proposed communications plan for rolling out our wait time transparency tool. We will**
> > > **Also reach out to (b) who is pulling together a number oF PR advisors to help**
> > >
> > > **David**
> > >
> > > **| Accessible | Quality | Innovative | Agile | Integrated**

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<Access and Quality Tool Implementation Plan Draft 03302017_Final.doc>

AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [brucem(b) (6) mac.com]
Sent: 4/5/2017 1:54:21 AM
To: Poonam Alaigh [(b) (6) @hotmail.com]
CC: David shulkin [Drshulkin@aol.com]; Ike Perlmutter [(@frenchangel59.com]
Subject: Re: Yes Access Website Launch

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Sent from my iPhone

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To: David shulkin
Cc: Ike Perlmutter; Poonam Alaigh
Subject: Re: Yes Access Website Launch

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> David
>
> | Accessible | Quality | Innovative | Agile | Integrated
>
> <Access and Quality Tool Implementation Plan Draft 03302017_Final.doc>

AMERICAN OVERSIGHT

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From: David shulkin [Drshulkin@aol.com]
Sent: 4/4/2017 1:40:11 PM
To: Bruce Moskowitz [brucem(b) (6) mac.com]
CC: Ike Perlmutter [(@frenchangel59.com]; Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Yes Access Website Launch
Attachments: Untitled attachment 15315.doc; Untitled attachment 15318.htm

Bruce- attached is a proposed communications plan for rolling out our wait time transparency tool. We will Also reach out to (b) who is pulling together a number oF PR advisors to help

David

| Accessible | Quality | Innovative | Agile | Integrated

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Internal VA Use Only

Public facing website: "Access and Quality in the VA"
Implementation Plan

Purpose

To highlight the strategies that will be used to communicate the development of the Department of Veterans Affairs' (VA's) website designed for Veterans to make informed decisions about where they receive their healthcare. Develop coordination plan detailing VA's transformation effort to modernize culture, processes, and capabilities in order to put the needs, expectations and interests of Veterans and beneficiaries first.

This will take VA to a whole new level of transparency by allowing Veterans to fully understand how their VA's are doing in access and quality. Where possible, VA will provide an easy comparison to private sector facilities, allowing Veterans to make informed decisions about their care

Strategy

This communications strategy for the Access and Quality Tool Implementation Plan will follow two key themes. The plan and its subsequent communications will leave the audience with a clear understanding of not only the goals and the timeline for the Access and Quality Tool, but also the level of transparency this tool provides, i.e., allowing Veterans access to easy to use, easy to understand access and quality data about their VA. Second, the plan will reinforce the message that the development and improvements of the Access and Quality tool is a collaboration between VA, Veterans, our Congressional partners and VSO's.

Major themes supporting this strategy include:

- Transparency: Healthcare performance data, access or quality, is very complex. This tool will take highly complex data and make it usable to the highest number of Veterans. This tool is one in the toolbox VA is introducing to restore Veterans trust and confidence.

- VA will attempt to elicit member support with regular congressional briefings and phone calls. This is done to capture both Members and Staff feedback as well as the opportunity to capture feedback from the Veterans they represent.
    - VA will elicit VSO support with regular VSO briefings explaining quarterly updates to content and web transactions, and
    - Focus group with VSOs for initial feedback on the website

Working Draft

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Risks

There is **moderate risk** that stakeholders will not accept Access and Quality Tool as a solution for transparency about our access and quality data. . Veterans are unhappy with the ability to determine how long they will have to wait for care, making their decision about where to get care difficult. Veterans want information to help them plan reliable healthcare interactions with VA. We anticipate that Veterans will be open to trying a new website that consolidates the information they want in a single website that provides import consumer information.

There is **low risk** that Congress will question on whether or not we should be devoting resources to this modernization and transparency effort instead of other improvement options.

Goal and Objectives

Through implementation of the communications plan, VA will achieve the following goals:

- Veterans, employees, Congress, and stakeholders will recognize that VA has created and implemented a clear plan to communicate our performance data related to access and quality in a clear and understandable manner.
    - Ensure VA's quality and access data is transparent to all our stakeholders
    - Demonstrate improvements with Veteran access to VA services with features deployed on the website
    - Establish a periodic update schedule of briefings for Congress, VSOs, and stakeholders.
    - Detail to Congress the achievements and progress gained since the development of the Access and Quality Tool and what assistance from Congress is needed to achieve further progress.
    - Clearly articulate the Access and Quality Tool accomplishments and what they mean for Veterans.
- VA employees need awareness of the information included here, they need to be able to speak to comparisons between their facility and other VA's and private sector
- Congressional schedule permitting: Congress and VSOs will receive an initial project brief that will detail content, web transactions, and services launch schedule. Should the Congressional schedule not allow for a briefing prior to implementation, VA will follow-up with a briefing to share detail content, web transactions and begin to gather feedback about the live site.
    - Demonstrate that Access and Quality Tool is a long term plan, but Veterans and employees will benefit from many of the changes quickly, as new projects and services launch.
    - Provide quarterly updates with a clear explanation of what Veterans and employees can expect to see during each web transaction update.

Audiences

- Veterans
- Veterans families, caregivers and Survivors
- VA Employees
- Congress
    - HVAC, SVAC, HAC, SAC
- Veterans Service Organizations and advocacy groups
    - Big Six, State (NASDVA) and County VSOs,
    - Advocacy groups, like IAVA, Got Your Six, RWB, and SVA
- Media
    - National and Local

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Stakeholder Notifications

(Briefings will be offered to VSOs and Congressional members, with messages developed from the below materials.)

- RTQ Statement
- Fact Sheet
- National News Release
- VHA leadership
- PAO's
- Employee Notification and Guidance Message

Messages

- Healthcare performance data, access or quality, is very complex. This tool will take highly complex data and make it transparent to the highest number of Veterans. This tool is one in the toolbox VA is introducing to restore Veterans trust and confidence in the VA.
- The Access and Quality Tool provides Veterans and their dependents with information they need to make informed decisions about their healthcare.
- The Access and Quality Tool was developed for VA to provide Veterans with easy to use data related to;
    - new and established patient wait times
    - satisfactions scores for access to primary and specialty care
    - timeliness of urgent appointments
    - information about the quality of healthcare delivered at every medical center compared to local private sector hospitals.
- The Access and Quality website will be a continuous work in progress as we continue to receive feedback from Veterans, employees, media, VSO's and our congressional partners, to improve the site's tools and capabilities based on Veterans input.
- Incorporating this feedback will ensure that Veteran Access Tool is a Veteran-driven, Veteran-designed point of access for the services our Veterans deserve.

RTQ/Statement

The Department of Veterans Affairs is pleased to announce the Access and Quality Tool. This tool is designed to increase transparency related to our quality and access data, providing Veterans with an easy to use, easy to understand website that allows them to quickly compare their VA with other VA's and private sector healthcare facilities enabling them to make informed decisions about their healthcare. This website is one tool VA is introducing to restore Veterans trust and confidence in their VA.

Action Plan/Timeline

Date	Action	Lead	Product
Up to 4/4	Usability Testing with Veterans	VA Digital Service	Input to final design
Up to 4/4	Final edits to content are complete and ready for off the record briefings. **The web page should**	OSVA/VHA	Input to final design

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	not be published and made available to the public until April 12th!		
4/5	SECVA demo/interview with 60 Minutes. This interview is about much more than the webpage, but Dr. Shulkin does want to do a demo of the webpage for them. 60 minutes will not air until much later so this does not negate the exclusive we are offering Donovan.	OSVA	
4/5	Congressional Briefing	OCLA	Briefing and Fact Sheet
4/7	Frontline Senior Leader and PAO brief. This date is flexible but this has to happen on or before the 7th to give the field time to prepare. We should also be sending guidance on how to proactively promote this and, for those who have long wait times, guidance on how to pivot towards their plan of actions to improve access. **All facilities and VISNs should be promoting this locally/regionally on April 12th.**	VHA Comms	Call
4/10	SECVA exclusive interview/demo with Donovan Slack.	OPIA/ VHA comms	Interview
4/11	Publication of live site (Overnight)		
4/12	All Employee notifications and guidance	OSVA/ VHA Comms	Email notification PAO call
4/12	Go Live date	VA Digital Service	Public website
4/12	Official Soft Launch – Notifications, press release, aggressive amplification on VA and VHA social media, and a larger demo for press at a media round table (with Shereef and AUSH).	OSVA	
	*Include release in AFGE comments	OSVA/ Speech writers	Speech

Attachments

TAB A: FAQ Sheet – attached
TAB B: National News Release – in development
TAB C: Employee Message – in development

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Working Draft

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/7/2017 8:32:47 PM
To: IP [(b) (6)@frenchangel59.com]
Subject: Re: SALUTE update

Thanks- these programs look good and we will see if we can work with them

David

Sent from my iPhone

On Apr 7, 2017, at 3:19 PM, IP <(b) (6)@frenchangel59.com> wrote:

> David,
>
> As you know (b) (6) is one of the top executives at The Walt Disney Company.
>
> I told (b) (6) that you may be able to give him some good ideas and recommendations.
>
> I think he will be able to help us a lot with the VA.
>
> Anything you can do will be appreciated.
>
> Thank you in advance.
>
> All my Best,
> Ike

From: (b) (6) [mailto(b) (6)@disney.com]
Sent: Friday, April 07, 2017 1:43 PM
To: IP
Subject: Re: SALUTE update

Yes, feel free to share with him. Thank you Ike.
Best regards,
(b) (6)

From: Ike <(b) (6)@marvel.com>
Date: Friday, April 7, 2017 at 10:35 AM
To: "(b) (6) <(b) (6)@disney.com>
Subject: RE: SALUTE update

(b) (6)

This is excellent. It looks like a good list of meetings and events. It is also very good that you are the executive sponsor for Disney. I know this means a lot to you.

Are you ok if I share this with Secretary Shulkin? He may have some good ideas or recommendations.

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All my Best,

Ike

From: (b) (6) [mailto:(b) (6) @disney.com]
Sent: Thursday, April 06, 2017 10:36 PM
To: IP
Subject: FW: SALUTE update

Hi Ike,

I thought you'd like to see some of the progress we're making in Glendale with the Heroes Work Here and Salute programs at Disney. As we've discussed, I'm the executive sponsor of these efforts and so I receive these updates and am asked to participate/help craft the strategy.

Best regards,

(b) (6)

From: "(b) (6) (b) (6) @abc.com>
Date: Thursday, April 6, 2017 at 3:02 PM
To: "(b) (6) (b) (6) @disney.com>
Subject: SALUTE update

Good Afternoon (b) (6)

I hope you're doing great. I know how busy you are so we wanted to create a document giving you a quick overview of the initiatives and goals SALUTE has and is working on for 2017. We're still working on ways to get Disney veterans involved along with ways we can affect veterans externally and do good.

I'll update the sheet about every 4-6 weeks so not to over burden. If at any time you would like more detailed information, please don't hesitate to reach out and we can walk through it (with or without the team).

SITREP = a periodic report of the current military situation ☺

All my best,
(b)

<image001.png>
(b) (6)
Vice President, National Sales Manager
W: (b) (6)
F: (b) (6)
500 Circle Seven Drive

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Glendale, CA 91201
(b) (6) [redacted]@abc.com


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****

THINK GREEN - SAVE PAPER - THINK BEFORE YOU PRINT!

<SALUTE SITREP 040517.pptx>

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Message

From: IP [(b) (6)@frenchangel59.com]
Sent: 4/7/2017 7:19:39 PM
To: David shulkin [drshulkin@aol.com]
Subject: FW: SALUTE update
Attachments: SALUTE SITREP 040517.pptx

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I think he will be able to help us a lot with the VA.

Anything you can do will be appreciated.

Thank you in advance.

All my Best,
Ike

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I'll update the sheet about every 4-6 weeks so not to over burden. If at any time you would like more detailed information, please don't hesitate to reach out and we can walk through it (with or without the team).

SITREP = a periodic report of the current military situation ☺

All my best,
(b)

(b) (6)
Vice President, National Sales Manager
W: (b) (6)
F: (b) (6)
500 Circle Seven Drive
Glendale, CA 91201
(b) (6) @abc.com
Disney | abc Television Group

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Burbank-Glendale SALUTE SITREP
April 2017

Accomplishments

- Established monthly Leadership meetings (3rd Friday of month)
- Established quarterly membership meetings
- Finalized draft of BG SALUTE SOPs/Guidelines for leadership team review
- Organized "At Ease" monthly liaison event

Key Meetings & Engagements

- **9 Jan** - Meeting with HWH and HSH to discuss FY 17 HWH plans
- **26 Jan** – Meeting to discuss Veterans Issues for Corporate Citizenship
- **24 Feb** – DATG Quarterly Veterans Brunch
- **3 Mar** – USC MBV, HWH, and SALUTE Presentation and Liaison Dinner
- **10 Mar** – General Membership Meeting
- **28 Mar** – HWH and B-G SALUTE meeting with Col. Jack Jacobs (Ret), MOH recipient
- **30 Mar** – Meeting with veteran employee resource groups from Fox and Lionsgate
- **21 Apr** – Guidelines finalization meeting
- **TBD** – Joint West Coast SALUTE teams (BGP and DLR) meeting

Planned Sponsored Events

- **29 Mar** – Host speaker event with Rebecca Murga
- **12 Apr** – Table at GC3 Environmentality Fair at GCAT
- **12 May** – Screen "No Greater Love" with filmmaker Q&A
- **20 May (tentative)**- VoluntEARS event with Mission Continues
- **FY17Q4 (tentative)** – Host FourBlock's Veteran Career Readiness Program on Studio Lot
- **11 Nov** – Commemorate Veterans Day

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Message

From: Carolyn Clancy [(b) (6) @gmail.com]
Sent: 1/29/2017 3:26:17 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Briefing Jake today

Brief addendum -- forgot to mention that he asked about the new Director at Tomah -- was very impressed with her handling of the recent dental issue.

On Fri, Jan 27, 2017 at 6:21 PM, David shulkin <Drshulkin@aol.com> wrote:
Thanks

Sent from my iPhone

> On Jan 27, 2017, at 6:06 PM, Carolyn Clancy <(b) (6) @gmail.com> wrote:
>
> Peter and I briefed Jake today on SAIL -- he made his preferences very clear that he wanted 1-2 pages, not the lengthy presentation. In conversation with him I let him know that I had been a political appointee through Tommy Thompson, Bush's first term HHS Secretary and former GOP governor of Wisconsin (he and Jake are friends).
>
> He told us he was there as a senior WH advisor focused on getting folks through confirmations and into the right slots at the VA (no names or specifics). Carolyn

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/28/2017 1:48:47 AM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: Briefing Jake today

I agree

Sent from my iPhone

On Jan 27, 2017, at 8:35 PM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:

> In a week or so, you will be in control of all this- at least Carolyn was honest and transparent.

From: David shulkin <Drshulkin@aol.com>
Sent: Friday, January 27, 2017 6:20 PM
To: Poonam Alaigh
Cc: Vivieca Wright Simpson
Subject: Fwd: Briefing Jake today

Everyone is politiking

Sent from my iPhone

Begin forwarded message:

> **From:** Carolyn Clancy <(b) (6) @gmail.com>
> **Date:** January 27, 2017 at 6:06:16 PM EST
> **To:** David shulkin <drshulkin@aol.com>
> **Subject: Briefing Jake today**
>
> Peter and I briefed Jake today on SAIL -- he made his preferences very clear that he wanted 1-2 pages, not the lengthy presentation. In conversation with him I let him know that I had been a political appointee through Tommy Thompson, Bush's first term HHS Secretary and former GOP governor of Wisconsin (he and Jake are friends).
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From: Poonam Alaigh [(b) (6) @hotmail.com]
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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/27/2017 11:21:01 PM
To: Carolyn Clancy [(b) (6) @gmail.com]
Subject: Re: Briefing Jake today

Thanks

Sent from my iPhone

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/27/2017 11:20:37 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
CC: Vivieca Wright Simpson [vivieca.Wright@va.gov]
Subject: Fwd: Briefing Jake today

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Message

From: David Shulkin [drshulkin@aol.com]
Sent: 2/4/2017 6:11:52 PM
To: (b) (6) @gmail.com
Subject: Fwd: Undeliverable: [EXTERNAL] manchin
Attachments: details.txt; PostHQFR for Shulkin - Sen Manchin.docx; PostHQFR for Shulkin - Sen Manchin (3).docx

The e-mail address you entered couldn't be found. Please check the recipient's e-mail address and try to resend the message. If the problem continues, please contact your helpdesk.

Diagnostic information for administrators:
Generating server: va.gov
(b) (6) @va.gov
#550 5.1.1 RESOLVER.ADR.RecipNotFound; not found ##
Original message headers:

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Received: from gwsmta1.va.gov (10.239.10.121) by VAPNSMSGPF13.vha.med.va.gov
 (10.229.64.55) with Microsoft SMTP Server id 14.3.294.0; Sat, 4 Feb 2017
 11:15:07 -0600
X-SBRS: None
X-MID: 734150418
X-VA-EXT: gwsmta1.tic.va.gov
X-VA-EXT-MID: 734150418
Received: from gws-ipssl-nat.tic.va.gov (HELO ipssl-host75.is.centurylink.net)
 ([10.239.98.75])  by gwsmta1.va.gov with ESMTP; 04 Feb 2017 17:15:06 +0000
X-Qwest-Status: hEUBLG9ErOsrnKeZ
Received: from gwema04-mta.va.gov (unknown [152.130.76.126]) by
 ipssl-host75.is.centurylink.net (Postfix) with ESMTP id E47E427F73A5       for
 (b) (6) r@va.gov>; Sat,  4 Feb 2017 17:15:02 +0000 (UTC)
X-SBRS: 3.5
```

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X-MID: 160417782
Subject: [EXTERNAL] manchin
X-Cloudmark-SP-Filtered: true
X-Cloudmark-SP-Result: v=1.1 cv=rEoJqX/9jwCAtrc3pPM+YRelbSX3NQ5HG9BS3V3/OAg= c=1 sm=1
 a=w3OYpBnu7V5qPwg+504b2w==:17 a=-yWkdOb8XrGfK0YC4qUA:9 a=QEXdDO2ut3YA:10
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X-IronPort-Anti-Spam-Result:
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X-VA-EXT: gwema04-mta.tic.va.gov
X-VA-EXT-MID: 160417782
Received: from omr-m001e.mx.aol.com ([204.29.186.1]) by gwema04-mta.va.gov
 with ESMTP/TLS/AES256-SHA; 04 Feb 2017 17:14:51 +0000
Received: from mtaomg-mba02.mx.aol.com (mtaomg-mba02.mx.aol.com
 [172.26.133.112]) by omr-m001e.mx.aol.com (Outbound Mail Relay) with ESMTP id
 E83DA3800084; Sat, 4 Feb 2017 12:14:50 -0500 (EST)
Received: from core-mfa02c.mail.aol.com (core-mfa02.mail.aol.com
 [172.27.110.2]) by mtaomg-mba02.mx.aol.com (OMAG/Core Interface) with ESMTP
 id B49A338000083; Sat, 4 Feb 2017 12:14:50 -0500 (EST)
Received: from 71.224.193.164 by webstg-m05.mail.aol.com (10.74.71.79) with
 HTTP (WebMailUI); Sat, 04 Feb 2017 12:14:50 -0500
Date: Sat, 4 Feb 2017 12:14:50 -0500
From: David Shulkin <drshulkin@aol.com>
To: <vivieca.wright@va.gov>, (b) (6) va.gov>
Message-ID: <15a0a1f08e4-75f3-d063@webstg-m05.mail.aol.com>
MIME-Version: 1.0
Content-Type: multipart/mixed;
 boundary="----=_Part_67077_1817526986.1486228490466"
X-MB-Message-Source: WebUI
X-MB-Message-Type: User
X-Mailer: JAS STD
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x-aol-global-disposition: G
X-AOL-VSS-INFO: 5800.7501/114291
X-AOL-VSS-CODE: clean
DKIM-Signature: v=1; a=rsa-sha256; c=relaxed/relaxed; d=mx.aol.com;
 s=20150623; t=1486228490;
 bh=oynUKIJFUoZIpASpKDpmweLzMgmT/CpFhCygj6axo3U=;
 h=From:To:Subject:Message-Id:Date:MIME-Version:Content-Type;
 b=IYHdx5htRgOiIUc/gJvXi0DrzVWeVkJs5VDxBVPgZJc7V3BiJkGBxg5s/iJ1zfEwc
  KnZCiU9PD4ukuzoav74pvkqVlqUOWyHhhpENTSOBXB3YGpGIFAj1NBLLugkSfp2ABt
  1npWv6Bd6Nj4PEyjD/EAp7mPZLNAMT06sds3b65g=
x-aol-sid: 3039ac1a857058960c0a7b29
Return-Path: drshulkin@aol.com

Attached Message

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To	vivieca.wright@va.gov; (b) (6) r@va.gov
Subject	[EXTERNAL] manchin
Date	Sat, 4 Feb 2017 12:14:50 -0500

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Reporting-MTA: dns;va.gov
Received-From-MTA: dns;gwsmta1.va.gov
Arrival-Date: Sat, 4 Feb 2017 17:15:07 +0000

Final-Recipient: rfc822;(b) (6) va.gov
Action: failed
Status: 5.1.1
Diagnostic-Code: smtp;550 5.1.1 RESOLVER.ADR.RecipNotFound; not found

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Questions for the Record for Dr. David J. Shulkin, Presumptive Nominee to be the Secretary of Veterans Affairs, US Department of Veterans Affairs from Senator Joe Manchin, III

1. In the past, you have stated that you would not have used the "40 mile" and "30 day" rule if you had designed the Choice program. Please elaborate on how you would like to see Choice fixed and what measures you would use in considering eligibility for referral to care in the community?

I know of no health system that has designed a system around mileage and wait times. The reason I believe we must look at alternatives to these criteria is that mileage and wait times do not differentiate between veterans that need urgent care and veterans that desire elective care. Such a system also does not differentiate between those that have other healthcare options available to them and those that have none. We are embarking upon an exploration of a number of different models that would propose alternative criteria and then we would need to get veteran input into these models. We also need to do economic modeling of these models to determine the cost of new options. Once we have completed this initial work we would begin to socialize our ideas with veterans, veteran service organizations, members of Congress and the Administration, and our staff.

2. As of February 1, 2017 per the VA's website, there are 388,364 pending claims in VA's queue waiting for a decision. Of those, there are 97,119 backlogged rating-related claims backlogged. Please elaborate on your plan to:
    a. Get these backlogged claims processed within the next 60 days,
    b. Reduce the backlog to zero?
    c. Ensure all new and pending claims are processed within 125 days?

3. Mandatory overtime of Veterans Benefit Administration employees has previously been used to reduce claims. While the current "hiring freeze" executive order is in effect, is the Department allowed to institute mandatory overtime if the claims backlog reaches a certain threshold? Do you anticipate that you will need to require mandatory overtime in the next 90 days?

4. Is there ever a reason why a veteran would be taken off the Agent Orange Registry? If so, what are the parameters that the Department of Veterans Affairs uses to make such a judgement?

5. You have mentioned in previous public statements that eradicating veterans homelessness is not a single event; it requires a long term commitment. Now that the number of homeless veterans has diminished, how do you plan to reach the remaining population of

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homeless veterans who are so difficult to reach? Additionally, are there specific initiatives in place to handle female veteran homelessness?

6. The pernicious nature of post-traumatic stress is especially traumatic for rural veterans who do not always have access to high quality mental health and/or cannot receive care in a timely manner. Please elaborate on you plan to improve treatment, wait times, and increase options for rural Veterans with PTSD to ensure their safety and health.

7. How is the Department of Veterans Affairs currently differentiating treatment options, as well as facilities, for female victims of Military Sexual Trauma? Are there policy alternatives regarding treatment and facility structure being considered now that are different than the status quo?

8. Will you continue to advance the MyVA concepts and programs put into place under Secretary McDonald's leadership? Are there components of MyVA that you will differ from?

9. You have previously stated that you do not and will not support a whole sale privatization of the Veterans Health Administration, and rather, you support an "integrated" model. Please elaborate on what you mean by "integrated" model.

10. What statutory authorities do you need to remove employees who are low-performing and/or not working in the best interest of America's veterans?

11. The Veteran Success on Campus (VSOC) program has been widely successful and there are many campuses, like West Virginia University, that meet the requirements for VSOC, but still are on the wait list. Will you commit to supporting additional funding in The President's FY18 budget that will make it so more of our nation's veterans have access to this program?

12. Both Healthnet and TriWest have a footprint in West Virginia and my office has received complaints about the inability to reach a representative by phone and the lengthy approval process. Lengthy approval times often lead to a financial burden on the veteran and their family. Please elaborate on what VA is currently doing and what you envision VA will do when contracting with third party administrators in the future?

13. What do you believe are the factors that create appointment wait times and how do you plan on mitigating those factors to ensure timely, quality care for our nation's veterans?

14. Will you commit to ensuring that VA continues to invest in the veteran transportation program?

15. With VA's expertise on substance abuse and the Department's robust Office of Research and Development, I believe that you are well equipped to be on the forefront of alterative pain therapy research for the entire country. Please elaborate on how you will increase

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the number of alternative treatments for pain management. What investments will you make and are there authorities you need from Congress?

16. The Department of Veterans Affairs is often charged with having a corrosive culture that breeds unethical, and sometimes unlawful, behavior that is not veteran-centric. While there have been improvements under Secretary McDonald's leadership, there is still work to be done. What are specific actions that you will implement to ensure that the culture of VA will continue to improve?

17. Please elaborate on specific ways the Department of Veterans Affairs and Congress can work together to improve the claims backlog.

18. Do you support an expansion of the Caregivers programs beyond post-9/11 veteran era?

19. Do you believe there are improvements or changes that need to be made in the way VA determines service connected disabilities? Would you be open to reexamining the compensation and pension exam process?

20. The difficulty veterans face in scheduling appointments is a frequent complaint to my office. Please elaborate on ways to improve scheduling to make it easier both for VA scheduling staff and the veteran.

21. What are ways that you would like to see access to Mental Health improve? What is being done to help prevent the overprescribing of opioids and benzodiazepines?

22. In the past, you have stated that you would not have used the "40 mile" and "30 day" rule if you had designed the Choice program. Please elaborate on how you would like to see Choice fixed and what measures you would use in considering eligibility for referral to care in the community?

23. A frustration that many veterans have is that even though there is a VA regional office in their community, they have to contact a call-center to get an update on the status of their claim or to ask questions. How can the Veterans Benefits Administration be more accessible to veterans directly? Furthermore, have you considered embedding VBA counselors in VA Medical Centers to help veterans and their families understand their benefits during a hospitalization?

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Questions for the Record for Dr. David J. Shulkin, Presumptive Nominee to be the Secretary of Veterans Affairs, US Department of Veterans Affairs from Senator Joe Manchin, III

1. As of February 1, 2017 per the VA's website, there are 388,364 pending claims in VA's queue waiting for a decision. Of those, there are 97,119 backlogged rating-related claims backlogged. Please elaborate on your plan to:
    a. Get these backlogged claims processed within the next 60 days,
    b. Reduce the backlog to zero?
    c. Ensure all new and pending claims are processed within 125 days?

    Response: VBA makes every effort to work claims in a timely manner. We recognize that some pending claims require additional time to process to ensure VA meets its legal obligations to assist Veterans in the development of their claims. Complex claims (involving multiple body systems or a high number of claimed contentions) do tend to take longer as VA considers additional evidence and/or new medical conditions throughout the claims process. Additionally, late evidence or new contentions stop the momentum made in processing the claim, since they usually require a new round of evidence-gathering, medical examinations, and analysis, thus prolonging the determination of a decision. VBA is focused on resolving specific rating claims – our oldest claims, fully developed claims, and special interest claims (homeless, extreme financial hardship, former prisoners of war, terminally ill, etc.). Based on claim characteristics that make a claim more complex as well as VA's responsibility to help Veterans develop their claims, VA expects some claims to take longer than 125 days. One of VBA's published strategic target is to reduce the disability rating claims backlog to less than 10 percent of the total rating inventory by FY 2021.

2. Mandatory overtime of Veterans Benefit Administration employees has previously been used to reduce claims. While the current "hiring freeze" executive order is in effect, is the Department allowed to institute mandatory overtime if the claims backlog reaches a certain threshold? Do you anticipate that you will need to require mandatory overtime in the next 90 days?
    Response: VBA continues to use overtime for employees processing compensation rating claims. Additionally, VBA has authorized overtime for specific pension and non-rating work. VBA is considering all options, to include mandatory overtime, to ensure that Veterans are getting the best care and services possible.

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3. Is there ever a reason why a veteran would be taken off the Agent Orange Registry? If so, what are the parameters that the Department of Veterans Affairs uses to make such a judgement

   Response: There is no reason that a Veteran should be taken off the Agent Orange Registry.

4. You have mentioned in previous public statements that eradicating veterans homelessness is not a single event; it requires a long term commitment. Now that the number of homeless veterans has diminished, how do you plan to reach the remaining population of homeless veterans who are so difficult to reach? Additionally, are there specific initiatives in place to handle female veteran homelessness?
   Response: VA will continue until the goal of all Veterans having permanent, sustainable housing with access to high quality health care and other supportive services is met. While significant advances have been made in reducing Veteran homelessness, there are sub-populations of homeless Veterans who are hard to reach and engage in services (e.g., chronically homeless, those with serious mental illness, and justice involved, and those not eligible for VHA health care services). The 2017 President's Budget includes $1.6 billion for VA programs that prevent or end homelessness among Veterans including funding for case management support for the nearly 80,000 existing Housing and Urban Development-VA Supportive Housing (HUD-VASH) vouchers, grant funding for community-based prevention and rapid rehousing services provided through the Supportive Services for Veteran Families (SSVF) program, clinical outreach and treatment services through Health Care for Homeless Veterans (HCHV), service intensive transitional housing through the Grant and Per Diem (GPD) and prevention services to justice involved Veterans in the Veteran Justice Program (VJP); and employment supports in Homeless Veterans Community Employment Services (HVCES).

   All of our homeless programs serve woman Veterans and we continue to evaluate additional service options for this important and growing population. Last year, the National Center on Homelessness Among Veterans conducted a study to look at population projections of Veterans likely to either be a risk of or actually become homeless and access VA care over the next 10 years. Women Veterans and Veterans who had served in the OEF/OIF era were identified as two subpopulations projected to grow in number while those older than age 55 were projected to decline. The National Center has commissioned two subsequent studies to map both current need profiles of homeless women Veteran served within VA and outcomes associated with different program utilization patterns. We expect to have results from these studies within the next six months which will be essential to accurately mapping where we need to strategically direct resources to address this projected demand. At this time, we

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believe that current VHA program capacity, particularly in the Supportive Services for Veterans and Families (SSVF) and HUD-VASH programs which provide the bulk of services for women Veterans who are homeless or at-risk for homelessness, is sufficient to support these projections for at least the near term.

5. The pernicious nature of post-traumatic stress is especially traumatic for rural veterans who do not always have access to high quality mental health and/or cannot receive care in a timely manner. Please elaborate on you plan to improve treatment, wait times, and increase options for rural Veterans with PTSD to ensure their safety and health.
Response: VA's Office of Rural Health has collaborated with VA Connected Care and Mental Health to establish a regional telemental health hub network to enhance access to care for Veterans residing in rural areas and/or in areas with identified access challenges. These regional hubs leverage VA's established and successful use of telemental health to provide staffing solutions to facilities that are particularly access challenged. Four hubs were initiated in June 2016 and are located in South Carolina, Utah, Pennsylvania, and the Washington-Oregon area. Six additional hubs were approved to come online in 2017. Regardless of their location, the hubs are available to provide services to Veterans and VA clinics throughout the country. The regional hubs provide a variety of services to include consistent, timely access to a full episode of treatment (e.g., evidence-based psychotherapy, pharmacotherapy, and primary care mental health integration services) for commonly seen conditions including posttraumatic stress disorder, depression, and substance use disorders.

   VA's National Center for PTSD also offers a variety of resources to improve the treatment of PTSD, including a Consultation Program to build competency for treating PTSD among Community Providers. Consultation is available free of charge, and it offers education, training, and other information to non-VA health professionals who treat Veterans with PTSD. The services are consistent with evidence-based practices for PTSD and VA consensus statements such as the VA/DoD Clinical Practice Guidelines for PTSD. The goal is to improve the care available to all Veterans with PTSD regardless of where they receive services.

6. How is the Department of Veterans Affairs currently differentiating treatment options, as well as facilities, for female victims of Military Sexual Trauma? Are there policy alternatives regarding treatment and facility structure being considered now that are different than the status quo
Response: VHA policy requires that mental health services be provided in a manner that recognizes that gender-sensitive issues can be important components of care. VA recognizes that some Veterans will benefit from treatment in an environment where all the Veterans are of one gender. This may help address a Veteran's concern about safety and may improve a Veteran's

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ability to disclose, address gender-specific concerns, and engage fully in treatment; however, VA also recognizes that mixed-gender programs have advantages. This may help Veterans challenge assumptions and confront fears about the opposite sex in a protected environment and may provide an emotionally corrective experience. Given these considerations, VA does not promote one model as universally appropriate for all Veterans; the needs of a specific Veteran dictates which model is clinically most appropriate. Gender-sensitive mental health care contains these key components:

- *Comprehensiveness*: Includes full continuum of service availability for women;
- *Choice*: Considers treatment modality (e.g., mixed-gender, women-only service options);
- *Competency (of clinician)*: Addresses women's unique treatment needs; and
- *Innovation*: Provides creative options and settings for subgroups of women, especially when caseloads of women are small.

7. Will you continue to advance the MyVA concepts and programs put into place under Secretary McDonald's leadership? Are there components of MyVA that you will differ from?
Response: MyVA is an initiative to drive continuous improvement across the entire VA enterprise- as opposed to driving change from within each of the three administrations (Cemeteries, Benefits and Health). I believe this is important to continue as veterans view VA as one organization and not three separate organizations. The MyVA initiative set organizational priorities, established metrics and timelines, and assigned accountable managers. With this approach, VA has improved numerous processes that have resulted in meaningful differences to veterans. If confirmed as Secretary, I would continue with efforts for continuous improvement and accelerate our efforts to make meaningful changes on behalf of veterans. Almost certainly VA's organizational priorities will change and evolve under a new Secretary. It would be my hope that we would have goals that were bold and would be realized through our transformational change that we plan to undertake within VA.

8. You have previously stated that you do not and will not support a whole sale privatization of the Veterans Health Administration, and rather, you support an "integrated" model. Please elaborate on what you mean by "integrated" model.
Response: By an "integrated" model, I am referring to a system that integrates the best of what the VA offers veterans and the best of what the private sector can offer together. A successful VA system would be more than just the intersection of VA and the private sector but it would have additional value added for veterans. By using VA's considerable capabilities in care coordination, case management, and quality oversight, VA can make sure that veterans receive an integrated experience and do not have the gaps in care that too many

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Americans experience in the our health care system. I believe such an integrated model of care can provide our veterans with healthcare outcomes that will be the best care available anywhere. Please see my article that I published in the New England Journal of Medicine where I described this model for the country. ***www. nejm.org.doi/full.10.1056/NEJMp160***

9. What statutory authorities do you need to remove employees who are low-performing and/or not working in the best interest of America's veterans?
Response: I know that the vast majority of the VA workforce is highly professional, motivated to taking care of our veterans and the cream of the crop. There are times when employees get off track and need help in either getting back on track or moving out of the VA. While we already have and leverage existing laws to help move off track employees out of the workforce, additional legislation is needed. More specifically:

   - The Choice Act VA needs to be modified specific to SES removal procedures to ensure constitutionality.
   - The Merit Systems Protection Board need to be directed to a lower burden of proof and deference to the agency's choice of penalty.
   - We need the authority to use indefinite suspensions where there is reasonable cause to believe an employee has done something to harm or endanger a patient or a coworker.
   - 5 U.S.C. 7511(a)(1)(A), (B), and (C) and 5 C.F.R. 752.401(2), (3) and (5) need modified to allow those individuals serving a probationary period or on a temporary appointment to be separated without full due process and appeal rights.

10. The Veteran Success on Campus (VSOC) program has been widely successful and there are many campuses, like West Virginia University, that meet the requirements for VSOC, but still are on the wait list. Will you commit to supporting additional funding in The President's FY18 budget that will make it so more of our nation's veterans have access to this program?
Response: Vocational Rehabilitation and Employment (VR&E) Service currently maintains a list of 175 schools that have expressed an interest in becoming a VetSuccess on Campus (VSOC) site. We are looking at opportunities to fill select additional VSOC positions if this approved in the FY 18 budget.

11. Both Healthnet and TriWest have a footprint in West Virginia and my office has received complaints about the inability to reach a representative by phone and the lengthy approval process. Lengthy approval times often lead to a financial burden on the veteran and their family. Please elaborate on what VA is currently doing and what you envision VA will do when contracting with third party administrators in the future?
Response: VA recognizes that there have been issues with customer service and timeliness of authorizations for care into the community. VA is actively

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engaged with both (Third Party Administrators (TPAs)) to improve service and reach our united goal of providing the best health care experience for our Veterans and the providers who care for them. In October 2016, VA and Health Net agreed to an expedited payment plan to assure community providers can continue serving our nation's Veterans. VA has also formed a provider rapid response team to address provider issues brought to the attention of Community Care. The team's goal is to respond to providers within 72 hours, and the team engages individually with each provider to resolve problems and works with the TPAs to complete payments where appropriate. VA is also offering more Provider education on how the billing and payment processes work to help reduce problems. Since late 2016, all correctly submitted/clean provider claims are being paid timely (within 30 days). Claims that are rejected and denied due to errors require additional interaction on both sides and result in delays and reprocessing of claims.

VA has partnered with the TPAs to embed staff in over 40 VA medical centers to improve the communication and coordination of care for veterans. We continue to grow that number and we will certainly look into creating this type of service in West Virginia.

Daily monitoring of the contract via VA contract officer representatives and the TPA operations staff occurs to resolve issue and ensure Veterans are receiving timely access to health services. VA representatives are engaging in weekly correspondence with each contractor on issues of performance not meeting contract specifications. VA will also continue to issue letters of corrections in areas where performance is subpar.

The future Community Care Network returns the Veteran communications, scheduling, customer service, and care coordination to the VAMCs. Based on lessons learned with the current contracts, VA will utilize the new contracted networks to assure that Veterans receive care in the community while not relying on other parties for these very important functions.

12. What do you believe are the factors that create appointment wait times and how do you plan on mitigating those factors to ensure timely, quality care for our nation's veterans?

13. Will you commit to ensuring that VA continues to invest in the veteran transportation program?
Response: Yes, I commit to continuing the Veterans Transportation Service that transports Veterans to and from their appointments, especially, in rural areas where both community care and VA care are less available. This is an area in which we have been able to partner with our VSO groups.

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14. With VA's expertise on substance abuse and the Department's robust Office of Research and Development, I believe that you are well equipped to be on the forefront of alterative pain therapy research for the entire country. Please elaborate on how you will increase the number of alternative treatments for pain management. What investments will you make and are there authorities you need from Congress?
Response: In response to Section 932 of the Comprehensive Addiction and Recovery Act (CARA), VA developed an ambitious plan to expand research, education, and clinical delivery of complementary and integrative health (CIH) approaches for pain management as well as mental health. The Integrative Health Coordinating Center in the Office of Patient Centered Care & Cultural Transformation is working to make the evidence-based CIH approaches—including acupuncture, chiropractic, yoga, tai chi, meditation, and massage—more widely available to veterans nationally. Our commitment is that every medical center will offer at least two of these therapies routinely for veterans with pain. In addition, the Office of Research and Development is collaborating with the National Center of Complementary and Integrative Health at NIH and the DoD to fund a large research initiative supporting demonstration projects developing the most effective ways to deliver CIH for pain in our military populations

15. The Department of Veterans Affairs is often charged with having a corrosive culture that breeds unethical, and sometimes unlawful, behavior that is not veteran-centric. While there have been improvements under Secretary McDonald's leadership, there is still work to be done. What are specific actions that you will implement to ensure that the culture of VA will continue to improve?
Response: Employees want to work in an environment where they have the tools and resources they need to be able to serve their patients. As a health care executive this is what the type of environment I strive to have for our staff and their patients. Employees want a place that has systems that work, co-workers that are well trained and supported, and a culture of respect. If confirmed as Secretary, I would work hard to have a work environment that supports our staff and allows them to do their best for our veterans. Part of what is needed is to be able to support, retain, and recognize those employees that share the organization's values and are high performers and to be able to remove those that have strayed from these values. When people are allowed to remain in the workplace, despite poor performance or bad behavior, it is demoralizing to all employees.

16. Please elaborate on specific ways the Department of Veterans Affairs and Congress can work together to improve the claims backlog.
Response: We appreciate Congress's ongoing support for our budget for staffing, and information technology advancements and sustainment. We fully expect that as the needs arise for legislative intervention that we will be able to collaborate with members of congress to ensure that the needs of our nation's

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Veterans and their families are met with the highest level of care and compassion.

17. Do you support an expansion of the Caregivers programs beyond post-9/11 veteran era?
Response: I support programming for all caregivers of all Veterans, regardless of the Veteran's era of service or the reason why the Veteran needs the assistance of a caregiver. I cannot, however, support the expansion of the current Program of Comprehensive Assistance for Family Caregivers without considerable concern for how the cost will impact other services and supports to Veterans. VA welcomes collaboration with Congress to establish a sustainable program that provides assistance and support to all caregivers. I am exploring the option of a study to determine the cost avoidance that may be seen with the expansion of Caregivers to give us a better understanding of the true costs involved in expanding the program.

18. Do you believe there are improvements or changes that need to be made in the way VA determines service connected disabilities? Would you be open to reexamining the compensation and pension exam process?
Response: VA agrees, in principle, that there is a need for revision of the 1945 regulations that are found in 38 CFR Part 4, the VA Schedule for Rating Disabilities (VASRD). While VA has undertaken several changes, in the past, to update and clarify regulations for individual sections of 38 CFR Part 4, VA has not had major revision of VASRD that can be viewed as a complete modernization of its evaluative criteria.

In 2009, the Veterans Benefits Administration (VBA) Under Secretary for Benefits (USB), on behalf of the Secretary for Veterans Affairs (VA), directed the revision and update of the 15 body systems that are contained in the VASRD, under the authority of 38 U.S.C. § 1155. To date, VA has published for notice and commented on six of the VASRD regulations, which are currently under review for final publication. VA is working to publish proposed updates to the Federal Register for the remaining body systems. VA plans to complete these regulations by the end of 2018. Additionally, VBA continues to work to modernize efforts related to the disability evaluation process, to include accessibility to Veteran's benefits and system and procedural enhancements to improve the timeliness and quality of rating decisions.

We have consistently taken steps to improve the compensation and pension examination process. We now receive disability benefit questionnaires (DBQs) from Veterans seen by their private providers. We have increased the type of examinations that can be done by medical disability examination contract providers as well as by VHA clinicians. And we are working to implement system enhancements that more efficiently and quickly process evidence through

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automation. Finally, in FY 2016, VBA and VHA collaborated on a multi-prong Breakthrough Initiative to Improve the C&P Exam Process, and these efforts are ongoing. This included providing training to individuals involved in the C&P exam process in VBA and VHA as well as educating Veterans on what to expect before, during, and after their C&P examination.

19. The difficulty veterans face in scheduling appointments is a frequent complaint to my office. Please elaborate on ways to improve scheduling to make it easier both for VA scheduling staff and the veteran.
Response: VistA Scheduling Enhancements (VSE) is a cost-effective, interim solution built in partnership with the private sector to bring an urgently needed modern interface to the antiquated VistA scheduling package. VSE makes it easier for schedulers to schedule and coordinate follow up appointments with other Veteran appointments, keep track of Veteran appointment preferences, and reduce scheduling errors all via a simplified point and click process. VSE is currently being piloted in multiple clinical settings at five VA facilities. If the pilot is successful, VSE will be implemented nationally until a permanent and complete solution is available.

VA provides uniform face to face training that teaches all schedulers how to optimally meet all of the scheduling needs of Veterans. This training includes simulation using VA's computerized system, working through real life challenge scenarios and focusing on optimization of customer service.

Based upon Veteran feedback, VA is implementing "patient centered scheduling," whereby Veterans are offered the option to schedule follow-up appointments upon leaving clinic even when appointment needs are a year or more into the future – this replaces the "recall system" that constrained Veterans to only schedule their appointment as it got closer to their appointment date.

VA also implemented call centers for Veterans to more easily request and cancel appointments by phone.

The Veteran Appointment Request (VAR) Mobile App enables Veterans to self-schedule appointments or request someone call them to make an appointment via either a smart phone or desktop computer. The system is currently being utilized at 21 sites and is being evaluated for possible expansion.

Finally, VA has awarded a contract for a commercial scheduling package, called MASS. Mass is now being implemented in a pilot site within VA to determine how it functions and compares to the alternatives detailed above. A off the shelf system, while more costly, might be the best solution to VA's long standing scheduling issues.

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20. What are ways that you would like to see access to Mental Health improve? What is being done to help prevent the overprescribing of opioids and benzodiazepines?

Response: Timely access so high-quality mental health care is an imperative for VHA. As of December 31, 2016, every VA Medical Center endorsed their capability to provide same-day mental health services to Veterans in urgent need. This represents a critical first step in our MH access plans but it is only the beginning. Veterans do not only need access to an appointment, they need access to a full episode of care which may require a succession of appointments over a short period of time. VHA is already the nation's leader in integrating mental health services in primary care teams, an effort we continue to expand. In addition, we are rapidly expanding telemental health care across the system to expand capacity as well as making improvements in the CHOICE program when community providers are the best match to a Veteran's needs. Such demands can be a major obstacle to seeking care for many Veterans and can be overcome by delivering telemental health services directly to their homes, offices, or even to their parked cars. Finally, we are ensuring that expanded access means high quality, evidence-based, compassionate care which ensures a steady increase in trust, compliance, continuity, satisfaction and clinical outcomes.

As of December 31, 2016, every VA Medical Center has the capability to provide urgent mental health services to Veterans in urgent need. This represents a critical first step in our MH access plans but it is only the beginning. Veterans do not only need access to an appointment, they may require a succession of appointments over a short period of time. VA's CHOICE program must also be improved to ensure that administrative steps do not impede prompt access to community mental health providers when they are the best match to a Veteran's needs. Further, we must continue to develop our telemental health hub network to ensure that Veterans can receive MH services when and where they need and prefer them. This is particularly important for Rural Veterans but is also of significant value for Veterans who can't miss work or school or leave dependent children at home while they travel to VA. Such demands can be a major obstacle to seeking care for many Veterans and can be overcome by delivering telemental health services directly to their homes, offices or even to their cell phones. VA is already a leader in integrating Mental Health services in Primary Care settings across the nation but we need to further develop this capacity. Our more than 1,000 Mental Health Peer Support Specialists in Mental Health (and in many Primary Care) Clinics serve as mental health navigators to further enhance access and continuity of Mental Health care but we have a need to enhance their training and increase their numbers and reach across VA. Finally, we must ensure that Mental Health access in VA means access to high-quality, evidence-

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based, compassionate care which ensures a steady increase in trust, compliance, continuity, satisfaction, and clinical outcomes. This will require additional hires, expansion of available Mental Health disciplines (including the current 'mission critical occupations' of psychologists and psychiatrists, as well as Licensed Professional Mental Health Counselors, Marriage and Family Therapists, Social Workers, Vocational Rehabilitation Specialists, Addictions Specialists, Advance Practice Mental Health Nurses, Psychiatric Physician Assistants, and Clinical Pharmacists). Full staffing, a full array of services, and enhanced availability across the nation are key components of VA's Mental Health Access improvement plan.

21. In the past, you have stated that you would not have used the "40 mile" and "30 day" rule if you had designed the Choice program. Please elaborate on how you would like to see Choice fixed and what measures you would use in considering eligibility for referral to care in the community?
Response: I know of no health system that has designed a system around mileage and wait times. The reason I believe we must look at alternatives to these criteria is that mileage and wait times do not differentiate between veterans that need urgent care and veterans that desire elective care. Such a system also does not differentiate between those that have other healthcare options available to them and those that have none. We are embarking upon an exploration of a number of different models that would propose alternative criteria and then we would need to get veteran input into these models. We also need to do economic modeling of these models to determine the cost of new options. Once we have completed this initial work we would begin to socialize our ideas with veterans, veteran service organizations, member of Congress and the Administration, and our staff.

22. A frustration that many veterans have is that even though there is a VA regional office in their community, they have to contact a call-center to get an update on the status of their claim or to ask questions. How can the Veterans Benefits Administration be more accessible to veterans directly? Furthermore, have you considered embedding VBA counselors in VA Medical Centers to help veterans and their families understand their benefits during a hospitalization?
Response: Besides our national call centers; every regional office has a public contact team that can assist Veterans and claimants with submitting claims for benefits or getting a status on their claim. VA continues to look for ways to increase access to Veterans. Many of the VA Medical Centers do have VBA personnel onsite on an adhoc basis to assist with claims related questions. Any expansion would require balancing of available resources. Finally, VA cultivates close partnerships with Veterans Service Organizations, which help Veterans and their families understand and navigate VA benefit programs.

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 5/13/2017 10:36:48 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: Do you know your flight

Yes

Sent from my iPhone

> On May 13, 2017, at 5:19 PM, Poonam Alaigh <(b) (6) n@hotmail.com> wrote:
>
> To Boston- are you leaving on Tuesday- if so I can try to coordinate so we are on the same one
>
> Sent from my iPhone

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Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 5/13/2017 9:19:37 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Do you know your flight

To Boston- are you leaving on Tuesday- if so I can try to coordinate so we are on the same one

Sent from my iPhone

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Message

From: Bruce Moskowitz [brucem(b) (6) mac.com]
Sent: 6/11/2017 10:23:50 AM
To: Poonam Alaigh [(b) (6) @hotmail.com]
CC: David shulkin [drshulkin@aol.com]
Subject: 1030 call in number

(b) (6) access (b) (6)

Sent from my iPhone

On Jun 10, 2017, at 7:30 PM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:

> Completely agree- let's discuss tomorrow before our 11am- what time should we get on the call- should we use the same call in number?
>
> Sent from my iPhone
>
> On Jun 10, 2017, at 7:28 PM, Bruce Moskowitz <brucem(b) (6) mac.com> wrote:
>
> > I have been in contact with the most knowledgeable physician in telemedicine (b) (6) and will contact the head of Yale Psychiatry who was in charge of the research. Our best chance is to assemble a team quickly to get it done. We do not need to do more research we need to act.
> >
> > Sent from my iPad
> > Bruce Moskowitz M.D.
> >
> > On Jun 10, 2017, at 7:22 PM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:
> >
> > > Yes of course- I just cut and paste the link
> > >
> > > Sent from my iPad
> > >
> > > On Jun 10, 2017, at 7:21 PM, Marc Sherman <mbs(b) (6) gmail.com> wrote:
> > >
> > > > Agree... Except for the forwarding part of course.
> > > >
> > > > Marc Sherman
> > > > (b) (6)
> > > >
> > > > On Jun 10, 2017 7:20 PM, "Poonam Alaigh" <(b) (6) @hotmail.com> wrote:
> > > > This is really good- I will forward to my VA team.
> > > > Thanks a ton
> > > >
> > > > Sent from my iPad
> > > >
> > > > On Jun 10, 2017, at 10:20 AM, Bruce Moskowitz <brucem(b) (6) mac.com> wrote:

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Again Kaiser is at forefront with mental health telemedicine. They offer this 24-7. This is what needs to get done and include the DOD.

I thought you would be interested in the following story from The Wall Street Journal.

Medical Care Means Mental Health, Too

https://www.wsj.com/article_email/medical-care-means-mental-health-too-1497037174-lMyQjAxMTE3MTE3MDgxNDAwWj/

Download the Wall Street Journal app here: WSJ.

Sent from my iPad
Bruce Moskowitz M.D.

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 2/26/2017 2:10:55 AM
To: IP [(b)(6)@frenchangel59.com]
Subject: Re: Designs on the V.A. - The New York Times

Yes a good article- this is the team that (b) (6) leads- the US digital team

Thanks for letting me know

David

Sent from my iPhone

On Feb 25, 2017, at 7:21 PM, IP <(b)(6)@frenchangel59.com> wrote:

> David,
>
> I don't know if you saw this article.
>
> Have a nice weekend.
>
> Ike
>
> https://www.nytimes.com/2017/02/24/opinion/designs-on-the-va.html?action=click&pgtype=Homepage&clickSource=story-heading&module=opinion-c-col-left-region&_r=0

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Message

From: IP [[redacted]@frenchangel59.com]
Sent: 2/26/2017 12:21:49 AM
To: David shulkin [drshulkin@aol.com]
Subject: Designs on the V.A. - The New York Times

David,

I don't know if you saw this article.

Have a nice weekend.

Ike

https://www.nytimes.com/2017/02/24/opinion/designs-on-the-va.html?action=click&pgtype=Homepage&clickSource=story-heading&module=opinion-c-col-left-region&_r=0

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 5/25/2017 11:40:44 PM
To: Bruce Moskowitz [brucem(b) (6) mac.com]
Subject: Re: (No Subject)

Just saw this- so we are all set

David

Sent from my iPhone

On May 25, 2017, at 7:33 PM, Bruce Moskowitz <brucem(b) (6) mac.com> wrote:

> Yes just sent you an email for June 19 call with the two principals (b) (6) and (b) (6) rd
>
> Sent from my iPhone
>
> On May 25, 2017, at 6:15 PM, David shulkin <Drshulkin@aol.com> wrote:
>
> > Do we have a coNtact at AU yet? They do have an IPA we can use
> >
> > Sent from my iPhone
> >
> > Begin forwarded message:
> >
> > **From:** "(b) (6) (b) (6) R." (b) (6) @va.gov>
> > **Date:** May 25, 2017 at 6:08:49 PM EDT
> > **To:** DJS <vacodjs1@va.gov>, "'drshulkin@aol.com'" <drshulkin@aol.com>
> > **Subject: FW: (No Subject)**
> >
> > Reminder when you connect with Bruce
> >
> > ---
> >
> > **From:** Mitchell, Pam
> > **Sent:** Thursday, May 25, 2017 6:05 PM
> > **To:**
> > **Cc:** (b) (6)
> > **Subject:** FW: (No Subject)
> >
> > **Hi, (b) (6) –**
> >
> > **Please see below. Do you know who Dr. Shulkin spoke with at AU, or can you find out?**
> >
> > **Thanks**
> > **Pam**
> >
> > ---
> >
> > **From:** Mitchell, Pam
> > **Sent:** Wednesday, May 24, 2017 10:10 AM

AMERICAN OVERSIGHT

To: DJS
Cc: (b) (6) Bonjorni, Jessica (WMC); Alaigh, Poonam, M.D.
Subject: RE: (No Subject)

Dr. Shulkin –

American University has an IPA agreement with another Federal agency, which we can also use. I will get this moving. Is there a specific contact at AU who reached out to you with whom we can follow up?

Thank you
Pam

From: DJS
Sent: Tuesday, May 23, 2017 5:16 PM
To: Mitchell, Pam
Subject: RE: (No Subject)

Thanks

Sent with Good (www.good.com)

-----Original Message-----
From: Mitchell, Pam
Sent: Tuesday, May 23, 2017 05:00 PM Eastern Standard Time
To: (b) (6) DJS
Cc: Alaigh, Poonam, M.D.; Bonjorni, Jessica (WMC)
Subject: RE:

I'll check with the team to see if we have an existing IPA with AU.

-----Original Message-----
From: (b) (6)
Sent: Tuesday, May 23, 2017 3:24 PM
To: DJS; Mitchell, Pam
Cc: Alaigh, Poonam, M.D.; Bonjorni, Jessica (WMC)
Subject: RE:

We could use an IPA bring in employees of AU; for students, we'll need to look at other options. I would be happy to talk to AU. Is there a POC I can reach out to?

Many thanks,

(b)

-----Original Message-----
From: DJS
Sent: Tuesday, May 23, 2017 3:13 PM
To: Mitchell, Pam
Cc: (b) (6) Alaigh, Poonam, M.D.

AMERICAN OVERSIGHT

Subject:

(b) are we able to use an IPA with American University to get some additional help into HR -

Sent with Good (www.good.com)

AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [brucem(b) (6) mac.com]
Sent: 5/25/2017 11:33:57 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: (No Subject)

Yes just sent you an email for June 19 call with the two principals (b) (6) and (b) (6)

Sent from my iPhone

On May 25, 2017, at 6:15 PM, David shulkin <Drshulkin@aol.com> wrote:

> Do we have a coNtact at AU yet? They do have an IPA we can use
>
> Sent from my iPhone
>
> Begin forwarded message:
>
> **From:** "(b) (6) (b) (6) R." (t(b) (6) va.gov>
> **Date:** May 25, 2017 at 6:08:49 PM EDT
> **To:** DJS <vacodjs1@va.gov>, "'drshulkin@aol.com'" <drshulkin@aol.com>
> **Subject: FW: (No Subject)**
>
> Reminder when you connect with Bruce
>
> ---
>
> **From:** Mitchell, Pam
> **Sent:** Thursday, May 25, 2017 6:05 PM
> **To:**
> **Cc:** (b) (6)
> **Subject:** FW: (No Subject)
>
> **Hi, (b) (6) –**
>
> **Please see below. Do you know who Dr. Shulkin spoke with at AU, or can you find out?**
>
> **Thanks**
> **Pam**
>
> ---
>
> **From:** Mitchell, Pam
> **Sent:** Wednesday, May 24, 2017 10:10 AM
> **To:** DJS
> **Cc:** (b) (6) Bonjorni, Jessica (WMC); Alaigh, Poonam, M.D.
> **Subject:** RE: (No Subject)
>
> **Dr. Shulkin –**
>
> **American University has an IPA agreement with another Federal agency, which we can also use. I will get this moving. Is there a specific contact at AU who reached out to you with whom we can follow up?**

AMERICAN OVERSIGHT

Thank you
Pam

From: DJS
Sent: Tuesday, May 23, 2017 5:16 PM
To: Mitchell, Pam
Subject: RE: (No Subject)

Thanks

Sent with Good (www.good.com)

-----Original Message-----
From: Mitchell, Pam
Sent: Tuesday, May 23, 2017 05:00 PM Eastern Standard Time
To: (b) (6) DJS
Cc: Alaigh, Poonam, M.D.; Bonjorni, Jessica (WMC)
Subject: RE:

I'll check with the team to see if we have an existing IPA with AU.

-----Original Message-----
From: (b) (6)
Sent: Tuesday, May 23, 2017 3:24 PM
To: DJS; Mitchell, Pam
Cc: Alaigh, Poonam, M.D.; Bonjorni, Jessica (WMC)
Subject: RE:

We could use an IPA bring in employees of AU; for students, we'll need to look at other options. I would be happy to talk to AU. Is there a POC I can reach out to?

Many thanks,

(b)

-----Original Message-----
From: DJS
Sent: Tuesday, May 23, 2017 3:13 PM
To: Mitchell, Pam
Cc: (b) (6) Alaigh, Poonam, M.D.
Subject:

Paula- are we able to use an IPA with American University to get some additional help into HR -

Sent with Good (www.good.com)

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 5/25/2017 10:15:30 PM
To: Bruce Moskowitz [brucem(b) (6) mac.com]
Subject: Fwd: (No Subject)

Do we have a coNtact at AU yet? They do have an IPA we can use

Sent from my iPhone

Begin forwarded message:

From: "(b) (6) (b) (6) R." (b) (6) va.gov>
Date: May 25, 2017 at 6:08:49 PM EDT
To: DJS <vacodjs1@va.gov>, "'drshulkin@aol.com'" <drshulkin@aol.com>
Subject: FW: (No Subject)

Reminder when you connect with Bruce

From: Mitchell, Pam
Sent: Thursday, May 25, 2017 6:05 PM
To:
Cc: (b) (6)
Subject: FW: (No Subject)

Hi, (b) (6) –

Please see below. Do you know who Dr. Shulkin spoke with at AU, or can you find out?

Thanks
Pam

From: Mitchell, Pam
Sent: Wednesday, May 24, 2017 10:10 AM
To: DJS
Cc: (b) (6) Bonjorni, Jessica (WMC); Alaigh, Poonam, M.D.
Subject: RE: (No Subject)

Dr. Shulkin –

American University has an IPA agreement with another Federal agency, which we can also use. I will get this moving. Is there a specific contact at AU who reached out to you with whom we can follow up?

Thank you
Pam

From: DJS
Sent: Tuesday, May 23, 2017 5:16 PM
To: Mitchell, Pam
Subject: RE: (No Subject)

AMERICAN OVERSIGHT

Thanks

Sent with Good (www.good.com)

-----Original Message-----
From: Mitchell, Pam
Sent: Tuesday, May 23, 2017 05:00 PM Eastern Standard Time
To: (b) (6) DJS
Cc: Alaigh, Poonam, M.D.; Bonjorni, Jessica (WMC)
Subject: RE:

I'll check with the team to see if we have an existing IPA with AU.

-----Original Message-----
From: (b) (6)
Sent: Tuesday, May 23, 2017 3:24 PM
To: DJS; Mitchell, Pam
Cc: Alaigh, Poonam, M.D.; Bonjorni, Jessica (WMC)
Subject: RE:

We could use an IPA bring in employees of AU; for students, we'll need to look at other options. I would be happy to talk to AU. Is there a POC I can reach out to?

Many thanks,

(b)

-----Original Message-----
From: DJS
Sent: Tuesday, May 23, 2017 3:13 PM
To: Mitchell, Pam
Cc: (b) (6) Alaigh, Poonam, M.D.
Subject:

(b) are we able to use an IPA with American University to get some additional help into HR -

Sent with Good (www.good.com)

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 2/5/2017 3:44:58 PM
To: (b) (6) [(b) (6) @gmail.com]
Subject: Re: Here are the additional Brown questions

Im not 100 percent sure- can you send me back what you have from Brown ?

Sent from my iPhone

On Feb 5, 2017, at 10:20 AM, (b) (6) <(b) (6) @gmail.com> wrote:

> On Brown, does this mean that you were ok with the other questions? And no other edits.
>
> On Feb 4, 2017 3:14 PM, "David Shulkin" <drshulkin@aol.com> wrote:
> After you get these, I am waiting for you to double check your list and see if I have missed any.
>
> I think I may have gotten them all- but my list only adds up to 11 members.
>
> We still have Senator Baldwins that we are going to return separately and are not included in the Committee member questions

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Message

From: (b) (6) [(b) (6) @gmail.com]
Sent: 2/5/2017 3:20:06 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Re: Here are the additional Brown questions

On Brown, does this mean that you were ok with the other questions? And no other edits.

On Feb 4, 2017 3:14 PM, "David Shulkin" <drshulkin@aol.com> wrote:

After you get these, I am waiting for you to double check your list and see if I have missed any.

I think I may have gotten them all- but my list only adds up to 11 members.

We still have Senator Baldwins that we are going to return separately and are not included in the Committee member questions

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Message

From: David Shulkin [drshulkin@aol.com]
Sent: 2/4/2017 8:14:44 PM
To: vivieca.wright@va.gov; (b) (6) @gmail.com
Subject: Here are the additional Brown questions
Attachments: posthearingBrown Supplemental Questions.docx

After you get these, I am waiting for you to double check your list and see if I have missed any.

I think I may have gotten them all- but my list only adds up to 11 members.

We still have Senator Baldwins that we are going to return separately and are not included in the Committee member questions

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Brown Supplemental Questions

Last December, ProPublica and The Virginian-Pilot issued a report, based on data gathered from VA's Agent Orange Registry, which assess that children born to servicemembers who had self-reported Agent Orange exposure during or after the Vietnam War were 34 percent more likely to have a birth defect than children born to servicemembers who had not self-reported exposure.

a. On Tuesday I received a response from VA-that you signed and your letter said VA recommended to ProPublica that the report be peer reviewed, but my question to you is if VA had been collecting this information

Response:

As was mentioned in the letter "a voluntary registry such as the Agent Orange Registry, may have bias, or a systematic deviation, that results if those who volunteer are not representative of the entire population of concern." Any research based on or conclusions that are drawn from flaws in a dataset are potentially suspect for this reason. Desiring quality data and study design, VA has initiated the Vietnam Era Health Retrospective Observational Study (VE-HEROeS). Peer review is an accepted practice to ensure scientific integrity.

b. Why did it take a FOIA request to produce a study on data that VA already had at its finger tips?

Response:

As mentioned above, the voluntary Agent Orange Registry did not provide a quality data set for research. VA has initiated the Vietnam Era Health Retrospective Observational Study with the aim to aim to develop scientific, peer-reviewed evidence that will inform policy decisions.

c. What is the timeline for VA's Agent Orange working group to review whether to include bladder cancer, hypothyroidism, Parkinson's-like symptoms, and hypertension to the list of presumptive conditions?

Response: A VA Technical Working Group has reviewed the National Academy of Medicine's Veterans and Agent Orange, Update 2014 and is in the process of drafting recommendations for the Secretary of Veterans Affairs. Every two years, National Academy of Medicine (NAM) publishes a report on Agent Orange. The newest one came out March 2016. It elevated 4 conditions where there is higher category of evidence/link to agent orange: bladder cancer, hypothyroidism, Parkinson's-like symptoms, and hypertension. VA Directive 0215 is a roadmap to how VA deals with this report from NAM. In general, there are 4 recommended steps - technical workgroup, IOM strategic workgroup, IOM taskforce, and then to the Secretary. The current VA response document has cleared the first 2 and is now at the IOM taskforce We expect the document to clear IOM taskforce by Feb 17 and then to

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the Secretary and depending upon who the Secretary is at that time it is likely to be determined within 2 months of this date. This would be approximately the end of April. Once the Secretary makes final determination, it goes to OMB before it gets published which generally takes 3-4 months.

d. I know VA has had the information from the Agent Orange Registry for years, yet VA says more research is needed, particularly from male servicemembers. These veterans and their families have waited too long for VA to do the right thing. Is the only reason VA isn't acting because of funding?

Response:

VA relies on scientific, peer-reviewed evidence to inform policy decisions, and such evidence for transgenerational effects due to Agent Orange exposure does not currently exist, as reported in the most recent Veterans & Agent Orange Report issued by the National Academy of Medicine. However, VA continuously monitors the development of new scientific approaches that may provide additional insight. If confirmed as secretary I would commit to making this determination as soon as we were able to . I would not tolerate unnecessary delays as I too believe that these veterans and families have been waiting too long..

From: Wright, Vivieca (Simpson)
Sent: Friday, February 03, 2017 6:00 PM
To: Zenooz, Ashwini; Lee, Jennifer S. (VACO)
Cc: (b) (6) (b) (6) (b) (6) (b) (6) R.; Jensen, Jon M.
Subject: QFRs for Brown

Want to make sure these are on your radar – thanks.

1. Last December, ProPublica and The Virginian-Pilot issued a report, based on data gathered from VA's Agent Orange Registry, which assess that children born to servicemembers who had self-reported Agent Orange exposure during or after the Vietnam War were 34 percent more likely to have a birth defect than children born to servicemembers who had not self-reported exposure.

a. On Tuesday I received a response from VA-that you signed and your letter said VA recommended to ProPublica that the report be peer reviewed, but my question to you is if VA had been collecting this information for over 40 years, why didn't VA initiate its own study? (Deferred to VHA)

b. Why did it take a FOIA request to produce a study on data that VA already had at its finger tips? (Deferred to VHA)

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c. What is the timeline for VA's Agent Orange working group to review whether to include bladder cancer, hypothyroidism, Parkinson's-like symptoms, and hypertension to the list of presumptive conditions?

Response: A VA Technical Working Group has reviewed the National Academy of Medicine's Veterans and Agent Orange, Update 2014 and is in the process of drafting recommendations for the Secretary of Veterans Affairs.

d. I know VA has had the information from the Agent Orange Registry for years, yet VA says more research is needed, particularly from male servicemembers. These veterans and their families have waited too long for VA to do the right thing. Is the only reason VA isn't acting because of funding? (Deferred to VHA)

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/24/2017 12:22:44 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: Promise to Veterans - like Access Declaration

Great

Sent from my iPhone

> On Jan 24, 2017, at 6:43 AM, Poonam Alaigh <(b) (6) n@hotmail.com> wrote:
>
> I am working with the team on developing a "Promise To Veteran" or something like that declaration to be delivered in 100 days- as you prepare for your hearing, please start jotting down relevant elements that you want included where we provide greater choice- we can discuss more on Thursday
>
> Sent from my iPad

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Message

From: Poonam Alaigh [(b) (6)@hotmail.com]
Sent: 1/24/2017 11:43:25 AM
To: David shulkin [drshulkin@aol.com]
Subject: Promise to Veterans - like Access Declaration

I am working with the team on developing a "Promise To Veteran" or something like that declaration to be delivered in 100 days- as you prepare for your hearing, please start jotting down relevant elements that you want included where we provide greater choice- we can discuss more on Thursday

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 3/10/2017 2:17:41 AM
To: (b) (6) [(b) (6) @me.com]
CC: (b) (6) [(b) (6) @gmail.com]
Subject: Fwd: Time-sensitive update and questions

Ill try you tommorow at 1 pm

Sent from my iPhone

Begin forwarded message:

From: "(b) (6) <(b) (6) @me.com>
Date: March 9, 2017 at 6:20:40 PM EST
To: David shulkin <Drshulkin@aol.com>
Subject: Re: Time-sensitive update and questions

David

Your choice: Friday at 1 pm or Sunday at 0930 or 1700.

(b)

From: "David J. Shulkin" <Drshulkin@aol.com>
Date: Thursday, March 9, 2017 at 6:16 PM
To: (b) (6) <(b) (6) @me.com>
Cc: <vivieca.wright@va.gov>, <gina.farisee@va.gov>
Subject: Re: Time-sensitive update and questions

(b) (6) yes im ok with them referring qualified people- the problem with (b) or others with his profile is that in these positions (assistant secretaries and above) with their connections with these companies they would be very restricted in doing business with these companies and therefore it would be hard to do these jobs since we deal alot with these companies. Im not sure they would make it through vetting either.

Im traveling until sunday with no down time except friday about 1 pm- if that does not work we could connect on sunday afternoon if that might work

Thanks again

Sent from my iPhone

On Mar 9, 2017, at 5:10 PM, (b) (6) <(b) (6) @me.com> wrote:

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David

Question

1. <!--[if !supportLists]--><!--[endif]-->I have a time-sensitive question you can answer by reply or by phone (see (b) (6) **below)**
2. <!--[if !supportLists]--><!--[endif]-->Also, speak this weekend about all of this, but also about your 60 day plan and the challenges?

Update: good news – more excellent connections and some pro bono help

1. <!--[if !supportLists]--><!--[endif]-->New information
   a. <!--[if !supportLists]--><!--[endif]-->Spoke with (b) (6) **of** (b) (6) : he has offered to ask his three (HR, GC, CIO) practice leaders to make a good effort to turn up "A" players for each functional chief, especially if such candidates are likely to be available; this is particularly helpful

   b. <!--[if !supportLists]--><!--[endif]-->Spoke with **Jim Byrne, AGC Lockheed Martin** with extensive government experience. Good vibes. Definitely changing back to some Federal agency and VA is high on his list. "Gets" what it will take to be successful for you.

      He will be connecting me to the Deputy CIO of Lockheed itself if he is open to changing plus one other CIO.

   c. <!--[if !supportLists]--><!--[endif]-->Being virtually intro'd to **CIO of Dignity Health** ((b) (6) , prospective candidate or source) and **CMedO of Tenet** (b) (6) , source or resource); expect conversations next day or three; will send c.v. if appropriate; (b) (6) (b) (6) of Dossier made the connections; he was Critelli's COO and has his own startup now.

   d. <!--[if !supportLists]--><!--[endif]-->Spoke with (b) (6) , **retired senior IBM exec**, now consulting; (b) (6) (b) (6) made the connection.

      (b) is a powerhouse and well-connected (IBM, national engineering assn, more). He offered to

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help but I asked that he wait until I reviewed it with you:

(b) is associated with two entities as sources you probably already know: Mitre Corporation's Center for Connected Government which works with VA; the new CIO, Laverne Council (formerly with the VA) and her people would be aware of qualified candidates who would, in addition in his opinion, have a good attitude toward the potential of the VA. And he is associated with Allied Research, a minority-owned firm run by two people he admires who lead a small firm focused on helping homeless vets and vets remote from facilities. **Are you ok with his polling them for candidates and referring them to me? Are you ok with one or both or neither?**

They know there is no quid pro quo and no promise of any result of their so doing. If you are ok with this, I will call him back ASAP and have him make the calls. I trust (b) to do the right thing. One of his relatives (WWII vet) was so well-treated at the end of his life that the family wrote and called VA to tell them.

(b) also added to my criteria list: candidate attitude must be that he/she will become part of the VA community and believe that the people are mostly trying to do good (unlike the focus of the press)

e. <!--[if !supportLists]--><!--[endif]-->I am now in touch with and will post you as soon as I have info:
   f. <!--[if !supportLists]--><!--[endif]-->(b) (6) **at Major Lindsey Africa (legal search firm)** <source?> via (b) (6) of McDermott Emery
   g. <!--[if !supportLists]--><!--[endif]-->(b) (6), **HR chief of American Express** <candidate> Via Centerbridge c.v. attached

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h. <!--[if !supportLists]--><!--[e[redacted] **of Isaacson Miller** (search firm: not for profits) <source?> via [redacted]

2. <!--[if !supportLists]--><!--[endif]-->Am available for phone call this evening, tomorrow evening and at other times and on Sunday. Presume you have your own timetable for contacting people whose c.v.'s I previously sent ([redacted] et al).

Best,

[redacted]

[redacted]
O. [redacted] | M. [redacted] | F. [redacted]
www.s[redacted].com

Chair, Vistage CEO Board NYC Metro (CEO peer advisory board)

President: The Point Group Network (private CEO coach network)

Member: Business Executives for National Security

Former Host: Master Class (CEO interview with student Q&A series at Pace University)

Former Board Member: Harvard Community Partners (pro bono alumni service for not for profit leaders in CT)

Random House Author: what made jack welch JACK WELCH, How Ordinary People Become Extraordinary Leaders (Random House 2007)

<[redacted] Resume March 2017.pdf.pdf>

<[redacted] resume.pdf.pdf>

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<Heslop convo.docx>

<Bio Byrne_one pg_Sep 21.docx>

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/10/2017 12:45:06 AM
To: (b) (6) [(b) (6) @gmail.com]

Can you see how i can get a copy of a recent pay stub to see how much i am getting paid and whats being deducted?

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 2/21/2017 12:38:53 PM
To: (b) (6) [(b) (6) @gmail.com]
Subject: Fwd: FEEDBACK | a great idea on tele health
Attachments: 100daysrevisedgadeedits2.docx; Untitled attachment 15526.htm

Print attachment

Sent from my iPhone

Begin forwarded message:

From: "(b) (6) <(b) (6)@mayo.edu>
Date: February 20, 2017 at 8:58:00 AM EST
To: David Shulkin <drshulkin@aol.com>, "mbs(b) (6) gmail.com" <mbs(b) (6) gmail.com>
Cc: "(b)@frenchangel59.com" <(b)@frenchangel59.com>, "brucem(b) (6) mac.com" <brucem(b) (6) mac.com>
Subject: FEEDBACK | a great idea on tele health

Hi – thank you Dr. Shulkin; included w/in the attached document are some suggested edits.

You both are better positioned to know which of these merit inclusion based on your priorities and understanding of the context of the VA/what you hope to articulate to the President in your update. My edits reflect how best to position the public side of the message; and the priorities expressed by the "group of five academic medical center organizations."

Happy to modify or talk more in follow-up as you feel is warranted.

Thanks, (b)

From: David Shulkin [mailto:drshulkin@aol.com]
Sent: Sunday, February 19, 2017 1:21 PM
To: mbs(b) (6) gmail.com
Cc: (b)@frenchangel59.com; brucem(b) (6) mac.com; (b) (6)
Subject: Re: a great idea on telehealth

Ike, Marc, Bruce and (b)

Attached is a revised list of actionable items for POTUS and a second one for SecVA.

As I mentioned on the call (and (b) hopefully Bruce was able to connect with you)- this is meant to be a starting place and the messaging has to be right. I think if the President can talk about how these actions are delivering on his promise of his 10 point plan its even better.

Thanks again to all and I look forward to seeing your edits.

David

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-----Original Message-----
From: Marc Sherman <mbs(b) (6) gmail.com>
To: David shulkin <Drshulkin@aol.com>
Cc: Ike Perlmutter <[redacted]@frenchangel59.com>; Bruce Moskowitz <brucem(b) (6) mac.com>
Sent: Sun, Feb 19, 2017 11:03 am
Subject: Re: a great idea on telehealth

I have some thoughts on this Executive Order (EO) you proposed, with the caveat that I am not a constitutional lawyer. Please also know that I am providing these thoughts to spur the discussion **so the solution can be chosen with as much likelihood of success as possible**, not to stifle it or the need to clear implement telemedicine.

It seems to me that an EO to allow telemedicine to be conducted by a doctor **from one VA facility to a doctor at another VA** facility is no problem. Although, do you really need an EO for that? It seems you could do that without an EO. I wonder if an EO from a doctor at a VA facility to a doctor at a private facility would carry the day. I predict that it will challenged by the states. I am not suggesting that the states win that challenge, but I do think it will be controversial, time consuming and take focus away. Any reaction or further thoughts? Also, what other EOs could advance the ball faster?

On Fri, Feb 17, 2017 at 9:01 PM, David shulkin <Drshulkin@aol.com> wrote:
Ike- here is one additional action item to consider- an executive order from POTUS
to expand access for veterans by giving VA the ability to do telemedicine across state lines- it would be a big help.

Just an idea

David

DRAFT

Executive Order to allow VA Doctors Freedom to Deliver Telehealth care to Veterans

Many of our Veterans currently have to travel hundreds of miles to see their VA doctor. Red tape is keeping our VA physicians from using technology, in the form of telemedicine, to care for our Veterans using their mobile phone or computers.

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered as follows:

A Department of Veterans Affairs health care professional may practice the health care profession of the health care professional at any location in any State, regardless of where such health care professional or the patient is located, when the health care professional is using telemedicine to provide treatment to an individual.

Department health care professional' means a health care professional who is--

(A) authorized by the Secretary to provide health care under this chapter; and

(B) is appointed by the Department under title 5 or title 38, United States Code.

The health care professional would be required to adhere to all quality standards relating to the provision of telemedicine in accordance with applicable policies of the Department; and would be required to have an active, current, full, and unrestricted license, registration, or certification in a State to practice the health care profession of the health care professional. **VA providers who are covered**

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by the Federal Tort Claims Act when caring for patients in person would similarly be covered when delivering care via telemedicine to a patient no matter where the provider or patient is located.

VA providers who meet the above requirements, and who are also participating in and checking their state PDMP, would also be exempt from conducting at least 1 in-person medical examination with a patient before prescribing them a controlled substance, which currently requires veterans to travel hundreds of miles to a VA facility in order to receive needed care.

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OBJECTIVE	DESCRIPTION	FORMAT	DATE	100 DAY MESSAGE
Improve Access to Care	Enhance digital healthcare delivery – permit ~~Allow for~~ VA doctors nationwide to provide telehealth services into veterans homes using digital and telecommunications technology – make pain management of focus of those efforts. ~~and phone and allow for VA doctors to manage pain better through telehealth~~	POTUS Executive Order	Early March	Provide Immediate Access to veterans who are waiting for care- through use of technology and best doctors Complete a "community by community assessment of the healthcare capacity" and continue to increase number of community provider/care partners where there are gaps
Provide modern and efficient facilities for veterans	Announce a private-public partnership model in Omaha Nebraska to ensure "best use of taxpayer dollars" and afford convenient, timely access for veterans to the highest quality health care. that would alleviate the need for a new hospital facility and instead provide veterans with modern ambulatory care- using 10% of the money allocated and private funds to build the rest	POTUS Announcement	Early March	Stop business as usual and start to show how private sector practices can benefit veterans and taxpayers – the approach will ensure "best use of taxpayer dollars" and afford convenient, timely access for veterans to the highest quality health care.
Give veterans more choice for selecting their care	Seeking swift action by Congress to authorize legislation for expanding	POTUS Announcement	Before March 7th	Congress needs to act both to extend the current Choice program

Commented [(b)]: Would encourage "improved" vs. immediate – "immediate" is a high bar that may or may not be met in all cases – "improved" gives room to make improvements.

AMERICAN OVERSIGHT

	choice options for veterans to be signed immediately by the President			which ends August 7th but also to offer legislation for a better program for veterans
Eliminate Fraud and Abuse	President directs the Secretary to establish a special advisor reporting to the Secretary to ensure aggressive action to identify fraud and abuse	POTUS Announcement	Early March	Part of his 10 point plan to address this issue
Make VA employees accountable	Encourage Congress to work with Secretary of VA to get meaningful Accountability reform passed and he would sign immediately	POTUS Announcement	House planning on passing a bill March 14th	Allows the Secretary to remove bad employees and would help to retain and recruit high quality staff
Create closer collaboration between VA and DOD	President to direct the SecDef and SecVA to present him with recommendations within 120 days for improved flow of medical record information and for better transitioning from service to VA	POTUS Announcement	June 1st	May address the medical records issue by providing a mechanism for VA to use the DOD electronic medical records contract and therefore avoid a lengthy contracting process
Be more responsive to Veteran issues and problem resolution	Install the White House/VA Hotline	POTUS to announce the date of the hotline	June 2017	Faster problem resolution and visibility by the WH

Commented [(b)]: Insert – we've put a system in place to ensure that problems are addressed in timely fashion; that those responsible for decisionmaking have the information/context to formulate timely solutions in response.

AMERICAN OVERSIGHT

VA SECRETARY PLANS TO COMPLIMENT PRESIDENT's ACTIONS

OBJECTIVE	DESCRIPTION	FORMAT	DATE	100 DAY MESSAGE
Get decisions sooner to veterans on benefits	VA Benefits is going paperless and automating its systems	SecVA Announcement	March	Part of our benefits modernizations approach
Modernize our IT systems	Work to replace our current older systems. Work with tech industry to find solutions for our veterans	SecVA Announcement	July 1at	Build and begin to implement IT strategy that markedly improves appointment scheduling, billing, electronic health record, quality of care.
Zero Suicide Approach to Mental Health	Launch an aggressive new approach for suicide prevention	SECVA Announcement	April	
Appeals Modernization To reduce the time waiting for appeal decisions	Encourage Congress to adopt VA Appeal legislation	SECVA Messaging	March	
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AMERICAN OVERSIGHT

	partners like the Cohen Veteran network			
Make VA more efficient for better service to veterans	Work on organizational restructuring through the VA Modernization office and announce plans for supply chain and contract management improvements	SECVA Messaging	June	
Bring new talent to help lead VA	Announcement cooperation with leading AMC's and professional organizations	SECVA Announcement	May	Improve the leadership, talent pool, bringing more seasoned, strategic talent to key positions to advance the VA Build a companion strategy that "brings Dr. Shulkin to the 365K employees" – provide forums for him to engage the entire VA; and motivate, engage top leadership, then cascade those conversations to subsets of the organizational structure
Insert				

Commented [(b)]: Insert – Build and implement comprehensive communications strategy to change the dialogue nationally about the VA

A subset of that – bring more talent, w/ strong strategic capability to the VA Communications/PRF

A second subset – develop and impellent VA Communications Fellowship program that brings talent from associated academic medical centers to VA on a regular basis and is associated w/ or sanctioned by the White House fellowship program

AMERICAN OVERSIGHT

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 2/20/2017 4:14:14 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Fwd: FEEDBACK | a great idea on tele health
Attachments: 100daysrevisedgadeedits2.docx; Untitled attachment 15531.htm

Sent from my iPhone

Begin forwarded message:

From: "(b) (6) <(b) (6)@mayo.edu>
Date: February 20, 2017 at 8:58:00 AM EST
To: David Shulkin <drshulkin@aol.com>, "(b) s(b) (6) gmail.com" <mbs(b) (6) gmail.com>
Cc: "(b)@frenchangel59.com" <(b)@frenchangel59.com>, "brucem(b) (6) mac.com" <brucem(b) (6) mac.com>
Subject: FEEDBACK | a great idea on tele health

Hi – thank you Dr. Shulkin; included w/in the attached document are some suggested edits.

You both are better positioned to know which of these merit inclusion based on your priorities and understanding of the context of the VA/what you hope to articulate to the President in your update. My edits reflect how best to position the public side of the message; and the priorities expressed by the "group of five academic medical center organizations."

Happy to modify or talk more in follow-up as you feel is warranted.

Thanks, (b)

From: David Shulkin [mailto:drshulkin@aol.com]
Sent: Sunday, February 19, 2017 1:21 PM
To: mbs(b) (6) gmail.com
Cc: (b)@frenchangel59.com; brucem(b) (6) mac.com; (b) (6)
Subject: Re: a great idea on telehealth

Ike, Marc, Bruce and (b)

Attached is a revised list of actionable items for POTUS and a second one for SecVA.

As I mentioned on the call (and (b) hopefully Bruce was able to connect with you)- this is meant to be a starting place and the messaging has to be right. I think if the President can talk about how these actions are delivering on his promise of his 10 point plan its even better.

Thanks again to all and I look forward to seeing your edits.

David

AMERICAN OVERSIGHT

-----Original Message-----
From: Marc Sherman <mbs(b) (6) gmail.com>
To: David shulkin <Drshulkin@aol.com>
Cc: Ike Perlmutter <[redacted]@frenchangel59.com>; Bruce Moskowitz <brucem(b) (6) mac.com>
Sent: Sun, Feb 19, 2017 11:03 am
Subject: Re: a great idea on telehealth

I have some thoughts on this Executive Order (EO) you proposed, with the caveat that I am not a constitutional lawyer. Please also know that I am providing these thoughts to spur the discussion **so the solution can be chosen with as much likelihood of success as possible**, not to stifle it or the need to clear implement telemedicine.

It seems to me that an EO to allow telemedicine to be conducted by a doctor **from one VA facility to a doctor at another VA** facility is no problem. Although, do you really need an EO for that? It seems you could do that without an EO. I wonder if an EO from a doctor at a VA facility to a doctor at a private facility would carry the day. I predict that it will challenged by the states. I am not suggesting that the states win that challenge, but I do think it will be controversial, time consuming and take focus away. Any reaction or further thoughts? Also, what other EOs could advance the ball faster?

On Fri, Feb 17, 2017 at 9:01 PM, David shulkin <Drshulkin@aol.com> wrote:
Ike- here is one additional action item to consider- an executive order from POTUS
to expand access for veterans by giving VA the ability to do telemedicine across state lines- it would be a big help.

Just an idea

David

DRAFT

Executive Order to allow VA Doctors Freedom to Deliver Telehealth care to Veterans

Many of our Veterans currently have to travel hundreds of miles to see their VA doctor. Red tape is keeping our VA physicians from using technology, in the form of telemedicine, to care for our Veterans using their mobile phone or computers.

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered as follows:

A Department of Veterans Affairs health care professional may practice the health care profession of the health care professional at any location in any State, regardless of where such health care professional or the patient is located, when the health care professional is using telemedicine to provide treatment to an individual.

Department health care professional' means a health care professional who is--

(A) authorized by the Secretary to provide health care under this chapter; and

(B) is appointed by the Department under title 5 or title 38, United States Code.

The health care professional would be required to adhere to all quality standards relating to the provision of telemedicine in accordance with applicable policies of the Department; and would be required to have an active, current, full, and unrestricted license, registration, or certification in a State to practice the health care profession of the health care professional. **VA providers who are covered**

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by the Federal Tort Claims Act when caring for patients in person would similarly be covered when delivering care via telemedicine to a patient no matter where the provider or patient is located.

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Insert				

Commented [(b)(6)]: Insert – Build and implement comprehensive communications strategy to change the dialogue nationally about the VA

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Message

From: Marc Sherman [(b) (6) gmail.com]
Sent: 2/6/2017 11:01:15 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Tom

Sounds good. See you then.

Marc Sherman
(b) (6)

On Feb 6, 2017 5:33 PM, "David shulkin" <Drshulkin@aol.com> wrote:
Marc- Not tonight unfortunately but lets catch up
Tomorrow

Sent from my iPhone

> On Feb 6, 2017, at 4:00 PM, Marc Sherman <mbs(b) (6) gmail.com> wrote:
>
> Tom and I had a good lunch meeting today. I am in a meeting for a few hours. Are you available to talk when I am finished (maybe 2 hours +/-)? What number ?
>
> Marc Sherman
> (b) (6)

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 2/6/2017 10:33:27 PM
To: Marc Sherman [mbs(b) (6) gmail.com]
Subject: Re: Tom

Marc- Not tonight unfortunately but lets catch up
Tomorrow

Sent from my iPhone

> On Feb 6, 2017, at 4:00 PM, Marc Sherman <mbs(b) (6) mail.com> wrote:
>
> Tom and I had a good lunch meeting today. I am in a meeting for a few hours. Are you available to talk when I am finished (maybe 2 hours +/-)? What number ?
>
> Marc Sherman
> (b) (6)

AMERICAN OVERSIGHT

Message

From: Marc Sherman [mbs(b) (6) gmail.com]
Sent: 2/6/2017 9:00:29 PM
To: David shulkin [drshulkin@aol.com]
Subject: Tom

Tom and I had a good lunch meeting today. I am in a meeting for a few hours. Are you available to talk when I am finished (maybe 2 hours +/-)? What number ?

Marc Sherman
(b) (6)

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/23/2017 2:58:56 AM
To: (b) (6) [(b) (6) @gmail.com]
Subject: Re: Monday

Im ok going to his office

Sent from my iPhone

> On Jan 22, 2017, at 9:43 PM, (b) (6) <(b) (6) r@gmail.com> wrote:
>
> Hello, would be opening to meeting with speaker Gingrich at his office tmrw vs. Your office? I think it may stir unnecessary chatter if he comes in the bldg right now.
>
> If no concern, will leave meeting as is with him coming to us.

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/23/2017 2:58:34 AM
To: (b) (6) [(b) (6) @gmail.com]
Subject: Re: Monday

No issues

Sent from my iPhone

> On Jan 22, 2017, at 9:43 PM, (b) (6) <(b) (6) r@gmail.com> wrote:
>
> Hello, would be opening to meeting with speaker Gingrich at his office tmrw vs. Your office? I think it may stir unnecessary chatter if he comes in the bldg right now.
>
> If no concern, will leave meeting as is with him coming to us.

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6)@gmail.com]
Sent: 1/23/2017 2:43:35 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Monday

Hello, would be opening to meeting with speaker Gingrich at his office tmrw vs. Your office? I think it may stir unnecessary chatter if he comes in the bldg right now.

If no concern, will leave meeting as is with him coming to us.

AMERICAN OVERSIGHT

Message

From: SreyRam Kuy [(b) (6) @gmail.com]
Sent: 2/15/2017 4:47:19 PM
To: David shulkin [Drshulkin@aol.com]; David.Shulkin@va.gov
Subject: Re: RWJ Clinical Scholar
Attachments: Bio - Dr. SreyRam Kuy 2-2017.pdf; Dr. SreyRam Kuy CV - VA 2017.pdf

Secretary Shulkin,

Thank you so much for taking the time to chat with me last month. I wanted to say how much I admire your work to improve health for our veterans. I would love the opportunity to be a part of that great work you are doing. I've attached my CV and a short bio.

As Chief Medical Officer for Medicaid in the Louisiana Department of Health, I hope my experience improving health in a complex $14 billion health system serving 1.6 million lives can be extrapolated to help care for our veterans. Please do keep me in mind if any opportunities arise. I'm often in DC, and would love any opportunity to talk at your convenience. Thank you so much! And, thank you for all you do for our veterans.

Respectfully,
SreyRam

SreyRam Kuy, MD, MHS, FACS
Email: (b) (6) @gmail.com
Phone: (b) (6)

> On Sun, Dec 4, 2016 at 2:03 PM, SreyRam Kuy <(b) (6) @gmail.com> wrote:
>> Dr. Shulkin,
>>
>> Yes, January would be great! I absolutely understand, it must be
>> extraordinarily busy with transition going on. Please know that if
>> there's any way I can help or contribute at all during this very busy
>> time, I'd be more than delighted to do so!
>>
>> Warmly,
>> SreyRam
>>
>>
>> SreyRam Kuy, MD, MHS, FACS
>>
>>
>>
>> On Sat, Dec 3, 2016 at 10:23 PM, David shulkin <Drshulkin@aol.com> wrote:
>>> Id be glad to- though very busy now with the transition of administration
>>> Can we talk in january?
>>>
>>> Sent from my iPhone

AMERICAN OVERSIGHT

Bio: SreyRam Kuy, MD, MHS, FACS



SreyRam Kuy, MD, MHS, FACS currently serves as Chief Medical Officer for Medicaid in the Louisiana Department of Health. As CMO for Louisiana Medicaid, Dr. Kuy leads the drive for improving healthcare quality, promoting cost effectiveness and increasing health information technology adoption in a $14 billion health system serving 1.6 million patients. Under her leadership, Louisiana Medicaid was the first state to develop a Zika prevention strategy for pregnant Medicaid patients; enabled women with breast cancer to have access to needed reconstructive surgery and BRCA testing, led efforts to coordinate medical disaster relief efforts during Louisiana's Great Flood, and is leading Louisiana Medicaid's initiative to tackle the opioid epidemic as the first state in the South to implement a prescription opioid policy. She has developed state wide health performance metrics, pay for performance incentives, and established novel "Medicaid Expansion Early Wins measures" which enable the state of Louisiana to assess how access to healthcare directly impacts lives, which have been profiled by NPR and are being implemented in other states.

Prior to serving as Chief Medical Officer for Louisiana Medicaid, Dr. Kuy served in numerous leadership roles, including Director of the Center for Innovations in Quality, Outcomes and Patient Safety, Assistant Chief of General Surgery, Chair of the Systems Redesign Committee, and on the Quality, Safety & Value Board at Overton Brooks VA Medical Center. Dr. Kuy's work successfully reducing patient mortality & morbidity and decreasing adverse safety events was profiled by the VA National Center for Patient Safety. Her work increasing veterans' access to care through clinic efficiency was profiled by the Association for VA Surgeons, and templates she developed were disseminated for implementation at VA medical centers across the country.

Dr. Kuy attended medical school at Oregon Health & Sciences University, then finished general surgery residency. She earned her master's degree in health policy, public health and outcomes research at Yale University School of Medicine as a Robert Wood Johnson Clinical Scholar. Dr. Kuy has published more than 40 articles in JAMA Surgery, Surgery, American Journal of Surgery and other medical journals on healthcare quality and patient safety.

In 2017, Dr. Kuy was selected to be a Presidential Leadership Scholar, a joint program by President Clinton and President Bush and run by the presidential centers of Lyndon B. Johnson, George H.W. Bush, William J. Clinton and George W. Bush. Dr. Kuy has also received Business Report's 40 Under 40 Award for her work to improve healthcare quality in the Louisiana Medicaid population and the Ford Foundation's Gerald E. Bruce Community Service Award for her work serving veterans. Dr. Kuy was also selected for the Early Career Achievement Award in 2017 by Oregon Health & Sciences University School of Medicine.

SreyRam Kuy, MD, MHS, FACS **Email:** (b) (6) gmail.com **Phone:** (b) (6)

AMERICAN OVERSIGHT

SreyRam Kuy, MD, MHS, FACS

Medicaid Chief Medical Officer, Louisiana Department of Health

Associate Professor of Surgery, Louisiana State University – New Orleans

PROFILE:

- ✓ **As Chief Medical Officer of Louisiana Medicaid, I lead the state's drive to improve healthcare quality, engage healthcare providers and stakeholders, develop quality performance metrics and integrate cost effectiveness into a $14 billion health system which serves 1.6 million lives.**

- ✓ **Supervise staff members comprising the Quality Team, Pharmacy Team, Clinical Policy Team, Health Information Technology Team and Benefits & Covered Services Team.**

- ✓ **Advise the Secretary of Health on critical public health issues, communicate policies and vision to state legislators and the Governor and represent Medicaid to the media on issues ranging from opioids to zika and healthcare quality.**

- ✓ **Lead initiatives for emerging public health threats such as coordinating medical efforts at Flood Shelters, developing a Zika transmission prevention policy, and working with the Governor's office and state legislators to implement strategies tackling the opioid crisis.**

- ✓ **Oversee $26 million CMS grant for state Health Information Technology projects; including increasing EHR adoption among providers, ED discharge data linkage to primary care physicians, advancing a Telehealth network, implementing an EHR system in the Department of Corrections, and enabling providers to achieve meaningful use HIT.**

- ✓ **More than a decade of experience in the VA systems in Oregon, Texas, Connecticut, Wisconsin and Louisiana as a trainee, provider and administrator. Served as Assistant Chief of the General Surgery Section, Director of the Center for Innovations in Quality, Outcomes and Patient Safety, Chair of the Systems Redesign Committee and Board Member on the Quality, Safety and Value Board at Overton Brooks VA Medical Center. Worked with the Pentad on SAIL performance reports, HEDIS and Joint Commission ORYX core measures. Led initiatives to improve veterans' access to care through a 50% reduction in surgery clinic no shows.**

- ✓ **Worked to successfully decrease veteran mortality and reduce patient safety adverse events at Overton Brooks VA Medical Center. Developed biweekly provider educational series, broadcast remotely to outlying VA Community Based Outpatient Clinics in Louisiana and East Texas.**

AMERICAN OVERSIGHT

PERSONAL:

Office Address: Louisiana Medicaid, Department of Health
628 North 4th Street, Baton Rouge, LA 70802

Mobile Telephone: (b) (6) [redacted]

Office Telephone: 225-342-5381

Email Address: (b) (6) [redacted]@gmail.com
SreyRam.Kuy@LA.Gov

Citizenship: United States

EDUCATION:

2017 Presidential Leadership Scholars Program
Nominated and selected to be a Presidential Leadership Scholar – a joint executive leadership training program by Presidents Bush and Clinton and run by the presidential centers of Lyndon B. Johnson, George H. W. Bush, William J. Clinton and George W. Bush

2016 Healthcare Executive Leadership Program in Health Policy and Management
Heller School of Policy and Management, Brandeis University

2009 M.H.S. (Master of Health Science)
Yale University School of Medicine, Robert Wood Johnson Clinical Scholar

2005 M.D. (Medical Degree)
Oregon Health & Sciences University School of Medicine

2000 B.S. (Bachelor of Science, Philosophy), magna cum laude
Oregon State University

2000 B.S. (Bachelor of Science, Microbiology), magna cum laude
Oregon State University

POSTGRADUATE TRAINING:

2009-2012 Residency, General Surgery (PGY 3-5)
Medical College of Wisconsin

2007-2009 Robert Wood Johnson Clinical Scholar Fellowship
Yale University School of Medicine

2005-2007 Residency, General Surgery (PGY 1-2)
University of Texas Health Sciences Center at San Antonio

AMERICAN OVERSIGHT

APPOINTMENTS:

2016-present Chief Medical Officer, Medicaid, Louisiana Department of Health and Hospitals

As CMO of Louisiana Medicaid I lead the drive to improve healthcare quality, cost effectiveness and Health Information Technology in a $14 billion health system which serves 1.6 million lives. My work includes managing the Quality Team, Pharmacy Team, Clinical Policy Team, Health Information Technology Team and a Benefits & Covered Services Team. In addition, I lead initiatives for emerging public health threats such as coordinating medical efforts at Flood Shelters, developing a Zika transmission prevention policy, and working with the Governor's office and legislatures to implement strategies tackling the opioid crisis.

- Health Information Technology Team: lead the state's electronic health record adoption initiative and health information technology strategy, oversee CMS grant for Health Information Technology and a National Governors' Association HIT grant
- Quality Team: Develop and evaluate incentivized quality performance measures for providers & health plans to improve outcomes, safety, and quality of care for the state of Louisiana. Manage a Quality Team comprised of physicians, nurses & policy analysts addressing health care quality. Creation of a "Search by Score" site that promotes quality, transparency and adoption in Louisiana healthcare.
- Clinical Policy Team overseeing the evidence based approach for coverage of new benefits and services for Medicaid beneficiaries
- Benefits and Covered Services Team: manage all covered services and benefits in the Louisiana Medicaid system
- Pharmacy Team: overseeing Medicaid prescription coverage
- Rapidly respond to emergent public health issues (such as Zika virus, Opioid epidemic, drug shortages, flooding and emergency natural disasters) and develop guidance for providers and health plans
- Work with Louisiana healthcare stake holders, including Managed Care Organizations, hospital associations, healthcare providers, health facilities and institutions, patient advocacy groups to ensure high quality care for Louisiana's Medicaid population, and efficient use of resources

2014-2016 Director, Center for Innovations in Quality, Outcomes and Patient Safety, OBVAMC

- Develop and lead initiatives to meet Joint Commission ORYX core measures, SAIL performance measures, and monitor PSI occurrences.
- Develop programs that lead to sustained improvement in quality, outcomes and safety in the Surgical Services at the OBVAMC.
- Work on reducing mortality and adverse events profiled in the VA National Center for Patient Safety newsletter and website. Work on decreasing clinic no-shows featured in the Association of VA Surgeons newsletter and website.
- Collaborate with section chiefs to assess needs for quality improvement; develop, monitor and assess quality measures and initiatives; monitor

AMERICAN OVERSIGHT

analyze and assess surgical outcomes; integrate quality improvement tools and surgical outcome measures to create a cohesive program for the OBVAMC Surgical Services.

- Partner with VA clinical, policy and operational leaders to implement and evaluate different ways to make surgical healthcare safer, more effective and more affordable.

2015-2016 Assistant Chief, General Surgery Section
Overton Brooks VA Medical Center (OBVAMC)

- Integrate quality improvement tools and surgical outcome measures to create a cohesive program for General Surgery Section, leading to improved patient safety with a decrease in patient mortality and reduction in Critical Incident Network Tracking adverse events
- Work on SAIL and Joint Commission performance measures (pressure ulcer prevention, accidental puncture monitoring, smoking cessation/flu immunization documentation)
- Led initiative to improve veterans access to care through decreased surgery clinic no shows, with more than 50% reduction in clinic no shows
- Develop, monitor and assess quality and efficiency measures and initiatives for the General Surgery Section
- Monitor, analyze and assess surgical outcomes for the General Surgery Section
- Review Quality Improvement tools and surveys
- Collaborate with other section chiefs (Anesthesiology, ENT, General Surgery, ENT, Neurosurgery, Ophthalmology, Orthopedics, Podiatry, Urology, Vascular and Thoracic Surgery) to assess needs for a collaborative, comprehensive surgical care

2014-2016 Director, Surgical Services Grand Rounds Lecture Series, OBVAMC

- Developed a CME accredited academic curriculum for Grand Rounds Lecture Series; recruited local and national speakers
- Incorporated telecommunication to broadcast Grand Rounds Lectures remotely, available to outlying VA Community Based Outpatient Clinics (CBOCs) in Louisiana and Texas and also to employee's computer desktops to allow greater educational reach

2017-present Associate Professor, Department of Surgery
Louisiana State University – New Orleans

2014-2016 Assistant Professor, Department of Surgery
Louisiana State University – Shreveport

2014-2016 Staff Surgeon, Overton Brooks Veterans Affairs Medical Center (OBVAMC)

- Had highest RVU's and total number of cases in general surgery section
- Performed first laparoscopic assisted Low Anterior Resection at OBVAMC

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- Developed a laparoscopic training course for residents, OR staff and surgeons; taught at OBVAMC and LSU

2014-2015 Consultant, Parkland Center for Clinical Innovation
Consultant on surgical site infection risk prediction modeling

BOARD CERTIFICATION
2014 American Board of Surgery # 059382

MEDICAL LICENSURE:
State of Texas # P9893 – Expiration 5/31/2017
State of Wisconsin #53724-20 – Expiration 10/3/2017
State of Tennessee #MD0000050960 – Expiration 3/31/2018
State of Louisiana #300710 – Expiration 3/31/2017

POSTGRADUATE COURSES:
10/2014 Cleveland Clinic, Advanced Laparoscopic Colorectal Master Class
11/2014 Florida Hospital, Laparoscopic General Surgery Master Class
7/2015 University of South Florida, Laparoscopic Colectomy Mini-Fellowship
9/2015 Methodist MITE, Advanced Hernia and Abdominal Wall Repair Master Class
2/2016 Life Cell, Complex Abdominal Wall Reconstruction Bioskills Lab

LEADERSHIP/HEALTHCARE POLICY TRAINING & EXPERIENCE:

American College of Surgeons Health Policy Award — June 12-18, 2016
"Leadership Program in Health Policy and Management" Executive Education Program at Brandeis University Heller School for Social Policy and Management.

American Medical Association Campaign School — 2013
Training in healthcare policy, legislation and politics in Washington, D.C.

American College of Surgeons Advocacy Grant — 2012

Robert Wood Johnson Clinical Scholar, Yale University School of Medicine — 2007 – 2009
Fellowship in healthcare policy & management, public health and research.

Healthcare Policy Synergy Workshop, Institute of Medicine. Washington, D.C. — 2008
Healthcare policy training, development of health disparities proposal

Robert Wood Johnson Foundation Cover the Uninsured Week Oregon Committee
Organized symposium on the uninsured in Oregon, speaker Governor Kitzhaber — 2003

American Academy of Family Physicians National Congress — 2000
Authored resolution on "Presentation of the AAFP Universal Health Care Coverage Task Force Report and Inclusion of Resident and Student Feedback

Kaiser Family Foundation Barbara Jordan Health Policy Scholar — 2000
Worked in Washington DC office of US Senator Tom Harkin. Wrote speeches on The Breast & Cervical Cancer Treatment Act and Re-authorization of the Older Americans Act, attended hearings, wrote briefs on prescription drug coverage, coverage for experimental studies, and healthcare instrument safety.

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HEALTH POLICY PANELS/KEY NOTE SPEAKER/PRESENTATIONS

The Louisiana Story: Tackling Preterm Birth through Collaboration and Innovation — Dec 2016
CMS Quality Conference, Baltimore, MD

Achieving Viral Load Suppression through Collaboration – The Louisiana Story — Dec 2016
HIV Affinity Group National Conference, Washington DC

Medicaid Expansion and Access to Healthcare: Learning from Louisiana — Dec 2016
Louisiana Public Health Institute

Bridging the Gap Between Health Care and Health Equity — Oct 2016
National Academy for State Health Policy, Pittsburgh, PA

HIV Affinity – The Louisiana Story — Nov 2016
HIV Health Improvement Affinity Group National Webinar

Medicaid Industry Who's Who Series, "Mostly Medicaid" — Sept 2016
State Spotlight Series: Achieving Healthcare Quality

Medicaid Expansion and Improving Healthcare Quality in Louisiana — Sept 2016
American Association on Intellectual & Developmental Disabilities,Alexandria,LA

Panel Member: Using National Data Sources to Understand Healthcare Quality, Access and Disparities Among Women — 2015
AcademyHealth 2015 Annual Research Meeting, Minneapolis, Minnesota

Panel Member: Emerging Issues in Gender-Based and Women's Health. — 2009
AcademyHealth 2009 Annual Research Meeting, Chicago, Illinois.

Moderator, Robert Wood Johnson Alumni Careers in Health Policy. — 2008
Robert Wood Johnson Clinical Scholars National Conference, Washington, D.C.

Panel Member: The Many Avenues to Pursuing a Career in Health Policy. — 2007
Barbara Jordan Health Policy Scholars Conference, Washington, D.C.

TOWN HALLS

Town Hall Meeting — August 2016
Flood Recovery, Mold and Tetanus Vaccination, Mental Health Crisis Hotline

Town Hall Meeting — August 2016
Flood Recovery, Prescription Co-Pay Waivers, Early Refills for Prescriptions

Rotary Club of Shreveport — July 2016
Key Note Speaker: Medicaid Expansion

Shreveport Medical Society — July 2016
Key Note Speaker: Medicaid Expansion

COMMITTEE SERVICE AND ORGANIZATIONS

National Quality Forum — 2016-present
Medicaid Innovation Accelerator Committee

Alliance for a Healthier Generation — 2016-present
Obesity Prevention Task Force

Opioid Commission — 2016-present

Comparing Outcomes of Drugs and Appendectomy (CODA) — 2016-present
National Stakeholder Advisory Board

National Academy for State Health Policy — 2016-present
Public and Population Health Advisory Group

AcademyHealth — 2016-present

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State Health Research and Policy Interest Group Advisory Committee

American College of Surgeons 2016-2019
Committee on Diversity Issues

Robert Wood Johnson Foundation Clinical Scholars Alumni Association 2016-2018
Co-President

Chair, Medicaid Quality Committee 2016-present

Louisiana Commission on HIV, AIDS and Hep C 2016-present
Office of Public Health designee, appointed by Governor Edwards

Louisiana Task Force on Telehealth Access 2016-present
Appointed by Secretary

Executive Committee, Medicaid Evidence-based Decisions Project, Portland, OR 2016-present

Chair, Improving Veterans Access to Care Committee 2015

Board Member, Quality, Safety and Value Board, OBVAMC 2015-2016

Chair, Systems Redesign Committee, OBVAMC 2015-2016

Chair, General Surgery Faculty Recruitment Committee, OBVAMC 2015-2016

Federation of State Medical Boards (FSMB) 2015-2016
Appointed Representative to Accreditation Council for Continuing Medical Education Accreditation Review Committee (review accreditation for CME)

National Board of Medical Examiners (NBME) 2011 – 2015
NBME Board Member
Appointed by American Medical Association as one of 80 Board Members governing the NBME, overseeing a $100 million annual budget that governs the USMLE, the Post-Licensure Assessment System, and works with specialty boards to protect the public health.

NBME Diversity and Inclusion Task Force 2013 – 2015
Tasked to improve diversity and inclusion in the executive leadership of the NBME and the USMLE exam contents.

Association for Academic Surgery
Membership Committee 2013 – 2015
Information and Technology Committee 2010 – 2012
Program Committee 2016 – present

Association of Women Surgeons, Communications Committee, Vice-Chair 2012 – 2014

Medical Society of Milwaukee County, Board of Directors 2012 – 2014

American Medical Association
Chair, Wisconsin Resident & Fellow Governing Council 2011 – 2013
AMA Surgical Caucus, Executive Committee 2010 – 2011
Wisconsin Medical Society, AMA Resident Delegate 2010 – 2011

Robert Wood Johnson Clinical Scholars National Conference, Planning Committee 2008

Oregon Health & Science University Medical School First Year, Class President 2000 - 2001

Habitat for Humanity, Oregon State University Campus Chapter President 1988-1999

Science Student Council, President 1997-1998

Phi Eta Sigma National Honor Society, Oregon State University Chapter President 1997-1998

Oregon State University Undergraduate Senate, Senator 1997-1998

Talons Women's Leadership & Service Honorary Society, Vice-President 1997-1998

Medical Careers Explorer Scouts, Corvallis Chapter President 1995-1996

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PEER-REVIEWED PUBLICATIONS

1. **Kuy S**, Romero R. Eliminating Critical Incident Tracking Network Patient Safety Events at a Veterans Affairs Institution through Crew Resource Management Training. *American Journal of Medical Quality. In Press.*
2. **Kuy S**, Romero R. Improving Staff Perception of a Safety Climate with Crew Resource Management Training. *Journal of Surgical Research. In Press*
3. **Kuy S**. Rapidly Growing, Bleeding Mass on a Golfer's Back. *JAMA Surgery. In Press*
4. **Kuy S**, Romero R, Rose K, Vincent L. Perineal Pain and Malodorous Drainage in a Rectal Cancer Patient. *BMJ Postgraduate Medical Journal. In Press*
5. Koo D, **Kuy S**, Ogunleye A, Sangji N. A Tradition of Advocacy in the American College of Surgeons: Protecting our patients, advancing our profession. *Bull Am Coll Surg. In Press*
6. Eskander M, Neuwirth M, **Kuy S**, Keshava H, Meizoso J. Technology for Teaching: New Tools for 21st Century Surgeons. *Bull Am Coll Surg. In Press*
7. **Kuy S**, Dua A, Rieland J, Cronin D. Cavernous Transformation of the Portal Vein. *Journal of Vascular Surgery.* 2016 Feb;63(2):529.
8. **Kuy S**, Jenkins P, Romero R, Samra N, Kuy S. The Rising Incidence and Mortality of Clostridium Difficile Associated Megacolon. *JAMA Surgery.* 2015 Oct 7:1-2.
9. **Kuy S**, Romero R, Kuy S. Gas Gangrene in a Diabetic Foot. *Journal of the Louisiana State Medical Society.* 2015 Sep-Oct;167(5):213-214. Epub 2015 Oct 15.
10. **Kuy S**. Carotid Body Tumor. *Journal of the Louisiana State Medical Society.* 2015 Jul-Aug;167(4):165. Epub 2015 Aug 15.
11. Busch K, Keshava H, **Kuy S**, Nezgoda J, Picou A. Teaching in the Operating Room: New Lessons for Training Surgical Residents. *Bull Am Coll Surg.* 2015 Aug;100(8):29-34.
12. Ogunleye A, Bliss L, **Kuy S**, Leichtle S. Political Advocacy in Surgery: The Case for Individual Engagement. *Bull Am Coll Surg.* 2015 Aug;100(8):40-4.
13. Dua A, **Kuy S**, Desai S, Heller J, Lee C. Diagnosis and Management of a Ruptured Mycotic Popliteal Pseudoaneurysm. *Vascular.* 2015 Aug;23(4):419-21
14. **Kuy S**, Dua A. Uncertainty in management of carotid stenosis in women – reply. *JAMA Surgery.* 2014;149(4):402-3.
15. **Kuy S**, Dua A, Desai S, Chappidi Rohit, Patel B, Seabrook G, Brown K, Lewis B, Rossi P, Lee C. The Increasing Incidence of Thromboembolic Events among Hospitalized Patients with Inflammatory Bowel Disease. *Vascular.* 2014 Jul 1.pii: 1708538114541799.
16. **Kuy S**, Dua A, Lee C, Patel B, Desai S, Dua A, Szabo A, Patel P. National Trends in Utilization of IVC Filters in the United States, 2000-2009. *Journal of Vascular Surgery: Venous and Lymphatic Disorders.* 2014 Jan;2(1):15-20.
17. Dua A, **Kuy S**, Lee CJ, Upchurch G Jr, Desai S. Epidemiology of Aortic Aneurysm Repair in the United States from 2000 to 2010. *Journal of Vascular Surgery.* 2014;59(6):1512-7.
18. Dua A, McMaster J, Desai P, Desai S, **Kuy S**, Mata M, Cooper J. The Association between Blunt Cardiac Injury and Isolated Sternal Fracture. *Journal of Cardiology Research and Practice.* 2014;2014:629687
19. Dua A, Dua A, Jechow S, Desai S, **Kuy S**. Idiopathic Spontaneous Rupture of an Intercostal Artery. *Wisconsin Medical Journal.* 2014;113(3):116-8.
20. Dua A, Aziz A, Desai S, McMaster J, **Kuy S**. National Trends in the Adoption of Laparoscopic Cholecystectomy over 7 years in the United States and Impact of Laparoscopic Approaches Stratified by Age. *Minimally Invasive Surgery.* 2014;2014:635461.

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21. **Kuy S**, Juern J, Weigelt J. Laparoscopic Primary Repair of Traumatic Intrapericardial Diaphragmatic Hernia. *Journal of Laparoscopic Surgeons* 2014;18(2):333-7.
22. **Kuy S**, Dua A, Rossi P, Seabrook G, Lewis B, Patel B, Lee C, Desai S, Brown K. Carotid Endarterectomy National Trends Over a Decade: Does gender matter? *Annals of Vascular Surgery*. 2013 Dec 6. pii: S0890-5096(13)00641-9.
23. Dua A, Desai SS, Dua A, Charlton-Ouw K, Dongerkery SP, Patel B, **Kuy S**, McMaster J, Darlow M, Shapiro ML. The Impact of Co-Morbid Conditions and Insurance Status on Trauma Patient Outcomes. *TRAUMA*. 2013, Vol. 15 Issue 3, p239
24. **Kuy S**, Rossi P, Seabrook G, Brown K, Lewis B, Rilling W, Martin G, Patel B, Dua A, McMaster J, Desai S, Lee C. Endovascular Management of a Traumatic Renal-Caval Arteriovenous Fistula in a Pediatric Patient. *Annals of Vascular Surgery*. Dec 2013. pii: S0890-5096(13)00472-X.
25. **Kuy S**, Dua A, Desai S, Dua A, Patel B, Tondravi N, Seabrook G, Brown K, Lewis B, Lee C, Kuy S, Subbarayan R, Rossi P. Surgical Site Infections Following Lower Extremity Revascularization Procedures Involving Groin Incisions. *Annals of Vascular Surgery*. 2013 Nov 1. doi:pii: S0890-5096(13)00423-8.
26. Dua A, Dua A, Desai S, Kuy S, Sharma R, Jechow S, McMaster J, Patel B, **Kuy S**. Gender Based Differences in Management and Outcomes of Cholecystitis. *American Journal of Surgery*. 2013 Nov;206(5):641-6.
27. **Kuy S**, He C, Cronin D. Renal Mucormycosis: A Rare and Potentially Lethal Complication of Kidney Transplantation. *Case Reports in Transplantation*. October 2013;2013:915423
28. McMaster J, Dua A, Desai S, **Kuy S**. Short Term Outcomes Following Breast Cancer Surgery in Pregnant Women. *Gynecologic Oncology*. 2013 Sep 13. doi:pii: S0090-8258(13)01177-3.
29. Kulaylat AN, Zheng F, **Kuy S**, Bittner JG. Early Surgical Specialization: a new paradigm. *Bull Am Coll Surg*. 2013 Aug;98(8):43-9.
30. Baker J, Misra S, Manimala NJ, **Kuy S**, Gantt G. The Role of Politics in Shaping Surgical Training. *Bull Am Coll Surg*. 2013 Aug;98(8):17-25..
31. **Kuy S**, Seabrook G, Rossi P, Lewis B, Dua A, Brown K. Management of Carotid Stenosis in Women. *JAMA Surgery*. 2013 Aug;148(8):788-90. Epub June 26, 2013.
32. Dua A, Patel B, **Kuy S**, Seabrook G, Tondravi N, Brown K, Lewis B, Rossi P. Asymptomatic 50–75% Internal Carotid Artery Stenosis in 288 Patients: Risk Factors for Disease Progression and Ipsilateral Neurological Symptoms. *Perspectives in Vascular Surgery and Endovascular Therapy*. 2013 Dec; 24(4):165-70. doi: 10.1177/1531003513491986.
33. Dua A, Patel B, Heller J, **Kuy S**, Dubose J, Tomasek JS, Larssen EM, Desai S. Variability in the Management of Superficial Venous Thrombophlebitis between Phlebologists and Vascular Surgeons. *Perspectives in Vascular Surgery and Endovascular Therapy*. 2013 Jun;25(1-2):5-10.
34. Desai P, Dua A, McMaster J, Patel B, Dua A, **Kuy S**, Desai S, Krzowski-Firych J. Infectious Mononucleosis-Like Syndrome Presented in Toxoplasmosis Infection. *J Surg Rad*. 2013:134-136.
35. **Kuy S**, Vickery M, Dua A, Rosner G. Appendiceal endometriosis mimicking appendicitis. *JAMA Surgery*. 2013 May 1;148(5):481.
36. **Kuy S**, Somberg L, Paul J, Brown N, Saving A, Codner P. Undetected Penetrating Bladder Injuries Presenting as a Spontaneously Expulsed Bullet During Voiding: A Rare Entity and Review of the Literature. *Journal of Emergency Medicine*. 2013 May 25: S0736-4679(13)00356-9.
37. Dua A, Desai S, **Kuy S**, Patel B, Dua A, Desai P, Darlow M, Shirqavi J, Charlton-Ouw K, Shortell C. Predicting outcomes using the national trauma data bank: Optimum management of

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traumatic and blunt thoracic injury. *Perspectives in Vascular Surgery and Endovascular Therapy.* Sep;24(3):123-127, ePub: March 26, 2013.

38. **Kuy S**, Dua A, Desai SS, Baraniewski H, Lee C. Ruptured Mycobacterial Aneurysm of the Carotid Artery. *Perspectives in Vascular Surgery and Endovascular Therapy.* 2013;25(3-4):53-6.
39. Dua A, Desai S, McMaster J, Aziz A, Dua A, **Kuy S**. The Role of Platelets in Vascular Trauma Patients Compared to Patients with Chronic Vascular Disease. *Vascular Disease Management.* 2013;10(11):E240-E243.
40. **Kuy S**, Codner P, Guralnick M, Dua A, Paul J. Combined rectovesicular injuries from low velocity penetrating trauma in an adult. *Wisc Med J.* 2013;112(1):32-34.
41. **Kuy S**, Greenberg C, Gusani N, Dimick J, Kao L, Brasel K. Health services research resources for surgeons. *J Surg Res.* 2011;171(1):e69-73.
42. **Kuy S**, Sosa J, Desai R, Roman S, Rosenthal R. Age matters: A study of clinical and economic outcomes following cholecystectomy in elderly Americans. *Am J Surg.* 2011;201(6):789-796.
43. **Kuy S**, Roman SA, Desai R, Sosa JA. Outcomes Following Cholecystectomy in Pregnant and Non-pregnant Women. *Surgery.* 2009;146(2):358-366.
44. **Kuy S**, Roman S, Desai R, Sosa J. Outcomes following thyroid and parathyroid surgery in pregnant women. *Arch Surg.* 2009;144(5):399-406. Commentary by F Moore.
45. **Kuy S**. Stand up for patients. *Bull Am Coll Surg.* 2008;93(8):23-24.
46. Franks K, Li H, **Kuy S**, Kong W. Photodissociation of ICN at 266 nm and BrCN at 230 nm using brute force orientation. *Chemical Physics Letters*. 1999;302:151-156.

EDITORIALS/TECHNICAL NOTES/NEWSLETTER ARTICLES/MEDICAL BLOGS

1. **Kuy S,** Romero R, Cypher E. Shreveport: A Success Story. Creating a Culture of Safety at the Overton Brooks VA Medical Center. *Topics in Patient Safety. Veterans Affairs National Center for Patient Safety*. September 2014;14(5):1,4.
2. **Kuy S**. Profiles in Leadership. *Association of Women Surgeons Blog*. September 2014.
3. **Kuy S**. Health Services Research for Surgeons. *Association of Women Surgeons Website.* 2014.
4. **Kuy S**. Women Surgeon Leaders for the 21st Century. *Association of Women Surgeons Newsletter*. July 25, 2014
5. **Kuy S.** The Imperative to Improve Gallbladder Disease Treatment and Outcomes for Men. *Robert Wood Johnson Foundation Human Capitol Blog*. November 22, 2013.
6. **Kuy S.** Society for Vascular Surgery Trainee Advocacy Award Essay. *Society for Vascular Surgery* website. 2012.
7. **Kuy S**. Information & technology review: Online health resources for surgeons. *Association for Academic Surgery Newsletter*. Fall, 2010:6-7.
8. **Kuy S**. Stand up for patients. *Los Angeles Times*. February 28, 2008.

BOOKS AND BOOK CHAPTERS

1. **Kuy S** (senior editor), Kwon R, Hochman M. 50 Studies Every Surgeon Should Know. Oxford Press. (Planned release 2017)

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2. Provo B, **Kuy S**. Venous insufficiency ulcers. In Domino FJ (Ed.), The 5-Minute Clinical Consult 2015, Philadelphia: Lippincott Williams and Wilkins.
3. Aljoudi M, Dua A, **Kuy S.** Cervical Bruit. In Domino FJ (Ed.), The 5-Minute Clinical Consult 2016, Philadelphia: Lippincott Williams and Wilkins.
4. Dua A, Aljoudi M, **Kuy S.** Absent or Diminished Pulse. In Domino FJ (Ed.), The 5-Minute Clinical Consult 2016, Philadelphia: Lippincott Williams and Wilkins.
1. Aljoudi M, McMaster J, **Kuy S.** Breast Cancer and Pregnancy. In Domino FJ (Ed.), The 5-Minute Clinical Consult 2016, Philadelphia: Lippincott Williams and Wilkins.
2. Dua A, Desai S, **Kuy S.** Inguinal Mass. In Domino FJ (Ed.), The 5-Minute Clinical Consult 2016, Philadelphia: Lippincott Williams and Wilkins.

PRESENTATIONS

1. Reducing Surgery Cancellations in a Tertiary Hospital: A Three Year Review. Association of VA Surgeons 2016 Meeting; Virginia Beach, VA April 2016.
2. Why We Don't Come to Clinic: Patient Perspectives. Association of VA Surgeons 2016 Meeting; Virginia Beach, VA April 2016.
3. The Myth of Sisyphus: Is Reducing Surgery Clinic No-Shows Impossible? Association of VA Surgeons 2016 Meeting; Virginia Beach, VA April 2016.
4. It Takes a Village: Referring Providers Impact Patient No Shows. Association of VA Surgeons 2016 Meeting; Virginia Beach, VA April 2016.
5. Reducing Surgical Site Infections Utilizing a Prevention Bundle and a Multidisciplinary Approach at a Veterans Affairs Hospital. The American College of Surgeons NSQIP 2015 Meeting; Chicago, IL; July 2015.
6. Transformational Change: Creating a Culture of Safety in the Operating Room. Presented at: The American College of Surgeons NSQIP 2015 Meeting; Chicago, IL; July 2015.
7. Outlier to Leader: Designing a Risk Stratification Intervention to Decrease 30 Day Surgical Mortality in a Veterans Affairs Hospital. The American College of Surgeons NSQIP 2015 Meeting; Chicago, IL; July 2015.
8. Outlier to Leader: Designing a Risk Stratification Intervention to Decrease 30 Day Surgical Mortality in a Veterans Affairs Hospital. Presented at: The Association of VA Surgeons 2015 Meeting; Miami, FL; May 2015.
9. Transformational Change: Creating a Culture of Safety in the Operating Room. Presented at: The Association of VA Surgeons 2015 Meeting; Miami, FL; May 2015.
10. The Rising Incidence and Mortality of Clostridium Difficile Associated Megacolon. Presented at: The Association of VA Surgeons 2015 Meeting; Miami, FL; May 2015.
11. The Increasing Incidence of Thromboembolic Events Among Patients with Inflammatory Bowel Disease. Presented at: American College of Surgeons 2013 Clinical Congress; Washington DC; October 2013.
12. Diagnosis and Management of a Ruptured Popliteal Mycotic Pseudoaneurysm. Presented at: Eastern Vascular Society. Sulfur Springs, West Virginia. September 21, 2013. (First Place Winner of the 2013 Resident Award)
13. Ruptured Carotid Mycotic Tuberculoid Aneurysm from Intravesical BCG. Presented at: Midwestern Vascular Surgical Society. Chicago, Illinois; September 8, 2013

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14. Do women experience delays in carotid endarterectomy? Presented at: Society for Vascular Surgery Annual Meeting; San Francisco, California; May 31, 2013. (Winner of Sectional Poster Competition)
15. National trends in utilization of IVC filters over a decade in the United States, 2000-2009. Presented at: Society for Vascular Surgery Annual Meeting; San Francisco, California; May 31, 2013.
16. Surgical site infections and complications following vascular groin procedures. Presented at: Peripheral Vascular Surgery Society meeting; Park City, Utah; February 1, 2013.
17. Endovascular management of a traumatic renal-caval arteriovenous fistula in a pediatric patient. Presented at: International Symposium on Endovascular Therapy; Miami, Florida; January 22, 2013.
18. Carotid endarterectomy national trends over a decade: Does gender matter? Presented at: Midwestern Vascular Surgery annual meeting; Milwaukee, Wisconsin; September 6, 2012.
19. Asymptomatic 50-75% internal carotid artery stenosis in 288 patients: Risk factors for disease progression and ipsilateral neurological symptoms. Presented at: Midwestern Vascular Surgery annual meeting; Milwaukee, Wisconsin; September 6, 2012.
20. A study of clinical and economic outcomes following cholecystectomy in elderly Americans. Presented at: Department of Surgery grand rounds, Medical College of Wisconsin; Milwaukee, Wisconsin; June 10, 2010.
21. Predictors of in-hospital mortality following cholecystectomy among hospitalized patients. Presented at: 5th annual Academic Surgical Congress; San Antonio, Texas; February 3, 2010.
22. Predictors of in-hospital mortality following cholecystectomy. Presented at: American Medical Association 2010 research symposium; San Diego, California; November 5, 2010 (Honorable Mention Prize).
23. Outcomes following breast surgery in pregnant women. Presented at: 90th annual meeting of the New England Surgical Society; Newport, Rhode Island; September 13, 2009.
24. Outcomes following breast surgery in pregnant women. Presented at: Department of Surgery grand rounds, Yale University School of Medicine; New Haven, Connecticut; September 9, 2009.
25. Gender based differences in management and outcomes of cholecystitis. Presented at: AcademyHealth 2009 annual research meeting; Chicago, Illinois; June 28, 2009.
26. Gender based disparities in outcomes of cholecystitis. Presented at: New England science symposium; Boston, Massachusetts; April 3, 2009.
27. Women have better outcomes in cholecystitis. Presented at: American Medical Women's Association conference, Women's Health 2009, 17th Annual Congress; Williamsburg, Virginia; March 27-29, 2009.
28. Outcomes following cholecystectomy in pregnant and non-pregnant women. Presented at: 4th Annual Academic Surgical Congress; Fort Myers, Florida; February 3-6, 2009.
29. Outcomes following thyroid and parathyroid surgery in pregnant women. Presented at: Robert Wood Johnson Clinical Scholars 2008 National Conference; Washington, D.C.; November 18-21, 2008.

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30. Disparities in outcomes following thyroid and parathyroid surgery in pregnant and non-pregnant women. Presented at: Disparities in Surgical Care symposium; Boston, Massachusetts; Oct 27-28, 2008.
31. Outcomes following thyroidectomy and parathyroidectomy in pregnant women in the US, 1999-2005. Presented at: 89th annual meeting of the New England Surgical Society; Boston, Massachusetts; September 26-28, 2008.
32. Outcomes following thyroid and parathyroid surgery in pregnant women. Presented at: Department of Surgery grand rounds, Yale University School of Medicine; New Haven, Connecticut; September 24, 2008.
33. Are Drains Necessary After Craniosynostosis Surgery? American Society of Plastic Surgeons: Plastic Surgery Senior Residents Conference. Houston, Texas. March 17-19, 2005.
34. The Effects of Heat Treatment on Lactoferrin Concentration in Breast Milk. International Health Medical Education Consortium Conference. Havana, Cuba. March 12-15, 2002

JOURNAL REVIEWER

JAMA Surgery Reviewer	2016-present
Journal of Surgical Research Reviewer	2016-present
British Medical Journal Case Reports Reviewer	2014-present

TEACHING EXPERIENCE:

Louisiana State University – New Orleans, Associate Professor of Surgery	2017-present
Louisiana State University – Shreveport, Assistant Professor of Surgery	2014-2016
Lecturer, Surgery Resident SCORE Curriculum	2016
Lecturer, Third Year Medical Student Curriculum	2014-2016
Clinical Preceptor, First Year Medical Students	2014-2016
Yale University School of Medicine	
Course Facilitator, Introduction to Research	2007 – 2009
Oregon State University	
Teaching Assistant, General Microbiology	1999
Teaching Assistant, Introduction to Microbiology	1998 – 1999
Teaching Assistant, Biology	1997

HONORS, AWARDS & GRANTS

Early Career Achievement Award, Oregon Health & Sciences University School of Medicine — 2017

Presidential Leadership Scholar — 2017
Executive Leadership Training led by President Bush and President Clinton, held over 6 months onsite at the George H. W. Bush Presidential Center, William J. Clinton Presidential Center, George W. Bush Presidential Center & Lyndon B. Johnson Presidential Center.

American College of Surgeons Health Policy Scholar — 2016

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Award provides $8,000 grant, one of two general surgeons awarded to attend the "Leadership Program in Health Policy and Management" Executive Education Program at Brandeis University Heller School for Social Policy and Management.

Business Report's 2016 "Forty Under 40" Award — 2016
Award in recognition of leadership, community service and career accomplishments

Ford Family Foundation Gerald E. Bruce Leadership & Community Service Award — 2016
Award provides $5,000 grant, recognizing excellence in leadership & service.

Certificate of Appreciation, Overton Brooks VA Medical Center — 2015
Presented by Medical Center Director for work in promoting diversity, invited Keynote Speaker for VA's Asian Pacific American Celebration Month

Making a Difference Award, Overton Brooks VA Medical Center — 2014
Recognition of excellence in clinical care

Certificate of Appreciation, Overton Brooks VA Medical Center — 2014
Presented by Medical Center Director for Surgical Services' Achievement in Reducing Adverse Events and Mortality

American College of Surgeons Advocacy Travel Grant — 2012

American Medical Association 2010 Research Symposium Honorable Mention Prize — 2010

Medical College of Wisconsin Affiliated Hospitals (MCWAH) Research Award — 2010

New England Surgical Society 89th Annual Resident Research Competition Award — 2008

Robert Wood Johnson Foundation Clinical Scholars Fellowship. National award providing two years of training in health services research, Yale University School of Medicine — 2007 – 2009

Surgery Intern of the Year Award, Department of Surgery, University of Texas Health Sciences Center at San Antonio — 2006

Oregon Health & Science University ROSE Award (Recognition of Outstanding Service and Excellence) — 2001

Ralph Bosworth, MD Memorial Scholarship — 2000

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Dr. JoAnne J. Trow Woman of Distinction Award	2000
Waldo-Cummings Outstanding Student Award	2000
Phi Kappa Phi Honor Society Tunison Award	1999
OSU Department of Microbiology Mark H. MiddleKauf Scholarship	1999
OSU Department of Microbiology Joseph E. Simmons Scholarship	1999
OSU College of Agricultural Science Jesse Hanson Scholarship	1999
OSU College of Science Heitmeyer Scholarship	1996
Presidential Scholar	1996
Laurel G. Case, MD Memorial Scholarship	1996
Robert C. Byrd Honors Scholar	1996
Valedictorian, Crescent Valley High School	1996

NEWS ARTICLES:

Read about Dr. Kuy's work reducing mortality and patient safety adverse events profiled in the VA National Center for Patient Safety here: http://www.patientsafety.va.gov/features/Shreveport_A_Success_Story.asp

Read about Dr. Kuy's work improving veterans' access to care through clinic efficiency profiled by the Association of VA Surgeons here: http://www.avasnews.com/single-post/2016/05/16/REDUCING-NO-SHOWS

Read about Dr. Kuy's work at Louisiana Medicaid improving healthcare quality profiled by Mostly Medicaid here: http://www.mostlymedicaid.com/?p=1821

Read about Dr. Kuy's work with Medicaid Expansion to improve patient health profiled by Business Reports 40 Under 40 here: https://www.businessreport.com/article/forty-40-qa-sreyram-kuy

GRANTS AWARDED:

Zero to Three Grant 2016
"Text4Baby"
$10,000 grant for Technical Assistance implementing Text4Baby, a program aimed at improving birth outcomes for pregnant women in Louisiana Medicaid.

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National Governors Association Grant 2016
"Getting the Right Information to the Right Health Care Providers, at the Right Time- How States Can Improve Data Flow"
Awarded to Louisiana Medicaid's Health Information Technology Team, one of three states to receive this grant in the form of Technical Assistance

Centers for Medicare & Medicaid Services Grant 2016
"Louisiana's Health Information Technology (HIT) and Health Information Exchange (HIE) Implementation Advance Planning".
Support adoption and meaningful use of certified EHR technology activities, promote interoperability among EHRs, state HIEs and the Medicaid system; and provide for the design, development and implementation of the appropriate data infrastructure for FY 2017 and 2018.
Total grant awarded: $25,900,382

GRANT APPLICATION IN SUBMISSION
Submitted to PCORI 12/2016
"Provider-Targeted Strategies to Improve Patient-Centered Care for a Medicaid-Insured Population by Reducing Opioid Over-Prescribing and Increasing Provider Knowledge of Opioid Harms and Alternative Therapies for Chronic Non-Cancer Pain"

Principal Investigator:
SreyRam Kuy, MD, MHS, FACS (Louisiana Department of Health)

Total Project Cost: $4 million

AMERICAN OVERSIGHT

REFERENCES

(b) (6)
Chief, Surgical Service, Overton Brooks VA Medical Center
Associate Professor, Louisiana State University – Shreveport
Phone: (b) (6)
Email (b) (6) @va.gov

Dr. (b) (6)
Board of Governors, PCORI
Harold H Hines Professor of Medicine, Yale School of Medicine
Director, Yale Robert Wood Johnson Foundation Clinical Scholars Program
Director, Center for Outcomes Research and Evaluation
Email: (b) (6) @yale.edu

Dr. (b) (6)
Charles Knight, Sr Endowed Professor of Surgery
Chief, Surgical Oncology, Louisiana State University – Shreveport
Phone: (b) (6)
Email: (b) @lsuhsc.edu

Dr. (b) (6) (b) (6)
Associate Program Director of Pulmonary & Critical Care Medicine Fellowship
Overton Brooks VA Medical Center
Associate Professor, Louisiana State University – Shreveport
Phone: (b) (6)

Dr. (b) (6)
President-Elect, Vassar College
Professor of Public Health
Faculty Director of the Yale Global Health Leadership Institute
Brady-Johnson Professor of Grand Strategy
Master of Branford College, Yale University – School of Public Health
Email: (b) (6) @yale.edu

AMERICAN OVERSIGHT

Message

From: Vivieca Simpson [(b) (6) @gmail.com]
Sent: 6/7/2017 1:04:40 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re:

Yes, I agree.

On Jun 6, 2017 21:49, "David shulkin" <Drshulkin@aol.com> wrote:
Yeah think we need to send him home-

Sent from my iPhone

> On Jun 6, 2017, at 8:58 PM, Vivieca Simpson <(b) (6) @gmail.com> wrote:
>
> OMG! Heard that (b) behaved horribly. Scott was so angry. The entire group was stunned. Glad I was not there.

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 6/7/2017 1:39:02 AM
To: Vivieca Simpson [(b) (6) @gmail.com]
Subject: Re:

Yeah think we need to send him home-

Sent from my iPhone

> On Jun 6, 2017, at 8:58 PM, Vivieca Simpson <(b) (6) 2@gmail.com> wrote:
>
> OMG! Heard that (b) behaved horribly. Scott was so angry. The entire group was stunned. Glad I was not there.

AMERICAN OVERSIGHT

Message

From: Vivieca Simpson [(b) (6) @gmail.com]
Sent: 6/7/2017 12:58:44 AM
To: David shulkin [drshulkin@aol.com]

OMG! Heard that (b) behaved horribly. Scott was so angry. The entire group was stunned. Glad I was not there.

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 3/14/2017 10:31:13 AM
To: William S Gould [(b) (6) @verizon.net]
Subject: Re: Invitation to meet with BCG CEO

Any word on his schedule?

Sent from my iPhone

On Mar 9, 2017, at 4:36 PM, William S Gould <(b) (6) @verizon.net> wrote:

> Thanks, I'm running traps for the 7:30 a.m. slot to see whether (b) is in town that early. Will get back to you and (b) (6) as soon as I have info. BR, Scott
> W. Scott Gould
> (b) (6)
> (b) (6) MD (b) (6)
> cell: (b) (6)
> tel: (b) (6)
>
> ---
>
> **From:** (b) (6) <(b) (6) @gmail.com>
> **Date:** Thursday, March 9, 2017 at 3:22 PM
> **To:** David Shulkin <drshulkin@aol.com>
> **Cc:** William S Gould <(b) (6) @verizon.net>
> **Subject:** Re: Invitation to meet with BCG CEO
>
> Mr. Gould thank you. Will be in touch with a time, likely morning.
>
> On Mar 9, 2017 3:15 PM, "David shulkin" <Drshulkin@aol.com> wrote:
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>
> Sent from my iPhone
>
> On Mar 9, 2017, at 10:23 AM, William S Gould <(b) (6) @verizon.net> wrote:
>
> > David:
> >
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> >
> > BR,
> >
> > Scott
> >
> > W. Scott Gould

AMERICAN OVERSIGHT

(b) (6)
(b) (6) MD (b) (6)
cell (b) (6)
tel: (b) (6)

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 3/9/2017 10:09:08 PM
To: William S Gould [(b) (6) @verizon.net]
Subject: Re: Invitation to meet with BCG CEO

Ok

Sent from my iPhone

On Mar 9, 2017, at 4:36 PM, William S Gould <(b) (6) @verizon.net> wrote:

> Thanks, I'm running traps for the 7:30 a.m. slot to see whether (b) is in town that early. Will get back to you and (b) (6) as soon as I have info. BR, Scott
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> **Cc:** William S Gould <(b) (6) @verizon.net>
> **Subject:** Re: Invitation to meet with BCG CEO
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> Mr. Gould thank you. Will be in touch with a time, likely morning.
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> > BR,
> >
> > Scott
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> > W. Scott Gould

AMERICAN OVERSIGHT

(b) (6)
(b) (6) MD (b) (6)
cell: (b) (6)
tel (b) (6)

AMERICAN OVERSIGHT

Message

From: William S Gould [(b) (6) @verizon.net]
Sent: 3/9/2017 9:36:14 PM
To: (b) (6) [(b) (6) @gmail.com]; David shulkin [Drshulkin@aol.com]
Subject: Re: Invitation to meet with BCG CEO

Thanks, I'm running traps for the 7:30 a.m. slot to see whether (b) is in town that early. Will get back to you and (b) as soon as I have info. BR, Scott
W. Scott Gould
(b) (6)
(b) (6) MD (b)
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>
> BR,
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> W. Scott Gould
> (b) (6)
> (b) (6) MD (b)
> cell: (b) (6)
> tel (b) (6)

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 3/9/2017 8:09:46 PM
To: William S Gould [(b) (6) @verizon.net]
CC: (b) (6) [(b) (6) @gmail.com]
Subject: Re: Invitation to meet with BCG CEO

Id like that- let me see if i can fit in somehow

Sent from my iPhone

On Mar 9, 2017, at 10:23 AM, William S Gould <(b) (6) @verizon.net> wrote:

> David:
>
> Tight timing, but thought I'd offer — Boston Consulting Group CEO, (b) (6) is in town next Wednesday. He is a member of President Trump's Business Advisory board. There might be some interesting learnings that (b) can share about how outside advisors have articulated messages and influenced the President to complement your own journey in this area. Maybe a coffee at the Off-the-Record Bar at Haye Adams?
>
> BR,
>
> Scott
>
> W. Scott Gould
> (b) (6)
> (b) (6) MD (b) (6)
> cell (b) (6)
> tel: (b) (6)

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/7/2017 1:31:10 PM
To: Ike Perlmutter [[redacted]@frenchangel59.com]

Ike- Sorry i missed you last evening

Should i call you this morning?

David

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 2/23/2017 12:39:40 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: Today

Why tell them anything?

Sent from my iPhone

> On Feb 23, 2017, at 7:26 AM, Poonam Alaigh <(b) (6) n@hotmail.com> wrote:
>
> What should I tell ahs today about my next move- we have announced it internally already - I just want to be honest but careful - should I say something specifically to Brian
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 2/23/2017 12:26:47 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Today

What should I tell ahs today about my next move- we have announced it internally already - I just want to be honest but careful - should I say something specifically to Brian

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 2/28/2017 2:13:27 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Re: Look at 12 min 38 seconds where Potus talks about me

He appears to be so comfy in a playful way with you- it's all good

Sent from my iPad

On Feb 27, 2017, at 8:54 PM, David Shulkin <drshulkin@aol.com> wrote:

> https://m.youtube.com/watch?v=9fW-ejUDLrc
>
> Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 2/28/2017 1:54:25 AM
To: David Shulkin [drshulkin@aol.com]
BCC: (b) [(b) (6) @gmail.com]; Poonam Alaigh [(b) (6) @hotmail.com]; (b) (6) [(b) (6) @gmail.com]; (b) (b) (6) [(b) @sunnyshulkin.com]; (b) (6) [(b) @sunnyshulkin.com]; (b) (6) [(b) (6) @gmail.com]; (b) (6) [(b) (6) @gmail.com]; (b) (6) [(b) (6) me.com]; (b) (6) [(b) (6) @gmail.com]; Vivieca Wright Simpson [vivieca.Wright@va.gov]
Subject: Look at 12 min 38 seconds where Potus talks about me

https://m.youtube.com/watch?v=9fW-ejUDLrc

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/7/2017 12:42:47 AM
To: Darin Selnick(b) (6) @gmail.com]
Subject: Fwd: Executive Order - Telehealth
Attachments: Executive Order - Draft - v17 3.13.17.docx; Untitled attachment 15707.htm

This is the other one I have

I think Vivieca has 14 plus others- but none have been vetted or moved forward at this point

Sent from my iPhone

Begin forwarded message:

> **From:** "(b) (6) (b) (6) R." (b) (6) va.gov>
> **Date:** April 6, 2017 at 12:25:55 PM EDT
> **To:** 'David shulkin' <Drshulkin@aol.com>
> **Subject: Executive Order - Telehealth**
>
> Latest version

AMERICAN OVERSIGHT

Executive Order: Ensuring our veterans get the care they need wherever and whenever they need it.

Executive Order

_ _ _ _ _ _ _

Ensuring our veterans get the care they need wherever and whenever they need it.

By the authority vested in me as President of the United States by the Constitution and the laws of the United States of America, it is hereby ordered as follows:

Section1: Purpose. The purpose of this Executive Order is to enable the transformation of the Department of Veterans Affairs (VA) into a modern health care system by directing VA to deliver clinical services to veterans using advanced technologies, predominately telehealth, and aligning the executive branches of government to support the provision of comprehensive veteran's health care services through advanced technologies.

The VA Telehealth program is a modern, veteran- and family-centered health care delivery model that leverages information and telecommunication technologies to connect veterans with their clinicians and allied or ancillary health care professionals irrespective of the provider's location or the veteran's location.

Telehealth enhances the capacity of the VA health care system to deliver services, empowering VA to deliver critical or needed health care service to veterans located in areas where medical providers or specialty care may be unavailable. It also increases the accessibility of VA care, bringing VA provider services to locations most convenient for veterans, including clinics in remote communities and veterans' homes.

Section 2: Policy.

It is the policy of the Executive branch that to achieve important Federal interests, including but not limited to ensuring the availability of clinical care for veterans receiving care from VA, VA shall use every available resource and authority to enhance access to care, including through the use of telehealth where appropriate.

Section 3: Actions

(a) The Secretary of Veterans Affairs, with the support of the Office of Management and Budget and the Department of Justice (DOJ), will promulgate regulations establishing standards for VA providers delivering telehealth within the scope of their employment, irrespective of the provider's location or the Veteran's location within a State as that term is defined in title 38, United States Code (U.S.C.) § 101(20). These regulations shall not be subject to the requirements of Executive Order 13132. Within the confines of Federal law, these standards will supersede any conflicting standards that may exist at a State or local level.

(b) In order to create the infrastructure for a modern health care system, VA will propose a plan to modernize the internet capacity, technical field staffing, and technology supporting VA telehealth within the next 90 days.

Draft SIMPLE

AMERICAN OVERSIGHT

(c) As part of the plan required under paragraph (b), VA will identify any obstacles, including statutory, regulatory, and budgetary, that will need to be resolved for VA to implement the plan for a modern health care system referenced in the previous paragraph.

(d) In order to ensure delivery of comprehensive telehealth services irrespective of a veteran's location, the Attorney General will establish a Special Registration Class for VA telehealth providers under the authority of 21 U.S.C. § 831(h) to allow VA telehealth providers engaged in the practice of telemedicine (as that term is used in 21 U.S.C. 802(54)) to prescribe controlled substances in full compliance with the Controlled Substances Act within the next 90 days.

(e) In general, VA will recommend, and the Department of Justice (DOJ) will provide, legal representation requested by a VA-employed provider for, or other appropriate response to, a disciplinary or legal action initiated by a State or State licensing board against the provider for furnishing telehealth services within the scope of employment and when authorized by VA.

Section 4: General Provisions.

(a) Nothing in this order shall be construed to impair or otherwise affect the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented subject to the availability of appropriations.

(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

Signature Block and Date

Draft Sample

AMERICAN OVERSIGHT

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/6/2017 5:36:00 PM
To: Ike Perlmutter [[redacted]@frenchangel59.com]
Subject: Fwd: Executive Order - Telehealth
Attachments: Executive Order - Draft - v17 3.13.17.docx; Untitled attachment 15712.htm

Here is the priority executive order

Ill send more points later

David

Latest version

AMERICAN OVERSIGHT

Executive Order: Ensuring our veterans get the care they need wherever and whenever they need it.

Executive Order

_ _ _ _ _ _ _

Ensuring our veterans get the care they need wherever and whenever they need it.

By the authority vested in me as President of the United States by the Constitution and the laws of the United States of America, it is hereby ordered as follows:

Section1: Purpose. The purpose of this Executive Order is to enable the transformation of the Department of Veterans Affairs (VA) into a modern health care system by directing VA to deliver clinical services to veterans using advanced technologies, predominately telehealth, and aligning the executive branches of government to support the provision of comprehensive veteran's health care services through advanced technologies.

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Section 2: Policy.

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Section 3: Actions

(a) The Secretary of Veterans Affairs, with the support of the Office of Management and Budget and the Department of Justice (DOJ), will promulgate regulations establishing standards for VA providers delivering telehealth within the scope of their employment, irrespective of the provider's location or the Veteran's location within a State as that term is defined in title 38, United States Code (U.S.C.) § 101(20). These regulations shall not be subject to the requirements of Executive Order 13132. Within the confines of Federal law, these standards will supersede any conflicting standards that may exist at a State or local level.

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Draft SIMPLE

AMERICAN OVERSIGHT

(c) As part of the plan required under paragraph (b), VA will identify any obstacles, including statutory, regulatory, and budgetary, that will need to be resolved for VA to implement the plan for a modern health care system referenced in the previous paragraph.

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(e) In general, VA will recommend, and the Department of Justice (DOJ) will provide, legal representation requested by a VA-employed provider for, or other appropriate response to, a disciplinary or legal action initiated by a State or State licensing board against the provider for furnishing telehealth services within the scope of employment and when authorized by VA.

Section 4: General Provisions.

(a) Nothing in this order shall be construed to impair or otherwise affect the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented subject to the availability of appropriations.

(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

Signature Block and Date

Draft Sample

AMERICAN OVERSIGHT

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 2/16/2017 2:28:37 AM
To: Jennifer Lee [(b) (6)]@gmail.com]
Subject: Re: listening sessions

Yes sounds good

Sent from my iPhone

> On Feb 15, 2017, at 7:44 PM, Jennifer Lee <(b) (6)e@gmail.com> wrote:
>
> Hi David,
>
> FYI - Darin Selnick called me tonight to talk about legislative proposals. I think he could help us. Should I involve him in the listening sessions?
> I'd like to quickly sketch a plan for these with help from Poonam and (b) (6) Will include Darin only if you think it's okay.
>
> Thanks
> Jen
>
>
>
>
>

AMERICAN OVERSIGHT

Message

From: Jennifer Lee [(b) (6) @gmail.com]
Sent: 2/16/2017 12:44:37 AM
To: David Shulkin [drshulkin@aol.com]
Subject: listening sessions

Hi David,

FYI - Darin Selnick called me tonight to talk about legislative proposals. I think he could help us. Should I involve him in the listening sessions?
I'd like to quickly sketch a plan for these with help from Poonam and (b) (6). Will include Darin only if you think it's okay.

Thanks
Jen

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 5/18/2017 11:10:27 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: Your wish

Thank you for this

Call me if u want to hear about ush commission

Sent from my iPhone

> On May 18, 2017, at 7:06 PM, Poonam Alaigh <(b) (6) n@hotmail.com> wrote:
>
> And most importantly we would have been stuck with a complicated and controversial model that we would still be selling if I hadn't taken charge in real time at the 4 corners briefing and changed the model with the staffers when they dismissed the model that excluded the low performing medical centers. Baligh was there and was speechless and stunned as I worked that meeting to a consensus and then simply committed to it knowing that I would be able to bring you along no matter how tough it was going to be. But I had confidence in our trust for one another- and that no matter how resistant you could have been, you would ultimately come around and understand my perspective because the most important thing was for this, for you to succeed- not knowing if I was ever going to be part of it- this was creating your legacy - and saving the health care system for our Veterans.
>
>
>
> Sent from my iPad
>
>> On May 18, 2017, at 11:52 AM, David shulkin <Drshulkin@aol.com> wrote:
>>
>> I want you involved in these things- and you are the only one i trust and have confidence in- all i am asking you to do is let me have the ability to get things i need without you first stopping them- you can definitely have major involvement without contradicting my requests-
>>
>>
>>
>> Sent from my iPhone
>>
>>> On May 18, 2017, at 12:20 PM, Poonam Alaigh <(b) (6) n@hotmail.com> wrote:
>>>
>>> I know I complicate and disrupt things but anything good that comes out of VHA has all my finger prints on it- without me involved, it will be a heavy lift and will not be the BEST it could be - think about myVA Access, Access website- it's your choice and you are the boss- I am simply a worker bee - you say I am a partner but it shows that you really don't have confidence in my ability or competency when you talk like that- we need to have healthy disagreements to get to the best scenario - not discussions like these. I am here to be part of change and innovation but can also simply be following orders, which is not going to make me happy in the least. I am really hoping we can go beyond all this and get to a level set where we have seamless understanding- hasn't been easy in the least, fortunately there is still time and you have options- I only want the very best for you- that is and will always be my primary goal
>>>
>>> Sent from my iPhone
>>

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 5/18/2017 11:06:08 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Your wish

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Sent from my iPad

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>>
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>>
>> Sent from my iPhone
>

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 5/18/2017 4:47:45 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: Your wish

I want you involved in these things- and you are the only one i trust and have confidence in- all i am asking you to do is let me have the ability to get things i need without you first stopping them- you can definitely have major involvement without contradicting my requests-

Sent from my iPhone

> On May 18, 2017, at 12:20 PM, Poonam Alaigh <(b) (6) n@hotmail.com> wrote:
>
> I know I complicate and disrupt things but anything good that comes out of VHA has all my finger prints on it- without me involved, it will be a heavy lift and will not be the BEST it could be - think about myVA Access, Access website- it's your choice and you are the boss- I am simply a worker bee - you say I am a partner but it shows that you really don't have confidence in my ability or competency when you talk like that- we need to have healthy disagreements to get to the best scenario - not discussions like these. I am here to be part of change and innovation but can also simply be following orders, which is not going to make me happy in the least. I am really hoping we can go beyond all this and get to a level set where we have seamless understanding- hasn't been easy in the least, fortunately there is still time and you have options- I only want the very best for you- that is and will always be my primary goal
>
> Sent from my iPhone

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Message

From: IP [(b) (6)@frenchangel59.com]
Sent: 4/13/2017 12:55:51 PM
To: David shulkin [drshulkin@aol.com]
Subject: FW: Article

FYI

From: (b) (6) EOP/WHO [mailto(b) (6)@who.eop.gov]
Sent: Wednesday, April 12, 2017 10:26 PM
To: IP; Kushner, Jared C. EOP/WHO
Cc: (b) (6) EOP/WHO
Subject: RE: Article

Incredible. We need to lean all the way into this.

In the meantime, we are plowing ahead on the action items we discussed.

Thanks for everything.

From: IP [mailto(b)@frenchangel59.com]
Sent: Wednesday, April 12, 2017 10:01 PM
To: Kushner, Jared C. EOP/WHO <(b)@who.eop.gov>; (b) (6) EOP/WHO (b) (6)@who.eop.gov>
Cc: (b) (6) EOP/WHO <(b) who.eop.gov>
Subject: FW: Article

I think you will find this very interesting.

From: (b) (6) [mailto(b) (6) @pcommgroup.com]
Sent: Wednesday, April 12, 2017 8:22 PM
To: IP
Subject: RE: Article

This type of accountability in life let alone government is so rare; will be an honor to support Doctor Shulkin. What a man.

From: IP [mailto(b)@frenchangel59.com]
Sent: Wednesday, April 12, 2017 5:05 PM
To: (b) (6) <(b) (6) @pcommgroup.com>
Subject: FW: Article

FYI

From: David shulkin [mailto:Drshulkin@aol.com]
Sent: Wednesday, April 12, 2017 1:27 PM
To: Ike Perlmutter; Laurie Perlmutter; Bruce Moskowitz; Marc Sherman
Subject: Fwd: Article

I wanted to share the front page story today

Already the web site which just went live today has 450000 hits- nothing like that never been seen before at VA

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(b) (6) [redacted] was a big help

Feel free to share with the ceos

David

https://www.usatoday.com/staff/3975/donovan-slack/

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The Department of Veterans Affairs has a new message on public scrutiny: Bring it on.

President Trump's pick to lead the agency, VA Secretary David Shulkin, is unveiling a new web site that will reveal for the first time exactly how care at every VA hospital and clinic across the country compares with nearby private-sector hospitals and national averages.

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"He doesn't understand why people are waiting this long, and he wants to fix it. My answer to him is, the way that you fix this is not by internally motivating people to fix it — you actually need the external environment, people looking, saying I don't understand why it's 45 days," he said.

"In my experience in health care — but it's like every other industry — industries don't change from within, they change from outside competition, and they change from outside forces, and that's very much my philosophy."

That's a marked shift from his predecessor, former Procter & Gamble CEO Bob McDonald, who as secretary focused heavily on trying to spur internal cultural change, assailed critical media coverage and said that revealing internal quality ratings of VA hospitals would cause veterans "unwarranted distress" and possibly dissuade them from getting care.

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Sent: 4/12/2017 9:22:05 PM
To: L Perl [(b) (6) @gmail.com]
Subject: Re: Article

Thanks Laurie

I am sure the work has just begun but with you and Ike's help i am confident we can make a difference

David

Sent from my iPhone

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AMERICAN OVERSIGHT

Message

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Sent: 4/12/2017 9:01:19 PM
To: David shulkin [Drshulkin@aol.com]
CC: Ike Perlmutter [(@frenchangel59.com]; Bruce Moskowitz [brucem(b) (6) mac.com]; Marc Sherman [mbs(b) (6) gmail.com]
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Sent: 4/12/2017 5:46:59 PM
To: David shulkin [Drshulkin@aol.com]
CC: Ike Perlmutter [(@frenchangel59.com]; Laurie Perlmutter [(b) (6) @gmail.com]; Marc Sherman [mbs(b) (6) gmail.com]
Subject: Re: Article

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Sent from my iPad
Bruce Moskowitz M.D.

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Subject: Fwd: Article

I wanted to share the front page story today

Already the web site which just went live today has 450000 hits- nothing like that never been seen before at VA

(b) (6) was a big help

Feel free to share with the ceos

David

https://www.usatoday.com/staff/3975/donovan-slack/

USA Today: Exclusive: New VA chief on public scrutiny: Bring it (12 April, Donovan Slack, 37M online visitors/mo; McLean, VA)

The Department of Veterans Affairs has a new message on public scrutiny: Bring it on.

President Trump's pick to lead the agency, VA Secretary David Shulkin, is unveiling a new web site that will reveal for the first time exactly how care at every VA hospital and clinic across the country compares with nearby private-sector hospitals and national averages.

The site set to go live Wednesday, accesstocare.va.gov, also shows if veterans are satisfied with wait times at each facility and how long they are actually waiting on average.

Shulkin, the only holdover from the Obama administration in Trump's Cabinet, told USA TODAY that he believes transparency is a critical step toward fixing the beleaguered VA, something he said he conveyed to Trump.

"He doesn't understand why people are waiting this long, and he wants to fix it. My answer to him is, the way that you fix this is not by internally motivating people to fix it — you actually need the external environment, people looking, saying I don't understand why it's 45 days," he said.

"In my experience in health care — but it's like every other industry — industries don't change from within, they change from outside competition, and they change from outside forces, and that's very much my philosophy."

That's a marked shift from his predecessor, former Procter & Gamble CEO Bob McDonald, who as secretary focused heavily on trying to spur internal cultural change, assailed critical media coverage and said that revealing internal quality ratings of VA hospitals would cause veterans "unwarranted distress" and possibly dissuade them from getting care.

Shulkin himself had worried veterans might be scared away, but he says now that he's in charge — he was previously undersecretary for health — he decided transparency is the best option. He provided a

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demonstration of the new web site to USA TODAY on Monday that showed wide variations in wait times.

In the greater Los Angeles area, for example, the average wait for new patients seeking mental health appointments ranged from eight days in Long Beach, Calif., to 87 days at a clinic in Santa Fe Springs, Calif.

In New York and New Jersey, average waits range from three days at a clinic on Staten Island to 58 days at a VA clinic in Morristown, N.J.

Shulkin said the information will empower the public to ask questions — including members of Congress and others outside the VA who can hold it accountable. And it helps veterans and their family members make more informed decisions about where to seek care.

"It starts giving people now some choice on essentially what they want to do," Shulkin said.

At the Phoenix VA, which made headlines in 2014 after schedulers kept secret wait lists and veterans died waiting to be seen, the average wait is now 19 days for new primary care appointments and eight days for new mental health patients, according to the new site.

But on satisfaction, only 69% of veterans surveyed say they usually got an appointment when they needed one in Phoenix. The national average on that question is 85%, Shulkin said.

He noted that all of the roughly 150 VA hospitals now provide same-day services for veterans needing urgent or immediate appointments, a goal he had set when he started at the agency in 2015.

The site also shows how each VA compares to nearby private-sector facilities on more than a dozen quality measures, including complication rates after hip or knee surgery. It also displays national averages, allowing the public to see where VA care is lagging or better in average quality.

Shulkin is a practicing physician who still sees VA patients via videolink in his top-floor office at VA headquarters in Washington. He is quickly ramping up plans to deliver on Trump's campaign promises, including setting up a White House hotline for VA complaints that Shulkin says should be up and running by June 1. He is also putting together a task force to investigate fraud and abuse at the agency.

His philosophy about transparency stems to his early career days in the 1990s, he said, when he was chief medical officer of the University of Pennsylvania Health System. The state of Pennsylvania released death rates for cardiac surgery programs and Penn's was the highest.

"And everyone until then had thought, well Penn was the best. Now all of a sudden we have data, it's the worst," Shulkin said. "Well, I learned — not easily — I learned that was a gift to me to drive internal change, and I could never have stood up as a young kid and said, 'guys we have a problem here.' But when the reporters and the newspaper articles were saying you have an outcomes problem here, mortality's three times as high as other hospitals in Pennsylvania, that allowed me to drive internal change."

Shulkin hopes releasing all the internal data on the sprawling VA system, which encompasses more than 1,200 medical clinics in addition to hospitals, will help him do the same.

"I really think that this is going to be, when we look back, this is going to be a turning point for VA because the leaders that aren't focused on what they're doing have no place now to hide and so they're going to have to truly be accountable for their results," he said.

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 5/12/2017 8:52:45 PM
To: Djs Shulkin [vacodjs1@va.gov]
Subject: Fwd: Women's Health

Sent from my iPhone

Begin forwarded message:

> **From:** Poonam Alaigh <(b) (6) @hotmail.com>
> **Date:** May 12, 2017 at 2:04:27 PM EDT
> **To:** David shulkin <Drshulkin@aol.com>
> **Subject: Re: Women's Health**
>
> http://www.sunshinestatenews.com/story/va-agrees-debbie-wasserman-schultzs-call-change-mammogram-guidelines
>
> https://wassermanschultz.house.gov/press-releases/wasserman-schultz-on-va-breast-cancer-screening-guidelines-announcement/
>
> http://dev.breastcancerdatacenter.com/uncategorized/va-agrees-with-debbie-wasserman-schultzs-call-to-change-mammogram-guidelines-3/
>
> Sent from my iPhone
>
> On May 8, 2017, at 2:57 PM, David shulkin <Drshulkin@aol.com> wrote:
>
> > Great
> >
> > Sent from my iPhone
> >
> > On May 8, 2017, at 12:55 PM, Bruce Moskowitz <brucem(b) (6) mac.com> wrote:
> >
> > > This is a Veteran and head of Hopkins women's health.
> > >
> > > Sent from my iPad
> > > Bruce Moskowitz M.D.
> > >
> > > Begin forwarded message:
> > >
> > > > **From:** (b) (6) <(b) (6) @jhmi.edu>
> > > > **Date:** May 8, 2017 at 12:16:14 PM EDT
> > > > **To:** Bruce Moskowitz <brucem(b) (6) mac.com>
> > > > **Subject: RE: Women's Health**

AMERICAN OVERSIGHT

Dr. Moskowitz,
As per our conversation yesterday, attached is a my brief Biosketch from JH. I also attached the NIH brief bio template we use for grant applications. It has a little more detail, while sparing you the longer version of my CV.

If I can be of any service in helping to improve women's health related to the VA, I would be honored to do so.

(b)
Mobile (b) (6)

(b) (6) MD
The Dorothy Edwards Professor and
Director of Gynecology and Obstetrics
Obstetrician/Gynecologist-in-Chief
Johns Hopkins Hospital
Johns Hopkins Medicine

600N. Wolfe St./Phipps 264
Baltimore, Md 21287-1264
443-287-(b)

-----Original Message-----
From: Bruce Moskowitz
[mailto:brucem(b) (6) mac.com]
Sent: Saturday, May 06, 2017 7:07 PM
To: (b) (6) <(b) (6) @jhmi.edu>
Subject: Re: Women's Health

Anytime at your convenience

Sent from my iPad
Bruce Moskowitz M.D.

> On May 6, 2017, at 6:48 PM, (b) <(b) (6) @jhmi.edu> wrote:
>
> Is there a good time to reach u tomorrow? (b)
>
> Sent from my iPhone

AMERICAN OVERSIGHT

On May 6, 2017, at 6:44 PM, Bruce Moskowitz <brucem(b) (6)@mac.com> wrote:

Excellent this is an important initiative to Congress and I am available 24-7 to discuss. Call me anytime (b) (6)

Sent from my iPhone

> On May 6, 2017, at 6:22 PM, (b) (6) (b) (6) (@jhmi.edu> wrote:
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AMERICAN OVERSIGHT

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(b) (6)

Sent from my iPhone

<(b) Brief biosketch for Dr. Moskowitz May 2017 .pdf>

<2017 (b) _NIH_template_biosketch for Dr. Moxkowitz .docx>

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 5/12/2017 6:04:27 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Women's Health

http://www.sunshinestatenews.com/story/va-agrees-debbie-wasserman-schultzs-call-change-mammogram-guidelines

https://wassermanschultz.house.gov/press-releases/wasserman-schultz-on-va-breast-cancer-screening-guidelines-announcement/

http://dev.breastcancerdatacenter.com/uncategorized/va-agrees-with-debbie-wasserman-schultzs-call-to-change-mammogram-guidelines-3/

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> > (b)
> > Mobile (b) (6)

AMERICAN OVERSIGHT

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The Dorothy Edwards Professor and
Director of Gynecology and Obstetrics
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AMERICAN OVERSIGHT

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Sent from my iPhone

<(b) Brief biosketch for Dr. Moskowitz May 2017 .pdf>
<2017 (b) _NIH_template_biosketch for Dr. Moxkowitz .docx>

AMERICAN OVERSIGHT

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Sent: 5/8/2017 6:57:35 PM
To: Bruce Moskowitz [brucem(b) (6) mac.com]
CC: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: Women's Health

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<2017 (b) _NIH_template_biosketch for Dr. Moxkowitz .docx>

AMERICAN OVERSIGHT

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From: Bruce Moskowitz [brucem(b) (6) mac.com]
Sent: 5/8/2017 4:55:49 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]; drshulkin@aol.com
Subject: Fwd: Women's Health
Attachments: (b) Brief biosketch for Dr. Moskowitz May 2017 .pdf; Untitled attachment 15789.htm; 2017(b) _NIH_template_biosketch for Dr. Moxkowitz .docx; Untitled attachment 15792.htm

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Bruce Moskowitz M.D.

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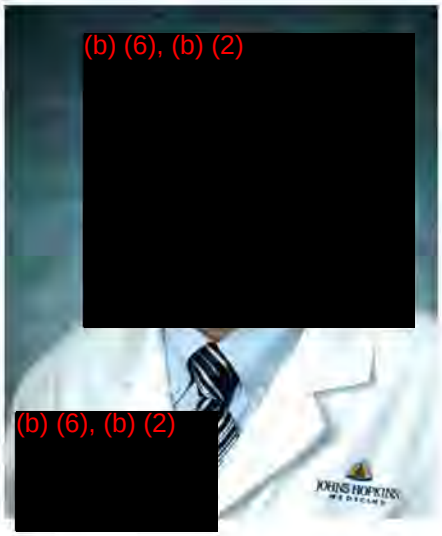

JOHNS HOPKINS MEDICINE

(b) (6) M.D., FACOG
Col USAF MC (ret)
The Dr. Dorothy Edwards Professor and
Director of Gynecology and Obstetrics
The Johns Hopkins School Of Medicine

Gynecologist / Obstetrician-in-Chief
The Johns Hopkins Hospital

Director of Gynecology and Obstetrics
Johns Hopkins Medicine

Office Phone :(b) (6)
Mobile (b) (6)
E-mail: (b) (6) @jhmi.edu

Current position:

(b) (6), (b) (2)

Background:

(b) (6), (b) (2)

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BIOGRAPHICAL SKETCH

Provide the following information for the Senior/key personnel and other significant contributors.
Follow this format for each person. **DO NOT EXCEED FIVE PAGES.**

NAME: (b) (6), (b) (2)

eRA COMMONS USER NAME (credential, e.g., agency login): asatin2

POSITION TITLE: (b) (6), (b) (2)
(b) (6), (b) (2)

EDUCATION/TRAINING *(Begin with baccalaureate or other initial professional education, such as nursing, include postdoctoral training and residency training if applicable. Add/delete rows as necessary.)*

INSTITUTION AND LOCATION	DEGREE *(if applicable)*	Completion Date MM/YYYY	FIELD OF STUDY
(b) (6), (b) (2)			

Please refer to the Biographical Sketch sample in order to complete sections A, B, C, and D of the Biographical Sketch.

A. Personal Statement

(b) (6), (b) (2)

AMERICAN OVERSIGHT

(b) (6), (b) (2)

[redacted]

B. Positions and Honors

Positions and Employment

(b) (6), (b) (2)

[redacted]

Selected National Leadership Positions:

(b) (6), (b) (2)

[redacted]

Other Selected Experience and Professional Memberships

(b) (6), (b) (2)

[redacted]

AMERICAN OVERSIGHT

(b) (6), (b) (2)

[redacted]

Selected Honors

(b) (6), (b) (2)

[redacted]

C. Contributions to Science

(b) (6), (b) (2)

[redacted]

AMERICAN OVERSIGHT

(b) (6), (b) (2)

[redacted]

(b) (6), (b) (2)

[redacted]

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(b) (6), (b) (2)

[redacted]

D. Research Support

Research Support

(b) (6), (b) (2)

[redacted]

Relevant Completed Research Support

(b) (6), (b) (2)

[redacted]

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 3/5/2017 3:47:26 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re:

I think this will make a big difference

Thanks for doing this

Sent from my iPhone

On Mar 5, 2017, at 10:37 AM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:

> David I am going to cancel everything on my calendar and deal with this head on this week- trying to change our flights so that we can get back earlier later today instead of tomorrow. I think I will have to bring everyone in a room and fix it until we are satisfied- not patch work. The latest was that Recall reminder is eliminated but gave the field until April to make sure it was done. Also, in VSE- there is a field that still states " Recall Reminder" which they cannot change in this VSE enhancement - I was speaking with Laverne on this before she left, but unsuccessful. I will now readdress with Rob. This is still causing confusion in the field since we say it's eliminated but the system still prompts them to do so.
>
> I will roll up my sleeves and shake the Access team up- they were reluctant in the past to take any specific guidance, but it's different now
>
> Sent from my iPhone
>
> On Mar 5, 2017, at 5:28 AM, David shulkin <Drshulkin@aol.com> wrote:
>
> > More press on the IG wait time fall out -
> >
> > Are we sure we got rid of recall yet? I suspect some did and some did not
> >
> > http://www.newsobserver.com/news/business/article136295603.html
> >
> > Sent from my iPhone

AMERICAN OVERSIGHT

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From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 3/5/2017 3:37:35 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re:

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AMERICAN OVERSIGHT

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From: (b) (6) [(b) (6) @gmail.com]
Sent: 4/18/2017 2:28:59 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: For Mr. Perlmutter

Sent from my iPhone

Begin forwarded message:

From: "IP" <(b)@frenchangel59.com>
Date: April 18, 2017 at 8:04:16 AM EDT
To: "David shulkin" <drshulkin@aol.com>
Subject: FW: For Mr. Perlmutter

Please read and discuss before I answer. Thank you

Dear President Trump:

You have no doubt seen the report in the media about the Washington, DC VA. The good news is the VA was already in the process of evaluating the issues at that hospital and are starting to get their arms around many of the problems. Also, I am pleased to report that the Secretary removed the hospital director within hours of learning about the problems, action that is unheard of in the VA environment historically.

The Secretary has been taking strong actions to clean up VA. He recently terminated the hospital director in Shreveport, LA and is in the process of demoting two senior executives from two other hospitals. There are more actions underway. We are progressing on evaluating and understanding the vast problems and risks in the VA system and working as quickly as possible to reform them.

Best,

Ike

-----Original Message-----

From: (b) (6) EOP/WHO

AMERICAN OVERSIGHT

[mailto:(b) (6) @who.eop.gov]

Sent: Monday, April 17, 2017 6:11 PM

To: Marisol Garcia

Subject: For Mr. Perlmutter

Marisol - please see attached for Mr. Perlmutter from the President!

Best,

(b) (6)

Executive Assistant to the President of the United States

Office (b) (6)

Cell: (b) (6)

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/18/2017 2:07:38 PM
To: (b) (6) [(b) (6) @gmail.com]
Subject: Fwd: For Mr. Perlmutter
Attachments: [Untitled].pdf; Untitled attachment 15809.htm

Sent from my iPhone

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> Best,
> Ike
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> From: (b) (6) EOP/WHO
> [mailto(b) (6) @who.eop.gov]
> Sent: Monday, April 17, 2017 6:11 PM
> To: Marisol Garcia
> Subject: For Mr. Perlmutter
>
> Marisol - please see attached for Mr. Perlmutter from the President!
>
> Best,
> (b) (6)
>
> Executive Assistant to the President of the United States
> Office: (b) (6)
> Cell: (b) (6)

AMERICAN OVERSIGHT

(b) (6)

Trump's Promise to Veterans

By Rebecca Burgess

Donald Trump pitched himself as a friend to the American military, and to veterans in particular. His campaign pledged to fix the Department of Veterans Affairs "by firing the corrupt and incompetent VA executives who let our veterans down." Since taking office, however, President Trump hasn't defined what, if anything, his administration will do to make good on that promise. Here are a couple of obvious wrongs he can easily make right.

In 2015, a pair of senior VA officials were accused of defrauding the department to the tune of $400,000. Diana Rubens and Kimberly Graves, the directors of two regional VA offices, had allegedly manipulated the department's hiring and transfer systems for personal financial gain. Ms. Rubens was accused of pressuring a subordinate to leave the VA's Philadelphia office so she could take the job herself, move from Washington, and collect a $288,000 relocation payout. Similarly, Ms. Graves received more than $129,000 by engineering a move from Philadelphia to St. Paul, Minn.

Allison Hickey resigned in October 2015 as the VA undersecretary for benefits amid investigations into her role in the scheme. Ms. Rubens and Ms. Graves were called to appear before the House Veterans Affairs Committee that November, but they refused to testify, invoking their Fifth Amendment right against self-incrimination. Instead of being fired, the pair were demoted. Due to a VA "paperwork mistake," however, the demotion had to be rescinded in December 2015 and reissued.

Then the two got a reprieve from the Merit Systems Protection Board, the quasi-judicial agency whose mission, in part, is to review the disciplining of federal employees.

Corruption at the VA isn't punished, while the Pentagon claws back signing bonuses.

The MSPB is the successor of the U.S. Civil Service Commission, originally set up to protect federal workers from partisan recrimination.

In early 2016 the MSPB fully reversed the punishments of Ms. Rubens and Ms. Graves. Furthermore, the VA did not to try to recover the taxpayer funds that the pair had collected for relocating. It seems that since "senior officials" approved the $400,000, it would have been somehow improper to ask for the money back.

Yet the Los Angeles Times revealed in October 2016 that the Defense Department had been forcing National Guard veterans to repay re-enlistment bonuses—sometimes up to $20,000—they had received during the mid-2000s. The Pentagon said the bonuses were improperly awarded. Nearly 10,000 soldiers, the Times reports, have faced everything from retroactive interest to wage garnishment to tax liens. Debt collectors and tanked credit scores, the result of the retroactive action, will haunt many of them for the foreseeable future.

Unlike the senior VA officials, these soldiers weren't accused of conspiring to game the system. Rather, each signed a service contract and happily took the bonus that the military, under pressure to make up enlistment shortfalls, was eagerly offering. Many consequently deployed for multiple tours. What a way to thank them for their service.

Auditors later determined that the incentive program of the California Army National Guard had been operated like a slush fund, with as much as $100 million misspent. The program's onetime leader, former Master Sgt. Toni Jaffe, was sentenced in May 2012 to 30 months in prison after pleading guilty to filing $15.2 million in false claims. Three other officers were put on probation and forced to pay restitution.

Yet, for some reason, the Pentagon decided to claw back money from the veterans who had received the bonuses. Congress, it turns out, knew about the situation—or at least the California delegation did. When the story hit the press, then-Defense Secretary Ash Carter ordered a halt to the bonus hunting. But the order focused mostly on reviewing and streamlining the process. "This process has dragged on too long, for too many service members," Mr. Carter's statement said. "Too many cases have languished without action." Little was said about the underlying injustice of the matter.

Process is certainly important. As Alexander Pope mused: "For Forms of Government let fools contest; Whate'er is best administer'd is best." But Alexander Hamilton countered the point in Federalist 68. "The true test of a good government," he wrote, "is its aptitude and tendency to produce a good administration."

The rules at the Defense Department and the VA must apply to senior officials and enlisted soldiers alike. Without consistency, even the best process fails from the standpoint of justice.

Exhibit A: the VA, where employees are rewarded because they technically followed a process. Exhibit B: the Pentagon, which could not protect even itself with its own processes. If Mr. Trump wants to do right by veterans and the military, he could begin by insisting on consistency.

Ms. Burgess manages the Program on American Citizenship at the American Enterprise Institute.

Kimberley A. Strassel is away.

My Childhood as a Roaming Catholic

HOUSES OF WORSHIP
By Michael Kerrigan

In April 1978 my family traded Boston urbanity for the relatively untamed South. We had followed career opportunities for my dad before, but never outside the Northeast. My parents put on a brave face during the two-day drive

The road trip was soon over, and in time we would settle into our new community. But there was no way of knowing how long it would take, especially after our first Sunday in town, which happened to be Easter. It left us even more disoriented than when we arrived, and 40 years later I remember it well.

My mom and dad cradle

It must have been, because we went in and experienced an Easter Sunday I'll never forget. The priest looked like a cast member from "Hair" as he led an entrance procession inspired more by Frampton than Bach. His vestments, such as they were, barely hid casual attire underneath, and had the permanence of NBA

rediscover what made them fall in love in the first place. Immediately my sister and I tried to identify the unlucky couple among the parishioners.

During the Our Father, everyone in the pews held hands, even across the aisle. This wasn't just tolerated. It was a necessary condition, the closing of the [illegible] and

before the priest would throw

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Back U.S.S

Who Lost Ru

By Peter Conradi
(Oneworld, 370 pa

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AMERICAN OVERSIGHT

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Message

From: Poonam Alaigh [(b) (6)@hotmail.com]
Sent: 5/27/2017 4:40:23 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Weekend events

I figured as much

Sent from my iPad

> On May 26, 2017, at 8:10 PM, David shulkin <Drshulkin@aol.com> wrote:
>
> Ok good to know especially since im speaking
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> Sent from my iPhone
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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

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From: Poonam Alaigh [(b) (6)@hotmail.com]
Sent: 5/27/2017 2:46:48 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Weekend events

No comparison

Sent from my iPhone

> On May 26, 2017, at 10:05 PM, David shulkin <Drshulkin@aol.com> wrote:
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AMERICAN OVERSIGHT

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From: David shulkin [Drshulkin@aol.com]
Sent: 5/27/2017 12:22:29 AM
To: Poonam Alaigh [(b) (6)@hotmail.com]
Subject: Re: Weekend events

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Sent from my iPhone

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AMERICAN OVERSIGHT

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Sent: 5/27/2017 12:10:49 AM
To: Poonam Alaigh [(b) (6)@hotmail.com]
Subject: Re: Weekend events

Ok good to know especially since im speaking

Sent from my iPhone

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AMERICAN OVERSIGHT

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From: Poonam Alaigh [(b) (6)@hotmail.com]
Sent: 5/27/2017 12:09:36 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Weekend events

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AMERICAN OVERSIGHT

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From: David shulkin [Drshulkin@aol.com]
Sent: 5/26/2017 10:54:25 PM
To: Poonam Alaigh [(b) (6)@hotmail.com]
Subject: Re: Weekend events

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>>>> The only thing I have is a formal Monday morning ceremony. You told me about the concert on Sunday but have no tickets. My office has been in contact with (b) (6) relentlessly about additional details on the Memorial Day activities, but not unexpectedly, she has not provided anything additional on how to participate on the Memorial Day activities. It would have been great if (b) could have been part of more, but I don't even know how to go about it.
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>>>> From experience, I know that (b) (6) is passive and on sidelines when it pertains to me and wishes I wasn't ever around in your sphere of influence, she didn't even let me know about the game yesterday when the time changed and never brings me into anything - and I know that you can't possibly have this stuff as a "to-do" on your list
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>>>>> On May 26, 2017, at 7:38 AM, David shulkin <Drshulkin@aol.com> wrote:
>>>>>
>>>>> Dont forget about rolling thunder sunday and the memorial day concert sunday night
>>>>>
>>>>> Does protocol have you in a box on monday?
>>>>>
>>>>> If you want to go to a bike race monday morning of wiunded warriors i am starting them off about 9 am - before arlington starts at 1010
>>>>>
>>>>> gI film festival going on all weekend - very cool -you and i went last year at candian embassy
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>>>>> If i hear of other stuff ill let you know
>>>>>
>>>>> Sent from my iPhone
>>>>>
>>>>>> On May 26, 2017, at 7:08 AM, Poonam Alaigh <(b) (6)@hotmail.com> wrote:
>>>>>>

AMERICAN OVERSIGHT

>>>>>> We will be there- getting there in Sunday
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>>>>>>> Sent from my iPhone
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>>>

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 5/26/2017 10:46:32 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: Weekend events

Concert is casual
Arlington is formal

Sent from my iPhone

> On May 26, 2017, at 5:28 PM, Poonam Alaigh <(b) (6) n@hotmail.com> wrote:
>
> We have box seats for the Monday event, I will be there for the 9am bike race and we got tickets for the Sunday concert. Are you going attend anything at the GI film festival- if so, what?
>
> Are you going to wear a jacket or suit for the concert- I heard its business attire
>
> Sent from my iPad
>
>> On May 26, 2017, at 8:42 AM, Poonam Alaigh <(b) (6) n@hotmail.com> wrote:
>>
>> K- send me the specifics and details on the places and times and I will just show up with (b) as long as we don't have to get any tickets
>>
>> Sent from my iPad
>>
>>> On May 26, 2017, at 8:33 AM, David shulkin <Drshulkin@aol.com> wrote:
>>>
>>> No tickets needed for concert- just go
>>>
>>> We did that last year and it was great
>>>
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AMERICAN OVERSIGHT

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>>>>>>> Sent from my iPhone
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>>>

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6)@hotmail.com]
Sent: 5/26/2017 9:28:12 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Weekend events

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Are you going to wear a jacket or suit for the concert- I heard its business attire

Sent from my iPad

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>>>>>>
>>>>>> Sent from my iPhone

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>>>>
>>

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/8/2017 8:56:04 PM
To: (b) (6) [(b) (6) @gmail.com]
Subject: Re: revised to 5

I was thinking of one slide period

Sent from my iPhone

On Apr 8, 2017, at 4:19 PM, (b) (6) <(b) (6) @gmail.com> wrote:

> Thanks.
>
> 1 slide for each sub priority, or one slide for each priority with a graphic?
>
> On Apr 8, 2017 4:11 PM, "David Shulkin" <drshulkin@aol.com> wrote:

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) @gmail.com]
Sent: 4/8/2017 8:19:01 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Re: revised to 5

Thanks.

1 slide for each sub priority, or one slide for each priority with a graphic?

On Apr 8, 2017 4:11 PM, "David Shulkin" <drshulkin@aol.com> wrote:

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/8/2017 8:11:19 PM
To: (b) (6) [redacted]@gmail.com
Subject: revised to 5
Attachments: priorities.pptx

AMERICAN OVERSIGHT

The Secretary's 5 Priorities

- Greater Choice for Veterans
  - -Revise the 40/30 Rule
  - -Build an Integrated Network of Care
  - - Empower veterans through transparency of information
- Modernize our System
  - -Infrastructure Improvements and Consolidations
  - -EMR Interoperability and Modernization
- Focus Resources More Efficiently
  - -Foundational Services in VA
  - -VA/DOD/Community Coordination
  - -Deliver on Accountability and Effective Management practices
- Improve Timeliness of Services
  - - Wait times and Accessibility for Care
  - - Decisions on Appeals
  - - Performance on Disability Claims
- Suicide Prevention

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 2/11/2017 6:46:26 PM
To: (b) (6) [(b) (6) @gmail.com]
Subject: Re: Role

Ok thanks for providing me this as i begin to think about how we will run the department- it will be a process rather than a big bang decision

Sent from my iPhone

> On Feb 11, 2017, at 1:38 PM, (b) (6) <(b) (6) r@gmail.com> wrote:
>
>
> Good Afternoon Dr. Shulkin,
>
> Attached is my description to be the Senior Operations Officer for the Office of Secretary. It allows me the opportunity to build upon my current role. While allowing me the opportunity to grow by inserting myself more in the revolutionary transformational activities and representing the Department when appropriate.
>
> A major criticism for myself with this past year is my professional growth. Many opportunities to leap but I did not take advantage , instead I would say that the (b) (6) now is the same (b) (6) that started last year in 2016.
>
> Thanks for the opportunity to provide my thoughts.
>
> (b)
> <Senior Operations Officer.docx>

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) @gmail.com]
Sent: 2/11/2017 6:38:36 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Role
Attachments: Senior Operations Officer.docx

Good Afternoon Dr. Shulkin,

Attached is my description to be the *Senior Operations Officer* for the Office of Secretary. It allows me the opportunity to build upon my current role. While allowing me the opportunity to grow by inserting myself more in the revolutionary transformational activities and representing the Department when appropriate.

A major criticism for myself with this past year is my professional growth. Many opportunities to leap but I did not take advantage , instead I would say that the (b) (6) now is the same (b) (6) that started last year in 2016.

Thanks for the opportunity to provide my thoughts.

(b)

AMERICAN OVERSIGHT

Senior Operations Officer

Major Duties and Responsibilities:

1. Serves as the confidential advisor to the Secretary, responsible for the operational direction for the Office of the Secretary. Provide strategic advice to Secretary on opportunities to strengthen policies that advance the mission of the Department of Veterans Affairs. Provides principle management direction for the day to day operations, private engagements and control immediate access to the Secretary.

2. Perform sensitive duties on complex assignments of special importance to the Secretary and functions at a maximum level of responsibility and with a high degree of independence and authority.

3. Collaborate regularly with the White House, Congress and Veteran Service Organizations to provide critical updates and information on VA-wide initiatives. Establish and maintain cooperative working relationships with stakeholders, and identify new and establish collaborative relationships.

4. Communicate across all levels within the Executive Branch and private sector bridging functional communities to develop mutually agreed strategies to support mission critical initiatives.

5. Participate in key meetings and contribute to the development and evaluation of agency-wide policy and programs. Ensure appropriate and responsive follow-up and accountability and facilitates resolution of matters requiring the Secretary's attention.

6. Serve as resource for VA Senior leaders and staff on key modernization priorities; track outcomes and impacts for dissemination.

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 4/4/2017 7:35:27 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Re: Response from (b) (6)

Don't really know him- had some experience during the Hamilton project and wasn't impressed - seemed like a nice guy though

Sent from my iPhone

On Apr 4, 2017, at 2:02 AM, David Shulkin <drshulkin@aol.com> wrote:

> Thoughts?
>
> Sent from my iPad
>
> Begin forwarded message:
>
> **From:** (b) (6) @verizon.net
> **Date:** April 3, 2017 at 5:07:16 PM EDT
> **To:** Drshulkin@aol.com
> **Subject: Response from** (b) (6)
>
> Hi Dr. Shulkin, I received a message from you through Linkedin. Thank you for remembering me from our meeting in Trenton regarding gainsharing and the BOME; I'm not sure if we also met through Dr. (b) (6) but he is a big fan of yours and has spoken of you often. I'd welcome the chance to speak with you about possible opportunities in Washington, which I've heard is a pretty interesting place these days. Is there someone in your office I can contact to schedule a call at your convenience?
>
> Best regards,
>
> (b) (6)
> (b) (6)
> (b) @verizon.net

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/4/2017 1:02:52 AM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Fwd: Response from (b) (6)

Thoughts?

Sent from my iPad

Begin forwarded message:

From: (b) (6) @verizon.net
Date: April 3, 2017 at 5:07:16 PM EDT
To: Drshulkin@aol.com
Subject: Response from (b) (6)

Hi Dr. Shulkin, I received a message from you through Linkedin. Thank you for remembering me from our meeting in Trenton regarding gainsharing and the BOME; I'm not sure if we also met through Dr. (b) (6), but he is a big fan of yours and has spoken of you often. I'd welcome the chance to speak with you about possible opportunities in Washington, which I've heard is a pretty interesting place these days. Is there someone in your office I can contact to schedule a call at your convenience?

Best regards,

(b) (6)
(b) (6)
(b) @verizon.net

AMERICAN OVERSIGHT

Appointment

From: Marisol Garcia [(b)@frenchangel59.com]
Sent: 4/15/2017 12:37:06 AM
To: L Perl [(b) (6)@gmail.com]; (b) (6)@hotmail.com; David shulkin [Drshulkin@aol.com]; Bruce Moskowitz [brucem(b) (6)mac.com]; mbs(b) (6)gmail.com; (@frenchangel59.com; (b) (6)@va.gov

Subject: VA
Location: Conference Call

Start: 4/15/2017 2:00:00 PM
End: 4/15/2017 2:45:00 PM
Show Time As: Tentative

Recurrence: (none)

Saturday, April 15th

10:00 AM – 10:45 AM EST

Dial-in Information:

US: 1-866-244-(b) (6)

International: 719-457-(b) (6)

Passcode: (b) (6)

Participants:

Laurie Perlmutter, Poonam Alaigh, Secretary David Shulkin, Dr. Bruce Moskowitz, Marc Sherman and Ike

Thank you,

Marisol Garcia

(b) (6) (Office)

(b) (6) (Cell)

AMERICAN OVERSIGHT

(b) @frenchangel59.com

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 5/8/2017 1:14:07 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Fw: VA - Follow-up
Attachments: VA initiatives follow up Conference Call May 6 2017.docx

David- we should review this list when we meet on Wednesday evening, in addition to other things.

In the meantime, do you have the power point on the real estate restructuring that you want to send to Marc- if so, just send it along to all of us, so that we can close that piece and have him work that angle.

From: Marc Sherman <mbs(b) (6) gmail.com>
Sent: Saturday, May 6, 2017 6:34 PM
To: Marisol Garcia
Cc: L Perl; Poonam Alaigh; David shulkin; Bruce Moskowitz; IP
Subject: Re: VA - Follow-up

I have attached is a memo that memorializes today's discussion and agreed actions / timing from our 2pm call

AMERICAN OVERSIGHT

VA Conference Call

AGENDA and CALL NOTES

Saturday May 6, 2017

- Status of crisis management initiative (ID existing and unexpected risks / field report cards)
  - The VA will institute upward feedback and other related programs
  - (b) (6), the Chief HR Officer from the Mayo Clinic has contacted Bruce to lend her expertise in the HR side
  - CNN is about to do a piece on Women's issues at the VA.
  - Poonam will bring in PR to do a Press Release on the VA's lowering the age for mammograms to age 40 and promote the other VA women's initiatives. Then, Fox will be given an exclusive. This is TIME SENSITIVE because it is a preemptive measure.

- Apple status (call and initiatives)
  - The NDA with Apple has been signed
  - (b) (6) is on point for the VA.
  - Bruce has arranged a call with the VA (Darin and (b) (6) on Monday May 8 to discuss the plan to move forward.
  - Two reps from each AMC has been assigned to participate and advise on this proposed effort with Apple
  - Then the AMC reps, Bruce and the VA will instigate a call with Apple within the week.
  - Bruce will integrate the VA Digital Service Team interim head, (b) (6), into the process.
  - The call will address two initiatives, transportable medical records and geotagging, but ultimately there are 5 or 6 initiatives with Apple in all

- CIO candidates and status
  - David has interviewed several candidates but has settled on (b) (6) from the Department of the Navy. David has spoken with SECNAV and he has agreed to detail (or transfer) Mr. (b) (6) to the VA as CIO.
  - Melissa Glynn has withdrawn her name from consideration.

- Real Estate facilities initiative (Plan / David's discussions / Marc's discussions)
  - David and Poonam will send the PowerPoint proposed facilities plan to Marc
  - Marc will proceed to initiate and develop the "Congressional Plan" through Rep Roe and Senator Iskson.
  - Marc will contact Tom this weekend to set up a meeting with Isakson
  - Marc will call Rep Roe to set up a meeting with him
  - The facilities list will not be used for now

AMERICAN OVERSIGHT

- EHR status
  - David is working toward a solution. Will keep us advised on progress

- PR / Crisis management
  - Marc has reached out to a restructuring PR Crisis management firm. They are talking internally on whether they can assist. Marc will report back when they respond.
  - The crisis firms of the AMC's will be a potential backup if this firm does not want to proceed.

- Undersecretary
  - David asked that we hold off on exploring this for another week

- DOD PTSD office
  - Marc was introduced to The Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) and suggested a possible meeting between the VA and the DCoE to explore mutually beneficial issues and initiatives.
  - The DCoE provides the Military Health System with current and emerging psychological health and traumatic brain injury clinical and educational information. They identify gaps and prioritize needs in psychological health and TBI research, and then translate that research into clinical practice to improve patient outcomes. DCoE is a division of the Defense Health Agency Operations directorate. DHA is a joint, integrated combat support agency that supports the Military Health System
  - The mission of the DCoE is to improve the lives of our nation's service members, veterans and their families by advancing excellence in psychological health and traumatic brain injury prevention and care.
  - The DCoE's initiatives could be equally beneficial to the VA and may lead to an early detection program for the VA
  - Marc will contact his friend for an introduction of Dr. Alaigh to Dr. (b) (6) [redacted], its Director **[DONE, May 6, 2017]**

- Telemedicine
  - The Domestic Policy Council is giving the VA a hard time about this.
  - The EO drafted is taking a long time, so in the alternative
  - Seventeen governors have already agreed to allow telemedicine in their states. The VA will proceed to implement a telemedicine program in those 17 states. Timing was not discussed, so David and Poonam should provide the expected timing.
  - Once the 17 states are up and running, a PR announcement will be released promoting the progress of the VA, the lives that are being saved and the benefits of telemedicine, thanking the 17 governors for saving lives, with the hope that the PR shames the other states into following on.
  - If this does not get done in one week, we will go back to push the EO option

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- Supply Chain initiative
  - The meeting that Bruce has planned at the Baltimore VA on May 15 will solve this issue as well as the issue of drug control, general digital inventory control and controlled substance control.
  - The cost will be $25,000 per VA site.

- The following additional items were discussed:

  - VA pays salary of Pres/VP of unions. POTUS may address this in the next contract negotiations
  - Mandatory Flu shots – Poonam will publicize this requirement for next Flu season.
  - Laurie reported on the visit she and Ike had with a VAMC director today
    - Employees worried about closings – VA will work on disseminating info to relieve this anxiety
    - Some medical centers are performing procedures that they are not best suited for and possibly cause repeated procedures. – VA HQ will ask employees to ID these types of issues.
    - Several employees are alleged to have committed crimes but are still employed due to a belief that no one can be fired.
      - Ike and Laurie will ask the employee if they can disclose this to David / Poonam and if the employee would discuss this with David and Poonam – If so, Poonam will make it clear that these types of employees can be terminated and they will deal with the fallout later.
      - It is expected that the Accountability bill that passed the House and is currently in the Senate will largely cure this.
  - P-Cards – The meeting Bruce is having on inventory will also cover standard practices on P-cards in the AMCs. Bruce will share this info with Marc since Marc has restructured P-card systems in major, large institutions.

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Message

From: Poonam Alaigh [(b) (6)@hotmail.com]
Sent: 5/7/2017 2:18:17 PM
To: Bruce Moskowitz [brucem(b) (6) mac.com]
CC: Marc Sherman [mbs(b) (6) gmail.com]; Marisol Garcia [(b)@frenchangel59.com]; L Perl [(b) (6) @gmail.com]; David shulkin [Drshulkin@aol.com]; IP [@frenchangel59.com]
Subject: Re: VA - Follow-up

Lol- and in case you missed it Marc. Bruce is referring to the number 25.

On a serious note- a great capture that will help guide us and keep us focused. We have already started working on it - also, let David and I know if anyone if you is in DC and we we will do our usual dinner meeting

Sent from my iPhone

> On May 6, 2017, at 6:46 PM, Bruce Moskowitz <brucem(b) (6) mac.com> wrote:
>
> Thank you I will not disclose to your wife the confidential information but somehow you omitted it in your notes!
>
> Sent from my iPhone
>
>> On May 6, 2017, at 6:34 PM, Marc Sherman <mbs(b) (6) mail.com> wrote:
>>
>> I have attached is a memo that memorializes today's discussion and agreed actions / timing from our 2pm call
>>
>>
>> <VA initiatives follow up Conference Call May 6 2017.docx>

AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [brucem(b) (6) mac.com]
Sent: 5/6/2017 10:45:52 PM
To: Marc Sherman [mbs(b) (6) gmail.com]
CC: Marisol Garcia [(b)@frenchangel59.com]; L Perl [(b) (6) @gmail.com]; Poonam Alaigh [(b) (6) @hotmail.com]; David shulkin [Drshulkin@aol.com]; IP [@frenchangel59.com]
Subject: Re: VA - Follow-up

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> <VA initiatives follow up Conference Call May 6 2017.docx>

AMERICAN OVERSIGHT

Appointment

From: Marisol Garcia [(b)@frenchangel59.com]
Sent: 5/5/2017 9:14:07 PM
To: L Perl [(b) (6)@gmail.com]; (b) (6)@hotmail.com; David shulkin [Drshulkin@aol.com]; Bruce Moskowitz [brucem(b) (6)mac.com]; mbs(b) (6)gmail.com; (@frenchangel59.com

Subject: VA - Follow-up
Location: Conference Call - Ike is The Host

Start: 5/6/2017 6:00:00 PM
End: 5/6/2017 6:45:00 PM
Show Time As: Tentative

Recurrence: (none)

Saturday, May 6th

2:00 PM – 2:45 PM EST

Dial-in Information:

US: 1-866-244-(b) (6)

International: 719-457-(b) (6)

Passcode: (b) (6)

Participants:

Laurie Perlmutter, Poonam Alaigh, Secretary David Shulkin, Dr. Bruce Moskowitz, Marc Sherman and Ike

Thank you,

Marisol Garcia

(b) (6) (Office)

(b) (6) (Cell)

AMERICAN OVERSIGHT

(b) @frenchangel59.com

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/19/2017 2:11:01 PM
To: Bruce Moskowitz [brucem(b) (6) mac.com]
Subject: Re:

Ok thanks

Sent from my iPhone

> On Apr 19, 2017, at 9:59 AM, Bruce Moskowitz <brucem(b) (6) mac.com> wrote:
>
> Not that important actually I would send (b) (6)
>
> Sent from my iPad
> Bruce Moskowitz M.
>> On Apr 19, 2017, at 9:49 AM, David shulkin <Drshulkin@aol.com> wrote:
>>
>> Bruce- my office tells me I have a number of conflicts next friday making it difficult to get out to Bethesda to meet (b) (b) (6) - the major conflict is that Debbie Wasserman Schultz has requested that i present to her caucus on appropriations
>>
>> My team who i trust ((b) (6) will be at the meeting with (b) but i wasnt sure how critical you felt it was that i be there and whether we should look at rescheduling?
>>
>> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [brucem(b) (6) mac.com]
Sent: 4/19/2017 1:59:21 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re:

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> My team who i trust ((b) (6) will be at the meeting with (b) but i wasnt sure how critical you felt it was that i be there and whether we should look at rescheduling?
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/19/2017 1:49:27 PM
To: Bruce Moskowitz [brucem(b) (6) mac.com]

Bruce- my office tells me I have a number of conflicts next friday making it difficult to get out to Bethesda to meet (b) (b) (6) - the major conflict is that Debbie Wasserman Schultz has requested that i present to her caucus on appropriations

My team who i trust ((b) (6) will be at the meeting with (b) but i wasnt sure how critical you felt it was that i be there and whether we should look at rescheduling?

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/18/2017 3:30:40 AM
To: Vivieca Simpson [(b) (6) @gmail.com]
Subject: Re:

Wow

Sent from my iPhone

> On Jan 17, 2017, at 10:16 PM, Vivieca Simpson <(b) (6) 2@gmail.com> wrote:
>
> Checking on a 100 day rule tomorrow to make sure you are not locked in - I am told it says after an administration change you can't move a career employee for 100 days.

AMERICAN OVERSIGHT

Message

From: Vivieca Simpson [(b) (6) @gmail.com]
Sent: 1/18/2017 3:16:10 AM
To: drshulkin@aol.com

Checking on a 100 day rule tomorrow to make sure you are not locked in - I am told it says after an administration change you can't move a career employee for 100 days.

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/14/2017 2:39:45 AM
To: Vivieca Simpson [(b) (6) @gmail.com]

Would you like to be my guest at the opening concert at the Lincoln memorial on the 19 th from 4-6 and a pre show at 2-4 ?

Sent from my iPhone

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 1/12/2017 3:56:12 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Re: Progress Report on Community Care

I will keep trying- in the meantime, I have spoken to the person I know who would be good-(b) (6) to take on that role- he is the person who started Health Republic in NJ- he will think about it and let me know over the weekend

---

From: David Shulkin <drshulkin@aol.com>
Sent: Thursday, January 12, 2017 10:45 AM
To: (b) (6) @hotmail.com
Subject: Re: Progress Report on Community Care

I am aware- very concerning

But I am not ready to make a decision yet

I do want you to meet with him today about Rich- I know you are trying.

-----Original Message-----
From: Alaigh, Poonam <Poonam.Alaigh@va.gov>
To: drshulkin <drshulkin@aol.com>
Sent: Thu, Jan 12, 2017 10:27 am
Subject: FW: Progress Report on Community Care

Baligh put out this report without any mention of the Under Secretary- and what appears to be without your knowledge or review.

I think this is of concern. I also sent him a couple of text messages last night, but no real response to getting together today, though asked him for his availability

---

From: Lee, Jennifer S. (VACO)
Sent: Thursday, January 12, 2017 9:54 AM
To: Alaigh, Poonam
Subject: FW: Progress Report on Community Care

Be sure to scroll all the way down

From: Shulkin, David J., MD
Sent: Friday, January 06, 2017 8:52 PM
To: Lee, Jennifer S. (VACO)
Subject: FW: Progress Report on Community Care

-----Original Message-----
From: Wright, Vivieca (Simpson)
Sent: Friday, January 06, 2017 10:37 AM Eastern Standard Time

AMERICAN OVERSIGHT

To: Shulkin, David J., MD
Subject: Progress Report on Community Care

From: (b) (6)
Sent: Friday, January 06, 2017 10:22 AM
To: Wright, Vivieca (Simpson)
Cc: Hyduke, Barbara; (b) (6)
Subject: Progress Report on Community Care

Vivieca –

I'm sending this to you for awareness because the SecVA is asking for this report.

(b) (6)
Acting Executive Director
Office of Communications
Veterans Health Administration
Department of Veterans Affairs
Office: (b) (6)
Cell: (b) (6)

I CARE **VA Core Values:** Integrity Commitment Advocacy Respect Excellence
VA Core Characteristics: Trustworthy | Accessible | Quality | Innovative | Agile | Integrated

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 1/12/2017 3:45:57 PM
To: (b) (6) @hotmail.com
Subject: Re: Progress Report on Community Care

I am aware- very concerning

But I am not ready to make a decision yet

I do want you to meet with him today about Rich- I know you are trying.

-----Original Message-----
From: Alaigh, Poonam <Poonam.Alaigh@va.gov>
To: drshulkin <drshulkin@aol.com>
Sent: Thu, Jan 12, 2017 10:27 am
Subject: FW: Progress Report on Community Care

Baligh put out this report without any mention of the Under Secretary- and what appears to be without your knowledge or review.

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To: Wright, Vivieca (Simpson)
Cc: Hyduke, Barbara; (b) (6)
Subject: Progress Report on Community Care

Vivieca –

AMERICAN OVERSIGHT

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(b) (6)
Acting Executive Director
Office of Communications
Veterans Health Administration
Department of Veterans Affairs
Office: (b) (6)
Cell: (b) (6)



VA Core Values: Integrity Commitment Advocacy Respect Excellence
VA Core Characteristics: Trustworthy | Accessible | Quality | Innovative | Agile | Integrated

AMERICAN OVERSIGHT

Message

From: Robert McDonald [(b) (6) @gmail.com]
Sent: 1/14/2017 3:44:43 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re:

David, it is very kind of (b) (6) and you to invite (b) (6) and me, but I think my presence would be an unnecessary distraction. We plan to pack up and exit our apartment. Thanks for thinking of us. Bob

On Fri, Jan 13, 2017 at 9:37 PM, David shulkin <Drshulkin@aol.com> wrote:
(b) would you and (b) (6) like to join (b) (6) and me at the Presidents Innagural Ball on the 20 th as our guests?

David

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/14/2017 2:37:16 AM
To: bob mcDonald [(b) (6) @gmail.com]

Bob- would you and (b) like to join (b) and me at the Presidents Innagural Ball on the 20 th as our guests?

David

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Jennifer Lee [(b) (6) @gmail.com]
Sent: 1/14/2017 2:50:45 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re:

I would love to! Thank you so much for the invite!

On Jan 13, 2017 9:39 PM, "David shulkin" <Drshulkin@aol.com> wrote:
Would you like to be my guest at the opening concert at the Lincoln memorial on the 19 th from 4-6 and a pre show at 2-4 ?

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/14/2017 2:39:29 AM
To: Jennifer Lee [(b) (6) @gmail.com]

Would you like to be my guest at the opening concert at the Lincoln memorial on the 19 th from 4-6 and a pre show at 2-4 ?

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/19/2017 5:33:22 PM
To: (b) (6) [(b) (6) @gmail.com]
Subject: Re: 278 Form

Excellent

Sent from my iPhone

On Jan 19, 2017, at 12:21 PM, (b) (6) <(b) (6) @gmail.com> wrote:

> confirmed that both OGE and VA are reviewing right now.
>
> (b) (6)
>
> On Thu, Jan 19, 2017 at 12:11 PM, (b) (6) <(b) (6) @gmail.com> wrote:
>
> Both VA and OGE must "pre-clear" the report and then David will need to sign again for the actual submission. Then it goes to SVAC.
>
> (b) (6)
>
> On Thu, Jan 19, 2017 at 12:08 PM, (b) (6) <(b) (6) @gmail.com> wrote:
>
> is now here with the agency ((b) (6)) to conduct the review.
>
> (b) (6)

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) @gmail.com]
Sent: 1/19/2017 5:21:16 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Re: 278 Form

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(b) (6)

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is now here with the agency ((b) (6)) to conduct the review.

(b) (6)

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 3/3/2017 9:20:14 PM
To: IP [(b) (6)@frenchangel59.com]
CC: Bruce Moskowitz [brucem(b) (6) mac.com]; (b) (6) ((b) (6) (l(b) (6) va.gov]; (b) @frenchangel59.com
Subject: Re: RE:

(b) (6)

Sent from my iPhone

> On Mar 3, 2017, at 4:04 PM, IP <(b) (6)@frenchangel59.com> wrote:
>
> 4:00 PM is perfect.
>
> David, please email me the best number for you tomorrow and I will call you
> and Bruce.
>
> We don't need an 800#.
>
> Thank you,
>
> Ike
>
> -----Original Message-----
> From: Bruce Moskowitz [mailto:bruce(b) (6) @mac.com]
> Sent: Friday, March 03, 2017 3:57 PM
> To: David shulkin
> Cc: Ike Perlmutter; (b) (6) ((b) (6)
> Subject: Re:
>
> Yes anytime
>
> Sent from my iPad
> Bruce Moskowitz M.D.
>
>> On Mar 3, 2017, at 3:55 PM, David shulkin <Drshulkin@aol.com> wrote:
>>
>> I would like to review the agenda I have prepared for the President on
> Monday
>>
>> Would you have time on Saturday at either 1 pm or 4 pm?
>>
>> (b) (6) can you send the Potus agenda out and set up a conference number?
>
>>
>> Sent from my iPhone
>

AMERICAN OVERSIGHT

Message

From: IP [(b) (6)@frenchangel59.com]
Sent: 3/3/2017 9:04:30 PM
To: 'Bruce Moskowitz' [brucem(b) (6) mac.com]; 'David shulkin' [Drshulkin@aol.com]
CC: (b) (6) ((b) (6) (t(b) (6) va.gov]; (b) @frenchangel59.com
Subject: RE:

4:00 PM is perfect.

David, please email me the best number for you tomorrow and I will call you and Bruce.

We don't need an 800#.

Thank you,

Ike

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From: Bruce Moskowitz [mailto:bruce(b) (6) @mac.com]
Sent: Friday, March 03, 2017 3:57 PM
To: David shulkin
Cc: Ike Perlmutter; (b) (6) R. (b) (6)
Subject: Re:

Yes anytime

Sent from my iPad
Bruce Moskowitz M.D.

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>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 3/3/2017 8:55:19 PM
To: Ike Perlmutter [(b) (6)@frenchangel59.com]; Bruce Moskowitz [brucem(b) (6)mac.com]
CC: (b) (6) R. (b) (6) [(b) (6)va.gov]

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Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [brucem(b) (6) mac.com]
Sent: 1/16/2017 4:56:09 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
CC: (b) (6) [(b) @mayo.edu]; David shulkin [Drshulkin@aol.com]; Marc Sherman [mbs(b) (6) gmail.com]
Subject: Re: Fellowship: Communications, VA

Thank you

Sent from my iPad
Bruce Moskowitz M.D.

On Jan 16, 2017, at 11:54 AM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:

> Dr Moskowitz, Marc and (b) - good to meet all of you. We look forward to continuing this dialogue and exploring further this exciting way to ensure both the success of VA and the ability to communicate it.
>
> (b) (6) my personal cell phone number is (b) (6) - lets plan on speaking this week- either tomorrow or Wednesday. Will text you some times that work on my end and we can confirm.
>
> Thanks
>
> Poonam
>
> Sent from my iPad
>
> On Jan 16, 2017, at 9:58 AM, (b) (6) (b) (6) @mayo.edu> wrote:
>
> > Thanks very much Dr. Shulkin. Dr. Alaigh, feel free to reach as it's convenient for you. Best option this week is my cell phone (b) (6) I will be connected throughout this week.
> >
> > Best,
> >
> > (b) (6)
> > Chair | Mayo Clinic Department of Public Affairs
> > (c) (b) (6)
> >
> > On Jan 16, 2017, at 2:06 PM, David shulkin <Drshulkin@aol.com> wrote:
> >
> > > (b) (6) this makes a great deal of sense. Im going to ask Dr Poonam Alaigh, my senior advisor to work through the details with you.
> > >
> > > I understand youll be busy in Davos but she is very responsive to email
> > >
> > > David

AMERICAN OVERSIGHT

Sent from my iPhone

On Jan 16, 2017, at 12:32 AM, (b) (6) <(b) (6)@mayo.edu> wrote:

> Hi -- comfortable w/ that approach, will be important to gain a better understanding of what skills are needed (social media; media relations; issues management; etc.); role the person would have relative to the existing staff/the Secretary; details of this person's "on boarding" into the role (logistics of office details, etc.).
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> Apologize for "diving into the details," but would need to address these to tee up for success; happy to work these through w/ whomever you designate/recommend Dr. Shulkin. Away, traveling this week (World Economic Forum, Davos), but available to "dive in" next week and accomplish some of this remotely in the interim.
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AMERICAN OVERSIGHT

Are those two options mutually exclusive? What if it were closely offered in the beginning (because you know who you are getting), and then once implemented, widely publicized to deliver the message that the VA is cutting edge and the place to be for prestige (which (b) can speak to as a member of the progra

AMERICAN OVERSIGHT

m...enhanced by the PR that (b) (6) Mayo pedigree adds) which will then start to draw other market-wide talent and get you top talent, but at your discretion.

On Sun, Jan 15, 2017 at 4:42 PM, David shulkin <Drshulkin@aol.com> wrote:

(b) (6) I think the issue is whether the "executive sabbatical" should be

AMERICAN OVERSIGHT

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PM,
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u>
wrote:

AMERICAN OVERSIGHT

Hi Dr. Shulkin – thanks for your time this afternoon; I'm keen l

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yinterestedinassistingw/yourideaoffafellowshiptosuppo

AMERICAN OVERSIGHT

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next steps" to advance this idea; happy to talk w/ whomever you

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feel is best on timeline you feel is right.

If better, hap

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p y t o w o r k t h i s i n t o t h e m i x o f t o p i c s s h e p h e r d e d b y M a r c h S h e r m

AMERICAN OVERSIGHT

a n a n d D r . M o s k o w i t z _ w i l l f o l l o w y o u r l e a d .

T h a n k y o u f o r

AMERICAN OVERSIGHT

your continued service to our nation.

Best,

(b) (6)

AMERICAN OVERSIGHT

(b)
(6)

Chair | Mayo Clinic Department of Public Affairs

200 First St SW | Ro

AMERICAN OVERSIGHT

chester.MN559055 cell: (b) (6)
office: (b) (6)
e-mail: (b) (6)@m

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AMERICAN OVERSIGHT

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Chair | Mayo Clinic Department of Public Affairs
(c) (b) (6)

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AMERICAN OVERSIGHT

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Sent from my iPhone

On Jan 15, 2017, at 3:58 PM, (b) (6) [redacted] <(b) (6)@mayo.edu> wrote:

> Hi Dr. Shulkin – thanks for your time this afternoon; I'm keenly interested in assisting w/ your

AMERICAN OVERSIGHT

idea of a fellowship to support the VA Communications – please let me know your thoughts on "next steps" to advance this idea; happy to talk w/ whomever you feel is best on timeline you feel is right.

If better, happy to work this into the mix of topics sheph

AMERICAN OVERSIGHT

erded by Marc h Sher man and Dr. Mosk owitz – will follo w your lead.

Thank you for your contin ued servic e to our nation .

Best,

(b) (6)

Chair |Mayo Clinic Depart ment of Public Affairs 200 First Street S.W. | Rochest er, MN 55905

AMERICAN OVERSIGHT

cell:
(b) (6)

(b) (6)

e-mail:
(b) (6)
mayo.edu

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
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To: (b) (6) [(b) @mayo.edu]
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AMERICAN OVERSIGHT

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On Sun, Jan 15, 2017 at 4:42 PM, David shulkin <Drshulkin@aol.com> wrote:

[redacted] i think the issue is whether the "executive sabbatical" should be publicly announced and widely disseminated or if it should be selectively offered to members of our group and a few hand picked others?

Sent from my iPhone

On Jan 15, 2017, at 3:58 PM, [redacted] <[redacted]@mayo.edu> wrote:

> Hi Dr. Shulkin – thanks for your time this afternoon; I'm keenly interested in assisting w/ your idea of a fellowship to support the VA Communications – please let me know your thoughts on "next steps" to advance this idea; happy to talk w/ whomever you feel is best on timeline you feel is right.
>
> If better, happy to work this into the mix of topics shepherded by March Sherman and Dr. Moskowitz – will follow your lead.
>
> Thank you for your continued service to our nation.
>
> Best,

AMERICAN OVERSIGHT

(b) (6)

Chair |Mayo Clinic Department of Public Affairs
200 First Street S.W. | Rochester, MN 55905

cell: (b) (6) |office: (b) (6)

e-mail: (b) @mayo.edu

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) @mayo.edu]
Sent: 1/16/2017 5:32:53 AM
To: David shulkin [Drshulkin@aol.com]; Bruce Moskowitz [brucem(b) (6) mac.com]; Marc Sherman [mbs(b) (6) gmail.com]
Subject: Fellowship: Communications, VA

Hi -- comfortable w/ that approach; will be important to gain a better understanding of what skills are needed (social media; media relations; issues management; etc.); role the person would have relative to the existing staff/the Secretary; details of this person's "on boarding" into the role (logistics of office details, etc.).

Apologize for "diving into the details," but would need to address these to tee up for success; happy to work these through w/ whomever you designate/recommend Dr. Shulkin. Away, traveling this week (World Economic Forum, Davos), but available to "dive in" next week and accomplish some of this remotely in the interim.

Thanks,

(b) (6)
Chair | Mayo Clinic Department of Public Affairs
(c) (b) (6)

On Jan 15, 2017, at 11:06 PM, Bruce Moskowitz <brucem(b) (6) mac.com> wrote:

> Agree
>
> Sent from my iPad
> Bruce Moskowitz M.D.
>
> On Jan 15, 2017, at 5:04 PM, David shulkin <Drshulkin@aol.com> wrote:
>
> > I like this!
> >
> > Sent from my iPhone
> >
> > On Jan 15, 2017, at 4:50 PM, Marc Sherman <mbs(b) (6) gmail.com> wrote:
> >
> > > Are those two options mutually exclusive? What if it were closely offered in the beginning (because you know who you are getting), and then once implemented, widely publicized to deliver the message that the VA is cutting edge and the place to be for prestige (which (b) can speak to as a member of the program...enhanced by the PR that (b) (6) Mayo pedigree adds) which will then start to draw other market-wide talent and get you top talent, but at your discretion.
> > >
> > > On Sun, Jan 15, 2017 at 4:42 PM, David shulkin <Drshulkin@aol.com> wrote:
> > > (b) (6) i think the issue is whether the "executive sabbatical" should be publicly announced and widely disseminated or if it

AMERICAN OVERSIGHT

should be selectively offered to members of our group and a few hand picked others?

Sent from my iPhone

On Jan 15, 2017, at 3:58 PM, (b) (6) <(b) (6)@mayo.edu> wrote:

> Hi Dr. Shulkin – thanks for your time this afternoon; I'm keenly interested in assisting w/ your idea of a fellowship to support the VA Communications – please let me know your thoughts on "next steps" to advance this idea; happy to talk w/ whomever you feel is best on timeline you feel is right.
>
> If better, happy to work this into the mix of topics shepherded by March Sherman and Dr. Moskowitz – will follow your lead.
>
> Thank you for your continued service to our nation.
>
> Best,
>
> (b) (6)
>
> Chair |Mayo Clinic Department of Public Affairs
> 200 First Street S.W. | Rochester, MN 55905
>
> cell: (b) (6) |office: (b) (6)
>
> e-mail: (b) @mayo.edu

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/15/2017 10:04:47 PM
To: Marc Sherman [mbs(b) (6) gmail.com]
CC: (b) (6) [(b) @mayo.edu]; Bruce Moskowitz [brucem(b) (6) mac.com]
Subject: Re: Fellowship: Communications, VA

I like this!

Sent from my iPhone

On Jan 15, 2017, at 4:50 PM, Marc Sherman <mbs(b) (6) gmail.com> wrote:

> Are those two options mutually exclusive? What if it were closely offered in the beginning (because you know who you are getting), and then once implemented, widely publicized to deliver the message that the VA is cutting edge and the place to be for prestige (which (b) can speak to as a member of the program...enhanced by the PR that (b) (6) Mayo pedigree adds) which will then start to draw other market-wide talent and get you top talent, but at your discretion.
>
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> (b) (6) i think the issue is whether the "executive sabbatical" should be publicly announced and widely disseminated or if it should be selectively offered to members of our group and a few hand picked others?
>
> Sent from my iPhone
>
> On Jan 15, 2017, at 3:58 PM, (b) (6) (b) (6) @mayo.edu> wrote:
>
> > Hi Dr. Shulkin – thanks for your time this afternoon; I'm keenly interested in assisting w/ your idea of a fellowship to support the VA Communications – please let me know your thoughts on "next steps" to advance this idea; happy to talk w/ whomever you feel is best on timeline you feel is right.
> >
> > If better, happy to work this into the mix of topics shepherded by March Sherman and Dr. Moskowitz – will follow your lead.
> >
> > Thank you for your continued service to our nation.
> >
> > Best,
> >
> > (b) (6)

AMERICAN OVERSIGHT

Chair |Mayo Clinic Department of Public Affairs
200 First Street S.W. | Rochester, MN 55905

cell: (b) (6) |office: (b) (6)

e-mail: (b) @mayo.edu

AMERICAN OVERSIGHT

Message

From: Marc Sherman [mbs(b) (6) gmail.com]
Sent: 1/15/2017 9:50:49 PM
To: David shulkin [Drshulkin@aol.com]
CC: (b) (6) [(b) @mayo.edu]; Bruce Moskowitz [brucem(b) (6) mac.com]
Subject: Re: Fellowship: Communications, VA

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Sent from my iPhone

On Jan 15, 2017, at 3:58 PM, (b) (6) (b) (6)@mayo.edu> wrote:

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> If better, happy to work this into the mix of topics shepherded by March Sherman and Dr. Moskowitz – will follow your lead.
>
> Thank you for your continued service to our nation.
>
> Best,

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Chair |Mayo Clinic Department of Public Affairs
200 First Street S.W. | Rochester, MN 55905

cell: (b) (6) |office: (b) (6)

e-mail: (b) @mayo.edu

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AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/15/2017 9:42:29 PM
To: (b) (6) [(b) @mayo.edu]
CC: Marc Sherman [mbs(b) (6) gmail.com]; Bruce Moskowitz [brucem(b) (6) mac.com]
Subject: Re: Fellowship: Communications, VA

(b) i think the issue is whether the "executive sabbatical" should be publicly announced and widely disseminated or if it should be selectively offered to members of our group and a few hand picked others?

Sent from my iPhone

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> Thank you for your continued service to our nation.
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> Best,
>
> (b) (6)
> Chair | Mayo Clinic Department of Public Affairs
> 200 First Street S.W. | Rochester, MN 55905
> cell: (b) (6) | office: (b) (6)
> e-mail: (b) @mayo.edu

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) @mayo.edu]
Sent: 1/15/2017 8:58:38 PM
To: drshulkin@aol.com
Subject: Fellowship: Communications, VA

Hi Dr. Shulkin – thanks for your time this afternoon; I'm keenly interested in assisting w/ your idea of a fellowship to support the VA Communications – please let me know your thoughts on "next steps" to advance this idea; happy to talk w/ whomever you feel is best on timeline you feel is right.

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Best,

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Chair | Mayo Clinic Department of Public Affairs
200 First Street S.W. | Rochester, MN 55905
cell: (b) (6) | office: (b) (6)
e-mail: (b) @mayo.edu

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/18/2017 6:37:14 PM
To: Jennifer Lee [(b) (6) @gmail.com]
Subject: Re: IVF

No i wasnt

Sent from my iPhone

> On Jan 18, 2017, at 1:11 PM, Jennifer Lee <(b) (6) e@gmail.com> wrote:
>
> Heads up- heard from ash just now
> there is concern brewing again about IVF today - Tester and Murray
>
> Some expected leg call today did not happen. I was not aware of this and not invited to it
>
> I just learned Sloan and Baligh are making last minute contract mods to IVF benefit as of this morning. Maybe you are already aware?
>
> Am trying to catch jon jensen and baligh but wanted you to know just in case Murray reaches out.
>

AMERICAN OVERSIGHT

Message

From: Jennifer Lee [(b) (6) @gmail.com]
Sent: 1/18/2017 6:11:50 PM
To: David Shulkin [drshulkin@aol.com]
Subject: IVF

Heads up- heard from ash just now
there is concern brewing again about IVF today - Tester and Murray

Some expected leg call today did not happen. I was not aware of this and not invited to it

I just learned Sloan and Baligh are making last minute contract mods to IVF benefit as of this morning. Maybe you are already aware?

Am trying to catch jon jensen and baligh but wanted you to know just in case Murray reaches out.

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/13/2017 10:27:22 PM
To: (b) (6) [(b) (6) @gmail.com]
Subject: Fwd: drshulkin.com Contact: Form Submission

Sent from my iPhone

Begin forwarded message:

From: donotreply@godaddy.com
Date: January 4, 2017 at 12:34:59 PM EST
To: drshulkin@aol.com
Subject: **drshulkin.com Contact: Form Submission**



Name
(b) (6)
Email
(b) @hotmail.com
Subject
Treatment protocol for tylenol with codeine
Message
I am trying to find the VA's pain management protocol using Tylenol with codeine. They seem to vary widely from facility to facility. Below is the answer (or non-answer) I received this morning. Recently you requested assistance from VA. Below is our response. If you wish to reopen this issue, you may do so within the next 14 days. Thank you for allowing us to be of service to you. Response By Email (Department of Veterans Affairs) (01/04/2017 12:10 PM) Dear Mr. (b) (6) Thank you for your inquiry on our web site. This is a question you must address to your care team at your VA health care facility. We do not know any medical protocols. For further assistance, please feel free to contact us at 1-877-222-8387 (7am – 7pm CT). Bryan I Contact Representative, VA Health Resource Center Topeka, KS

This message was submitted from your website contact form:
http://www.drshulkin.com/contact.html

Use your free GoDaddy Email Marketing Starter account to follow up with contacts who agreed to receive email campaigns! Click here to get started.

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 1/12/2017 3:50:43 AM
To: (b) (6) [redacted] (b) (6) [redacted] (b) (6) [redacted] va.gov]
Subject: Fwd: CIO nominee idea

Print

Sent from my iPad

Begin forwarded message:

From: Jennifer Lee <(b) (6) [redacted]@gmail.com>
Date: January 11, 2017 at 2:10:57 PM EST
To: David Shulkin <drshulkin@aol.com>
Subject: CIO nominee idea

Hi David,
Ron told Ash they need good names for the Assistant Secretary of OIT.

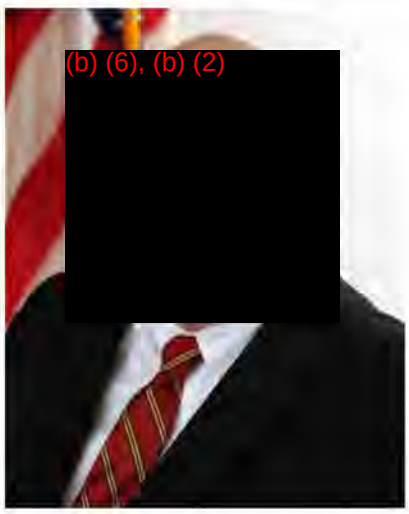
this guy would be awesome. He used to work for Senator Hatch and is now CMO at ONC.

Dr. (b) (6) [redacted]

www.healthit.gov/newsroom/(b) (6) [redacted] (b) (6) [redacted]-md

(b) (6) [redacted]@mac.com

(b) (6) [redacted] (b) (6), (b) (2) [redacted] **M.D.**



Chief Medical Information Officer,

AMERICAN OVERSIGHT

Executive Director, (b) (6), (b) (2) [redacted]

(b) (6), (b) (2) [redacted]

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 1/12/2017 3:50:27 AM
To: Jennifer Lee [(b) (6) @gmail.com]
Subject: Re: CIO nominee idea

Ok

Sent from my iPad

On Jan 11, 2017, at 2:10 PM, Jennifer Lee <(b) (6) @gmail.com> wrote:

> Hi David,
> Ron told Ash they need good names for the Assistant Secretary of OIT.
>
> this guy would be awesome. He used to work for Senator Hatch and is now CMO at ONC.
>
> Dr. (b) (6), (b) (2)
>
> www.healthit.gov/newsroom/(b) (6)(b) (6), (b) -md
>
> (b) (6) @mac.com

(b) (6), (b) (2) **M.D.**



Chief Medical Information Officer,

(b) (6), (b) (2)

AMERICAN OVERSIGHT



AMERICAN OVERSIGHT

Message

From: Jennifer Lee [(b) (6) @gmail.com]
Sent: 1/11/2017 7:10:57 PM
To: David Shulkin [drshulkin@aol.com]
Subject: CIO nominee idea

Hi David,
Ron told Ash they need good names for the Assistant Secretary of OIT.

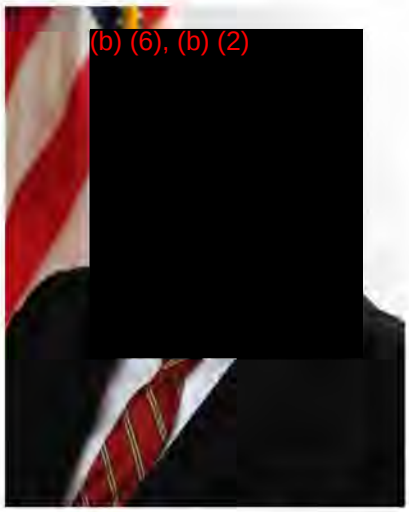
this guy would be awesome. He used to work for Senator Hatch and is now CMO at ONC.

Dr. (b) (6), (b) (2)

www.healthit.gov/newsroom/(b) (6)(b) (6), (b) -md

(b) (6) @mac.com

(b) (6), (b) (2) **M.D.**



Chief Medical Information Officer,

(b) (6), (b) (2)

AMERICAN OVERSIGHT

(b) (6), (b) (2)



AMERICAN OVERSIGHT

Message

From: Darin Selnick [(b) (6)@gmail.com]
Sent: 1/16/2017 11:34:55 PM
To: (b) (6)))(b) (6) va.gov]
CC: David shulkin [drshulkin@aol.com]
Subject: Re:

Hi (b) (6)

Dr. Shulkin would like to have set up a post confirmation meeting with former Secretary Principi.

His contact information is (b) (6)@yahoo.com.

Thanks so much.

Darin Selnick

On Mon, Jan 16, 2017 at 7:12 AM, David shulkin <Drshulkin@aol.com> wrote:
Darin- (b) (6) is best to handle details of my calendar

Thanks

David

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Darin Selnick [(b) (6) @gmail.com]
Sent: 1/16/2017 3:18:18 PM
To: David shulkin [Drshulkin@aol.com]
CC: (b) (6) [(b) (6) ((b) (6) va.gov]
Subject: Re:

Great, I will let them know.

Darin

Sent from my iPhone

> On Jan 16, 2017, at 7:12 AM, David shulkin <Drshulkin@aol.com> wrote:
>
> Darin- (b) (6) is best to handle details of my calendar
>
>
> Thanks
>
> David
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/16/2017 3:12:23 PM
To: Darin Selnick (b) (6) @gmail.com]
CC: (b) (6) ((b) (6) ((b) (6) va.gov]

Darin- (b) (6) is best to handle details of my calendar

Thanks

David

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/19/2017 5:33:51 PM
To: (b) (6) (b) (6) @gmail.com]
Subject: Re: A question/thought

Good

Sent from my iPhone

On Jan 19, 2017, at 12:10 PM, (b) (6) <(b) (6) @gmail.com> wrote:

> Thursday would be better. Will have someone reach out to him.
>
> (b) (6)
>
> On Thu, Jan 19, 2017 at 12:07 PM, David shulkin <Drshulkin@aol.com> wrote:
> Marc- let me check and get back to you
>
> Sent from my iPhone
>
> > On Jan 19, 2017, at 11:45 AM, Marc Sherman <(b) (6) gmail.com> wrote:
> >
> > David
> >
> > I expect to be in DC next Wednesday and Thursday. I was originally supposed to join you, Ike and Bruce for your meeting in Florida a few weeks back but was unable to make it. It was so enjoyable talking on the phone, I thought a quick face to face would be nice. But, I know how overwhelmed your schedule must be right now. If by chance getting together makes sense to you, would you be free for lunch on Wendesday?
> >
> > Best
> >
> > Marc
> (b) (6)
> >
> >

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6)@gmail.com]
Sent: 1/19/2017 5:10:39 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: A question/thought

Thursday would be better. Will have someone reach out to him.

(b) (6)

On Thu, Jan 19, 2017 at 12:07 PM, David shulkin <Drshulkin@aol.com> wrote:
Marc- let me check and get back to you

Sent from my iPhone

> On Jan 19, 2017, at 11:45 AM, Marc Sherman (b) s(b) (6) gmail.com> wrote:
>
> David
>
> I expect to be in DC next Wednesday and Thursday. I was originally supposed to join you, Ike and Bruce for your meeting in Florida a few weeks back but was unable to make it. It was so enjoyable talking on the phone, I thought a quick face to face would be nice. But, I know how overwhelmed your schedule must be right now. If by chance getting together makes sense to you, would you be free for lunch on Wendesday?
>
> Best
>
> Marc
(b) (6)
>
>

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/19/2017 5:07:24 PM
To: Marc Sherman [(b) (6) @gmail.com]
BCC: (b) (6) [(b) (6) @gmail.com]
Subject: Re: A question/thought

Marc- let me check and get back to you

Sent from my iPhone

> On Jan 19, 2017, at 11:45 AM, Marc Sherman <mbs(b) (6) mail.com> wrote:
>
> David
>
> I expect to be in DC next Wednesday and Thursday. I was originally supposed to join you, Ike and Bruce for your meeting in Florida a few weeks back but was unable to make it. It was so enjoyable talking on the phone, I thought a quick face to face would be nice. But, I know how overwhelmed your schedule must be right now. If by chance getting together makes sense to you, would you be free for lunch on Wendesday?
>
> Best
>
> Marc
(b) (6)
>
>

AMERICAN OVERSIGHT

Message

From: Marc Sherman [mbs(b) (6) gmail.com]
Sent: 1/19/2017 4:45:36 PM
To: David shulkin [Drshulkin@aol.com]
CC: IP [@frenchangel59.com]; Bruce Moskowitz [brucem(b) (6) mac.com]
Subject: Re: A question/thought

David

I expect to be in DC next Wednesday and Thursday. I was originally supposed to join you, Ike and Bruce for your meeting in Florida a few weeks back but was unable to make it. It was so enjoyable talking on the phone, I thought a quick face to face would be nice. But, I know how overwhelmed your schedule must be right now. If by chance getting together makes sense to you, would you be free for lunch on Wendesday?

Best

Marc
(b) (6)

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) @jhmi.edu]
Sent: 1/16/2017 2:07:03 PM
To: David shulkin [Drshulkin@aol.com]; Marc Sherman [mbs(b) (6) gmail.com]
CC: (b) (6) [(b) @mayo.edu]; (b) (6) ccf.org; L Perl [(b) (6) @gmail.com]; (b) (6) M.D. (b) (6) @mayo.edu]; (b) (6) partners.org; IP [@frenchangel59.com]; Bruce Moskowitz [brucem(b) (6) mac.com]
Subject: Re: A question/thought

David

I agree with your comments. The ability of Medicare and Medicaid to negotiate drug prices is an important issue that Congress will likely address this year. The VA/DOD might be a model for them to review

(b)

From: David shulkin <Drshulkin@aol.com>
Sent: Monday, January 16, 2017 9:03 AM
To: Marc Sherman
Cc: (b) (6) (b) (6) ccf.org; L Perl; (b) (6) M.D.; (b) (6) partners.org; (b) (6) IP; Bruce Moskowitz
Subject: Re: A question/thought

Marc- VA pharm purchasing is the model for what we want to do with other purchasing ((b) (6) comment). We current buy drugs with DOD at the best rates anywhere and weve consolidated our formularies. If we add Medicare it will collapse the system and add no benefit to VA- But i like the idea of working with other federal agencies in non pharma spend- i think we start there.

Sent from my iPhone

On Jan 16, 2017, at 8:26 AM, Marc Sherman <mbs(b) (6) gmail.com> wrote:

> A thought?
>
> I remember (b) telling us that the Veterans Administration has a pharmaceutical purchasing program. Why couldn't that program be combined with Medicare / Medicaid in order to increase the buying power and reduce costs for the VA, it's patients and Medicare / Medicaid patients and providers in order to increase the buying power and reduce costs for the VA, Medicare / Medicaid patients and providers?
>
> Marc Sherman
> (b) (6)
>
> On Jan 15, 2017 3:35 PM, "(b) (6) <(b) (6) @mayo.edu> wrote:
>
> > Hi – my notes from today's call.....enjoy the rest of your Sunday!

AMERICAN OVERSIGHT

From: Marc Sherman [mailto:(b) (6) gmail.com]
Sent: Sunday, January 15, 2017 12:01 PM
To: Marisol Garcia; Bruce Moskowitz; David shulkin; L Perl; (b) (6) IP; (b) (6) M.D.; (b) (6) @ccf.org; (b) (6) partners.org; (b) (6) (b) (6) @partners.org
Subject: Re: Conference Call with the new head of the VA, Doctor David Shulkin. The President Elect plans to announce the committee members very soon

All

I have attached the agenda for today's 2pm EST call. Thanks to everyone for setting aside the time on your weekend to participate. You will note that the agenda identifies procedural and informational topics as well as substantive topics. The purpose of the call is not to delve deeply into the substantive topics although discussion of them is necessary to put procedure and information into perspective and derive a go forward plan. You will also notice that there are some links attached to the substantive topics. Those links for today are meant to provide context for the topics and future considerations. I don't expect we will be delving deeply into the links today other than for context purposes.

I look forward to our call at 2pm.

FOR REFERENCE: NOTE THAT THE DIAL IN FOR TODAY'S CALL IS

US: 1-866-244-(b) (6)
International: 719-457-(b) (6)
Passcode: (b) (6)

Marc

Marc Sherman

(b) (6)

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/16/2017 2:03:58 PM
To: Marc Sherman [mbs(b) (6) gmail.com]
CC: (b) (6) [(b) @mayo.edu]; (b) (6) ccf.org; L Perl [(b) (6) @gmail.com]; (b) (6) M.D. (b) (6) @mayo.edu]; (b) (6) partners.org; (b) (6) [(b) (6) @jhmi.edu]; IP [@frenchangel59.com]; Bruce Moskowitz [brucem(b) (6) mac.com]
Subject: Re: A question/thought

Marc- VA pharm purchasing is the model for what we want to do with other purchasing ((b) (6) comment). We current buy drugs with DOD at the best rates anywhere and weve consolidated our formularies. If we add Medicare it will collapse the system and add no benefit to VA- But i like the idea of working with other federal agencies in non pharma spend- i think we start there.

Sent from my iPhone

On Jan 16, 2017, at 8:26 AM, Marc Sherman <mbs(b) (6) gmail.com> wrote:

> A thought?
>
> I remember (b) telling us that the Veterans Administration has a pharmaceutical purchasing program. Why couldn't that program be combined with Medicare / Medicaid in order to increase the buying power and reduce costs for the VA, it's patients and Medicare / Medicaid patients and providers in order to increase the buying power and reduce costs for the VA, Medicare / Medicaid patients and providers?
>
> Marc Sherman
> (b) (6)
>
> On Jan 15, 2017 3:35 PM, "(b) (6) <(b) (6)@mayo.edu> wrote:
>
> > Hi – my notes from today's call.....enjoy the rest of your Sunday!
> >
> > **From:** Marc Sherman [mailto:mbs(b) (6) gmail.com]
> > **Sent:** Sunday, January 15, 2017 12:01 PM
> > **To:** Marisol Garcia; Bruce Moskowitz; David shulkin; L Perl; (b) (6) IP; (b) (6) M.D.; (b) (6) ; (b) (6) @ccf.org; (b) (6) partners.org; (b) (6) (b) (6) @partners.org
> > **Subject:** Re: Conference Call with the new head of the VA, Doctor David Shulkin. The President Elect plans to announce the committee members very soon
> >
> > All
> >
> > I have attached the agenda for today's 2pm EST call. Thanks to everyone for setting aside the time on your weekend to participate. You will note that the agenda identifies procedural and

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informational topics as well as substantive topics. The purpose of the call is not to delve deeply into the substantive topics although discussion of them is necessary to put procedure and information into perspective and derive a go forward plan. You will also notice that there are some links attached to the substantive topics. Those links for today are meant to provide context for the topics and future considerations. I don't expect we will be delving deeply into the links today other than for context purposes.

I look forward to our call at 2pm.

FOR REFERENCE: NOTE THAT THE DIAL IN FOR TODAY'S CALL IS

US: 1-866-244-(b) (6)

International: 719-457-(b) (6)

Passcode: (b) (6)

Marc

Marc Sherman

(b) (6)

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Message

From: Marc Sherman [mbs(b) (6) gmail.com]
Sent: 1/16/2017 1:26:35 PM
To: (b) (6) [(b) @mayo.edu]
CC: (b) (6) ccf.org; L Perl [(b) (6) @gmail.com]; (b) (6) M.D. [(b) (6) @mayo.edu]; (b) (6) partners.org; (b) (6) [(b) (6) .@jhmi.edu]; IP [@frenchangel59.com]; Bruce Moskowitz [brucem(b) (6) mac.com]; David shulkin [drshulkin@aol.com]
Subject: A question/thought

A thought?

I remember (b) telling us that the Veterans Administration has a pharmaceutical purchasing program. Why couldn't that program be combined with Medicare / Medicaid in order to increase the buying power and reduce costs for the VA, it's patients and Medicare / Medicaid patients and providers in order to increase the buying power and reduce costs for the VA, Medicare / Medicaid patients and providers?

Marc Sherman
(b) (6)

On Jan 15, 2017 3:35 PM, "(b) (6) <(b) (6)@mayo.edu> wrote:

Hi – my notes from today's call.....enjoy the rest of your Sunday!

From: Marc Sherman [mailto:mbs(b) (6) gmail.com]
Sent: Sunday, January 15, 2017 12:01 PM
To: Marisol Garcia; Bruce Moskowitz; David shulkin; L Perl; (b) (6) IP; (b) (6) M.D.; (b) (6) ; Ann(b) (6) (b) (6) @ccf.org; (b) (6) partners.org; (b) (6) (b) (6) @partners.org
Subject: Re: Conference Call with the new head of the VA, Doctor David Shulkin. The President Elect plans to announce the committee members very soon

All

I have attached the agenda for today's 2pm EST call. Thanks to everyone for setting aside the time on your weekend to participate. You will note that the agenda identifies procedural and informational topics as well as substantive topics. The purpose of the call is not to delve deeply into the substantive topics although discussion of them is necessary to put procedure and information into perspective and derive a go forward plan. You will also notice that there are some links attached to the substantive topics. Those links for today are meant to provide context for the topics and future considerations. I don't expect we will be delving deeply into the links today other than for context purposes.

I look forward to our call at 2pm.

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FOR REFERENCE: NOTE THAT THE DIAL IN FOR TODAY'S CALL IS

US: 1-866-244-(b) (6)

International: 719-457-(b) (6)

Passcode: (b) (6)

Marc

Marc Sherman

(b) (6)

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/12/2017 10:49:45 PM
To: Poonam Alaigh [(b) (6)@hotmail.com]
Subject: Fwd: (The SAIL Organization) Re: LOGO DESIGN PROJECT

Take a look at the logo file

If you need to log in again

Drshulkin@aol.com
(b) (6)

Sent from my iPhone

Begin forwarded message:

From: "(b) (6) (LogoJeeves)" <application@teamwork.com>
Date: January 12, 2017 at 4:46:23 PM EST
To: drshulkin@aol.com
Subject: (The SAIL Organization) Re: LOGO DESIGN PROJECT
Reply-To: "(b) (6) (LogoJeeves)" <tw.18.19307926.47@replies.teamwork.com>

===== WRITE YOUR REPLY ABOVE THIS LINE =====



Only visible to LogoJeeves & David Shulkin

Jan 12
16:46 (b) (6) replied to this message

AMAZING PROMOTIONAL DEAL
GET COMPLETE WEBSITE PACKAGE FOR JUST 199$ ONLY!!

Hello **David**,
We are designing the logo for your business **THE SAIL ORGANIZATION**. I have share the initial concepts with you and let me know your feedback on it. Plus now you can get an amazing deal for your this or any other brand for the website.

Package includes :-

- Unlimited Pages
- Unlimited Free Revisions
- Custom Layout
- Mobile Responsive (compatible with IOS, Android, Tablets etc..)
- Unique Interface
- SEO Friendly Design
- WordPress CMS (Content Management System)
- Appointment Plugin/Chat Plugins
- WordPress (Add, delete Products, Pages, Pictures, Videos)
- Testing And Deployment

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- Cross Browser Compatible
- Complete Ownership And Copyrights
- Lead Capturing Forms
- Contact Us Forms
- 100% Satisfaction Guarantee

SUGGEST ME A GOOD TIME TO CALL SO WE CAN DISCUSS YOUR NEEDS AND START WORKING ON YOUR PROJECT OR SEND ME AN EMAIL ABOUT YOUR NEEDS SO I CAN SEND YOU A PROPOSAL FOR WEBSITE AND START WORKING ON YOUR PROJECT TODAY.

waiting for your response.

thanks,
(b)
Sr.Project Manager
(b) (6) <!--[if !supportLineBreakNewLine]-->

Jan 04
16:42

(b) (6) replied

Hello David,

Hope this email finds you well.
Please have a look at the initial concepts for the logo and let me know your feedback on it. Feel free to mention any changes that would be required so we can do the needful and get back to you with the revisions in timely manner.

Thanks,
(b)

Dec 30
12:38

(b) (6) wrote

Hi David,

I will be working with you to ensure a satisfactory and timely completion of your project as per your requirements. If you have any questions, revision requests or any other design related queries, please do not hesitate to contact me.
Please note that our normal turnaround time is 24 to 48 business hours Monday to Friday,
revisions received on weekends will be sent out on Monday.
Also, to ensure that no revision requests are missed out and to keep track of all communication it is highly advised that all comments are posted in this thread only. Commenting on the files themselves and opening up new threads to post comments might result in your revisions being missed out resulting in delays in the turnaround time.

Please find attached invoice of the payment.

thanks,
(b) (6)

Message Details

Message: LOGO DESIGN PROJECT

Project: The SAIL Organization

Company: David Shulkin

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Copied To: Support Manager, David Shulkin

Not interested?: Stop receiving email notifications from this message

YOU CAN POST A REPLY TO THIS MESSAGE BY REPLYING TO THIS EMAIL.

P.S. Just in case: You can retrieve your password by clicking here

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Message

From: (b) (6) [(b) (6) @gmail.com]
Sent: 1/18/2017 8:44:48 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Ed

https://www.washingtonpost.com/video/politics/betsy-devoss-confirmation-hearing-in-three-minutes/2017/01/17/5f2d8e7c-dd34-11e6-8902-610fe486791c_video.html

This clip is intense

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/13/2017 4:32:42 AM
To: Jennifer Lee [(b) (6) @gmail.com]
Subject: Re: Only if you need a laugh...

Yup

Sent from my iPhone

> On Jan 12, 2017, at 11:26 PM, Jennifer Lee (b) (6) mail.com> wrote:
>
> I saw this and it reminded me of VA
> Lol!
> <20170112_213328.jpg>

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Message

From: Jennifer Lee [(b) (6) @gmail.com]
Sent: 1/13/2017 4:26:27 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Only if you need a laugh...
Attachments: 20170112_213328.jpg

I saw this and it reminded me of VA
Lol!

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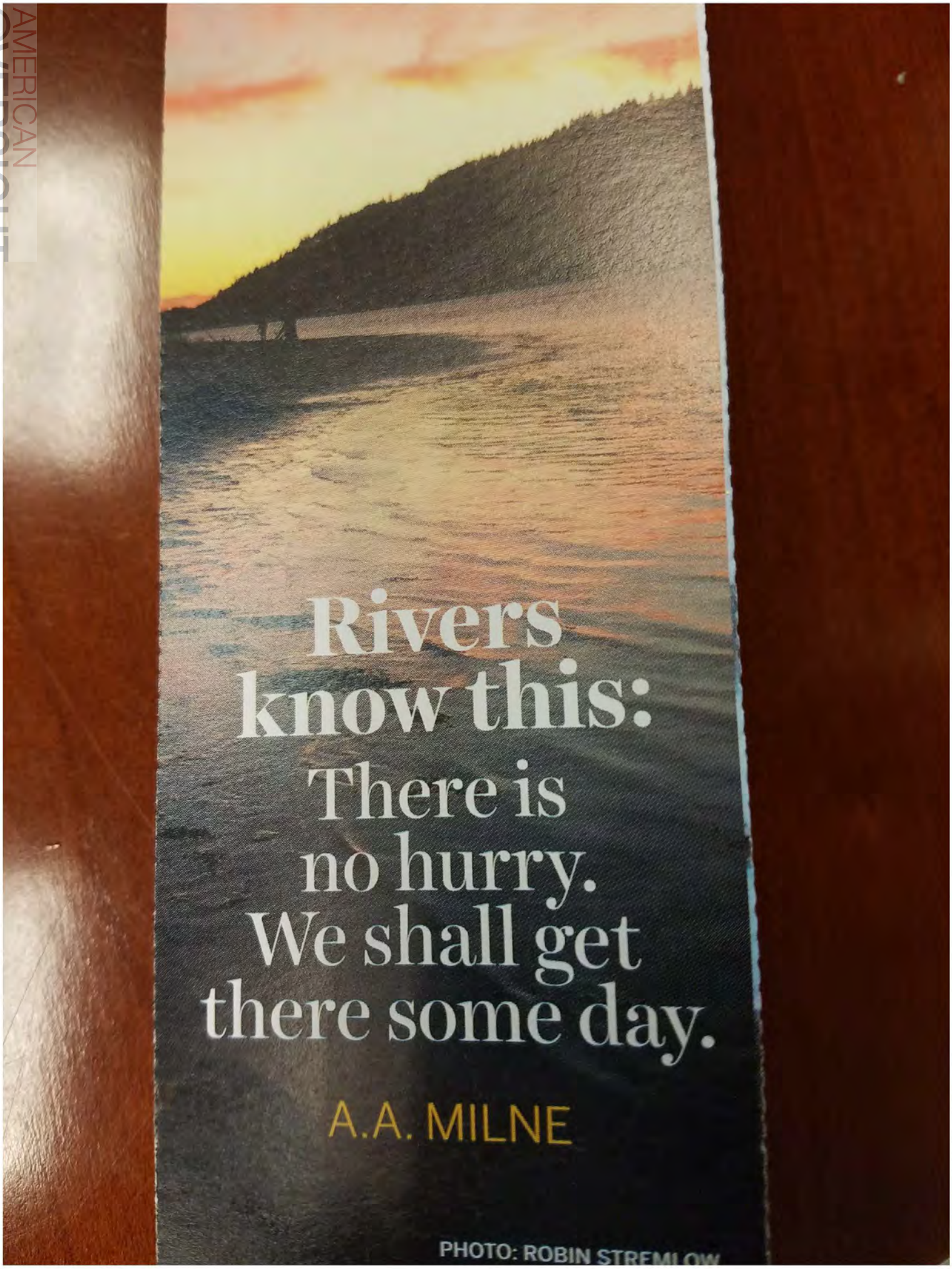

VA-19-0799-J-000387
DS_00008016

Message

From: (b) (6) [(b) @donaldtrump.com]
Sent: 1/11/2017 5:18:34 PM
To: drshulkin@aol.com; (b) (6) @gmail.com
Subject: Release - ASAP

President-Elect Donald J. Trump Nominates Dr. David J. Shulkin as Secretary of Veterans Affairs

(New York, NY) – Today President-elect Donald J. Trump today announced his intention to nominate Dr. David J. Shulkin as Secretary of Veterans Affairs.

As the current Undersecretary for Health at the Department of Veterans Affairs, Dr. Shulkin leads the nation's largest integrated healthcare system, currently serving 8.76 million veterans every year at over 1,700 locations. Dr. Shulkin has exemplified strong leadership in this position and in various other roles throughout his career, including as a chief executive and a doctor in academia and leader in entrepreneurial roles.

"I have no doubt Dr. Shulkin will be able to lead the turnaround our Department of Veterans Affairs needs. His sole mandate will be to serve our veterans and restore the level of care we owe to our brave men and women in the military," said President-elect Donald J. Trump. "Sadly our great veterans have not gotten the level of care they deserve, but Dr. Shulkin has the experience and the vision to ensure we will meet the healthcare needs of every veteran. Dr. Shulkin is an incredibly gifted doctor who is using his elite talents for medicine to care for our heroes, and Americans can have faith he will get the job done right."

"It is my honor to serve as President-elect Trump's Secretary of Veterans Affairs," said Dr. David Shulkin. "President-elect Trump's commitment to caring for our veterans is unquestionable, and he is eager to support the best practices for care and provide our Veterans Affairs' teams with the resources they need to improve health outcomes. We are both eager to begin reforming the areas in our Veterans Affairs system that need critical attention, and do it in a swift, thoughtful and responsible way."

Before serving as Under Secretary for Health, Dr. Shulkin served in numerous chief executive roles including serving as President at Morristown Medical Center, Goryeb Children's Hospital, and Atlantic Rehabilitation Institute, and the Atlantic Health System Accountable Care Organization. Dr. Shulkin also previously served as President and CEO of Beth Israel Medical Center in New York City. Dr. Shulkin has held numerous physician leadership roles including the Chief Medical Officer of the University of Pennsylvania Health System, the Hospital of the University of Pennsylvania, Temple University Hospital, and the Medical College of Pennsylvania Hospital. Dr. Shulkin has also held academic positions including the Chairman of Medicine and Vice Dean at Drexel University School of Medicine. As an entrepreneur, Dr. Shulkin founded and served as the Chairman and CEO of DoctorQuality one of the first consumer-oriented sources of information for quality and safety in healthcare.

Dr. Shulkin is a board-certified internist, a fellow of the American College of Physicians. He received his medical degree from the Medical College of Pennsylvania, his internship at Yale University School of Medicine and residency and Fellowship in General Medicine at the University of Pittsburgh

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Presbyterian Medical Center. He received advanced training in outcomes research and economics as a Robert Wood Johnson Foundation Clinical Scholar at the University of Pennsylvania.

* * *

All media requests should be directed to Media@ptt.gov

(b) (6)
DEPUTY COMMUNICATIONS DIRECTOR
Donald J. Trump for President, Inc.
C (b) (6)

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) @va.gov]
Sent: 1/16/2017 1:12:53 PM
To: 'Drshulkin@aol.com' [Drshulkin@aol.com]
Subject: Re: [EXTERNAL] Re:

Sir - FYI - the Secretary's flight departed Omaha this morning on time - thru Atlanta. Amazing! Thank you.

(b)

From: Robert McDonald [mailto(b) (6) @gmail.com]
Sent: Sunday, January 15, 2017 10:00 PM
To: David shulkin <Drshulkin@aol.com>; (b) (6)
Subject: [EXTERNAL] Re:

David, I will spend whatever time you wish. I'm heading back to DC early in the morning, weather permitting. We are having an ice storm in Omaha. If I am lucky and we get out on time, I will be in DC by noon. I can come to the office if you wish. I can also change my schedule for the balance of the week. Just let me know what meets your needs. Thanks. Bob

On Sun, Jan 15, 2017 at 9:58 PM, David shulkin <Drshulkin@aol.com> wrote:

> Bob- i know you are traveling back but im hoping that we might find sone tine to connect so I can get your advice. I cannot imagine ever being as prepared as you are but knowing that you may be a call away would be a great comfort.
>
> David
>
> Sent from my iPhone

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/12/2017 9:13:18 AM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re:(b)

I wont

Sent from my iPhone

> On Jan 12, 2017, at 2:37 AM, Poonam Alaigh <(b) (6) n@hotmail.com> wrote:
>
> For that one- please don't respond
>
> Sent from my iPhone
>
>> On Jan 11, 2017, at 11:45 PM, David shulkin <Drshulkin@aol.com> wrote:
>>
>> Ok
>>
>> (b) (6) sent me an email
>>
>> Sent from my iPhone
>>
>>> On Jan 11, 2017, at 11:11 PM, Poonam Alaigh <(b) (6) n@hotmail.com> wrote:
>>>
>>> Just make sure you personally thank him if you haven't already
>>>
>>> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 1/12/2017 7:37:44 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re:(b)

For that one- please don't respond

Sent from my iPhone

> On Jan 11, 2017, at 11:45 PM, David shulkin <Drshulkin@aol.com> wrote:
>
> Ok
>
> (b) (6) sent me an email
>
> Sent from my iPhone
>
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>>
>> Just make sure you personally thank him if you haven't already
>>
>> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/12/2017 4:45:09 AM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re:(b)

Ok

(b) (6) sent me an email

Sent from my iPhone

> On Jan 11, 2017, at 11:11 PM, Poonam Alaigh <(b) (6) n@hotmail.com> wrote:
>
> Just make sure you personally thank him if you haven't already
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 1/12/2017 4:11:01 AM
To: drshulkin@aol.com
Subject: (b)

Just make sure you personally thank him if you haven't already

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Jennifer Lee [(b) (6) @gmail.com]
Sent: 1/11/2017 3:33:40 PM
To: David Shulkin [drshulkin@aol.com]
Subject: if you need something to lighten your day

http://www.disabledveterans.org/2017/01/06/idiocity-va-public-affairs-tells-top-advocate-help-veterans/

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/18/2017 6:58:58 PM
To: Carolyn Clancy [(b) (6) @gmail.com]
Subject: Re: brief note

Ok lets talk more about this

Sent from my iPhone

> On Jan 18, 2017, at 1:41 PM, Carolyn Clancy <(b) (6) y@gmail.com> wrote:
>
> I spent the weekend at the annual meeting of the Society of Medical Administrators (many deans, some business CEOs, assorted others) -- gave a presentation on opioid safety and pain management with Peter Slavin and folks were very impressed with our numbers / progress.
>
> also saw (b) (6) from Hopkins -- having razzed him a bit by email when I read a few weeks ago that he, (b) (6) and others had met with the President-Elect, he told me multiple times late Sunday how impressed he was with your conversation and how much he wants to help.
>
> An out of the box thought fragment just popped into my head re the first 100 days -- what if we framed our efforts along the lines of 'Making Veterans Healthcare Great' (not to be confused with VHA / VA) and also emphasized a Veteran-owned system -- I am thinking we could have a true grassroots Veterans advisory group not limited to organizational members, though not excluding them either (if you think this is nuts I will desist -- otherwise will work with Tracy) -- optics will be huge in the next period. Carolyn

AMERICAN OVERSIGHT

Message

From: Carolyn Clancy [(b) (6) @gmail.com]
Sent: 1/18/2017 6:41:14 PM
To: David shulkin [drshulkin@aol.com]
Subject: brief note

I spent the weekend at the annual meeting of the Society of Medical Administrators (many deans, some business CEOs, assorted others) -- gave a presentation on opioid safety and pain management with (b) (6) and folks were very impressed with our numbers / progress.

also saw (b) (6) from Hopkins -- having razzed him a bit by email when I read a few weeks ago that he, (b) (6) and others had met with the President-Elect, he told me multiple times late Sunday how impressed he was with your conversation and how much he wants to help.

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AMERICAN OVERSIGHT

Message

From: Vivieca Simpson [(b) (6) @gmail.com]
Sent: 1/14/2017 3:21:23 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re:

Tom's numbers
(b) (6)

On Jan 14, 2017 08:02, "David shulkin" <Drshulkin@aol.com> wrote:
Can we quietly find out what we need to do to assume the acting role on the 20 th? Is there a swearing in or does the succession just seamlessly flow to the USH?

In terms of an acting USH i can just appoint?

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Vivieca Simpson [(b) (6) @gmail.com]
Sent: 1/14/2017 3:15:34 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re:

Sure

On Jan 14, 2017 08:02, "David shulkin" <Drshulkin@aol.com> wrote:
Can we quietly find out what we need to do to assume the acting role on the 20 th? Is there a swearing in or does the succession just seamlessly flow to the USH?

In terms of an acting USH i can just appoint?

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/14/2017 1:02:33 PM
To: Vivieca Simpson [(b) (6) @gmail.com]

Can we quietly find out what we need to do to assume the acting role on the 20 th? Is there a swearing in or does the succession just seamlessly flow to the USH?

In terms of an acting USH i can just appoint?

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 1/13/2017 1:53:54 AM
To: (b) (6) @hotmail.com
Subject: Re: Monday

good

-----Original Message-----
From: Poonam Alaigh <(b) (6) @hotmail.com>
To: David Shulkin <drshulkin@aol.com>
Sent: Thu, Jan 12, 2017 7:59 pm
Subject: Re: Monday

We are on our way now

Sent from my iPhone

On Jan 12, 2017, at 7:49 PM, David Shulkin <drshulkin@aol.com> wrote:

> oh no= I hate when that happens
>
> -----Original Message-----
> From: Poonam Alaigh <(b) (6) @hotmail.com>
> To: David Shulkin <drshulkin@aol.com>
> Sent: Thu, Jan 12, 2017 7:48 pm
> Subject: Monday
>
> I am on the usual train # 135 leaving metropark at 6:40pm in case you are on the same train.
>
> Stuck here near Delaware due to police activity- don't know how long it's going to be before we get going again- probably a couple of hours
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 1/13/2017 12:59:19 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Re: Monday

We are on our way now

Sent from my iPhone

On Jan 12, 2017, at 7:49 PM, David Shulkin <drshulkin@aol.com> wrote:

> oh no= I hate when that happens
>
> -----Original Message-----
> From: Poonam Alaigh <(b) (6) @hotmail.com>
> To: David Shulkin <drshulkin@aol.com>
> Sent: Thu, Jan 12, 2017 7:48 pm
> Subject: Monday
>
> I am on the usual train # 135 leaving metropark at 6:40pm in case you are on the same train.
>
> Stuck here near Delaware due to police activity- don't know how long it's going to be before we get going again- probably a couple of hours
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 1/13/2017 12:52:39 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Re: Monday

Maybe this is a sign

Sent from my iPhone

On Jan 12, 2017, at 7:49 PM, David Shulkin <drshulkin@aol.com> wrote:

> oh no= I hate when that happens
>
> -----Original Message-----
> From: Poonam Alaigh <(b) (6) @hotmail.com>
> To: David Shulkin <drshulkin@aol.com>
> Sent: Thu, Jan 12, 2017 7:48 pm
> Subject: Monday
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>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 1/13/2017 12:49:39 AM
To: (b) (6) @hotmail.com
Subject: Re: Monday

oh no= I hate when that happens

-----Original Message-----
From: Poonam Alaigh <(b) (6) @hotmail.com>
To: David Shulkin <drshulkin@aol.com>
Sent: Thu, Jan 12, 2017 7:48 pm
Subject: Monday

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Stuck here near Delaware due to police activity- don't know how long it's going to be before we get going again- probably a couple of hours

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 1/13/2017 12:48:47 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Monday

I am on the usual train # 135 leaving metropark at 6:40pm in case you are on the same train.

Stuck here near Delaware due to police activity- don't know how long it's going to be before we get going again- probably a couple of hours

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) ptt.gov]
Sent: 1/17/2017 3:17:48 PM
To: (b) (6) [(b) (6) @gmail.com]
CC: (b) (6) (b) (6) @ptt.gov]; David Shulkin [drshulkin@aol.com]
Subject: Re: Shulkin - Finger Prints

That is something you would have to work out with your Agency how they can transfer his fingerprints to the FBI. We have a Fingerprint machine here with a direct hook-up to the FBI - if he wishes he can come to 1800 E St NW and we will get him printed here.Let me kno if he decides to come here

On Tue, Jan 17, 2017 at 9:32 AM, (b) (6) <(b) (6) @gmail.com> wrote:
Good Morning (b) a and (b)

David Shulkin, VA Nominee will be submitting his finger prints electronically at 10:45. Per the instructions on Tab 8 - please let us know where the electrons should go.

Thanks,
(b) (6)

AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [brucem(b) (6) mac.com]
Sent: 1/13/2017 11:40:34 PM
To: David shulkin [drshulkin@aol.com]
Subject: VA

For second position
(b) (6) MD - CMO American Cancer Society - AA

(b) (6) MD MPH - BWH Cardiologist now President of Wellesley College - AA

(b) (6) MD MPH - Chrm Surgery East Virginia School of Medicine - former Pres American College of Surgeons - AA

(b) (6) MD - Director Division of Member Services American College of Surgeons - AA

from my iPhone

AMERICAN OVERSIGHT

Message

From: Vivieca Simpson [(b) (6) @gmail.com]
Sent: 1/16/2017 7:53:51 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re:

Got it

On Jan 16, 2017 07:59, "David shulkin" <Drshulkin@aol.com> wrote:
Vivieca- id like to get the following four items wrapped up by 1/25 or sooner- i dont know if we need formal IBs or if we just need a official memo of the results of the investigation- we need these for the hearing

1. The san juan employee who was in the robbery- specificically what i was told and what i testified and then where wevare now

2. The testimony i gave in phx that i was accused of giving wrong info- this is where i was able to produce the actual prep materials that i testified to

3. Finish the flow health investigation of our employees

4. The issue related to (b) (6) hiring- was it done properly or not?

Thanks

If you have time today call me and ill tell you about the people internally still fighting us- but if you are enjoying the holiday- no worries we can catch up next week

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/16/2017 12:59:23 PM
To: Vivieca Simpson [(b) (6) @gmail.com]

Vivieca- id like to get the following four items wrapped up by 1/25 or sooner- i dont know if we need formal IBs or if we just need a official memo of the results of the investigation- we need these for the hearing

1. The san juan employee who was in the robbery- specificically what i was told and what i testified and then where wevare now

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3. Finish the flow health investigation of our employees

4. The issue related to (b) (6) hiring- was it done properly or not?

Thanks

If you have time today call me and ill tell you about the people internally still fighting us- but if you are enjoying the holiday- no worries we can catch up next week

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) @gmail.com]
Sent: 1/15/2017 3:50:30 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Re: materials for us to use for the Senate Form

Ok.

On Jan 15, 2017 10:47 AM, "David Shulkin" <drshulkin@aol.com> wrote:

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 1/15/2017 3:47:52 PM
To: drshulkin@aol.com
CC: (b) (6) @gmail.com
Subject: materials for us to use for the Senate Form
Attachments: Additional lectures.docx

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Additional lectures since Previous Senate Form Completed

2015	Consumerism and Healthcare Insurance Panel Discussion: Morris County Chamber of Commerce- Morristown NJ
2015	Impact of Provider Reimbursement Systems on Pharmaceutical Development: Panel Discussion- R and D Summit- Miami, Florida
2016	Systemic Improvements in Healthcare Paralyzed Veterans of America Arlington, VA
2016	Innovations in Medicine Lake Nona Impact Forum Orlando, FL
2016	Quality of Care Keynote American College of Medical Quality Annual Meeting Washington DC
2016	Building the Big Data Economy. Panel Discussion Bloomberg News – Newseum Washington DC
2016	Transforming VA Healthcare Using Telehealth Keynote: American Telehealth Association Minneapolis, MN
2016	Giving Back through Public Service Commencement Keynote, PACE University New York, NY
2016	Technology and Medical Advances New Jersey Tech Council Keynote Newark, NJ
2016	Decisions for Healthcare Leaders Commencement Keynote, Thomas Jefferson University School of Medicine, Philadelphia, PA
2016	Precision Medicine and Research for Veterans

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LaunchPad Milken Foundation
National Press Club, Washington DC

2016 Adapt or Die- Invisible Wounds of War
Bush Institute, Dallas Tx

2016 Interagency Innovation- Department of Defense
Collaborations- National Defense University
Washington DC

2016 Veteran Well Being: Preventing Suicide
National Press Club Washington DC

2015 American Legion Annual Conference
Future of Veterans Affairs, Baltimore MD

2015 Paralyzed Veterans of America
Centers of Excellence, Jacksonville Fl

2015 Keynote: Ending Homelessness Among Veterans
Congressional Black Caucus, Washington DC

2015 American Council for Technology and Industry Advisory
Council – Working with the Private Sector, Washington, DC

2015 Using Information Technology to Advance America's
Healthcare Priorities. Department of Defense/VA and
Government HIT Summit Alexandria, Virginia

2015 Academic Medicine and the Veterans Affairs: The
Impact on American Medicine- AAMC Annual Meeting
Council of Deans- Baltimore, MD

2015 Federal Healthcare and Implications for the Future
Keynote: AMSUS- The Society for Federal Health
Professionals. San Antonio, Texas

2015 Technology Applications to the Veterans Healthcare System
Keynote: AFCEA International Bethesda, MD

2015 Ineroperability and Integrated Care. Federal Healthcare
Executive Forum. Washington, DC

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2016 Future Models of VA Care. Paralyzed Veterans of America Arlington, VA

2016 Addressing the Needs of Veterans, Disabled Veterans of America, Crystal City, VA

2016 Innovation in Government. Lake Nona Impact Forum Orlando, Florida

2016 Innovation in the VA Health System
American College of Healthcare Executives Annual Session, Chicago, IL

2016 Federal Models of Caring for Patients National Association of Community Health Centers
Washington, DC

2016 VA Healthcare. Commission on Care
Washington, DC

2016 Research in Veterans Brain Health
VA Brain Trust Summit, Wash DC

2011 Strategic Future of VA
VA Strategic Summit
Washington DC

2016 VA Care vs. Private Sector Care
VA Heathcare 2016, Pentagon City, VA

2016 VA's Role in Medical Education
Resident Fellows Section
American Medical Association, Chicago IL

2016 Advances in Mental Health
White House Summit on Making Healthcare Better
White House, Washington DC

2016 What's Next for VA?
Keeping the Promise Conference
Washington DC

2016 Addiction and Healing: Forum with

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Senators Booker and Menendez
and the Surgeon General
Livingston, NJ

2016 Re-inventing Veterans Health care
Disabled American Veterans Annual Conference
Atlanta, GA

2016 Progress at the Veterans Health Administration
Veterans Foreign Wars, Annual Meeting
Charlotte, NC

2016 Rehabilitation in Disabled Veterans. Paralyzed
Veterans of America- Keynote Orlando, FL

2016 Best Practices in Veterans Care
International Veterans Conference
Seoul, South Korea

2016 Advances in Care of CNS Disorders
Cohen Veterans Network
Washington DC

2016 Advancing Veterans Health Care
American Legion National Conference
Cincinnati OH

2016 Blind Rehabilitation Care
Blind Veterans of America National Meeting
Milwaukee, WI

2016 Developments in Veterans Healthcare
Potomac Officers Society
Tysons Corner, Virginia

2016 Pharmaceutical Best Practices
Wisconsin Society of Pharmacists Keynote
Wisconsin Dells, WI

2016 Suicide Prevention. White House Summit
on Suicide. White House

2016 Caregiving in Home Settings
Elizabeth Dole Foundation – Hidden Heroes
Washington DC

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2016	Precision Medicine Association of Academic Health Centers Washington DC
2016	Military Wellness Initiative United State Congress Center Washington DC
2016	Predictive Analytics creating Breakthroughs US News and World Report Futures Conference Washington, DC
2016	International Health Technology Presentation to the Crowne Prince and Princess of Denmark Washington, DC

Additonal Publications since I completed the last Senate Form

. Shulkin DJ. Beyond the VA Crisis- Transforming into a High Performance Network. New England Journal of Medicine-2016:374(11):1003-5.

46. Shulkin DJ. Why VA Healthcare is Different. Federal Practitioner 2016 May Issue

47. Shulkin D. How the VA's Stand Down Resolved 56,000 Plus Urgent-Care Consults. New England Journal of Medicine Catalyst. April 14, 2016 catalyst,nejm.com

48. Califf, RM, Robb MA, Bindman AV, Shulkin DS, et al. Transforming Evidence Generation to Support Health and Healthcare Decisions. New England Journal of Medicine 375(24):2395-2400 December 15, 2016

65. Shulkin D. VA needs skilled healthcare leaders to speed system reforms. Modern Healthcare January 2, 2016

4. Shulkin D. VA Voluntary Service Celebrates 70 Years. Veterans' Choices 2016:64(1):2

5. Shulkin D. VA is Saving Lives Everyday. Omaha World-Herald.

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6. October 10th 2016.

7. Shulkin D. How VA's Million Veteran Program Will Advance the National Movement Toward Precision Medicine. Bloomberg News Blog 2016

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Message

From: David Shulkin [drshulkin@aol.com]
Sent: 1/14/2017 3:40:36 PM
To: (b) (6) @gmail.com
Subject: Re: (No Subject)

interesting

-----Original Message-----
From: (b) (6) <(b) (6) @gmail.com>
To: David Shulkin <drshulkin@aol.com>
Sent: Sat, Jan 14, 2017 10:13 am
Subject: Re: Fwd: (No Subject)

I've searched everywhere for Thomas g. Bowman, including yellow pages. I asked Vivieca to find, she's looking.

(b) (6) works for them now by the way. But I won't ask her.

On Jan 14, 2017 9:44 AM, '(b) (6) <(b) (6) @gmail.com> wrote:
Oh no, ok. Jon doesn't have a number. Let me keep looking.

On Jan 14, 2017 9:29 AM, "David Shulkin" <drshulkin@aol.com> wrote:

The email bounced back unfortunately

-----Original Message-----
From: David Shulkin <drshulkin@aol.com>
To: (b) (6) (b) (6) va.gov>
Sent: Sat, Jan 14, 2017 9:26 am
Subject: Re: (No Subject)

ok that's good enough

-----Original Message-----
From: (b) (6) (b) (6) va.gov>
To: 'David shulkin' <Drshulkin@aol.com>
Sent: Sat, Jan 14, 2017 8:12 am
Subject: RE: (No Subject)

Hi we don't have his phone number , but I'll ask (b) .

Here is his email (b) (6) @vetstaff.senate.gov

-----Original Message-----
From: David shulkin [Drshulkin@aol.com]
Sent: Saturday, January 14, 2017 08:07 AM Eastern Standard Time
To: (b) (6)
Subject:

Any chance you still have tom bomans phone number?

Sent from my iPhone

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Message

From: (b) (6) [(b) (6) @gmail.com]
Sent: 1/14/2017 3:13:19 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Re: Fwd: (No Subject)

I've searched everywhere for Thomas g. Bowman, including yellow pages. I asked Vivieca to find, she's looking.

(b) (6) works for them now by the way. But I won't ask her.

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Sent: Sat, Jan 14, 2017 9:26 am
Subject: Re: (No Subject)

ok that's good enough

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Here is his email (b) (6) @vetstaff.senate.gov

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From: David shulkin [Drshulkin@aol.com]
Sent: Saturday, January 14, 2017 08:07 AM Eastern Standard Time
To: (b) (6)
Subject:

Any chance you still have tom bomans phone number?

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: [redacted] [redacted]@gmail.com]
Sent: 1/14/2017 2:44:10 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Re: Fwd: (No Subject)

Oh no, ok. [redacted] doesn't have a number. Let me keep looking.

On Jan 14, 2017 9:29 AM, "David Shulkin" <drshulkin@aol.com> wrote:

The email bounced back unfortunately

-----Original Message-----
From: David Shulkin <drshulkin@aol.com>
To: [redacted] va.gov>
Sent: Sat, Jan 14, 2017 9:26 am
Subject: Re: (No Subject)

ok that's good enough

-----Original Message-----
From: [redacted] va.gov>
To: 'David shulkin' <Drshulkin@aol.com>
Sent: Sat, Jan 14, 2017 8:12 am
Subject: RE: (No Subject)

Hi we don't have his phone number , but I'll ask [redacted] .

Here is his email [redacted]@vetstaff.senate.gov

-----Original Message-----
From: David shulkin [Drshulkin@aol.com]
Sent: Saturday, January 14, 2017 08:07 AM Eastern Standard Time
To: [redacted]
Subject:

Any chance you still have tom bomans phone number?

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 1/14/2017 2:29:04 PM
To: (b) (6) @gmail.com
Subject: Fwd: (No Subject)

The email bounced back unfortunately

-----Original Message-----
From: David Shulkin <drshulkin@aol.com>
To: (b) (6) ([b) (6) va.gov>
Sent: Sat, Jan 14, 2017 9:26 am
Subject: Re: (No Subject)

ok that's good enough

-----Original Message-----
From: (b) (6) ([b) (6) va.gov>
To: 'David shulkin' <Drshulkin@aol.com>
Sent: Sat, Jan 14, 2017 8:12 am
Subject: RE: (No Subject)

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Sent: Saturday, January 14, 2017 08:07 AM Eastern Standard Time
To: (b) (6)
Subject:

Any chance you still have tom bomans phone number?

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/16/2017 3:32:20 AM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Fwd: [EXTERNAL] Fwd: e-News 1/13/17

At least you can count on our nj friends!

Sent from my iPhone

Begin forwarded message:

> **From:** "Shulkin, David J., MD" <David.Shulkin@va.gov>
> **Date:** January 15, 2017 at 10:19:06 PM EST
> **To:** 'Dr Shulkin' <drshulkin@aol.com>
> **Subject: FW: [EXTERNAL] Fwd: e-News 1/13/17**
>
> Sent with Good (www.good.com)
>
> -----Original Message-----
> **From:** (b) (6) [(b) (6) gmail.com]
> **Sent:** Sunday, January 15, 2017 09:41 AM Eastern Standard Time
> **To:** Shulkin, David J., MD
> **Subject:** [EXTERNAL] Fwd: e-News 1/13/17
>
> Good morning.
> Thought you'd want to see this. He says some nice things about you.
> Congressman Freylinghuysen, himself a veteran, has been a strong supporter of veterans.
> He's even popped in on some of our New Jersey JWV meetings to say hello.
>
> Best regards,
> (b)
>
> (b) (6) , Ph.D.
> *Colonel, U.S. Army Retired*
> *70 Howard Avenue*
> *Passaic, NJ 07055-5328*
> *see my website: www.ProcessMakesPerfect.net*
>
> (b) (6)
>
> ***They've yet to build the box that I can't think outside of.***
>
> ---------- Forwarded message ----------
> From: **Congressman Rodney Frelinghuysen** (b) (6) @congressnewsletter.net>
> Date: Fri, Jan 13, 2017 at 5:52 PM

AMERICAN OVERSIGHT

Subject: e-News 1/13/17
To: "(b) (6) @gmail.com" (b) (6) @gmail.com>

If you are having trouble viewing this message or would like to share it on a social network, you can view the message online.

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e-News 1/13/17

- **Setting the Stage for Another Healthcare Debate**
- **A New Jersey Voice for Veterans**
- **Sussex VA Clinic Open for Business!**
- **A World War II prisoner's words live on**
- **New Tankers for Existing Mission at Joint Base McGuire-Dix-Lakehurst**
- **House Votes to INSPIRE Women**
- **Salute: Brigadier General Alfred Abramson, Picatinny's New Leader!**
- **Salute: Leanna Brown**
- **Salute: Morris County's Art in the Atrium**

Setting the Stage for Another Healthcare Debate

The state of America's healthcare system is very much in the headlines these days. This week, the Congress approved the procedural steps that will allow House and the Senate to consider enacting a new patient-centered system that gives every American access to quality, affordable health care.

Make no mistake: this afternoon's vote was ***not*** a vote to repeal the Affordable Care Act. The so-called "reconciliation"

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legislation we passed simply lays out the timing and procedural steps necessary for a repeal and a replacement of Obamacare.

Let's face it: the status quo is unacceptable. Obamacare is failing. Beyond the havoc it's wreaked in the job market, especially for small businesses, we have seen skyrocketing premiums, soaring deductibles, and fewer choices for patients and their families.

Here's the reality:

Higher premiums. President Obama promised premiums would decline by $2,500 per family. Instead, average annual family premiums in the employer-sponsored market have jumped by about $4,300 and now total more than $18,000 annually.

Even higher deductibles. Deductibles for individual plans in the employer-sponsored market are up an average of 60 percent since 2010 – from $917 to $1,478 in 2016. For many families, these higher deductibles are like having no coverage at all.

An even bigger bill for taxpayers. Because premiums have skyrocketed, so have the federal subsidies needed to prop up Obamacare. According to one independent study, taxpayers will pay nearly $10 billion more for subsidies in 2017.

Even fewer choices. For 2016, only 2 percent of eligible customers had one insurer to choose from. For next year, that number has jumped to 17 percent. In 2016, New Jersey has five insurance Obamacare providers. This year, New Jersey has TWO!

All of these trends are heading in the wrong direction. That is why there is a real urgency to end this failed experiment before it causes much more damage.

Frankly, the worst is yet to come because where there is little competition, costs skyrocket and the market collapses. That is the catalyst for what some experts call the Obamacare "death spiral." Insurers are warning that their losses from Obamacare are "unsustainable" and they are dropping out of the marketplace at a rapid pace.

Of course, I recognize that 22 million people are now depending on Obamacare for their coverage. Speaker Paul Ryan has promised that they will not be left in the lurch: "Once Obamacare is repealed, we will make sure there is a **stable**

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transition period so that people don't have the rug pulled out from under them."

That is why the first order of the new Congress is to repeal Obamacare and quickly transition from government-controlled healthcare to a 21st Century health system that's personalized and patient-centered.

But that debate was not the debate we conducted today in the House. But that debate will certainly arrive in coming weeks and I look forward to it.

A New Jersey Voice for Veterans

Much more work needs to be done to fix the widespread problems at the Veterans Adminstration. Every day we must focus on needs of men and women veterans and improve the department's ability to provide our veterans the care and benefits they have earned.

This week, the incoming Trump Administration indicated it was serious about VA reform with its selection of Dr. David Shulkin as the next Secretary of Veterans Affairs.

David Shulkin knows healthcare, he knows veterans and he knows New Jersey, having served as the President of Morristown Medical Center. I am confident that he will deliver!

Shulkin was appointed Undersecretary for Health by President Obama in March of 2015 as the VA grappled with several scandals involving long wait times for veterans at VA hospitals, reports of a cover-up and skyrocketing construction costs at VA hospitals.

In a very tangible way, Dr. Shulkin has already helped New Jersey veterans. I met with him at this time last year to seek his support for the establishment of a Community-Based Outpatient Clinic in Sussex County. His assistance, coupled with our persistence, led to the opening of that clinic in Newton this week.

Sussex VA Clinic Open for Business!

The Sussex County Veterans Community-Based Outpatient Clinic (CBOC) opened its doors on Monday, marking the beginning of the next chapter of veterans' health care in Sussex County!

But the job does not end today. The challenge of local elected officials and veterans leaders in the months ahead is to make

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sure all veterans know that the facility is there for them and that the services match our veterans' needs. It's all about access, but it's also all about providing enhanced care for our deserving veterans - men and women alike.

The Sussex Clinic is located at 222 High Street in Newton and will be open on weekdays from 8 a.m. to 4:30 p.m.

Read David Danzis' article in the Tuesday ***New Jersey Herald*** here.

Worth a Read: "**A World War II prisoner's words live on, thanks to a buddy**" in Monday's ***Washington Post***.

New Tankers for Existing Mission at Joint Base McGuire-Dix-Lakehurst

The Air Force announced this week that it will field 24 new KC-46 tankers in New Jersey at Joint Base McGuire-Dix-Lakehurst – an endorsement of JBMDL as one of the nation's premier air mobility installations. Clearly, the strong work that aircraft and crews at McGuire have done over the years to maintain the critically important 'air bridge' from the continental U.S. to the Middle East, Europe, Africa and beyond put this base in a strong position.

As immediate past Chairman of the House Appropriations Subcommittee on Defense, I have for years advocated for basing the KC-46 tanker at JBMDL with senior Air Force leaders, including Secretary Deborah Lee James, and various Chiefs of Staff of the Air Force. My message over the years has been simple: McGuire has the location, the facilities, the experience and the workforce to ensure that the Air Force maintains its 'global reach.' Nothing is more important for the warfighter!

I can't think of a better base to host the new tanker. This is a good day for the nation, our military, New Jersey, the Joint Base and the 40,000 people who work there.

JBMDL had been competing with many bases for the next Main Operating Base 4 (MOB 4) for the KC-46A, including bases Dover, Del., Abilene, Texas; Spokane, Wash., Grand Forks, N.D., Charleston, S.C.; Tacoma, Wash. Little Rock, Ark., Tampa, Fla. and Mascoutah, Ill..

The first new tankers are expected to arrive at JBMDL no later than the Spring of 2021.

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House Votes to INSPIRE Women

This week the House passed the *Inspiring the Next Space Pioneers, Innovators, Researchers, and Explorers (INSPIRE) Women Act* (H.R. 321). This legislation complements my ongoing efforts to encourage young women (and young men) to pursue careers in Science, Technology, Engineering, Mathematics (STEM) fields.

As the name implies, this bill is specifically targeted to encourage women to advance America's space exploration efforts.

As I visit schools across my Congressional District, I am encouraged to see girls and young women deciding at an early age to pursue STEM careers. These skills are the backbone of our 21st Century workforce. Yet studies show women are falling behind their male counterparts in attaining these in-demand skills. As a nation, we need to encourage more women to pursue careers in STEM fields, where they can bring their creativity, expertise, and problem-solving skills to the table.

Learn more about the INSPIRE Act here.

Picatinny Arsenal continues to be very active on STEM. Twelve students from the Pre-Engineering Academy at Central High School in Newark, New Jersey, visited Picatinny last month to learn about STEM career opportunities.

During the visit, the students toured Picatinny's 3D printing lab, checked out military vehicles, learned about remote weapons and discussed Explosive Ordnance Disposal technology. EOD operators diffuse bombs and other explosive devices.

The tour was coordinated by the Picatinny STEM office, the Morris County Chamber of Commerce, the AT&T Pioneers and the Secretary of the Army's office. For the complete story, click here.

Salute: Brigadier General Alfred Abramson, the new Commanding General at Picatinny Arsenal. I was honored to meet BGEN Abramson this morning in my Washington office. Welcome!

Salute: A final farewell to former State Senator, Assemblywoman, Councilwoman **Leanna Brown**. Read William Westhoven's article in the Morris County ***Daily Record*** here.

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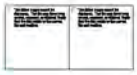
Salute: Congratulations to Art in the Atriumwhich this year is celebrating its 25th anniversary of its efforts to develop an appreciation of fine art, especially African American art, across northern New Jersey. ACA's commitment to art education enriches Morris County and is one element that makes our community one of the finest places to live, work and raise a family.



Contact Information

WASHINGTON, D.C.
2306 Rayburn House Office Building
Washington, DC 20515-3011
(202) 225-5034



NEW JERSEY
30 Schuyler Place, Second Floor
Morristown, NJ 07960
(973) 984-0711

Update My Profile - Unsubscribe - Privacy Policy

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VA-19-0799-J-000428

DS_00008057

Message

From: Carolyn M Clancy [(b) (6) @gmail.com]
Sent: 1/11/2017 4:34:09 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Well??

So within 31 seconds of tweet my texts are still rolling in.

Thank you!!

Someone just announced here at the summit☺☺

> On Jan 10, 2017, at 11:08 PM, David shulkin <Drshulkin@aol.com> wrote:
>
> <image1.png>
> I
>
> Sent from my iPhone
>
>> On Jan 10, 2017, at 11:06 PM, Carolyn M Clancy <(b) (6) y@gmail.com> wrote:
>>
>> That you were meeting with Trump -- also picked up by The Hill
>>
>>
>>> On Jan 10, 2017, at 8:41 PM, David shulkin <Drshulkin@aol.com> wrote:
>>>
>>> What did the tweet say?
>>>
>>> Sent from my iPhone
>>>
>>>> On Jan 10, 2017, at 7:32 PM, Carolyn M Clancy <(b) (6) y@gmail.com> wrote:
>>>>
>>>> The meeting Monday was terrific and Poonam did a wonderful job. While there (b) (6) told me 'I just saw a tweet ....' Many many fingers crossed
>>>

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/11/2017 4:08:14 AM
To: Carolyn M Clancy [(b) (6) @gmail.com]
Subject: Re: Well??
Attachments: image1.png

I

Sent from my iPhone

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>>

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●●○○○ Sprint 10:51 PM

Tweet

Trump meeting again with VA UnderSec for Health David Shulkin today, to talk about ... VA stuff.

1/9/17, 10:42 AM

6 RETWEETS 21 LIKES



Leo Shane III @LeoShane · 1d

There have been conversations within Trump transition team about keeping Shulkin on in his role. Not being considered as a VA Sec (for now).

4 9



Paula Minger @Paulaminger1 · 1d

@LeoShane Shulkin has reached out directly to vets and families to assist in navigating the VA. A strong positive.

Reply to Leo Shane III

Home Notifications Moments Messages Me

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VA-19-0799-J-000431

DS_00008060

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/11/2017 4:07:05 AM
To: Carolyn M Clancy [(b) (6) @gmail.com]
Subject: Re: Well??

Ok thanks

Sent from my iPhone

> On Jan 10, 2017, at 11:06 PM, Carolyn M Clancy <(b) (6) y@gmail.com> wrote:
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AMERICAN OVERSIGHT

Message

From: Carolyn M Clancy [(b) (6) @gmail.com]
Sent: 1/11/2017 4:06:35 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Well??

That you were meeting with Trump -- also picked up by The Hill

> On Jan 10, 2017, at 8:41 PM, David shulkin <Drshulkin@aol.com> wrote:
>
> What did the tweet say?
>
> Sent from my iPhone
>
>> On Jan 10, 2017, at 7:32 PM, Carolyn M Clancy <(b) (6) y@gmail.com> wrote:
>>
>> The meeting Monday was terrific and Poonam did a wonderful job. While there (b) (6) told me 'I just saw a tweet ....' Many many fingers crossed
>

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/11/2017 1:41:07 AM
To: Carolyn M Clancy [(b) (6) @gmail.com]
Subject: Re: Well??

What did the tweet say?

Sent from my iPhone

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AMERICAN OVERSIGHT

Message

From: Carolyn M Clancy [(b) (6) @gmail.com]
Sent: 1/11/2017 12:32:25 AM
To: David shulkin [drshulkin@aol.com]
Subject: Well??

The meeting Monday was terrific and Poonam did a wonderful job. While there (b) (6) told me 'I just saw a tweet ....' Many many fingers crossed

AMERICAN OVERSIGHT

Message

From: [redacted] [redacted]@gmail.com]
Sent: 1/14/2017 1:28:44 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re:

Yes, I saw and I added to your calendar last night.

I was gonna put [redacted] at 730. I'll do that this morning.

On Jan 14, 2017 8:20 AM, "David shulkin" <Drshulkin@aol.com> wrote:
Yes

Did yoU see i need to meet with meese at 245

Maybe i do [redacted] before the retreat starts?

Sent from my iPhone

On Jan 14, 2017, at 8:05 AM, [redacted] <[redacted]@gmail.com> wrote:

Sure. We talked about this yesterday in a little bit of detail.

[redacted] o wants to meet with you Tuesday, do you want that to occur?

On Jan 14, 2017 8:00 AM, "David shulkin" <Drshulkin@aol.com> wrote:
The week of the 23 rd and the day of the 30 th i want to spend most of my time in hearing prep and senate visits.

Ill need briefs with vba, nca and the board

Ill need a legislative brief

Well need visits to svac and other key senators- youll need to coordinate this through [redacted]

Well need to start on hearing testimony writing

I dont want to do much interaction with mcdonalds team till after the twentieth so lets develop our own schedule

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/14/2017 1:20:42 PM
To: (b) (6) [(b) (6) @gmail.com]
Subject: Re:

Yes

Did yoU see i need to meet with (b) (6) at 245

Maybe i do (b) before the retreat starts?

Sent from my iPhone

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> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) @gmail.com]
Sent: 1/14/2017 1:05:33 PM
To: David shulkin [Drshulkin@aol.com]
CC: Vivieca Simpson [(b) (6) @gmail.com]
Subject: Re:

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Sent from my iPhone

AMERICAN OVERSIGHT

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From: David shulkin [Drshulkin@aol.com]
Sent: 1/14/2017 1:00:40 PM
To: (b) (6) [(b) (6) @gmail.com]
CC: Vivieca Simpson [(b) (6) @gmail.com]

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Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 1/10/2017 4:49:43 AM
To: Poonam Alaigh [(b) (6) @hotmail.com]

https://www.washingtonpost.com/news/powerpost/wp/2017/01/09/why-trump-still-hasnt-named-a-leader-for-the-department-of-veterans-affairs/?utm_term=.098dc1636cad

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: Jennifer Lee [(b) (6) @gmail.com]
Sent: 1/10/2017 12:10:35 AM
To: David Shulkin [drshulkin@aol.com]
Subject: conversation today

Hi David,
Ash had a very helpful conversation today.
I think it is a good idea for you to call Steve, but I hope you can give me a quick ring before you do so I can share some background
Thank you
Jen

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/15/2017 3:35:33 AM
To: (b) (6) [(b) (6) @gmail.com]
Subject: Re: Paperwork

Slow going

Sent from my iPhone

> On Jan 14, 2017, at 8:14 PM, (b) (6) <(b) (6) r@gmail.com> wrote:
>
> How is it coming? Are you ok?

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) @gmail.com]
Sent: 1/15/2017 1:14:20 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Paperwork

How is it coming? Are you ok?

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 1/18/2017 7:21:02 PM
To: vivieca.Wright@va.gov
Subject: Fwd:
Attachments: Senate Prehearing questions.docx

-----Original Message-----
From: David Shulkin <drshulkin@aol.com>
To: viviecas2 <(b) (6) @gmail.com>
Sent: Mon, Jan 16, 2017 5:56 pm
Subject: Re:

Vivieca- I took a look at these questions and I am glad you farmed them out. There are some tough and specific questions. I took a shot at a few that might be helpful to those writing them, but most I will leave to the sme's that will try to answer them.

-----Original Message-----
From: Vivieca Simpson <(b) (6) @gmail.com>
To: David shulkin <Drshulkin@aol.com>
Sent: Mon, Jan 16, 2017 2:53 pm
Subject: Re:

Got it

On Jan 16, 2017 07:59, "David shulkin" <Drshulkin@aol.com> wrote:
Vivieca- id like to get the following four items wrapped up by 1/25 or sooner- i dont know if we need formal IBs or if we just need a official memo of the results of the investigation- we need these for the hearing

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2. The testimony i gave in phx that i was accused of giving wrong info- this is where i was able to produce the actual prep materials that i testified to

3. Finish the flow health investigation of our employees

4. The issue related to (b) (6) hiring- was it done properly or not?

Thanks

If you have time today call me and ill tell you about the people internally still fighting us- but if you are enjoying the holiday- no worries we can catch up next week

Sent from my iPhone

AMERICAN OVERSIGHT

Pre-Hearing Questions for the Honorable David J. Shulkin, Presumptive Nominee to be Secretary of Veterans Affairs, U.S. Department of Veterans Affairs

From Chairman Isakson

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

   Our most significant challenge will be to address the systemic challenges that face VA. Over the past 18 months that I have served as USH we have been focused on addressing the acute issues that VA faced in its' crisis in access and its erosion of confidence with the American people. We've made real progress and to turn the corner in many areas, but its now time to address the systemic issues that are required in a transformation of a business.

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

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

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

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

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

AMERICAN OVERSIGHT

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

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

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

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

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

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

AMERICAN OVERSIGHT

9. The Veterans Choice Program, created by section 101 of Public Law 113-146, the Veterans Access, Choice and Accountability Act of 2014, would expire August 7, 2017, without Congressional action. Going forward, how do you envision expanding veterans' access to non-VA care while preserving within the Veterans Health Administration (VHA) the care and services VHA performs well?

AMERICAN OVERSIGHT

Senator Jerry Moran
Pre-Hearing Questions for the Record for
Presumptive Nominee, David J Shulkin,
to be Secretary of Veterans' Affairs

Q. How would you describe the culture and functionality of the highest echelon in the VA Central Office? What changes would you make in the VA Central Office? Please be specific and candid.

Q. What distinguishes you from the current VA leadership team? Do you plan to lead and manage the VA differently than the current VA leadership team? What are the differences? Please be specific.

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

1. Fill top management positions with highly qualified leaders

2. Focus on the highest clinical needs of our veterans first, including both physical and behavioral health issues

3. Build an integrated system of care - utilizing what VA does best and what the private sector does best all with the goal of improving quality and service for our veterans.

Biggest Challenges:

Meeting the growing demands of veterans with the resources that are allocated

Addressing the manpower and management needs of the system

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

AMERICAN OVERSIGHT

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

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

Q. Please provide information regarding the Office of General Counsel, to include: FY09-FY17 funding levels, full-time personnel and their duty station, and job descriptions for the positions within the Office of General Counsel. Please also describe and explain the breadth of the Office of General Counsel's work and advisement. If the Office of General Counsel advises you take a position or make a decision that is counter to President-elect Trump's positions and commitments to reform the VA, will you follow the advisement of the Office of General Counsel? Is the Secretary of the VA required by law to execute the position or decision advised by the Office of General Counsel? Explain options available to the Secretary of the VA to take a position or make a decision counter to the advisement of the Office of General Counsel.

Q. If the VA Inspector General (IG) provides a report with findings of wrongdoing and criminal action, do you intend to notify Congress prior to or in tandem with the disclosure of the IG's report? In detail, please explain the authorities and actions you will execute to hold accountable the employees identified in the IG's report. Regarding similar instances under the leadership of Secretary McDonald, he refused to execute and utilize authorities provided to him. Do you intend to break with this precedent and use the authorities granted to the Secretary of Veterans Affairs?

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

AMERICAN OVERSIGHT

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

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

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We need to do a better job on onboarding employees and cut the time from posting a job to getting a person who is able to begin serving veterans.

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 1/16/2017 10:56:18 PM
To: (b) (6) @gmail.com
Subject: Re:
Attachments: Senate Prehearing questions.docx

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AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 1/8/2017 4:34:42 PM
To: (b) (6) @hotmail.com
Subject: slide
Attachments: poonamsg.pptx

AMERICAN OVERSIGHT

Innovations from VA



SUCCESS REPORTED IN LIVER TRANSPLANT

DENVER, May 11 (AP)—The first successful surgical transplant of a human liver was disclosed by surgeons here today.

Two teams of doctors accomplished the feat in a six-hour operation at Veterans Administration Hospital last Sunday.

The patient, William Grigsby, 47 years old, of Denver, is said by surgeons to be responding well, showing all signs of recovery after the first critical week, and that the operation is apparently a success.

Mr. Grigsby, a janitor at the Denver County jail, was dying of a malignant tumor when the surgery was proposed to him, a hospital official said. The healthy liver was taken from another V.A. hospital patient minutes after he died of a brain tumor.

Only once before has a liver transplant been known to have been attempted between humans. That was at the same hospital here, two months ago. The patient died.

Spokesmen said the transplant, if successful, would open up a new area of treatment to previously incurable diseases amenable to this type of surgery. But they emphasize the technique is meticulous and complex, with many perils.

The New York Times

First Liver Transplant



CT Scanner



Artificial Kidney



7 Lasker Awards



3 Nobel Prizes



Nicotine Patches



Cardiac Pacemaker

VETERANS HEALTH ADMINISTRATION

0

AMERICAN OVERSIGHT

Message

From: Jennifer Lee [(b) (6) @gmail.com]
Sent: 1/9/2017 2:42:27 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Updates

I just spoke with Vivieca.
I've tried a few routes to get Steve's cell and wasn't able to.

The best I could get was Ron Thomas. He is friendly to us and has been asking to speak with Ash (after the sleep apnea meeting he requested)
Ron Thomas: 202 870 (b) (cell)
202 621 (b) (office)

Ron and Ash were supposed to have lunch. Ron canceled at the last minute because of some "urgent meeting" of the ART that was requested by Sloan today.
Ash will see Ron tomorrow. She could send a message then or ask for Steve's contact info.

I spoke with (b) (6).
(b) (6) Shereef and I will likely see the Secretary very early tomorrow morning before MVAC.

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 1/8/2017 4:38:48 PM
To: (b) (6) @hotmail.com
Subject: Re: Tomorrow morning

yes send cell

-----Original Message-----
From: Poonam Alaigh <(b) (6) @hotmail.com>
To: David shulkin <Drshulkin@aol.com>
Sent: Sun, Jan 8, 2017 8:41 am
Subject: Re: Tomorrow morning

Do you want me to send you his cell number? Didnt understand your message.

When will you send him a message- today or tomorrow?

From: David shulkin <Drshulkin@aol.com>
Sent: Sunday, January 8, 2017 8:37 AM
To: Poonam Alaigh
Subject: Re: Tomorrow morning

Yes i have an email not a trxt but you can send if you can

Sent from my iPhone

On Jan 8, 2017, at 8:20 AM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:

> Can you also send a text to Vivek personally to let him know that you are involved with an emergency and I will be filling in- that way we conduct ourselves with respect

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 1/8/2017 1:41:02 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Tomorrow morning

Do you want me to send you his cell number? Didnt understand your message.

When will you send him a message- today or tomorrow?

From: David shulkin <Drshulkin@aol.com>
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AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/8/2017 1:37:25 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: Tomorrow morning

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Sent from my iPhone

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AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6)@hotmail.com]
Sent: 1/8/2017 1:20:54 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Tomorrow morning

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AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 1/21/2017 11:13:13 PM
To: mbs(b) (6) gmail.com
Subject: Re: Time to talk

I could do 2 pm tommorow

Sent from AOL Mobile Mail

-----Original Message-----
From: Marc Sherman <mbs(b) (6) gmail.com>
To: David shulkin <drshulkin@aol.com>
Sent: Sat, Jan 21, 2017 06:07 PM
Subject: Re: Time to talk

Any availability later tonight, or perhaps 2pm tomorrow?

Marc Sherman
(b) (6)

On Jan 21, 2017 6:04 PM, "David Shulkin" <drshulkin@aol.com> wrote:
I am completely booked till 7 pm -sorry maybe I could do something earlier in the day or tuesday

Sent from AOL Mobile Mail

-----Original Message-----
From: Marc Sherman <mbs(b) (6) gmail.com>
To: David shulkin <drshulkin@aol.com>
Sent: Sat, Jan 21, 2017 05:53 PM
Subject: Re: Time to talk

I suggested that to Ike, but he was hoping to have a short conversation before that and he is tied up on Monday/Tuesday. What would be the earliest you could do it tomorrow? I have to be finished by 5:15.

Marc Sherman
(b) (6)

On Jan 21, 2017 5:47 PM, "David Shulkin" <drshulkin@aol.com> wrote:
Marc- I can't make it at 4 either today or tomorrow

What about delaying till our breakfast?

Sent from AOL Mobile Mail

AMERICAN OVERSIGHT

-----Original Message-----
From: Marc Sherman <mbs[redacted]gmail.com>
To: David shulkin <Drshulkin@aol.com>
Sent: Sat, Jan 21, 2017 05:32 PM
Subject: Re: Time to talk

Sorry, I went out and didn't have my phone. Could you talk for 15 minutes at 4pm?

Marc Sherman
[redacted]

On Jan 21, 2017 1:46 PM, "David shulkin" <Drshulkin@aol.com> wrote:
Early evening tomorrow works fine

Sent from my iPhone

> On Jan 21, 2017, at 12:24 PM, Marc Sherman <mbs[redacted]gmail.com> wrote:
>
> David.
>
> I am looking forward to breakfast on Thursday. Ike and I were wondering if you have time for a 15 minute call late afternoon or early evening tomorrow to discuss IT?
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> Marc
>
> Marc Sherman
[redacted]

AMERICAN OVERSIGHT

Message

From: Marc Sherman [mbs(b) (6) gmail.com]
Sent: 1/21/2017 11:07:44 PM
To: David shulkin [drshulkin@aol.com]
Subject: Re: Time to talk

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AMERICAN OVERSIGHT

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From: David Shulkin [drshulkin@aol.com]
Sent: 1/21/2017 11:04:23 PM
To: mbs(b) (6) gmail.com
Subject: Re: Time to talk

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AMERICAN OVERSIGHT

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>
> Marc Sherman
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AMERICAN OVERSIGHT

Message

From: Marc Sherman [mbs(b) (6) gmail.com]
Sent: 1/21/2017 10:53:35 PM
To: David shulkin [drshulkin@aol.com]
Subject: Re: Time to talk

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>
> Marc Sherman
(b) (6)

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 1/21/2017 10:47:16 PM
To: mbs(b) (6) gmail.com
Subject: Re: Time to talk

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What about delaying till our breakfast?

Sent from AOL Mobile Mail

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From: Marc Sherman <mbs(b) (6) gmail.com>
To: David shulkin <Drshulkin@aol.com>
Sent: Sat, Jan 21, 2017 05:32 PM
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> Marc Sherman
> (b) (6)

AMERICAN OVERSIGHT

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From: Marc Sherman [mbs(b) (6) gmail.com]
Sent: 1/21/2017 10:32:17 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Time to talk

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>
> Marc Sherman
(b) (6)

AMERICAN OVERSIGHT

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From: David shulkin [Drshulkin@aol.com]
Sent: 1/21/2017 6:46:33 PM
To: Marc Sherman [mbs(b) (6) gmail.com]
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>
> Marc
>
> Marc Sherman
> (b) (6)

AMERICAN OVERSIGHT

Message

From: Marc Sherman [mbs(b) (6) gmail.com]
Sent: 1/21/2017 5:24:05 PM
To: David shulkin [drshulkin@aol.com]; IP [@frenchangel59.com]
Subject: Time to talk

David.

I am looking forward to breakfast on Thursday. Ike and I were wondering if you have time for a 15 minute call late afternoon or early evening tomorrow to discuss IT?

Marc

Marc Sherman
(b) (6)

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 1/16/2017 1:58:45 AM
To: (b) (6) @gmail.com
Subject: Fwd: NOTES | Conference Call with the new head of the VA, Doctor David Shulkin. The President Elect plans to announce the committee members very soon
Attachments: Veterans Administration Healthcare Advisory Group.docx

please print for me and lets keep off of VA email.

-----Original Message-----
From: (b) (6) <(b) (6)@mayo.edu>
To: Marc Sherman <mbs(b) (6) gmail.com>; Bruce Moskowitz <brucem(b) (6) mac.com>; IP <(@frenchangel59.com>; L Perl <(b) (6) @gmail.com>
Cc: David shulkin <drshulkin@aol.com>; (b) (6) M.D., M.D. (b) (6) @mayo.edu>; (b) (6) <(b) (6) @jhmi.edu>; (b) (6) <(b) (6) partners.org>; (b) (6) <(b) (6) ccf.org>
Sent: Sun, Jan 15, 2017 3:35 pm
Subject: NOTES | Conference Call with the new head of the VA, Doctor David Shulkin. The President Elect plans to announce the committee members very soon

Hi – my notes from today's call.....enjoy the rest of your Sunday!

From: Marc Sherman [mailto:mbs(b) (6) gmail.com]
Sent: Sunday, January 15, 2017 12:01 PM
To: Marisol Garcia; Bruce Moskowitz; David shulkin; L Perl; (b) (6) IP; (b) (6) M.D.; (b) (6) ; (b) (6) ; (b) (6) @ccf.org; (b) (6) partners.org; (b) (6) @partners.org
Subject: Re: Conference Call with the new head of the VA, Doctor David Shulkin. The President Elect plans to announce the committee members very soon

All

I have attached the agenda for today's 2pm EST call. Thanks to everyone for setting aside the time on your weekend to participate. You will note that the agenda identifies procedural and informational topics as well as substantive topics. The purpose of the call is not to delve deeply into the substantive topics although discussion of them is necessary to put procedure and information into perspective and derive a go forward plan. You will also notice that there are some links attached to the substantive topics. Those links for today are meant to provide context for the topics and future considerations. I don't expect we will be delving deeply into the links today other than for context purposes.

I look forward to our call at 2pm.

FOR REFERENCE: NOTE THAT THE DIAL IN FOR TODAY'S CALL IS

US: 1-866-244-(b)

International: 719-457-(b)

Passcode: (b) (6)

Marc

AMERICAN OVERSIGHT

Marc Sherman
(b) (6) [redacted]

AMERICAN OVERSIGHT

Veterans Administration Healthcare Advisory Group

Sunday | January 15

Attendees: David Shulkin; Ike Perlmutter; Laurie Perlmutter; Marc Sherman; [redacted] (b) (6) [redacted] (b) (6) [redacted] (b) (6) [redacted]; (b) (6) [redacted]

- Staying radio silent for media interviews (D. Shulkin)
- Marc Sherman, Intro:
    - Congratulations David on your nomination
    - Have a common goal to make the VA to provide the best care for our vets – as efficient and cost effective manner as possible
    - More procedural, next steps vs. substantive – will put context around substantive issues
    - Output of today's call will be shared w/ the President-elect – pretty quickly
    - Here to provide assistance to David in his new role
- Dr. David Shulkin's Comments:
    - Thank you for volunteering to step up to this
    - Veteran's deserve the very best in American medicine – appreciate you taking time on a Sunday to do this
    - Priorities of the President – what they've committed to do for the country
        - Appoint VA Secretary to do the types of things we're doing on this call
        - #1 priority is to get confirmed – can't show "presumption" to the Senate
        - When talking – "if confirmed" – appreciate the true process
        - #2 – employees who work w/in the VA – 365K employees
            - Hard to get rid of employees we can't tolerate in private settings
            - Detail them – reassign, grow unhappy and fester
            - Need to identify the bad employees and deal w/ them
            - Can be a cancer to the good employees
        - #3 – create a commission to investigate the fraud/abuse in the system
            - Many groups looking at it/don't want to be duplicate, need to quickly identify
        - #4 – improving access and choose one's provider
            - Remove the 40-mile/30-day provision
            - Doing some economic modeling
        - #5 – increase the mental health professionals + increase the effectiveness of interventions
            - Appreciates the co-morbidity of mental health diagnoses
    - My priority is the President's to make rapid priority on these issues
    - Snapshot of current state of the health part of the VA
        - Mixed news – problems, but areas of progress (not reported)

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- Lack of managing talent in the VA – for as big as the VA is, would be amazed by lack of experience, private sector experience – people haven't developed the sophistication you would expect (pay scales is part of the issue)
- Need additional management talent
- In the area of access, have made progress – same-day mental health access in primary care across all major medical centers in each region
- Six of the medical centers – "good morning, would you like to be seen today" mentality/culture change
- W/out a lot of fanfare, 18% of veterans were being seen by community partners, now that's at 31% -- make slow, steady progress – very well received by Veterans
- Released an RFP, need help from committee – replace TPAs that are managing community care programs – two years ago, only two submitted
    - Was release against Dr. Shulkin's authorization – released keeping community model exactly the same; did not recognize that Administration was likely going to want to do something transformative
    - Do we pull the RFP back, or keep it on the street to see how they respond
        - Some may spend $millions on an RFP
- Community by community assessment of healthcare capacity needs contract is "out" – assessing VA wait times and assessing what the community offers – how would you build a healthcare market for the veterans in each market
- IT – a little bit of a mess right now; have a couple of different ways to go – off the shelf vs. more cloud-based information exchanges – issue not resolved due to timing
    - Demos and concepts developed – welcome this group's feedback
    - What happens in transition, leader of IT disappears – will not have a new leader of IT for 7-9 months; organization is "at risk" in this transition period
    - If we don't make clear, directional
    - Ivanka's husband's specialty is IT, has offered full resources to VA as needed (I. Perlmutter)
    - May want to go outside for this interim period (b) (6)
    - What needs to be done to keep IT lead in place (M. Sherman)
        - Needs to be asked and feel real support; respected by upper level management (D. Shulkin)
        - Very hard to find very good IT people, should keep her (I. Perlmutter)
        - Would encourage that people on the call reach out to her – if silent, departs at noon on the 20th of January (D. Shulkin)
        - Express support of this group to her; happy to sit w/ you and assurances of this group (M. Sherman)
- Short-term:

AMERICAN OVERSIGHT

        - Change the dialogue nationally about the VA, need to make some changes in the PR department – not doing interviews until after the hearings – will be an opportunity to talk
            - 60 Minutes and all the major outlets all want to talk
        - Get someone w/ managed care experience into the organization – asked for Ron Williams from Aetna as a public service – need
        - Remove some of the bureaucracy – some of it is absurd; cut through the red tape
    - Long-term:
        - Term privatization is a hot button w/ Veterans service group – like to describe it as an integrated care network for veterans
            - Take advantage of VA + private sector network – take advantage of where the service is the best
            - At 33% community care, nationwide – will vary market to market
        - Pay attention to both education and research – needs to benefit veterans
        - Just recruited a new head of research from Harvard – will help us think through choices
        - Rationalize the VA structure/physical facilities – get much more aggressive in that planning
            - South Dakota – census of 1-2 inpatients a day, closing
        - Address the issue of suicide – have to figure out what more we can do; our intervention is ineffective
        - Appeals modernization – broken, have do something about that
- Opportunity to save money is common purchasing – your thoughts (b) (6)
    - Should be looking at a partial of full outsourcing of purchasing who know how to do it; would be interested in knowing how you would do it (D. Shulkin)
        - Not enough experience w/in VA to do it; could save a lot of money (b) (6)
- Reimbursement for the private sector, a lot of complaint about people not being paid (b) (6)
    - TC3 works, where we get into trouble is when we use a third party as an intermediary, not paying w/in the 30-day timeframe (D. Shulkin)
- A lot of duplication – can't get information we need (patient records) (B. Moskowitz)
- Two broad areas (JHN)
    - Infrastructure of scheduling of billing, appointment making, EHR, quality analytics – do you have an electronic health record or not
        - Exist at certain levels – some vulnerabilities – EHR is one of them; #1 problem is hat we have capabilities, but no mechanism for constant updates – no software developers (D. Shulkin)
            - If VA asked to develop in-house, that's a red flag for me; even if we can develop it, better if we develop it privately
    - How do you bring best practices to the veterans -- a lot of great practices w/in the VA, can you identify the best and spread vs. it being imported from the outside

AMERICAN OVERSIGHT

        - Couldn't agree more; have focused on that to get the morale – "diffusion of excellence" effort – have done 410 replications of best practices; writing a book; an area we've made progress (D. Shulkin)
    - If we could help you tweak the "best practices"; with infrastructure, you should have the best managed care organization, delivery system – hard issues have to be dealt w/ and here's why – happy to help you do that ((b) (6)
        - Need the competency to assess those infrastructure needs – need talent to do that; I came up on the clinical side (D. Shulkin)
        - Because we have the infrastructure, we can help assess the systems capabilities ((b)
            - Perhaps a person or a couple of people from the organizations represented can assess (I. Perlmutter)
            - Kaiser is awfully good at this side; one organization to consider looking at on this side ((b) (6)
- Two observations and a suggestion: ((b) (6)
    - As you transfer to the private sector, the TPA function, the math has to work – will determine the pace of transition and capital investment
    - Regulations – we told the President-elect, good to have 80% of the regulations to go away; challenge is to diminish regulations and to ensure the appropriate level of fraud protection
    - Running "home-based program" in four markets – comprehensive program around PTSD; doing a lot of good; has not spread as quickly as we would have expected
    - Issue of regulation is something work tackling (D. Shulkin)
        - VA not permitted to ban smoking – only hospital in the country (tobacco lobby)
        - Can't treat family members – have not been allowed to
    - Do you have a list of regulations that cause you most problems (M. Sherman)
- More than welcome to come to Baltimore to learn ((b) (6)
    - Training programs in particular may have application as you formulate your vision for what you want it to be
- If it makes sense, you freeze the contracts around the country – does it make sense to do so, in hopes that you get a best handle on construction expenditures (I. Perlmutter)
    - The very large construction projects, seems to makes sense – hesitant to do it related to recruitment (D. Shulkin)
        - May make sense to pull back on the RFPs for community care management until we have a better sense for direction
        - My sense, makes sense to pull back on the RFP, think about better ways, go back out into the market w/ the right RFP (M. Sherman)
            - President-elect will support you from a business perspective (I. Perlmutter)
            - Implication is cost/service overruns and going in a direction you don't ultimately want to go (M. Sherman)
        - Can we push forward w/ closing some locations and push more Veterans to private care (I. Perlmutter)

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- Dr. Shulkin's confirmation is set for January 31 – hold on sharing information in follow-up until after that time (I. Perlmutter)
- Complex care for veterans is incompletely compensated; should Veterans have access to FEHBP – politically this might be a time to look at this ([redacted]
    - Tri-care is not seen as a good payer in most settings (Dr. (b) (6)
    - Would love to grow this practice, but not at a big financial burden ([redacted]
- (b) (6) – wife of veteran that was blinded in 2005 – extraordinary advocate on behalf of Veterans (L. Perlmutter)
    - A lot of the illness is caused by lack of jobs (B. Moskowitz)
        - Link: Heroes Work Here at Disney
            - May be an opportunity to corral large companies to assist in hiring – Veteran employment (M. Sherman)
- Where do we go from here: (M. Sherman)
    - Immediate issues:
        - Regulation
        - IT
    - David Shulkin – come back to us w/ priorities
    - Capital closures – proceeding w/ that phase to bring more cash into the mix for care for Veterans
- PR – sabbatical program for Communications/PR – Mayo "head of social media" – 3 month sabbatical to come and teach our staff; executive that had some infrastructure capability; attach some prestige to it; name as White House Fellows; coming direct from military PR (D. Shulkin)
    - Make it bi-directional – spend some time w/ us + w/ VA ((b) (6)
    - Capture this idea (D. Shulkin)
- Additional Item (from Ike Perlmutter and B. Moskowitz) – Mack Center of Technological Innovation at Wharton School of Business has volunteered to offer its expertise to the VA to assist in any way

To Do:

- Dr. D. Shulkin:
    - Share name of IT person in place at VA w/ advisory group; encourage IT leaders at group to reach out to her
    - Share list of regulations causing the most problems
    - Share the recommendation on location closing
- M. Sherman and D. Shulkin to meet w/ the IT person later this week

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) @mayo.edu]
Sent: 1/15/2017 8:35:41 PM
To: Marc Sherman [(b) (6) gmail.com]; Bruce Moskowitz [brucem(b) (6) mac.com]; IP [@frenchangel59.com]; L Perl [(b) (6) @gmail.com]
CC: David shulkin [drshulkin@aol.com]; (b) (6) M.D. [(b) (6) @mayo.edu]; (b) (6) [(b) (6) @jhmi.edu]; (b) (6) partners.org; (b) (6) ccf.org
Subject: NOTES | Conference Call with the new head of the VA, Doctor David Shulkin. The President Elect plans to announce the committee members very soon
Attachments: Veterans Administration Healthcare Advisory Group.docx

Hi – my notes from today's call.....enjoy the rest of your Sunday!

From: Marc Sherman [mailto:mb(b) (6) gmail.com]
Sent: Sunday, January 15, 2017 12:01 PM
To: Marisol Garcia; Bruce Moskowitz; David shulkin; L Perl; (b) (6) IP; (b) (6) M.D.; (b) (6) (b) (6) ; (b) (6) ccf.org; (b) (6) partners.org; (b) (6) (b) (6) @partners.org
Subject: Re: Conference Call with the new head of the VA, Doctor David Shulkin. The President Elect plans to announce the committee members very soon

All

I have attached the agenda for today's 2pm EST call. Thanks to everyone for setting aside the time on your weekend to participate. You will note that the agenda identifies procedural and informational topics as well as substantive topics. The purpose of the call is not to delve deeply into the substantive topics although discussion of them is necessary to put procedure and information into perspective and derive a go forward plan. You will also notice that there are some links attached to the substantive topics. Those links for today are meant to provide context for the topics and future considerations. I don't expect we will be delving deeply into the links today other than for context purposes.

I look forward to our call at 2pm.

FOR REFERENCE: NOTE THAT THE DIAL IN FOR TODAY'S CALL IS

US: 1-866-244-(b) (6)

International: 719-457-(b) (6)

Passcode: (b) (6)

Marc

Marc Sherman
(b) (6)

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Veterans Administration Healthcare Advisory Group

Sunday | January 15

Attendees: David Shulkin; Ike Perlmutter; Laurie Perlmutter; Marc Sherman; (b) (6); (b) (6); (b) (6); (b) (6); (b) (6)

- Staying radio silent for media interviews (D. Shulkin)
- Marc Sherman, Intro:
  - Congratulations David on your nomination
  - Have a common goal to make the VA to provide the best care for our vets – as efficient and cost effective manner as possible
  - More procedural, next steps vs. substantive – will put context around substantive issues
  - Output of today's call will be shared w/ the President-elect – pretty quickly
  - Here to provide assistance to David in his new role
- Dr. David Shulkin's Comments:
  - Thank you for volunteering to step up to this
  - Veteran's deserve the very best in American medicine – appreciate you taking time on a Sunday to do this
  - Priorities of the President – what they've committed to do for the country
    - Appoint VA Secretary to do the types of things we're doing on this call
    - #1 priority is to get confirmed – can't show "presumption" to the Senate
    - When talking – "if confirmed" – appreciate the true process
    - #2 – employees who work w/in the VA – 365K employees
      - Hard to get rid of employees we can't tolerate in private settings
      - Detail them – reassign, grow unhappy and fester
      - Need to identify the bad employees and deal w/ them
      - Can be a cancer to the good employees
    - #3 – create a commission to investigate the fraud/abuse in the system
      - Many groups looking at it/don't want to be duplicate, need to quickly identify
    - #4 – improving access and choose one's provider
      - Remove the 40-mile/30-day provision
      - Doing some economic modeling
    - #5 – increase the mental health professionals + increase the effectiveness of interventions
      - Appreciates the co-morbidity of mental health diagnoses
  - My priority is the President's to make rapid priority on these issues
  - Snapshot of current state of the health part of the VA
    - Mixed news – problems, but areas of progress (not reported)

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- Lack of managing talent in the VA – for as big as the VA is, would be amazed by lack of experience, private sector experience – people haven't developed the sophistication you would expect (pay scales is part of the issue)
- Need additional management talent
- In the area of access, have made progress – same-day mental health access in primary care across all major medical centers in each region
- Six of the medical centers – "good morning, would you like to be seen today" mentality/culture change
- W/out a lot of fanfare, 18% of veterans were being seen by community partners, now that's at 31% -- make slow, steady progress – very well received by Veterans
- Released an RFP, need help from committee – replace TPAs that are managing community care programs – two years ago, only two submitted
    - Was release against Dr. Shulkin's authorization – released keeping community model exactly the same; did not recognize that Administration was likely going to want to do something transformative
    - Do we pull the RFP back, or keep it on the street to see how they respond
        - Some may spend $millions on an RFP
- Community by community assessment of healthcare capacity needs contract is "out" – assessing VA wait times and assessing what the community offers – how would you build a healthcare market for the veterans in each market
- IT – a little bit of a mess right now; have a couple of different ways to go – off the shelf vs. more cloud-based information exchanges – issue not resolved due to timing
    - Demos and concepts developed – welcome this group's feedback
    - What happens in transition, leader of IT disappears – will not have a new leader of IT for 7-9 months; organization is "at risk" in this transition period
    - If we don't make clear, directional
    - Ivanka's husband's specialty is IT, has offered full resources to VA as needed (I. Perlmutter)
    - May want to go outside for this interim period (b) (6)
    - What needs to be done to keep IT lead in place (M. Sherman)
        - Needs to be asked and feel real support; respected by upper level management (D. Shulkin)
        - Very hard to find very good IT people, should keep her (I. Perlmutter)
        - Would encourage that people on the call reach out to her – if silent, departs at noon on the 20th of January (D. Shulkin)
        - Express support of this group to her; happy to sit w/ you and assurances of this group (M. Sherman)
- Short-term:

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        - Change the dialogue nationally about the VA, need to make some changes in the PR department – not doing interviews until after the hearings – will be an opportunity to talk
            - 60 Minutes and all the major outlets all want to talk
        - Get someone w/ managed care experience into the organization – asked for Ron Williams from Aetna as a public service – need
        - Remove some of the bureaucracy – some of it is absurd; cut through the red tape
    - Long-term:
        - Term privatization is a hot button w/ Veterans service group – like to describe it as an integrated care network for veterans
            - Take advantage of VA + private sector network – take advantage of where the service is the best
            - At 33% community care, nationwide – will vary market to market
        - Pay attention to both education and research – needs to benefit veterans
        - Just recruited a new head of research from Harvard – will help us think through choices
        - Rationalize the VA structure/physical facilities – get much more aggressive in that planning
            - South Dakota – census of 1-2 inpatients a day, closing
        - Address the issue of suicide – have to figure out what more we can do; our intervention is ineffective
        - Appeals modernization – broken, have do something about that
- Opportunity to save money is common purchasing – your thoughts (b) (6)
    - Should be looking at a partial of full outsourcing of purchasing who know how to do it; would be interested in knowing how you would do it (D. Shulkin)
        - Not enough experience w/in VA to do it; could save a lot of money (b) (6)
- Reimbursement for the private sector, a lot of complaint about people not being paid (b) (6)
    - TC3 works, where we get into trouble is when we use a third party as an intermediary, not paying w/in the 30-day timeframe (D. Shulkin)
- A lot of duplication – can't get information we need (patient records) (B. Moskowitz)
- Two broad areas (JHN)
    - Infrastructure of scheduling of billing, appointment making, EHR, quality analytics – do you have an electronic health record or not
        - Exist at certain levels – some vulnerabilities – EHR is one of them; #1 problem is hat we have capabilities, but no mechanism for constant updates – no software developers (D. Shulkin)
            - If VA asked to develop in-house, that's a red flag for me; even if we can develop it, better if we develop it privately
    - How do you bring best practices to the veterans -- a lot of great practices w/in the VA, can you identify the best and spread vs. it being imported from the outside

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        - Couldn't agree more; have focused on that to get the morale – "diffusion of excellence" effort – have done 410 replications of best practices; writing a book; an area we've made progress (D. Shulkin)
    - If we could help you tweak the "best practices"; with infrastructure, you should have the best managed care organization, delivery system – hard issues have to be dealt w/ and here's why – happy to help you do that (b) (6)
        - Need the competency to assess those infrastructure needs – need talent to do that; I came up on the clinical side (D. Shulkin)
        - Because we have the infrastructure, we can help assess the systems capabilities (b
            - Perhaps a person or a couple of people from the organizations represented can assess (I. Perlmutter)
            - Kaiser is awfully good at this side; one organization to consider looking at on this side (b) (6)
- Two observations and a suggestion: (b) (6)
    - As you transfer to the private sector, the TPA function, the math has to work – will determine the pace of transition and capital investment
    - Regulations – we told the President-elect, good to have 80% of the regulations to go away; challenge is to diminish regulations and to ensure the appropriate level of fraud protection
    - Running "home-based program" in four markets – comprehensive program around PTSD; doing a lot of good; has not spread as quickly as we would have expected
    - Issue of regulation is something work tackling (D. Shulkin)
        - VA not permitted to ban smoking – only hospital in the country (tobacco lobby)
        - Can't treat family members – have not been allowed to
    - Do you have a list of regulations that cause you most problems (M. Sherman)
- More than welcome to come to Baltimore to learn (b) (6)
    - Training programs in particular may have application as you formulate your vision for what you want it to be
- If it makes sense, you freeze the contracts around the country – does it make sense to do so, in hopes that you get a best handle on construction expenditures (I. Perlmutter)
    - The very large construction projects, seems to makes sense – hesitant to do it related to recruitment (D. Shulkin)
        - May make sense to pull back on the RFPs for community care management until we have a better sense for direction
        - My sense, makes sense to pull back on the RFP, think about better ways, go back out into the market w/ the right RFP (M. Sherman)
            - President-elect will support you from a business perspective (I. Perlmutter)
            - Implication is cost/service overruns and going in a direction you don't ultimately want to go (M. Sherman)
        - Can we push forward w/ closing some locations and push more Veterans to private care (I. Perlmutter)

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- Dr. Shulkin's confirmation is set for January 31 – hold on sharing information in follow-up until after that time (I. Perlmutter)
- Complex care for veterans is incompletely compensated; should Veterans have access to FEHBP – politically this might be a time to look at this ([redacted]
    - Tri-care is not seen as a good payer in most settings (Dr. (b) (6)
    - Would love to grow this practice, but not at a big financial burden ([redacted]
- (b) (6) – wife of veteran that was blinded in 2005 – extraordinary advocate on behalf of Veterans (L. Perlmutter)
    - A lot of the illness is caused by lack of jobs (B. Moskowitz)
        - Link: Heroes Work Here at Disney
            - May be an opportunity to corral large companies to assist in hiring – Veteran employment (M. Sherman)
- Where do we go from here: (M. Sherman)
    - Immediate issues:
        - Regulation
        - IT
    - David Shulkin – come back to us w/ priorities
    - Capital closures – proceeding w/ that phase to bring more cash into the mix for care for Veterans
- PR – sabbatical program for Communications/PR – Mayo "head of social media" – 3 month sabbatical to come and teach our staff; executive that had some infrastructure capability; attach some prestige to it; name as White House Fellows; coming direct from military PR (D. Shulkin)
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    - Share name of IT person in place at VA w/ advisory group; encourage IT leaders at group to reach out to her
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    - Share the recommendation on location closing
- M. Sherman and D. Shulkin to meet w/ the IT person later this week

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/13/2017 5:41:03 PM
To: Bruce Moskowitz [brucem(b) (6) mac.com]
Subject: Re: Conference call

How about sunday at 1 pm?

Sent from my iPhone

> On Jan 13, 2017, at 12:37 PM, Bruce Moskowitz <brucem(b) (6) mac.com> wrote:
>
> I should give you a briefing of possible topics prior to the call so you can be prepared. I will make myself available at your convenience. Thank you.
>
> Sent from my iPad
> Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [brucem(b) (6) mac.com]
Sent: 1/13/2017 5:37:29 PM
To: David shulkin [drshulkin@aol.com]
Subject: Conference call

I should give you a briefing of possible topics prior to the call so you can be prepared. I will make myself available at your convenience. Thank you.

Sent from my iPad
Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/14/2017 11:06:28 PM
To: Jennifer Lee [(b) (6) @gmail.com]
Subject: Re: VCL, etc.

These topics are all good for hearing prepA please share with avivieca

Sent from my iPhone

> On Jan 14, 2017, at 5:29 PM, Jennifer Lee (b) (6) gmail.com> wrote:
>
> Hi David,
> We met with the OIG yesterday to get a preview of the VCL draft report that will be coming out imminently. It was not good - very critical of the governance and lack of clinical oversight. Also there was a report of a poorly handled case in June 2016 related to rollover/backup centers. I can't imagine this won't get picked up by press.
>
> I just want you to know I'm coming up with a plan to respond to the issues raised and will work with Steve on proposed action steps for your review.
> we will need changes in oversight and governance, as recommended by OIG.
>
> whenever you want more detail, just let me know. In the meantime will keep working this with the team.
>
> Is there anything else I can update you on right now?
>
> Besides suicide, some other timely issues include:
> -IVF
> -LeJeune rule
> -potential effects of ACA repeal scenarios
>
> some other less urgent, but important issues:
> -EHR and scheduling
> -Long term care
> -Hep C
> -women's health
> -telehealth
> -DoD-VA collaboration (creative ideas of more we can do)
>
> Thanks
> Jen

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Message

From: Jennifer Lee [(b) (6) @gmail.com]
Sent: 1/14/2017 10:29:09 PM
To: David Shulkin [drshulkin@aol.com]
CC: (b) (6) @hotmail.com
Subject: VCL, etc.

Hi David,
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-Long term care
-Hep C
-women's health
-telehealth
-DoD-VA collaboration (creative ideas of more we can do)

Thanks
Jen

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/13/2017 8:39:10 PM
To: (b) (6) [(b) (6) @gmail.com]
Subject: Re: Set/Reset MAX Password Request

Ok

Sent from my iPhone

On Jan 13, 2017, at 3:31 PM, (b) (6) <(b) (6) @gmail.com> wrote:

> unfortunately no, I called several people and they said the user name is for your protection.
>
> (b) (6)
>
> On Fri, Jan 13, 2017 at 3:21 PM, (b) (6) <(b) (6) @gmail.com> wrote:
> let me see if I can
>
> (b) (6)
>
> On Fri, Jan 13, 2017 at 3:20 PM, David shulkin <Drshulkin@aol.com> wrote:
> Can you change the user name to something simpler?
>
> Sent from my iPhone
>
> Begin forwarded message:
>
> > **From:** "Integrity.gov" <notifications@integrity.gov>
> > **Date:** January 13, 2017 at 3:06:04 PM EST
> > **To:** drshulkin@aol.com
> > **Subject: Set/Reset MAX Password Request**
> >
> > Dear Integrity User Integrity User,
> >
> > You have requested the setting/resetting of your MAX.gov account password on the MAX.gov Manage Password page.
> >
> > To set your password, click on the Password Reset Link below within 2 hours (i.e. by 05:05 PM, January 13, 2017).
> >
> > PASSWORD RESET LINK (you may need to copy and paste this link into your browser):
> > https://max.gov/chpw?token=1b06d2d4&email=C6906E72-1E2A-45F8-BA9C-D8104D396840@integrity.gov
> >
> > Then follow the instructions on the webpage.

AMERICAN OVERSIGHT

Notes:
- If it is already past 05:05 PM, January 13, 2017, please click on the link below to obtain an updated password set/reset email.
https://max.gov/maxportal/(b) (6) [redacted]

- If your email system has removed the above Password Reset Link, please follow the instructions in the Alternative Password Reset Service Section below.

For assistance please contact the MAX Support team at maxsupport@max.gov or 202-395-6860.

Thank you
The MAX Support Team

---- Alternative Password Reset Service Section ----

If your Email system has completely removed the MAX Password Reset Link referenced above from this Email, you may still set your password using the following simple procedure:

1. Copy (ctrl+c) the following Alternate Password Reset Key into your clipboard:

Alternate Password Reset Key: (b) (6) [redacted]

2. Paste it into the appropriate place on the Alternate Password Reset form

- If the webpage is no longer open you may reopen it by copying/pasting or typing the following URL shortcut as the browser URL address: "max.gov/altreset"

3. Then click the SUBMIT button and follow the instructions on the webpage.

(msg 120)

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) @gmail.com]
Sent: 1/13/2017 8:31:12 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Set/Reset MAX Password Request

unfortunately no, I called several people and they said the user name is for your protection.

(b) (6)

On Fri, Jan 13, 2017 at 3:21 PM, (b) (6) <(b) (6) @gmail.com> wrote:
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Can you change the user name to something simpler?

Sent from my iPhone

Begin forwarded message:

From: "Integrity.gov" <notifications@integrity.gov>
Date: January 13, 2017 at 3:06:04 PM EST
To: drshulkin@aol.com
Subject: Set/Reset MAX Password Request

Dear Integrity User Integrity User,

You have requested the setting/resetting of your MAX.gov account password on the MAX.gov Manage Password page.

To set your password, click on the Password Reset Link below within 2 hours (i.e. by 05:05 PM, January 13, 2017).

PASSWORD RESET LINK (you may need to copy and paste this link into your browser):
https://max.gov/chpw?token=1b06d2d4&email=C6906E72-1E2A-45F8-BA9C-D8104D396840@integrity.gov

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3. Then click the SUBMIT button and follow the instructions on the webpage.

(msg 120)

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/13/2017 8:20:44 PM
To: (b) (6) [(b) (6) @gmail.com]
Subject: Fwd: Set/Reset MAX Password Request

Can you change the user name to something simpler?

Sent from my iPhone

Begin forwarded message:

> **From:** "Integrity.gov" <notifications@integrity.gov>
> **Date:** January 13, 2017 at 3:06:04 PM EST
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(msg 120)

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Sent: 1/13/2017 8:20:04 PM
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I reset password (b) (6)

Sent from my iPhone

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(msg 120)

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/9/2017 12:52:56 AM
To: Jennifer Lee [(b) (6) @gmail.com]
Subject: Re: time to talk?

Send me your cell number

I lost my cobtacts

Sent from my iPhone

> On Jan 7, 2017, at 4:45 PM, Jennifer Lee (b) (6) mail.com> wrote:
>
> Hi David,
> Scott Gould called me today. I'm guessing he shared most of the same info with you yesterday, but if you have a minute I can do a download.
> thanks
> Jen

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Message

From: Jennifer Lee [(b) (6) @gmail.com]
Sent: 1/7/2017 9:45:34 PM
To: David Shulkin [drshulkin@aol.com]
Subject: time to talk?

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thanks
Jen

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 1/11/2017 11:58:15 AM
To: Poonam Alaigh [(b) (6) @hotmail.com]; LaVerne Council [(b) (6) @gmail.com]
Subject: See paragraph starting with Trump

http://www.nytimes.com/aponline/2017/01/11/us/politics/ap-us-veterans-affairs-problems.html

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) @gmail.com]
Sent: 1/12/2017 3:34:48 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Bio Form Tab 1
Attachments: ShulkinTAB1-incomingdocs.pdf

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OFFICE OF THE PRESIDENT-ELECT

Office of Presidential Appointments

APPOINTEE INFORMATION SHEET

NOTICE: Review the instructions attached to this form. Return to the Office of Presidential Appointments as soon as complete. This information is necessary to begin the clearance process. Return via email to Incomingdocs@ptt.gov or contact the office for alternate submission methods.

PART I: TO BE COMPLETED BY POTENTIAL APPOINTEE

1. FULL NAME (Last, First, Middle): SHULKIN, DAVID, Jonathan	2. SOCIAL SECURITY NUMBER: (b) (6), (b) (2)	
3. CURRENT RESIDENTIAL ADDRESS (Number, Street, City, State, ZIP Code): (b) (6), (b) (2)		
4. VOTING ADDRESS IN 2016 (Number, Street, City, State, ZIP Code): (b) (6), (b) (2)		
5. PLACE OF BIRTH (City, State; if not U.S., state country): (b) (6), (b) (2)	6. GENDER: MALE	7. DATE OF BIRTH: (b) (6), (b) (2)
8. ETHNIC HERITAGE: (b) (6), (b) (2)	9. RACE: (b) (6), (b) (2)	10. POLITICAL PARTY
11. HOME PHONE: (b) (6)	12. CELL PHONE: (b) (6)	13. WORK PHONE: (b) (6)
14. PERSONAL EMAIL: DRshulkin@aol.com	15. WORK EMAIL: DAVID.shulkin@va.gov	
16. CURRENT POSITION (Title, Company): Under Secretary for Health, Dept of Veteran Affairs	17. WORK ADDRESS (Number, Street, City, State, Zip): 810 Vermont, Washington DC 20420	
18. SPOUSE: (b) (6), (b) (2)	19. CHILDREN (2): (b) (6), (b) (2)	
20. NAME AND HOME STATE (For official announcement and nomination): (b) (6), (b) (2) PA		
21. EDUCATION (Degree, Institution, Year): (b) (6), (b) (2)	22. AWARDS	
23. MILITARY SERVICE (Rank, Branch, Years): (b) (6), (b) (2)	24. PREVIOUS PRESIDENTIAL APPOINTMENTS: Under Secretary for Health	

PART II: TO BE COMPLETED BY PRESIDENTIAL PERSONNEL

1. POSITION		
2. TYPE	3. VICE	4. TERM
5. POTUS APPROVAL	6. SECURITY PACKAGE SENT	7. COUNSEL START

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(b) (6), (b) (2)



AMERICAN OVERSIGHT

Message

From: Jennifer Lee [(b) (6) @gmail.com]
Sent: 1/10/2017 1:10:35 AM
To: David Shulkin [drshulkin@aol.com]
Subject: fyi background- Ron Thomas

Here is more background on Ron Thomas, former VA DAS for Policy. Currently a partner in a Veterans and Defense lobbying firm. West Point grad and lawyer.
https://thomasrileystrategiesllc.net/veterans-lobbyists/

gentle reminder- (b) (6) pronounced (b) (6) :)

perhaps you should speak to Ron too? Ash found him very friendly and open to dialogue.

Ron Thomas: 202 870 (b) (cell)
202 (b) (6) (office)

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Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 1/5/2017 10:44:00 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Before noon

Call me or I can stop by before noon to discuss strategy for my lunch with (b) today- we just have one shot with time being of the essence- so want to be prepared as well as I can for it

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/8/2017 5:22:31 PM
To: David Shulkin [drshulkin@aol.com]
CC: Vivieca Simpson [(b) (6) @gmail.com]
Subject: Fwd: Updated VHA Modernization: Strategy and Implementation document

Vivieca- what do you think of this email?

Sent from my iPhone

Begin forwarded message:

There are! Anytime Monday is good. Driving to Michigan. Merry Christmas!

Rich

-----Original Message-----
From: Snyder, Robert
Sent: Saturday, December 24, 2016 08:03 AM Eastern Standard Time
To: Stone, Richard A., MD
Subject: RE: Updated VHA Modernization: Strategy and Implementation document

Thanks Rich. We'll try to be careful…I'm not looking to get anyone sideways with David, but this has become ridiculous. I think I am going to eventually have to have candid conversations with both (b) (6) and the Secretary about this. However, I really don't want to deal with David's insecurities on Christmas Eve or Christmas day. Is there a time that would be convenient for you to connect on the phone for a quick chat on Monday?

In the meantime, I hope you have a very Merry Christmas. I assume there are plenty of grand kids involved?

V/R,

Bob

Robert D. Snyder

Chief of Staff

Department of Veterans Affairs

AMERICAN OVERSIGHT

Office: (202) 461-4808

Cell: (202) 590-6883

Learn more: https://myva.va.gov



From: Stone, Richard A., MD
Sent: Friday, December 23, 2016 5:38 PM
To: Snyder, Robert
Subject: FW: Updated VHA Modernization: Strategy and Implementation document

Bob
These are the original slides before any edits from David. I want to emphasize this is my work without the endorsement of the Under Secretary. This violates his instructions.

Rich

-----Original Message-----
From: (b) (6)
Sent: Friday, December 23, 2016 05:18 PM Eastern Standard Time
To: Shulkin, David J., MD
Cc: (b) (6) Wright, Vivieca (Simpson); Stone, Richard A., MD
Subject: RE: Updated VHA Modernization: Strategy and Implementation document

Absolutely, see attached. Thanks, Kate

(b) (6) MD, MBA

Executive Director

Office of Strategic Integration|Veterans Engineering Resource Center

Veterans Health Administration

AMERICAN OVERSIGHT

From: Shulkin, David J., MD
Sent: Friday, December 23, 2016 5:08 PM
To: (b) (6)
Cc: (b) (6) Wright, Vivieca (Simpson); Stone, Richard A., MD
Subject: RE: Updated VHA Modernization: Strategy and Implementation document

(b) (or anyone still reading emails this close to Christmas) - does anyone have this in a non pdf format (preferably a powerpoint format) so i can make my proposed edits?

-----Original Message-----
From: (b) (6)
Sent: Wednesday, December 21, 2016 10:35 AM Eastern Standard Time
To: Shulkin, David J., MD
Cc: (b) (6) Wright, Vivieca (Simpson); Stone, Richard A., MD
Subject: RE: Updated VHA Modernization: Strategy and Implementation document

HI Dr. Shulkin, I am aware that Dr. Stone shared a draft Transition Team slide deck with you, but I wanted to insure you have the most current draft of the deck, and of the white paper. Thanks, (b)

(b) (6) MD, MBA

Executive Director

Office of Strategic Integration|Veterans Engineering Resource Center

Veterans Health Administration

-----Original Message-----
From: Shulkin, David J., MD
Sent: Monday, December 12, 2016 04:20 PM Eastern Standard Time
To: (b) (6) Wright, Vivieca (Simpson); Stone, Richard A., MD
Cc: (b) (6)
Subject: RE: Updated VHA Modernization: Strategy and Implementation document

(b) I have taken a very brief look at this and it looks great- so thank you for the good work here.

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I will take a more detailed look at it later tonight.

If we make changes as a group- that's great – please include Dr. Alaigh on all communications as well as she is

helping coordinate this for me.

Thanks

David

From: (b) (6)
Sent: Monday, December 12, 2016 4:15 PM
To: Wright, Vivieca (Simpson); Shulkin, David J., MD; Stone, Richard A., MD
Cc: (b) (6) (b) (6)
Subject: Updated VHA Modernization: Strategy and Implementation document

Hi Vivieca, Dr. Shulkin and Dr. Stone. Attached please find an updated version of the VHA Modernization document we discussed today. I have aligned the power point elements to the eight work groups (starting on page 2) as we discussed. I added additional language to augment the concepts, making attempts where appropriate to use language from the Independent Assessments, 10 Points, Commission on Care, business literature, VHA Websites, etc.

To facilitate, I made a high level executive assignment for each workgroup to insure that there is a main POC for each effort. I realize that some workgroups have several components which spread across the organization, but I selected an executive sponsor who, in my opinion, has the most "skin" in the game, or experience in this topic. I denoted that Dr. Stone has the lead for organizing, planning, integrating and implementing the effort.

The document remains otherwise largely unchanged. Please share widely after you have reviewed. Thank you, (b)

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WORKGROUPS. Although VHA's Modernization will be a multi-phased approach spanning several years, immediate action is also required and planned. Modernization efforts already underway include the following, to insure that Veterans come first:

1. <!--[if !supportLists]--> <!--[endif]-->**HIGH PERFORMING NETWORK.** Designed to assess and re-engineer care delivery by market, this workgroup's efforts include identifying foundational VHA services, strengthening Communities of Excellence, developing and implementing a standardized methodology to address low performing and underutlized facities, and cultivating the care coordination capacity of VHA. By developing a standard methodology that integrates the balance between available VHA (internal capacity) and community services (external capacity), variation in quality and cost of care, and changing demographic trends in the Veteran population (demand), this team is establishing institutional ground rules for future services and optimal footprint of VHA. (Executive Lead: Baligh Yehia, MD)

2. <!--[if !supportLists]--> <!--[endif]-->**VALUE-BASED PURCHASING:** Value Based Purchasing: By developing a system to promote the quality and value of services that community providers deliver to Veterans, this workgroup is developing a method to shift from volume-based payment to payment more closely related to outcomes and performance. (Executive Lead: Baligh Yehia, MD)

3. <!--[if !supportLists]--> <!--[endif]-->**COORDINATION/SHARING HEALTHCARE SERVICES:** This workgroup is addressing enahnced VHA coordination with other federal entities such as the Department of Defense and Health and Human Services. In addition, public private partnerships are being explored to amplify support to Veterans in the community, and address capital deficits in VHA. (Executive Lead: Carolyn Clancy, MD)

4. <!--[if !supportLists]--> <!--[endif]-->**ELIGILIBILITY:** In order to provide the foundation for informed decisions pertaining to future services and optimal footprint of VHA, this workgroup is investigating the impact of changes in Veteran eligiblity on the utilization of healthcare and social services, including grandfathering current enrolees. (Executive Lead: Jennifer Lee, MD)

5. <!--[if !supportLists]--> <!--[endif]-->**GOVERNANCE:** The focus of this workgroup is to identify and address governance gaps, accomodating alternative perspectives such as the establishment of a governance board to define strategic direction, separate VHA leadership from political intervention, and ensure accountabilty for performance, and redesign the hiring process. (Executive Lead: David Shulkin, MD)

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6. <!--[if !supportLists]--> <!--[endif]-->**OPTIMIZE MANAGEMENT:** Flattening VHA Central Office, the Veterans Integrated Service Networks, and Faclity Management through program analysis and commitment to the implementation of integrated clinical and administrative practice teams will reduce administrative burden and promote decision making at the right level. Integrating services across the organization will enhance the Veteran's experience, and promote whole health medicine, empowering Veteran well-being. In addition, optimization of central management will accelerate supply chain and result in other cost reductions as redundancies are reduced. (Executive Lead: Rich Stone, MD)

7. <!--[if !supportLists]--> <!--[endif]-->**IT INTEGRATION:** A lack of standard interoperable enterprise VHA systems and tools impacts VHA's operations and data. Focusing on the establishment of an integrated IT system to support business functions and foster a comprehensive and interoperable digital health platform, this workgroup is dedicated to seamlessly integrate VHA's core processes. (Executive Lead: Jennifer Lee, MD)

8. <!--[if !supportLists]--> <!--[endif]-->**ACHIEVE THE FULL VA MISSION:** While the mission of patient care is VHA's primary focus, efforts to rapidly modernize care must be coordinated with three additional congressionally mandated responsiblities: health professions education, research and medical preparedness. This workgroup focuses on training more primary care and behavioral health students, accelerating precision medicine and fostering innovation, providing access to VA research data (as appropriate) for non-VA researchers, and fostering emergency preparedness to meet the needs of all citizens. (Executive Lead: Jennifer Lee, MD)

(b) (6) MD, MBA

Executive Director

Office of Strategic Integration|Veterans Engineering Resource Center

(b) (6) VACO 878

Office of the Principal Deputy Under Secretary for Health

AMERICAN OVERSIGHT

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/5/2017 7:01:02 PM
To: Jennifer Lee [(b) (6) @gmail.com]
Subject: Re: Yale issue

Great

Sent from my iPhone

> On Jan 5, 2017, at 1:17 PM, Jennifer Lee (b) (6) @gmail.com> wrote:
>
> Hi David,
> we have taken care of the Yale Flowhealth issue. our team spoke with the Dean and their legal team. they think it is nonsense and they do not plan to respond.
>
>
>

AMERICAN OVERSIGHT

Message

From: Jennifer Lee [(b) (6) @gmail.com]
Sent: 1/5/2017 6:17:01 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Yale issue

Hi David,
we have taken care of the Yale Flowhealth issue. our team spoke with the Dean and their legal team. they think it is nonsense and they do not plan to respond.

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/5/2017 10:26:15 PM
To: Marisol Garcia [(b)@frenchangel59.com]
CC: Bruce Moskowitz [brucem(b) (6) mac.com]
Subject: Re: Meeting in Palm beach, Florida with Mr. Ike Perlmutter and Doctor Bruce Moskowitz

Got it

Sent from my iPhone

On Jan 5, 2017, at 4:43 PM, Marisol Garcia <(b)@frenchangel59.com> wrote:

> Hi Dave,
>
> Below is the information for tomorrow.
>
> Friday, January 6, 2017
>
> **9:00 AM**
>
> The meeting will be at Mar-a-Lago.
>
> **The Mar-a-Lago Club, L.C.**
>
> 1100 South Ocean Boulevard
>
> Palm Beach, Florida 33480
>
> (561) 832-2600
>
> **Attendees:**
> Dave Shulkin
> Doctor Bruce Moskowitz
> Mr. Ike Perlmutter
>
> I've cancel the hotel room at Mar-a-Lago. If you need anything please reach out to me. I am available 24/7.
>
> Best,
>
> Marisol
> (b) (6) (Office)

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(b) (6) [redacted] (Cell)

AMERICAN OVERSIGHT

Message

From: Marisol Garcia [(b)@frenchangel59.com]
Sent: 1/5/2017 9:43:16 PM
To: David shulkin [Drshulkin@aol.com]
CC: Bruce Moskowitz [brucem(b) (6) mac.com]
Subject: Meeting in Palm beach, Florida with Mr. Ike Perlmutter and Doctor Bruce Moskowitz

Hi Dave,

Below is the information for tomorrow.

Friday, January 6, 2017

9:00 AM

The meeting will be at Mar-a-Lago.

The Mar-a-Lago Club, L.C.

1100 South Ocean Boulevard

Palm Beach, Florida 33480

(561) 832-2600

Attendees:
Dave Shulkin
Doctor Bruce Moskowitz
Mr. Ike Perlmutter

I've cancel the hotel room at Mar-a-Lago. If you need anything please reach out to me. I am available 24/7.

Best,

Marisol
(b) (6) (Office)
(b) (6) (Cell)

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) @gmail.com]
Sent: 1/5/2017 7:07:35 PM
To: David Shulkin [drshulkin@aol.com]
Subject: BOARDING PASS
Attachments: MNYX10.pdf

(b) (6)

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UNITED TSA PRE

MNYX10 11C 35
UA 4200

SHULKIN/DAVIDJONATHAN

Washington-Reagan Natl to Newark-Liberty Intl

UA 4200	GATE	BOARDING BEGINS	SEAT
DCA-EWR	**10**	**2:27 PM**	**11C**
Thursday, January 05, 2017	Gate May Change	Boarding ends: 2:37 PM Flight departs: 2:52 PM Flight arrives: 4:14 PM	Aisle Economy

BOARDING GROUP **4**

Operated by Expressjet Airlines dba United Express

Confirmation: **MNYX10**
Ticket: 01623308581182

A STAR ALLIANCE MEMBER

When traveling from Washington-National, D.C., (DCA), all flights depart from Terminal B, at gates 10, 11, 12, 14 and 16. You can check in at Terminal B by door 2.

Bag check must be completed no later than 45 minutes before departure. You are welcome to bring on board one carry-on bag and one personal item. You must be at the boarding gate at least 15 minutes prior to departure. Failure to be at the boarding gate by the required time could result in the loss of your seat without compensation, regardless of whether you are already checked in or have a confirmed seat. Refer to United's Contract of Carriage at united.com for more information on United's terms and conditions.



The United MileagePlus Explorer Card.

- Free checked bag[1]
- Priority boarding privileges
- Two United Club℠ passes
- Double miles on United® tickets

For additional details and to apply, go to UnitedExplorerCard.com.

1 **FREE CHECKED BAG:** Free bag is for first standard checked bag for the primary Cardmember and one companion traveling on the same reservation. Service charges for additional/oversized/overweight bags may apply. Purchase of ticket(s) with Card is required. See www.united.com/chasebag for details. Accounts subject to credit approval. Restrictions and limitations apply. United MileagePlus credit cards are issued by Chase Bank USA, N.A. Offer subject to change. See www.UnitedExplorerCard.com for pricing and rewards details.

MileagePlus: Miles accrued, awards and benefits issued are subject to the rules of the United MileagePlus program. For details, see www.united.com.

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UNITED TSA PRE

MNYX10 10C **125**
UA 1633

SHULKIN/DAVIDJONATHAN

Newark-Liberty Intl to West Palm Beach

UA 1633	GATE	BOARDING BEGINS	SEAT	
EWR-PBI	**B41**	**4:54 PM**	**10C**	BOARDING GROUP **5**
Thursday, January 05, 2017	Gate May Change	Boarding ends: 5:14 PM Flight departs: 5:29 PM Flight arrives: 8:32 PM	Aisle Economy Plus	

Confirmation: **MNYX10**
Ticket: 01623308581182

A STAR ALLIANCE MEMBER

New York/Newark terminal information
United-operated flights arrive and depart from Terminals A, B and C. Transportation between terminals is available by bus or AirTrain.
United check-in counters are located at Terminal A and Terminal C. Customers departing from Terminal B should use the check-in facilities in Terminal C.
Global Services and United Global First customers should go to Level 3, Door 4, and take the escalator to C-2 to check in at the Global Services reception lobby.

Bag check must be completed no later than 45 minutes before departure. You are welcome to bring on board one carry-on bag and one personal item. You must be at the boarding gate at least 15 minutes prior to departure. Failure to be at the boarding gate by the required time could result in the loss of your seat without compensation, regardless of whether you are already checked in or have a

AMERICAN OVERSIGHT

UNITED

Confirmation:
MNYX10

Special Service Receipt

Issue Date: January 05, 2017

Traveler
SHULKIN/DAVIDJONATHAN

Ticket Number
01623308581182

Method of Payment
Visa (b) (6)

Cardholder Name
DAVID SHULKIN

FLIGHT INFORMATION

Day, Date	Flight	Departure City/Time	Arrival City/Time	Aircraft
Thu,05JAN17	UA4200	WASHINGTON-REAGAN NATL (DCA) **2:52 PM**	NEWARK-LIBERTY INTL (EWR) **4:14 PM**	ERJ 145
Thu,05JAN17	UA1633	NEWARK-LIBERTY INTL (EWR) **5:29 PM**	WEST PALM BEACH (PBI) **8:32 PM**	737-800

FEE INFORMATION

Special Service Document	Description	Quantity	Fees
01629252133283	Economy Plus EWR - PBI	1	$84.00
	TOTAL FEES:		**$84.00**

Reminders

- **Check-in Requirement -** Bags must be checked and boarding passes obtained at least 45 minutes prior to scheduled departure. Baggage will not be accepted and advance seat assignments may be cancelled if this condition is not met.
- **Boarding Requirement -** Passengers must be prepared to board at the departure gate with their boarding pass at least 15 minutes prior to scheduled departure.
- **Refunds for Premium Seats** will be automatically made to the original form of payment. Refunds will only be processed for customers that do not travel in a Premium Seat and have their boarding pass reissued with a new seat assignment.

For up to the minute flight information, go to mobile.united.com.

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Message

From: (b) (6) [(b) (6) @gmail.com]
Sent: 1/5/2017 6:26:33 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re:

Understand

On Jan 5, 2017 1:01 PM, "David shulkin" <Drshulkin@aol.com> wrote:
(b) (6) very quietly please find me the next flight or flights today to west palm beach florida- Need to do this asap and text me what you find

M going to need to visit the west palm va but we can deal with that later when i call you

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/5/2017 6:01:29 PM
To: (b) (6) [(b) (6) @gmail.com]

(b) (6) very quietly please find me the next flight or flights today to west palm beach florida- Need to do this asap and text me what you find

M going to need to visit the west palm va but we can deal with that later when i call you

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/10/2017 4:37:23 PM
To: (b) (6) [(b) (6) @bernardassociatesllc.com]
Subject: Re: Media

It was fun

Not sure of the outcome if any

Sent from my iPhone

On Jan 10, 2017, at 11:23 AM, (b) (6) <(b) (6) @bernardassociatesllc.com> wrote:

> Excellent! How did the meeting go??
>
> Best of luck! I am pulling for you!!
>
> (b) (6) MD, MBA
> President - Bernard Associates, LLC
> The Competition Consultants
> ***HELPING CLIENTS WIN***
>
> 194 Park Ave.
> Morristown, NJ 07960
> Tel. (b) (6)
>
> Check out our website: www.BernardAssociatesLLC.com
>
> **From:** David shulkin [mailto:Drshulkin@aol.com]
> **Sent:** Monday, January 09, 2017 8:44 PM
> **To:** (b) (6) <(b) (6) @bernardassociatesllc.com>
> **Subject:** Fwd: Media
>
> Thought youd enjoy
>
> Sent from my iPhone
>
> Begin forwarded message:
>
> > **From:** (b) (6) <(b) (6) @gmail.com>
> > **Date:** January 9, 2017 at 5:01:28 PM EST
> > **To:** David Shulkin <drshulkin@aol.com>
> > **Subject: Media**
> >
> > 1. http://thehill.com/homenews/administration/313309-mcconnell-meets-with-trump-in-new-York
> > 2.https://www.washingtonpost.com/news/post-politics/wp/2017/01/09/the-full-transcript-from-the-trump-transition-teams-monday-call-to-reporters-5/?utm_term=.ad947d7e6af4

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(b) (6) [redacted]

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) @bernardassociatesllc.com]
Sent: 1/10/2017 4:23:55 PM
To: 'David shulkin' [Drshulkin@aol.com]
Subject: RE: Media

Excellent! How did the meeting go??

Best of luck! I am pulling for you!!

(b) (6) MD, MBA
President - Bernard Associates, LLC
The Competition Consultants
HELPING CLIENTS WIN

194 Park Ave.
Morristown, NJ 07960
Tel (b) (6)

Check out our website: www.BernardAssociatesLLC.com

From: David shulkin [mailto:Drshulkin@aol.com]
Sent: Monday, January 09, 2017 8:44 PM
To: (b) (6) <(b) (6) @bernardassociatesllc.com>
Subject: Fwd: Media

Thought youd enjoy

Sent from my iPhone

Begin forwarded message:

> **From:** (b) (6) <(b) (6) @gmail.com>
> **Date:** January 9, 2017 at 5:01:28 PM EST
> **To:** David Shulkin <drshulkin@aol.com>
> **Subject: Media**
>
> 1. http://thehill.com/homenews/administration/313309-mcconnell-meets-with-trump-in-new-York
> 2.https://www.washingtonpost.com/news/post-politics/wp/2017/01/09/the-full-transcript-from-the-trump-transition-teams-monday-call-to-reporters-5/?utm_term=.ad947d7e6af4
>
> (b) (6)

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) me.com]
Sent: 1/10/2017 2:35:38 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Media

Super. Put it on your calendar please. 8 pm? I can also do it an hour on either side.

(b)

From: "David J. Shulkin" <Drshulkin@aol.com>
Date: Tuesday, January 10, 2017 at 9:13 AM
To: (b) (6) <(b) (6) me.com>
Subject: Re: Media

Thursday evening would work

Sent from my iPhone

On Jan 10, 2017, at 9:11 AM, (b) (6) <(b) (6) me.com> wrote:

> How about a replay by phone call:
>
> Today at 4 or 5?
> This evening after 7?
> Thursday evening after 7?
>
> (b)

> **From:** David Shulkin <Drshulkin@aol.com>
> **Date:** Tuesday, January 10, 2017 at 8:08 AM
> **To:** '(b) (6) <(b) (6) me.com>
> **Subject:** Re: Media
>
> Already met
>
> Sent from my iPhone
>
> On Jan 10, 2017, at 7:34 AM, (b) (6) <(b) (6) me.com> wrote:
>
> > Presuming you really do meet with him, will you have a one-pager or sound bite plan at the ready?
> >
> > (b)

AMERICAN OVERSIGHT

From: David Shulkin <Drshulkin@aol.com>
Date: Tuesday, January 10, 2017 at 6:45 AM
To: "(b) (6) <(b) (6) me.com>
Subject: Fwd: Media

Sent from my iPhone

Thought youd enjoy

Sent from my iPhone

Begin forwarded message:

From: (b) (6)
(b) (6) @gmail.com>
Date: January 9, 2017 at 5:01:28 PM EST
To: David Shulkin <drshulkin@aol.com>
Subject: Media

1. http://thehill.com/homenews/administration/313309-mcconnell-meets-with-trump-in-new-York
2.https://www.washingtonpost.com/news/post-politics/wp/2017/01/09/the-full-transcript-from-the-trump-transition-teams-monday-call-to-reporters-5/?utm_term=.ad947d7e6af4

(b) (6) (b) (6)

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/10/2017 2:13:16 PM
To: (b) (6) [(b) (6) me.com]
Subject: Re: Media

Thursday evening would work

Sent from my iPhone

On Jan 10, 2017, at 9:11 AM, (b) (6) <(b) (6) me.com> wrote:

> How about a replay by phone call:
>
> Today at 4 or 5?
> This evening after 7?
> Thursday evening after 7?
>
> (b)

> **From:** David Shulkin <Drshulkin@aol.com>
> **Date:** Tuesday, January 10, 2017 at 8:08 AM
> **To:** '(b) (6) <(b) (6) me.com>
> **Subject:** Re: Media
>
> Already met
>
> Sent from my iPhone
>
> On Jan 10, 2017, at 7:34 AM, (b) (6) <(b) (6) me.com> wrote:
>
> > Presuming you really do meet with him, will you have a one-pager or sound bite plan at the ready?
> >
> > (b)

> > **From:** David Shulkin <Drshulkin@aol.com>
> > **Date:** Tuesday, January 10, 2017 at 6:45 AM
> > **To:** '(b) (6) <(b) (6) me.com>
> > **Subject:** Fwd: Media
> >
> > Sent from my iPhone

AMERICAN OVERSIGHT

Thought youd enjoy

Sent from my iPhone

Begin forwarded message:

From: (b) (6)
(b) (6) @gmail.com>
Date: January 9, 2017 at 5:01:28 PM EST
To: David Shulkin <drshulkin@aol.com>
Subject: Media

1. http://thehill.com/homenews/administration/313309-mcconnell-meets-with-trump-in-new-York
2.https://www.washingtonpost.com/news/post-politics/wp/2017/01/09/the-full-transcript-from-the-trump-transition-teams-monday-call-to-reporters-5/?utm_term=.ad947d7e6af4

(b) (6)

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) me.com]
Sent: 1/10/2017 2:11:37 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Media

How about a replay by phone call:

Today at 4 or 5?
This evening after 7?
Thursday evening after 7?

(b)

From: David Shulkin <Drshulkin@aol.com>
Date: Tuesday, January 10, 2017 at 8:08 AM
To: "(b) (6) <(b) (6) me.com>
Subject: Re: Media

Already met

Sent from my iPhone

On Jan 10, 2017, at 7:34 AM, (b) (6) <(b) (6) me.com> wrote:

> Presuming you really do meet with him, will you have a one-pager or sound bite plan at the ready?
>
> (b)

> **From:** David Shulkin <Drshulkin@aol.com>
> **Date:** Tuesday, January 10, 2017 at 6:45 AM
> **To:** "(b) (6) <(b) (6) me.com>
> **Subject:** Fwd: Media
>
> Sent from my iPhone
>
> > Thought youd enjoy
> >
> > Sent from my iPhone
> >
> > Begin forwarded message:

AMERICAN OVERSIGHT

From: (b) (6)
(b) (6) @gmail.com>
Date: January 9, 2017 at 5:01:28 PM EST
To: David Shulkin <drshulkin@aol.com>
Subject: Media

1.
http://thehill.com/homenews/administration/313309-mcconnell-meets-with-trump-in-new-York
2.https://www.washingtonpost.com/news/post-politics/wp/2017/01/09/the-full-transcript-from-the-trump-transition-teams-monday-call-to-reporters-5/?utm_term=.ad947d7e6af4

(b) (6)

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/10/2017 1:08:22 PM
To: (b) (6) [(b) (6) me.com]
Subject: Re: Media

Already met

Sent from my iPhone

On Jan 10, 2017, at 7:34 AM, (b) (6) <(b) (6) me.com> wrote:

> Presuming you really do meet with him, will you have a one-pager or sound bite plan at the ready?
>
> (b)
>
> ---
>
> **From:** David Shulkin <Drshulkin@aol.com>
> **Date:** Tuesday, January 10, 2017 at 6:45 AM
> **To:** "(b) (6) <(b) (6) me.com>
> **Subject:** Fwd: Media
>
> Sent from my iPhone
>
> > Thought youd enjoy
> >
> > Sent from my iPhone
> >
> > Begin forwarded message:
> >
> > **From:** (b) (6) (b) (6) @gmail.com>
> > **Date:** January 9, 2017 at 5:01:28 PM EST
> > **To:** David Shulkin <drshulkin@aol.com>
> > **Subject: Media**
> >
> > 1. http://thehill.com/homenews/administration/313309-mcconnell-meets-with-trump-in-new-York
> > 2.https://www.washingtonpost.com/news/post-politics/wp/2017/01/09/the-full-transcript-from-the-trump-transition-teams-monday-call-to-reporters-5/?utm_term=.ad947d7e6af4

AMERICAN OVERSIGHT

(b) (6) [redacted]

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) me.com]
Sent: 1/10/2017 12:34:05 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Media

Presuming you really do meet with him, will you have a one-pager or sound bite plan at the ready?

(b)

From: David Shulkin <Drshulkin@aol.com>
Date: Tuesday, January 10, 2017 at 6:45 AM
To: "(b) (6) <(b) (6) me.com>
Subject: Fwd: Media

Sent from my iPhone

Thought youd enjoy

Sent from my iPhone

Begin forwarded message:

From: (b) (6) <(b) (6) @gmail.com>
Date: January 9, 2017 at 5:01:28 PM EST
To: David Shulkin <drshulkin@aol.com>
Subject: Media

1. http://thehill.com/homenews/administration/313309-mcconnell-meets-with-trump-in-new-York
2.https://www.washingtonpost.com/news/post-politics/wp/2017/01/09/the-full-transcript-from-the-trump-transition-teams-monday-call-to-reporters-5/?utm_term=.ad947d7e6af4

(b) (6)

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/10/2017 11:45:53 AM
To: (b) (6) [(b) (6) me.com]
Subject: Fwd: Media

Sent from my iPhone

Thought youd enjoy

Sent from my iPhone

Begin forwarded message:

From: (b) (6) <(b) (6) @gmail.com>
Date: January 9, 2017 at 5:01:28 PM EST
To: David Shulkin <drshulkin@aol.com>
Subject: Media

1. http://thehill.com/homenews/administration/313309-mcconnell-meets-with-trump-in-new-York
2.https://www.washingtonpost.com/news/post-politics/wp/2017/01/09/the-full-transcript-from-the-trump-transition-teams-monday-call-to-reporters-5/?utm_term=.ad947d7e6af4

(b) (6)

AMERICAN OVERSIGHT

Message

From: Laverne Council [(b) (6) @gmail.com]
Sent: 1/10/2017 1:54:22 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Media

Can't wait ...proud of you.

On Jan 9, 2017, at 7:16 PM, David shulkin <Drshulkin@aol.com> wrote:

> Dont really know- but it was fun
>
> More details tommorow at dinner over drinks
>
> Sent from my iPhone
>
> On Jan 9, 2017, at 7:00 PM, Laverne Council <(b) (6) @gmail.com> wrote:
>
> > Way to go! How did it go?
> >
> > On Jan 9, 2017, at 6:45 PM, David shulkin <Drshulkin@aol.com> wrote:
> >
> > Sent from my iPhone
> >
> > Begin forwarded message:
> >
> > **From:** (b) (6)
> > <(b) (6) @gmail.com>
> > **Date:** January 9, 2017 at 5:01:28 PM EST
> > **To:** David Shulkin <drshulkin@aol.com>
> > **Subject: Media**
> >
> > 1.
> > http://thehill.com/homenews/administration/313309-mcconnell-meets-with-trump-in-new-York
> > 2.https://www.washingtonpost.com/news/post-politics/wp/2017/01/09/the-full-transcript-from-the-trump-transition-teams-monday-call-to-reporters-5/?utm_term=.ad947d7e6af4
> >
> > (b) (6)

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/10/2017 1:43:59 AM
To: (b) (6) [(b) (6) @bernardassociatesllc.com]
Subject: Fwd: Media

Thought youd enjoy

Sent from my iPhone

Begin forwarded message:

From: (b) (6) <(b) (6) @gmail.com>
Date: January 9, 2017 at 5:01:28 PM EST
To: David Shulkin <drshulkin@aol.com>
Subject: Media

1. http://thehill.com/homenews/administration/313309-mcconnell-meets-with-trump-in-new-York
2.https://www.washingtonpost.com/news/post-politics/wp/2017/01/09/the-full-transcript-from-the-trump-transition-teams-monday-call-to-reporters-5/?utm_term=.ad947d7e6af4

(b) (6)

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/10/2017 12:16:37 AM
To: Laverne Council [(b) (6) @gmail.com]
Subject: Re: Media

Dont really know- but it was fun

More details tommorow at dinner over drinks

Sent from my iPhone

On Jan 9, 2017, at 7:00 PM, Laverne Council <(b) (6) @gmail.com> wrote:

> Way to go! How did it go?
>
> On Jan 9, 2017, at 6:45 PM, David shulkin <Drshulkin@aol.com> wrote:
>
> Sent from my iPhone
>
> Begin forwarded message:
>
> **From:** (b) (6) <(b) (6) @gmail.com>
> **Date:** January 9, 2017 at 5:01:28 PM EST
> **To:** David Shulkin <drshulkin@aol.com>
> **Subject: Media**
>
> 1. http://thehill.com/homenews/administration/313309-mcconnell-meets-with-trump-in-new-York
> 2.https://www.washingtonpost.com/news/post-politics/wp/2017/01/09/the-full-transcript-from-the-trump-transition-teams-monday-call-to-reporters-5/?utm_term=.ad947d7e6af4
>
> (b) (6)

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/9/2017 11:58:19 PM
To: (b) (6) @yahoo.com
Subject: Re: Media

Yes

Sent from my iPhone

On Jan 9, 2017, at 6:42 PM, Michael Tepper <(b) (6) @yahoo.com> wrote:

> Even more excellent.
> So, from the article I'm not sure - did you have the meeting today?
>
> David shulkin wrote on 01/09/2017 05:42 PM:
>
> > Now in post
> >
> > Sent from my iPhone
> >
> > Begin forwarded message:
> >
> > **From:** (b) (6) <(b) (6) @gmail.com>
> > **Date:** January 9, 2017 at 5:01:28 PM EST
> > **To:** David Shulkin <drshulkin@aol.com>
> > **Subject: Media**
> >
> > 1. http://thehill.com/homenews/administration/313309-mcconnell-meets-with-trump-in-new-York
> > 2.https://www.washingtonpost.com/news/post-politics/wp/2017/01/09/the-full-transcript-from-the-trump-transition-teams-monday-call-to-reporters-5/?utm_term=.ad947d7e6af4
> >
> > (b) (6)

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/9/2017 11:45:23 PM
To: LaVerne Council [(b) (6) @gmail.com]
Subject: Fwd: Media

Sent from my iPhone

Begin forwarded message:

From: (b) (6) <(b) (6) @gmail.com>
Date: January 9, 2017 at 5:01:28 PM EST
To: David Shulkin <drshulkin@aol.com>
Subject: Media

1. http://thehill.com/homenews/administration/313309-mcconnell-meets-with-trump-in-new-York
2.https://www.washingtonpost.com/news/post-politics/wp/2017/01/09/the-full-transcript-from-the-trump-transition-teams-monday-call-to-reporters-5/?utm_term=.ad947d7e6af4

(b) (6)

AMERICAN OVERSIGHT

Message

From: Michael Tepper [(b) (6) @yahoo.com]
Sent: 1/9/2017 11:42:00 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Fwd: Media

Even more excellent.
So, from the article I'm not sure - did you have the meeting today?

David shulkin wrote on 01/09/2017 05:42 PM:

> Now in post
>
> Sent from my iPhone
>
> Begin forwarded message:
>
> **From:** (b) (6) <(b) (6) @gmail.com>
> **Date:** January 9, 2017 at 5:01:28 PM EST
> **To:** David Shulkin <drshulkin@aol.com>
> **Subject: Media**
>
> 1. http://thehill.com/homenews/administration/313309-mcconnell-meets-with-trump-in-new-York
> 2.https://www.washingtonpost.com/news/post-politics/wp/2017/01/09/the-full-transcript-from-the-trump-transition-teams-monday-call-to-reporters-5/?utm_term=.ad947d7e6af4
>
> (b) (6)

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/9/2017 10:42:20 PM
To: Michael Tepper [(b) (6) @yahoo.com]
Subject: Fwd: Media

Now in post

Sent from my iPhone

Begin forwarded message:

From: (b) (6) <(b) (6) @gmail.com>
Date: January 9, 2017 at 5:01:28 PM EST
To: David Shulkin <drshulkin@aol.com>
Subject: Media

1. http://thehill.com/homenews/administration/313309-mcconnell-meets-with-trump-in-new-York
2.https://www.washingtonpost.com/news/post-politics/wp/2017/01/09/the-full-transcript-from-the-trump-transition-teams-monday-call-to-reporters-5/?utm_term=.ad947d7e6af4

(b) (6)

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/9/2017 10:41:34 PM
To: (b) (6) [(b) @sunnyshulkin.com]; (b) (6) @sunnyshulkin.com]
Subject: Fwd: Media

Now in wash post

Sent from my iPhone

Begin forwarded message:

> **From:** (b) (6) <(b) (6) @gmail.com>
> **Date:** January 9, 2017 at 5:01:28 PM EST
> **To:** David Shulkin <drshulkin@aol.com>
> **Subject: Media**
>
> 1. http://thehill.com/homenews/administration/313309-mcconnell-meets-with-trump-in-new-York
> 2.https://www.washingtonpost.com/news/post-politics/wp/2017/01/09/the-full-transcript-from-the-trump-transition-teams-monday-call-to-reporters-5/?utm_term=.ad947d7e6af4
>
> (b) (6)

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/9/2017 10:41:10 PM
To: (b) [(b) (6) @hotmail.com]
Subject: Fwd: Media

Now in wash post

Sent from my iPhone

Begin forwarded message:

> **From:** (b) (6) <(b) (6) @gmail.com>
> **Date:** January 9, 2017 at 5:01:28 PM EST
> **To:** David Shulkin <drshulkin@aol.com>
> **Subject: Media**
>
> 1. http://thehill.com/homenews/administration/313309-mcconnell-meets-with-trump-in-new-York
> 2.https://www.washingtonpost.com/news/post-politics/wp/2017/01/09/the-full-transcript-from-the-trump-transition-teams-monday-call-to-reporters-5/?utm_term=.ad947d7e6af4
>
> (b) (6)

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) @gmail.com]
Sent: 1/9/2017 10:01:28 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Media

1. http://thehill.com/homenews/administration/313309-mcconnell-meets-with-trump-in-new-York
2.https://www.washingtonpost.com/news/post-politics/wp/2017/01/09/the-full-transcript-from-the-trump-transition-teams-monday-call-to-reporters-5/?utm_term=.ad947d7e6af4

(b) (6)

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/5/2017 10:46:02 PM
To: Vivieca Simpson [(b) (6) @gmail.com]
Subject: Re: [EXTERNAL] Re: Lunch at Joe's Seafood

Thats good

Im on my way to margolar

Not to meet trump but supposably one of the key guys he listen to

Lets see

Sent from my iPhone

On Jan 5, 2017, at 5:42 PM, Vivieca Simpson <(b) (6) @gmail.com> wrote:

> ---------- Forwarded message ----------
> From: "Wright, Vivieca (Simpson)" <Vivieca.Wright@va.gov>
> Date: Jan 5, 2017 17:33
> Subject: FW: [EXTERNAL] Re: Lunch at Joe's Seafood
> To: "(b) (6) @gmail.com" <(b) (6) @gmail.com>
> Cc:
>
> ---
>
> **From:** ron thomas [mailto:(b) @thomasrileystrategies.net]
> **Sent:** Thursday, January 05, 2017 12:57 PM
> **To:** Wright, Vivieca (Simpson)
> **Subject:** Re: [EXTERNAL] Re: Lunch at Joe's Seafood
>
> Absolutely. I moved the ball on that info you gave me already. My cell is (b) (6)
>
> Ron Thomas
> Managing Principal
> ThomasRiley Strategies, LLC
> 1455 Pennsylvania Ave NW
> Suite 400
> Washington, DC 20004
> (b) (6) office
> (b) (6) mobile
> www.thomasrileystrategiesllc.net
>
> On Jan 5, 2017, at 12:50 PM, Wright, Vivieca (Simpson) <Vivieca.Wright@va.gov> wrote:

AMERICAN OVERSIGHT

Same here – let's stay in touch – !

From: ron thomas [mailto:(b) @thomasrileystrategies.net]
Sent: Thursday, January 05, 2017 12:49 PM
To: Wright, Vivieca (Simpson)
Subject: [EXTERNAL] Re: Lunch at Joe's Seafood

Hi Vivieca,

Thanks again for your time today.
It was a pleasure talking with you.

Ron Thomas
Managing Principal
ThomasRiley Strategies, LLC
1455 Pennsylvania Ave NW
Suite 400
Washington, DC 20004
202.621.(b) (6) office
202-870-(b) mobile
www.thomasrileystrategiesllc.net
Please excuse any typos as I am on my mobile device.
Sent via Cloze

On Jan 5, 2017, at 11:30 AM, Vivieca Wright <vivieca.wright@va.gov> met:

Reservation made for 11:30 under the name Vivieca Wright-Simpson

AMERICAN OVERSIGHT

Message

From: Vivieca Simpson [(b) (6) @gmail.com]
Sent: 1/5/2017 10:42:41 PM
To: drshulkin@aol.com
Subject: Fwd: FW: [EXTERNAL] Re: Lunch at Joe's Seafood

---------- Forwarded message ----------
From: "Wright, Vivieca (Simpson)" <Vivieca.Wright@va.gov>
Date: Jan 5, 2017 17:33
Subject: FW: [EXTERNAL] Re: Lunch at Joe's Seafood
To: "(b) (6) @gmail.com" <(b) (6) @gmail.com>
Cc:

From: ron thomas [mailto:(b) @thomasrileystrategies.net]
Sent: Thursday, January 05, 2017 12:57 PM
To: Wright, Vivieca (Simpson)
Subject: Re: [EXTERNAL] Re: Lunch at Joe's Seafood

Absolutely. I moved the ball on that info you gave me already. My cell is (b) (6)

Ron Thomas
Managing Principal
ThomasRiley Strategies, LLC
1455 Pennsylvania Ave NW
Suite 400
Washington, DC 20004
202.621.(b) (6) office
202-870- mobile
www.thomasrileystrategiesllc.net

On Jan 5, 2017, at 12:50 PM, Wright, Vivieca (Simpson) <Vivieca.Wright@va.gov> wrote:

> Same here – let's stay in touch – !
>
> **From:** ron thomas [mailto:(b) @thomasrileystrategies.net]
> **Sent:** Thursday, January 05, 2017 12:49 PM
> **To:** Wright, Vivieca (Simpson)
> **Subject:** [EXTERNAL] Re: Lunch at Joe's Seafood

AMERICAN OVERSIGHT

Hi Vivieca,

Thanks again for your time today.
It was a pleasure talking with you.

Ron Thomas
Managing Principal
ThomasRiley Strategies, LLC
1455 Pennsylvania Ave NW
Suite 400
Washington, DC 20004
202.621.[redacted] (b) (6) office
202-870-[redacted] mobile
www.thomasrileystrategiesllc.net
Please excuse any typos as I am on my mobile device.
Sent via Cloze

On Jan 5, 2017, at 11:30 AM, Vivieca Wright <vivieca.wright@va.gov> met:

Reservation made for 11:30 under the name Vivieca Wright-Simpson

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/6/2017 6:45:38 PM
To: Jennifer Lee [(b) (6) @gmail.com]
Subject: Re: Retreat next week

Im going to speak to nancy this weekend

Sent from my iPhone

> On Jan 6, 2017, at 11:17 AM, Jennifer Lee (b) (6) gmail.com> wrote:
>
> Hi David
> Do you know- did (b) (6) really meet w them in NY yesterday? Have you spoken w her?
>
> I'd like to ask you to consider postponing the retreat on 1/17. I have little confidence that it will be a productive meeting (given the low-trust environment)
>
> I think Rich will use the meeting as an excuse to say he has gotten "buy-in" from VHA senior leaders on his radical plan.
>
> At least it could potentially buy us some time to be able to say we have not had any input into his plan?
>
>

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/6/2017 6:43:27 PM
To: Jennifer Lee [(b) (6) @gmail.com]
Subject: Re: Retreat next week

Yes good idea

Sent from my iPhone

> On Jan 6, 2017, at 11:17 AM, Jennifer Lee (b) (6) mail.com> wrote:
>
> Hi David
> Do you know- did (b) (6) really meet w them in NY yesterday? Have you spoken w her?
>
> I'd like to ask you to consider postponing the retreat on 1/17. I have little confidence that it will be a productive meeting (given the low-trust environment)
>
> I think Rich will use the meeting as an excuse to say he has gotten "buy-in" from VHA senior leaders on his radical plan.
>
> At least it could potentially buy us some time to be able to say we have not had any input into his plan?
>
>

AMERICAN OVERSIGHT

Message

From: Jennifer Lee [(b) (6) @gmail.com]
Sent: 1/6/2017 4:17:59 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Retreat next week

Hi David
Do you know- did (b) (6) really meet w them in NY yesterday? Have you spoken w her?

I'd like to ask you to consider postponing the retreat on 1/17. I have little confidence that it will be a productive meeting (given the low-trust environment)

I think Rich will use the meeting as an excuse to say he has gotten "buy-in" from VHA senior leaders on his radical plan.

At least it could potentially buy us some time to be able to say we have not had any input into his plan?

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 1/8/2017 12:12:30 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Innovations demonstrating VA leadership in healthcare

I know you use a slide that talks about all the stuff that was discovered at the VA like- pacemakers, beta blockers and other things- can you send me that- I want to use it in the context of us leading the much needed radical reform of the America's health care system around " Whole Health Care"

AMERICAN OVERSIGHT

Message

From: Vivieca Simpson [(b) (6) @gmail.com]
Sent: 1/6/2017 1:22:57 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re:

We should question his business holdings and time away - sounds like another SCI case.

On Jan 5, 2017 20:13, "David shulkin" <Drshulkin@aol.com> wrote:
Vivieca- I wonder if (b) (6) has anything else on Rich I can use?

Ash (ms rumor) said Rich tried to get her to go to svac to lobby to bring in booz allen - his former employer. she said she refused telling him this was illegal. she thinks he is really bad news

I wonder what else he is doing

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/6/2017 1:13:33 AM
To: Vivieca Simpson [(b) (6) @gmail.com]

Vivieca- I wonder if (b) (6) has anything else on Rich I can use?

Ash (ms rumor) said Rich tried to get her to go to svac to lobby to bring in booz allen - his former employer. she said she refused telling him this was illegal. she thinks he is really bad news

I wonder what else he is doing

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Jennifer Lee [(b) (6) @gmail.com]
Sent: 1/6/2017 1:19:58 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Crunch time

Wow. that is awful!

I will talk to Carolyn. I bet she would do it. we will make sure they know.
Where is Bob Snyder in all this?

Ash is having lunch with one of the team on Monday. (b) (6) is close with one of them too.

I would bet Steve Young is in danger too? I'm going to talk with Steve tonight and see if he has any ideas.

On Thu, Jan 5, 2017 at 8:13 PM, David shulkin <Drshulkin@aol.com> wrote:
Do you think Carolyn understands how dangerous Rich is? She is on his list too

He plans to bring Gerry cox in to be pdush and use peter almenoff to take over her area

If you can motivate her to call (b) (6) that would be good- he needs to know i was against the rfp release and stone went to sloan around me.

I know this isnt carolyns thing or strong suit and i dobt know if she has it in her but .....

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/6/2017 1:13:36 AM
To: Jennifer Lee [(b) (6)@gmail.com]
Subject: Crunch time

Do you think Carolyn understands how dangerous Rich is? She is on his list too

He plans to bring Gerry cox in to be pdush and use peter almenoff to take over her area

If you can motivate her to call (b) (6) that would be good- he needs to know i was against the rfp release and stone went to sloan around me.

I know this isnt carolyns thing or strong suit and i dobt know if she has it in her but .....

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 1/6/2017 1:25:01 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re:

When we talk, we can discuss- will try to work on the plan tomorrow once we have agreement

---

From: David shulkin <Drshulkin@aol.com>
Sent: Thursday, January 5, 2017 8:13 PM
To: Poonam Alaigh
Subject:

Do you think its worth seeing if blackburn is willing to tell snyder that there ate a series of serious allegations about to break regarding Richs ethics and behavior?

Ash said she was asked by him to bring in booz allen - his former employer

His hostile behavior to women

And one other i will tell you about

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/6/2017 1:13:28 AM
To: Poonam Alaigh [(b) (6) @hotmail.com]

Do you think its worth seeing if blackburn is willing to tell snyder that there ate a series of serious allegations about to break regarding Richs ethics and behavior?

Ash said she was asked by him to bring in booz allen - his former employer

His hostile behavior to women

And one other i will tell you about

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/11/2017 1:09:25 PM
To: Scott R. Blackburn [(b) (6) @va.gov]
Subject: Fwd: Re:

Sent from my iPhone

Begin forwarded message:

> **From:** Poonam Alaigh <(b) (6) @hotmail.com>
> **Date:** January 11, 2017 at 6:17:03 AM EST
> **To:** David shulkin <Drshulkin@aol.com>
> **Subject: Re:**
>
> From today
>
> http://www.nytimes.com/aponline/2017/01/11/us/politics/ap-us-veterans-affairs-problems.html?_r=0
>
> Sent from my iPad
>
> On Jan 10, 2017, at 10:59 PM, David shulkin <Drshulkin@aol.com> wrote:
>
> > <image1.png>
> >
> > Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 1/11/2017 11:17:03 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re:

From today

http://www.nytimes.com/aponline/2017/01/11/us/politics/ap-us-veterans-affairs-problems.html?_r=0

Sent from my iPad

On Jan 10, 2017, at 10:59 PM, David shulkin <Drshulkin@aol.com> wrote:

<image1.png>

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/11/2017 3:59:51 AM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Attachments: image1.png

Sent from my iPhone

AMERICAN OVERSIGHT

Trump meeting again with VA UnderSec for Health David Shulkin today, to talk about ... VA stuff.

1/9/17, 10:42 AM

6 RETWEETS **21** LIKES



Leo Shane III @LeoShane · 1d

There have been conversations within Trump transition team about keeping Shulkin on in his role. Not being considered as a VA Sec (for now).

4 9



Paula Minger @Paulaminger1 · 1d

@LeoShane Shulkin has reached out directly to vets and families to assist in navigating the VA. A strong positive.

Reply to Leo Shane III

AMERICAN OVERSIGHT
VA-19-0799-J-000567
DS_00008196

Message

From: (b) (6) [(b) (6) @gmail.com]
Sent: 1/20/2017 8:52:49 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Thats you in the picture

Oh that is me.

On Jan 19, 2017 11:47 PM, "David shulkin" <Drshulkin@aol.com> wrote:
https://www.thestreet.com/video/13959311/inside-the-trump-white-house-david-shulkin.html

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/20/2017 4:47:20 AM
To: (b) (6) [(b) (6) @gmail.com]
Subject: Thats you in the picture

https://www.thestreet.com/video/13959311/inside-the-trump-white-house-david-shulkin.html

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Vivieca Simpson [(b) (6) @gmail.com]
Sent: 1/6/2017 1:19:21 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re:

We heard a lot of the same such as: they like him; he has a plan to downsize; concerning behavior. Etc. The difference is she was told we have no say- I was told we do have input. Did you see that (b) (6) met today - wonder if she would share.

On Jan 5, 2017 20:13, "David shulkin" <Drshulkin@aol.com> wrote:
Didnt it seem like Poonam heard something different from (b) than you heard at you lunch? Or could both what you heard and she heard be true?

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/6/2017 1:13:22 AM
To: Vivieca Simpson [(b) (6) @gmail.com]

Didnt it seem like Poonam heard something different from (b) than you heard at you lunch? Or could both what you heard and she heard be true?

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) @gmail.com]
Sent: 1/10/2017 9:36:25 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Fwd: FW: (No Subject)

Updates:

(b) (6) scheduled for 1/13 at 2

Dr. (b) is this your dctrs appt, doesn't say much on the calendar for 1/13. It's also the same time as your vtel with the diffusion summit in orlando.

Ok on 17/18. You'll see vivieca for a good chunk today.

I have a mediation with (b) (discrimination) tomorrow for ADR from 8-11.

Fya, I also have an attorney mediation with (b) (6) on Thursday (discrimination African american). Not happy about being the scapegoat for the Department, but I'm prepared.

Will email you when I get back to my desk at 11, the phone people will fix your phone while I'm away.

---------- Forwarded message ----------
From: "(b) (6) (b) (6) R." <(b) (6) va.gov>
Date: Jan 10, 2017 4:27 AM
Subject: FW: (No Subject)
To: (b) (6) " <(b) (6) @gmail.com>
Cc:

-----Original Message-----
From: David Shulkin [drshulkin@aol.com]
Sent: Tuesday, January 10, 2017 12:15 AM Eastern Standard Time
To: (b) (6)
Subject:

A few things tommorow

I've got to get a time rescheduled with (b) (6) this week

Do I have on my calander a doctors appt coming up

Let's discuss jan 17 and 18 with you me and vivieca

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 1/12/2017 3:38:51 PM
To: incomingdocs@ptt.gov
BCC: (b) (6) @gmail.com
Subject: Fwd: D. Shulkin-Bio Form Tab 1
Attachments: ShulkinTAB1-incomingdocs.pdf

Good Morning,

Please find the Bio Form TAB 1 attached to set up equip account.

David
-----Original Message-----
From: Shulkin, David J., MD, MD <David.Shulkin@va.gov>
To: 'incomingdocs@ptt.gov' <incomingdocs@ptt.gov>
Cc: 'David shulkin' <Drshulkin@aol.com>
Sent: Thu, Jan 12, 2017 10:33 am
Subject: D. Shulkin-Bio Form Tab 1

Good Morning,

Please find the Bio Form TAB 1 attached to set up equip account.

David

AMERICAN OVERSIGHT

OFFICE OF THE PRESIDENT-ELECT

Office of Presidential Appointments

APPOINTEE INFORMATION SHEET

NOTICE: Review the instructions attached to this form. Return to the Office of Presidential Appointments as soon as complete. This information is necessary to begin the clearance process. Return via email to Incomingdocs@ptt.gov or contact the office for alternate submission methods.

PART I: TO BE COMPLETED BY POTENTIAL APPOINTEE

1. FULL NAME (Last, First, Middle): Shulkin, David, Jonathan	2. SOCIAL SECURITY NUMBER: (b) (6), (b) (2)
3. CURRENT RESIDENTIAL ADDRESS (Number, Street, City, State, ZIP Code) (b) (6), (b) (2)	
4. VOTING ADDRESS IN 2016 (Number, Street, City, State, ZIP Code) (b) (6), (b) (2)	
5. PLACE OF BIRTH (City, State; if not U.S., state country) (b) (6), (b) (2)	6. GENDER: MALE / 7. DATE OF BIRTH (b) (6), (b) (2)
8. ETHNIC HERITAGE (b) (6), (b) (2)	9. RACE: White / 10. POLITICAL PARTY
11. HOME PHONE (b) (6), (b) (2)	12. CELL PHONE (b) (6), (b) (2) / 13. WORK PHONE (b) (6), (b) (2)
14. PERSONAL EMAIL: DRshulkin@aol.com	15. WORK EMAIL: DAVID.shulkin@va.gov
16. CURRENT POSITION (Title, Company): Under Secretary for Health, Dept of Veteran Affairs	17. WORK ADDRESS (Number, Street, City, State, Zip): 810 Vermont, Washington DC 20420
18. SPOUSE (b) (6), (b) (2)	19. CHILDREN (2) (b) (6), (b) (2)
20. NAME AND HOME STATE (For official announcement and nomination): DAVID J. Shulkin M.D. (b) (6), (b) (2) DA	
21. EDUCATION (Degree, Institution, Year) (b) (6), (b) (2)	22. AWARDS (SEE Attached)
23. MILITARY SERVICE (Rank, Branch, Years): N/A	24. PREVIOUS PRESIDENTIAL APPOINTMENTS: Under Secretary for Health

PART II: TO BE COMPLETED BY PRESIDENTIAL PERSONNEL

1. POSITION		
2. TYPE	3. VICE	4. TERM
5. POTUS APPROVAL	6. SECURITY PACKAGE SENT	7. COUNSEL START

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Message

From: (b) (6) [(b) (6) @gmail.com]
Sent: 1/11/2017 9:23:43 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Retain

https://www.google.com/amp/townhall.com/news/politics-elections/2017/01/11/veterans-care-still-high-risk-as-trump-mulls-va-head-n2269912%3famp=true

Have you seen this

AMERICAN OVERSIGHT

Message

From: (b) @sunnyshulkin.com [(b) @sunnyshulkin.com]
Sent: 1/10/2017 1:38:38 AM
To: David shulkin [Drshulkin@aol.com]
Subject: RE: Media

That's the spirit! Having fun and new experiences..it's what the good life is all about. It's not what comes of it. Congrats. Love you, (b)

> -------- Original Message --------
> Subject: Re: Media
> From: David shulkin <Drshulkin@aol.com>
> Date: Mon, January 09, 2017 7:12 pm
> To: (b) (6) @sunnyshulkin.com
>
> I cant call tonight since i am on a train and its too public
>
> But it went fine
>
> It was certainly fun and an experience- whether somethibg comes from it - i have to wait and see- maybe a week or so
>
> Im pretty happy though to have done it
>
> Sent from my iPhone
>
> On Jan 9, 2017, at 6:57 PM, <(b) (6) @sunnyshulkin.com> <(b) (6) @sunnyshulkin.com> wrote:
>
> > Can you say anymore? Or call us? Love, (b)
> >
> > -------- Original Message --------
> > Subject: Fwd: Media
> > From: David shulkin <Drshulkin@aol.com>
> > Date: Mon, January 09, 2017 5:41 pm
> > To: (b) (6) <(b) (6) @sunnyshulkin.com>, (b) (6) <(b) @sunnyshulkin.com>
> >
> > Now in wash post
> >
> > Sent from my iPhone
> >
> > Begin forwarded message:
> >
> > **From:** (b) (6) <(b) (6) @gmail.com>
> > **Date:** January 9, 2017 at 5:01:28 PM EST
> > **To:** David Shulkin <drshulkin@aol.com>
> > **Subject: Media**
> >
> > 1. http://thehill.com/homenews/administration/313309-mcconnell-meets-with-trump-in-new-York
> > 2.https://www.washingtonpost.com/news/post-politics/wp/2017/01/09/the-full-transcript-from-the-trump-transition-teams-monday-call-to-reporters-5/?utm_term=.ad947d7e6af4

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(b) (6) [redacted]

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/10/2017 12:12:59 AM
To: (b) @sunnyshulkin.com
BCC: (b) [(b) (6) @hotmail.com]
Subject: Re: Media

I cant call tonight since i am on a train and its too public

But it went fine

It was certainly fun and an experience- whether somethibg comes from it - i have to wait and see- maybe a week or so

Im pretty happy though to have done it

Sent from my iPhone

On Jan 9, 2017, at 6:57 PM, <(b) (6) @sunnyshulkin.com> <(b) (6) @sunnyshulkin.com> wrote:

> Can you say anymore? Or call us? Love, Mom
>
> > -------- Original Message --------
> > Subject: Fwd: Media
> > From: David shulkin <Drshulkin@aol.com>
> > Date: Mon, January 09, 2017 5:41 pm
> > To: (b) (6) <(b) (6) @sunnyshulkin.com>, (b) (6)
> > <(b) (6) sunnyshulkin.com>
> >
> > Now in wash post
> >
> > Sent from my iPhone
> >
> > Begin forwarded message:
> >
> > > **From:** (b) (6) <(b) (6) @gmail.com>
> > > **Date:** January 9, 2017 at 5:01:28 PM EST
> > > **To:** David Shulkin <drshulkin@aol.com>
> > > **Subject: Media**
> > >
> > > 1. http://thehill.com/homenews/administration/313309-mcconnell-meets-with-trump-in-new-York
> > > 2.https://www.washingtonpost.com/news/post-politics/wp/2017/01/09/the-full-transcript-from-the-trump-transition-teams-monday-call-to-reporters-5/?utm_term=.ad947d7e6af4
> > >
> > > (b) (6)

AMERICAN OVERSIGHT

Message

From: (b) @sunnyshulkin.com [(b) @sunnyshulkin.com]
Sent: 1/9/2017 11:57:34 PM
To: David shulkin [Drshulkin@aol.com]; (b) (6) [(b) @sunnyshulkin.com]
Subject: RE: Fwd: Media

Can you say anymore? Or call us? Love, (b)

-------- Original Message --------
Subject: Fwd: Media
From: David shulkin <Drshulkin@aol.com>
Date: Mon, January 09, 2017 5:41 pm
To: (b) (6) <(b) (6) @sunnyshulkin.com>, (b) (6)
<(b) @sunnyshulkin.com>

Now in wash post

Sent from my iPhone

Begin forwarded message:

From: (b) (6) <(b) (6) @gmail.com>
Date: January 9, 2017 at 5:01:28 PM EST
To: David Shulkin <drshulkin@aol.com>
Subject: Media

1. http://thehill.com/homenews/administration/313309-mcconnell-meets-with-trump-in-new-York
2.https://www.washingtonpost.com/news/post-politics/wp/2017/01/09/the-full-transcript-from-the-trump-transition-teams-monday-call-to-reporters-5/?utm_term=.ad947d7e6af4

(b) (6)

AMERICAN OVERSIGHT

Message

From: Marc Sherman [mbs(b) (6) gmail.com]
Sent: 1/15/2017 6:01:06 PM
To: Marisol Garcia [(b)@frenchangel59.com]; Bruce Moskowitz [brucem(b) (6) mac.com]; David shulkin [drshulkin@aol.com]; L Perl [(b) (6) @gmail.com]; (b) (6) [(b) (6) L@jhmi.edu]; IP [(@frenchangel59.com]; (b) (6) M.D. (b) (6) @mayo.edu]; (b) (6) [(b) @jhmi.edu]; Ann Jamieson (b) (6) @ccf.org]; (b) (6) ccf.org; (b) (6) partners.org; (b) (6) [(b) @mayo.edu]; (b) (6) @partners.org
Subject: Re: Conference Call with the new head of the VA, Doctor David Shulkin. The President Elect plans to announce the committee members very soon
Attachments: VA AC Conf Call Mtg Agenda v2 011517.pdf

All

I have attached the agenda for today's 2pm EST call. Thanks to everyone for setting aside the time on your weekend to participate. You will note that the agenda identifies procedural and informational topics as well as substantive topics. The purpose of the call is not to delve deeply into the substantive topics although discussion of them is necessary to put procedure and information into perspective and derive a go forward plan. You will also notice that there are some links attached to the substantive topics. Those links for today are meant to provide context for the topics and future considerations. I don't expect we will be delving deeply into the links today other than for context purposes.

I look forward to our call at 2pm.

FOR REFERENCE: NOTE THAT THE DIAL IN FOR TODAY'S CALL IS

US: 1-866-244-(b)

International: 719-457-(b)

Passcode: (b) (6)

Marc

Marc Sherman
(b) (6)

AMERICAN OVERSIGHT

AGENDA
VETERANS ADMINISTRATION

SUNDAY, JANUARY 15, 2017 | 2PM EST

Attendees:

David Shulkin
Ike Perlmutter
Laurie Perlmutter
Bruce Moskowitz
Marc Sherman
(b) (6)
(b) (6)
(b) (6)
(b) (6)

1. **Kickoff by Marc Sherman / Introductions**
2. **Perspective by David Shulkin**
    a. Current state of affairs
    b. Issues
        i. Day 1
        ii. Longer term
    c. View of the group's role
3. **Obstacles**
4. **Process**
5. **Timing**
6. **Role / impact of Capitol Hill / Regulatory Environment / Existing Regulations**

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7. **Role / impact of outside Veterans' Service Organizations**

   [https://en.wikipedia.org/wiki/List_of_veterans_organizations#United_States]

8. **Role / impact of Veterans' Advisory Committees [25 existing committees]**

9. **Cost and payment considerations and solutions**

10. **Possible Day 1 Issues**

    a. Patient care capabilities and deficiencies

       i. Administration of scheduling and quality of care in all service lines [especially Psych, ED, Chronic Care and Rehab]

       ii. IT (Electronic Records)

       iii. Physician and nursing retention

    b. Outstanding capital spending projects / Stop the bleeding

    c. Near term cost savings initiatives [Supply Chain, Coop, CPO]

    d. Veterans'' Employment & reentry programs & initiatives

       [http://heroesworkhere.disney.com]

    e. VA Fraud [https://www.va.gov/oig/publications/press-releases.asp]

    f. VA Facilities – efficiency

    g. Interrelationship and interplay of NIH

11. **Next Steps**

AMERICAN OVERSIGHT

Appointment

From: Marisol Garcia [(b) @frenchangel59.com]
Sent: 1/13/2017 9:17:34 PM
To: 'David shulkin' [drshulkin@aol.com]; L Perl [(b) (6) @gmail.com]; (b) (6) [(b) (6) @jhmi.edu]; 'IP' [@frenchangel59.com]; (b) (6) M.D.' (b) (6) @mayo.edu]; 'Bruce Moskowitz' [brucem(b) (6) mac.com]; (b) (6) [(b) @jhmi.edu]; (b) (6) [(b) (6) @ccf.org]; (b) (6) ccf.org; (b) (6) partners.org; (b) (6) [(b) @mayo.edu]; (b) (6) @partners.org; mbs(b) (6) gmail.com; (b) @frenchangel59.com

Subject: Conference Call with the new head of the VA, Doctor David Shulkin. The President Elect plans to announce the committee members very soon
Location: Conference Call - Sunday, January 15th

Start: 1/15/2017 7:00:00 PM
End: 1/15/2017 8:00:00 PM
Show Time As: Tentative

Recurrence: (none)

Sunday, January 15th

2:00 PM – 3:00 PM EST

Dial-in Information:

US: 1-866-244-(b) (6)

International: 719-457-(b) (6)

Passcode: (b) (6)

Thank you,

Marisol Garcia

(b) (6) (Cell)

(b) (6) @frenchangel59.com

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 1/6/2017 3:06:51 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re:

k

From: David shulkin <Drshulkin@aol.com>
Sent: Thursday, January 5, 2017 9:58 PM
To: Poonam Alaigh
Subject: Re:

I want jen and everyone else thinking im on a va site visit - which i am

Sent from my iPhone

On Jan 5, 2017, at 8:14 PM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:

> are you done- did you tell Jennifer Lee something- she sent me a note that you told her you were on a 'wild goose chase'
>
> Waiting for your call and we can discuss
>
> ---
>
> **From:** David shulkin <Drshulkin@aol.com>
> **Sent:** Thursday, January 5, 2017 8:13 PM
> **To:** Poonam Alaigh
> **Subject:**
>
> Should we invite freeda to the meeting on the 12 th?
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/6/2017 2:58:45 AM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re:

I want jen and everyone else thinking im on a va site visit - which i am

Sent from my iPhone

On Jan 5, 2017, at 8:14 PM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:

> are you done- did you tell Jennifer Lee something- she sent me a note that you told her you were on a 'wild goose chase'
>
> Waiting for your call and we can discuss
>
> ---
>
> **From:** David shulkin <Drshulkin@aol.com>
> **Sent:** Thursday, January 5, 2017 8:13 PM
> **To:** Poonam Alaigh
> **Subject:**
>
> Should we invite freeda to the meeting on the 12 th?
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 1/6/2017 1:14:56 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re:

are you done- did you tell Jennifer Lee something- she sent me a note that you told her you were on a 'wild goose chase'

Waiting for your call and we can discuss

From: David shulkin <Drshulkin@aol.com>
Sent: Thursday, January 5, 2017 8:13 PM
To: Poonam Alaigh
Subject:

Should we invite (b) to the meeting on the 12 th?

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/6/2017 1:13:13 AM
To: Poonam Alaigh [(b) (6) @hotmail.com]

Should we invite (b) to the meeting on the 12 th?

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [brucem(b) (6) mac.com]
Sent: 1/14/2017 1:34:28 PM
To: IP [(@frenchangel59.com]; mbs(b) (6) gmail.com; David shulkin [drshulkin@aol.com]
Subject: Faculty - Eastern Virginia Medical School (EVMS), Norfolk, Hampton Roads

Will discuss

President George W. Bush recognized Dr. (b) (6), leadership role in medicine and nominated him to the Board of Regents of the Uniformed Services University of the Health Sciences, and he was subsequently confirmed by the United States Senate. At the end of his tenure, Dr. (b) was awarded the Distinguished Service Medal. He currently serves as a consultant and is the Distinguished Visiting Surgeon in Combat Trauma Care for the United States Department of Defense.
https://www.evms.edu/education/centers_institutes_departments/surgery/faculty_staff/faculty/(b) (6)
.html

Sent from my iPad
Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: Jennifer Lee [(b) (6) @gmail.com]
Sent: 1/6/2017 8:39:12 PM
To: David Shulkin [drshulkin@aol.com]
Subject: quick call?

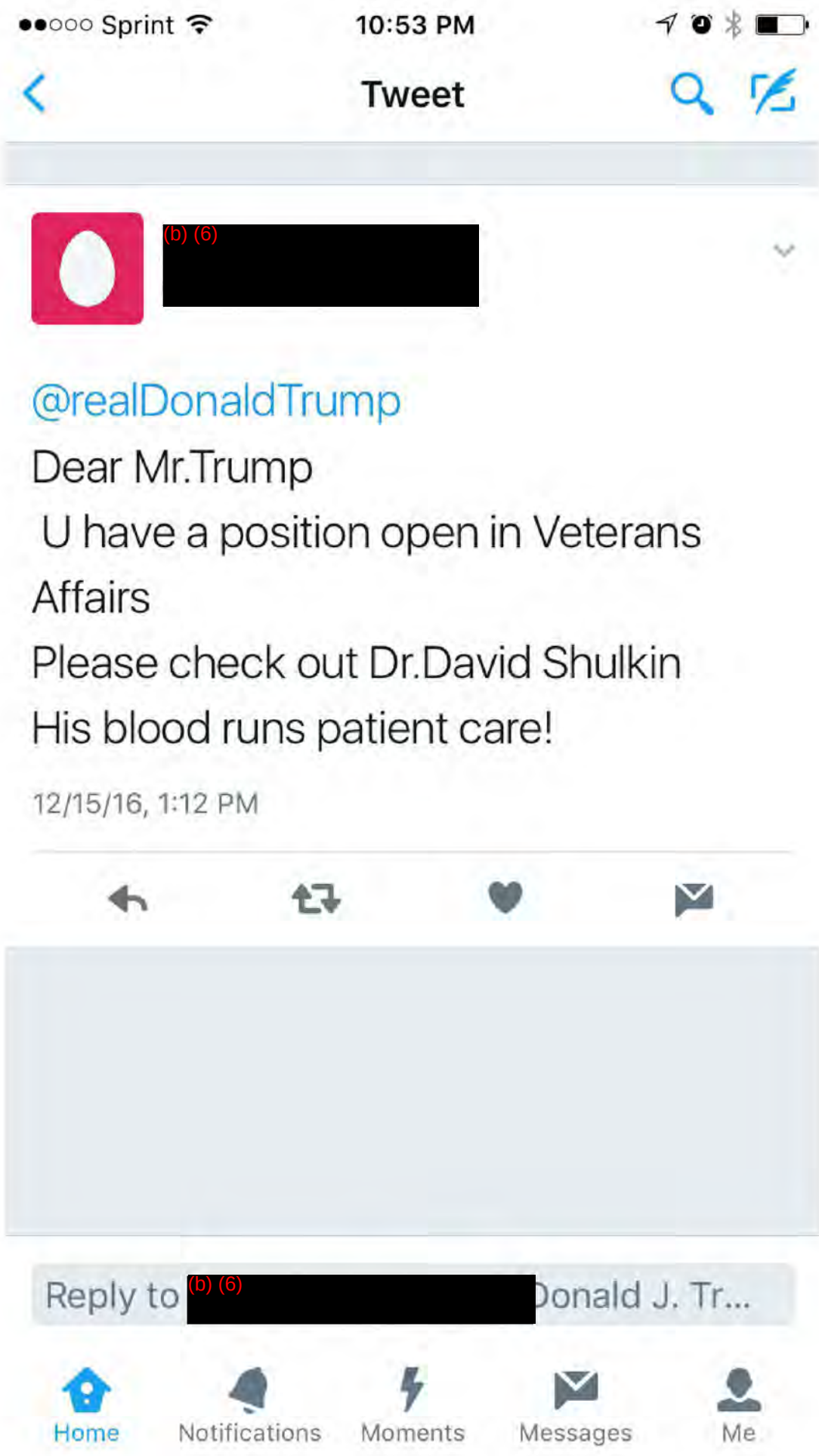
Can you give me a ring whenever you get a chance?
thanks
Jen

AMERICAN OVERSIGHT

Message

From: (b) (6) @gmail.com]
Sent: 1/11/2017 3:55:19 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Spreading like wildfire

AMERICAN OVERSIGHT



AMERICAN OVERSIGHT

Sent from my iPhone

On Jan 9, 2017, at 4:31 PM, David shulkin <Drshulkin@aol.com> wrote:

> Sent from my iPhone
>
> Begin forwarded
>
> **Subject: Re: Spreading like wildfire**
>
> http://thehill.com/homenews/administration/313309-mcconnell-meets-with-trump-in-new-york
>
> Sent from my iPhone
>
> On Jan 9, 2017, at 4:07 PM, David shulkin <Drshulkin@aol.com> wrote:
>
> > How did that happen?
> >
> > Sent from my iPhone
> >
> > Begin forwarded message:
> >
> > **From:** Poonam Alaigh <(b) (6) @hotmail.com>
> > **Date:** January 9, 2017 at 3:36:11 PM EST
> > **To:** David Shulkin <drshulkin@aol.com>
> > **Subject: Spreading like wildfire**
> >
> > Everyone's tweeting and now talking about you meeting with Him
> >
> > Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/9/2017 10:39:26 PM
To: Jen Shulkin [(b) (6) @gmail.com]
Subject: Re: Spreading like wildfire

Havnt seen yet but as send as i find them

Sent from my iPhone

On Jan 9, 2017, at 5:13 PM, Jen Shulkin <(b) (6) @gmail.com> wrote:

> send more. what tweets? how was it
>
> Jennie
>
> On Mon, Jan 9, 2017 at 4:31 PM, David shulkin <Drshulkin@aol.com> wrote:
>
> Sent from my iPhone
>
> Begin forwarded
>
> **Subject: Re: Spreading like wildfire**
>
> http://thehill.com/homenews/administration/313309-mcconnell-meets-with-trump-in-new-york
>
> Sent from my iPhone
>
> On Jan 9, 2017, at 4:07 PM, David shulkin <Drshulkin@aol.com> wrote:
>
> How did that happen?
>
> Sent from my iPhone
>
> Begin forwarded message:
>
> **From:** Poonam Alaigh <(b) (6) @hotmail.com>
> **Date:** January 9, 2017 at 3:36:11 PM EST
> **To:** David Shulkin <drshulkin@aol.com>
> **Subject: Spreading like wildfire**
>
> Everyone's tweeting and now talking about you meeting with Him
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Jen Shulkin [(b) (6) @gmail.com]
Sent: 1/9/2017 10:13:06 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Spreading like wildfire

send more. what tweets? how was it

Jennie

On Mon, Jan 9, 2017 at 4:31 PM, David shulkin <Drshulkin@aol.com> wrote:

Sent from my iPhone

Begin forwarded

Subject: Re: Spreading like wildfire

http://thehill.com/homenews/administration/313309-mcconnell-meets-with-trump-in-new-york

Sent from my iPhone

On Jan 9, 2017, at 4:07 PM, David shulkin <Drshulkin@aol.com> wrote:

How did that happen?

Sent from my iPhone

Begin forwarded message:

From: Poonam Alaigh <(b) (6) @hotmail.com>
Date: January 9, 2017 at 3:36:11 PM EST
To: David Shulkin <drshulkin@aol.com>
Subject: Spreading like wildfire

Everyone's tweeting and now talking about you meeting with Him

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/9/2017 9:31:35 PM
To: (b) (6) [(b) (6) @gmail.com]; (b) [(b) (6) @gmail.com]
Subject: Fwd: Spreading like wildfire

Sent from my iPhone

Begin forwarded

Subject: Re: Spreading like wildfire

http://thehill.com/homenews/administration/313309-mcconnell-meets-with-trump-in-new-york

Sent from my iPhone

On Jan 9, 2017, at 4:07 PM, David shulkin <Drshulkin@aol.com> wrote:

How did that happen?

Sent from my iPhone

Begin forwarded message:

From: Poonam Alaigh <(b) (6) @hotmail.com>
Date: January 9, 2017 at 3:36:11 PM EST
To: David Shulkin <drshulkin@aol.com>
Subject: Spreading like wildfire

Everyone's tweeting and now talking about you meeting with Him

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/9/2017 9:11:39 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: Spreading like wildfire

Ill call when i get above ground

Sent from my iPhone

On Jan 9, 2017, at 4:10 PM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:

> http://thehill.com/homenews/administration/313309-mcconnell-meets-with-trump-in-new-york
>
> Sent from my iPhone
>
> On Jan 9, 2017, at 4:07 PM, David shulkin <Drshulkin@aol.com> wrote:
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> > How did that happen?
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> > Sent from my iPhone
> >
> > Begin forwarded message:
> >
> > **From:** Poonam Alaigh <(b) (6) @hotmail.com>
> > **Date:** January 9, 2017 at 3:36:11 PM EST
> > **To:** David Shulkin <drshulkin@aol.com>
> > **Subject: Spreading like wildfire**
> >
> > Everyone's tweeting and now talking about you meeting with Him
> >
> > Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 1/9/2017 9:10:39 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Spreading like wildfire

http://thehill.com/homenews/administration/313309-mcconnell-meets-with-trump-in-new-york

Sent from my iPhone

On Jan 9, 2017, at 4:07 PM, David shulkin <Drshulkin@aol.com> wrote:

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> > **Date:** January 9, 2017 at 3:36:11 PM EST
> > **To:** David Shulkin <drshulkin@aol.com>
> > **Subject: Spreading like wildfire**
> >
> > Everyone's tweeting and now talking about you meeting with Him
> >
> > Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/9/2017 9:06:56 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Fwd: Spreading like wildfire

How did that happen?

Sent from my iPhone

Begin forwarded message:

> **From:** Poonam Alaigh <(b) (6) @hotmail.com>
> **Date:** January 9, 2017 at 3:36:11 PM EST
> **To:** David Shulkin <drshulkin@aol.com>
> **Subject: Spreading like wildfire**
>
> Everyone's tweeting and now talking about you meeting with Him
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 1/9/2017 8:36:11 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Spreading like wildfire

Everyone's tweeting and now talking about you meeting with Him

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/7/2017 1:59:57 PM
To: Ike Perlmutter [(b)@frenchangel59.com]
Subject: Veterans Affairs

Marisol- if you speak to Mr. Perlmutter today would you please let him know that I did not receive a call last night from Mr Prebius.

I wonder if he thinks I should just wait or if I should be doing something else.

Thank You

David Shulkin

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/7/2017 10:37:10 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Fwd: SG Talking points and agenda
Attachments: Advancing Emotional Well-being_conference materials.pdf; Untitled attachment 17301.htm; EWBAgendaDETAILED 1.5.17.docx; Untitled attachment 17304.htm; Shulkin-Emotional Well-Being Opening.010917.docx; Untitled attachment 17307.htm

Sent from my iPhone

Begin forwarded message:

From: "(b) (6) (b) (6) R." (b) (6) va.gov>
Date: January 7, 2017 at 1:45:18 PM EST
To: 'drshulkin' <drshulkin@aol.com>
Subject: SG Talking points and agenda

One more to follow

AMERICAN OVERSIGHT

ADVANCING EMOTIONAL WELL-BEING IN AMERICA

A joint convening of
The Office of the Surgeon General &
The Veterans Health Administration

AMERICAN OVERSIGHT

AGENDA

MONDAY, JANUARY 9

IBM
CTR FOR COGNITIVE GOVERNMENT
600 14TH STREET, NW
WASHINGTON, DC 20005

8:15am	Breakfast & Registration
	Please proceed to the 2nd floor and check in at security.

CREATING A NATIONAL AGENDA FOR EMOTIONAL WELL-BEING

9.00am	Welcome
9:10am	Perspectives
	The Honorable Dr. David Shulkin Under Secretary of Health
	Dr. Vivek Murthy U.S. Surgeon General
9:30am	Dr. Shulkin & Dr. Murthy In conversation
9:50am	Exercise: Social connection

DIALOGUE

Format: 3 brief "snapshots" by speakers will provide starting context. The discussion that follows each snapshot round will be focused on informing the national agenda. Discussions will be presided by Dr. Shulkin and Dr. Murthy.

SCIENCE SNAPSHOTS

10:00am	Spectrum of Stress (b) (6) [redacted]
	Prevention Science (b) (6) [redacted]
	Positive Psychology (b) (6) [redacted]
10:35am	Discussion
11:15am	Break

PRACTICE SNAPSHOTS

11:30am	Exercise: Contemplative practices
11:40am	EWB in the Military (b) (6) [redacted]
	EWB in Education (b) (6) [redacted]
	EWB in the Workplace (b) (6) [redacted]
12:15pm	Discussion
1:00pm	LUNCH & EWB Innovation Gallery Walk-Through
1:45pm	Exercise: Physical activity

SYSTEMS/POLICY SNAPSHOTS

1:50pm	EWB in Healthcare (b) (6) [redacted]
	EWB in Communities (b) (6) [redacted]
	ROI from EWB Interventions (b) (6) [redacted]
2:35pm	Discussion

NEXT STEPS

3:30pm	Exercise: Gratitude
3:40pm	Reflection & Next Steps
	Final remarks from Dr. Shulkin and Dr. Murthy
4:50 PM	Wrap-up
5:00 PM	Evening Reception, The Hamilton (downstairs)

AMERICAN OVERSIGHT

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THE HONORABLE DR. DAVID SHULKIN
UNDER SECRETARY OF HEALTH, DEPARTMENT OF VETERANS AFFAIRS

The Honorable Dr. David J. Shulkin is Under Secretary of Health for the United States Department of Veterans Affairs. As the Chief Executive of VA Healthcare, Dr. Shulkin leads the nation's largest integrated health care system with over 1,700 sites of care, serving 8.76 million Veterans each year. The Veterans Health Administration is also the nation's largest provider of graduate medical education and major contributor of medical research. Dr. Shulkin has oversight over the system that employs over 325,000 people who work in VA Healthcare.



DR. VIVEK H. MURTHY
U.S. SURGEON GENERAL

Vivek Murthy, MD, MBA, is the 19th Surgeon General of the United States. Dr. Murthy is responsible for communicating the best available scientific information to the public regarding ways to improve personal and public health. He also oversees the operations of the U.S. Public Health Service Commissioned Corps, comprised of approximately 6,700 uniformed health officers who serve in nearly 800 locations around the world to promote, protect, and advance the health and safety of our nation and our world. Dr. Murthy has devoted himself to improving public health through the lens of service, clinical care, research, education and entrepreneurship.

AMERICAN OVERSIGHT

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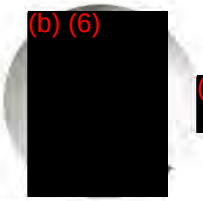
PARTICIPANTS



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POONAM ALAIGH

Poonam Alaigh, MD, serves as the Senior Advisor for Healthcare Delivery, US Department of Veterans Affairs. She is a physician executive with deep expertise in healthcare policy and healthcare delivery. Prior to joining the VA, Dr. Alaigh was the Commissioner of Health and Senior Services for New Jersey where she had direct operational oversight and management of the Department of Health and Senior Services with a budget of $3.8B, and 1,600 employees. In addition, she was the Executive Medical Director at Horizon Blue Cross Blue Shield of New Jersey.



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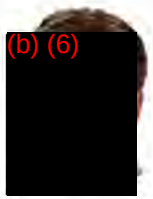

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AMERICAN OVERSIGHT

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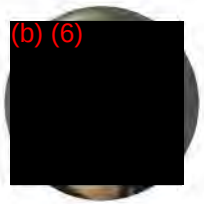

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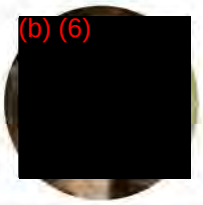

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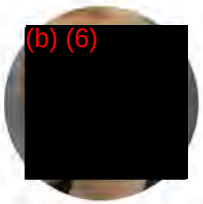

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AMERICAN OVERSIGHT

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PARTICIPANTS



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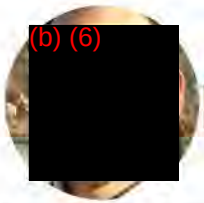

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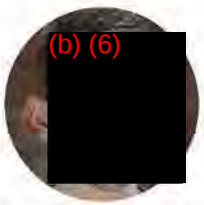

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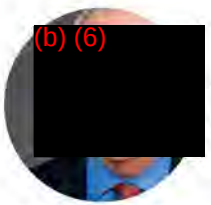

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AMERICAN OVERSIGHT

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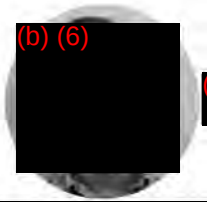

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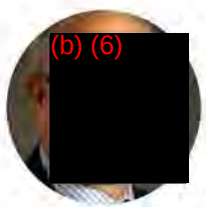
CAROLYN CLANCY

Carolyn M. Clancy, MD, serves as the Deputy Under Secretary for Health for Organizational Excellence of the Veterans Health Administration. Dr. Clancy is a nationally recognized physician executive and has oversight of VHA's performance, quality, safety, risk management, systems engineering, auditing, oversight, ethics and accreditation programs. She works collaboratively, leading the strategic direction of the Veterans Health Administration. In her current position she works closely with Department leaders as well as Veterans Service Organizations, Congress and their constituents addressing the immediate and long term needs of our Nation's Veterans.



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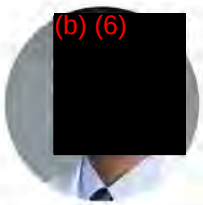

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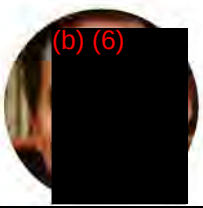

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AMERICAN OVERSIGHT

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PARTICIPANTS


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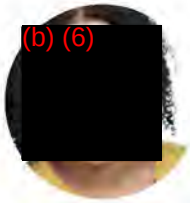
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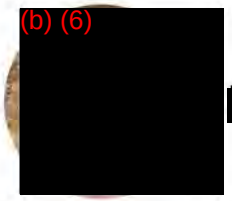
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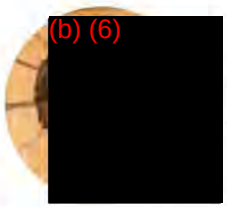
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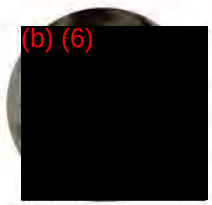
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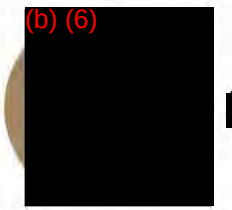
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AMERICAN OVERSIGHT

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PARTICIPANTS



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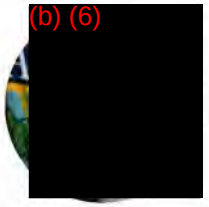

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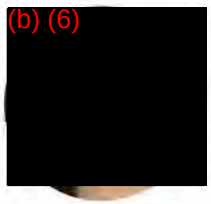

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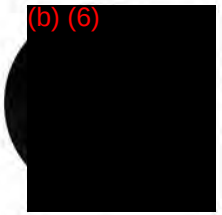

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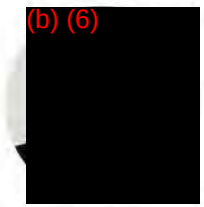

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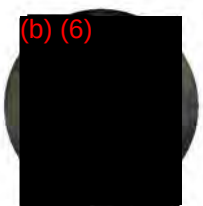

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technology and sensor and surveillance.



TRACY GAUDET

Tracy Gaudet, MD, is the Director of Veterans Health Administration's Office of Patient-Centered Care and Cultural Transformation. The VA is transforming both the philosophy and practice of healthcare, and is designing and deploying an approach to health that empowers and equips Veterans to take charge of their health and wellbeing. Dr. Gaudet is internationally known as an expert in transforming health care from a traditional, disease-based model to this new 21st century model based on patient-centered care.

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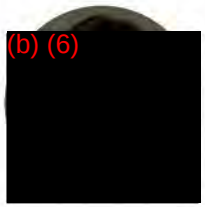
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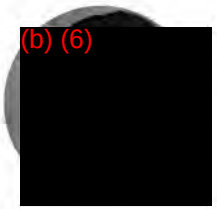
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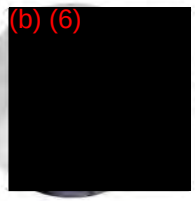
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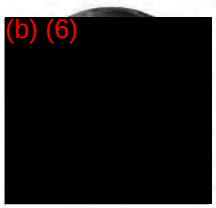
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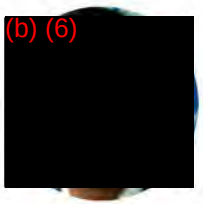
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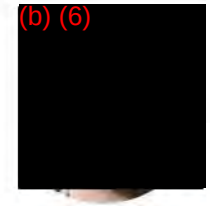

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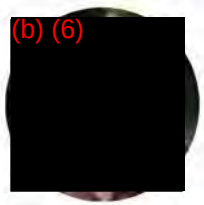

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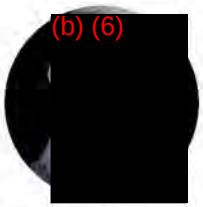

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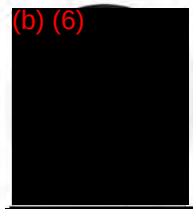

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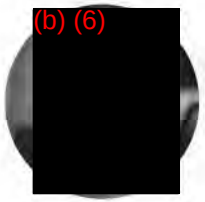

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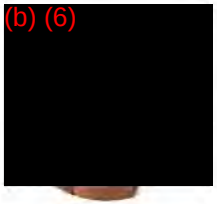

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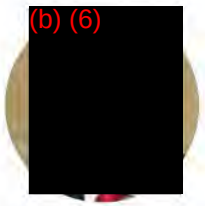
JENNIFER LEE

Jennifer S. Lee, MD, serves as the Deputy Under Secretary for Health for Policy and Services, Veterans Health Administration. Dr. Lee provides guidance to the Under Secretary for Health on health care policy, strategic objectives, and policy requirements for legislatively mandated health care delivery programs.



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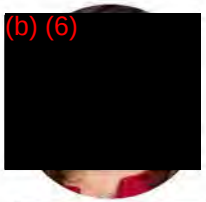

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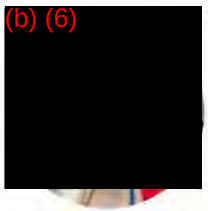

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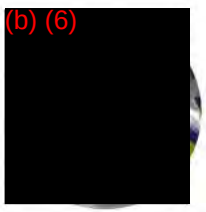

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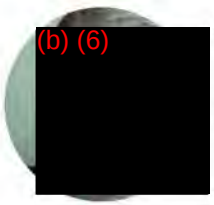

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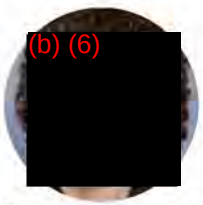

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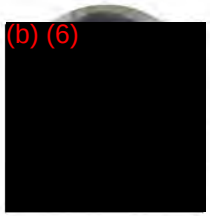

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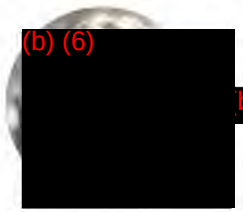

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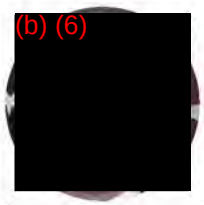

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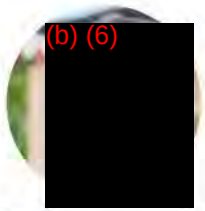

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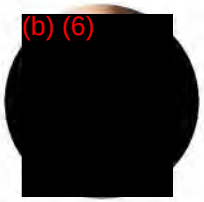
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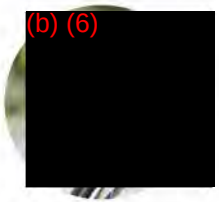
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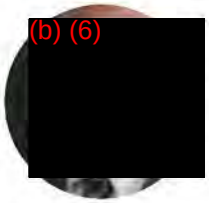

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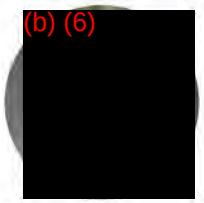

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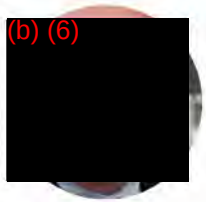

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SYLVIA TRENT-ADAMS

Rear Admiral (RADM) Sylvia Trent-Adams, PhD, RN, serves as Deputy Surgeon General, Office of the Surgeon General. She advises and supports the Surgeon General regarding operations of the US Public Health Service (USPHS) Commissioned Corps and in communicating the best available scientific information for the health of the nation. RADM Trent-Adams has held various positions in HHS, working to improve access to care for poor and underserved communities.



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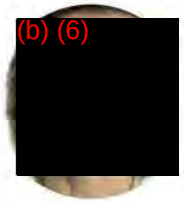
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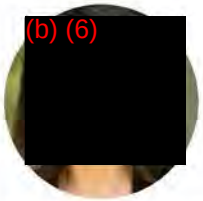
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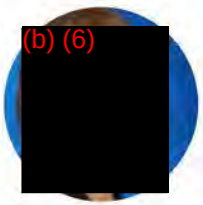
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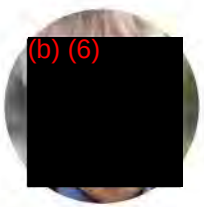
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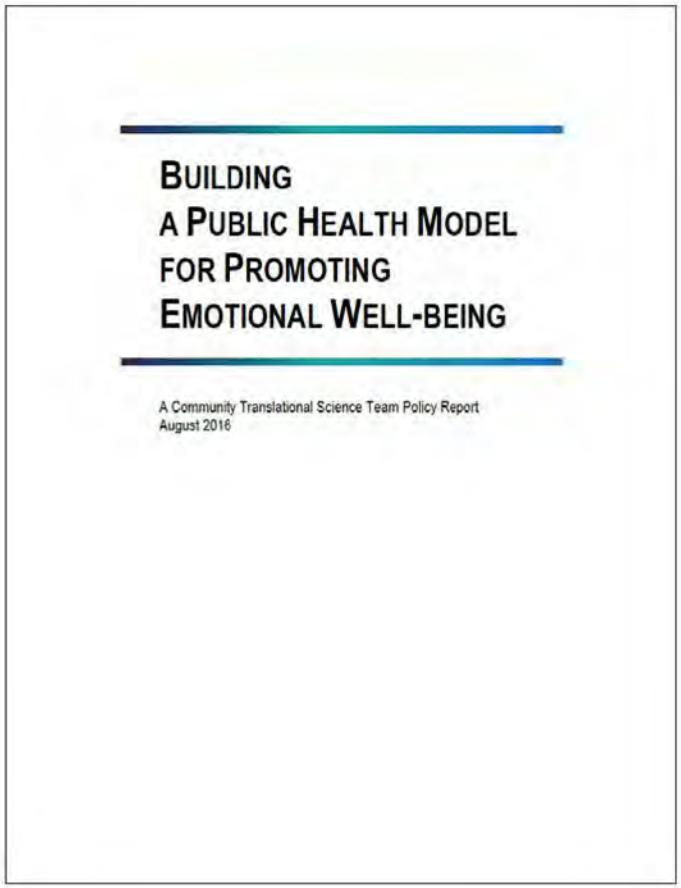
A REPORT ON EMOTIONAL WELL-BEING



For background, please refer to this 2016 report by the Community Translational Science Team at University of California, Los Angeles.

Accessible via download:
https://drive.google.com/open?id=0B0Qx6PmTtFX4SEpwV3FfR1poZk0

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Advancing Emotional Well-Being in America

A joint convening of the Office of the Surgeon General
& Veterans Health Administration

Agenda Draft v. 01.05.2017

TIME	PROGRAM	ASSETS
7:45 AM	**ARRIVAL TIME FOR STAFF**	
8:15 – 8:55AM	**BREAKFAST & REGISTRATION** Pick up name tags at the 2nd floor security desk.	Registration table Sign in sheets Name tags Sign for the convening. + Welcome sign (by elevator) + Welcome sign (by desk) + Welcome sign on the ground floor. Volunteer stationed on first level. Break Music
	ENVISIONING A EWB NATION (Create madlib sheets + sharpies = add on wall) What does an emotionally well nation look like? What are the way we reach optimal EWB? What types of progress would we make in science, policy, and practice?	Mad libs on tabloid Do the MadLib INSIDE (once they come through the desk). On Atrium wall. On glass wall.
	EWB GALLERY - SET UP Set-up, with walk-through at lunch	(Digital) IBM stations (Physical) Posters – VA From Gallery Participants: - Require laptops / tablet - Must bring own HDMI cord.

WELCOME & BIG-PICTURE FRAMING

8:55 AM (5 min)	**TRANSITION**	Cue with music (b) (6) - *Acknowledgement (7:42)*

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9:00 AM (7 min)	**WELCOME & OVERVIEW FOR THE DAY** ***Tracy Gaudet &*** (b) (6) *Set intention of the day. Come into conversation with each other about the future & EWB. Ground rules - social media and phones.* *A conversation of both head & heart focusing on the issue we are here to address/problem to solve*	Title Slide (Advancing EWB)
9:07 AM (1 min)	**BREATHING EXERCISE, SETTLE IN (1 MIN)**	Slides Lights OFF (or Dim)
9:08 AM (2 min)	**INTRODUCTION OF PRINCIPALS** ***Tracy Gaudet &*** (b) (6) Introduce Shulkin & Murthy Both come up and sit in	Slides Photos w/ Titles
9:10 AM (10 min)	**FRAMING REMARKS** ***VA Under Sec David Shulkin*** Add in topline messages from Shulkin. Dr. Shulkin will introduce Dr. Murthy and sit on stool at front while Dr. Murthy speaks in prep for Fireside Chat	Title Slide (Advancing EWB)
9:20 AM (10 min)	**FRAMING REMARKS** ***Dr. Murthy*** Broad picture of EWB Health equity Social determinants of health Add in topline messages from SG (b)	Cont'd: Title Slide (Advancing EWB)
9:30 AM (20 min)	**TRANSITION TO FIRESIDE** ***Tracy*** (b) (6) "Now we are moving into fireside." Confirm with SG/Shulkin if needed. **Shulkin & Murthy FIRESIDE CHAT** ***No questions from the audience.*** Dr. Murthy will start the fireside chat with questions and then it can be fluid conversation. **Potential Questions:** **Qs from SG:** - *We hear a lot about the challenges for vets. What*	Cont'd Title Slide (Advancing EWB)

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	have you learned in this position about EWB? - *What has the VA found?* - *Why is EWB important to the vet population?* - *How do you envision EWB being part of the future of the VA?* **Qs from Shulkin:** - *Why do you see this as a public health priority?* - *What have you seen in your travels around the country? Are there particular stories?* - *What would our country look like if EWB was a priority? What do you see?* - *How do we get there?* **Time keeper give 2 min warning** (b) (6)	
9:50 AM (10 min)	(b) (6) /Tracy - we want to experience of EWB for ourselves; first tool - social connection. For this exercise, we will have (b) (6) lead this exercise. **INTERSTL 1 Science + EWB Exercise** **THEME EMPATHY & SOCIAL CONNECTION** Use subset of The 36 Questions That Lead to Love http://nyti.ms/14BZ9Mf -- slides *** POSSIBLY SWAP WITH CONTEMPLATIVE *** LED BY (b) (6) Segue into the next activity.	SLIDE: Empathy & Social Connection Photos + titles for speakers AK Design the "Fortune Cookie" with questions 1 pair (instead of speed dating). Try out and time at OSG.

PART II: SCIENCE SNAPSHOTS

10:00 AM (5 min)	**FRAMING (5 min)** *Tracy* (b) (6) - Hearing 3 snapshots, curated to catalyze thinking around the science. - These snapshots will help frame the conversation that follows, in a forum that supports deep dialogue. - Introduce speakers and remind the group of the issues we are here to address	SLIDE: SNAPSHOT ONE: SCIENCE (b) (6) TO GATHER SPEAKERS

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10:05 AM (10 min)	TOPIC Neuroscience/Biology SPEAKER (b) (6) *University of Miami*	SLIDE: (b) intro slide (photo, name & title, talk title) + speaker slides TIMER: 8 min
10:15 AM (10 min)	TOPIC Prevention science SPEAKER (b) (6)	SLIDE: (b) intro slide (photo, name & title, talk title) + speaker slides TIMER: 8 min
10:25 AM (10 min)	TOPIC Positive psychology SPEAKER (b) (6)	SLIDE: (b) intro slide (photo, name & title, talk title) + speaker slides TIMER: 8 min
10:35 AM (40 min) 3 min

	we integrate positive psychology and prevention science? - What are the opportunities (and challenges/barriers) to bring interventions to scale? - Integration into the national agenda is a key step towards moving science forward. *What are other ways we can move the current science forward?* (b) (b) INTROS BREAK: bathroom	
11:15 (15 min - but tell people it's 10!)	**BREAK** * Possibly swap with interstitial above if audience is need of break earlier. **At 11:25, cue return with music.**	SLIDE: Break Break Music
11:25AM	**TRANSITION BACK**	Cue with Music *Bobby McFerrin - Don't Worry Be Happy (4:51)*

PART II: PRACTICE SNAPSHOTS

11:30 AM (10 min)	TRACY will introduce Exercise **INTERSTL 2 Science + EWB exercise (10 min)** **THEME CONTEMPLATIVE PRACTICES** Mindfulness Based Stress Reduction - Evidence-based (b) (6)	Cont'd Title Slide (Advancing EWB) SLIDE: Contemplative Practices Photos + titles for speakers
11:40 AM (5 min)	**FRAMING (5 min)** (b) (6) - Hearing 3 snapshots, curated to catalyze thinking around practice. - These snapshots will help frame the conversation that follows, in a forum that supports deep dialogue. - Introduce speakers and remind the group of the issues we are here to address	SLIDE: SNAPSHOT 2: EWB IN PRACTICE
11:45 AM (10 min)	TOPIC **EWB in the Military and among Veterans**	SLIDE:

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	SPEAKER	*Lieutenant General Eric B. Schoomaker*	Speaker intro slide (photo, name & title, talk title) + speaker talk slides TIMER: 8 min
11:55 AM (10 min)	TOPIC SPEAKER	EWB in Education / Schools (b) (6)	SLIDE: Speaker intro slide (photo, name & title, talk title) + speaker talk slides TIMER: 8 min
12:05 PM (10 min)	TOPIC SPEAKER	EWB in the Workplace/Corporate (b) (6)	SLIDE: Speaker intro slide (photo, name & title, talk title) + speaker talk slides TIMER: 8 min
12:15 PM (40 min) 3 min 37min	TRACY WILL INTRO DISCUSSION DISCUSSION PRACTICE Forward (45 min) FRAMING *Shulkin* POTENTIAL QUESTIONS FOR FRAMING (Will be on slide) - What are the institutions where we need to see EWB in practice? And what would that look like? - What are the common elements across practice settings that enable success? - What are the barriers and how might we overcome them? - What are the broader opportunities in this space? - How might we get employers to see the value in investing in EWB in the workforce? - What community approaches are needed? FACILITATOR *Carolyn Clancy*	SLIDE: SNAPSHOT 2: EWB IN PRACTICE SLIDE: QUESTIONS FOR DISCUSSION
12:55 (1 min)	(b) (6) /TRACY **TRANSITION TO LUNCH** Lunch outside. Come back when the bell rings.	

LUNCH

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12:55 PM (50 min)	**GALLERY WALK THROUGH + LUNCH** Ideally, the gallery stations can be independent. If contributors want to stay by their stations, that's great. If not, they can simply mingle. * Note: The extra time for lunch here gives us some buffer should the morning program run over time.	SLIDE: LUNCH Break Music

PART II (cont'd): SYSTEMS / POLICY SNAPSHOTS

1:40 PM	**TRANSITION**	Cue with Music *Beatles - Here Comes the Sun (3:06)* Katrina and the Waves- Walking on Sunshine (3:58) Ushers help get people back in the room
1:45 PM (5 min)	(b) (6), INTROS HERSELF **INTERSTL 3 EWB EXERCISE** **THEME CHANGING YOUR STATE THROUGH PHYSICAL ACTIVITY** Some type of activity that has been shown to alter mood? Music & Dance oriented (3 to 4 moves). If there is no story to go with this, will adjust as 5 min activity. Animals + colors; birthdays LED BY (b) (6)	SLIDE: Changing your state through Physical Activity + Music *Pharrell - Happy (3:53)*
1:50 PM (5 min)	(b) (6) INTROS **FRAMING (5 min)** *Tracy* (b) - Hearing 3 snapshots, curated to catalyze thinking around practice. - These snapshots will help frame the conversation that follows, in a forum that supports deep dialogue. - Introduce speakers and remind the group of the	SLIDE: SNAPSHOT 3: REIMAGINING SYSTEMS THROUGH POLICY

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	issues we are here to address		
1:55 PM (10 min)	TOPIC	EWB x healthcare (lifestyle intervention *in prevention and treatment; shown through evidence and support of Medicare + other plan). Pillars of culture of prevention. EWB = stress reduction & social connection.*	SLIDE: Speaker intro slide (photo, name & title, talk title) + speaker talk slides TIMER: 8 min
	SPEAKER	(b) (6)	
2:05 PM (10 min)	TOPIC	EWB x environments "total wealth" (natural, economic, social and human capital)	SLIDE: Speaker intro slide (photo, name & title, talk title) + speaker talk slides TIMER: 8 min
	SPEAKER	(b) (6)	
2:15 PM (10 min)	TOPIC	ROI in EWB interventions, incl criminal Justice	SLIDE: (b) intro slide (photo, name & title, talk title) + speaker talk slides TIMER: 8 min
	SPEAKER	(b) (6), *Washington State Institute for Public Policy (confirmed)*	
2:35 PM (45 min) 3 min 37 min	TRACY INTROS AND LEADS DISCUSSION SYSTEMS THROUGH POLICY FRAMING *Tracy* FACILITATOR *Tracy* + (b) (6) QUESTIONS (to be projected on screen) - What are the specific challenges and opportunities for EWB at the systems level? - How might we transform systems to support EWB? - How might we incentivize systems to integrate EWB? How might we make the case to stakeholders, including policy makers?		SLIDE: SYSTEMS THROUGH POLICY SLIDE: Questions for discussion
3:15 PM (10 min)	**TRACY -** (b) **BREAK** **Team help** (b) **move innovation stations**		SLIDE: Break (10 min) Put Gratitude exercise cards on every chair

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PART III: REFLECTION & NEXT STEPS

3:25 PM (5 min)	**TRANSITION**	Cue Music *Leslie Odom Jr - My Favorite Things (5:50)*
3:30 PM (10 min)	(b) (6) /TRACY **INTERSTL 4 STORY + EWB EXERCISE** **THEME GRATITUDE EXERCISE** LED BY (b) (6)	SLIDE: EWB Exercise Check with (b) - need cards? Gratitude exercise cards should be on every chair
3:40 PM (50 min) 10 min Short reflection 3 min 42 min	?TRANSITION PERSON? GROUP REFLECTION + NEXT STEPS FACILITATOR *SG* *((b) (6) , others open to helping with facilitation)* How people are feeling, etc.? Refine with SG. VIDEO (TBD) *Short video sharing selection of madlibs completed in the morning. Would be a nice way to book end, and tie back to the ideas people came into the room with. Will do this if the madlibs are good – Incorporate 'audacious goal' question into madlib.* KEY QUESTIONS to DRIVE DISCUSSION ROADMAP - Defining EWB (talking as emotional fitness? as emotional well-being? etc) - What do they think the most important discussion points/themes/breakthrough from our day together. - Based on that, what should our big audacious goal be for EWB? - What are the key next steps?	SLIDE: Reflection & Next Steps Make during lunch Slide on screen
4:30 PM (20 min)	**SUMMARY STATEMENTS** *Ideally this would be less time, especially if Shulkin & SG are active in the discussion*	

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	Nothing formal – brief remarks. Dr. Murthy will signal Dr. Shulkin to make final comments and Dr. Murthy will close. *Under Secretary David Shulkin, Veterans Health Administration (5 min)* *VADM Vivek H. Murthy, Office of the Surgeon General (5 min)*	
4:50 PM (3 min)	TRACY & (b) (6) Final note: feedback card (1 min + 4 min fill-out) Direction towards evening reception (2 min)	SLIDE: Thank you with logos of partners?
4:53PM (7 min) 5:00PM	Final Thank You to Partners (b) (6) **TRANSITION**	 Cue Music *Bob Marley - Three Little Birds (3:00)* *Beatles - All You Need is Love (3:47)*

5:00 PM (1hr)	**EVENING RECEPTION** Hamilton	
6:00PM	Final exit out of Building	

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DRAFT 1
Under Secretary for Health David J. Shulkin, M.D.
Emotional Well-Being Opening
January 9, 2017

Good morning, everyone.

It is my great pleasure to join our nation's distinguished Surgeon General in leading this important discussion.

Today, we will take the first steps on the path toward achieving our shared vision of making emotional well-being a pillar of health in America.

First, my sincere thanks to Dr. Vivek Murthy for co-hosting with me today.

I would like to thank Dr. Tracy Gaudet, Dr. (b) (6), and the teams from VA and the Surgeon General's Office for organizing this gathering.

I would also like to thank the thought leaders from the science, policy, and practice sectors who are here to share valuable experiences and insight.

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I realize you are contributing your time and expertise, and for that, I thank you.

The National Academy of Medicine—formerly the Institute of Medicine—as well as the Institute for Healthcare Improvement, have led the medical community in calling for a radical redesign of health care.

Most experts agree that we need to shift our focus from disease-driven health care to a more holistic approach.

The main challenge we face is that most physicians have been trained to treat the disease, not the person.

At VA, we are moving from "sick care" to "whole health care" by transitioning to a model that focuses on the person, prevention, and "well-being."

We are committed to providing health care for Veterans that is high-quality, evidence-based, and increasingly personalized.

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We have adopted non-traditional approaches, most notably care that is delivered by multidisciplinary teams and responsive to the needs of our patients.

We are committed to a "whole health" model of care that is personalized, proactive, and patient-driven.

VA is transforming our health system to start with the person rather than the disease, to partner with the Veteran to fully explore what they value, and then align their health care with those values.

At the core of this approach is mindful awareness—the opportunity for Veterans to explore their sense of meaning, aspiration, and purpose in life, and then build their health care in support of this.

That is a radical departure from the traditional medical model, and it is founded in emotional well-being.

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To make this transformation a reality, our first step is to educate both VA employees and Veterans.

The next step is to bring a patient-centered approach to the care of every Veteran who enters our doors.

Whole health is an approach to health care that empowers and equips patients to take charge of their own health and well-being, and live life to the fullest.

VA's Whole Health System is a systematic approach to providing whole health care early in the relationship between VA and the Veteran.

It starts with an exploration of what matters most to that person, emphasizes self-care in the context of well-being, and incorporates a full range of conventional and complementary and integrative health services.

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Our Whole Health System will move VA from a practice of episodic care to a true partnership across time, focused on helping Veterans live their fullest lives.

VA will partner with the Veteran at the point of enrollment in our health system, and create an overarching personal health plan that is founded in what they want their health for, and integrates care both in VA and the community.

Central to this approach are well-being programs, where Veterans can learn new skills and have the support they need to address their emotional and physical well-being.

Classes such as mindfulness, meditation, yoga, tai chi, nutrition, and movement will be offered.

These well-being programs will be easily accessible to Veterans throughout the country, either in VA or the community.

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This will be synergistic with clinical care, and provided in settings that are attentive to healing environments and relationships, and integrate holistic approaches into treatment plans.

VA draws its mission from President Lincoln's Second Inaugural Address—he charged our nation with caring for those "who shall have borne the battle," and their families.

But because we are the nation's largest integrated health system, and do not carry out our mission alone, what we do now will help set the course of American health care for decades to come.

We have an opportunity to improve care by modeling a system that:

- Leverages evidence-based, team-based, and patient-centric approaches to care.

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- Emphasizes physical and emotional well-being, not just disease management.
- Uses technology and innovation to continuously improve outcomes, and metrics to continuously monitor and improve performance.
- Welcomes new and complementary approaches such as meditation, tai chi, yoga, and health coaching based in integrative medicine.

The VA medical center in Fayetteville, North Carolina, is a national leader in training and using Whole Health Coaches to help Veterans address their emotional well-being and make lifestyle choices that correlate with good health.

Initially focusing this effort on homeless Veterans, the medical center saw the remarkable impact coaching had on their lives and health, and moved to integrate coaching into their care teams.

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This is just one example of how VA is moving rapidly from reactive disease management to proactive health care—it is health care for the 21st century.

VA's changing model of health care is not about creating a "new" system, but shaping the "right" system for Veterans.

VA has another opportunity—and a responsibility—before us.

We can share our vision, knowledge, experience, and achievements to help frame and contribute to the evolving paradigm of health care in America.

That is what brings us here today.

Now, it gives me great pleasure to introduce our next speaker.

Vice Admiral Vivek Murthy was confirmed as the 19th U.S. Surgeon General on December 15, 2014.

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As “America’s Doctor,” he is responsible for communicating the best available information to the public on improving personal and public health.

Dr. Murthy also oversees operations of the U.S. Public Health Service Commissioned Corps, comprised of 6,700 uniformed health officers who promote, protect, and advance the health and safety of our nation.

For the past two decades, he has devoted himself to improving public health through the lenses of service, clinical care, research, education, and entrepreneurship.

Please join me in giving a warm welcome to our nation’s Surgeon General, Dr. Vivek Murthy.

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/7/2017 10:36:59 PM
To: Poonam Alaigh [(b) (6)@hotmail.com]
Subject: Fwd: SG Talking points and agenda
Attachments: Shulkin-Emotional Well-Being.010917.pptx; Untitled attachment 17312.htm; Shulkin-Emotional Well-Being Closing.010917.docx; Untitled attachment 17315.htm

Sent from my iPhone

Begin forwarded message:

> **From:** "(b) (6) (b) (6) R." (b) (6) va.gov>
> **Date:** January 7, 2017 at 1:47:21 PM EST
> **To:** 'drshulkin' <drshulkin@aol.com>
> **Subject: RE: SG Talking points and agenda**
>
> Closing remarks here.
>
> -----Original Message-----
> **From:** (b) (6)
> **Sent:** Saturday, January 07, 2017 01:45 PM Eastern Standard Time
> **To:** 'drshulkin'
> **Subject:** SG Talking points and agenda
>
> One more to follow

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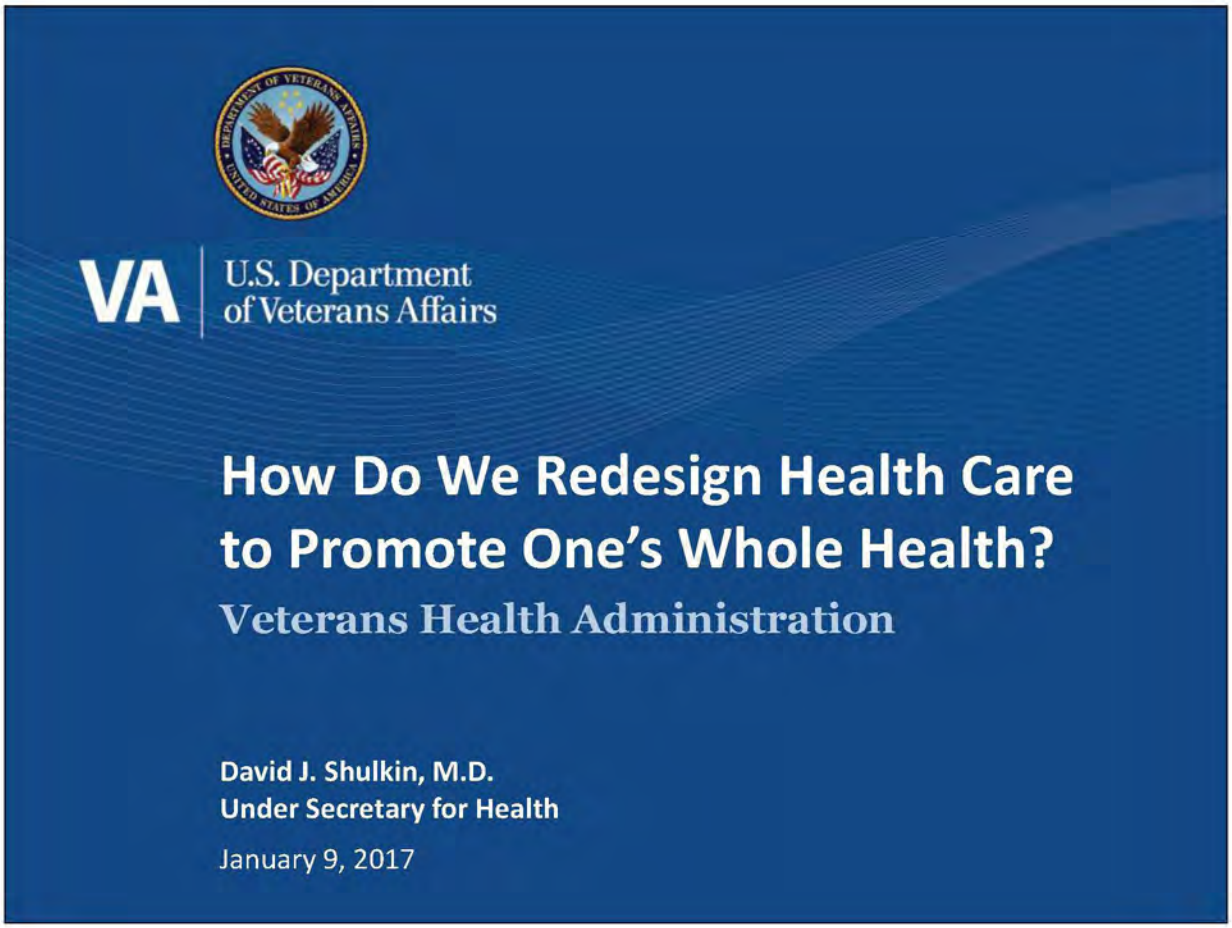

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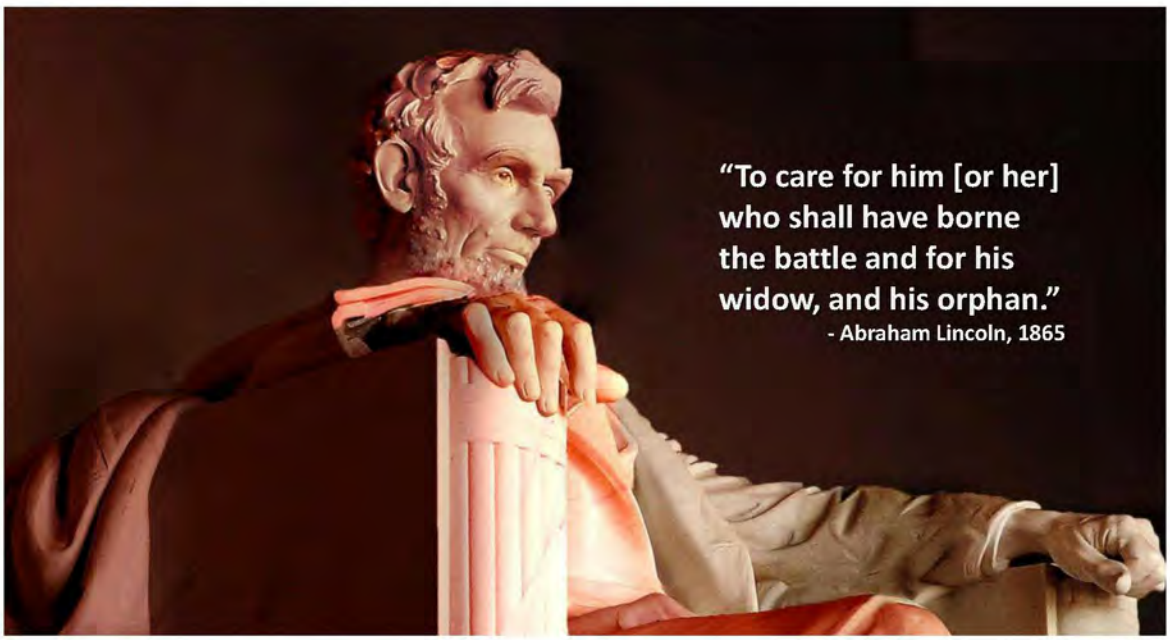
Fulfilling Our Mission



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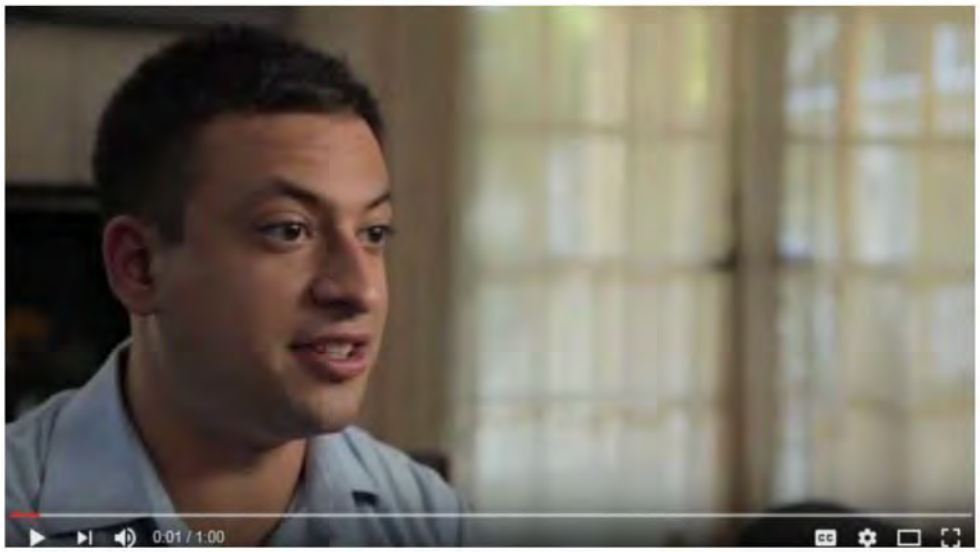
In Their Own Words



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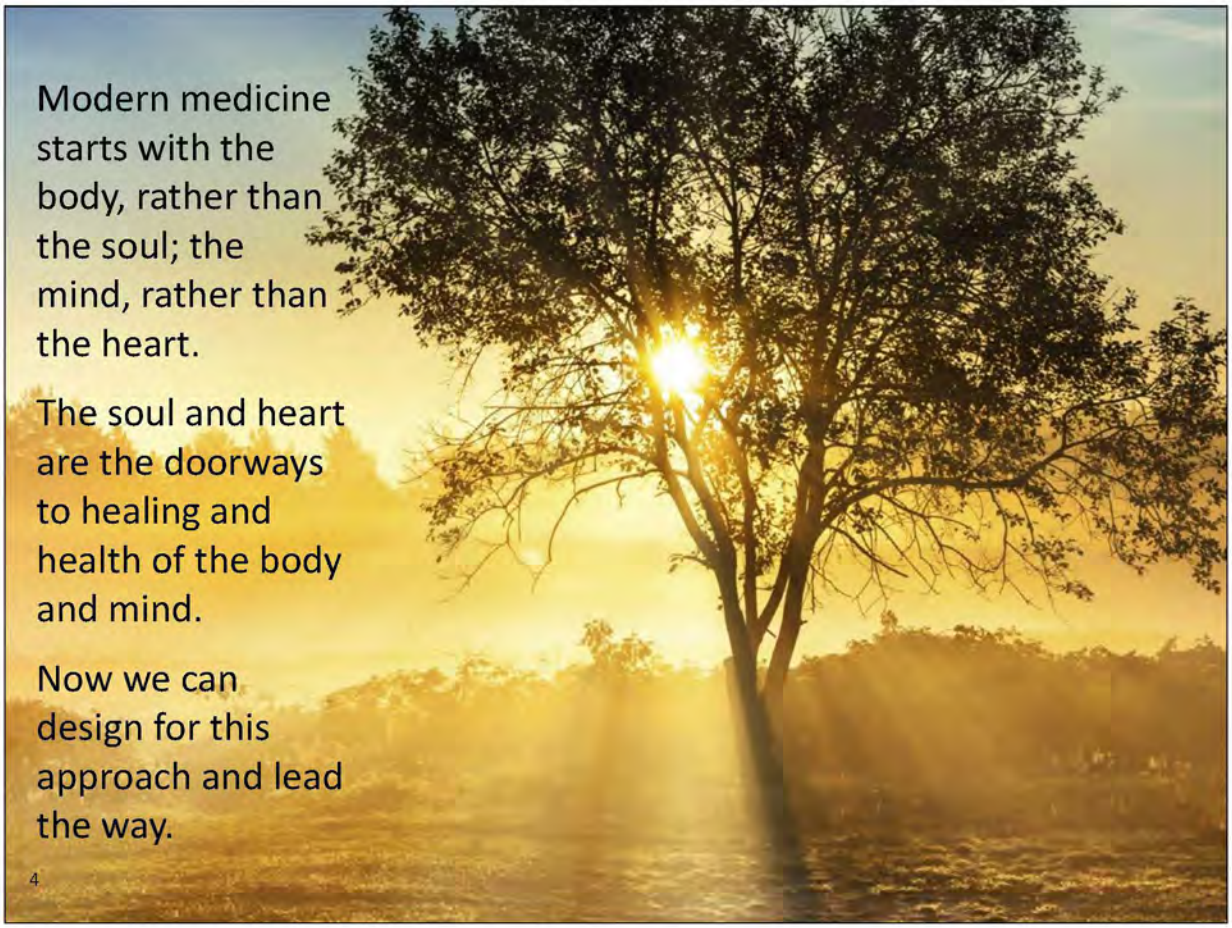

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Redesign of Health Care

What does this redesign of health care look like when we start with the person rather than the disease, when we start with what matters to the person, not what is the matter?

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Our Opportunity

- **Opportunity** – to redesign our health system to address emotional well-being as well as physical well-being
- **We meet a huge need** – for our Veterans, and for our Nation
- **Challenge** – the current approach to health care is a find-it, fix-it, disease-based approach; we do not have a core competency in engaging the whole person in optimizing their well-being

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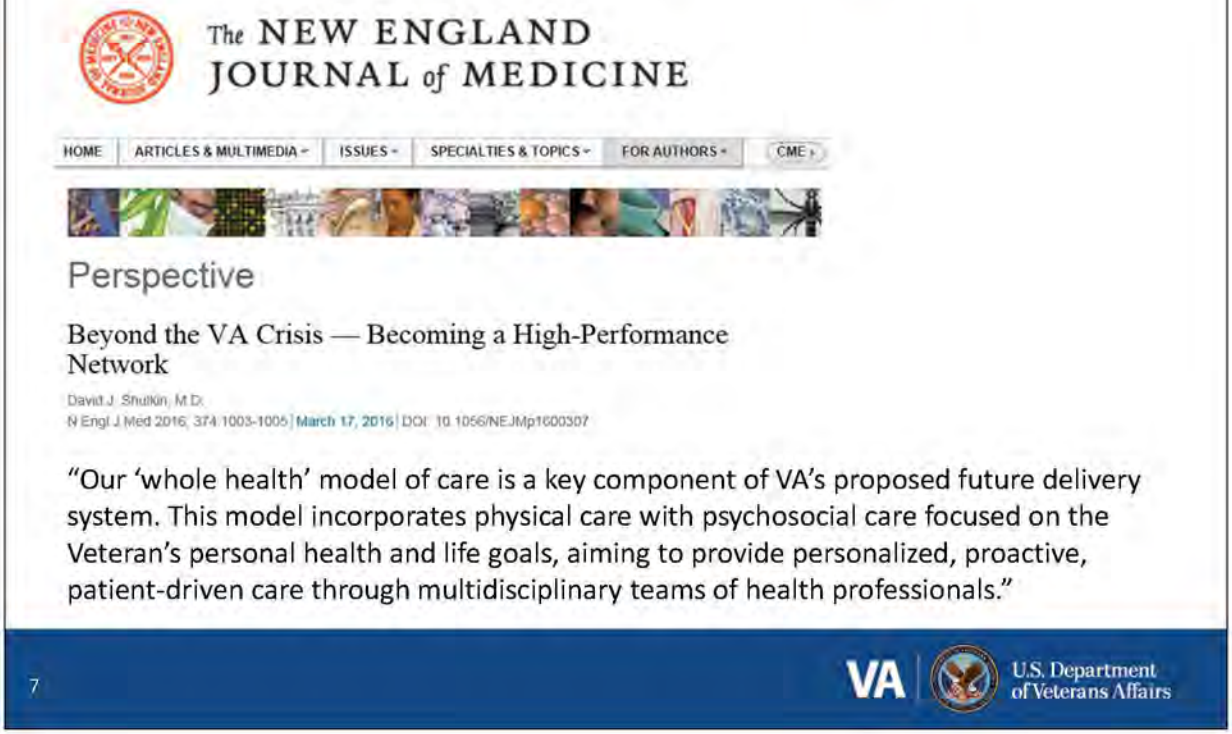
Whole Health Model of Care



Starting with the VHA Strategic Plan, and including the Blueprint for Excellence and this recent article in the NEJM, VHA is talking about WH as the future model of VA care.

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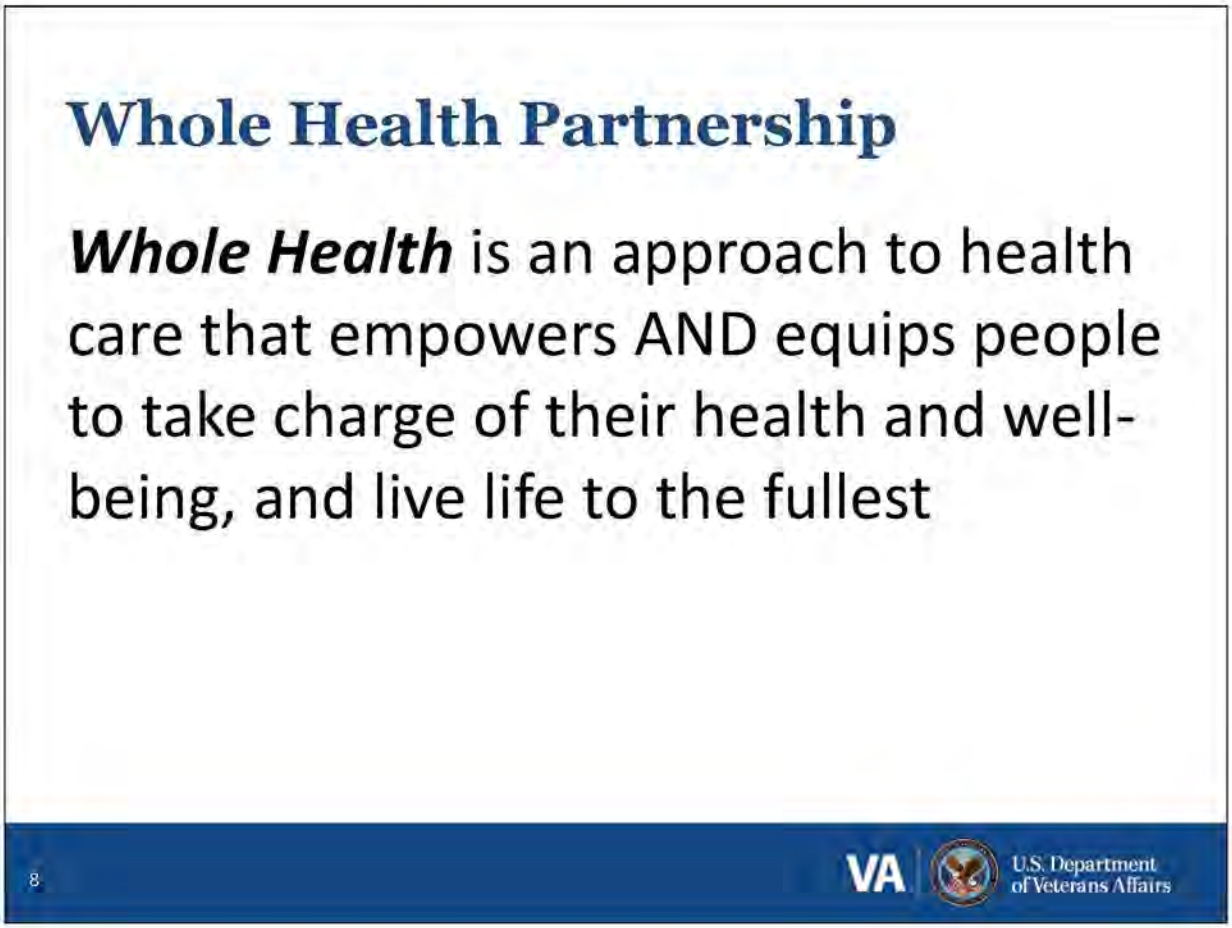

The Whole Health Partnership was developed by the Office of Patient Centered Care and Cultural Transformation (OPCC&CT) in collaboration with the Veteran Experience Committee (VEC) and endorsed by the National Leadership Council (NLC). In sum, the Whole Health Partnership is a systematic approach to provide whole health care early in the relationship between VA and the Veteran, emphasizing self-care in the larger context of well-being, and incorporating a full range of conventional and complementary and integrative health approaches. The Whole Health Partnership would move VA from focusing on episodic care to a more continuous engagement with the Veteran throughout his/her life. Additionally, the Whole Health Partnership model is the current vision for complementary and integrative health (CIH) integration in VA. The health care crisis in the United States has led to a call for transformation to a proactive model of care; VA has the opportunity to become the national leader in Whole Health care delivery and the Whole Health Partnership model is a roadmap to this paradigm shift.

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Whole Health System

The Human Element (empowers)

plus

Self Care (equips)

plus

Clinical Care (treats)

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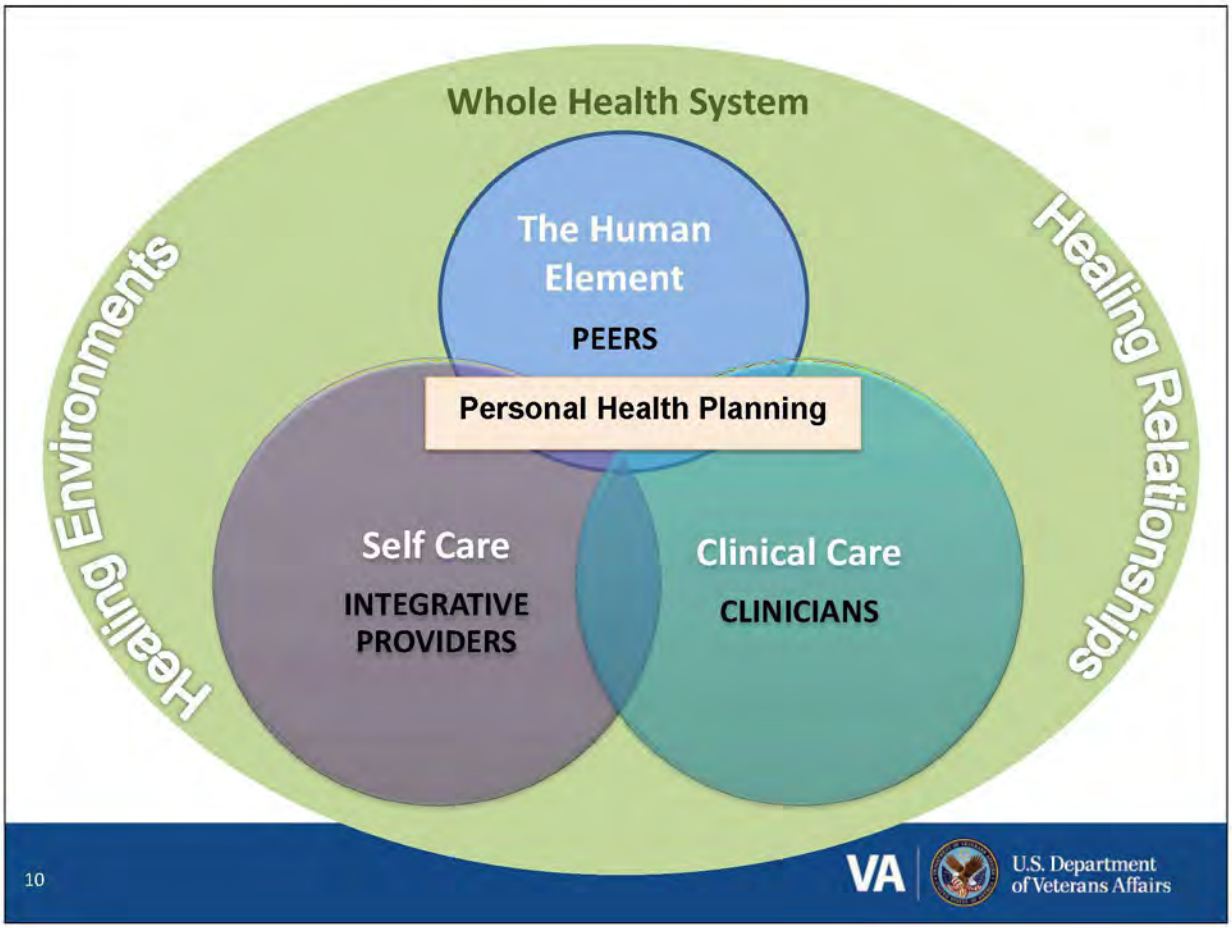

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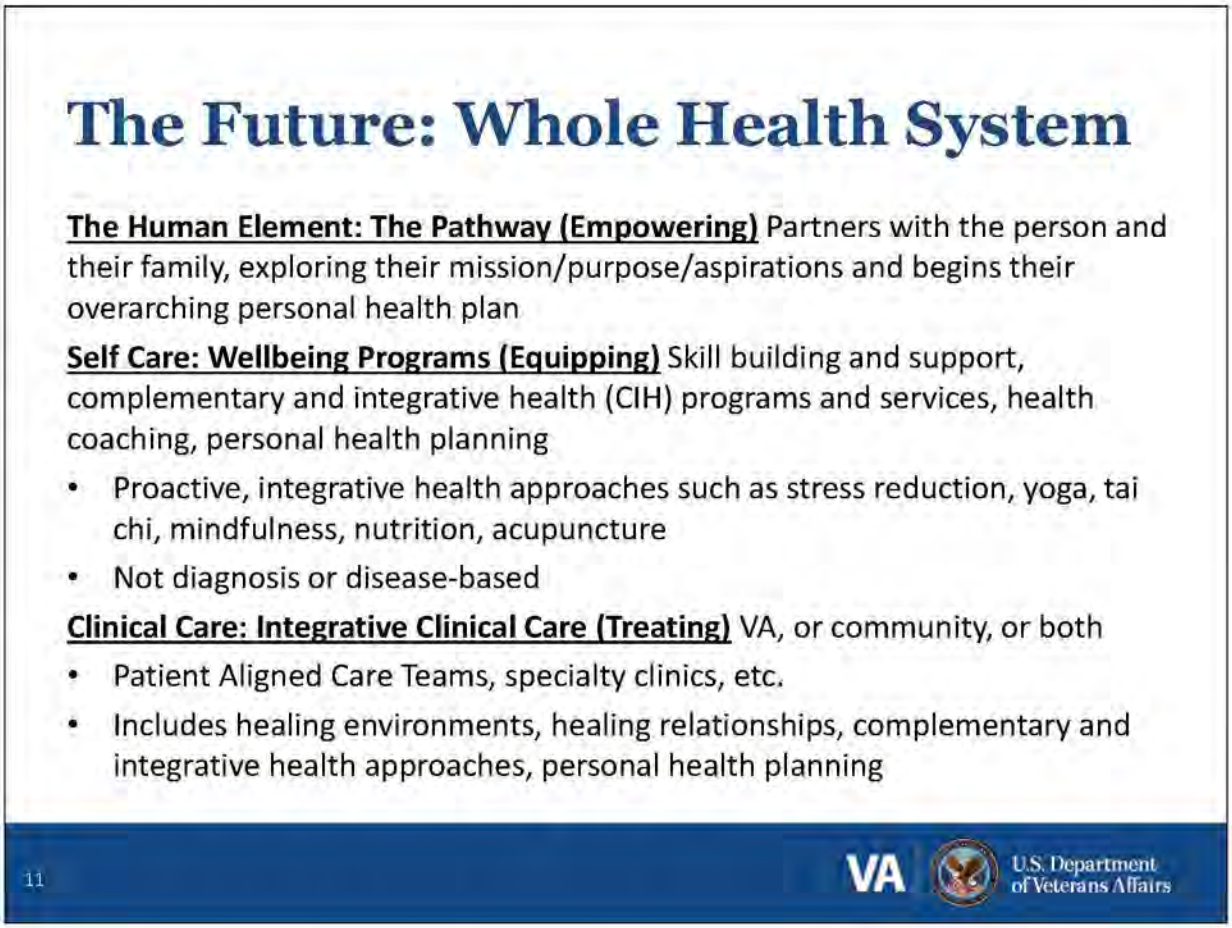

Whole Health Pathway: VA will partner with Veterans at the point of enrollment and create an overarching personal health plan that integrates care both in the VA and the community.

Wellbeing Centers: The core offering of CIH services, envisioned to be offered through Health and Wellbeing Centers, will be easily accessible to Veterans throughout the nation either within the VA setting or in the community. Not diagnosis or diseased based.

Medical Care: Clinical care will be provided in outpatient and inpatient settings which are attentive to healing environments and healing relationships and integrate holistic approaches into their treatment plans.

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Does It Really Matter to Start With What Really Matters?

- Study done by Hill, et al, N > **6,000**
- People who had a greater sense of purpose and direction in life were more likely to outlive their peers
- People with a sense of purpose had a **15%** lower risk of death compared to those who said they were aimless

And what happens if we intentionally link health care to this purpose?

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The Transformation Has Begun

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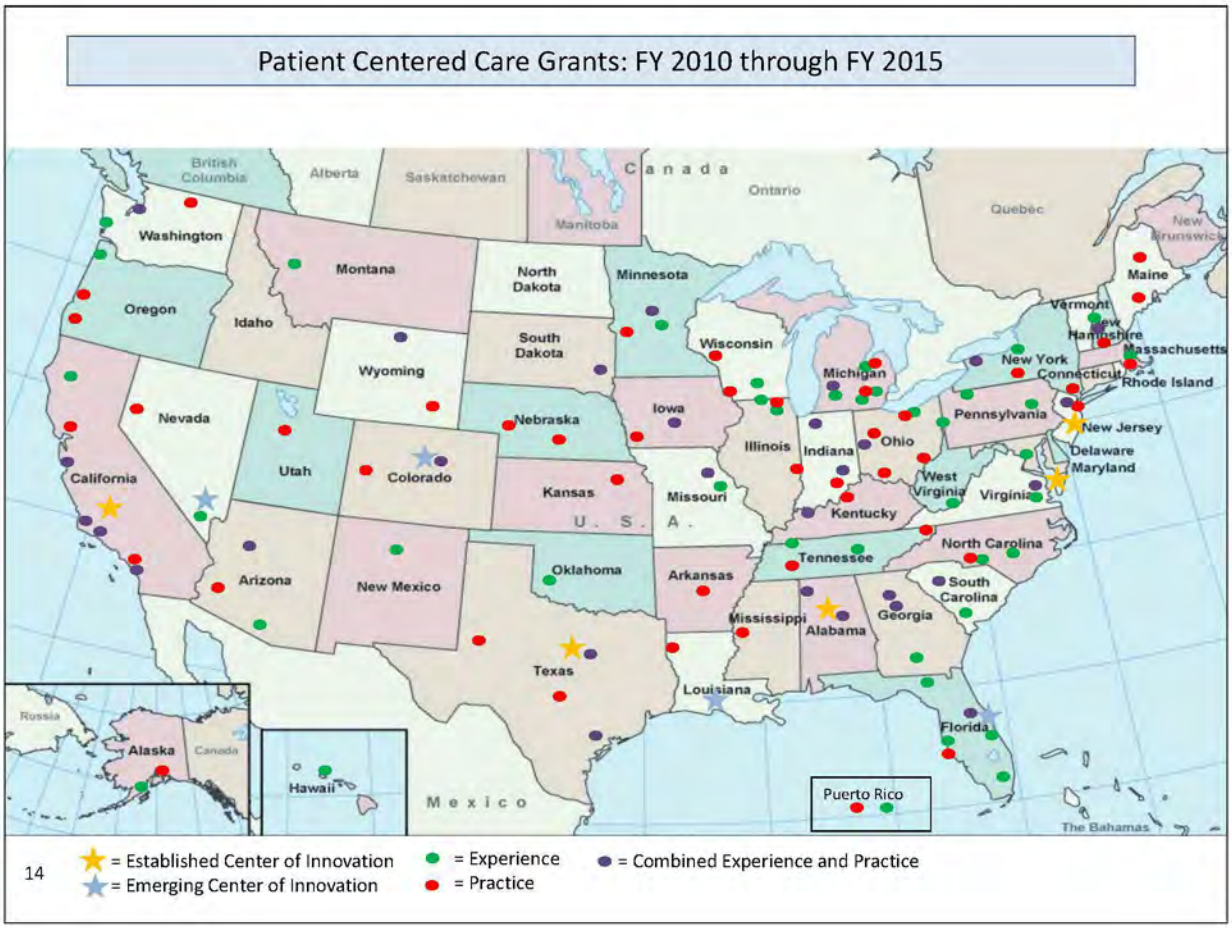

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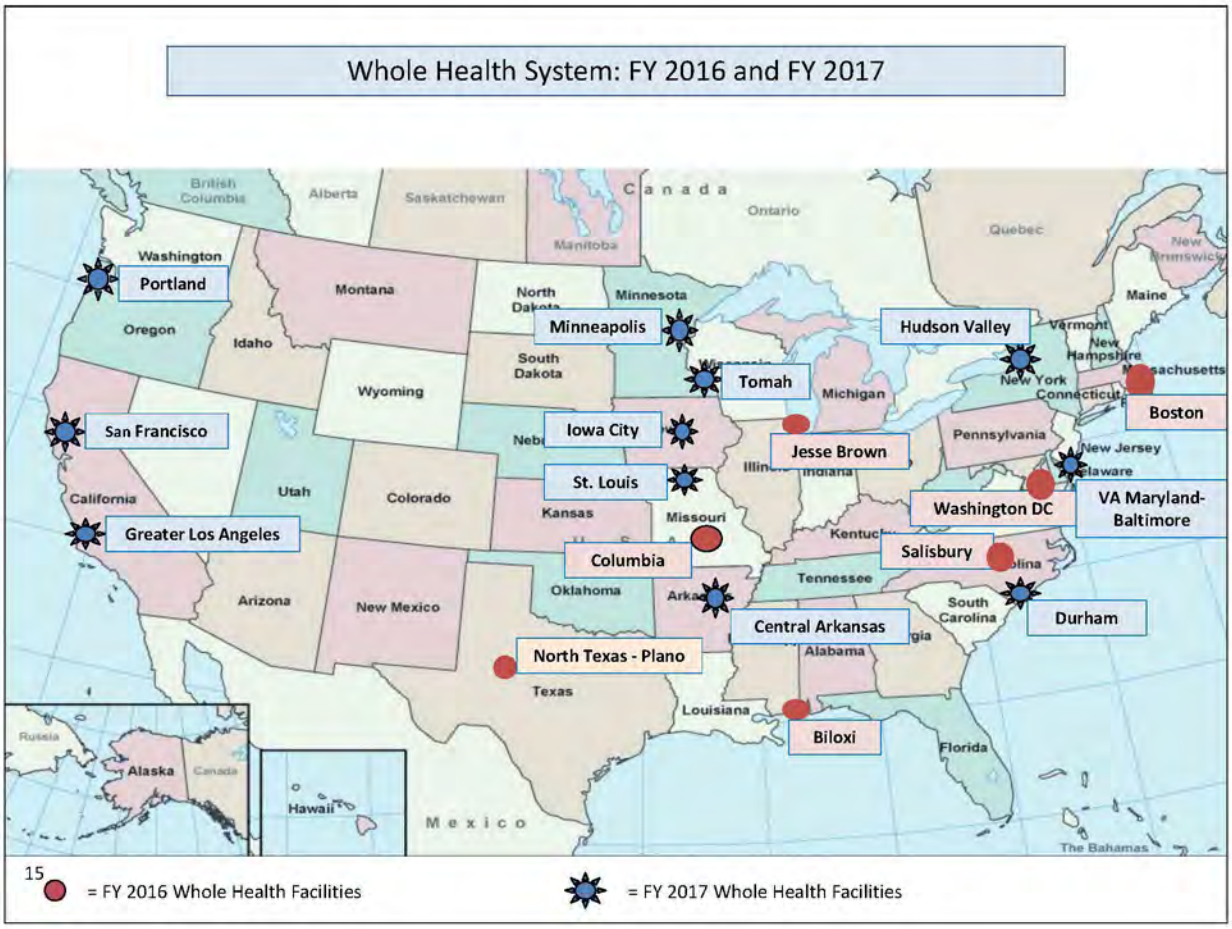

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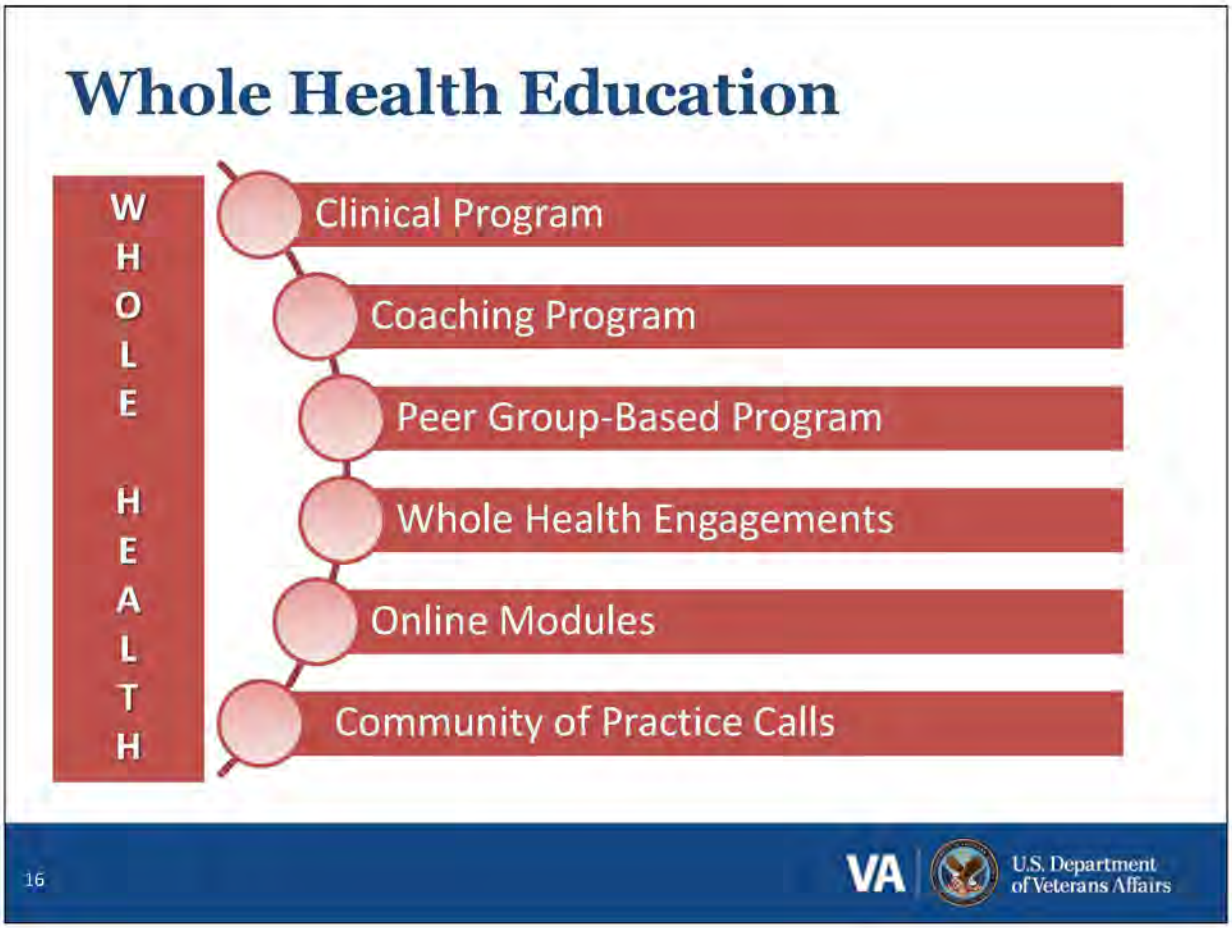

Whole Health Education Programs Nearly 2,000* VHA employees in Whole Health: 1,351 for the Whole Health Clinical Course, 646 for the Whole Health Coaching Course

47 total courses thru Feb. 2015: 16 sites have received clinical only, 5 sites have received coaching only, 26 sites have received both

68 by the end of FY 2015: 11 additional clinical courses, 2 centralized clinical trainings, 6 additional coaching courses, 2 centralized coaching trainings

Piloted the Whole Health Group-based Program at Little Rock, Denver, and Idaho Falls. The Program is led by Veteran peer, volunteer, or other non-clinical facilitators to provide Veteran participants the opportunity to receive education in improving their self-care behaviors to support their personal mission for life and health. 9-week program is designed around Components of Proactive Health and Well-being and uses the Personal Health Inventory. Participants clarify their own personal missions, aspirations and/or purpose; identify areas of health in which they would like to make behavior change(s); begin to create a personalized health plan that supports their mission; create goals and actions steps to optimize their health in service of their mission; and provide support to each other in achieving their goals.

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Strong Practice Toolkits



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Evidence Maps



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Research and Evaluation

- Lessons from the Field for Implementing PCC
- Compendium of VA Research Related to PCC
- Personal Health Inventory Analysis
- Whole Health Education Level 3&4 Evaluation
- Integrative Health Implementation
- Interactive Patient Care Evaluation
- PCC Metrics Project
- PRIMIER
- All Employee Survey
- Evaluation Toolkit



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All Whole Health courses evaluated by team of PhD researchers from Pacific Institute for Research and Evaluation. Completed levels 1-4 of Kirkpatrick's Levels for Training Evaluation.
With support from HSR&D, funded two QUERI teams to evaluate patient centered care strategies in 4 Centers of Innovation using scientific methods.

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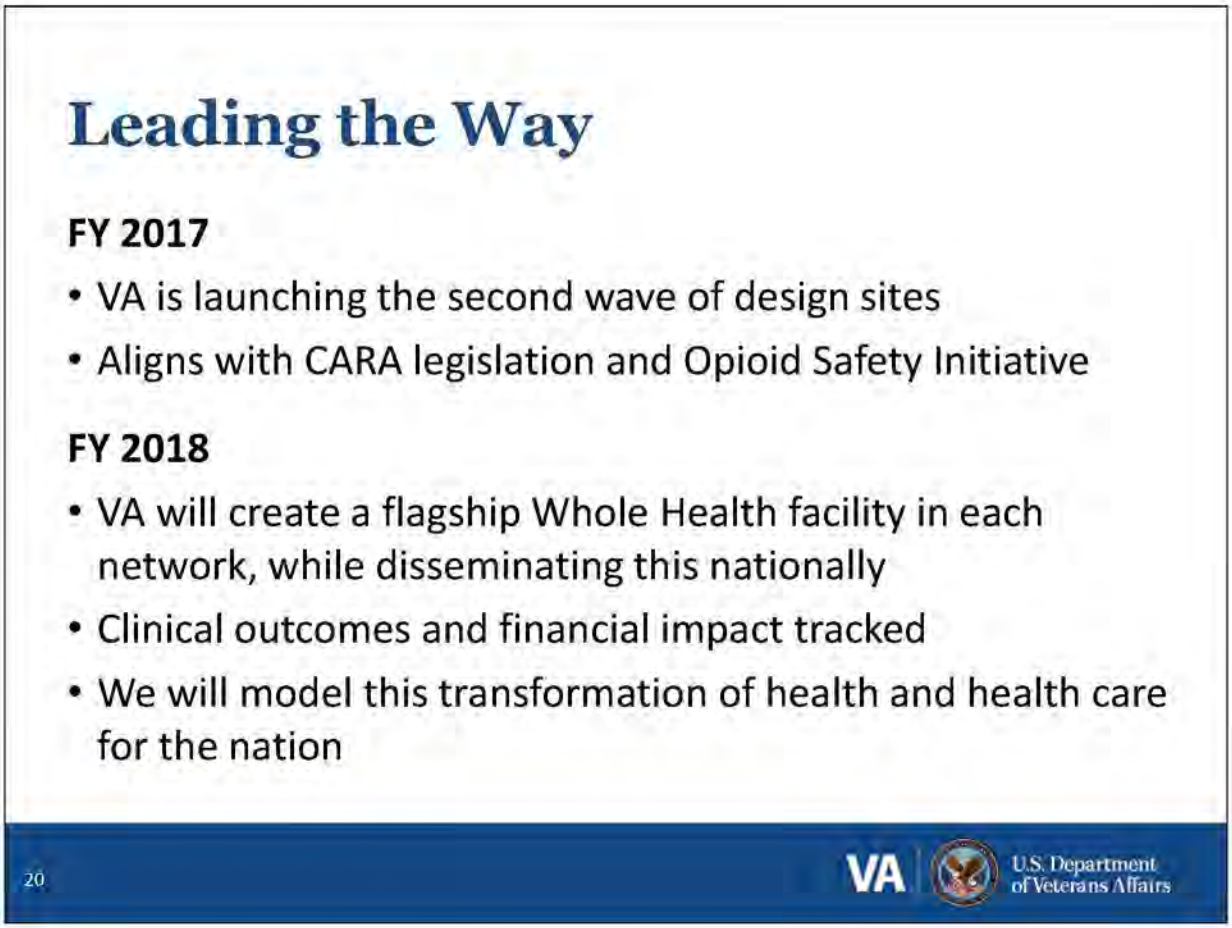

Our plan to move forward in implementation in bite-sized pieces is as follows:

CARA LEGISLATION:
Subtitle C—Complementary and Integrative Health (CIH)
Sec. 931 & 932. Expansion of research and education on and delivery of CIH to veterans.
Establishment of "Creating Options for Veterans' Expedited Recovery" Commission
Development of plan to expand research, education, and delivery of CIH to Veterans (within 180 days)
Sec. 933. Pilot program on integration of CIH and related issues for veterans and family members of Veterans.
To assess feasibility and advisability of using CIH and wellness-based programs to complement provision of pain management and related health care services, including mental health care services, to Veterans.
Start within 180 days of the plan/report developed by Commission
3 year pilot duration;
Minimum 15 geographically diverse sites; including at least two polytrauma rehab centers;
Within 30 months submit report to HVAC and SVAC
https://www.congress.gov/bill/114th-congress/senate-bill/524/text

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Conducted national Veteran Feedback Sessions as our new Internet site was developed and launched in FY 2014 with more than 500 visitors in the first full month, 9/14. Features downloadable education, resources, videos and podcasts to support Veterans in their journey to greater health and well-being.

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Good afternoon, everyone.

As we close out what has certainly been an informative and productive day, I want to again thank the Surgeon General and all of you for participating.

I know we will want to take some time to reflect on what we have learned today, and then determine our next steps.

One thing is clear to all of us: health care in America is ready for change.

Let's look at some of the reasons why.

Between 2000 and 2009, heart disease increased by 25 percent; diabetes by 32 percent; and strokes by 27 percent.

In most states, obesity is at or more than 40 percent.

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We spend more per capita on health care than any industrialized nation in the world, and yet our average life expectancy is no greater than countries that spend far less.

We spend more than $100 billion annually on treating heart disease, the number one killer of Americans.

But compared to medical treatment, at least 90 percent of all heart disease could be prevented by making some simple changes in lifestyle.

There is also a financial imperative for change in American health care.

Health care consumes 18 percent of our GNP, and it is projected to account for one-fifth of our economy by 2021.

Spending more is getting us less.

Taken together, these factors point strongly to the need to reassess how we deliver health care in this country.

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To be the provider of choice for our nation's Veterans, VA is creating an organization that puts Veterans in control of how, when, and where they are served to best achieve their goals.

We want to be a place Veterans are proud to call "My VA."

As part of that journey, we have been exploring what it takes to put the voice of the Veteran at the center of the practice and experience of health care.

We have heard overwhelmingly from Veterans that they want care that treats them as a whole person.

After all, no one knows better than Veterans themselves what they need to live life to the fullest.

We have the opportunity to redesign our health system to address both physical and emotional well-being.

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We meet a huge need, both for our Veterans, and for our nation.

As we know, the challenge is that the current approach to health care is a find-it, fix-it, diseased-based approach.

We do not have a core competency in engaging the whole person in optimizing their well-being.

VA's "whole health" model of care is a key component of our proposed future delivery system for Veterans.

This model incorporates physical care with psychosocial care focused on the Veteran's personal health and life goals.

It aims to provide personalized, proactive, patient-driven care through multidisciplinary teams.

VA has the opportunity—and the responsibility—to become the national leader in whole health care delivery.

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We are committed to this path, not only for VA, but for the nation.

We hope you are energized by today's discussion and ready to join us in this massive transformation of health care.

We in VA look forward to working with our partners to make our shared vision a reality for Veterans and all Americans.

Modern medicine starts with the body, rather than the soul, and the mind, rather than the heart.

The soul and heart are doorways to healing and health of body and mind.

Now we can design for this approach and lead the way.

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/7/2017 7:06:11 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Fwd: SG Talking points and agenda
Attachments: Advancing Emotional Well-being_conference materials.pdf; Untitled attachment 17320.htm; EWBAgendaDETAILED 1.5.17.docx; Untitled attachment 17323.htm; Shulkin-Emotional Well-Being Opening.010917.docx; Untitled attachment 17326.htm

Sent from my iPhone

Begin forwarded message:

From: "(b) (6) (b) (6) R." (b) (6) va.gov>
Date: January 7, 2017 at 1:45:18 PM EST
To: 'drshulkin' <drshulkin@aol.com>
Subject: SG Talking points and agenda

One more to follow

AMERICAN OVERSIGHT

ADVANCING EMOTIONAL WELL-BEING IN AMERICA

A joint convening of
The Office of the Surgeon General &
The Veterans Health Administration

AMERICAN OVERSIGHT

AGENDA

MONDAY, JANUARY 9

IBM
CTR FOR COGNITIVE GOVERNMENT
600 14TH STREET, NW
WASHINGTON, DC 20005

8:15am	Breakfast & Registration Please proceed to the 2nd floor and check in at security.

CREATING A NATIONAL AGENDA FOR EMOTIONAL WELL-BEING

9:00am	Welcome
9:10am	Perspectives The Honorable Dr. David Shulkin Under Secretary of Health Dr. Vivek Murthy U.S. Surgeon General
9:30am	Dr. Shulkin & Dr. Murthy In conversation
9:50am	Exercise: Social connection

DIALOGUE

Format: 3 brief "snapshots" by speakers will provide starting context. The discussion that follows each snapshot round will be focused on informing the national agenda. Discussions will be presided by Dr. Shulkin and Dr. Murthy.

SCIENCE SNAPSHOTS

10:00am	Spectrum of Stress (b) (6) [redacted] Prevention Science (b) (6) [redacted] Positive Psychology (b) (6) [redacted]
10:35am	Discussion
11:15am	Break

PRACTICE SNAPSHOTS

11:30am	Exercise: Contemplative practices
11:40am	EWB in the Military (b) (6) [redacted] EWB in Education (b) (6) [redacted] EWB in the Workplace (b) (6) [redacted]
12:15pm	Discussion
1:00pm	LUNCH & EWB Innovation Gallery Walk-Through
1:45pm	Exercise: Physical activity

SYSTEMS/POLICY SNAPSHOTS

1:50pm	EWB in Healthcare (b) (6) [redacted] EWB in Communities (b) (6) [redacted] ROI from EWB Interventions (b) (6) [redacted]
2:35pm	Discussion

NEXT STEPS

3:30pm	Exercise: Gratitude
3:40pm	Reflection & Next Steps Final remarks from Dr. Shulkin and Dr. Murthy
4:50 PM	Wrap-up
5:00 PM	Evening Reception, The Hamilton (downstairs)

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THE HONORABLE DR. DAVID SHULKIN
UNDER SECRETARY OF HEALTH, DEPARTMENT OF VETERANS AFFAIRS

The Honorable Dr. David J. Shulkin is Under Secretary of Health for the United States Department of Veterans Affairs. As the Chief Executive of VA Healthcare, Dr. Shulkin leads the nation's largest integrated health care system with over 1,700 sites of care, serving 8.76 million Veterans each year. The Veterans Health Administration is also the nation's largest provider of graduate medical education and major contributor of medical research. Dr. Shulkin has oversight over the system that employs over 325,000 people who work in VA Healthcare.



DR. VIVEK H. MURTHY
U.S. SURGEON GENERAL

Vivek Murthy, MD, MBA, is the 19th Surgeon General of the United States. Dr. Murthy is responsible for communicating the best available scientific information to the public regarding ways to improve personal and public health. He also oversees the operations of the U.S. Public Health Service Commissioned Corps, comprised of approximately 6,700 uniformed health officers who serve in nearly 800 locations around the world to promote, protect, and advance the health and safety of our nation and our world. Dr. Murthy has devoted himself to improving public health through the lens of service, clinical care, research, education and entrepreneurship.

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POONAM ALAIGH

Poonam Alaigh, MD, serves as the Senior Advisor for Healthcare Delivery, US Department of Veterans Affairs. She is a physician executive with deep expertise in healthcare policy and healthcare delivery. Prior to joining the VA, Dr. Alaigh was the Commissioner of Health and Senior Services for New Jersey where she had direct operational oversight and management of the Department of Health and Senior Services with a budget of $3.8B, and 1,600 employees. In addition, she was the Executive Medical Director at Horizon Blue Cross Blue Shield of New Jersey.

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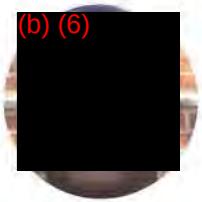

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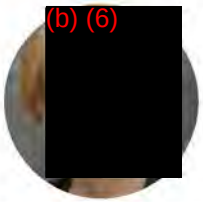

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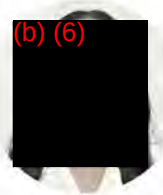

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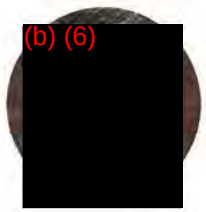

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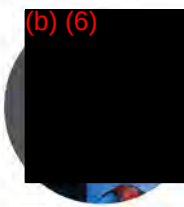

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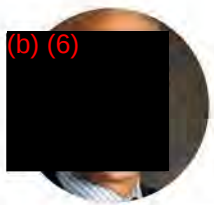
CAROLYN CLANCY

Carolyn M. Clancy, MD, serves as the Deputy Under Secretary for Health for Organizational Excellence of the Veterans Health Administration. Dr. Clancy is a nationally recognized physician executive and has oversight of VHA's performance, quality, safety, risk management, systems engineering, auditing, oversight, ethics and accreditation programs. She works collaboratively, leading the strategic direction of the Veterans Health Administration. In her current position she works closely with Department leaders as well as Veterans Service Organizations, Congress and their constituents addressing the immediate and long term needs of our Nation's Veterans.



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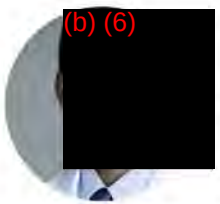

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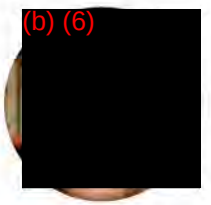

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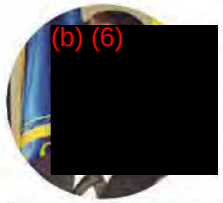

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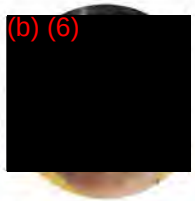

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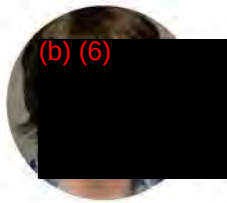

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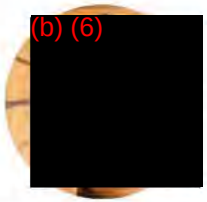

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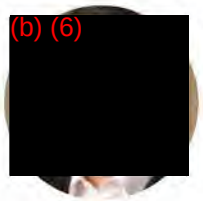

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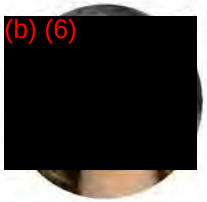

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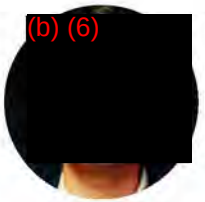

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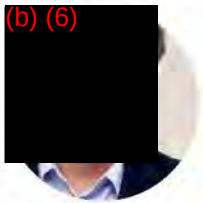

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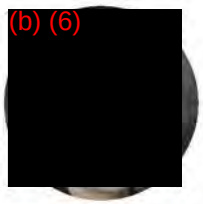

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TRACY GAUDET

Tracy Gaudet, MD, is the Director of Veterans Health Administration's Office of Patient-Centered Care and Cultural Transformation. The VA is transforming both the philosophy and practice of healthcare, and is designing and deploying an approach to health that empowers and equips Veterans to take charge of their health and wellbeing. Dr. Gaudet is internationally known as an expert in transforming health care from a traditional, disease-based model to this new 21st century model based on patient-centered care.

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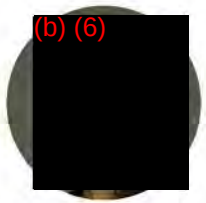
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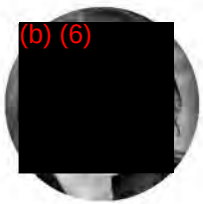
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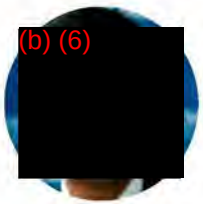
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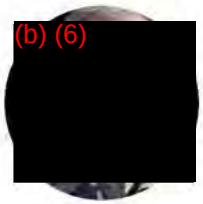

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JENNIFER LEE

Jennifer S. Lee, MD, serves as the Deputy Under Secretary for Health for Policy and Services, Veterans Health Administration. Dr. Lee provides guidance to the Under Secretary for Health on health care policy, strategic objectives, and policy requirements for legislatively mandated health care delivery programs.

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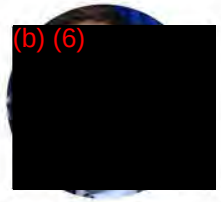
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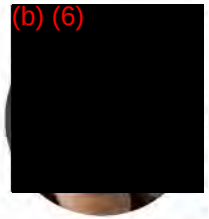
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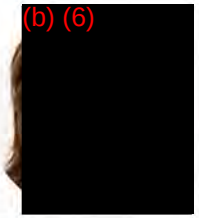
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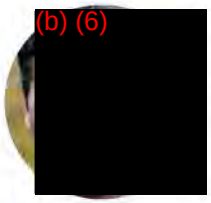
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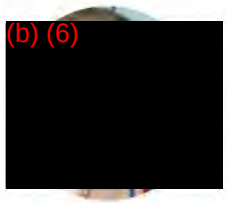
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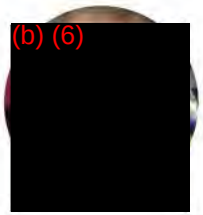
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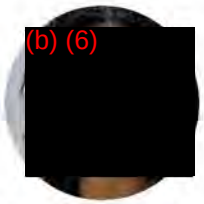

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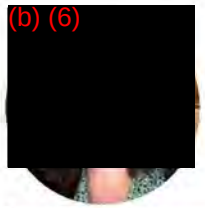

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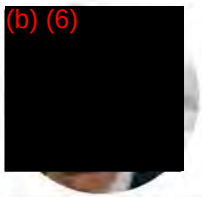

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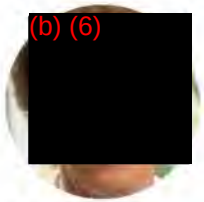

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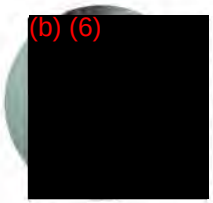

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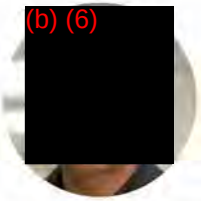

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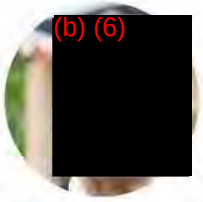

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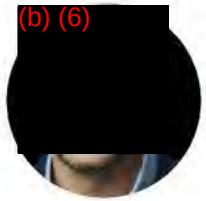

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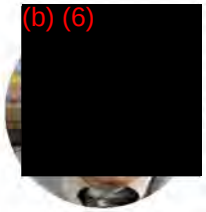

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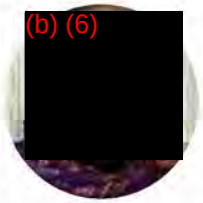

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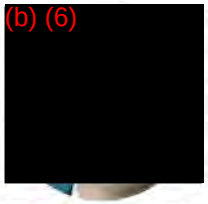

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SYLVIA TRENT-ADAMS

Rear Admiral (RADM) Sylvia Trent-Adams, PhD, RN, serves as Deputy Surgeon General, Office of the Surgeon General. She advises and supports the Surgeon General regarding operations of the US Public Health Service (USPHS) Commissioned Corps and in communicating the best available scientific information for the health of the nation. RADM Trent-Adams has held various positions in HHS, working to improve access to care for poor and underserved communities.



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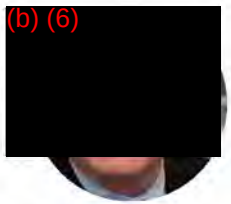

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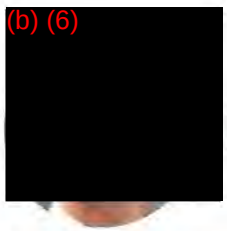

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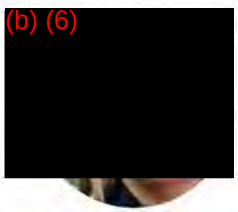

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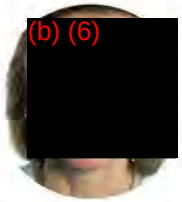
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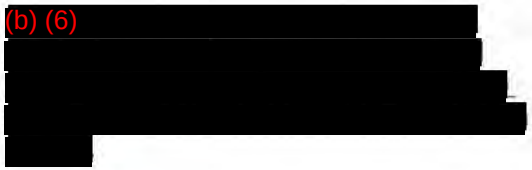
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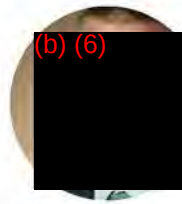
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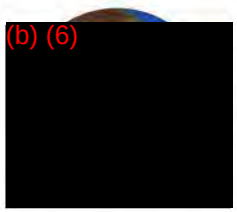
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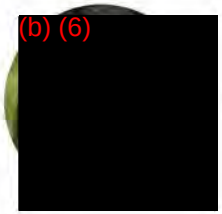
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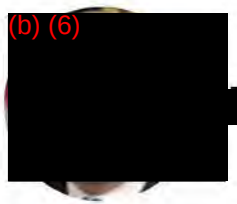
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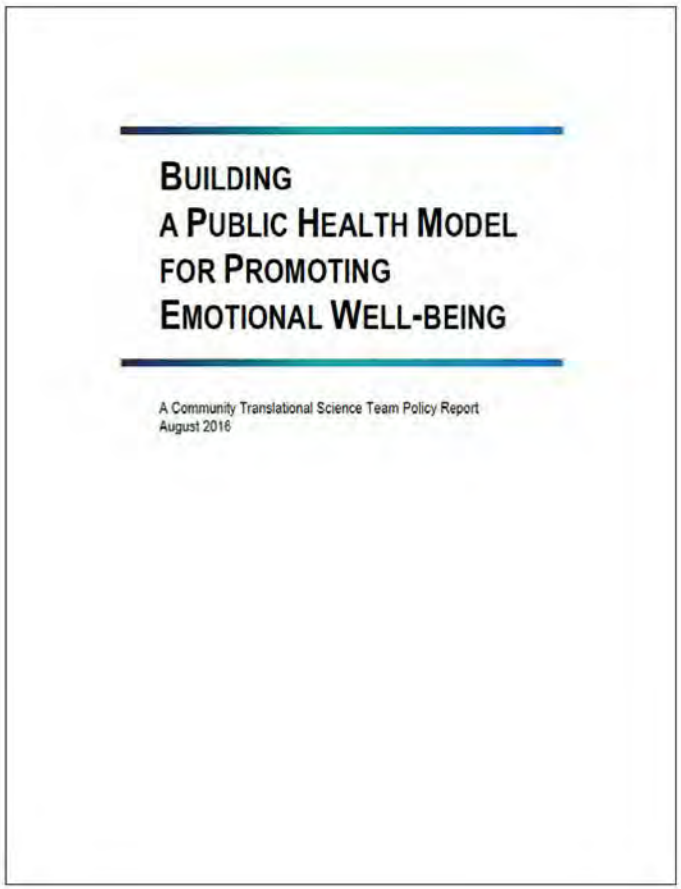

For background, please refer to this 2016 report by the Community Translational Science Team at University of California, Los Angeles.

Accessible via download:
https://drive.google.com/open?id=0B0Qx6PmTtFX4SEpwV3FfR1poZk0

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AMERICAN OVERSIGHT

Advancing Emotional Well-Being in America

A joint convening of the Office of the Surgeon General
& Veterans Health Administration

Agenda Draft v. 01.05.2017

TIME	PROGRAM	ASSETS
7:45 AM	**ARRIVAL TIME FOR STAFF**	
8:15 – 8:55AM	**BREAKFAST & REGISTRATION** Pick up name tags at the 2nd floor security desk.	Registration table Sign in sheets Name tags Sign for the convening. + Welcome sign (by elevator) + Welcome sign (by desk) + Welcome sign on the ground floor. Volunteer stationed on first level. Break Music
	ENVISIONING A EWB NATION (Create madlib sheets + sharpies = add on wall) What does an emotionally well nation look like? What are the way we reach optimal EWB? What types of progress would we make in science, policy, and practice?	Mad libs on tabloid Do the MadLib INSIDE (once they come through the desk). On Atrium wall. On glass wall.
	EWB GALLERY - SET UP Set-up, with walk-through at lunch	(Digital) IBM stations (Physical) Posters – VA From Gallery Participants: - Require laptops / tablet - Must bring own HDMI cord.

WELCOME & BIG-PICTURE FRAMING

8:55 AM (5 min)	**TRANSITION**	Cue with music (b) (6) [redacted] *Acknowledgement (7:42)*

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9:00 AM (7 min)	**WELCOME & OVERVIEW FOR THE DAY** ***Tracy Gaudet &*** (b) (6) *Set intention of the day. Come into conversation with each other about the future & EWB. Ground rules - social media and phones.* *A conversation of both head & heart focusing on the issue we are here to address/problem to solve*	Title Slide (Advancing EWB)
9:07 AM (1 min)	**BREATHING EXERCISE, SETTLE IN (1 MIN)**	Slides Lights OFF (or Dim)
9:08 AM (2 min)	**INTRODUCTION OF PRINCIPALS** ***Tracy Gaudet &*** (b) (6) Introduce Shulkin & Murthy Both come up and sit in	Slides Photos w/ Titles
9:10 AM (10 min)	**FRAMING REMARKS** ***VA Under Sec David Shulkin*** Add in topline messages from Shulkin. Dr. Shulkin will introduce Dr. Murthy and sit on stool at front while Dr. Murthy speaks in prep for Fireside Chat	Title Slide (Advancing EWB)
9:20 AM (10 min)	**FRAMING REMARKS** ***Dr. Murthy*** Broad picture of EWB Health equity Social determinants of health Add in topline messages from SG (b)	Cont'd: Title Slide (Advancing EWB)
9:30 AM (20 min)	**TRANSITION TO FIRESIDE** ***Tracy*** (b) (6) "Now we are moving into fireside." Confirm with SG/Shulkin if needed. **Shulkin & Murthy FIRESIDE CHAT** ***No questions from the audience.*** Dr. Murthy will start the fireside chat with questions and then it can be fluid conversation. **Potential Questions:** **Qs from SG:** - *We hear a lot about the challenges for vets. What*	Cont'd Title Slide (Advancing EWB)

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	have you learned in this position about EWB? - *What has the VA found?* - *Why is EWB important to the vet population?* - *How do you envision EWB being part of the future of the VA?* **Qs from Shulkin:** - *Why do you see this as a public health priority?* - *What have you seen in your travels around the country? Are there particular stories?* - *What would our country look like if EWB was a priority? What do you see?* - *How do we get there?* **Time keeper give 2 min warning** (b) (6)	
9:50 AM (10 min)	(b) (6) /Tracy - we want to experience of EWB for ourselves; first tool - social connection. For this exercise, we will have (b) (6) lead this exercise. **INTERSTL 1 Science + EWB Exercise** **THEME EMPATHY & SOCIAL CONNECTION** Use subset of The 36 Questions That Lead to Love http://nyti.ms/14BZ9Mf -- slides *** POSSIBLY SWAP WITH CONTEMPLATIVE *** LED BY (b) (6) Segue into the next activity.	SLIDE: Empathy & Social Connection Photos + titles for speakers AK Design the "Fortune Cookie" with questions 1 pair (instead of speed dating). Try out and time at OSG.

PART II: SCIENCE SNAPSHOTS

10:00 AM (5 min)	**FRAMING (5 min)** *Tracy* (b) (6) - Hearing 3 snapshots, curated to catalyze thinking around the science. - These snapshots will help frame the conversation that follows, in a forum that supports deep dialogue. - Introduce speakers and remind the group of the issues we are here to address	SLIDE: SNAPSHOT ONE: SCIENCE (b) (6), TO GATHER SPEAKERS

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10:05 AM (10 min)	TOPIC Neuroscience/Biology SPEAKER (b) (6) *University of Miami*	SLIDE: (b) intro slide (photo, name & title, talk title) + speaker slides TIMER: 8 min
10:15 AM (10 min)	TOPIC Prevention science SPEAKER (b) (6)	SLIDE: (b) intro slide (photo, name & title, talk title) + speaker slides TIMER: 8 min
10:25 AM (10 min)	TOPIC Positive psychology SPEAKER (b) (6)	SLIDE: (b) intro slide (photo, name & title, talk title) + speaker slides TIMER: 8 min
10:35 AM (40 min) 3 min

	we integrate positive psychology and prevention science? - What are the opportunities (and challenges/barriers) to bring interventions to scale? - Integration into the national agenda is a key step towards moving science forward. *What are other ways we can move the current science forward?* (b) (6) INTROS BREAK: bathroom	
11:15 (15 min - but tell people it's 10!)	**BREAK** * Possibly swap with interstitial above if audience is need of break earlier. **At 11:25, cue return with music.**	SLIDE: Break Break Music
11:25AM	**TRANSITION BACK**	Cue with Music *Bobby McFerrin - Don't Worry Be Happy (4:51)*

PART II: PRACTICE SNAPSHOTS

11:30 AM (10 min)	TRACY will introduce Exercise **INTERSTL 2 Science + EWB exercise (10 min)** **THEME CONTEMPLATIVE PRACTICES** Mindfulness Based Stress Reduction - Evidence-based (b) (6)	Cont'd Title Slide (Advancing EWB) SLIDE: Contemplative Practices Photos + titles for speakers
11:40 AM (5 min)	**FRAMING (5 min)** (b) (6) - Hearing 3 snapshots, curated to catalyze thinking around practice. - These snapshots will help frame the conversation that follows, in a forum that supports deep dialogue. - Introduce speakers and remind the group of the issues we are here to address	SLIDE: SNAPSHOT 2: EWB IN PRACTICE
11:45 AM (10 min)	TOPIC **EWB in the Military and among Veterans**	SLIDE:

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	SPEAKER	*Lieutenant General Eric B. Schoomaker*	Speaker intro slide (photo, name & title, talk title) + speaker talk slides TIMER: 8 min
11:55 AM (10 min)	TOPIC SPEAKER	EWB in Education / Schools (b) (6)	SLIDE: Speaker intro slide (photo, name & title, talk title) + speaker talk slides TIMER: 8 min
12:05 PM (10 min)	TOPIC SPEAKER	EWB in the Workplace/Corporate (b) (6)	SLIDE: Speaker intro slide (photo, name & title, talk title) + speaker talk slides TIMER: 8 min
12:15 PM (40 min) 3 min 37min	TRACY WILL INTRO DISCUSSION DISCUSSION PRACTICE Forward (45 min) FRAMING *Shulkin* POTENTIAL QUESTIONS FOR FRAMING (Will be on slide) - What are the institutions where we need to see EWB in practice? And what would that look like? - What are the common elements across practice settings that enable success? - What are the barriers and how might we overcome them? - What are the broader opportunities in this space? - How might we get employers to see the value in investing in EWB in the workforce? - What community approaches are needed? FACILITATOR *Carolyn Clancy*	SLIDE: SNAPSHOT 2: EWB IN PRACTICE SLIDE: QUESTIONS FOR DISCUSSION
12:55 (1 min)	(b) (6) /TRACY **TRANSITION TO LUNCH** Lunch outside. Come back when the bell rings.	

LUNCH

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12:55 PM (50 min)	**GALLERY WALK THROUGH + LUNCH** Ideally, the gallery stations can be independent. If contributors want to stay by their stations, that's great. If not, they can simply mingle. * Note: The extra time for lunch here gives us some buffer should the morning program run over time.	SLIDE: LUNCH Break Music

PART II (cont'd): SYSTEMS / POLICY SNAPSHOTS

1:40 PM	**TRANSITION**	Cue with Music *Beatles - Here Comes the Sun (3:06)* Katrina and the Waves- Walking on Sunshine (3:58) Ushers help get people back in the room
1:45 PM (5 min)	(b) (6) INTROS HERSELF **INTERSTL 3 EWB EXERCISE** **THEME CHANGING YOUR STATE THROUGH PHYSICAL ACTIVITY** Some type of activity that has been shown to alter mood? Music & Dance oriented (3 to 4 moves). If there is no story to go with this, will adjust as 5 min activity. Animals + colors; birthdays LED BY (b) (6)	SLIDE: Changing your state through Physical Activity + Music *Pharrell - Happy (3:53)*
1:50 PM (5 min)	(b) (6) /SHAVON INTROS **FRAMING (5 min)** *Tracy* (b) - Hearing 3 snapshots, curated to catalyze thinking around practice. - These snapshots will help frame the conversation that follows, in a forum that supports deep dialogue. - Introduce speakers and remind the group of the	SLIDE: SNAPSHOT 3: REIMAGINING SYSTEMS THROUGH POLICY

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	issues we are here to address		
1:55 PM (10 min)	TOPIC	EWB x healthcare (lifestyle intervention *in prevention and treatment; shown through evidence and support of Medicare + other plan). Pillars of culture of prevention. EWB = stress reduction & social connection.*	SLIDE: Speaker intro slide (photo, name & title, talk title) + speaker talk slides TIMER: 8 min
	SPEAKER	(b) (6)	
2:05 PM (10 min)	TOPIC	EWB x environments "total wealth" (natural, economic, social and human capital)	SLIDE: Speaker intro slide (photo, name & title, talk title) + speaker talk slides TIMER: 8 min
	SPEAKER	(b) (6)	
2:15 PM (10 min)	TOPIC	ROI in EWB interventions, incl criminal Justice	SLIDE: (b) intro slide (photo, name & title, talk title) + speaker talk slides TIMER: 8 min
	SPEAKER	(b) (6), *Washington State Institute for Public Policy (confirmed)*	
2:35 PM (45 min) 3 min 37 min	TRACY INTROS AND LEADS DISCUSSION SYSTEMS THROUGH POLICY FRAMING *Tracy* FACILITATOR *Tracy* + (b) (6) QUESTIONS (to be projected on screen) - What are the specific challenges and opportunities for EWB at the systems level? - How might we transform systems to support EWB? - How might we incentivize systems to integrate EWB? How might we make the case to stakeholders, including policy makers?		SLIDE: SYSTEMS THROUGH POLICY SLIDE: Questions for discussion
3:15 PM (10 min)	**TRACY -** (b) **BREAK** **Team help** (b) **move innovation stations**		SLIDE: Break (10 min) Put Gratitude exercise cards on every chair

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PART III: REFLECTION & NEXT STEPS

3:25 PM (5 min)	**TRANSITION**	Cue Music *Leslie Odom Jr - My Favorite Things (5:50)*
3:30 PM (10 min)	(b) (6) /TRACY **INTERSTL 4 STORY + EWB EXERCISE** **THEME GRATITUDE EXERCISE** LED BY (b) (6)	SLIDE: EWB Exercise Check with Richie - need cards? Gratitude exercise cards should be on every chair
3:40 PM (50 min) 10 min Short reflection 3 min 42 min	?TRANSITION PERSON? GROUP REFLECTION + NEXT STEPS FACILITATOR *SG* *(Ann, Shavon, others open to helping with facilitation)* How people are feeling, etc.? Refine with SG. VIDEO (TBD) *Short video sharing selection of madlibs completed in the morning. Would be a nice way to book end, and tie back to the ideas people came into the room with. Will do this if the madlibs are good – Incorporate 'audacious goal' question into madlib.* KEY QUESTIONS to DRIVE DISCUSSION ROADMAP - Defining EWB (talking as emotional fitness? as emotional well-being? etc) - What do they think the most important discussion points/themes/breakthrough from our day together. - Based on that, what should our big audacious goal be for EWB? - What are the key next steps?	SLIDE: Reflection & Next Steps Make during lunch Slide on screen
4:30 PM (20 min)	**SUMMARY STATEMENTS** *Ideally this would be less time, especially if Shulkin & SG are active in the discussion*	

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	Nothing formal – brief remarks. Dr. Murthy will signal Dr. Shulkin to make final comments and Dr. Murthy will close. *Under Secretary David Shulkin, Veterans Health Administration (5 min)* *VADM Vivek H. Murthy, Office of the Surgeon General (5 min)*	
4:50 PM (3 min)	TRACY & (b) (6) Final note: feedback card (1 min + 4 min fill-out) Direction towards evening reception (2 min)	SLIDE: Thank you with logos of partners?
4:53PM (7 min) 5:00PM	Final Thank You to Partners (b) (6) **TRANSITION**	 Cue Music *Bob Marley - Three Little Birds (3:00)* *Beatles - All You Need is Love (3:47)*

5:00 PM (1hr)	**EVENING RECEPTION** Hamilton	
6:00PM	Final exit out of Building	

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DRAFT 1
Under Secretary for Health David J. Shulkin, M.D.
Emotional Well-Being Opening
January 9, 2017

Good morning, everyone.

It is my great pleasure to join our nation's distinguished Surgeon General in leading this important discussion.

Today, we will take the first steps on the path toward achieving our shared vision of making emotional well-being a pillar of health in America.

First, my sincere thanks to Dr. Vivek Murthy for co-hosting with me today.

I would like to thank Dr. Tracy Gaudet, Dr. (b) (6) [redacted], and the teams from VA and the Surgeon General's Office for organizing this gathering.

I would also like to thank the thought leaders from the science, policy, and practice sectors who are here to share valuable experiences and insight.

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I realize you are contributing your time and expertise, and for that, I thank you.

The National Academy of Medicine—formerly the Institute of Medicine—as well as the Institute for Healthcare Improvement, have led the medical community in calling for a radical redesign of health care.

Most experts agree that we need to shift our focus from disease-driven health care to a more holistic approach.

The main challenge we face is that most physicians have been trained to treat the disease, not the person.

At VA, we are moving from "sick care" to "whole health care" by transitioning to a model that focuses on the person, prevention, and "well-being."

We are committed to providing health care for Veterans that is high-quality, evidence-based, and increasingly personalized.

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We have adopted non-traditional approaches, most notably care that is delivered by multidisciplinary teams and responsive to the needs of our patients.

We are committed to a "whole health" model of care that is personalized, proactive, and patient-driven.

VA is transforming our health system to start with the person rather than the disease, to partner with the Veteran to fully explore what they value, and then align their health care with those values.

At the core of this approach is mindful awareness—the opportunity for Veterans to explore their sense of meaning, aspiration, and purpose in life, and then build their health care in support of this.

That is a radical departure from the traditional medical model, and it is founded in emotional well-being.

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To make this transformation a reality, our first step is to educate both VA employees and Veterans.

The next step is to bring a patient-centered approach to the care of every Veteran who enters our doors.

Whole health is an approach to health care that empowers and equips patients to take charge of their own health and well-being, and live life to the fullest.

VA's Whole Health System is a systematic approach to providing whole health care early in the relationship between VA and the Veteran.

It starts with an exploration of what matters most to that person, emphasizes self-care in the context of well-being, and incorporates a full range of conventional and complementary and integrative health services.

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Our Whole Health System will move VA from a practice of episodic care to a true partnership across time, focused on helping Veterans live their fullest lives.

VA will partner with the Veteran at the point of enrollment in our health system, and create an overarching personal health plan that is founded in what they want their health for, and integrates care both in VA and the community.

Central to this approach are well-being programs, where Veterans can learn new skills and have the support they need to address their emotional and physical well-being.

Classes such as mindfulness, meditation, yoga, tai chi, nutrition, and movement will be offered.

These well-being programs will be easily accessible to Veterans throughout the country, either in VA or the community.

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This will be synergistic with clinical care, and provided in settings that are attentive to healing environments and relationships, and integrate holistic approaches into treatment plans.

VA draws its mission from President Lincoln's Second Inaugural Address—he charged our nation with caring for those "who shall have borne the battle," and their families.

But because we are the nation's largest integrated health system, and do not carry out our mission alone, what we do now will help set the course of American health care for decades to come.

We have an opportunity to improve care by modeling a system that:

- Leverages evidence-based, team-based, and patient-centric approaches to care.

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- Emphasizes physical and emotional well-being, not just disease management.
- Uses technology and innovation to continuously improve outcomes, and metrics to continuously monitor and improve performance.
- Welcomes new and complementary approaches such as meditation, tai chi, yoga, and health coaching based in integrative medicine.

The VA medical center in Fayetteville, North Carolina, is a national leader in training and using Whole Health Coaches to help Veterans address their emotional well-being and make lifestyle choices that correlate with good health.

Initially focusing this effort on homeless Veterans, the medical center saw the remarkable impact coaching had on their lives and health, and moved to integrate coaching into their care teams.

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This is just one example of how VA is moving rapidly from reactive disease management to proactive health care—it is health care for the 21st century.

VA's changing model of health care is not about creating a "new" system, but shaping the "right" system for Veterans.

VA has another opportunity—and a responsibility—before us.

We can share our vision, knowledge, experience, and achievements to help frame and contribute to the evolving paradigm of health care in America.

That is what brings us here today.

Now, it gives me great pleasure to introduce our next speaker.

Vice Admiral Vivek Murthy was confirmed as the 19th U.S. Surgeon General on December 15, 2014.

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As "America's Doctor," he is responsible for communicating the best available information to the public on improving personal and public health.

Dr. Murthy also oversees operations of the U.S. Public Health Service Commissioned Corps, comprised of 6,700 uniformed health officers who promote, protect, and advance the health and safety of our nation.

For the past two decades, he has devoted himself to improving public health through the lenses of service, clinical care, research, education, and entrepreneurship.

Please join me in giving a warm welcome to our nation's Surgeon General, Dr. Vivek Murthy.

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/7/2017 7:02:41 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Fwd: SG Talking points and agenda
Attachments: Shulkin-Emotional Well-Being.010917.pptx; Untitled attachment 17331.htm; Shulkin-Emotional Well-Being Closing.010917.docx; Untitled attachment 17334.htm

Sent from my iPhone

Begin forwarded message:

> **From:** "(b) (6) (b) (6) R." <(b) (6) va.gov>
> **Date:** January 7, 2017 at 1:47:21 PM EST
> **To:** 'drshulkin' <drshulkin@aol.com>
> **Subject: RE: SG Talking points and agenda**
>
> Closing remarks here.
>
> -----Original Message-----
> **From:** (b) (6)
> **Sent:** Saturday, January 07, 2017 01:45 PM Eastern Standard Time
> **To:** 'drshulkin'
> **Subject:** SG Talking points and agenda
>
> One more to follow

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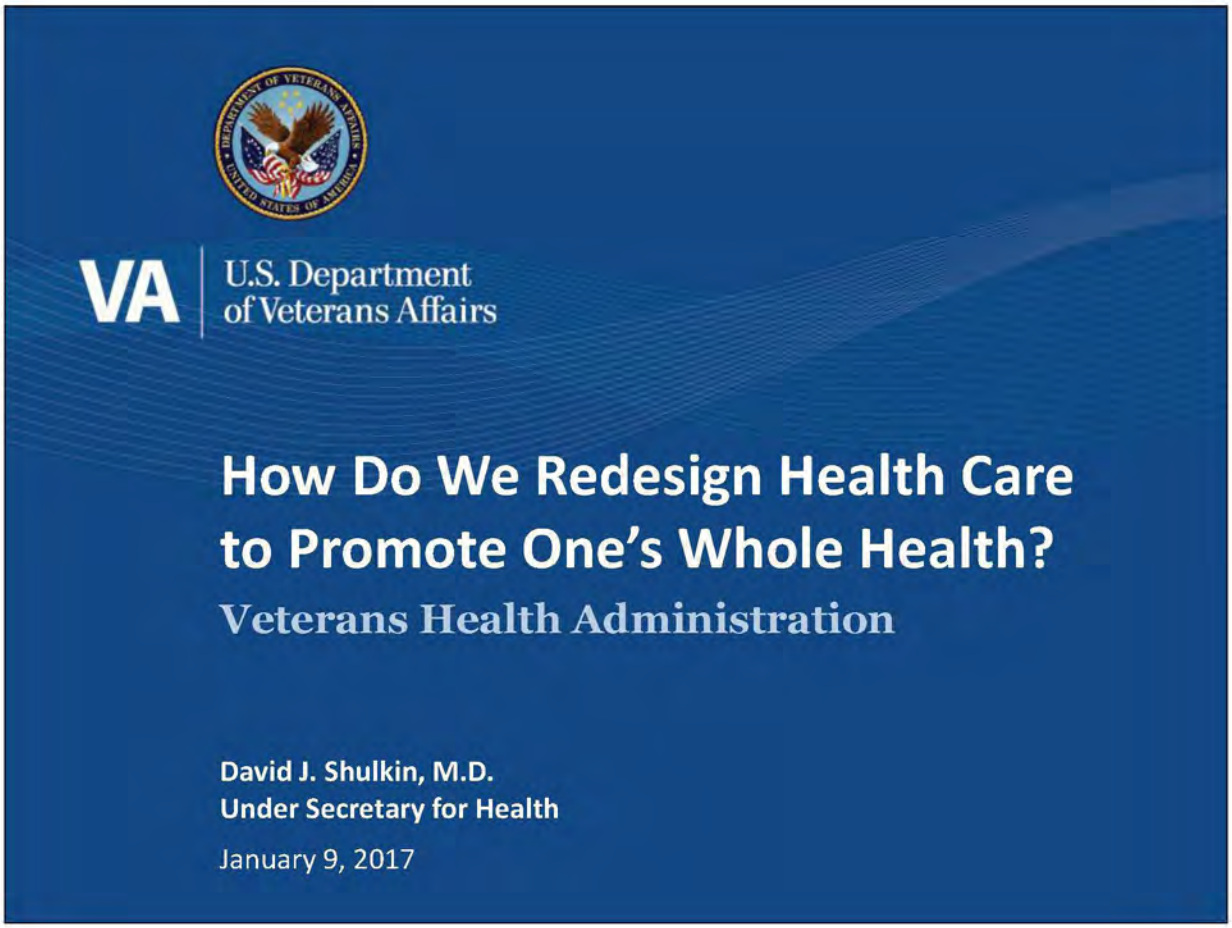

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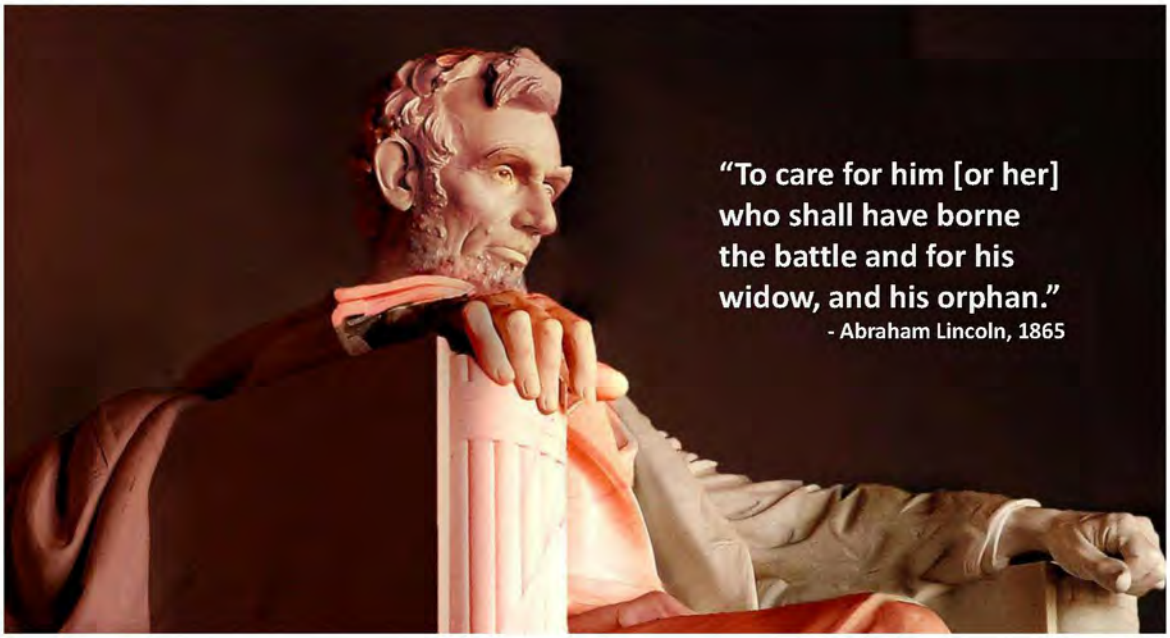
Fulfilling Our Mission



VA | U.S. Department of Veterans Affairs

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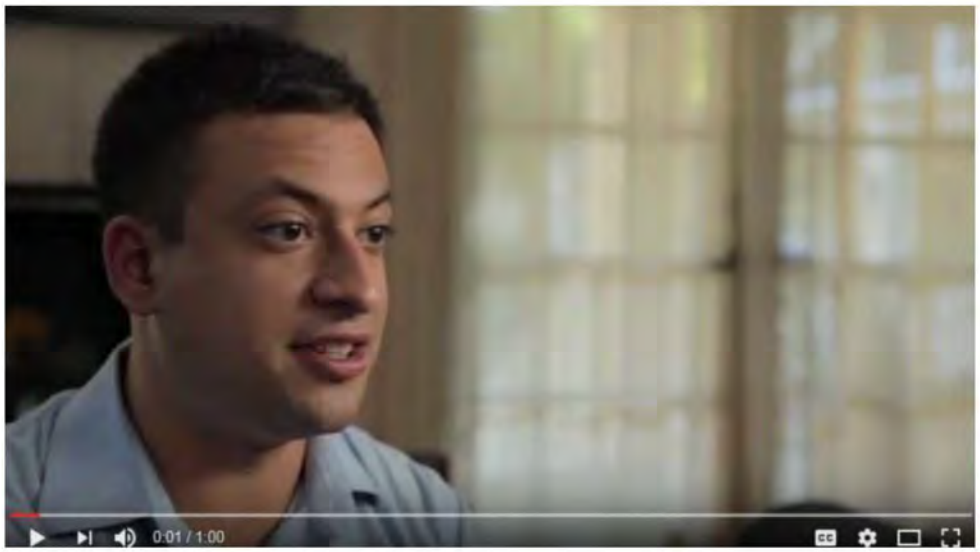
In Their Own Words



VA U.S. Department of Veterans Affairs

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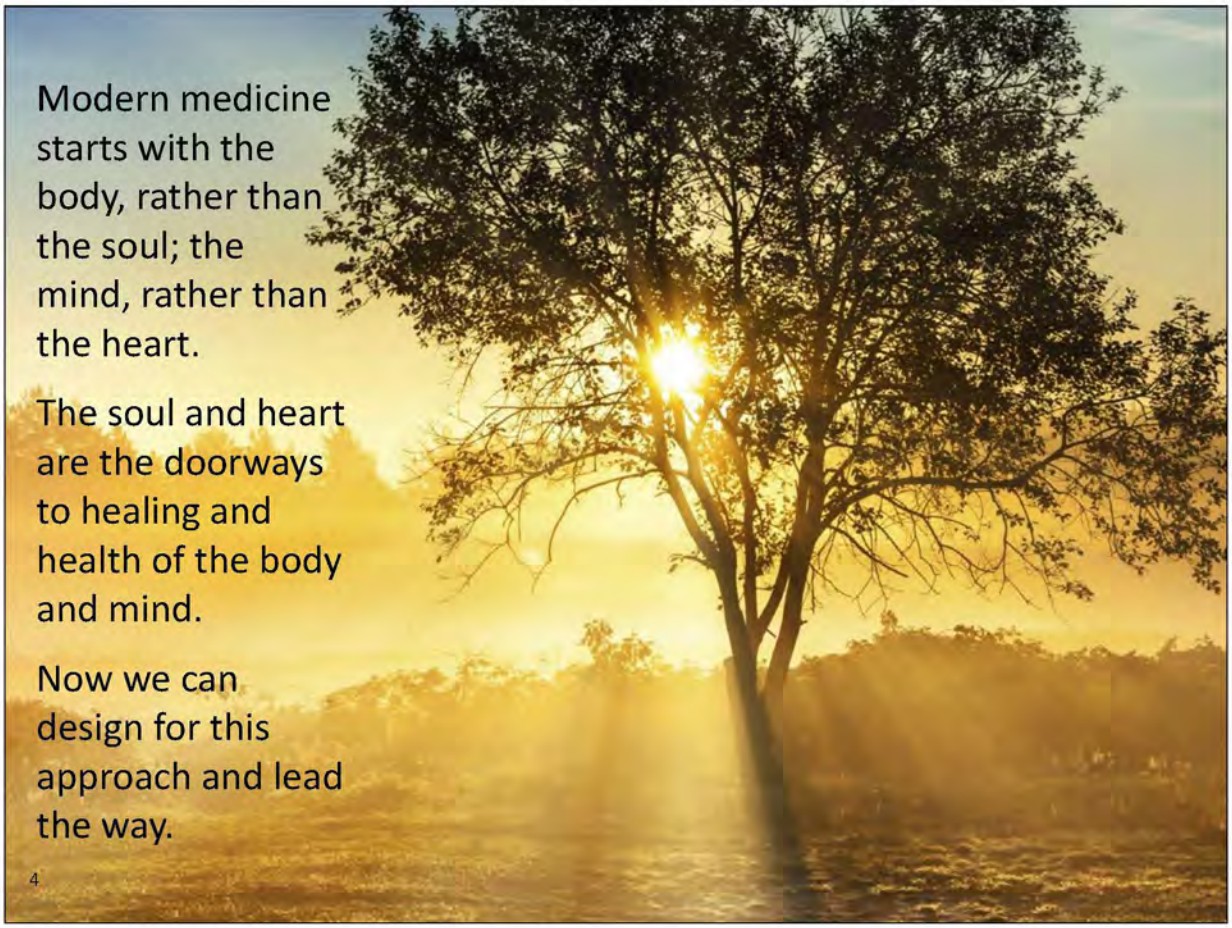

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Redesign of Health Care

What does this redesign of health care look like when we start with the person rather than the disease, when we start with what matters to the person, not what is the matter?

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Our Opportunity

- **Opportunity** – to redesign our health system to address emotional well-being as well as physical well-being
- **We meet a huge need** – for our Veterans, and for our Nation
- **Challenge** – the current approach to health care is a find-it, fix-it, disease-based approach; we do not have a core competency in engaging the whole person in optimizing their well-being

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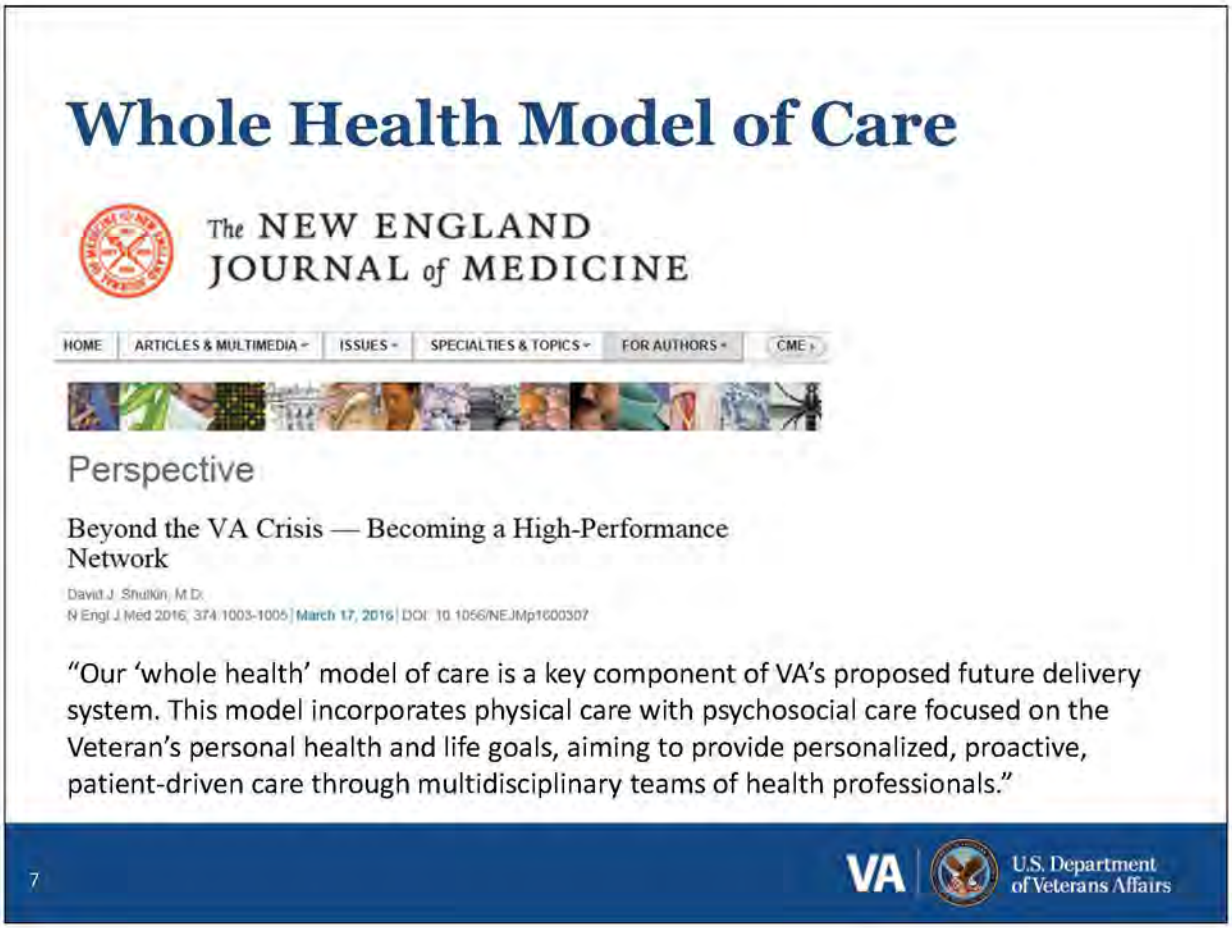

Starting with the VHA Strategic Plan, and including the Blueprint for Excellence and this recent article in the NEJM, VHA is talking about WH as the future model of VA care.

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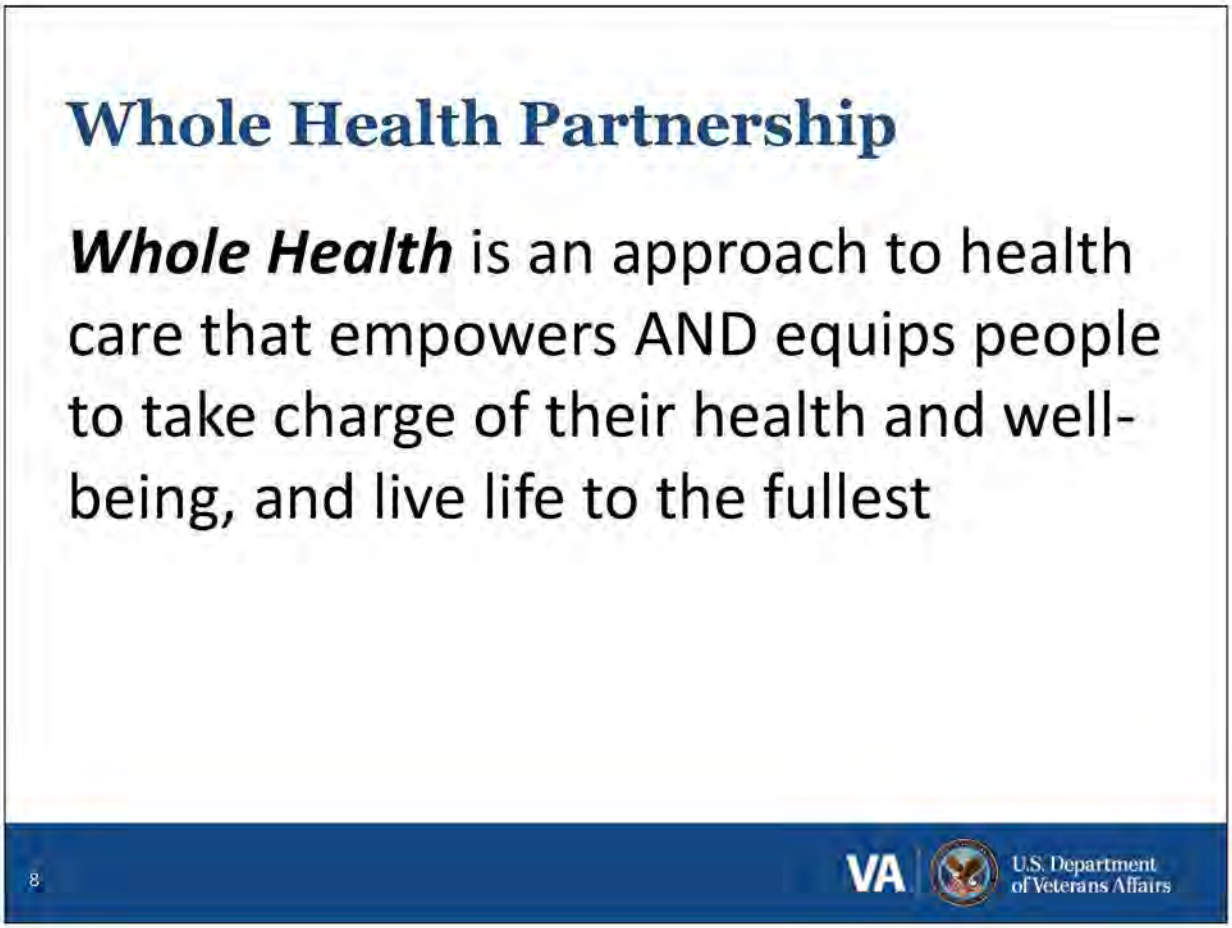

The Whole Health Partnership was developed by the Office of Patient Centered Care and Cultural Transformation (OPCC&CT) in collaboration with the Veteran Experience Committee (VEC) and endorsed by the National Leadership Council (NLC). In sum, the Whole Health Partnership is a systematic approach to provide whole health care early in the relationship between VA and the Veteran, emphasizing self-care in the larger context of well-being, and incorporating a full range of conventional and complementary and integrative health approaches. The Whole Health Partnership would move VA from focusing on episodic care to a more continuous engagement with the Veteran throughout his/her life. Additionally, the Whole Health Partnership model is the current vision for complementary and integrative health (CIH) integration in VA. The health care crisis in the United States has led to a call for transformation to a proactive model of care; VA has the opportunity to become the national leader in Whole Health care delivery and the Whole Health Partnership model is a roadmap to this paradigm shift.

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Whole Health System

The Human Element (empowers)

plus

Self Care (equips)

plus

Clinical Care (treats)

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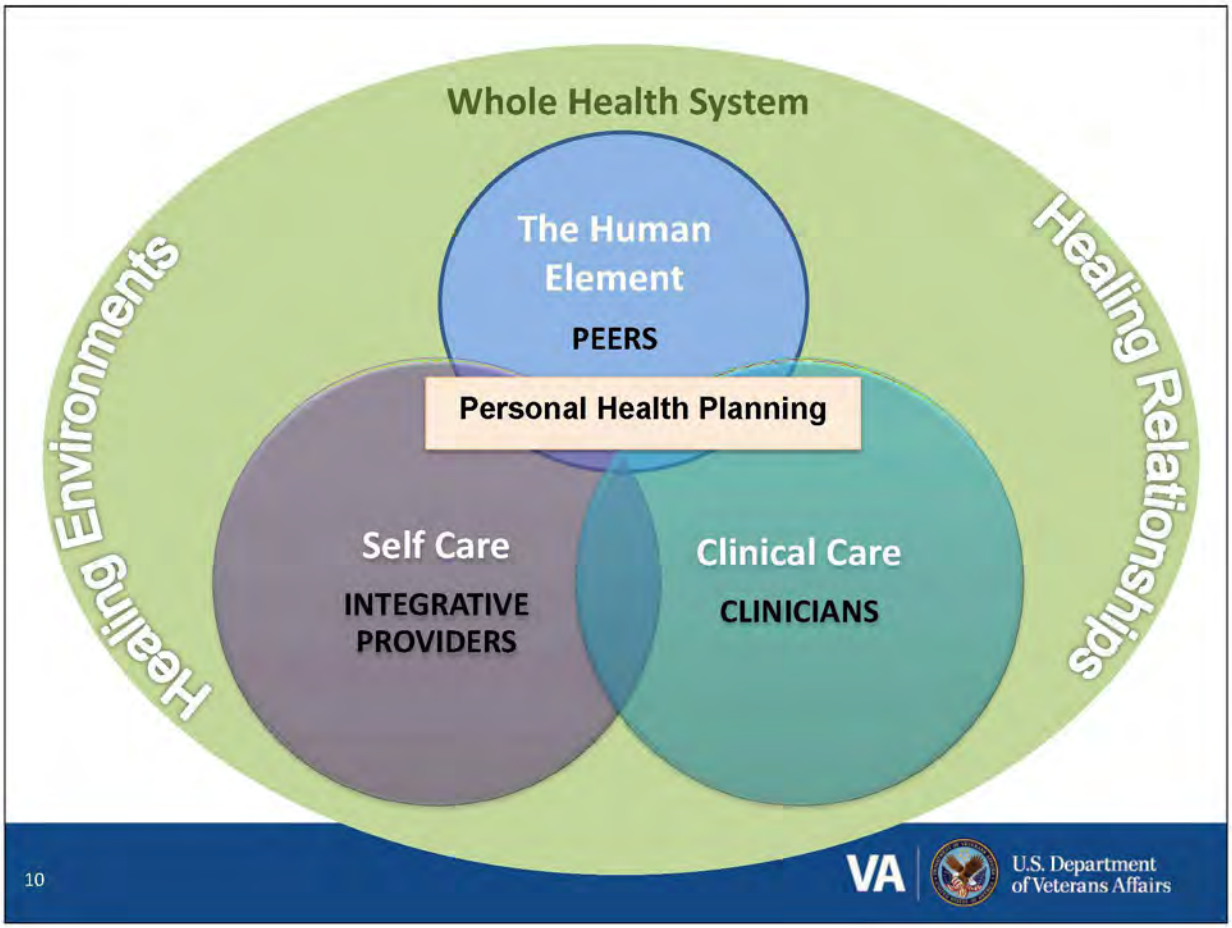

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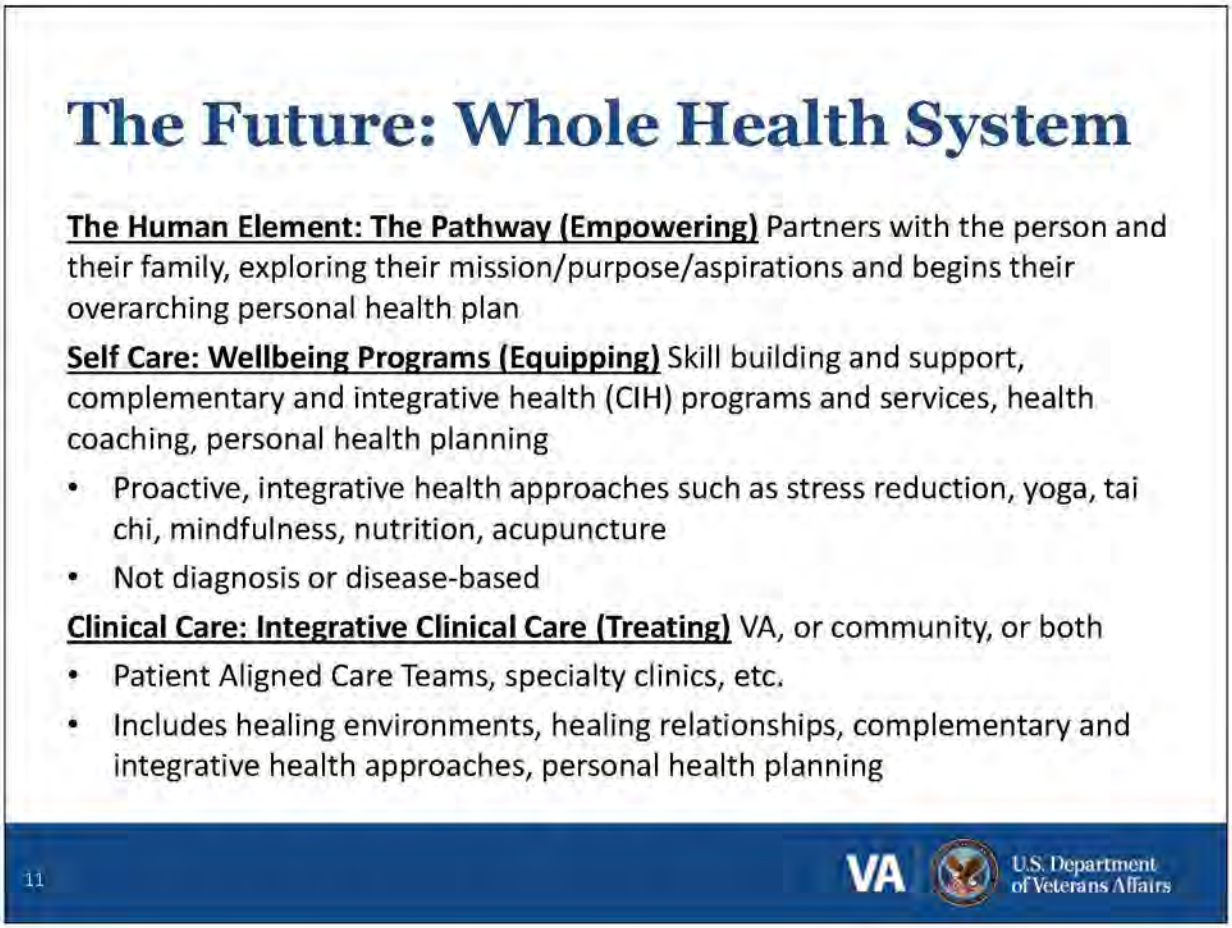

Whole Health Pathway: VA will partner with Veterans at the point of enrollment and create an overarching personal health plan that integrates care both in the VA and the community.

Wellbeing Centers: The core offering of CIH services, envisioned to be offered through Health and Wellbeing Centers, will be easily accessible to Veterans throughout the nation either within the VA setting or in the community. Not diagnosis or diseased based.

Medical Care: Clinical care will be provided in outpatient and inpatient settings which are attentive to healing environments and healing relationships and integrate holistic approaches into their treatment plans.

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Does It Really Matter to Start With What Really Matters?

- Study done by Hill, et al, N > **6,000**
- People who had a greater sense of purpose and direction in life were more likely to outlive their peers
- People with a sense of purpose had a **15%** lower risk of death compared to those who said they were aimless

And what happens if we intentionally link health care to this purpose?

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The Transformation Has Begun

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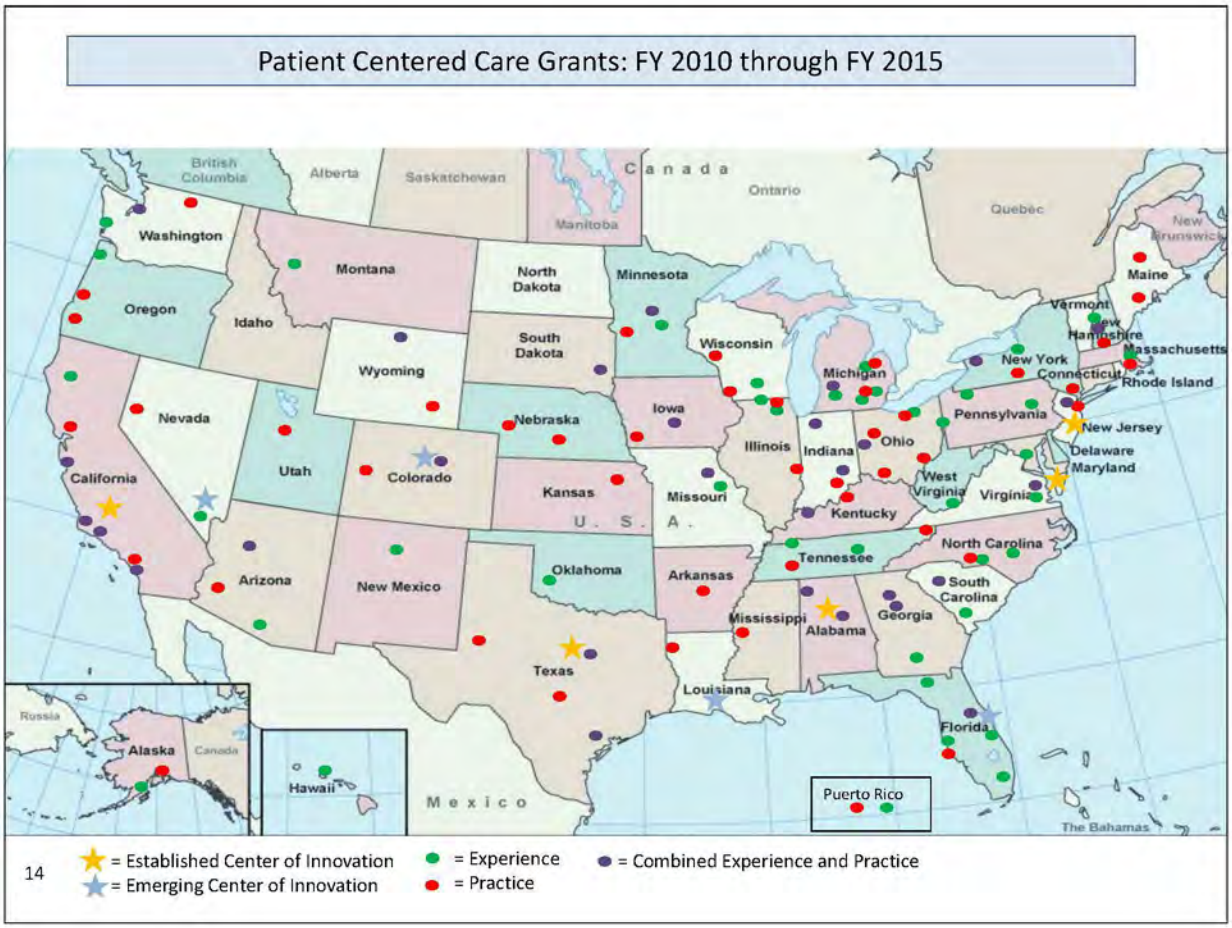

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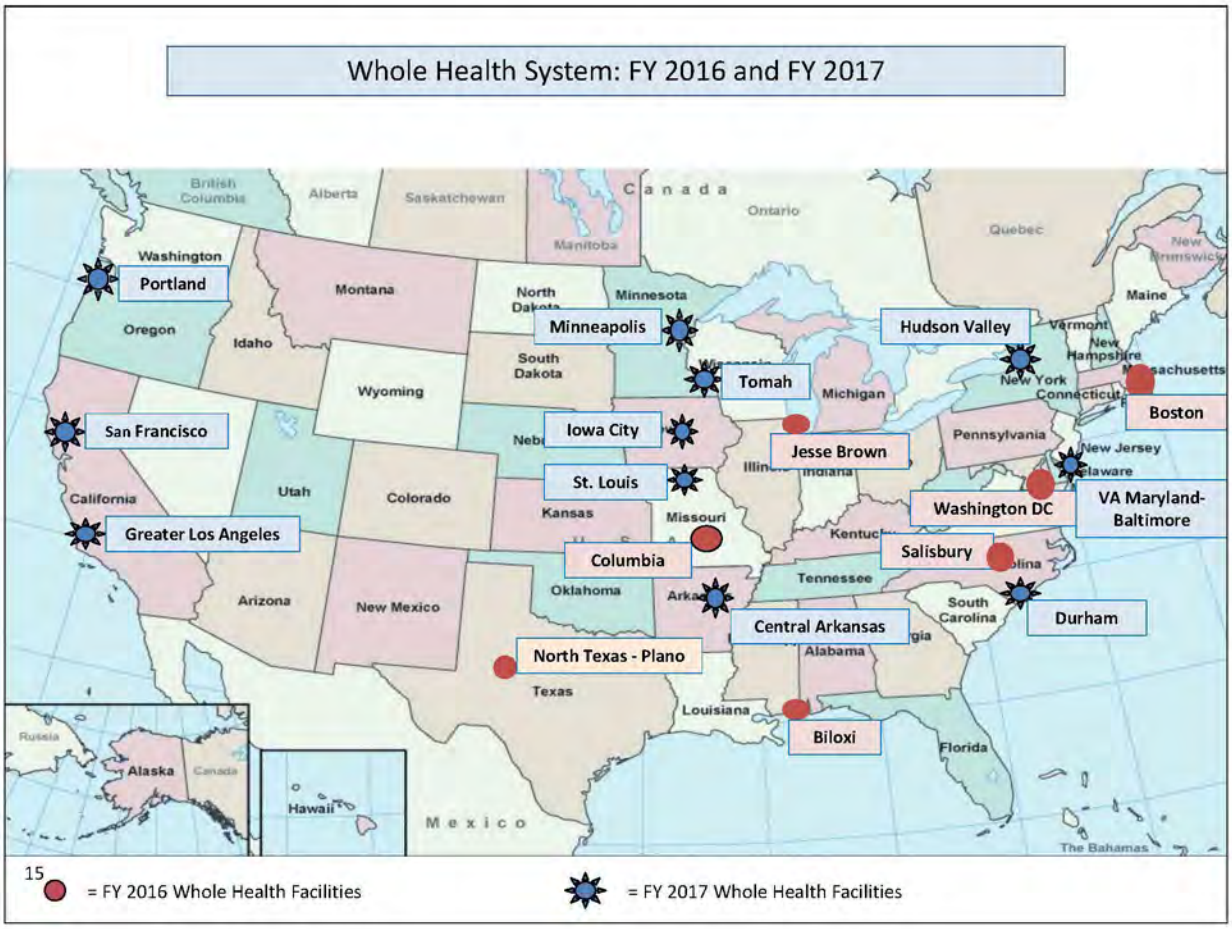

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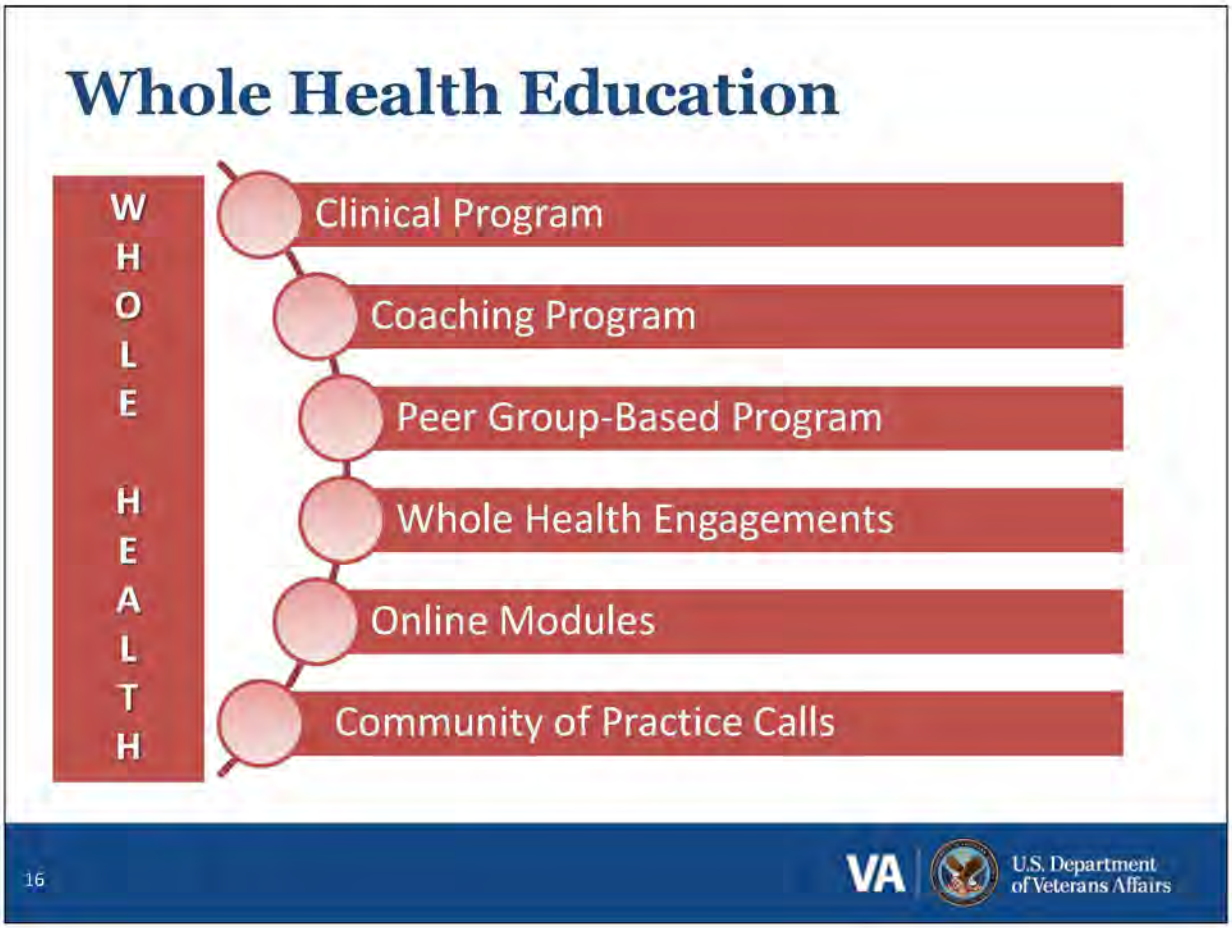

Whole Health Education Programs Nearly 2,000* VHA employees in Whole Health: 1,351 for the Whole Health Clinical Course, 646 for the Whole Health Coaching Course

47 total courses thru Feb. 2015: 16 sites have received clinical only, 5 sites have received coaching only, 26 sites have received both

68 by the end of FY 2015: 11 additional clinical courses, 2 centralized clinical trainings, 6 additional coaching courses, 2 centralized coaching trainings

Piloted the Whole Health Group-based Program at Little Rock, Denver, and Idaho Falls. The Program is led by Veteran peer, volunteer, or other non-clinical facilitators to provide Veteran participants the opportunity to receive education in improving their self-care behaviors to support their personal mission for life and health. 9-week program is designed around Components of Proactive Health and Well-being and uses the Personal Health Inventory. Participants clarify their own personal missions, aspirations and/or purpose; identify areas of health in which they would like to make behavior change(s); begin to create a personalized health plan that supports their mission; create goals and actions steps to optimize their health in service of their mission; and provide support to each other in achieving their goals.

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Strong Practice Toolkits



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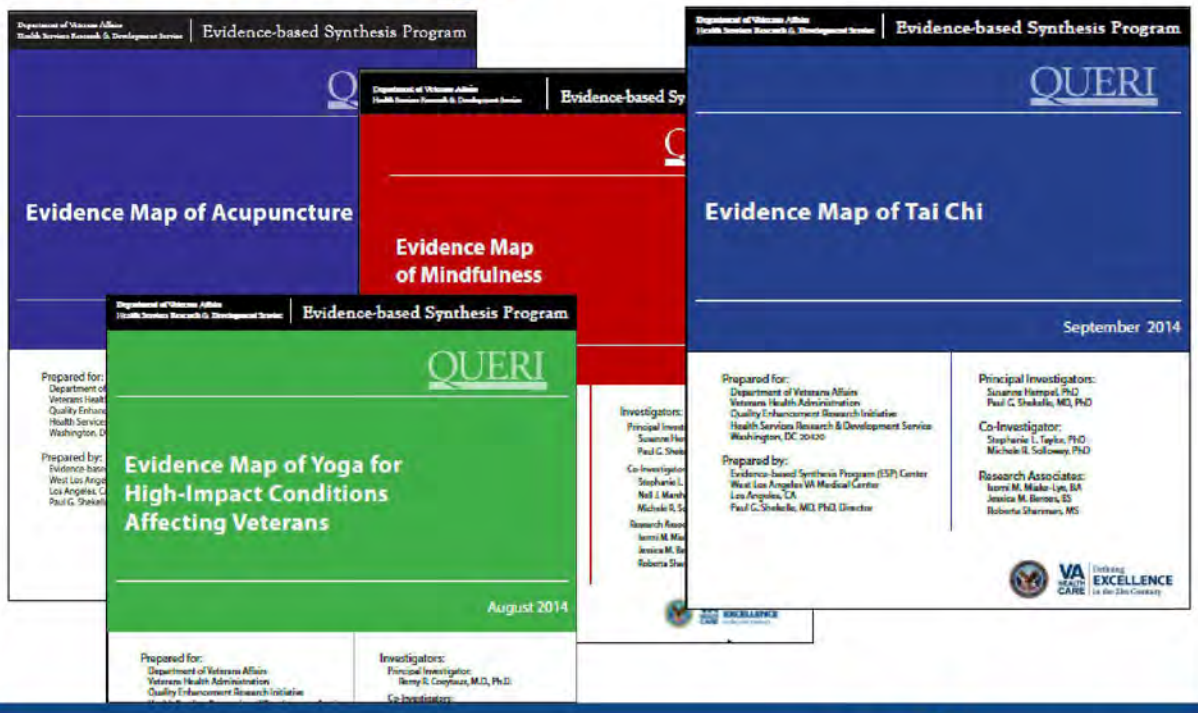
Evidence Maps



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Research and Evaluation

- Lessons from the Field for Implementing PCC
- Compendium of VA Research Related to PCC
- Personal Health Inventory Analysis
- Whole Health Education Level 3&4 Evaluation
- Integrative Health Implementation
- Interactive Patient Care Evaluation
- PCC Metrics Project
- PRIMIER
- All Employee Survey
- Evaluation Toolkit



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All Whole Health courses evaluated by team of PhD researchers from Pacific Institute for Research and Evaluation.
Completed levels 1-4 of Kirkpatrick's Levels for Training Evaluation.
With support from HSR&D, funded two QUERI teams to evaluate patient centered care strategies in 4 Centers of Innovation using scientific methods.

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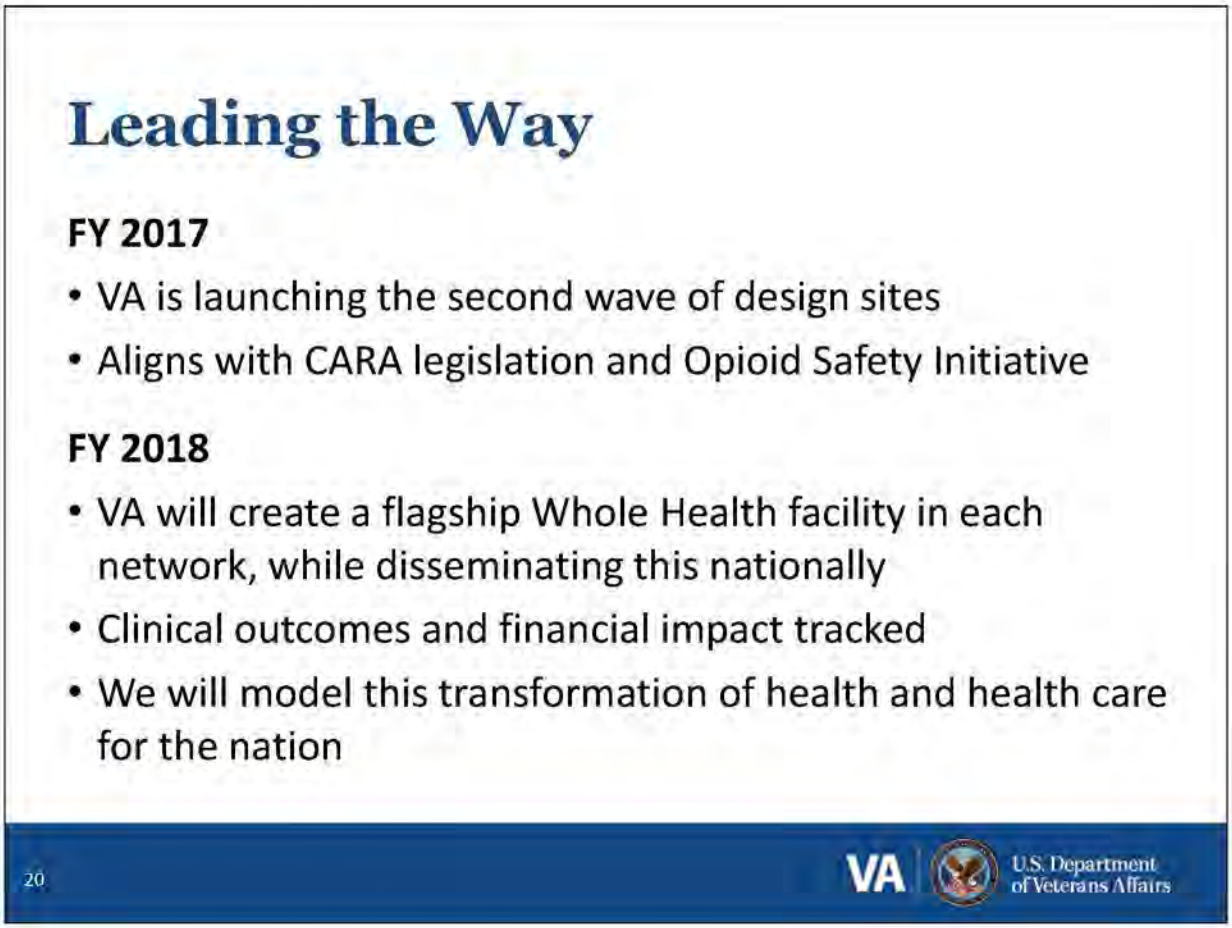

Our plan to move forward in implementation in bite-sized pieces is as follows:

CARA LEGISLATION:
Subtitle C—Complementary and Integrative Health (CIH)
Sec. 931 & 932. Expansion of research and education on and delivery of CIH to veterans.
Establishment of "Creating Options for Veterans' Expedited Recovery" Commission
Development of plan to expand research, education, and delivery of CIH to Veterans (within 180 days)
Sec. 933. Pilot program on integration of CIH and related issues for veterans and family members of Veterans.
To assess feasibility and advisability of using CIH and wellness-based programs to complement provision of pain management and related health care services, including mental health care services, to Veterans.
Start within 180 days of the plan/report developed by Commission
3 year pilot duration;
Minimum 15 geographically diverse sites; including at least two polytrauma rehab centers;
Within 30 months submit report to HVAC and SVAC
https://www.congress.gov/bill/114th-congress/senate-bill/524/text

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Conducted national Veteran Feedback Sessions as our new Internet site was developed and launched in FY 2014 with more than 500 visitors in the first full month, 9/14. Features downloadable education, resources, videos and podcasts to support Veterans in their journey to greater health and well-being.

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Good afternoon, everyone.

As we close out what has certainly been an informative and productive day, I want to again thank the Surgeon General and all of you for participating.

I know we will want to take some time to reflect on what we have learned today, and then determine our next steps.

One thing is clear to all of us: health care in America is ready for change.

Let's look at some of the reasons why.

Between 2000 and 2009, heart disease increased by 25 percent; diabetes by 32 percent; and strokes by 27 percent.

In most states, obesity is at or more than 40 percent.

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We spend more per capita on health care than any industrialized nation in the world, and yet our average life expectancy is no greater than countries that spend far less.

We spend more than $100 billion annually on treating heart disease, the number one killer of Americans.

But compared to medical treatment, at least 90 percent of all heart disease could be prevented by making some simple changes in lifestyle.

There is also a financial imperative for change in American health care.

Health care consumes 18 percent of our GNP, and it is projected to account for one-fifth of our economy by 2021.

Spending more is getting us less.

Taken together, these factors point strongly to the need to reassess how we deliver health care in this country.

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To be the provider of choice for our nation's Veterans, VA is creating an organization that puts Veterans in control of how, when, and where they are served to best achieve their goals.

We want to be a place Veterans are proud to call "My VA."

As part of that journey, we have been exploring what it takes to put the voice of the Veteran at the center of the practice and experience of health care.

We have heard overwhelmingly from Veterans that they want care that treats them as a whole person.

After all, no one knows better than Veterans themselves what they need to live life to the fullest.

We have the opportunity to redesign our health system to address both physical and emotional well-being.

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We meet a huge need, both for our Veterans, and for our nation.

As we know, the challenge is that the current approach to health care is a find-it, fix-it, diseased-based approach.

We do not have a core competency in engaging the whole person in optimizing their well-being.

VA's "whole health" model of care is a key component of our proposed future delivery system for Veterans.

This model incorporates physical care with psychosocial care focused on the Veteran's personal health and life goals.

It aims to provide personalized, proactive, patient-driven care through multidisciplinary teams.

VA has the opportunity—and the responsibility—to become the national leader in whole health care delivery.

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We are committed to this path, not only for VA, but for the nation.

We hope you are energized by today's discussion and ready to join us in this massive transformation of health care.

We in VA look forward to working with our partners to make our shared vision a reality for Veterans and all Americans.

Modern medicine starts with the body, rather than the soul, and the mind, rather than the heart.

The soul and heart are doorways to healing and health of body and mind.

Now we can design for this approach and lead the way.

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/4/2017 2:39:05 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: Quick advice

Ok or im around tonight too

Sent from my iPhone

On Jan 4, 2017, at 9:35 AM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:

> Lets just talk tomorrow- my day has already started and have a whole bunch of meetings lined up including the North Carolina company, nursing home project and the Sol barer company- don't want to think about this place right now
>
> Call me if you need to talk about the VA stuff though- will let you know how the Miguel discussion goes

---

From: David shulkin <Drshulkin@aol.com>
Sent: Wednesday, January 4, 2017 8:32 AM
To: Poonam Alaigh
Subject: Re: Quick advice

Just seeing- ill call when i can

Sent from my iPhone

> On Jan 4, 2017, at 7:02 AM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:
>
> If you get a chance before morning meeting- can you call me to discuss how I should negotiate my edit- got the termination letter, sent a message to Brian for a meeting but haven't heard anything- what are my options and how do I negotiate a severance- just some quick advice so I can get the ball rolling on this end today.
>
> I know you are going through a lot but let me know if you have a moment- thanks
>
> Sent from my iPhone

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Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 1/4/2017 2:35:19 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Quick advice

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AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/4/2017 1:32:44 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: Quick advice

Just seeing- ill call when i can

Sent from my iPhone

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Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 1/4/2017 12:02:34 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Quick advice

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I know you are going through a lot but let me know if you have a moment- thanks

Sent from my iPhone

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Message

From: Alaigh, Poonam [Poonam.Alaigh@va.gov]
Sent: 1/3/2017 8:19:04 PM
To: 'Poonam Alaigh' [(b) (6) @hotmail.com]; 'David Shulkin' [drshulkin@aol.com]
Subject: FW: [EXTERNAL] Value Based Health Care and the VA
Attachments: Variation in the Cost of Care for Primary TKAs_Arthroplasty Today.pdf; Adding Value by Talking More_NEJM 17 Nov 2016.pdf; Porter-Lee_Strategy to Fix Healthcare.pdf; Kaplan Porter_How to Solve The Cost Crisis In Health Care_HBR Sept 2011.pdf; TDABC in Health Care_Jan 2017.pdf; TDABC Recommended Readings (003).docx

Sent with Good (www.good.com)

-----Original Message-----
From: Kaplan, Robert [(b) (6) @hbs.edu]
Sent: Tuesday, January 03, 2017 02:08 PM Central Standard Time
To: Alaigh, Poonam
Subject: [EXTERNAL] Value Based Health Care and the VA

Dear Dr. Alaigh:

I very much appreciated the opportunity to share the HBS framework on Value-Based Health Care (VBHC) with you and the senior VA group this afternoon. I did want to follow up with your request on documentation of our approach. To do this quickly and responsively, I will edit the message I sent Dr. Shulkin a couple of weeks ago, which led to our conference call today.

The basic principles underlying VBHC are remarkably simple but quite powerful. We take, as the basic unit of analysis, the patient's medical condition (e.g., diabetes, joint osteoarthritis, hearing loss, coronary heart disease, PTSD). We want to increase the "value" from treating this condition, which we define as better outcomes achieved at lower total cost. For each medical condition, we want to:

1. Organize care around that medical condition (breaking down the silos between clinical and behavioral specialties)
2. Measure outcomes specific to that medical condition
3. Measure the total cost of caring for that condition over its cycle of care; and then use this information to reduce costs while sustaining or improving outcomes.

The attached article by Michael Porter and Dr. Tom Lee ("Strategy to Fix Health Care,") describes the six principles of the complete VBHC framework, but – for our near-term opportunities – we can focus on the first two principles, as outlined in the three points above (described on pp. 1-12 in the article). I

My particular focus is on the cost measurement piece (#3 above). Michael Porter and I wrote an article ("How to Solve the Cost Crisis in Health Care; also attached) on why we advocate time-driven activity-based costing (TDABC) as the preferred costing approach to apply to health care. I have learned that the data infrastructure for TDABC largely exists within the VA, but it has yet to be fully mobilized for the costing application. We get tremendous insight from measuring costs with TDABC for the same medical condition across multiple sites. I have attached a recent article ("Variation in the Cost of Care …") which documents the more than 2:1 variation in total costs for total knee arthroscopies that existed across 29 high-volume hospitals. I have attached a TDABC presentation (the pdf file), which gives an overview of the costing approach and also describes some of the projects underway. If you want, we can schedule another phone call and I can provide the voice-over commentary for the presentation.

Once you see the high cost variation, for treating the same input populations and getting the same outcomes, the opportunities for best practice identification and sharing become glaringly obvious. The short article describing the

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Mayo Clinic TJR cost comparison, which I described on the phone call, can be found at https://hbr.org/2015/10/the-mayo-clinic-model-for-running-a-value-improvement-program.

When I think of the VA system, with the same medical conditions being treated in 100 or 150 different facilities, we can learn so much from costing and benchmarking across the system. This is why I am so excited thinking about the pilot projects currently underway in the system, and how we might expand them. This is not something that will generate large cost savings in the next six months. But, properly done, this approach can enable the VA system – over a period of 3-5 years - to be more consistent in producing better patient outcomes, and at much lower system cost.

I have also attached a short recent article (from NEJM) where we describe the huge savings by thinking more holistically about how clinicians spend their time with patients. And I have also included a complete list of articles and cases on applying TDABC to health care.

I understand this is "too much information," but I hope you can sample and read selectively to get a sense of our approach and how it should be able to deliver considerable benefits to the VA – both effectiveness, in promoting better outcomes, and efficiency, achieving those better outcomes with a lower cost mix of resources.

I look forward to learning whether and how we can expand the collaborations between the VA and HBS.

Best regards,

Bob

Robert S. (Bob) Kaplan (b) (6) @hbs.edu
Senior Fellow and Marvin Bower Professor of Leadership Development, Emeritus
HARVARD | **BUSINESS** | **SCHOOL**
http://www.hbs.edu/faculty/Pages/profile.aspx?facId=6487

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(P) (b) (6)
(M) (b) (6)

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journal homepage: http://www.arthroplastytoday.org/

Original research

Variation in the cost of care for primary total knee arthroplasties

Derek A. Haas, MBA [a, b, *], Robert S. Kaplan, PhD [a]

[a] Harvard Business School, Boston, MA, USA
[b] Avant-garde Health, Boston, MA, USA

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Cost variation
TDABC
Total knee arthroplasty
Total joint arthroplasty

ABSTRACT

Background: The study examined the cost variation across 29 high-volume US hospitals and their affiliated orthopaedic surgeons for delivering a primary total knee arthroplasty without major complicating conditions. The hospitals had similar patient demographics, and more than 80% of them had statistically-similar Medicare risk-adjusted readmission and complication rates.

Methods: Hospital and physician personnel costs were calculated using time-driven activity-based costing. Consumable supply costs, such as the prosthetic implant, were calculated using purchase prices, and postacute care costs were measured using either internal costs or external claims as reported by each hospital.

Results: Despite having similar patient demographics and readmission and complication rates, the average cost of care for total knee arthroplasty across the hospitals varied by a factor of about 2 to 1. Even after adjusting for differences in internal labor cost rates, the hospital at the 90th percentile of cost spent about twice as much as the one at the 10th percentile of cost.

Conclusions: The large variation in costs among sites suggests major and multiple opportunities to transfer knowledge about process and productivity improvements that lower costs while simultaneously maintaining or improving outcomes.

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Introduction

Health care providers are coming under greater financial pressure, especially from more value-based and accountable payment methods. To cope, they need to understand their costs accurately over the full course of treatment by medical condition. Previous efforts to understand cost variation across providers have used measurement approaches that did not reflect the actual cost of the people and equipment used to deliver care. For example, studies of abdominal and congenital heart surgery [1,2] used the ratio of cost-to-charges (RCC) method, a widely-used but inaccurate health care costing method. The RCC method assumes that the cost to perform each service is the same percentage of the charge for each service. For instance, if total costs in a unit are $1.2 million and total charges are $2 million, the RCC method estimates the cost to perform each service as 60% of the service's charge. While the RCC approach is simple to understand and easy to implement, it is inaccurate because the charges have not been established based on actual costs of resources used to deliver each service.

We applied time-driven activity-based costing (TDABC) to study the cost variation for performing total joint arthroplasties (TJAs) at 29 high-volume hospitals. TDABC, a bottoms-up approach, uses process mapping to identify the types and costs of all personnel utilized in each step of a complete cycle of care [3-6]. TDABC has previously been used to examine the costs of TJAs at individual sites [7,8].

TJAs are one of the most commonly performed major surgeries in the country. Currently, more than 1 M joint arthroplasties are performed per year in the United States, and the number is projected to reach 4.05 M per year by 2030 [9,10]. Also, motivating this study is the increased use of bundled payments for joint arthroplasties, which causes hospitals to become more financially accountable for their costs of care. The Centers for Medicare and Medicaid Services introduced bundled payments in 2013 through a Bundled Payments for Care Improvement initiative, comprised of 4 models of bundled payments across a range of medical and surgical

One or more of the authors of this paper have disclosed potential or pertinent conflicts of interest, which may include receipt of payment, either direct or indirect, institutional support, or association with an entity in the biomedical field which may be perceived to have potential conflict of interest with this work. For full disclosure statements refer to http://dx.doi.org/10.1016/j.artd.2016.08.001.

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E-mail address: dhaas@hbs.edu

http://dx.doi.org/10.1016/j.artd.2016.08.001
2352-3441/© 2016 The Authors. Published by Elsevier Inc. on behalf of The American Association of Hip and Knee Surgeons. This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/).

Please cite this article in press as: D.A. Haas, R.S. Kaplan, Variation in the cost of care for primary total knee arthroplasties, Arthroplasty Today (2016), http://dx.doi.org/10.1016/j.artd.2016.08.001

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conditions, including TJAs. In April 2016, Centers for Medicare and Medicaid Services introduced the Comprehensive Care for Joint Replacements model for primary TJAs. This payment initiative holds hospitals financially accountable for all related Medicare Part A and B expenditures from the time of hospital admission through 90 days post discharge [11]. Beyond these public payer programs, a national alliance of leading providers has been established to offer orthopaedic surgeries at a fixed bundled price directly to large employers and employer groups [12].

The present study brought together 29 US-based sites to facilitate the measurement of their direct costs of providing a total knee arthroplasty (TKA) and help them to understand the primary drivers of cost variation across providers. Overall, Medicare data indicate that 95%-97% of hospitals were not statistically different from one another on risk-adjusted complication and readmission rates for TKAs (Table 1) [13]. While these quality measures are not comprehensive, the little variation among them indicates large opportunities to reduce the variation in costs of TKAs without adversely impacting outcomes. Previous research has documented wide variation in reimbursement rates and hospital and physician charges [14,15]. A recent study showed a 380% variation in reimbursement rates across the country for TKAs, including as much as a 2.67× difference within a single geographic market [16]. These studies, however, have not compared providers' actual costs for delivering TKAs over an entire cycle of care.

Material and methods

The article authors and the Institute of Healthcare Improvement organized a Joint Replacement Learning Community during calendar year 2014 to measure the value and improve the performance of the participating hospitals ("sites"). Hospitals that performed at least 200 primary TJAs in the prior year were eligible to participate. Thirty-two hospitals enrolled in the program, 29 were from the United States. The participating hospitals performed an average of 800 TJAs in 2013.

Nine of the US-based hospitals were academic medical centers; 20 were community hospitals. Their TJA patients had similar average age (65 years) and body mass index of 31 [17]. We excluded cases with major complicating conditions by studying only cases equivalent to a Medicare Severity-Diagnosis Related Group (MS-DRG) of 470. Twenty-four of the providers had risk-adjusted readmission and complications rates for TJAs that were no different than average based on Medicare Hospital Compare data. Two organizations had rates that were statistically better than average, and 3 organizations were worse on one or both outcome dimensions [13].

The analysis included costs over a care cycle that started with the initial office visit at which the decision for surgery was made and concluded 90 days post discharge. It included the costs of care delivered by physicians, whether employed at the hospital or not, and for postacute care, such as for rehabilitation and therapy.

Table 1
Medicare risk-adjusted complication and readmission rates [10].

Comparison	Risk-adjusted complication rate (%)	Risk-adjusted readmission rate (%)
Better than US national rate	3	2
No different than US national rate	95	97
Worse than US national rate	2	1

Source/notes: Hospital Compare data. 2015 [cited 2015 April 12]. Available from: https://data.medicare.gov/

Except for the postacute care costs, the analysis focused on direct personnel and consumable supply costs. We excluded space and equipment costs since our previous research projects found these costs to be less than 10% of personnel and supply costs [18]. We also excluded indirect costs, such as information technology, human resources, and billing, as assigning these costs accurately would have required extensive cost modeling and analysis for every indirect and overhead cost category in the hospital.

We used TDABC to measure the direct personnel costs and trained the sites on the approach [4-6]. TDABC involves identifying the clinical and administrative activities performed over the care cycle, including the types of clinicians and staff members that perform each activity and the amount of time each personnel type spends on each activity. The second step in the TDABC process calculates the cost per minute for each of the personnel types used in the care cycle. The cost per minute divides the fully loaded cost for each type of personnel (compensation plus benefits) by the quantity of time that each personnel type has available for performing productive work per year on average. The employee activity time is then multiplied by the employee's cost per minute and summed across all employees to calculate total personnel costs. For example, if a nurse spends 20 minutes with a patient during an office visit (inclusive of prep and follow-up time), and the fully loaded cost for that nurse is $1.50/minute, then the cost of nursing time for the visit is $30. The cost of all of the resources utilized as part of a particular service (eg, a clinic visit, a rehabilitation session, or a surgical intervention) can then be summed together to determine the total cost of that service [3].

The organizations used actual purchase prices, the price the organization paid to the manufacturer or distributor, as the cost for consumable supplies. For postacute care costs, the organizations used internal cost estimates when they provided the service and external claims data when internal cost data were not available.

The unit of analysis for the study was the average cost to deliver the care for primary TKAs at each site. The project teams reported their cost data in a common format with a web-based system, developed by the study authors, which then calculated the TDABC costs for each site. The authors analyzed the consolidated data to compare costs across sites for the complete care cycle, as well as for important segments within the care cycle, such as preoperative, day of surgery, postacute care, and for different categories of expense, principally personnel and purchased supplies. A unique capability of the TDABC costing approach enabled the authors to use accounting variance analysis to adjust for differences in labor cost rates across the sites [19]. The authors could also identify the variation in postacute care spending caused by differences in payments for different types of postacute care services (eg, home health care vs skilled nursing facility) across sites.

The sites had the option to either report costs for the site on average or to provide a breakdown of costs based on the practices of individual physicians. In the latter situation, we used an average cost across physicians for those sites.

The authors performed a separate analysis of the costs of the prosthetic implant, the largest single cost component for TKAs [20]. The sites replied to a survey asking them to report the average purchase price for prosthetic implants used in primary TKA procedures for DRG 470 over the 12 months ending September 30, 2013. They reported their average purchase price with in $500 ranges. For statistical analysis, we used the midpoint of each price point range [21].

Results

Table 2 summarizes the variation in costs across the 29 sites. Due to nondisclosure agreements with the participating hospitals, we show the cost comparisons in indexed form, rather than the actual

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Table 2
Distribution in indexed costs for primary total knee arthroplasties.

Measure	Higher percentile is a higher cost. Unit of analysis is a hospital and affiliated surgeons.					
	10th percentile	25th percentile	Median	75th percentile	90th percentile	Ratio of 90th to 10th percentile
Total personnel and consumable supply costs for hospital stay and orthopaedic office visits	0.77	0.88	1.00	1.09	1.24	1.6
Total consumable supply costs	0.62	0.90	1.00	1.08	1.41	2.3
Prosthetic implant cost	0.58	0.79	1.00	1.11	1.23	2.1
Bone cement costs	0.22	0.52	1.00	1.68	3.81	17.4
Total personnel costs	0.59	0.77	1.00	1.13	1.37	2.3
Total standardized personnel costs	0.68	0.82	1.00	1.14	1.31	1.9
Standardized personnel costs before day of surgery	0.57	0.84	1.00	1.62	2.10	3.7
Standardized personnel costs day of surgery before surgery	0.59	0.69	1.00	1.48	1.85	3.1
Standardized personnel costs during surgery	0.61	0.78	1.00	1.33	1.64	2.7
Standardized personnel costs in the postanesthesia care unit (PACU)	0.59	0.85	1.00	1.38	1.63	2.8
Standardized personnel costs during inpatient stay	0.74	0.84	1.00	1.14	1.35	1.8
Standardized personnel costs during postdischarge follow-up visits	0.34	0.53	1.00	1.43	2.00	5.9
Readmission cost	0.53	0.73	1.00	1.36	1.58	3.0
Standardized postacute care costs	0.74	0.88	1.00	1.22	1.63	2.2

Source/notes: Data from 29 JRLC partner sites.

cost data. We report the median cost in each cost comparison as 1.00; values greater than 1 represent higher costs and values below 1 represent lower costs. Higher percentiles represent higher costs (eg, for a site at the 90th percentile, 90% of sites had costs lower than it). The total personnel and consumable supply costs for the site at the 90th total cost percentile were 1.6× (60%) greater than the costs of the site at the 10th percentile. A site at the 90th percentile for total personnel and supply costs that improved to the 75th percentile would save 12%; a site at the 75th percentile that improved to the median would save 8%; a site at the median that improved to the 25th percentile would save 12%; and a site at the 25th percentile that improved to the 10th percentile would save 13%.

On average, consumables represented 59% and personnel 41% of personnel and supply costs. There was a 2.3× range in consumable costs between the 90th and 10th percentiles. Prosthetic implants, the largest consumables expense, had a 2.1× range between the 90th and 10th percentiles [20]. Other types of consumables had a much larger range. The cost of bone cement, for example, was 17× higher for the 90th percentile site than for the site at the 10th percentile. While we are not able to quantitatively explain all the variation in bone cement costs, anecdotally, the variation was caused by having different purchase prices for the same type of cement, using different types of cement (eg, premixed antibiotic cement is more expensive than hand-mixed or plain bone cement) and using different quantities of cement during the actual procedure.

Total personnel costs had a 2.3× range between the 90th and 10th percentiles, for example, the site at the 90th percentile spent 130% more on personnel than the site at the 10th percentile. Some of the cost variation across the hospitals could be attributed to the different compensation paid by each site to similar types of comparable employees (called a price variance by accountants). We controlled for this source of variation by also calculating costs using an average wage and benefit rate for each personnel type at all sites, for example, if we were doing a comparison across only 2 sites (instead of the 29 actually used) and site 1's nurses cost $1/minute while site 2's cost $1.5/minute, we would use an average rate of $1.25/minute for the cost of nursing time at each site when calculating standardized personnel costs. Total personnel costs after standardization still had a 1.9× difference between the 90th and 10th percentiles. This variation, called a quantity or productivity variance, is exclusively due to differences in the mix of personnel utilized and the quantity of time each type spent over the episode of care, factors that are much easier to change than local, and site-specific compensation rates.

We analyzed personnel cost variation at each stage of the care cycle: before day of surgery, day of surgery before the operation, surgical operation, postanesthesia care unit stay, inpatient stay, and postoperative orthopaedic follow-up visits. The greatest variation in personnel costs occurred during the postoperative follow-up visits, with a 5.9× range in costs from the 90th to the 10th percentiles. Since most sites had 2 follow-up visits within 90 days of discharge from the operation, the variation in follow-up visit personnel costs was driven by which employees saw patients and the time each spent with them during each follow-up visit, rather than by the number of visits.

The inpatient floor hospitalization costs were driven primarily by nursing costs. After standardizing for differences in wage rates among sites, the 2 largest drivers of nursing expenses were the length of the patient's hospital stay and the patient-to-nurse staffing ratio (ie, how many patients each nurse was expected to care for).

Cost estimates for patients discharged to the various types of postacute care (inpatient rehabilitation, skilled nursing facility, home with home health care, and home with outpatient therapy) varied by at least 6× between the 90th and 10th percentiles. We again used variance analysis by calculating an average cost for each type of postacute care. This enabled us to focus our analysis on the mix of postacute services used across hospitals. A 2.2× variation between the 90th and 10th percentiles for postacute care costs still remained. The variation was due to variation in discharge disposition (the type of setting patients were discharged to) and readmission rates, with most of the variation due to discharge disposition. We found no correlation between performing statistically better or worse than average on the Medicare Hospital Compare metrics and standardized personnel costs. We also found no correlation between standardized personnel costs up through discharge and standardized postacute care costs.

Discussion

Personnel costs were highest for the surgical operation and the inpatient hospitalization stay. The primary drivers of surgical operation costs were the duration of the operation, including time

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Table 3
Quartiles of postacute care spend and discharge disposition.

Quartiles of postacute care spend	Home with outpatient (%)	Home health (%)	Inpatient rehabilitation (%)	Skilled nursing facility (%)	Readmissions (%)
Highest	4	42	24	29	3
2nd highest	17	50	4	29	3
2nd lowest	23	57	7	13	3
Lowest	44	42	4	10	2

Source/notes: Data from 29 JRLC partner sites.

spent prepping and cleaning the room, and the mix of staff members used at each stage of the operation. Surgeons are by far the most expensive personnel type. Surgeons at the sites with the lowest surgical personnel costs per patient (after standardizing for differences in labor cost rates across sites, which varied by over 60%) had shorter surgery times either because they were faster or, more commonly, were present for fewer process steps of the surgery. At the low surgical personnel cost sites, the surgeon's time lasted only from first incision to the time closure began, at which point the surgeon left to prepare for the next case in a second operating room. Lower cost (but still qualified) staff members performed the remaining functions, including closure. From a productivity perspective, most of the surgeons who performed at least 300 TJAs per year had access to two operating rooms, half the surgeons who performed between 100 and 300 cases per year used 2 operating rooms, while all of the surgeons who performed under 100 cases per year had access to only 1 operating room for their procedures.

The cost of a surgeon with access to only 1 operating room is much higher, as the surgeon's time includes the actual operating time plus the time spent waiting for the current case to be finished, for the room to be cleaned and prepared, and for the next patient to be transferred to the room. A conflict can therefore arise between hospitals that want high utilization of their expensive operating rooms and surgeons who want high utilization of their time. Accurate cost accounting helps to resolve this conflict. Representative numbers based on our prior (unpublished) work have shown that, on average, a fully equipped operating room costs about $0.50 per minute of the available time. A fully staffed surgical team, including the surgeon, costs $10-$20 per minute. Even excluding the surgeon from the analysis, the cost per minute for the rest of the operating room team is typically above $5 per minute, an order of magnitude higher than the space cost. A hospital striving to get maximum utilization of its most expensive resources should learn how to keep its skilled surgical teams as productive as possible.

The other principal source of variation in day of surgery costs was the 2.1 to 1 variation (90th to 10th percentiles) due to implant purchase prices. A statistical analysis revealed that the most statistically and economically significant variable to explain this large variation was whether a joint committee of hospital administrators and surgeons made the purchase decision and negotiated with vendors [20]. Sites that used such a joint committee paid, on average, 17% less for implants than those without a joint purchasing committee. Volume played a statistically significant but small-in-magnitude role (3% reduction per 100 incremental surgeries).

The cost of bone cement also varied widely across sites, largely caused by variation in the type of cement used. For example, premixed antibiotic cement is much more expensive than other types. Research has shown, however, that hospitals do not necessarily need to purchase more expensive bone cement. A recent recommendation made by the American Academy of Orthopaedic Surgeons noted that in most cases, antibiotic cement is unnecessary, providing an actionable way for organizations to reduce costs quickly without compromising patient outcomes [22].

Postacute care was also costly. Table 3 shows that the major explanation of the variation in costs of postacute care arises from the discharge disposition for the patient. Sites in the lowest quartile of standardized postacute costs discharged 86% of their patients to their homes. Sites in the highest quartile discharged less than 50% of their patients to home. Home rehabilitation costs were 20% of the costs of skilled nursing facilities and 15% of the costs for extended inpatient facilities. There was no systematic relationship across sites between the average patient age and the standardized postacute care costs at each site. Several of the low postacute cost care sites reported that they set an expectation for discharge to home rehabilitation in presurgical visits with patients and their families and subsequently reinforced this communication during the hospital stay. During the hospital stay, the sites also designed their pain management and physical therapy to increase a patient's comfort level with being discharged to home. For example, one site used a prototype vehicle for the patient to practice entering and leaving and a 12-step staircase with rails on either side to practice going up and down stairs. While the extra time spent talking with patients and their families and the specialized therapy approaches did involve higher costs, these extra costs were less than $100 per patient, a savings of thousands of dollars when compared to discharging patients to skilled nursing and specialized rehab facilities. Sites that started physical therapy earlier in the postsurgical stage also discharged a higher percentage of patients to home health care.

Our data and methods are subject to a number of limitations. First is the nonrandomized sample of hospitals in the analysis. The 29 hospitals in the study each performed at least 200 primary TJAs per year, and all chose to participate in the Joint Replacement Learning Community program in 2014. A second limitation is that each hospital self-reported the data. While we continually questioned and challenged the hospitals to confirm that the reported data were correct, we were not able to independently verify the data ourselves. It is thus possible that some of the variation in cost is due to differences in how well and how accurately the hospitals captured information used to calculate the TDABC costs at their institution. A third limitation is that while hospitals had data on the discharge disposition of the patient, they did not have comprehensive data on the postacute care costs for the patients. The variation in postacute care costs is therefore based on the average cost for the discharge disposition used for patients, not the actual full cost for the 90 days post discharge. A fourth limitation, as noted in the Material and methods section, is that we did not include space and equipment costs in the analysis based on our prior experience that these do not typically represent a substantial cost on a per patient basis. It is possible though that varying use of advanced technology, such as computer navigation, advanced imaging, robotics, and custom jigs contributes to variation in cost across hospitals.

Conclusions

Hospitals with similar patient demographics and similar patient volumes for TKAs have wide variation in their costs over the TKA care cycle. This large variation suggests a great opportunity to lower

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costs while maintaining quality and patient outcomes by identifying and transferring the best practices of sites in the lowest percentiles of cost. These best practices improve the efficiency of care and productivity of employees and facilities, enabling them to handle much of the expected growth in TKA volume without adding costly new capacity. Several sites in the program made immediate and significant improvements based on what they learned from the analysis, such as optimizing the discharge disposition of the patients from the hospital and changing pain management to enable physical therapy to start earlier. Looking forward, policies such as bundled payments will lead to greater price (payment rate) pressure on hospitals, increasing the benefits from proactive management of actual costs over complete episodes of care. TDABC provides both accurate estimates of care cycle costs, as well as greater transparency into the drivers of those costs.

With almost all hospitals publically reporting similar outcomes on complication and readmission rates despite large variation in costs, such efficiency and productivity improvements should be possible while maintaining or improving outcomes. Further efforts, however, should strive to encourage hospitals and clinicians to adopt and report condition-specific patient-reported outcome metrics, which would allow a better comparison and improvement of quality and costs across providers.

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aware of the state protections and submit a substantial amount of paperwork to get redress.

Ultimately, surprise out-of-network billing is the result of a market failure: the lack of a competitively set price for physician services. There are various ways such a price could be established. We believe the best solution would be for states to require hospitals to sell a bundled ED care package that includes both facility and professional fees. In practice, that would mean that the hospital would negotiate prices for physician services with insurers and then apply these negotiated rates for certain designated specialties. The hospital would then be the buyer of physician services and the seller of combined physician and facility services. If physicians considered the hospital's payment rates too low, they could choose to work at another hospital.

This solution preserves price competition. Emergency physicians would compete on price and quality to offer services to hospitals. Hospitals would compete on the price and quality of their package of emergency services to be included in insurers' networks. Hospitals would also compete to offer sufficiently high rates to attract physicians. Insurers would compete on premiums and quality to attract employers and enrollees but would increase provider payments to create attractive networks. Most crucially, patients would always be protected.

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Adding Value by Talking More

Robert S. Kaplan, Ph.D., Derek A. Haas, M.B.A., and Jonathan Warsh, Ph.D.

The prevailing fee-for-service payment model has led U.S. health care administrators and physician practices to impose severe constraints on the time physicians spend talking, for which they are reimbursed poorly or not at all. New value-based reimbursement models, however, such as bundled payments, accountable care organizations, and shared savings plans, provide powerful incentives for physicians to regain control over the quantity and quality of time they spend talking. As we have helped dozens of organizations to estimate total care-cycle costs, we've identified many situations in which having physicians and other clinical personnel talk more with patients and each other can be the least expensive and most effective approach for delivering better patient care.

One important role of physicians' talking is to motivate patients to make earlier and better decisions about their care. Less than half of patients with chronic kidney disease, for example, currently prepare effectively to start dialysis. Ideally, a vascular surgeon should place a fistula or graft several months before the start of hemodialysis. But nephrologists, under pressure to maximize the number of patients they see per day, often lack sufficient time to persuade patients to start dialysis with a matured fistula or graft — a conversation that we calculate costs less than $200. The consequence is that too many patients begin dialysis with a catheter and subsequently have high rates of infections and other complications that not only harm them but also increase treatment costs during the next 6 months by more than $20,000.[1]

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Similarly, many patients with diabetes delay the recommended regimen of insulin injections. Physicians who take the time to understand patients' reasons for delaying can help overcome such resistance and thereby avoid higher-cost complications of untreated disease.

A related role of talking is motivating patients with chronic conditions to adhere to their treatment plans. Several studies have shown that spending more time addressing patients' concerns and discussing their management of their own chronic conditions leads to substantially higher levels of treatment adherence and fewer costly complications. For example, patients' adherence to statin therapy often drops substantially when they receive no encouragement from a clinician. The cost of the incremental physician and clinical staff time for talking with patients about the benefits of self-management is $100 to $200. Increasing the use of phone calls and electronic communications to monitor and encourage patient adherence is also inexpensive, perhaps tens or hundreds of dollars per year. Averting complications and hospital admissions saves tens of thousands of dollars.

Physicians can also productively use talking time to set patients' expectations. Several studies have shown that patients with high expectations for the outcomes of their care have greater improvement than those with low expectations.[2,3] These studies also showed that physicians' expectations can differ dramatically from those of their patients, a finding that suggests that a doctor–patient conversation could have a positive influence on patients' behavior and recovery.

Several orthopedic practices that we studied realized large benefits from educating and setting expectations with patients and their families. The conversations, often conducted by a nurse, required about 30 to 60 minutes of extra time, either one-on-one or as part of a group class. The discussions led to shorter inpatient stays, reductions in complications, and much higher rates of discharge to home rather than to a costly postacute care facility. The presurgical conversation cost less than $200 for the clinician time, and it produced cost savings of more than 10 times that amount, as well as better patient outcomes.

Talking is required for engaging patients in their care choices, and when patients are actively engaged in decision making, they have better outcomes and less expensive care.

Talking is also required for engaging patients in their care choices, and when patients are actively engaged in decision making, they have better outcomes and less expensive care. One study examined patients' choices of care for six conditions for which more than one choice was reasonable. Patients who received enhanced decision support had total care costs that were 5% lower than those of patients who didn't receive such support, and they had 12% fewer hospital admissions than the comparison group.[4] Studies involving high-risk geriatric patients indicate that conversations among physicians, patients, and family members led to better patient outcomes, including reduced mortality and higher quality of life, and substantially lower treatment expenses.[5]

More talk can increase interdisciplinary interactions with patients in outpatient settings. Kaiser Permanente Colorado, for example, has established Primary Care Plus, a program targeting higher-need Medicare beneficiaries with interdisciplinary team care and proactive nurse outreach. Kaiser Permanente developed a robust system for identifying these patients, who were then assigned to a program in which personal goals and priorities were central to the development of a care plan. The frequency of outreach calls fluctuated with changes in the acuteness of patients' needs, their family or caregiver situations, and their need for social supports.

Though the program required greater investment in care coordination, behavioral and social supports, and pharmacy and palliative care services, it reduced utilization of inpatient care and overall pharmacy costs. The cost for office visits was 21% higher among program participants than in a matched control group, but that increase was more than offset by inpatient costs that were 74% lower than those for the control group. A holistic focus on patients' goals and priorities, meeting social and behavioral health needs,

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interdisciplinary team care planning, and proactive outreach and care coordination helped avert inpatient stays, with their associated financial burdens and effects on quality of life.

Communication among clinicians as they work to reach the correct diagnosis and treatment plan also leads to higher-value care. The M.D. Anderson Head and Neck Cancer Center holds a weekly treatment-planning conference, attended by 50 participants from multiple medical specialties, to discuss all new patients. After a faculty member presents a proposed treatment plan for a patient, the group discusses it until agreement is reached. A discussion for a typical patient takes 1 to 2 minutes; when the patient has complex needs, it takes about 5. Assuming that the average cost of a participating professional's time is about $3 per minute, a 5-minute discussion costs $750. But as the center's vice chair has noted, about 30% of the discussions of patients with complex needs conclude with a different proposed treatment plan, one that will lead to substantially better care and lower total costs. A patient whose case is not subject to such a dialogue and who is incorrectly treated could receive hundreds of thousands of dollars in unnecessary and ineffective care. The extra cost of bringing 50 highly paid professionals together, for a nonreimbursable meeting, to discuss patients' treatment plans is repaid many times over.

Similarly, all the clinicians at Martini-Klinik, a prostate cancer center in Hamburg, Germany, meet weekly to determine the best course of action for patients who have presented during the previous week. They also participate in many other meetings to review cases of patients with complications or unusual conditions, to identify innovations in recent research literature, and to review and improve their absolute and relative performance. These meetings consume sizable amounts of clinician and support personnel time. But the clinic's patients have complication rates that are 75% below the German average, and its earned reputation for superior outcomes has enabled it to become the highest-volume prostate cancer treatment center in the world.

As these examples illustrate, increased physician communication is time very well spent when it leads to better patient outcomes and lower total costs. Clinicians who are reimbursed under new value-based payment plans should seize the initiative to determine how much of their valuable time should be spent in the various types of productive conversations, especially as they become more accountable for their results. Physicians now have the discretion, incentives, and accountability to use their time wisely and productively to reduce the total costs of patient care and improve the outcomes they deliver.

Disclosure forms provided by the authors are available at NEJM.org.

From Harvard Business School, Boston.

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FOCUS ON RESEARCH

A New Cell-Cycle Target in Cancer — Inhibiting Cyclin D–Dependent Kinases 4 and 6

Charles J. Sherr, M.D., Ph.D.

Orally available drugs that potently and specifically inhibit the activities of the cyclin D–dependent kinases CDK4 and CDK6 represent paradigm-shifting antineoplastic agents.[1] Unlike traditional cytotoxic drugs, which kill dividing cells by interfering with DNA replication (S phase) or mitosis (M phase) during the cell-division cycle, CDK4–CDK6 inhibitors arrest progression through the G1 phase, promoting transient cell-cycle withdrawal into a quiescent state (G0) or, possibly,

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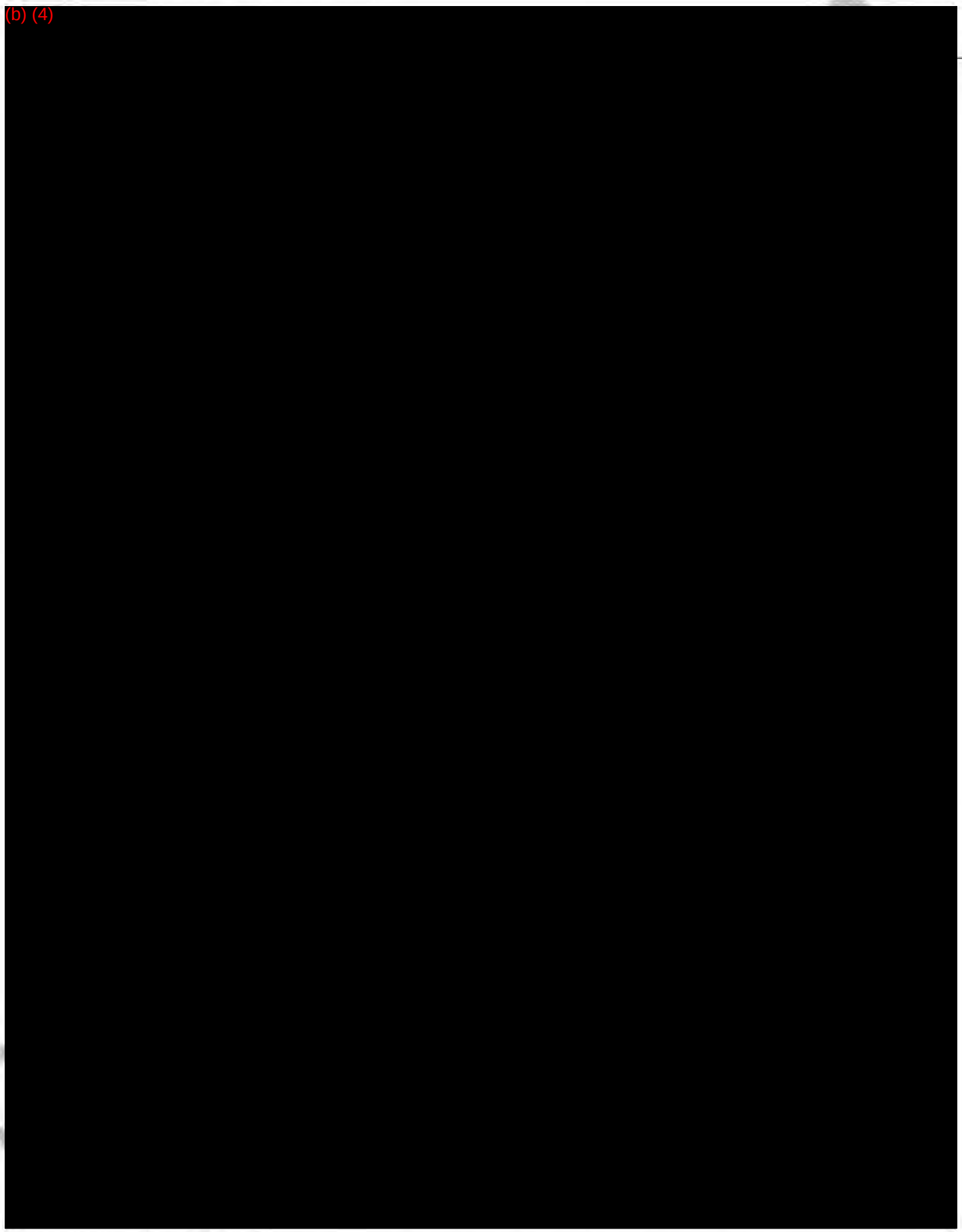

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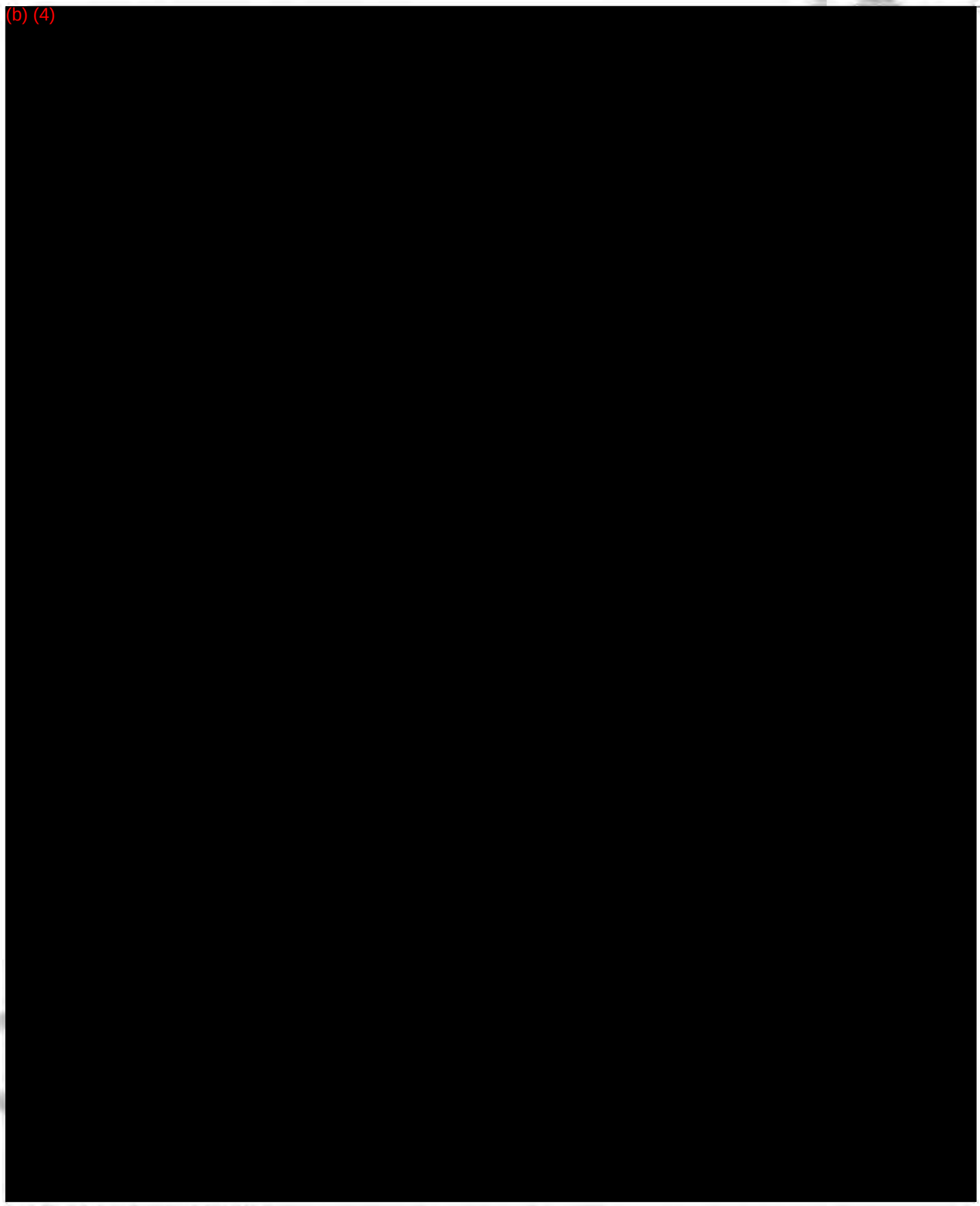

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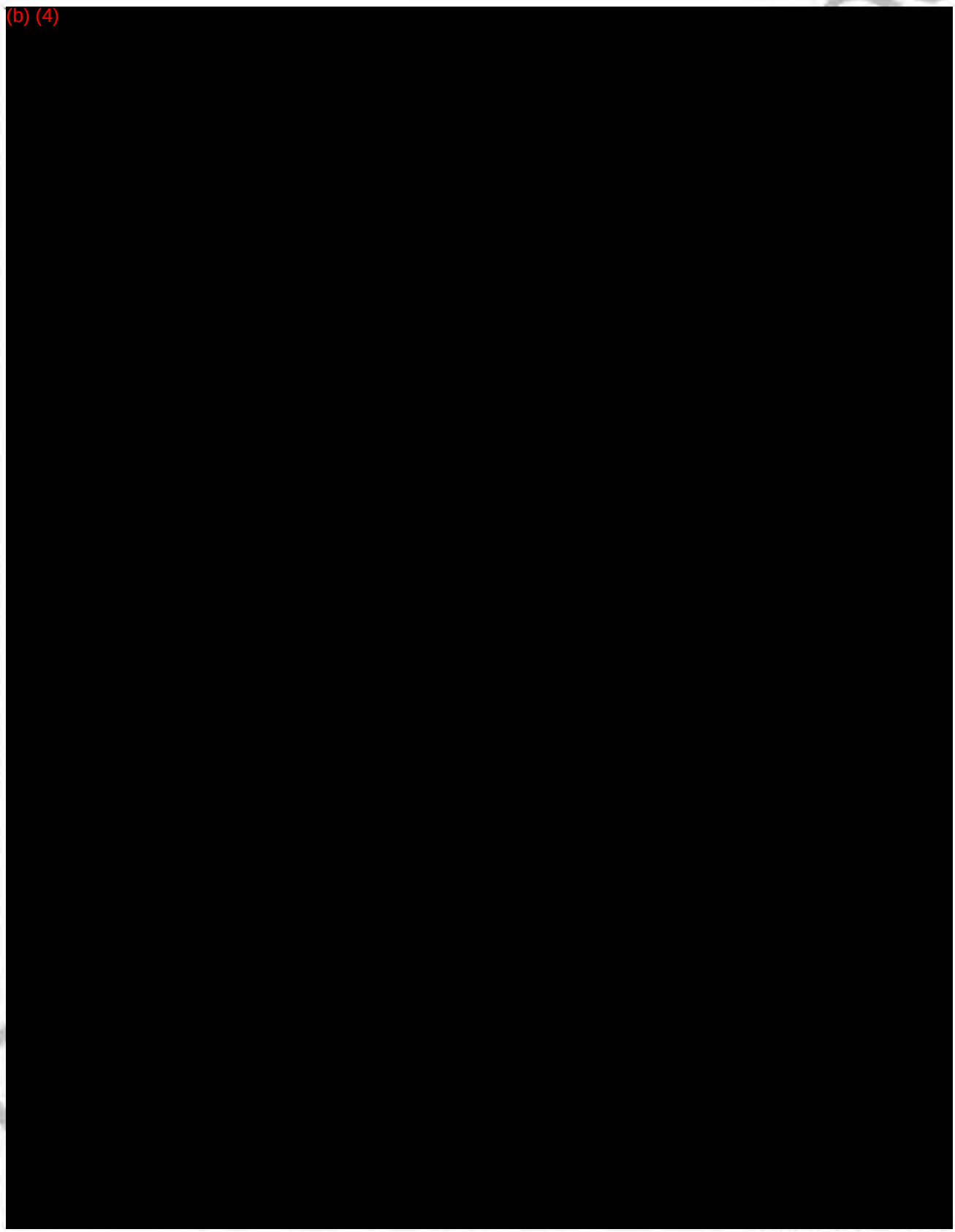

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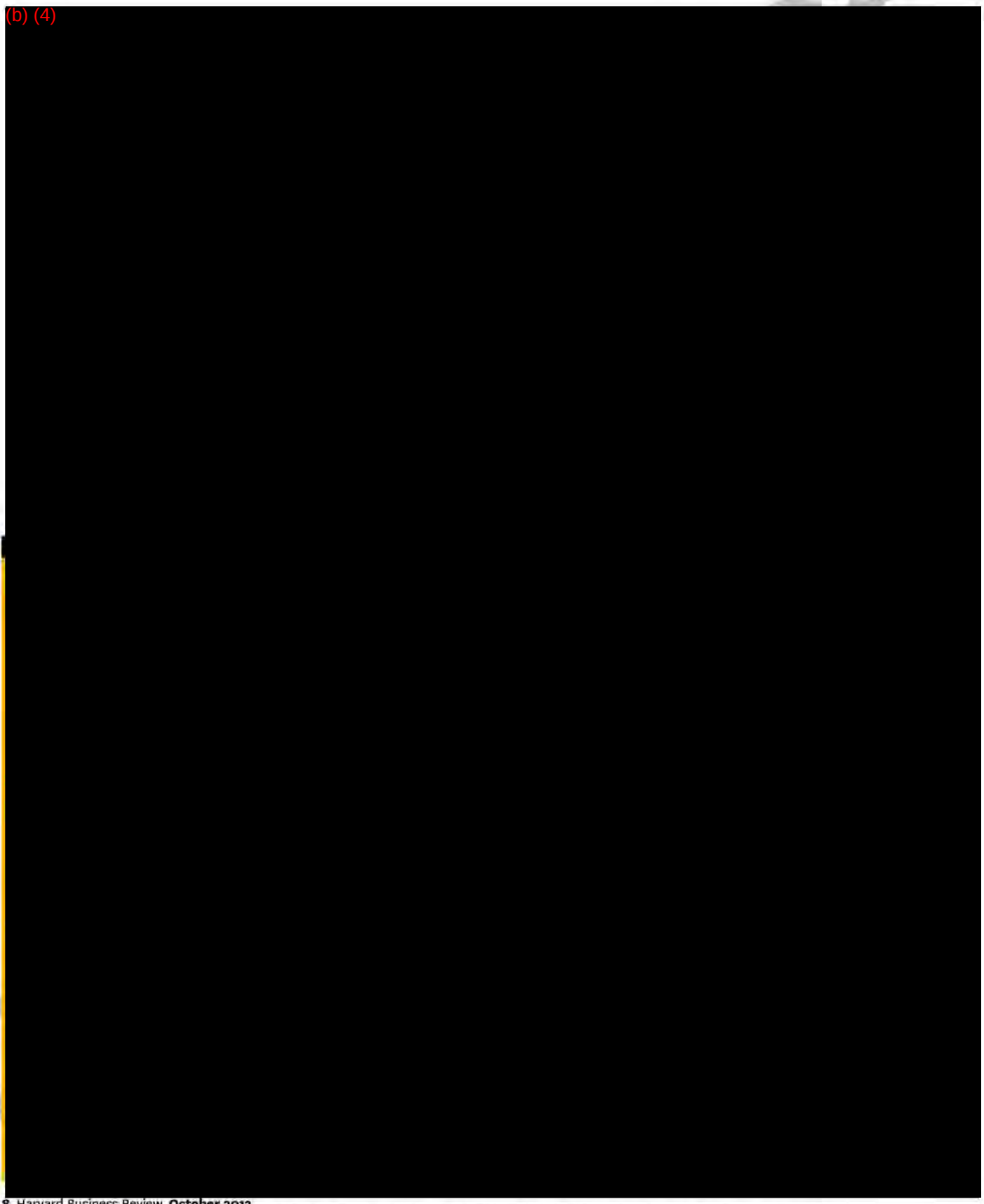

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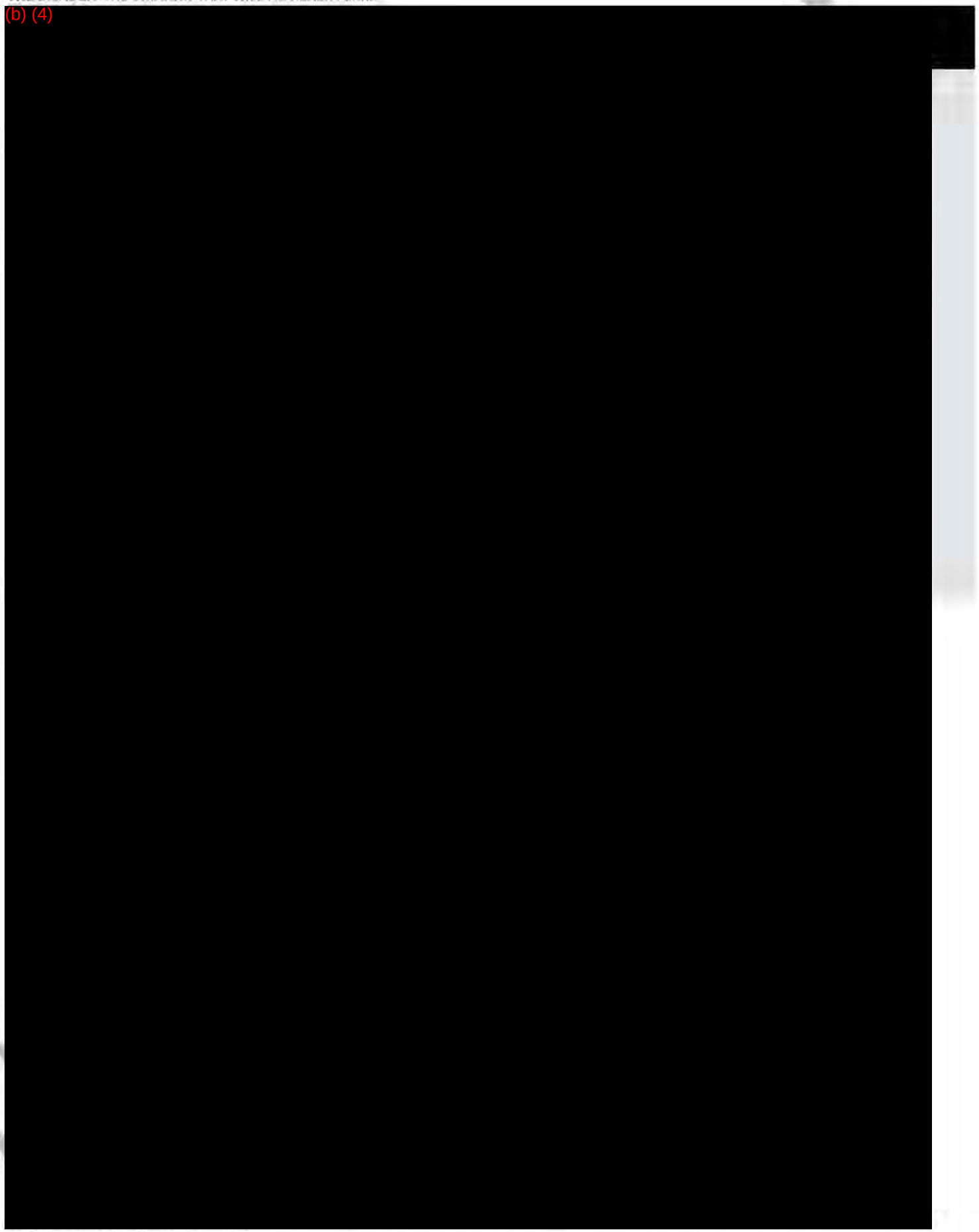

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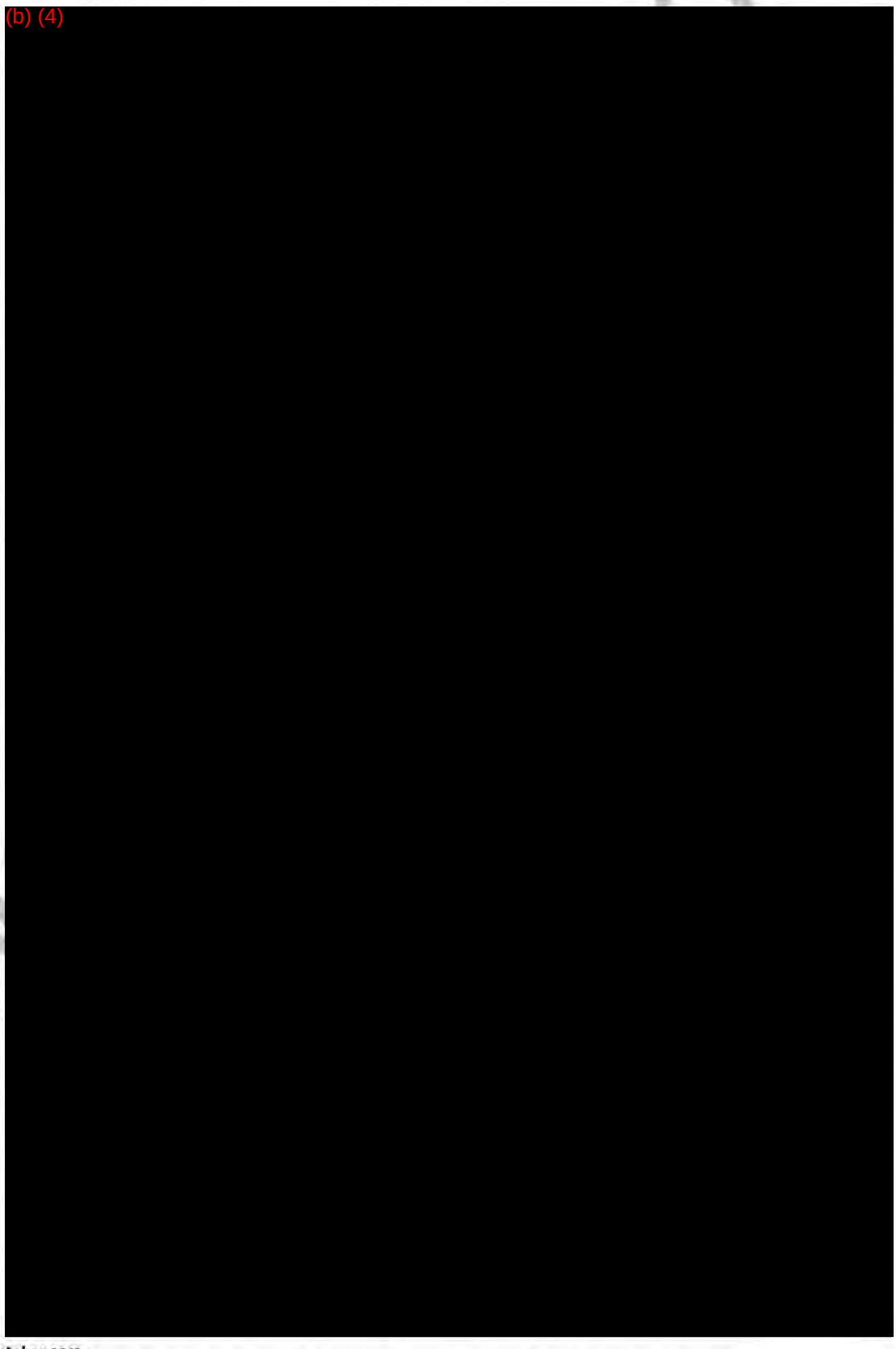

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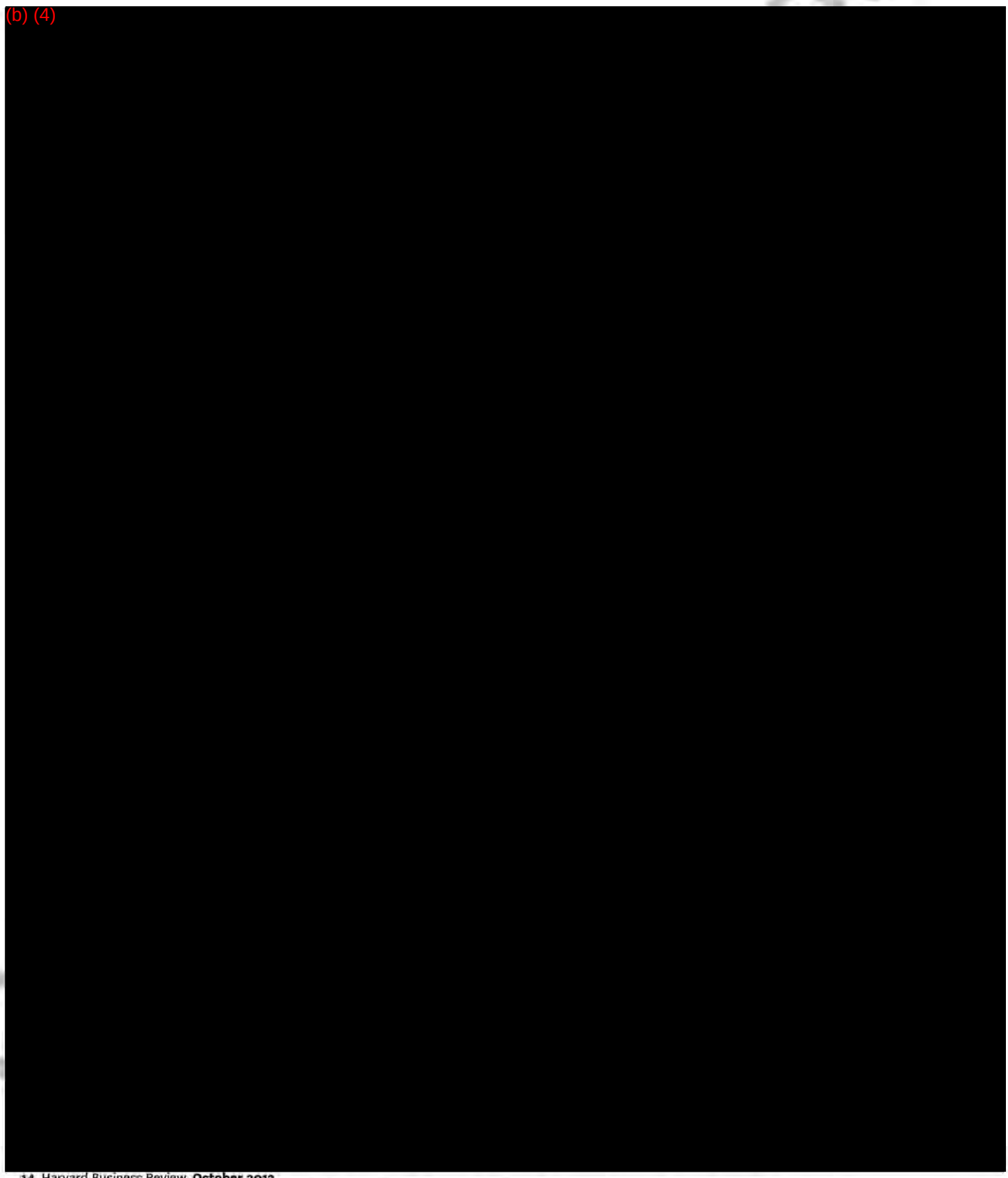

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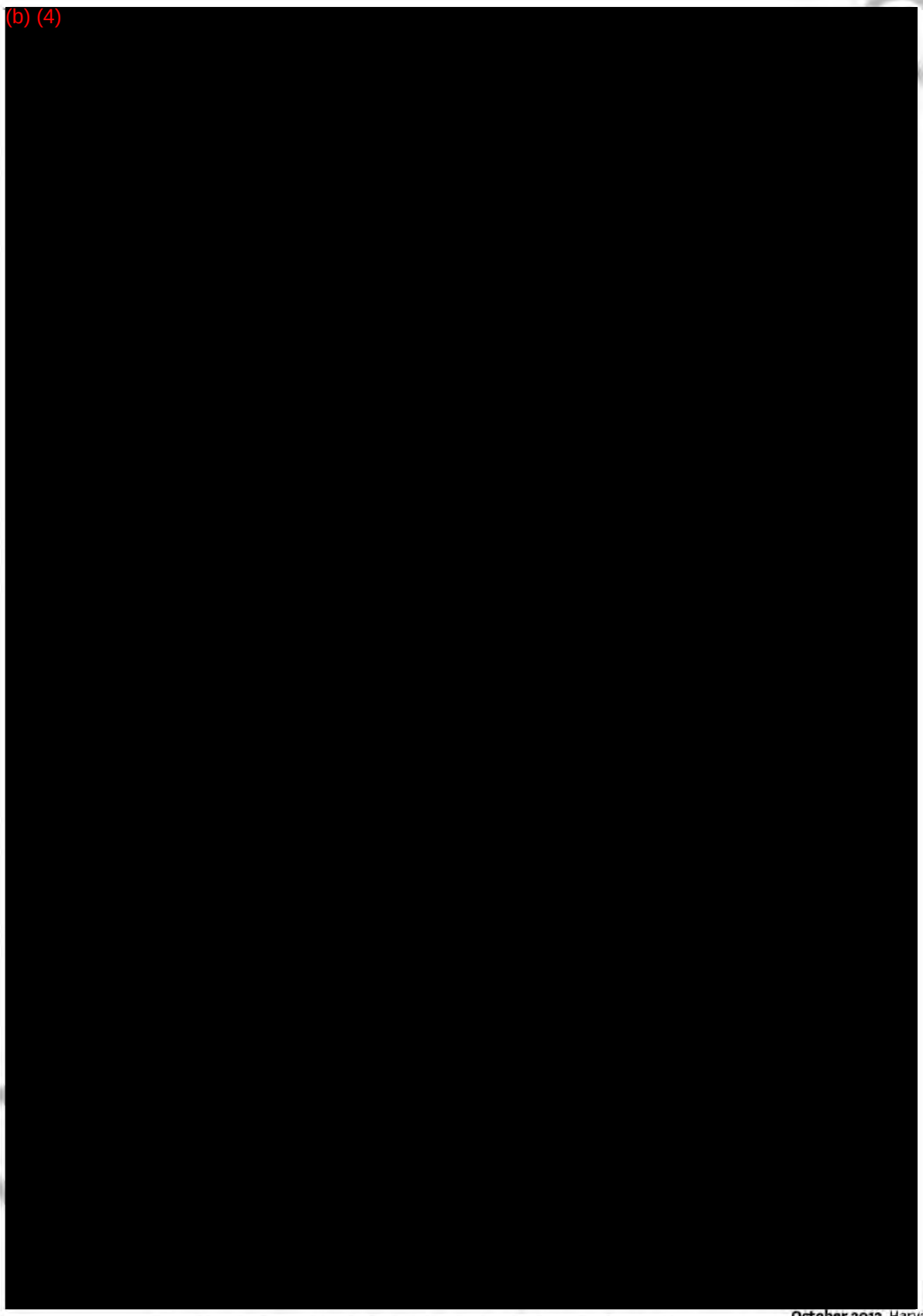

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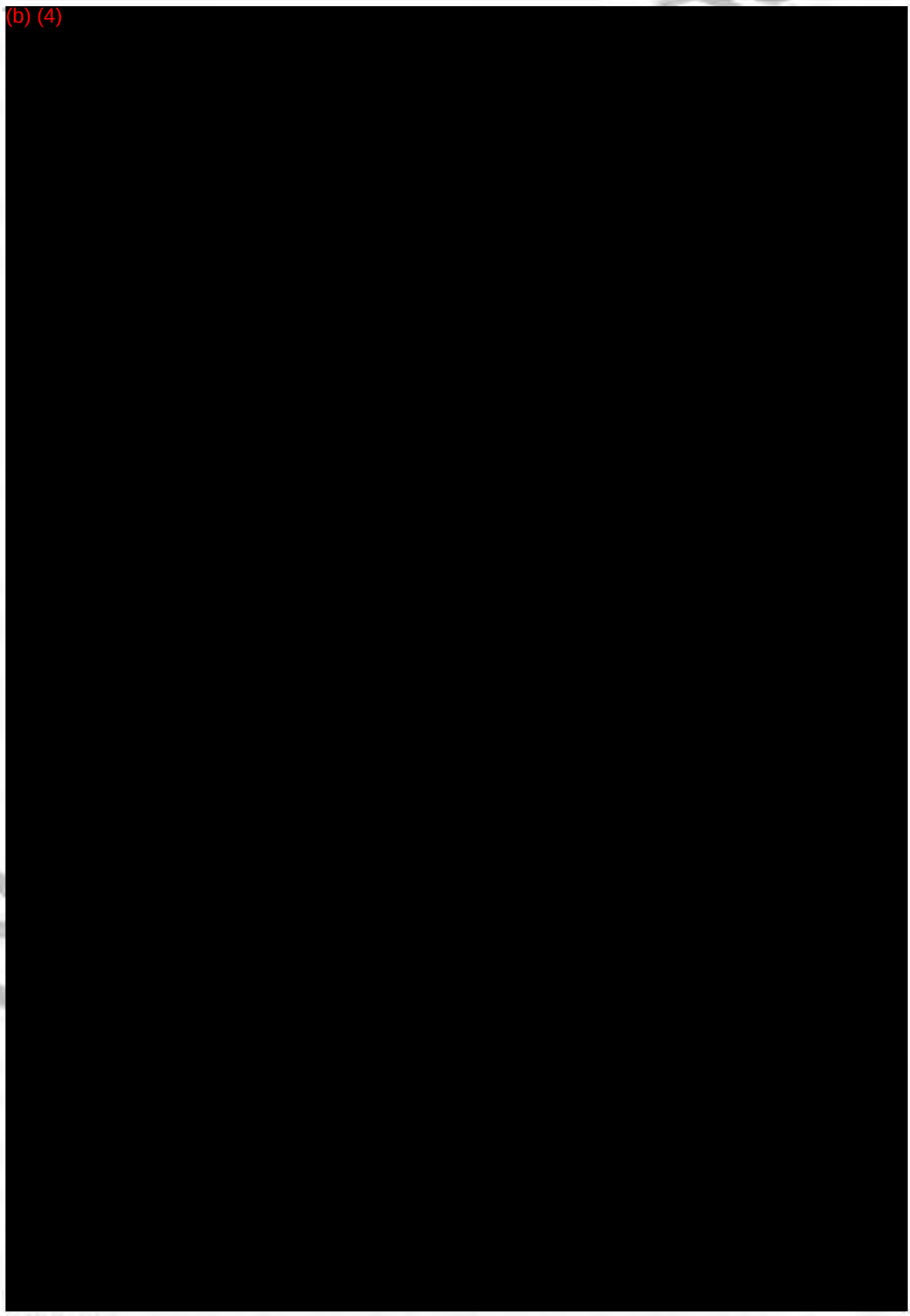

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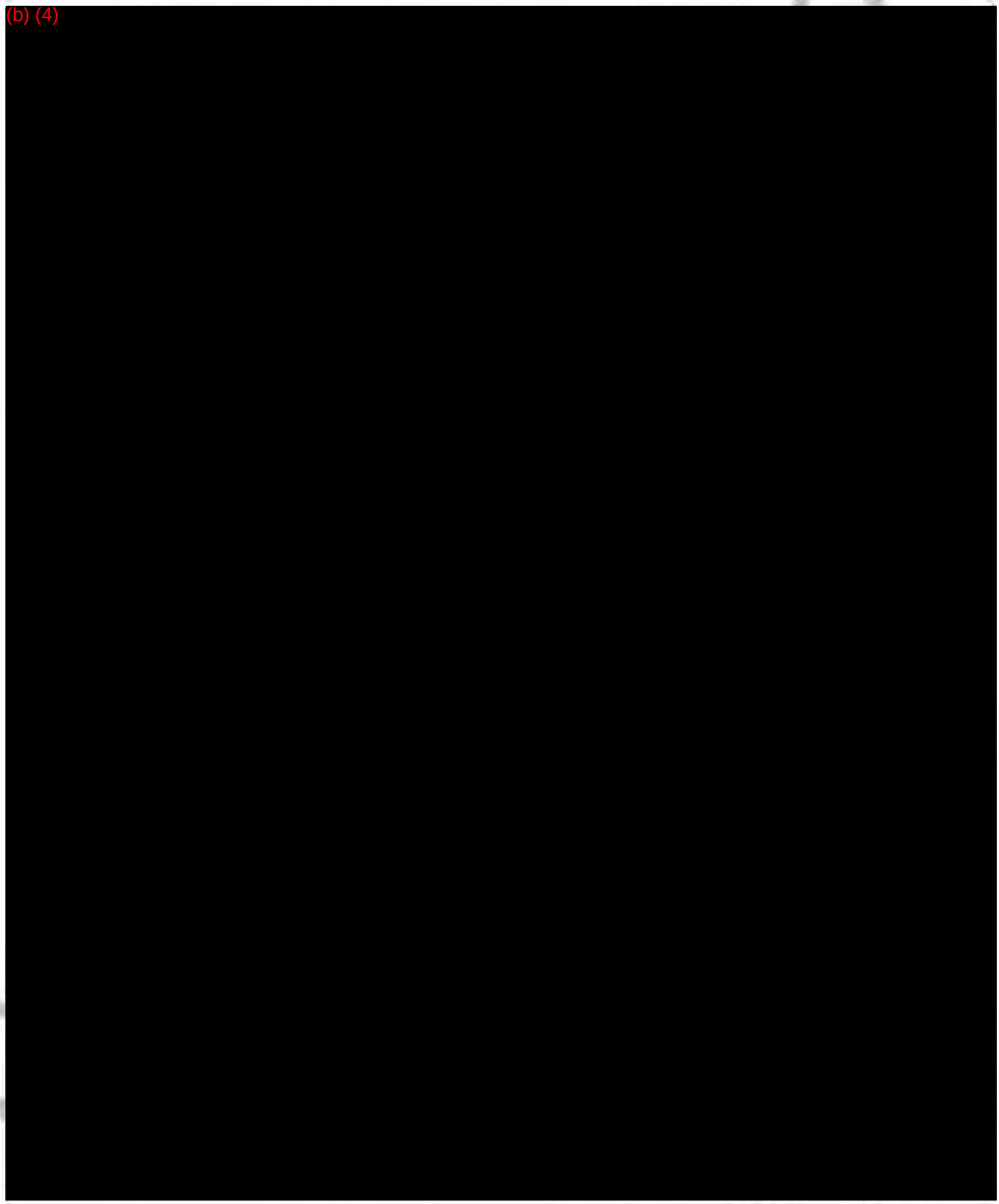

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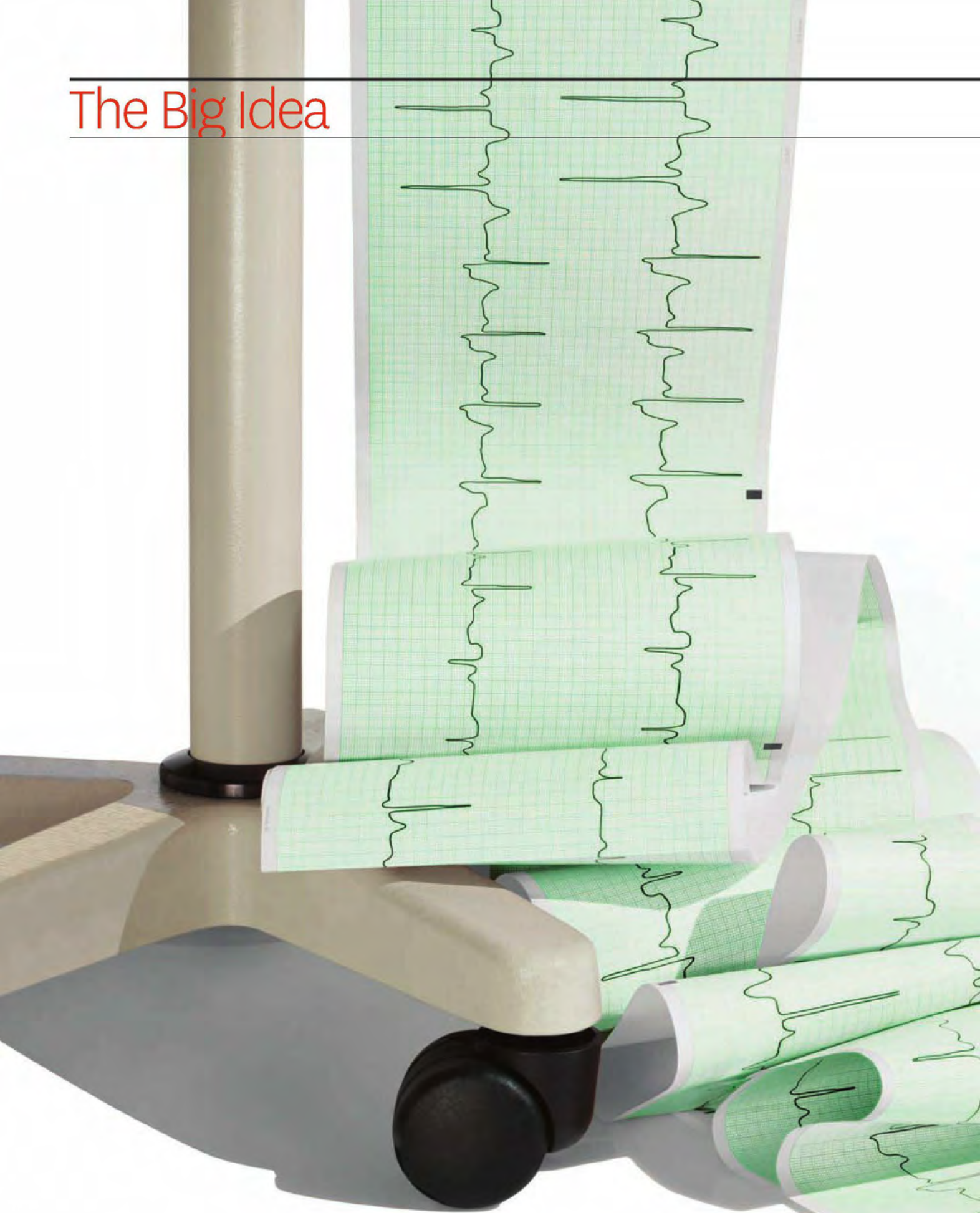

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How to Solve The Cost Crisis In Health Care

The biggest problem with health care isn't with insurance or politics. It's that we're measuring the wrong things the wrong way.

by Robert S. Kaplan and Michael E. Porter



PHOTOGRAPHY: MARK HOOPER

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U.S. health care costs currently exceed 17% of GDP and continue to rise.

Other countries spend less of their GDP on health care but have the same increasing trend. Explanations are not hard to find. The aging of populations and the development of new treatments are behind some of the increase. Perverse incentives also contribute: Third-party payors (insurance companies and governments) reimburse for procedures performed rather than outcomes achieved, and patients bear little responsibility for the cost of the health care services they demand.

But few acknowledge a more fundamental source of escalating costs: the system by which those costs are measured. To put it bluntly, there is an almost complete lack of understanding of how much it costs to deliver patient care, much less how those costs compare with the outcomes achieved. Instead of focusing on the costs of treating individual patients with specific medical conditions over their full cycle of care, providers aggregate and analyze costs at the specialty or service department level.

Making matters worse, participants in the health care system do not even agree on what they mean by costs. When politicians and policy makers talk about cost reduction and "bending the cost curve," they are typically referring to how much the government or insurers pay to providers—not to the costs incurred by providers to deliver health care services. Cutting payor reimbursement does reduce the bill paid by insurers and lowers providers' revenues, but it does nothing to reduce the actual costs of delivering care. Providers share in this confusion. They often allocate their costs to procedures, departments, and services based not on the actual resources used to deliver care but on how much they are reimbursed. But reimbursement itself is based on arbitrary and inaccurate assumptions about the intensity of care.

Poor costing systems have disastrous consequences. It is a well-known management axiom that what is not measured cannot be managed or improved. Since providers misunderstand their costs, they are unable to link cost to process improvements or outcomes, preventing them from making systemic and sustainable cost reductions. Instead, providers (and payors) turn to simplistic actions such as across-the-board cuts in expensive services, staff compensation, and head count. But imposing arbitrary spending limits on discrete components of care, or on specific line-item expense categories, achieves only marginal savings that often lead to higher total systems costs and poorer outcomes. For example, as payors introduce high copayments to limit the use of expensive drugs, costs may balloon elsewhere in the system should patients' overall health deteriorate and they subsequently require more services.

Poor cost measurement has also led to huge cross-subsidies across services. Providers are generously reimbursed for some services and incur losses on others. These cross-subsidies introduce major distortions in the supply and efficiency of care. The inability to properly measure cost and compare cost with outcomes is at the root of the incentive problem in health care and has severely retarded the shift to more effective reimbursement approaches.

Finally, poor measurement of cost and outcomes also means that effective and efficient providers go unrewarded, while inefficient ones have little incentive to improve. Indeed, institutions may be penalized when the improvements they make in treatments and processes reduce the need for highly reimbursed services. Without proper measurement, the healthy dynamic of competition—in which the highest-value providers expand and prosper—breaks down. Instead we have zero-sum competition in which health care providers destroy value by focusing on highly reimbursed services, shifting costs to other entities, or pursuing piecemeal and ineffective line-item cost reductions. Current health care reform initiatives will exacerbate the situation by increasing access to an inefficient system without addressing the fundamental

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Idea in Brief

Much of the rapid escalation in health care costs can be attributed to the fact that providers have an almost complete lack of understanding of how much it costs to deliver patient care. Thus they lack the knowledge necessary to improve resource utilization, reduce delays, and eliminate activities that don't improve outcomes.

Pilot projects under way at hospital systems in the U.S. and Europe demonstrate the transformative effect of a new approach that accurately measures costs—at the level of the individual patient with a given medical condition over a full cycle of care—and compares those costs to outcomes.

As providers and payors better understand costs, they will be positioned to achieve a true "bending of the cost curve" from within the system, not based on top-down mandates.

The sheer size of the opportunity to reduce health care costs—with no sacrifice in outcomes—is astounding.

value problem: how to deliver improved outcomes at a lower total cost.

Fortunately, we can change this state of affairs. And the remedy does not require medical science breakthroughs or top-down governmental regulation. It simply requires a new way to accurately measure costs and compare them with outcomes. Our approach makes patients and their conditions—not departmental units, procedures, or services—the fundamental unit of analysis for measuring costs and outcomes. The experiences of several major institutions currently implementing the new approach—the Head and Neck Center at MD Anderson Cancer Center in Houston, the Cleft Lip and Palate Program at Children's Hospital in Boston, and units performing knee replacements at Schön Klinik in Germany and Brigham & Women's Hospital in Boston—confirm our belief that bringing accurate cost and value measurement practices into health care delivery can have a transformative impact.

The remedy to the cost crisis does not require medical science breakthroughs or new governmental regulation. It simply requires a new way to accurately measure costs and compare them with outcomes.

Understanding the Value of Health Care

The proper goal for any health care delivery system is to improve the value delivered to patients. Value in health care is measured in terms of the patient outcomes achieved per dollar expended. It is not the number of different services provided or the volume of services delivered that matters but the value. More care and more expensive care is not necessarily better care.

To properly manage value, both outcomes and cost must be measured at the patient level. Measured outcomes and cost must encompass the entire cycle of care for the patient's particular medical condition, which often involves a team with multiple specialties performing multiple interventions from diagnosis to treatment to ongoing management. A medical condition is an interrelated set of patient circumstances that are best addressed in a coordinated way and should be broadly defined to include common complications and comorbidities. The cost of treating a patient with diabetes, for example, must include not only the costs associated with endocrinological care but also the costs of managing and treating associated conditions such as vascular disease, retinal disease, and renal disease. For primary and preventive care, the unit of value measurement is a particular patient population—that is, a group with similar primary care needs, such as healthy children or the frail and elderly with multiple chronic conditions.



Let's explore the first component of the health care value equation: health outcomes. Outcomes for any medical condition or patient population should be measured along multiple dimensions, including survival, ability to function, duration of care, discomfort and complications, and the sustainability of recovery. Better measurement of outcomes will, by itself, lead to significant improvements in the value of health care delivered, as providers' incentives shift away from performing highly reimbursed services and toward improving the health status of patients. Approaches for measuring health care outcomes have been described previously, notably in Michael Porter's 2010 *New England Journal of Medicine* article, "What Is Value in Health Care?"

While measuring medical outcomes has received growing attention, measuring the costs required to deliver those outcomes, the second component of the value equation, has received far less attention. In the value framework, the relevant cost is the total cost of all resources—clinical and administrative personnel, drugs and other supplies, devices, space, and equipment—used during a patient's full cycle of care for a specific medical condition, including the treatment of associated complications and common comorbidities. We increase the value of health care delivered to patients by improving outcomes at similar costs or

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by reducing the total costs involved in patients' care while maintaining the quality of outcomes.

A powerful driver of value in health care is that better outcomes often go hand in hand with lower total care cycle costs. Spending more on early detection and better diagnosis of disease, for example, spares patients suffering and often leads to less complex and less expensive care later. Reducing diagnostic and treatment delays limits deterioration of health and also lowers costs by reducing the resources required for care. Indeed, the potential to improve outcomes while driving down costs is greater in health care than in any other field we have encountered. The key to unlocking this potential is combining an accurate cost measurement system with the systematic measurement of outcomes. With these powerful tools in place, health care providers can utilize medical staff, equipment, facilities, and administrative resources far more efficiently, streamline the path of patients through the system, and select treatment approaches that improve outcomes while eliminating services that do not.

The Challenges of Health Care Costing

Accurate cost measurement in health care is challenging, first because of the complexity of health care delivery itself. A patient's treatment involves many different types of resources—personnel, equipment, space, and supplies—each with different capabilities and costs. These resources are used in processes that start with a patient's first contact with the organization and continue through a set of clinical consulta-

Myth #1

Charges are a good surrogate for provider costs.

The widespread confusion between what a provider charges, what it is actually reimbursed, and its costs is a major barrier to reducing the cost of health care. Providers have aggravated this problem by structuring important aspects of their costing systems around the way they are reimbursed. In the U.S., this is partly a historical artifact of the Medicare cost-plus reimbursement system, which requires hospital departments to prepare an annual Medicare Cost Report (MCR), detailing costs and charges by department. Rather than developing and maintaining accurate costing systems that are based on actual resource usage, separate from the regulatory standard required for reimbursement, hospitals defaulted to reimbursement-driven systems.

Unfortunately, that approach was flawed from the start because it was based on the use of highly aggregate data for estimating costs and the deeply flawed assumption that every billable event in a department has the same profit margin. Reimbursement-based costing also buries the costs of valuable but nonbillable events, such as patient consultations, in large overhead pools that are allocated arbitrarily and inaccurately to billable events.

Although costing systems for physician services differ from those used by hospitals, they suffer from the same problems. As is the case for hospitals, U.S. physicians are reimbursed not on the basis of an individual patient's resource use but on average estimates of relative demands—relative value units, or RVUs—on physician labor, practice expenses, and malpractice expenses in performing billable activities. These resource estimates are derived from specialty panels and national surveys of physicians, who stand to gain from overestimating the time and complexity of their work. Despite the required sign-off by government payors, the RVU estimates are not systematically measured or confirmed in practice settings. Reimbursing physicians on the basis of highly aggregate and likely inaccurate estimates of their costs introduces major incentive problems into the health care system. But the problems are compounded when the reimbursement rates are also used to allocate physician costs to patients, a purpose for which they were never intended.

We need to abandon the idea that charges billed or reimbursements paid in any way reflect costs. In reality, the cost of using a resource—a physician, nurse, case manager, piece of equipment, or square meter of space—is the same whether the resource is performing a poorly or a highly reimbursed service. Cost depends on how much of a resource's available capacity (time) is used in the care for a particular patient, not on the charge or reimbursement for the service, or whether it is reimbursed at all.

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tions, treatments, and administrative processes until the patient's care is completed. The path that the patient takes through the system depends on his or her medical condition.

The already complex path of care is further complicated by the highly fragmented way in which health care is delivered today. Numerous distinct and largely independent organizational units are involved in treating a patient's condition. Care is also idiosyncratic; patients with the same condition often take different paths through the system. The lack of standardization stems to some extent from the artisanal nature of medical practice—physicians in the same organizational unit performing the same medical process (for instance, total knee replacement) often use different procedures, drugs, devices, tests, and equipment. In operational terms, you might describe health care today as a highly customized job shop.

Existing costing systems, which measure the costs of individual departments, services, or support activities, often encourage the shifting of costs from one type of service or provider to another, or to the payor or consumer. The micromanagement of costs at the individual organizational unit level does little to reduce total cost or improve value—and may in fact destroy value by reducing the effectiveness of care and driving up administrative costs. (For more on the problems with current costing systems, see the three Myth sidebars.)

Any accurate costing system must, at a fundamental level, account for the total costs of all the resources used by a patient as she or he traverses the system. That means tracking the sequence and duration of clinical and administrative processes used by individual patients—something that most hospital information systems today are unable to do. This deficiency can be addressed; technology advances will soon greatly improve providers' ability to track the type and amount of resources used by individual patients. In the meantime, it is possible to determine the predominant paths followed by patients with a particular medical condition, as our pilot sites have done.

With good estimates of the typical path an individual patient takes for a medical condition, providers can use the time-driven activity-based costing (TDABC) system to assign costs accurately and relatively easily to each process step along the path. This improved version of activity-based costing requires that providers estimate only two parameters at each process step: the cost of each of the resources used in the process and the quantity of time the patient spends with each resource. (See Robert S. Kaplan and Steven R. Anderson's "Time-Driven Activity-Based Costing," HBR 2004.)

In its initial implementation, such a costing system may appear complex. But the complexity arises not from the methodology but from today's idiosyncratic delivery system, with its poorly documented processes for treating patients with particular conditions and its inability to map asset and expense categories to patient processes. As health care providers begin to reorganize into units focused on conditions, standardize their protocols and treatment processes, and improve their information systems, using the TDABC system will become much simpler.

To see how TDABC works in the health care context, we first explore a simplified example.

Costing the Patient: A Simple Example

Consider Patient Jones, who makes an outpatient visit to a clinic. To estimate the total cost of Jones's care, we first identify the processes he undergoes and the resources used in each process. Let's assume that Jones uses an administrative process for check-in, registration, and obtaining documentation for third-party reimbursement; and a clinical process for treatment. Just three clinical resources are required: an administrator (Allen), a nurse (White), and a physician (Green).

We begin by estimating the first of the two parameters: the quantity of time (capacity) the patient uses of each resource at each process. From information supplied by the three staffers, we learn that Jones spent 18 minutes (0.3 hours) with Administrator Allen, 24 minutes (0.4 hours) with Nurse White for a preliminary examination, and nine minutes (0.15 hours) with Physician Green for the direct examination and consultation.

Next, we calculate the capacity cost rate for each resource—that is, how much it costs, per hour or per minute, for a resource to be available for patient-related work—using the following equation:

$$\text{Capacity Cost Rate for Resource}_i = \frac{\text{Expenses Attributable to Resource}_i}{\text{Available Capacity of Resource}_i}$$

The numerator aggregates all the costs associated with supplying a health care resource, such as Allen, White, or Green. It starts with the full compensation of each person, including salary, payroll taxes, and fringe benefits such as health insurance and pensions. To that we add the costs of all other associated resources that enable Allen, White, and Green to be

FURTHER READING FROM THE AUTHORS

MEASURING VALUE AND OUTCOMES

"What Is Value in Health Care?"
by M.E. Porter
New England Journal of Medicine, 2010

Redefining Health Care: Creating Value-Based Competition on Results
by M.E. Porter and E.O. Teisberg
Harvard Business Review Press, 2006

"A Strategy for Health Care Reform: Towards a Value-Based System"
by M.E. Porter
New England Journal of Medicine, 2009

TIME-DRIVEN ACTIVITY-BASED COSTING

Time-Driven Activity-Based Costing: A Simpler and More Powerful Path to Higher Profits
by R.S. Kaplan and S.R. Anderson
Harvard Business Review Press, 2007

Cost and Effect: Using Integrated Cost Systems To Drive Profitability and Performance
by R.S. Kaplan and R. Cooper
Harvard Business Review Press, 1998

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available for patient care. These typically include a pro rata share of costs related to employee supervision, space (the offices each staffer uses), and the equipment, information technology, and telecommunications each uses in the normal course of work. In this way, the cost of many of the organization's shared or support resources can be assigned to the resources that directly interact with the patient.

Supervision cost, for example, can be calculated on the basis of how many people a manager supervises. Space costs are a function of occupancy area and rental rates; IT costs are based on an individual's use of computers and communications products and services. Assume that we find Nurse White's total cost to be as follows:

Annual compensation (including fringe benefits)	**$65,000**
Supervision cost (10% of nursing supervisor's full cost)	**$9,000**
Occupancy (9 sq. meters of space @ $1,200/sq. meter/year)	**$10,800**
Technology and support	**$2,560**
Annual total cost of Nurse White	**$87,360**
Monthly total cost of Nurse White	**$7,280**

We next calculate Nurse White's availability for patient care—the denominator of our capacity cost rate equation. This calculation starts with 365 days per year and subtracts all the time that the employee is not available for work. The calculation for Nurse White is as follows:

Start with	**365 days per year**
less weekend days	**104**
less vacation days	**20**
less holidays	**12**
less sick days	**5**
	224 available days per year
	18.7 days per month

Start with	**7.5 hours per available day**
less scheduled breaks (hours)	**0.5**
less meetings, training, education	**1.0**
Available clinical hours	**6 hours per day**

Nurse White is therefore available for patient work 112 hours per month (6 hours a day for 18.7 days). Dividing the monthly cost of the resource ($7,280) by monthly capacity (112 hours) gives us Nurse White's capacity cost rate: $65 per hour.

Let's assume that similar calculations yield capacity cost rates for Administrator Allen and Physician Green of $45 per hour and $300 per hour, respectively.

We calculate the total cost of Jones's visit to the facility by simply multiplying the capacity cost rate of each resource by the time (in hours) Jones spent using the resource, and then adding up the components:

(0.3 hours × $45)
(0.4 hours × $65)
+ (0.15 hours × $300)
Total cost of visit: $84.50

As this example demonstrates, accurately calculating the cost of delivering health care is quite straightforward under the TDABC system. Although the example is admittedly simplified, it captures almost all the fundamental concepts any health care provider needs to apply to estimate the cost of treating patients over their full cycles of care.

By capturing all the costs over the complete cycle of care for an individual patient's medical condition, we allow providers and payors to address virtually any costing question. Providers can aggregate and analyze patients' cost of care by age, gender, and comorbidity, or by treatment facility, physician, employer, and payor. They can calculate total and average costs for any category or subcategory of patients while still capturing the detailed data on individual patients needed to understand the sources of cost variation within each category.

The Cost Measurement Process

Moving beyond the simplified example, let's now look at the seven steps our pilot sites are using to estimate the total costs of treating their patient populations.

1. Select the medical condition. We begin by specifying the medical condition (or patient population) to be costed, including the associated complications and comorbidities that affect processes and resources used during the patient's care. For each condition, we define the beginning and end of the patient care cycle. For chronic conditions, we choose a care cycle for a period of time, such as a year.

2. Define the care delivery value chain. Next, we specify the care delivery value chain (CDVC), which charts the principal activities involved in a patient's care for a medical condition along with their locations. The CDVC focuses providers on the full care cycle rather than on individual processes, the typical unit of analysis for most process improvements and lean initiatives in health care.

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CREATING A COST MEASUREMENT SYSTEM

1 Select the medical condition and/or patient population to be examined

2 Define the care delivery value chain

3 Develop process maps of each activity in patient care delivery; identify the resources involved and any supplies used for the patient at each process

4 Obtain time estimates for each process step

5 Estimate the cost of supplying each patient care resource

6 Estimate the practical capacity of each resource provider, and calculate the capacity cost rate

7 Compute the total costs over each patient's cycle of care

(The exhibit "The Care Delivery Value Chain" shows the CDVC developed with the Brigham & Women's pilot site for patients with severe knee osteoarthritis.) This overall view of the patient care cycle helps to identify the relevant dimensions along which to measure outcomes and is also the starting point for mapping the processes that make up each activity.

3. Develop process maps of each activity in patient care delivery. Next we prepare detailed process maps for each activity in the care delivery value chain. Process maps encompass the paths patients may follow as they move through their care cycle. They include all the capacity-supplying resources (personnel, facilities, and equipment) involved at each process along the path, both those directly used by the patient and those required to make the primary resources available. (The exhibit "New-Patient Process Map" shows a process map for one segment of the patient care cycle at the MD Anderson Head and Neck Center.) In addition to identifying the capacity-supplying resources used in each process, we identify the consumable supplies (such as medications, syringes, catheters, and bandages) used directly in the process. These do not have to be shown on the process maps.

Our pilot sites used several approaches for creating process maps. Some project teams interviewed clinicians individually to learn about patient flow, while others organized "power meetings" in which people from multiple disciplines and levels of management discussed the process together. Even at this early stage in the project, the sessions occasionally identified immediate opportunities for process and cost improvement.

4. Obtain time estimates for each process. We also estimate how much time each provider or other resource spends with a patient at each step in the process. When a process requires multiple resources, we estimate the time required by each one.

For short-duration, inexpensive processes that vary little across patients, we recommend using standard times (rather than investing resources to record actual ones). Actual duration should be calculated for time-consuming, less predictable processes, especially those that involve multiple physicians and nurses performing complex care activities such as major surgery or examination of patients with complicated medical circumstances.

TDABC is also well suited to capture the effect of process variation on cost. For example, a patient who needs a laryngoscopy as part of her clinical visit requires an additional process step. The time estimate and associated incremental resources required can be easily added to the overall time equation for that patient. (See again the process map exhibit.)

To estimate standard times and time equations, our pilot sites have found it useful to bring together all the people involved in a set of processes for focused discussion. In the future, we expect providers will use electronic handheld, bar-code, and RFID devices to capture actual times, especially if TDABC becomes the generally accepted standard for measuring the cost of patient care.

5. Estimate the cost of supplying patient care resources. In this step, we estimate the direct costs of each resource involved in caring for patients. The direct costs include compensation for employees, depreciation or leasing of equipment, supplies, or other operating expenses. These data, gathered from the general ledger, the budgeting system, and other IT systems, become the numerator for calculating each resource's capacity cost rate.

We must also account for the time that many physicians, particularly in academic medical centers, spend teaching and doing research in addition to their clinical responsibilities. We recommend estimating the percentage of time that a physician spends on clinical activities and then multiplying the physician's compensation by this percentage to obtain the amount of pay accounted for by the physician's clinical work. The remaining compensation should be assigned to teaching and research activities.

Next, we identify the support resources necessary to supply the primary resources providing patient care. For personnel resources, as illustrated in the Patient Jones example, these include supervising employees, space and furnishings (office and patient treatment areas), and corporate functions that support patient-facing employees. When calculating the cost of supplies, we include the cost of the resources used to acquire them and make them available for patient use during the treatment process (for instance, purchasing, receiving, storage, sterilization, and delivery).

Finally, we need to allocate the costs of departments and activities that support the patient-facing work. We map those processes as we did in step 3 and then calculate and assign costs to patient-facing resources on the basis of their demands for the services of these departments, using the process that will be described in step 6.

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CASE STUDY: THE CARE DELIVERY VALUE CHAIN

Severe Knee Osteoarthritis Requiring Replacement

The care delivery value chain is both a descriptive and prescriptive tool. By systematically mapping the full set of activities delivered over the cycle of care for a medical condition, spanning multiple providers and nonclinical care settings, the CDVC enables analysis of how the set of activities *together* generates patient value and offers providers a systematic approach to analyze, improve, and integrate the configuration of care delivery.

	MONITORING/ PREVENTING	DIAGNOSING	PREPARING	INTERVENING	RECOVERING/ REHABBING	MONITORING/ MANAGING
INFORMING AND ENGAGING What do patients need to be educated about?	• Importance of exercise, weight reduction, proper nutrition	• Meaning of diagnosis • Prognosis (short- and long-term outcomes) • Drawbacks and benefits of surgery	• Setting expectations • Importance of nutrition, weight loss, vaccinations • Home preparation	• Expectations for recovery • Importance of rehab • Post-surgery risk factors	• Importance of rehab adherence • Longitudinal care plan	• Importance of exercise, maintaining healthy weight
MEASURING What measures need to be collected?	• Joint-specific symptoms and function (e.g., WOMAC scale) • Overall health (e.g., SF-12 scale)	• Loss of cartilage • Change in subchondral bone • Joint-specific symptoms and function • Overall health	• Baseline health status • Fitness for surgery (e.g., ASA score)	• Blood loss • Operative time • Complications	• Infections • Joint-specific symptoms and function • Inpatient length of stay • Ability to return to normal activities	• Joint-specific symptoms and function • Weight gain or loss • Missed work • Overall health
ACCESSING Where do patient care activities take place?	• PCP office • Health club • Physical therapy clinic	• Specialty office • Imaging facility	• Specialty office • Pre-op evaluation center	• Operating room • Recovery room • Orthopedic floor at hospital or specialty surgery center	• Nursing facility • Rehab facility • Physical therapy clinic • Home	• Specialty office • Primary care office • Health club
TYPICAL PATH OF PATIENT CARE						
CARE DELIVERY What activities are performed at each stage?	**MONITOR** • Conduct PCP exam • Refer to specialists, if necessary **PREVENT** • Prescribe anti-inflammatory medicines • Recommend exercise regimen • Set weight loss targets	**IMAGING** • Perform and evaluate MRI and x-ray -Assess cartilage loss -Assess bone alterations **CLINICAL EVALUATION** • Review history and imaging • Perform physical exam • Recommend treatment plan (surgery or other options)	**Overall prep** • Conduct home assessment • Monitor weight loss **SURGICAL PREP** • Perform cardiology, pulmonary evaluations • Run blood labs • Conduct pre-op physical exam	**ANESTHESIA** • Administer anesthesia (general, epidural, or regional) **SURGICAL PROCEDURE** • Determine approach (e.g., minimally invasive) • Insert device • Cement joint **PAIN MANAGEMENT** • Prescribe preemptive multimodal pain meds	**SURGICAL** • Immediate return to OR for manipulation, if necessary **MEDICAL** • Monitor coagulation **LIVING** • Provide daily living support (showering, dressing) • Track risk indicators (fever, swelling, other) **PHYSICAL THERAPY** • Daily or twice daily PT sessions	**MONITOR** • Consult regularly with patient **MANAGE** • Prescribe prophylactic antibiotics when needed • Set long-term exercise plan • Revise joint, if necessary
ORTHOPEDIC SURGEON						

For more on the CDVC, see *Redefining Health Care: Creating Value-Based Competition on Results*, by M.E. Porter and E.O. Teisberg (Harvard Business Review Press, 2006).

This approach to allocating support costs represents a major shift from current practice. To illustrate, let's compare the allocation of the resources required in a centralized department to sterilize two kinds of surgical tool kits, those used for total knee replacement and those used for cardiac bypass. Existing cost systems tend to allocate higher sterilization costs to cardiac bypass cases than to knee replacement cases because the charges (or direct costs) are higher for a cardiac bypass than for a knee replacement. Under TDABC, however, we have learned that more time and expense are required to sterilize the typically more complex knee surgery tools, so relatively higher sterilization costs should be assigned to knee replacements.

When costing support departments, a good guideline is the "rule of 1." Support functions that have only one employee can be treated as a fixed cost; they can be either not allocated at all or allocated using a simplistic method, as is currently done. But departments that have more than one person or more than one unit of any resource represent variable costs. The workload of these departments has expanded because of increased demand for the services and outputs they provide. Their costs should and can be assigned on the basis of the patient processes that create demand for their services.

Project teams tasked with estimating the cost to supply resources—the numerator of the capacity cost rate—should have expertise in finance, human

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resources, and information systems. They can do this work in parallel with the process mapping and time estimation (steps 3 and 4) performed by clinicians and team members with expertise in quality management and process improvement.

6. Estimate the capacity of each resource, and calculate the capacity cost rate. Determining the practical capacity for employees—the denominator in the capacity cost rate equation—requires three time estimates, which are gathered from HR records and other sources:

a. The total number of days that each employee actually works each year.

b. The total number of hours per day that the employee is available for work.

c. The average number of hours per workday used for nonpatient-related work, such as breaks, training, education, and administrative meetings.

$$\text{Monthly Practical Capacity of Resource} = \frac{a}{12} \times (b-c)$$

For physicians who divide their time among clinical, research, and education activities, we subtract time spent on research and education activities to obtain the number of hours per month that they are available for clinical work.

For equipment resources, we measure capacity by estimating the number of days per month and the number of hours per day that each piece of equipment can be used. This represents the upper limit on the capacity of the equipment. The actual capacity utilization of much health care equipment is sometimes lower because equipment capacity is supplied in large lumps. For instance, suppose a piece of equipment can do 10,000 blood tests a month. A hospital decides to buy the equipment knowing that it needs to process only 6,000 tests per month. In this case, we make an adjustment: The costing system should use the time required to perform 6,000 tests as the capacity of the resource. Otherwise, the tests actually performed on the equipment will, at best, cover only 60% of its cost. If the provider subsequently ends up using the equipment for a higher number of tests, it can adjust the capacity rate accordingly.

This treatment of capacity follows the rule of 1 and should be applied when the organization has only one unit of the equipment. Now suppose a provider has 12 facilities that each use equipment capable of performing 10,000 blood tests per month—but each facility performs only 6,000 tests per month. In that

Myth #2

Hospital overhead costs are too complex to allocate accurately.

Most health care leaders will eventually accept the idea that the direct costs of patient care, such as nurses, physicians, and consumable supplies (drugs, bandages, and syringes), ought to be assigned more accurately to individual patients. But many leaders believe that allocating the costs of indirect and support units cannot be done except with crude, arbitrary methods, often dressed up to look sophisticated. Typically, they use a "peanut butter" method, which spreads overhead and support costs across each department's billable activities (see Myth #1) using metrics such as the size of direct costs, head count, length of stay, assigned physical space, number of patients, number of procedures, RVUs supplied, or costs-to-charge ratios (Myth #1 again).

The effect of such arbitrary support-department allocations on the measured cost of services can be profound. In the past, Schön Klinik, like other hospitals in Germany, had reduced the capacity of its total knee replacement rehabilitation units in part because the existing cost system portrayed them as less profitable than acute-care units. During Schön Klinik's cost pilot, the project team discovered that the existing cost system allocated support-department costs largely on the basis of length of patient stay, not on the patient's use of support resources. Since Schön total knee replacement patients spent 75% of their stay in the rehab facility, rehab had been allocated about 75% of support department costs.

The TDABC analysis showed, however, that the demand for many support-unit services, such as medical billing, is far higher during the days a patient spends in the acute-care facility than during rehab days. With support costs properly assigned, the rehab facility showed improved profitability. Schön Klinik began to contemplate the expansion of its rehabilitation capacity—a complete reversal of its previous decision—and shifted its focus more intensively on reducing support costs incurred during the acute-care stay.

Once indirect costs have been accurately assigned, managers and physicians can look for ways to reduce demand for support-department services and improve the efficiency with which they are delivered. That, in turn, will enable organizations to lower their spending on these resources.

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case, the capacity of each resource unit should be set at the full 10,000 tests per month, not its expected number. We want the system to signal the cost of unused capacity when a provider chooses to supply capacity at multiple locations or facilities rather than consolidating its use of expensive equipment.

In addition to the lumpiness with which capacity gets acquired, factors such as peak load demands, surge capacity, and capacity acquired for future growth should be accounted for. This applies to both equipment and personnel. (Those factors can be incorporated, but the treatment is beyond the scope of this article.)

In practice, we have found that underutilization of expensive equipment capacity is often not a conscious decision but a failure of the costing system to provide visibility into resource utilization. That problem is corrected by the TDABC approach. We describe opportunities to improve resource capacity utilization later in the article.

To calculate the resource capacity cost rate, we simply divide the resource's total cost (step 5) by its practical capacity (step 6) to obtain a rate, measured in dollars or euros per unit of time, typically an hour or a minute.

7. Calculate the total cost of patient care. Steps 3 through 6 establish the structure and data components of the TDABC system. In the final step, the project team estimates the total cost of treating a patient by simply multiplying the capacity cost rates (including associated support costs) for each resource used in each patient process by the amounts of time the patient spent with the resource (step 4). Sum up all the costs across all the processes used during the patient's complete cycle of care to produce the total cost of care for the patient.

Opportunities to Improve Value

Our new approach actively engages physicians, clinical teams, administrative staff, and finance professionals in creating the process maps and estimating the resource costs involved in treating patients over their care cycle. This bridges the historical divide between managers and clinical teams that has often led to tensions and stalemates over cost-cutting steps. TDABC builds a common information platform that will unleash innovation based on a shared understanding of the actual processes of care. Even at our pilot site Schön Klinik, which already had an excellent departmental cost-control system, introducing TDABC revealed powerful new ways to improve its processes and restructure care delivery. Capitalizing on these value-creating opportunities—previously hidden by inadequate and siloed costing systems—is the key to solving the health care cost problem. Let's examine some of the most promising opportunities that proper costing reveals.

Eliminate unnecessary process variations and processes that don't add value. In our pilots, we have documented significant variation in the processes, tools, equipment, and materials used by physicians performing the same service within the same unit in the same facility. For example, in total knee replacement, surgeons use different implants, surgical kits, surgeons' hoods, and supplies, thereby introducing substantial cost variation in treating patients with the same condition at the same site. The surgical unit now measures the costs and outcomes that each surgeon produces. As a result, clinical practice leaders are able to have more constructive and better informed discussions about how best to standardize care and treatment processes to reduce the costs of variability and limit the use of expensive approaches and materials that do not demonstrably lead to improved outcomes.

In addition to reducing process variations, our pilot sites have eliminated steps or entire processes that did not improve outcomes. Schön Klinik, for example, lowered costs by reducing the breadth of tests included in its common laboratory panel after learning that many of the tests did not provide new information that would lead to improvement in outcomes.

Comparing practices across different countries for the same condition also reveals major opportunities for improvement. The reimbursement for a total joint replacement care cycle in Germany and Sweden is approximately $8,500, including all physician and technical services and excluding only outpatient rehabilitation. The comparable figure in U.S. medical centers is $30,000 or more. Since providers in all three countries report, in aggregate, similar margins on joint replacement care, U.S. providers' costs are likely two to three times as high as those of their European counterparts. By comparing process maps and resource costs for the same medical condition across multiple sites, we can determine how much of the cost difference is attributable to variations in processes, protocols, and productivity and how much is attributable to differences in resource or supply costs such as wages and implant prices. Our initial research suggests that although inputs are more expensive in

New-Patient Process Map

This process map describes a segment of the patient care cycle at MD Anderson Head and Neck Center. Process maps show the resources required for each activity and often reveal immediate opportunities for process improvement and cost reduction.

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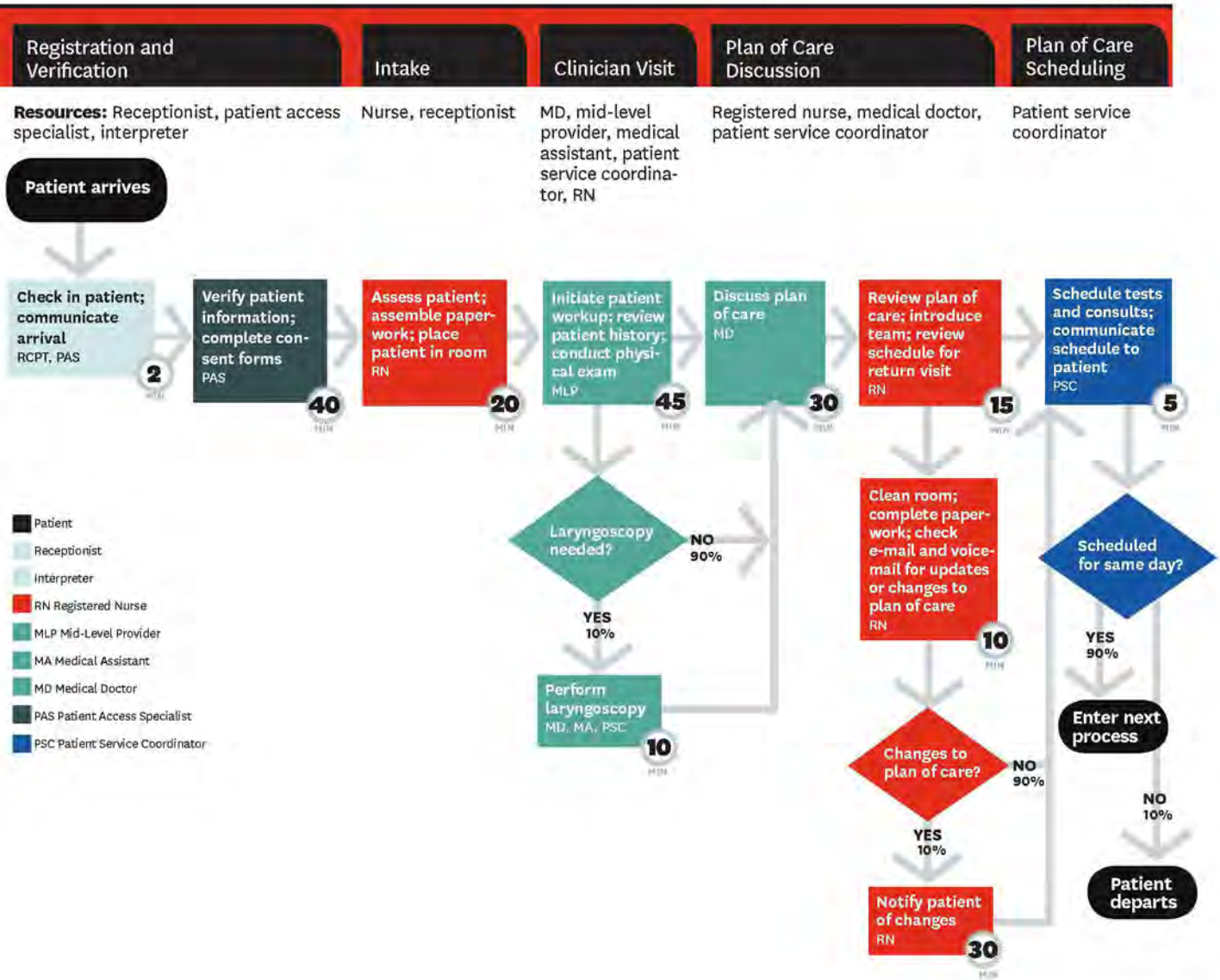

the United States, the higher cost in U.S. facilities is mainly due to lower resource productivity.

Improve resource capacity utilization. The TDABC approach identifies how much of each resource's capacity is actually used to perform processes and treat patients versus how much is unused and idle. Managers can clearly see the quantity and cost of unused resource capacity at the level of individual physicians, nurses, technicians, pieces of equipment, administrators, or organizational units. Resource utilization data also reveal where increasing the supply of certain resources to ease bottlenecked processes would enable more timely care and serve more patients with only modestly higher expenditures.

When managers have greater visibility into areas where substantial and expensive unused capacity exists, they can identify the root causes. For example, some underutilization of expensive space, equipment, and personnel is caused by poor coordination and delays when a patient is handed off from one specialty or service to the next. Another cause of low resource utilization is having specialized equipment available just in case the need arises. Some facilities that serve patients with unpredictable and rare medical needs make a deliberate decision to carry extra capacity. In such cases, an understanding of the actual cost of excess capacity should trigger a discussion on how best to consolidate the treatment of such patients. Much excess resource capacity, however, is due not to rare conditions or poor handoffs but to the prevailing tendency of many hospitals and clinics to provide care for almost every type of medical problem. Such fragmentation of service lines introduces costly redundancy throughout the health care system. It can also lead to inferior outcomes when providers handle a low volume of cases of each type. Accurate costing gives managers a valuable tool for consolidating patient care for low-volume procedures in fewer institutions, which

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would both reduce the high costs of unused capacity and improve outcomes.

Deliver the right processes at the right locations. Many services today are delivered in over-resourced facilities or facilities designed for the most complex patient rather than the typical patient. By accurately measuring the cost of delivering the same services at different facilities, rather than using figures based on averaged direct costs and inaccurate overhead allocations, providers are able to see opportunities to perform particular services at properly resourced and lower-cost locations. Such realignment of care delivery, already under way at Children's Hospital Boston, improves the value and convenience of more routine services for both patients and caregivers while allowing tertiary facilities to concentrate their specialized resources on truly complex care.

Match clinical skills to the process. Resource utilization can also be improved by examining whether all the processes currently performed by physicians and other skilled staff members require their level of expertise and training. The process maps developed for TDABC often reveal opportunities for appropriately skilled but lower-cost health care professionals to perform some of the processes currently performed by physicians without adversely affecting outcomes. Such substitutions would free up physicians and nurses to focus on their highest-value-added roles. (For an example from one of our pilot sites, see the sidebar "A Cancer Center Puts the New Approach to Work.")

Speed up cycle time. Health care providers have multiple opportunities to reduce cycle times for treating patients, which in turn will reduce demand for resource capacity. For example, reducing the time that patients have to wait will reduce demand for patient supervision and space. Speeding up cycle time also improves outcomes, both by minimizing the duration of patient uncertainty and discomfort and by reducing the risk of complications and minimizing disease progression. As providers improve

Myth #3
Most health care costs are fixed.

Many health care system participants, including economists and accountants, believe that most costs in health care are fixed because so much care is delivered using shared staff, space, and equipment. The result of this misguided thinking is that cost reduction efforts tend to focus on only the small fraction of costs seen as variable, such as drugs and supplies, which are sometimes referred to as marginal or incremental costs. This myth also motivates some health care organizations to expand through mergers, acquisitions, and organic growth in order to reap economies of scale by spreading their fixed costs over an increased volume of business.

But if most health care costs were truly fixed, we would not have the health care cost problem we do today. If most costs were fixed, growth in demand for health care would increase only that small fraction of costs that are variable, leading to lower average costs in the system, not the dramatically higher share of GDP now being devoted to health care.

To understand why most health care costs are not fixed, start with personnel costs, which are generally at least 50% of the total costs of health care providers, according to American Hospital Association statistics. Hint: Personnel costs are not fixed. Hospital executives can set the quantity, mix, and compensation of their personnel each year, or even more frequently. Personnel costs are fixed only when executives allow them to be. The claim that personnel costs are fixed is a reflection of management inattention, not of the nature of those costs.

Space costs are also not fixed. Space is perhaps an organization's most fungible resource. If demand for space is reduced, units can be consolidated into smaller space, and excess space can be repurposed, sold, or subleased. Similarly, equipment costs can be avoided if changes in processes, treatment protocols, or patient mix eliminate the demand for the resources. Equipment no longer needed can be retired or sold to other health care institutions that are expanding their capacity.

All told, we estimate that upwards of 95% of what health care managers think of as fixed costs are actually under their control and therefore not really fixed.

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their process flows and reduce redundancy, their patients will no longer have to be so "patient" as they receive a complete cycle of care.

Optimize over the full cycle of care. Health care providers today are typically organized around specialties and services, which complicates coordination, interrupts the seamless, integrated flow of patients from one process to the next, and leads to the duplication of many processes. In the typical care delivery process, for example, patients see multiple providers in multiple locations and undergo a separate scheduling interaction, check-in, medical consultation, and diagnostic workup for each one. This wastes resources and creates delays. The TDABC model makes visible the high costs of these redundant administrative and clinical processes, motivating professionals from different departments to work together to integrate care across departments and specialties. Eliminating unnecessary administrative and clinical processes represents one of the biggest opportunities for lowering costs.

With a complete picture of the time and resources involved, providers can optimize across the entire care cycle, not just the parts. Physicians and staff may shift more of their time and resources to the front end of the care cycle—to activities such as patient education and clinical team consultations—to reduce the likelihood of patients experiencing far more costly complications and readmissions later in the cycle.

Additionally, this resource- and process-based approach gives providers visibility into valuable nonbilled events in the cycle of care. These activities—such as nurse counseling time, physician phone calls to patients, and multidisciplinary care team meetings—can often make major contributions to efficiency and favorable outcomes. Because existing systems hide these costs in overhead (see Myth #1), such important elements of care are prone to be minimized or left unmanaged.

Capturing the Payoffs

"Calculating the return on investment of performance improvement has been missing from most of the quality improvement discussions in health care," Dr. Thomas Feeley at MD Anderson told us. "When measurement does occur, the assumptions are usually gross, inaccurate, and sometimes overstated," he added. "TDABC gave us a powerful tool to actually model the effect an improvement will have on costs." Accurate costing allows the impact of process

PILOT

A Cancer Center Puts The New Approach To Work

by Heidi W. Albright, MHA, and Thomas W. Feeley, MD

The University of Texas MD Anderson Cancer Center is a National Cancer Institute–designated Comprehensive Cancer Center, located in Houston, Texas. Seeing more than 30,000 new patients every year, MD Anderson accounts for approximately 20% of cancer care within the Houston region and 1% of cancer care nationally. MD Anderson is a medical condition–focused center that provides integrated, interdisciplinary care across the care cycle.

In collaboration with Michael Porter, we embarked on a major effort to expand clinical outcome measurement, beginning with a study of 2,468 patients in the Head and Neck Center, in 2008. We created the Institute for Cancer Care Excellence in December 2008 to support this effort. In 2010, with Robert Kaplan, we launched a pilot project, also within the Head and Neck Center, to assess the feasibility of applying modern cost accounting to health care delivery.

Traditionally, at MD Anderson, we used a charge-based cost accounting system. However, we realized that its cost allocations were problematic at several levels. For a start, the drivers of cost in health care had changed but the allocation methodology had not, with the result that our costing no

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PILOT

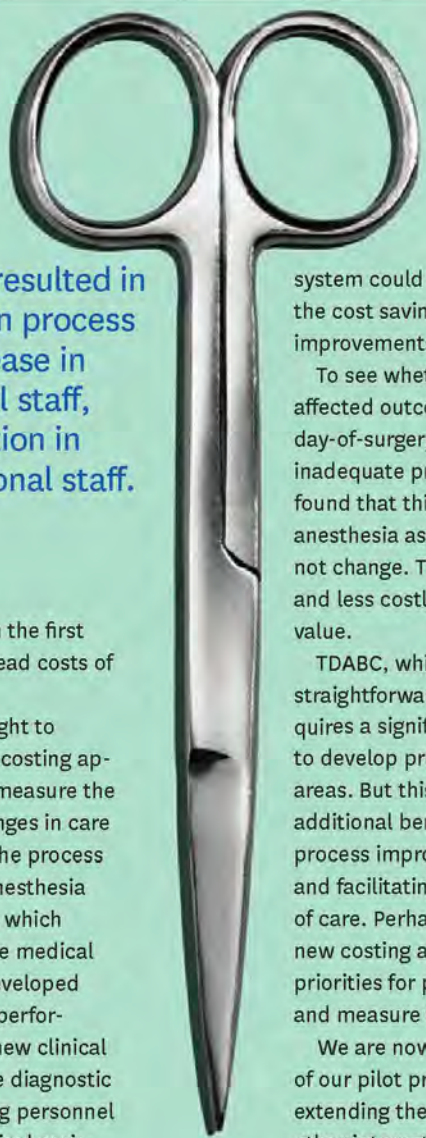
A Cancer Center Puts the New Approach to Work *continued*

longer reflected reality. What's more, MD Anderson routinely allocated more costs to services that were highly reimbursed. With impending health care reform set to shift the industry away from fee-for-service reimbursement to bundled or global payments, we needed a costing system that could provide more accurate patient-level costs by medical condition.

To determine whether time-driven activity-based costing (TDABC) would provide this level of accuracy, we worked with a team of clinicians and internal financial staff members in a pilot study. The team began by developing a care delivery value chain that mapped out the full treatment of a patient. Within each segment of care—the outpatient clinic, diagnostic imaging, the operating room, inpatient care, radiation therapy, and chemotherapy administration—we created process maps that also included all the resources involved. Each segment of the process map took approximately 40 hours to complete, with a team consisting of a project manager, a project coordinator, a process mapping expert, financial staff, clinical and business managers, and staff members from each function being mapped. (See the exhibit "New-Patient Process Map" for an example.)

The project team then estimated how much time it takes to perform each task and the capacity cost of each health care provider. We validated all the process steps, time estimates, and branching points with the help of frontline health personnel who were actually performing the tasks—not just departmental managers and senior leaders.

We then estimated the per-patient cost for each process step. Initially, we examined only personnel costs because they accounted for approximately 75% of total costs at the Head and Neck Center. Because of personnel and time constraints, we used an approximate procedure on the first pass to allocate the overhead costs of support departments.



The new process resulted in a 16% reduction in process time, a 12% decrease in costs for technical staff, and a 67% reduction in costs for professional staff.

Our pilot study also sought to evaluate whether the new costing approach would allow us to measure the cost consequences of changes in care processes. We examined the process for a patient visit to our Anesthesia Assessment Center (AAC), which occurs prior to surgery. The medical director of the AAC had developed two initiatives to improve performance: (1) implementing new clinical guidelines for preoperative diagnostic testing and (2) reorganizing personnel tasks—that is, having medical assistants perform some tasks previously performed by nurses and using nurses to perform some tasks previously performed by physicians.

The project team developed process maps for the AAC before and after the performance improvements, and then applied costs from the TDABC model to each map. The modified process resulted in a 16% (11-minute) reduction in process time, a 12% decrease in costs for technical staff, and a 67% reduction in costs for professional staff (physicians and other providers). Total costs fell 36%, from approximately $250 per patient (including direct and indirect costs) to $160. Our existing costing system could not provide visibility into the cost savings from these process improvements.

To see whether the cost reductions affected outcomes, we examined day-of-surgery cancellations due to inadequate preoperative workup and found that this critical outcome of the anesthesia assessment process did not change. Thus, the more efficient and less costly process improved value.

TDABC, which we have found straightforward to implement, requires a significant time investment to develop process maps for all care areas. But this investment has yielded additional benefits by supporting process improvement opportunities and facilitating the standardization of care. Perhaps most important, the new costing approach helps us set priorities for process improvements and measure their cost impact.

We are now completing the analysis of our pilot project data and will be extending the methodology to all our other integrated cancer care units. As we merge ongoing measurement of clinical outcomes in each of our care centers with patient-level costs for a full care cycle, we will be better positioned to drive value improvement and develop bundled prices for clinical care. Through this work, we hope to provide convincing evidence of the health care value that MD Anderson's integrative cancer treatment strategy actually delivers.

Heidi W. Albright is the director of the Institute for Cancer Care Excellence at MD Anderson Cancer Center. **Thomas W. Feeley** is the Helen Shafer Fly Distinguished Professor of Anesthesiology and the vice president of medical operations at MD Anderson Cancer Center.

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improvements to be readily calculated, validated, and compared.

The big payoff occurs when providers use accurate costing to translate the various value-creating opportunities into actual spending reductions. A cruel fact of life is that total costs will not actually fall unless providers issue fewer and smaller paychecks, consume less (and less expensive) space, buy fewer supplies, and retire or dispose of excess equipment. Facing revenue pressure due to lower reimbursements—particularly from government programs such as Medicare and Medicaid—providers today use a hatchet approach to cost reduction by mandating arbitrary cuts across departments. That approach jeopardizes both the quality and the supply of care. With accurate costing, providers can target their cost reductions in areas where real improvements in resource utilization and process efficiencies enable providers to spend less without having to ration care or compromise its quality.

Health care organizations today, like all other firms, conduct arduous and time-consuming budgeting and capacity planning processes, often accompanied by heated arguments, power negotiations, and frustration. Such difficulties are symptomatic of inadequate costing systems and can be avoided.

A TDABC budgeting process starts by predicting the volume and types of patients the provider expects. Using these forecasts combined with the process maps for treating each patient condition, providers can predict the quantity of resource hours required. This can then be divided by the practical capacity of each resource type to obtain accurate estimates of the quantity of each resource needed to meet the forecasted demand. Estimated monthly expense budgets for future periods can be easily obtained by multiplying the quantity of each resource category required by the monthly cost of each resource.

In this way, managers can make virtually all their costs "variable." They can readily see how efficiency improvements and process innovations lead to reduced spending on resources that are no longer needed. Managers also have the information they need to redeploy resources freed up as a result of process improvements. Leaders gain a tool they never had before: a way to link decisions about patient needs and treatment processes directly to resource spending.

Reinventing Reimbursement

If we are to stop the escalation of total health care costs, the level of reimbursement must be reduced. But how this is done will have profound implications for the quality and supply of health care. Across-the-board cuts in reimbursement will jeopardize the quality of care and likely lead to severe rationing. Reductions that enable the quality of care to be maintained or improved need to be informed by accurate knowledge of the total costs required to achieve the desired outcomes when treating individual patients with a given medical condition.

When providers understand the total costs of treating patients over their complete cycle of care, they can contemplate innovative reimbursement approaches without fear of sacrificing their financial sustainability.

The current system of reimbursement is disconnected from actual costs and outcomes and discourages providers and payors from introducing more cost-effective processes for treating patients. With today's inadequate costing systems, reimbursement rates have often been based on historical charges. That approach has introduced massive cross subsidies that reimburse some services generously and pay far below costs for others, leading to excess supply for well-reimbursed services and inadequate delivery and innovation for poorly reimbursed ones.

Adjusting only the level of reimbursement, however, will not be enough. Any true health care reform will require abandoning the current complex fee-for-service payment schedule altogether. Instead, payors should introduce value-based reimbursement, such as bundled payments, that covers the full care cycle and includes care for complications and common comorbidities. Value-based reimbursement rewards providers who deliver the best overall care at the lowest cost and who minimize complications rather than create them. The lack of accurate cost

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Accurate costing allows the impact of process improvements to be readily calculated, validated, and compared.

data covering the full cycle of care for a patient has been the major barrier to adopting alternative reimbursement approaches, such as bundled reimbursement, that are more aligned with value.

We believe that our proposed improvements in cost measurement, coupled with better outcome measurement, will give third-party payors the confidence to introduce reimbursement methods that better reward value, reduce perverse incentives, and encourage provider innovation. As providers start to understand the total costs of treating patients over their complete cycle of care, they will also be able to contemplate innovative reimbursement approaches without fear of sacrificing their financial sustainability. Those that deliver desired health outcomes faster and more efficiently, without unnecessary services, and with proven, simpler treatment models will not be penalized by lower revenues.

ACCURATELY MEASURING costs and outcomes is the single most powerful lever we have today for transforming the economics of health care. As health care leaders obtain more accurate and appropriate costing numbers, they can make bold and politically difficult decisions to lower costs while sustaining or improving outcomes. Dr. Jens Deerberg-Wittram, a senior executive at Schön Klinik, told us, "A good costing system tells you which areas are worth addressing and gives you confidence to have the difficult discussions with medical professionals." As providers and payors better understand costs, they will see numerous opportunities to achieve a true "bending of the cost curve" from within the system, not in response to top-down mandates. Accurate costing also unlocks a whole cascade of opportunities, such as process improvement, better organization of care, and new reimbursement approaches that will accelerate the pace of innovation and value creation. We are struck by the sheer size of the opportunity to reduce the cost of health care delivery with no sacrifice in outcomes. Accurate measurement of costs and outcomes is the previously hidden secret for solving the health care cost crisis. **HBR Reprint** R1109B

The authors would like to acknowledge the extensive and invaluable assistance of Mary Witkowski, Dr. Caleb Stowell, and Craig Szela in the preparation of this article.



"Actually, I don't know who these people are. They came with the frame."

CARTOON: CHRIS WILDT

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Applying Time-Driven ABC in Health Care

January 2017

Robert S. (Bob) Kaplan

Senior Fellow and Marvin Bower Professor of Leadership Development, Emeritus

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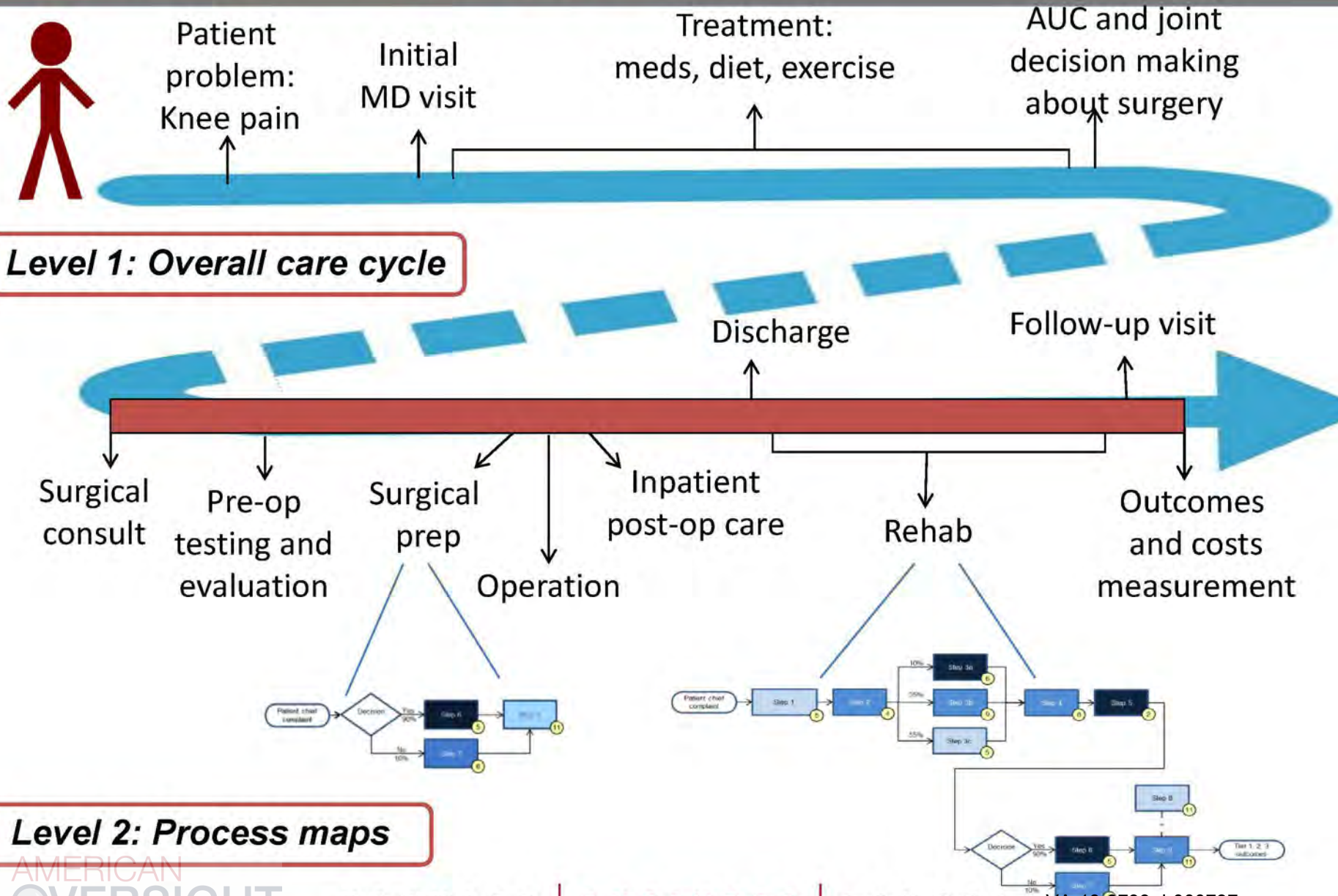
Outcomes and Costs should be measured for an acute medical condition's overall cycle of care



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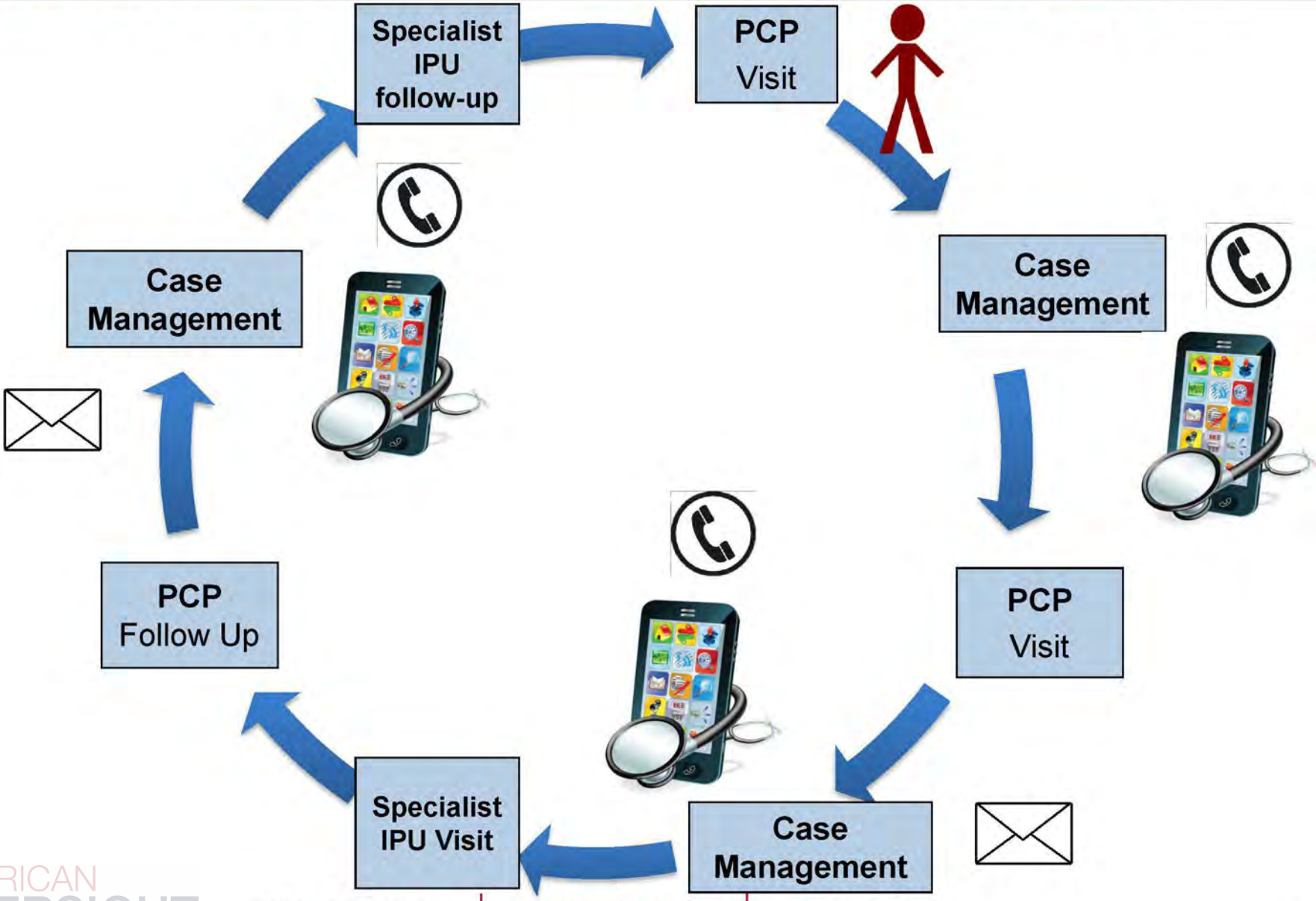
For chronic medical conditions and population-based care, measure outcomes and costs over an annual cycle.



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Poor cost measurement causes communication failures between clinical personnel and health care administrators.

I became a physician to cure patients and save lives.





You need to reduce headcount and cut costs and do it now!



Mission **vs.** **Margin**

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Time-Driven Activity-Based Costing (TDABC) "tears down the wall"



1 Determine Care Process

Identify

- **all activities** performed over the care cycle
- **who performs** each activity
- **length of time** for each activity

2 Calculate Cost Rates

- **cost per unit of time** for each type of personnel and equipment

3 Consumables

- **cost of devices, supplies, and drugs** used in the care cycle

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Finance personnel collaborate with clinicians to create the patient-level costing model

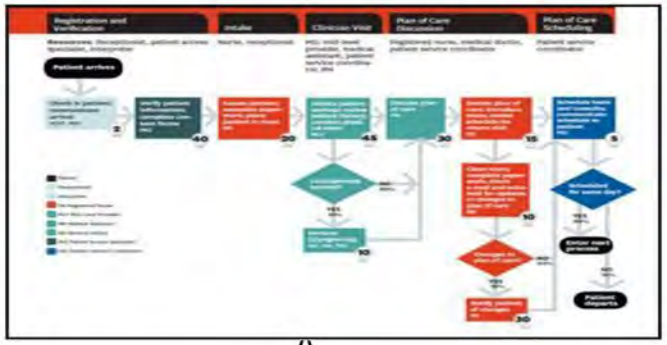
Cost = Quantity (Q) × Price (P)

Finance

"P"

Cost of Supplying Resources (People, Equipment, Space, Consumables)





"Q"

Clinicians and administrators

How we deliver care today for patients



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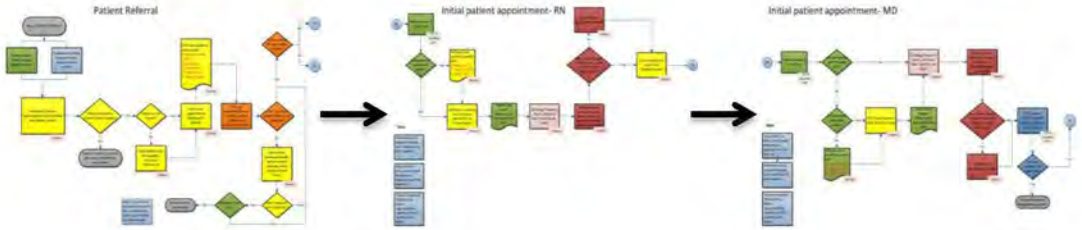
Compute total patient care costs by multiplying resource capacity cost rate by process times & summing across each patient's cycle of care

Initial consultation



	Minutes	Cost/ minute	*Total
MD	X_1	Y_1	136.13
RN	X_2	Y_2	68.04
CA	X_3	Y_3	6.17
ASR	X_4	Y_4	15.74
			$266.08

Surgical procedure



MD	X_1	Y_1	584.99
Anes.	X_2	Y_2	603.89
RN	X_3	Y_3	136.29
Tech	X_4	Y_4	97.82
OR	X_5	Y_5	329.16
			$1752.15

Follow-up or post-operative visit



MD	X_1	Y_1	55.19
RN	X_2	Y_2	13.61
CA	X_3	Y_3	3.09
ASR	X_4	Y_4	1.77
			$73.66

Source: Meg Abbott, MD & John Meara, MD Boston Children's Hospital

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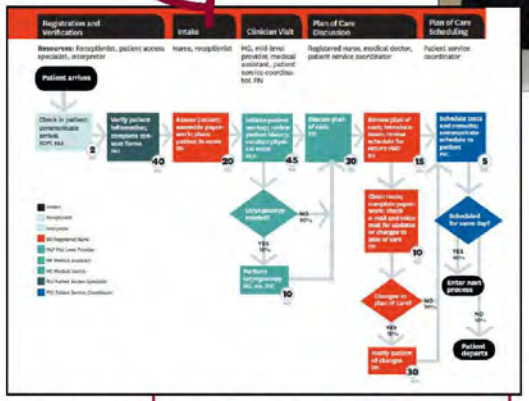
Time-Driven ABC provides a common platform – a single version of truth – for productive discussions among clinical & administrative personnel.

By standardizing on this procedure and we can achieve consistently excellent outcomes at lower cost.

We can skip this process and save $120 per patient.







How does TDABC help providers manage their costs

Process Improvement and Redesign

- **Eliminate** process steps and variations that **do not contribute to improved patient outcomes**
- **Redesign** processes to **reduce waste and idle time**
- **Optimize** processes and interventions over a **complete cycle of care**

Personnel and Resource Utilization

- All **clinicians work at the "top-of-their license"** → health care personnel, equipment and facilities have very different productivities and costs; **who** should be doing the work, **where**, and **how**?
- **Reduce unused capacity** of people, equipment, and facilities

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Current TDABC project sites



HBS cost measurement & management project areas

Chronic and Primary Care

- Chronic kidney disease
- Care transitions/preventing readmissions
- Congestive heart failure
- Dementia/Alzheimer's
- Diabetes
- Frail Elderly
- Palliative care
- Parkinson's

Ancillary and Indirect

- Radiology
- Pharmacy
- Billing

Acute Care

- Aero-digestive Disorder
- Anticoagulation
- Appendectomy
- Bariatric surgery
- Bone marrow transplant
- Cataracts
- Cancer: Head & Neck, Prostate, Breast (Mastectomy)
- Child birth (vaginal and C-section); pregnancy
- Colonoscopy, Colectomy, and EGD
- ECMO (Extra Corporeal Membrane Oxidation) and LVAD
- Heart valve replacement and repair; percutaneous coronary intervention
- Hernia
- Hysterectomy
- Interventional radiology
- Neurosurgical procedures
- Observation patients
- Orthopedic surgery (**knee and hip replacement**; spine, rotator cuff)

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VA-19-0799-J-000806

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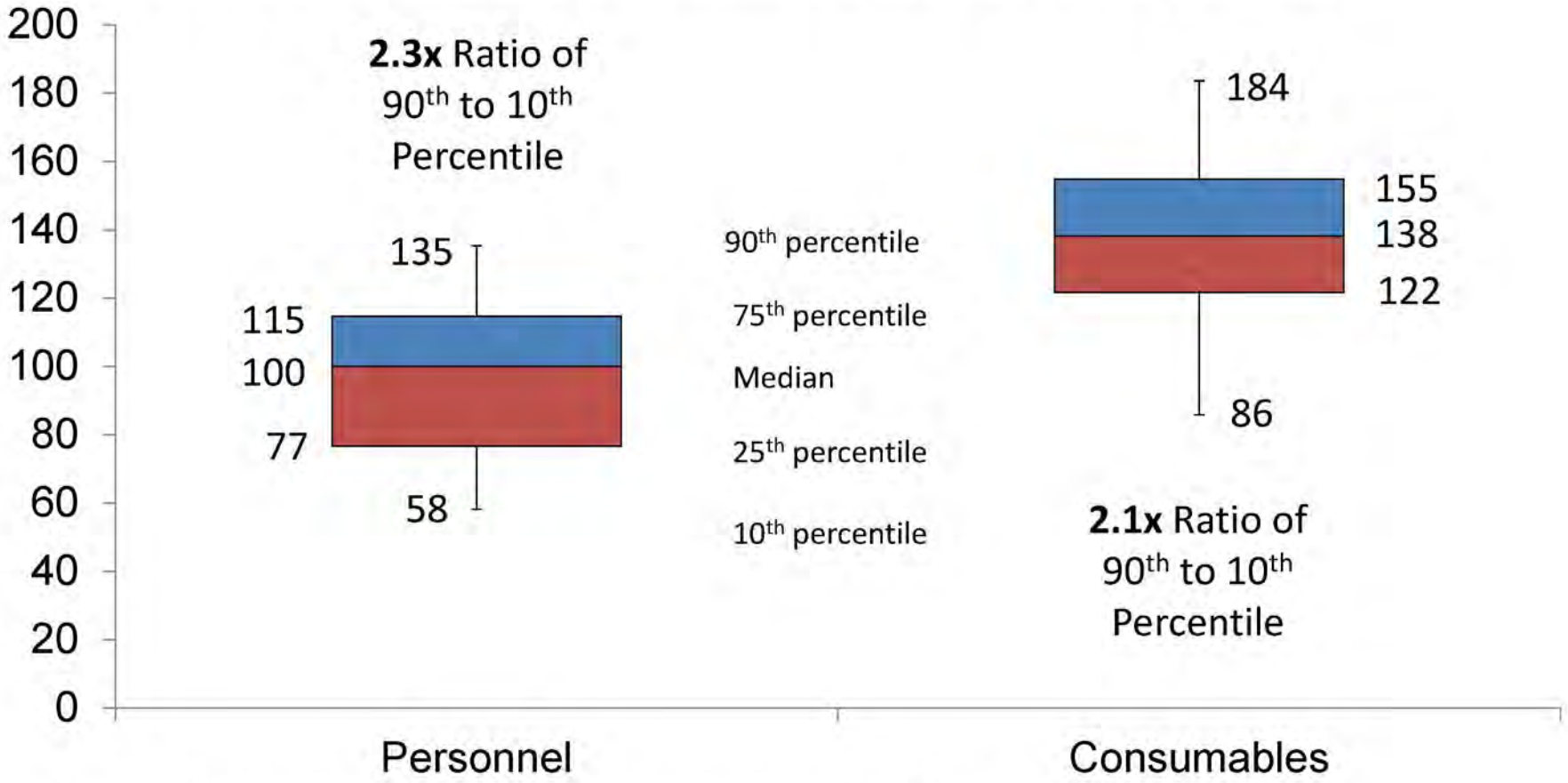
2014 Joint Replacement Learning Community: Range in total personnel and consumable costs for Total Knee Arthroscopy (TKA)

Indexed TKA Total Personnel and Consumable Costs at U.S. Organizations



N = 29 ; scope of care is decision for surgery through discharge plus follow-up visits within 90 days

Haas, Derek A. and Robert S. Kaplan, "Variation in the cost of care for primary total knee arthroplasties ," J Arthroplasty (September 2016).

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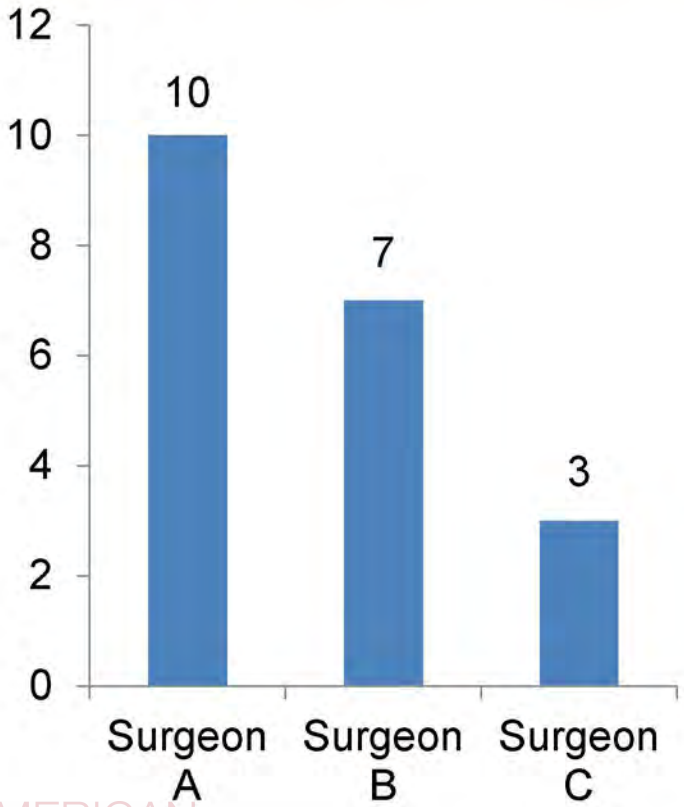
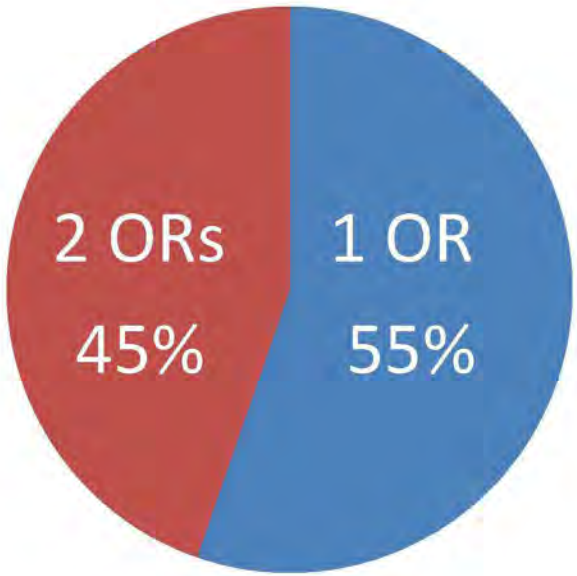
Large productivity differences exist between providers

Number of Joint Replacements Performed per Day per Surgeon with Similar Cut to Close Times



Number of Operating Rooms (OR) Used per Day by Ortho Surgeons in Joint Replacement Program



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Space & equipment costs are much lower than personnel costs

Data are illustrative

	Operating Room Cost per Minute of Time		
	Personnel	Equipment	Space
Shoulder surgery at Hospital A	$20/min	$.25/min	$.55/min
Cardiac surgery at Hospital B	$20/min	$1.30/min	$.40/min
Knee surgery at Hospital C	$25/min	$.25/min	$.35/min

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VA-19-0799-J-000809

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Discharge disposition, not readmissions, primary driver of variation in post acute care spend

Quartiles of Post Acute Care Spend	Home w/ Outpatient	Home Health	Inpatient Rehab	Skilled Nursing Facility	Readmissions	Standardized Cost
Highest	4%	42%	24%	29%	3%	
2nd Highest	17%	50%	4%	29%	3%	
2nd Lowest	23%	57%	7%	13%	3%	
Lowest	44%	42%	4%	10%	2%	

Organizations were categorized into quartiles based on their standardized post acute care costs; the percentages reflect the averages for each quartile of organizations

N = 27

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VA-19-0799-J-000810

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The financial opportunity from using best practices to move to the next bracket.

Total Personnel and Consumable Costs

Improvement	Percentage Savings TKA	THA
90th to 75th	15%	14%
75th to 50th	8%	16%
50th to 25th	13%	13%
25th to 10th	12%	12%

Moving to next bracket produces an annual savings of > $1 million for an organization performing 800 TJRs

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Current multi-site TDABC pilot: Aero-digestive IPU

- The IPU includes an ENT surgeon, Gastroenterologist, Pulmonologist and speech therapist.
- Create standard set of outcome measurements for **laryngeal cleft repair** and **eosinophilic esophagitis** in children
- Implement TDABC at each center and determine best practices and insights for generating better outcomes at lower costs.









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An international multi-organization program: ECMO

- A value study – measuring outcome and cost differences for all of the patients who have undergone treatment with extracorporeal membrane oxygenation (ECMO) in a calendar year
  - Costs: Detailed process maps and financial analysis from cannulation to decannulation
  - Outcome metrics including functional status outcomes and appropriate risk adjustment

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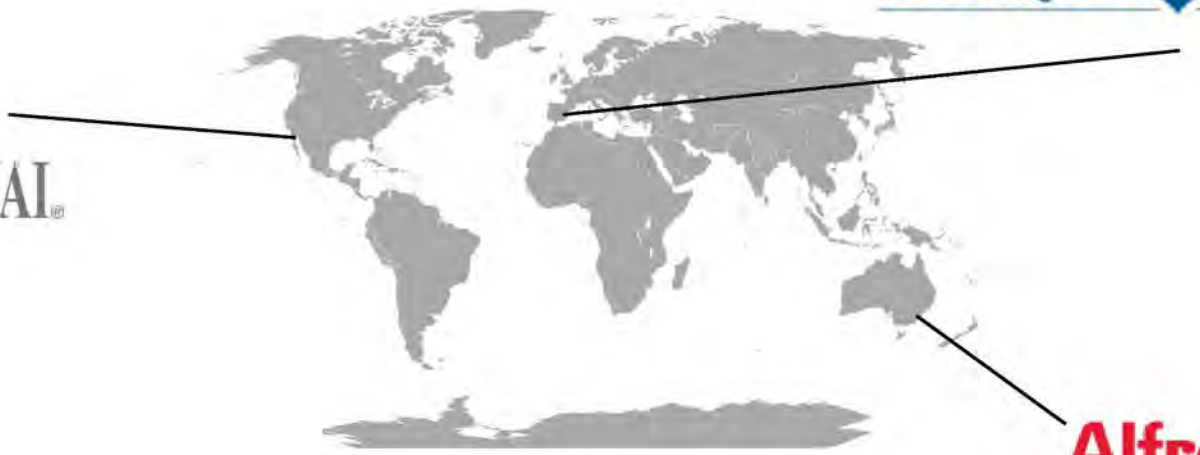

AlfredHealth

Multi-site TDABC pilot: Veterans Administration

- Largest single-payer system in North America
- 22 million veterans
- TDABC Pilots: **Audiology, Cardiac Cath, and Total Joint Replacement**
- 8 medical centers in 6 states
- 300K veterans in New England region
- Cardiac Cath multi-regional sites: Connecticut, Boston, Houston, Minneapolis, and Denver

VA | U.S. Department of Veterans Affairs

*Source: Congressional Research Service

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The TDABC Health Care ShareSite!

This site enables you to collaborate with HBS and TDABC implementers. It serves as central location for instruction and collaboration to support your organization's TDABC analyses.

For access, please contact Lila Kelso (lkelso@hbs.edu) 617-495-6436.

We look forward to working with you to improve value in health care!

- Lists
- Introduction and Overview
- Top 13 FAQs
- Library of Frequently Asked Questions (FAQs)
- Recommended reading
- Recommended viewing
- HBS Contacts
- Libraries
- Templates and examples
- Presentations
- Materials developed by MD Anderson

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VA-19-0799-J-000815

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- Lauren Phillips, "A Value Toolkit: How University of Utah Health Care is Creating and Measuring Value." HFMA Strategic Financial Planning Newsletter. Fall 2015.

Original Resources for Time-Driven Activity-Based Costing

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- Argyris, Chris, and Robert S. Kaplan. "Implementing New Knowledge: The Case of Activity-Based Costing." *Accounting Horizons* 8, no. 3 (September 1994): 83–105.

Short Applied Papers in HBR Online Forum

- Kaplan, Robert S., Mary L. Witkowski, Larry Higgins, Jon Warner, and Michael Sherman. October 03, 2013. "How to Design a Bundled Payment around Value." The paper describes the HBS partnership with two orthopedic surgeons and an insurer, Harvard Pilgrim Health Plan, to co-create a bundled payment offering to encourage value-based health-care delivery for a complete cycle of care for rotator cuff repairs.
- Kaplan, Robert S., Thomas W. Feeley, Mary L. Witkowski, and Heidi Albright. "Intelligent Redesign of Health Care." October 14, 2013. Paper reports how TDABC has helped MD Anderson's Center for Cancer Care Innovation drive operational changes and process improvements.

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- Kaplan, Robert S., Derek A. Haas, Yudit C. Krosner, and Nirvan Mukerji. "Delivering Higher Value Care Means Spending More Time with Patients." December 26, 2014.
- Kaplan, Robert S., Derek A. Haas, Dereesa Reid, Jonathan Warsh, and Michael E. West. "Getting Bundled Payments Right in Health Care." October 22, 2015. Paper describes how Hoag Orthopedic Institute (HOI), a specialty orthopedic hospital in southern California, and the Rothman Institute (RI), a private-practice physician group in metropolitan Philadelphia, have developed three core capabilities for successful bundling: excellent data on outcomes and costs, proactive management of the patient, and alignment between physicians and hospitals.
- Kaplan, Robert S., Derek A. Haas, Richard A. Helmers, March Rucci, and Meredith Brady. "The Mayo Clinic Model for Running a Value-Improvement Program." October 22, 2015. The paper describes the disciplined six-step process used by Mayo Clinic to use TDABC information to enhance care delivery and realize cost efficiencies. Mayo Clinic's projects have strong executive support, exceptional clinical leaders, and dedicated, multi-disciplinary project teams.
- Kaplan, Robert S., Robin P. Blackstone, Derek A. Haas, Nikhil G. Thaker, and Steven Frank. "Measuring and Communicating Health Care Value with Charts." October 26, 2015. The paper illustrates how to use a radar (spider web) chart to visually depict outcome and cost data simultaneously. The radar charts provides clinicians, managers, patients, regulators, and policy makers with a readily understandable snapshot of the value being delivered for a specific medical condition and allows them to compare that value across alternative treatments, clinicians, and facilities.
- Kaplan, Robert S., Catherine H. MacLean, Alexander Dresner, Derek A. Haas, and Thomas W. Feeley. "Health Care Providers Need a Value Management Office." December 2, 2015. To accelerate the dissemination and adoption of the value agenda, leading institutions, such as MD Anderson Cancer Center and the Hospital for Special Surgery, have established a new central office to oversee the creation of all the capabilities and information for measuring and improving outcomes and cost, setting priorities for continuous improvement projects, facilitating the creation of value-based payment models with insurers and employers, and ensuring that new information technology platforms are aligned with the value agenda.

Specific Application of Applying TDABC in Health Care Settings

TDABC in Anesthesia Care

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TDABC in resource limited Global Healthcare settings

Kaplan, Robert S., Bipin Mistry, and Karla Bertrand. "Hôpital Universitaire de Mirebalais, Partners In Health in Haiti." Harvard Business School Case 116-041, April 2016. (Revised May 2016.)

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TDABC for Orthopedic Surgery

Kaplan, Robert S., Pamela Greenhouse, and Anthony DiGioia. "To Reconcile Mission and Margin, Deliver Better Outcomes at Lower Costs." *Orthopedics Today* (December 2013).

DiGioia AM, et al, "Determining the True Cost to Deliver Total Hip and Knee Arthroplasty Over the Full Cycle of Care: Preparing for Bundling and Reference-Based Pricing," J Arthroplasty Volume 31, Issue 1, January 2016, Pages 1–6 ,

TDABC for Interventional Radiology

Oklu, Rahmi, Derek A. Haas, Robert S. Kaplan, Katelyn Brinegar, Nicole Bassoff, H. Benjamin Harvey, James A. Brink, and Anand Prabhakar. "Time-Driven Activity-Based Costing in IR." *Journal of Vascular and Interventional Radiology* 26, no. 12 (December 2015): 1827–1831.

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Kaplan, Robert S., Nancy McLaughlin, Michael A. Burke, Nisheeta P. Setlur, Douglas R. Niedzwiecki, Alan L. Kaplan, Christopher Saigal, Aman Mahajan, and Neil A. Martin. "Time-Driven Activity-Based Costing: A Driver for Provider Engagement in Costing Activities and Redesign Initiatives." *Neurosurgical Focus* 37, no. 5 (November 2014).

TDABC for Cancer Care

Thaker, Nikhil G., Thomas J. Pugh, Usama Mahmood, Tracy E. Spinks, Neil E. Martin, Rajat J. Kudchadker, Alexis B. Guzman, Tiffany M. Jones, Latoi S. Tatum, James R. Incalcaterra, Benjamin D. Frank, John Bingham, Robert S. Kaplan, Caleb Stowell, Thomas A. Buchholz, Deborah A. Kuban, Thomas W. Feeley, and Steven J. Frank. "Defining the Value Framework for Prostate Brachytherapy Using Patient-Centered Outcome Metrics and Time-Driven Activity-Based Costing." *Brachytherapy* 14 (2015).

Thaker, Nikhil G., Steven J. Frank, and Thomas W. Feeley. "Comparative costs of advanced proton and photon radiation therapies: lessons from time-driven activity-based costing in head and neck cancer." Journal of Comparative Effectiveness Research. 2015. Vol 4, No. 4: 297-301.

TDABC in the Emergency Department

Yun, Brian J., Anand M. Prabhakar, Jonathan Warsh, Robert Kaplan, John Brennan, Kyle E. Dempsey, and Ali S. Raja. "Time-Driven Activity-Based Costing in Emergency Medicine." *Annals of Emergency Medicine* 67.6 (2016): 765-72.

TDABC for Cardiac Surgery

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F Erhun, B Mistry, T Platchek, A Milstein, V G Narayanan, R S Kaplan, "Time-driven activity-based costing of multi-vessel coronary artery bypass grafting across national boundaries to identify improvement opportunities: study protocol," *BMJ Open*. 2015.

TDABC for a Primary Care Population

Gregory J. Hanson, Derek Haas, Dustin D. Kuchera, Gerald J. Sobolik, Richard A. Helmers, and Robert S. Kaplan "TDABC in Primary Care: Results of a Harvard/Mayo Clinic Collaboration," hfm [Healthcare Financial Management] *Magazine* (July 2016).

Case Studies

- Kaplan, Robert S., Bipin Mistry, and Karla Bertrand. "Hôpital Universitaire de Mirebalais, Partners In Health in Haiti." Harvard Business School Case 116-041, April 2016. (Revised May 2016.)
- Kaplan, Robert S., Mary L. Witkowski, and Jessica A. Hohman. "Boston Children's Hospital: Measuring Patient Costs." Harvard Business School Case 112-086, March 2012. (Revised January 2013.)
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- Kaplan, Robert S. and Michel E. Porter "Why Medical Bills Are a Mystery." *The New York Times*. 14 Apr 2012.
- "Searching for the True Cost of Health Care." *The Wall St. Journal*. February 23, 2014.
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- Young DW. "The folly of using RCCs and RVUs for intermediate product costing." *Healthc Financ Manage* 2007; **61**: 100–106.
- Painter MW and Chernew ME. "Counting Change: Measuring Health Care Prices, Costs, and Spending." Robert Wood Johnson Foundation. 2012.
- David Isaacs and Dominic Fitzgerald. "Seven alternatives to evidence based medicine." *British Medical Journal*. 319 (1991): 1618.

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/18/2017 3:46:45 AM
To: (b) (6) [(b) (6) @gmail.com]

Hosekeeper

(b) (6)
(b) (6)

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/7/2017 10:27:59 PM
To: Vivieca Simpson [(b) (6) @gmail.com]
Subject: Fwd: VHA Healthcare Delivery System Design Capability Project

Look at this- fyi

Sent from my iPhone

Begin forwarded message:

> Be careful in talking to her about him. She is an advocate for him. Talk only about the value of the contract and that we executed it after David Shulkin encouraged us to do so.
>
> Rich
>
> -----Original Message-----
> **From:** Sullivan, Jim VACO
> **Sent:** Thursday, December 29, 2016 09:46 AM Eastern Standard Time
> **To:** Stone, Richard A., MD
> **Subject:** FW: VHA Healthcare Delivery System Design Capability Project
>
> Reagan is trying every which way (he is trying at every level) to get this - he also tried to set up s bunch of issues with the contractor to discuss on how the contract should be managed, purpose, cost , etc - how do you want me to respond ? Should we or I talk with her about the background ? Are you in today ?
>
> Sent with Good (www.good.com)
>
> -----Original Message-----
> **From:** Wright, Vivieca (Simpson)
> **Sent:** Thursday, December 29, 2016 08:37 AM Eastern Standard Time
> **To:** Sullivan, Jim VACO
> **Subject:** VHA Healthcare Delivery System Design Capability Project
>
> Jim can you shoot me a copy of this contract.

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/7/2017 10:17:31 PM
To: (b) (6) @gmail.com

Lost your number

Call me (b) (6)

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/19/2017 6:50:39 PM
To: (b) (6) [redacted] va.gov]
Subject: Fwd: WSJ - Make the VA Great Again

Print

Sent from my iPhone

Begin forwarded message:

From: "Marisol Garcia" <(b) [redacted]@frenchangel59.com>
Date: January 19, 2017 at 12:45:09 PM EST
To: "David shulkin" <Drshulkin@aol.com>
Subject: WSJ - Make the VA Great Again

David,

Here's the website and videos.

http://www.tiffanysmiley.com/

Videos
https://www.youtube.com/watch?v=WnYc008XhSU

https://www.facebook.com/TiffanyMaeSmiley/videos/1844895662318078/?hc_ref=PAGES_TIMELINE

http://www.wsj.com/articles/make-the-va-great-again-1482882642

Make the VA Great Again

My husband was blinded in Iraq. At the VA rehab center, he was given books on cassette. Cassettes!

AMERICAN OVERSIGHT



ENLARGE
Former Army Maj. Scotty Smiley and his wife Tiffany. Photo: Amber Glanville

By
Tiffany Smiley
Dec. 27, 2016 6:50 p.m. ET
83 COMMENTS

On an April day in Iraq in 2005, my husband's world went black.

It came by way of a suicide car bomb. In one second, all the plans we had—for a military career, children and a happy life—seemed to go out the window. Quickly we learned that the

AMERICAN OVERSIGHT

federal bureaucracy, including the Department of Veterans Affairs, that would determine so much of our future was not up to the job.

My first encounter with the military bureaucracy came days after I arrived at Walter Reed to see Scotty, a West Point graduate, after he'd been flown in from Iraq. This was the other side of the country for me, away from everything and everyone I knew. I was supposed to be on "orders" and receiving a stipend for food, but somewhere along the way someone filled out the form incorrectly. The man I spoke to said that it would be a huge hassle to try to fix it, which seemed ridiculous in light of all that had happened, but I just accepted what he told me.

We got by on Scotty's first lieutenant pay and the generosity of friends and family. But there has to be a better way for our federal government to make it easier for the spouses, parents and siblings who have to quit their jobs and forfeit their livelihoods to care for an injured veteran.

My next challenge came when we entered the world of rehabilitation for the blind. Scotty was

AMERICAN OVERSIGHT

24-years-old and had his whole life ahead of him. I knew he needed a center that would teach him new things, challenge him and give him the confidence that he would once again be a contributing member of society. We were promised customized care at a blind rehab center. Unfortunately, when we got there, it was clear that no one was ready to rehabilitate post 9-11 warriors.

Here's an example. We kept asking for computer training because we knew that technology and computers were going to be key to a future of dignity and productivity for Scotty. So imagine how appalled I was when I was informed that computer training came last—behind belt braiding and woodshop. Also, he was given books on cassette. Cassettes!

Meanwhile, a wonderful church community in Georgia sent Scotty an iPod with tons of books and music already downloaded on it. What a lifesaver that was. It helped give Scotty hope that his future was not going to be braided belts and cassette tapes.

It should not be this hard.

AMERICAN OVERSIGHT

Once retired, Scotty spent most of his days filling out paperwork to get VA grants that were offered—things like housing grants to adapt our home to be safer and more efficient for him. After spending a month filling out these forms and searching for and contacting the right people, my husband was informed that he was not eligible for the largest grant because although 100% disabled and completely blind he needed to be missing a limb as well to qualify. Needless to say we shredded the forms and chalked it up to another government promise that would never become reality.

In a world where technology is making almost all aspects of life easier, why isn't there a website, a liaison, or an advocate to fill out government paperwork and get deserving veterans the benefits they were promised and deserved? When I asked for help, someone suggested we hire a lawyer.

Most recently, Scotty had an infection that needed emergency care. Upon arriving at the VA emergency room, which was packed, I noticed that there were at least four people behind the counter for paperwork. They

AMERICAN OVERSIGHT

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As Scotty's wife and caregiver, I quickly had to navigate staying with Scotty and a 3-year-old in a VA ER waiting room for five hours, then having to leave him so I could be home to get our kids off the bus only to return and pick Scotty up later. I was left wondering, what if I could not have left Scotty?

At every turn in this experience, this army wife has been asked to give more and more. Don't get me wrong: It is an honor to serve and be a hero to a hero. But often I find myself thinking about the soldier who does not have an advocate. What about the private who does not have a spouse?

We've been running our own business now for about six years, and I know that any business would fail with these VA kinds of policies. We're fortunate that we have options others do not. We bought his first talking phone, and now his iPhone that he uses like any other sighted individual; this solution worked for us, but I

AMERICAN OVERSIGHT

know there are many families that wouldn't be able to afford to buy those things.

Our men and women who have sacrificed on the battlefield deserve better when they come home. So unlike others who worry that our new president is a businessman, this background gives me hope. Because unlike most federal agencies, the VA is primarily about dealing with people—customers. If Donald Trump hopes to make America great again, a good start would be making the VA run more like a business, and giving the customer what the customer needs.

Mrs. Smiley is a caregiver, writer and motivational speaker.

AMERICAN OVERSIGHT

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From: Marisol Garcia [(b)@frenchangel59.com]
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AMERICAN OVERSIGHT

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Mrs. Smiley is a caregiver, writer and motivational speaker.

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/4/2017 10:49:50 PM
To: Jennifer Lee [(b) (6) @gmail.com]
Subject: Re: updates

Ok- always exciting in va

Thanks for keeping me updated

Sent from my iPhone

> On Jan 4, 2017, at 5:00 PM, Jennifer Lee (b) (6) @gmail.com> wrote:
>
> Hi, I wanted to give you 2 quick updates:
>
> 1) suicide prevention meeting with Sloane today was heated. the friction between VCL and suicide prevention came to a head when (b) brought a 2nd slide deck to the meeting that hadn't been vetted with (b) (6) or any of us. Sloan called him on it and said (b) (6) is in charge. We are meeting tomorrow - Steve, me, (b) (6) (b) to build a bridge and finally try to iron things out between the 2 programs
>
> 2) DHP briefing to ART went very well today actually. surprisingly really well. (b) (6) was very supportive and she asked OIT how they could deploy the program in VBA or NCA
> they liked the fact that OIT said it would be cheaper (not sure if true or not, but anyway). It made me wonder whether new Admin will really want to fork up billions for a COTS or not. we definitely better keep developing EHMP just in case.
> Just so you know, Rich Stone threw out the $500M number for a wedge in the meeting and several of them noted it.
>
> Call any time if you'd like more details.
> Thanks
> Jen
>

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Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 1/7/2017 2:10:57 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Re:

Let's talk through this over the weekend- I will text you and if the time works, we can connect- also, please send me the detailEd agenda, fireside discussion questions and any other prep stuff etc

Sent from my iPhone

On Jan 6, 2017, at 8:51 PM, David Shulkin <drshulkin@aol.com> wrote:

<wholehealthshort.pptx>

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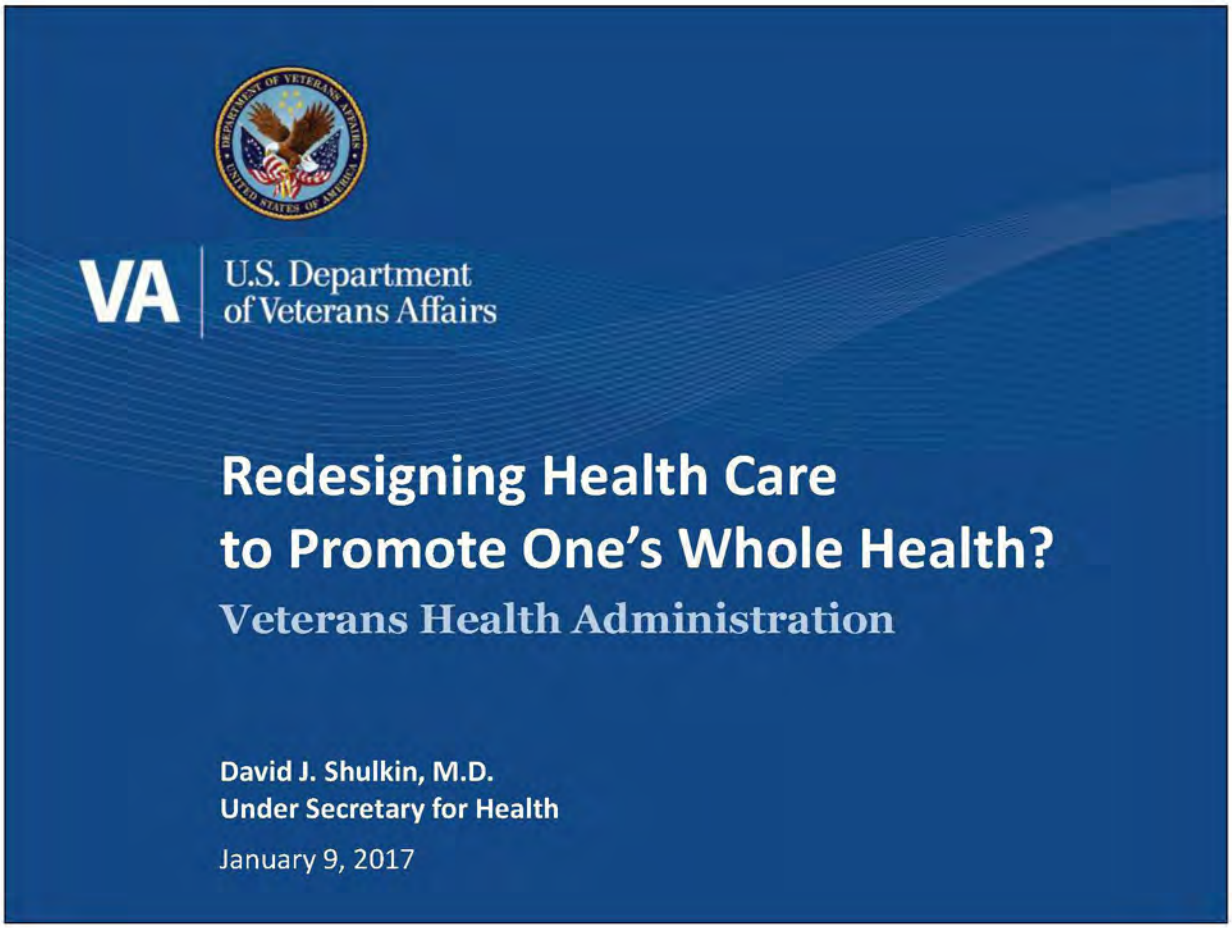
Message

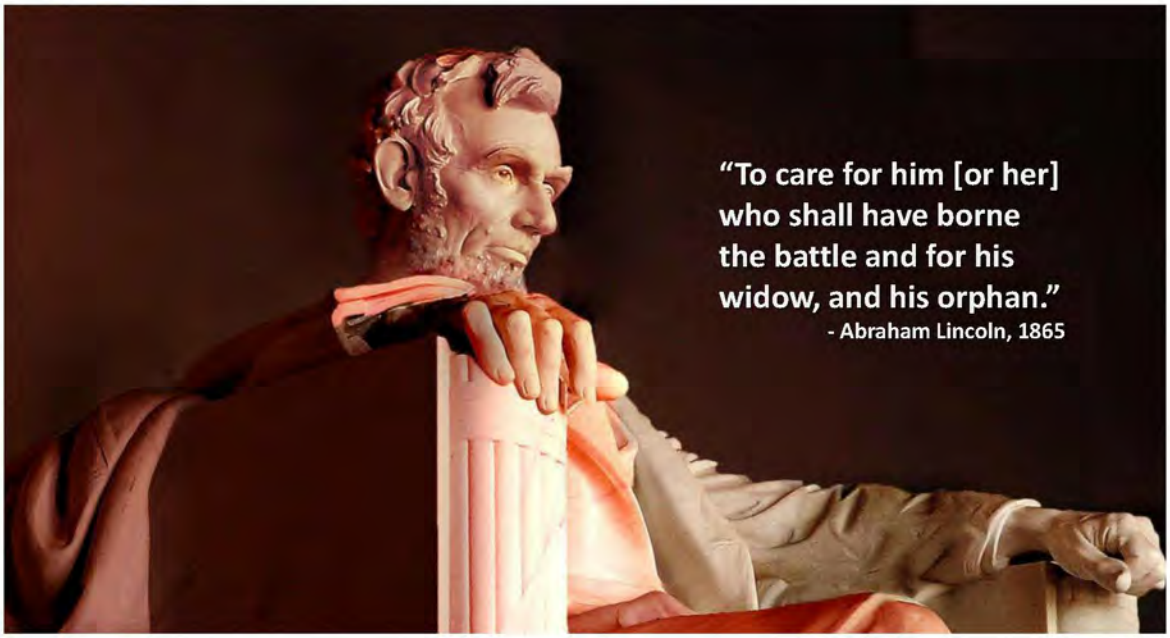
From: David Shulkin [drshulkin@aol.com]
Sent: 1/7/2017 1:51:04 AM
To: (b) (6) @hotmail.com
Attachments: wholehealthshort.pptx

AMERICAN OVERSIGHT



AMERICAN OVERSIGHT

Fulfilling Our Mission



VA | U.S. Department of Veterans Affairs

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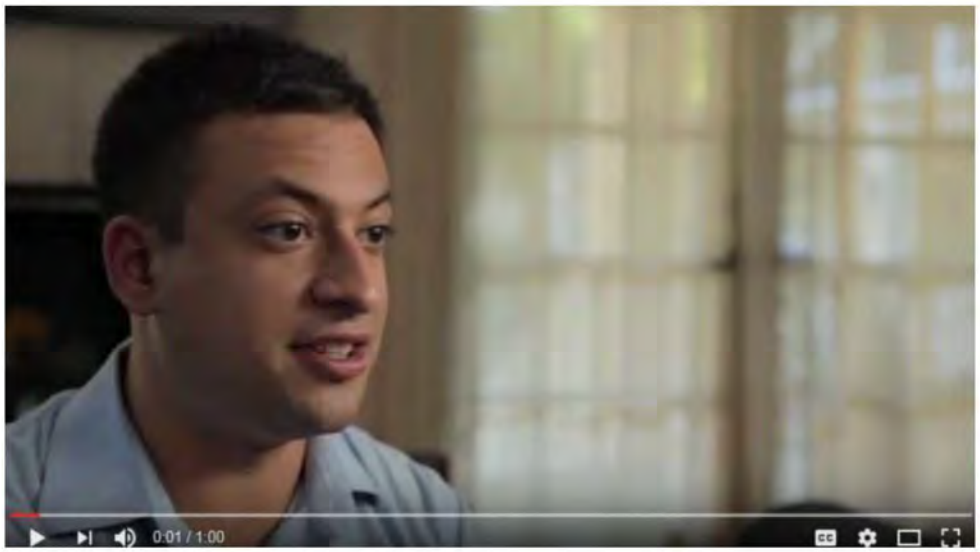
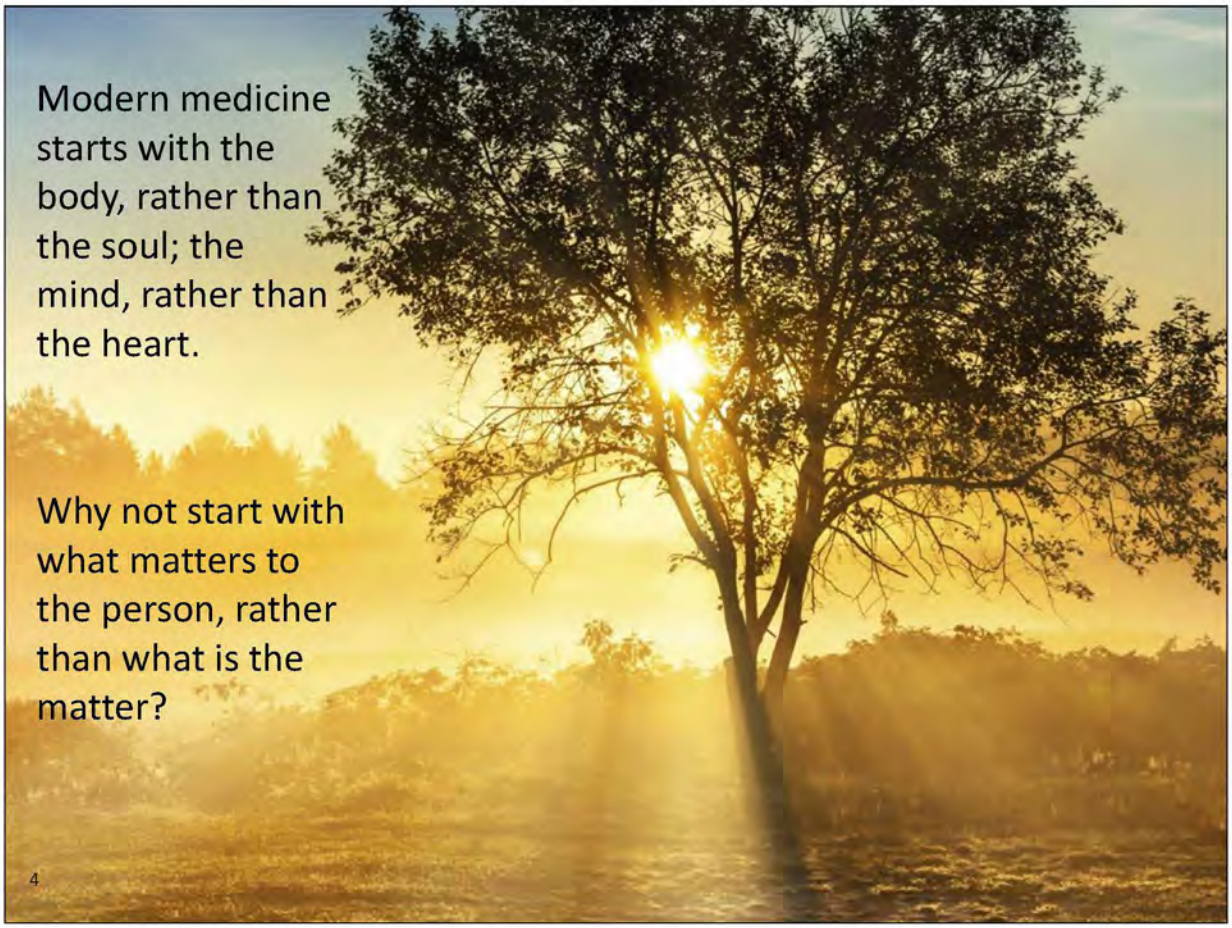
In Their Own Words



VA U.S. Department of Veterans Affairs

AMERICAN OVERSIGHT



AMERICAN OVERSIGHT

Learning Medicine on the Ski Slopes





VA | U.S. Department of Veterans Affairs

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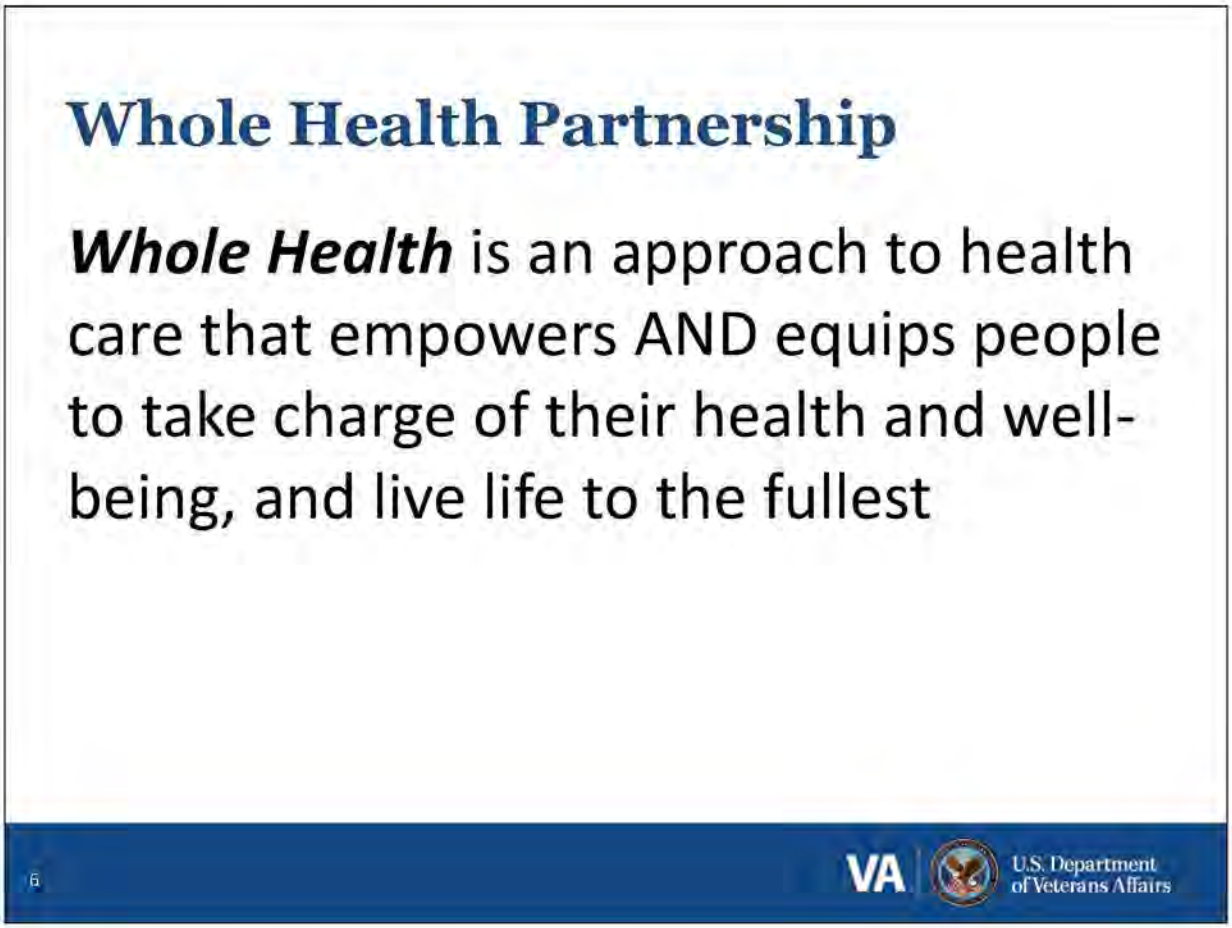

The Whole Health Partnership was developed by the Office of Patient Centered Care and Cultural Transformation (OPCC&CT) in collaboration with the Veteran Experience Committee (VEC) and endorsed by the National Leadership Council (NLC). In sum, the Whole Health Partnership is a systematic approach to provide whole health care early in the relationship between VA and the Veteran, emphasizing self-care in the larger context of well-being, and incorporating a full range of conventional and complementary and integrative health approaches. The Whole Health Partnership would move VA from focusing on episodic care to a more continuous engagement with the Veteran throughout his/her life. Additionally, the Whole Health Partnership model is the current vision for complementary and integrative health (CIH) integration in VA. The health care crisis in the United States has led to a call for transformation to a proactive model of care; VA has the opportunity to become the national leader in Whole Health care delivery and the Whole Health Partnership model is a roadmap to this paradigm shift.

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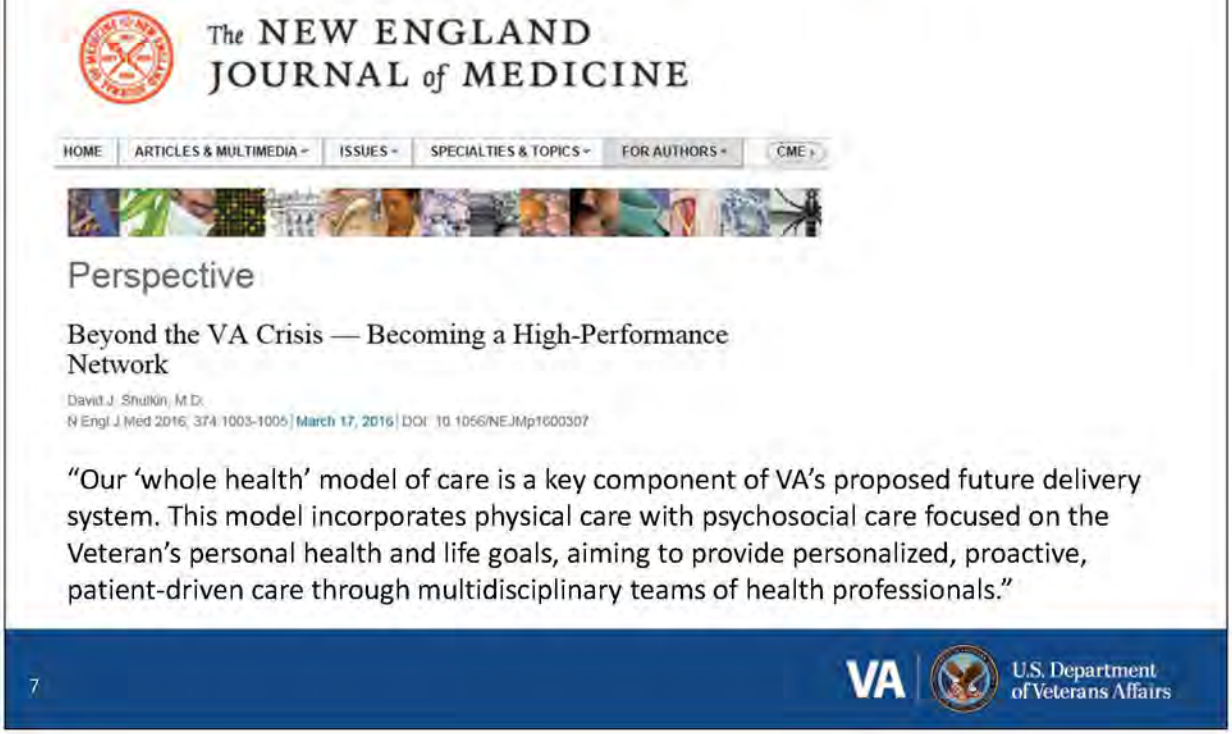
Whole Health Model of Care



Starting with the VHA Strategic Plan, and including the Blueprint for Excellence and this recent article in the NEJM, VHA is talking about WH as the future model of VA care.

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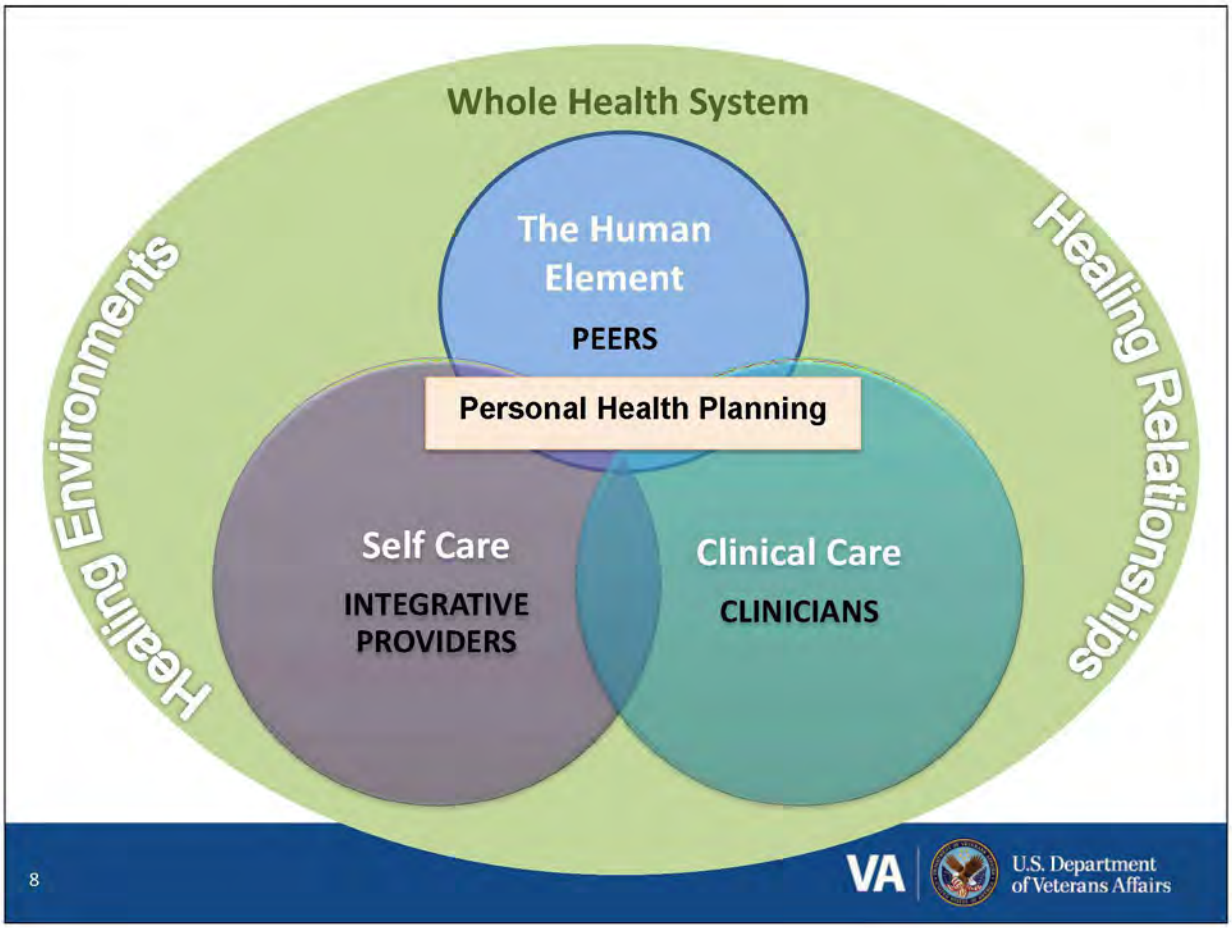
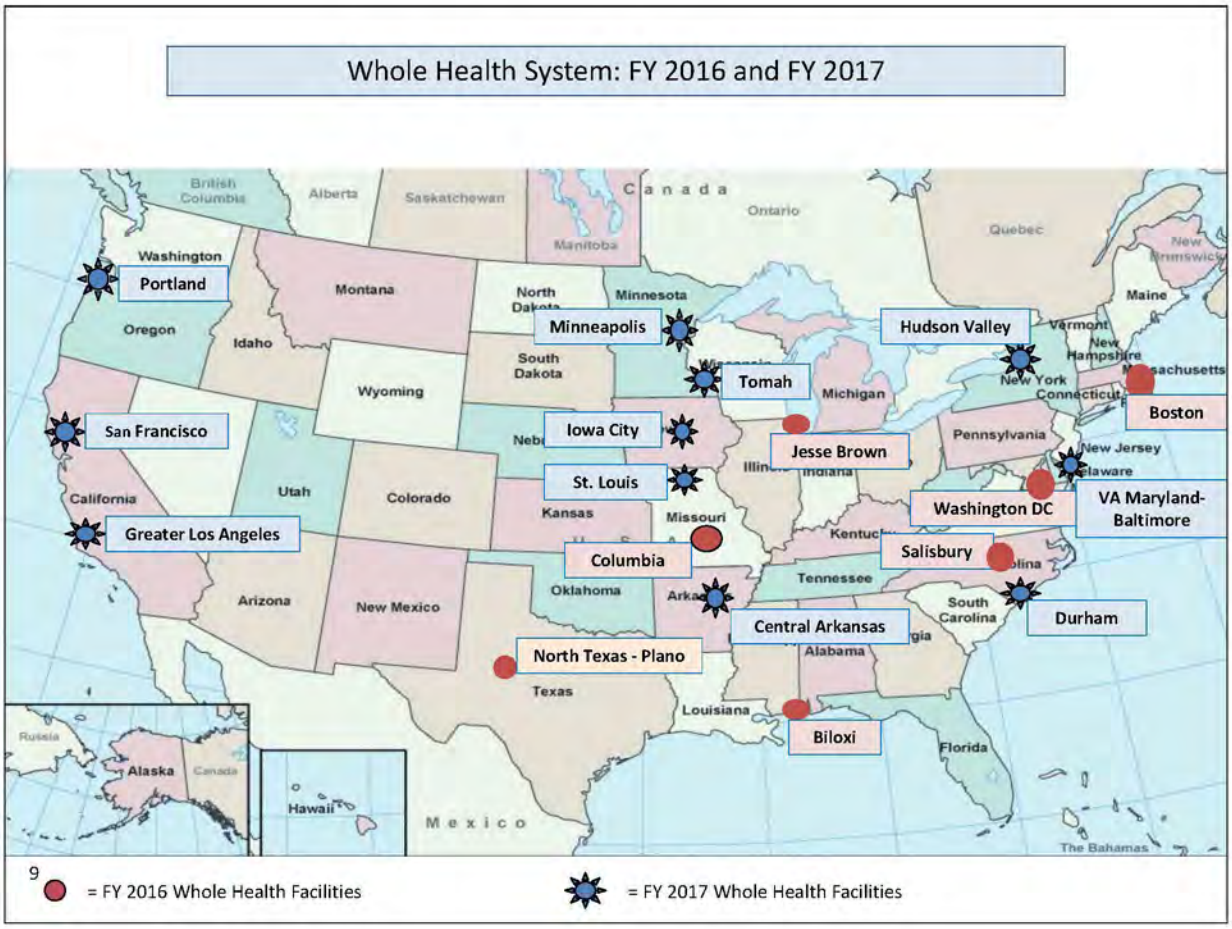


AMERICAN OVERSIGHT



AMERICAN OVERSIGHT

Why it Matters to Start With What Really Matters

People with a sense of purpose had a **15%** lower risk of death compared to those who said they were aimless

And what happens if we intentionally link health care to this purpose?

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/13/2017 3:53:09 PM
To: (b) (6) [(b) (6) @gmail.com]
Subject: Fwd: eQIP

Sent from my iPhone

Begin forwarded message:

From: (b) (6) (b) (6) @ptt.gov>
Date: January 12, 2017 at 2:24:41 PM EST
To: DrShulkin@aol.com
Subject: eQIP

THIS IS A TIME SENSITIVE REQUEST.

You have been initiated for a background investigation through eQIP.

There are four steps to processing your security clearance:

1. Complete the eQIP (SF-86) application
2. Sign/ scan 4 eQIP generated signature forms and return to (b) (6)
3. Submit fingerprints (we will be in touch with logistics)
4. Attend an indoctrination briefing (details to follow later)

If you are not a US Citizen or hold dual citizenship, please alert us before proceeding.

Accessing/ Completing eQIP:

The eQIP/ SF86 is a comprehensive document that requests work history, residence history, foreign travel and education history. **Please review the supplemental instructions provided to you in the appointee information binder which may expand the scope of certain questions based on your position.** Additionally you will be asked to provide contact information for references that span the scope of the investigation as well as personal details on your family and any foreign contacts. While eQIP saves your data as you progress, it is suggested that you gather the necessary information before completing the form. If you have previously completed an eQIP, your data should be saved.

Visit the eQIP application site at https://www.opm.gov/investigations/e-qip-application/. **Make sure that you are using Internet Explorer.** The site also provides access to a Quick Reference Guide and FAQs.

Click **Enter Applicant Site** and **Register for a Username/ Password.** You will be prompted to enter 4 golden questions. Your unique registration code is: (b) (6) We suggest that you copy and paste the code from this email directly into eQIP. (Note: If you receive an error when entering your golden questions and previously held a clearance through the DOD, type "unknown" as your place of birth).

The Standard Form (SF-86) is used for the purposes of your background investigation and will not be used for any other purpose within the organization.

Common Pitfalls:

- Do not use family members as references for residence or work history. The only exception is when you are reporting a period of unemployment you can use a spouse/ parent as a reference.
- Cluster your references geographically. The FBI will ultimately interview all of your references in person. The process is faster if your references are clustered geographically, so that they can minimize the involvement of different field offices.
- Pay close attention to the scope of each question **and to the supplemental instructions which may increase the scope**. Some questions ask for 10 years of history while others ask for lifetime history (ex: you only need to list schools attended in the last 10 years, but must list all degrees you have obtained in your lifetime).

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- If you are a male and have registered for the Selective Service, visit sss.gov to obtain your Selective Service number. Do not put unknown.
- You must list all arrests/ criminal charges, even if you believe they have been expunged.
- Do not lie about drug use. The FBI will interview associates, neighbors, co-workers, and family members and lying on the SF-86 is disqualifying. (Remember that marijuana is considered an illegal drug by the federal government regardless of local regulations.)
- Utilize the comments section to explain any adverse information that you are reporting on the SF-86.

Submission:

When all fields are complete, you will be prompted to certify your eQIP. At this time, the system will generate four signature forms (CER, REL, FCR, and MEL.) These forms need to be printed, hand signed, scanned, and returned to (b) (6) @ptt.gov

Continue clicking next until you are prompted to **Submit For Agency Review**. At this point you will no longer be able to access eQIP.

Note: We are required to review the eQIP for accuracy and completion. If we need to return your eQIP to you after certification, you will need to redo the Yes/No questions. If this is your first time completing the SF86 or if you have any questions, we are happy to review your submission with you prior to certification.

--

(b) (6)
Presidential Transition Team
(b) (6) @ptt.gov
(b) (6)

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) @gmail.com]
Sent: 1/4/2017 1:54:47 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Re: vso slides-

Ok

On Jan 3, 2017 8:46 PM, "David Shulkin" <drshulkin@aol.com> wrote:

> These slides are a little different than the prior slides - so lets use these for the vso
>
> I don't want to handout paper copies but rather just show these on the screen

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 1/4/2017 1:46:05 AM
To: (b) (6) [redacted]@gmail.com
Subject: vso slides-
Attachments: vsomodernization.pptx

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myVA
Putting Veterans First

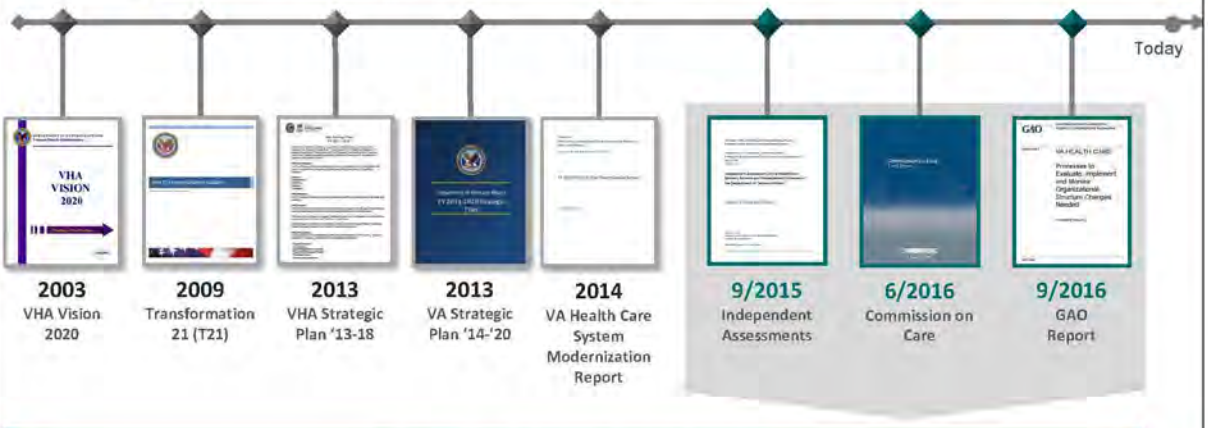
VSO Breakfast

VA Modernization

VA | U.S. Department of Veterans Affairs

AMERICAN OVERSIGHT

Despite Real Improvements, VA Has Not had a Major Organizational Change in 20 yrs



2003 VHA Vision 2020

2009 Transformation 21 (T21)

2013 VHA Strategic Plan '13-18

2013 VA Strategic Plan '14-'20

2014 VA Health Care System Modernization Report

9/2015 Independent Assessments

6/2016 Commission on Care

9/2016 GAO Report

As identified in several recent reports:

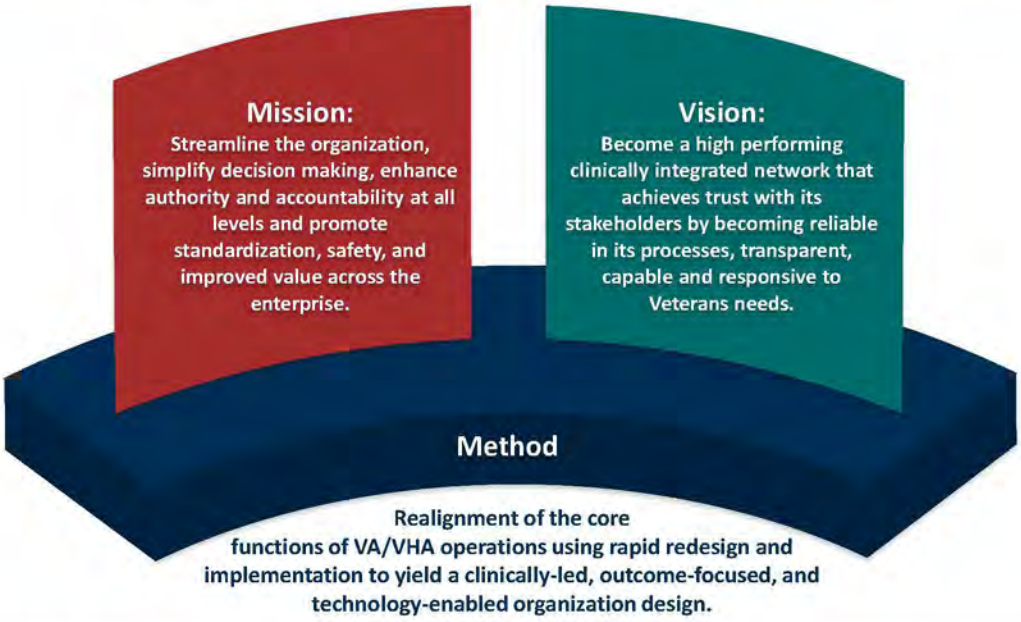
Even with the significant recent improvements in access, diffusion of best practices and employee engagement, incrementalism is not the answer to the additional improvements needed in VA

- The current organizational design does not support the goal of becoming an increasingly high-performing accountable healthcare organization

Source: Listed reports and assessments

AMERICAN OVERSIGHT

2017- VHA Modernization Mission, Vision, and Method



AMERICAN OVERSIGHT

Modernization builds toward a VA exhibiting best practices for clinically integrated payer-provider organizations

Guiding Principles	Description	Current Ongoing Work
High Performing (Veteran-Centric) Network of Care Providers	■ Achieving simpler navigation for veterans to choose best outcomes in care in an integrated network of VA and non-VA providers ■ Coordinated and integrated services with other federal agencies and community partners ■ Strengthen Foundational VA services to achieve best in class care	▪ High Performance Network workgorup ▪ Reengineer Care Delivery by Market ▪ Federal entity/Sharing Services workgroup
Value-Based and Cost-Efficient	■ Value Based purchasing tor community care network ■ Expand efforts to minimize costs and maximizing revenues	▪ Value-Based Purchasing workgroup ▪ Address underutilized or low performing facilities ▪ Logistics and Supply Chain workgroups ▪ Personnel Mix and Planning Workgroup
Accountable Governance and Management	■ Organization design, governance and management based on best practices for Large-scale, efficient, High-performing, clinically-integrated payer-provider organizations	▪ Governance workgroup ▪ Optimize Management workgroup ▪ Assess Service Line Management ▪ Address VACO/VISN/Facility Accountabilities
Achieving the full Mission for Veterans	■ Care Coordination for complex and vulnerable populations ■ Whole health model of care delivery implemented to address the physical, psychological and social determinants and of health ■ Ensure educational, research and emergency preparedness roles are not diluted.	▪ Care Coordination workgroup ▪ Whole Health Model workgroup ▪ Research, Education and Preparedness workgroups

Key Tactical Enabler Workgroup | ART Briefings

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Access to Community Care is a critical element of the new system design

Achieve VA's goal of delivering the "Best Care Anywhere" to veterans by:

- Balancing care provided by VA and the community
- Addressing increases in demand for care and changing needs of veterans
- Promoting operational efficiency and simplicity of choosing providers
- Balancing VA's clinical care, education, and research missions

The specific outcomes of the Office that will drive this include:

- At a national level, define VA-Delivered Foundational services and define resource requirements
- At the local level, provide principles for the remaining "locally determined" health services
  - Framework and approach for make vs. buy decisions
  - High-level governance toolkit for local evaluation
  - Avoid duplication with federal partners

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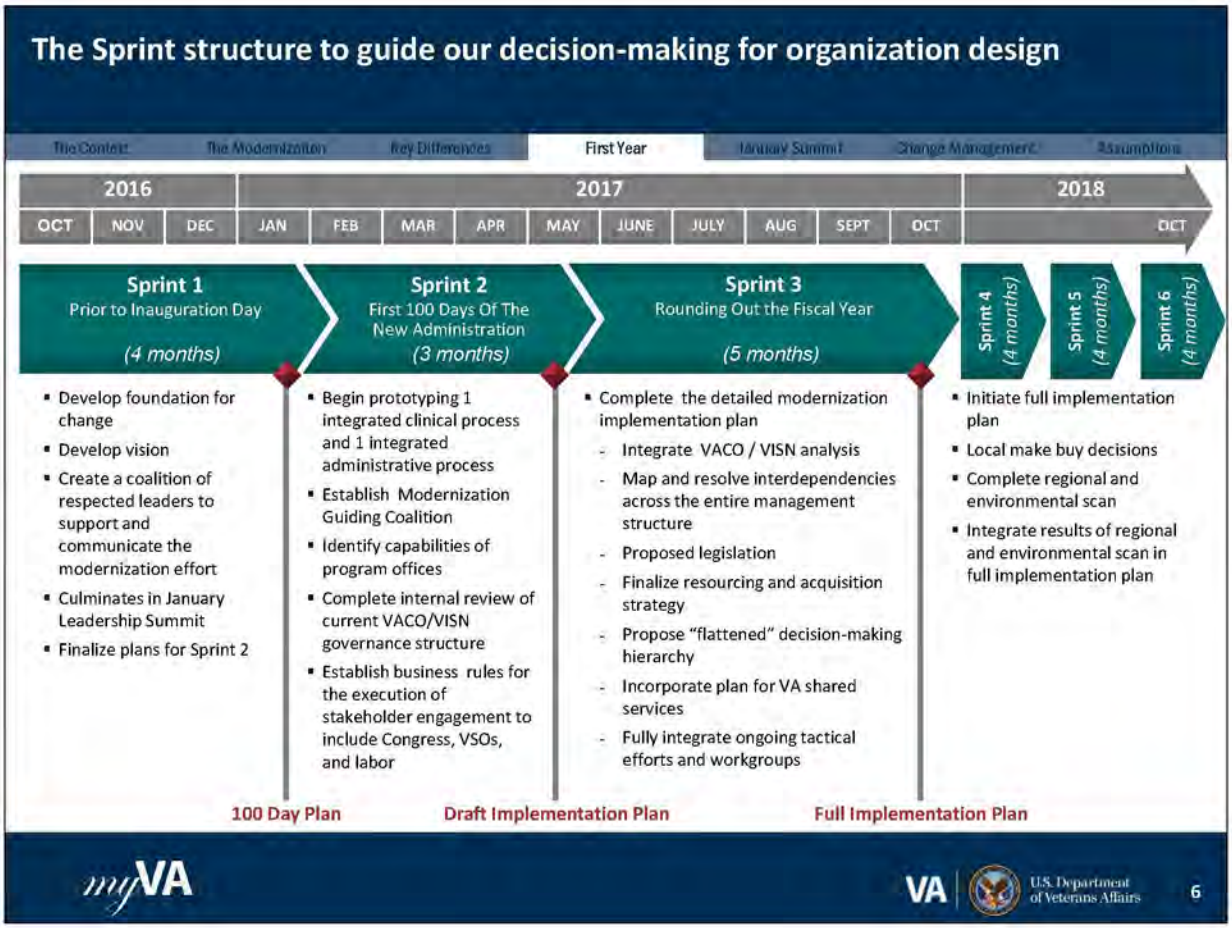

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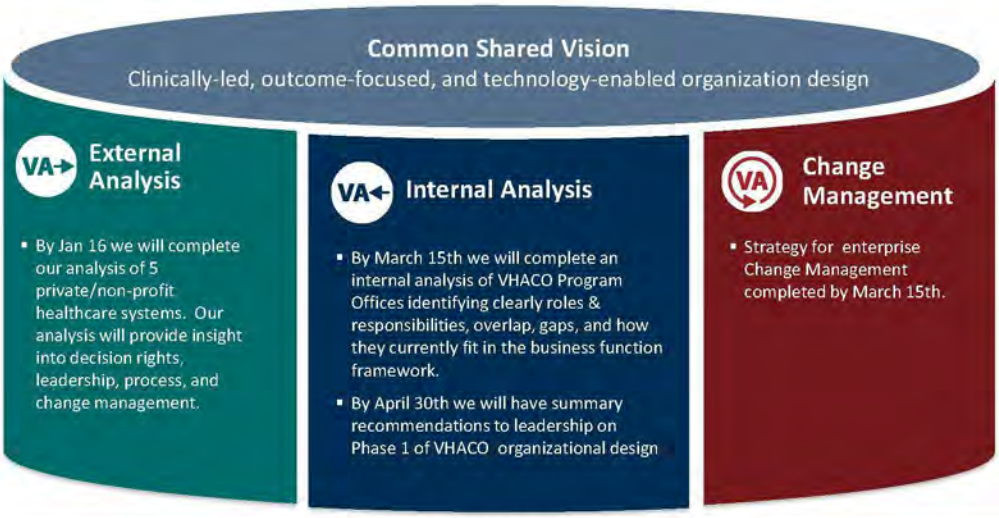
The Modernization project is driving toward Sprint 1 and Sprint 2 outcomes



First 100 Days

- Draft implementation plan at end of Sprint 2 (100 days of administration)
- Final public facing implementation plan at end of Sprint 3
- Communications and Change Management plans by end of Sprint 2
- Leadership Change Coalition established February 1, 2017

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Requirements and Assumptions

1. VHA will continue all four of our missions: Healthcare, Education, Research, Emergency response
2. As appropriate statutory relief from requirements that impede transformation
3. Improve budgetary flexibility by allowing ease of movement of funds between appropriation
4. Basic Design model for restructuring all of VA will take 12 months from approval to proceed
5. VHA will have accountability either through direct reporting or through tight service level agreements for key shared services
6. Customer-centric OIT transformation is critical to ensure the existing OIT infrastructure adequately supports the modernization of the VA
7. Labor management issues will not significantly slow transformation
8. EHR and Cost Accounting System modernizations will continue forward

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Why Modernization is Different from Prior Change Efforts



We benefit from the **findings of numerous recent studies** that have identified many challenges and shortfalls at VA. Our emphasis is now on **specific tactics and detailed implementation and execution plans**.



We can benefit from the **full duration of the new Administration** because we have already formed the basis of a future foundation for change.



An understanding and appreciation that **change cannot move faster than the pace of change management**; an Achilles heel for numerous prior change initiatives.



Specific mechanisms and approach to **engage staff at all levels of the VA** in organization diagnosis, design and, implementation.



An appreciation that **all levels of the management of the organization need to be examined** to ensure they are structured properly in order to deliver appropriate evaluate in the ongoing operation.

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VA-19-0799-J-000861

DS_00008490

Message

From: Bruce Moskowitz [brucem(b) (6) mac.com]
Sent: 1/7/2017 4:37:35 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Meeting

Today

Sent from my iPhone

On Jan 7, 2017, at 11:36 AM, David shulkin <Drshulkin@aol.com> wrote:

> Bruce- i thought 2 pm monday (not today) right?
>
> Sent from my iPhone
>
> On Jan 7, 2017, at 11:29 AM, Bruce Moskowitz <brucem(b) (6) mac.com> wrote:
>
> > Dr Shulkin is on schedule to meet with Reince Priebus at one and President elect Donald Trump at two today. I will keep everyone updated on the progress of the meeting. Sent from my iPad Bruce Moskowitz M.D.
>
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AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/7/2017 4:36:46 PM
To: Bruce Moskowitz [brucem(b) (6) mac.com]
Subject: Re: Meeting

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AMERICAN OVERSIGHT

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From: Bruce Moskowitz [brucem(b) (6) mac.com]
Sent: 1/7/2017 4:29:37 PM
To: (b)s(b) (6) gmail.com; IP [(@frenchangel59.com]; (b) (6) M. D. [(b) (6) partners.org]; (b) (6) ccf.org; (b) (6) [(b) (6) 1@jhmi.edu]; (b) (6) M.D. (b) (6) @mayo.edu]
CC: David shulkin [drshulkin@aol.com]
Subject: Meeting

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/30/2016 12:23:12 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: Next week

Yes

Sent from my iPhone

> On Dec 29, 2016, at 11:15 PM, Poonam Alaigh <(b) (6) n@hotmail.com> wrote:
>
> Will you be on the usual Sunday train to DC on January 8th?
>
> Sent from my iPad

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6)@hotmail.com]
Sent: 12/30/2016 4:15:58 AM
To: David shulkin [drshulkin@aol.com]
Subject: Next week

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Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/29/2016 6:46:24 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: Next week

I looked at we work pricing- i think you are right- we dont need to commit at this point

Sent from my iPhone

On Dec 29, 2016, at 1:00 PM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:

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> **From:** David shulkin <Drshulkin@aol.com>
> **Sent:** Thursday, December 29, 2016 12:55 PM
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(b) [redacted]

Sent from my iPad

On Dec 28, 2016, at 3:10 PM, Poonam Alaigh <(b) (6) [redacted]@hotmail.com> wrote:

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From: David shulkin [Drshulkin@aol.com]
Sent: 12/29/2016 6:30:13 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: Next week

Ok

Sent from my iPhone

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Message

From: David Shulkin [drshulkin@aol.com]
Sent: 12/29/2016 5:24:12 PM
To: (b) (6) @hotmail.com
Subject: Re: Next week

I actually think it makes a lot of sense to consider this- as I think we will potentially be doing a lot if business in DC for both NOAHH and Consulting.

And a month to month is great.

I know you might be tied up but I would certainly be willing to see it one time in the early evening.

-----Original Message-----
From: Poonam Alaigh <(b) (6) @hotmail.com>
To: David Shulkin <drshulkin@aol.com>
Sent: Thu, Dec 29, 2016 11:16 am
Subject: Fw: Next week

I dont think there is a need for us right now- see below

From: (b) (6) <(b) (6) @gmail.com>
Sent: Thursday, December 29, 2016 11:12 AM
To: Poonam Alaigh
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Lets speak on Friday, when I can give you more details on this and some of the other potential opportunities. In the meantime, was hoping you could attend this meeting with me- its close to the Sofitel on H street (I think) in DC, where we usually meet.

Thanks

AMERICAN OVERSIGHT

Message

From: Marisol Garcia [(b)@frenchangel59.com]
Sent: 1/6/2017 10:23:58 PM
To: 'David shulkin' [Drshulkin@aol.com]
Subject: RE: Car Service - Friday, January 6th at 8:30 AM

My pleasure – I will let Ike know.

From: David shulkin [mailto:Drshulkin@aol.com]
Sent: Friday, January 06, 2017 2:01 PM
To: Marisol Garcia
Subject: Re: Car Service - Friday, January 6th at 8:30 AM

Marisol- thank you for all of your help

Please let Ike know that i am boarding a plane back home now so i wont be accessible by cell till 5 pm if He needs me- feel free to leave a message or email

David Shulkin

Sent from my iPhone

On Jan 5, 2017, at 7:33 PM, Marisol Garcia <mg@frenchangel59.com> wrote:

January 6, 2017 Transportation: **Park Limousine at 8:30 AM**
561-832-2222
Confirmation # 74326

Pick-up address:
Double Tree Hilton Hotel WPB

Destination:
The Mar-a-Lago Club, L.C.
1100 South Ocean Boulevard
Palm Beach, Florida 33480

(561) 832-2600

*****Driver will wait and take you to the airport*** I will need flight and departure information for driver**

Best,

AMERICAN OVERSIGHT

Marisol

<StandardConfirmation.pdf>

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/6/2017 7:00:32 PM
To: Marisol Garcia [(b)@frenchangel59.com]
Subject: Re: Car Service - Friday, January 6th at 8:30 AM

Marisol- thank you for all of your help

Please let Ike know that i am boarding a plane back home now so i wont be accessible by cell till 5 pm if He needs me- feel free to leave a message or email

David Shulkin

Sent from my iPhone

On Jan 5, 2017, at 7:33 PM, Marisol Garcia <mg@frenchangel59.com> wrote:

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561-832-2222
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Destination:
The Mar-a-Lago Club, L.C.
1100 South Ocean Boulevard
Palm Beach, Florida 33480

(561) 832-2600

*****Driver will wait and take you to the airport*** I will need flight and departure information for driver**

Best,

Marisol

AMERICAN OVERSIGHT

<StandardConfirmation.pdf>

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/6/2017 1:17:44 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Fwd: Car Service - Friday, January 6th at 8:30 AM
Attachments: StandardConfirmation.pdf; Untitled attachment 17581.htm

(b) (6)

Limo

Sent from my iPhone

Begin forwarded message:

From: "Marisol Garcia" <(b) @frenchangel59.com>
Date: January 5, 2017 at 7:33:22 PM EST
To: "David shulkin" <Drshulkin@aol.com>
Cc: "Bruce Moskowitz" <brucem(b) (6) mac.com>
Subject: Car Service - Friday, January 6th at 8:30 AM

January 6, 2017 Transportation: **Park Limousine at 8:30 AM**
561-832-2222
Confirmation # 74326

Pick-up address:
Double Tree Hilton Hotel WPB

Destination:
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1100 South Ocean Boulevard
Palm Beach, Florida 33480

(561) 832-2600

*****Driver will wait and take you to the airport*** I will need flight and departure information for driver**

Best,

Marisol

AMERICAN OVERSIGHT

AMERICAN OVERSIGHT

PARK LIMOUSINE
139 N. County Road, Palm Beach, FL 33480

Confirmation

Reservation Confirmation #74326

Last Modified On: 01/05/2017 07:25 PM

Thank you for choosing Park Limousine. Below please find your confirmation. If any of the information appears to be incorrect, please contact our office immediately to correct it.

Pick-up Date:	01/06/2017 - Friday
Pick-up Time:	08:30 AM
ServiceType:	Charter
Passenger:	Dave Shulkin
Phone Number:	
No. of Pass:	1
Vehicle Type:	Sedan
Primary/Billing Contact:	Accounts Payable
Booking Contact:	Marisol Garcia
Payment Method:	Direct Bill/Invoice

Trip Routing Information:

PU: -- :Double Tree West Palm Beach, 1808 S Australian Avenue, West Palm Beach, FL 33409 - Ph: (561) 689-6888
WT: -- :Mar-A-Lago, 1100 South Ocean Boulevard, Palm Beach, FL 33480

Terms & Conditions/ Reservation Agreement:

The only schedule we're on is yours...

Rates shown on a reservation confirmation are **ESTIMATES ONLY**.

All cancellations for **transfers** booked in Sedan, SUV and Van for a Palm Beach County pick up must be received two (2) hours prior to contracted start time to avoid forfeiture of one hundred percent (100%) of the estimated trip total.

All cancellations for **transfers** booked in a Sedan, SUV and Van for a pick up outside of Palm Beach County must be received four (4) hours prior to contracted start time to avoid forfeiture of one hundred percent (100%) of the estimated trip total

Cancellation for **transfers** booked in all other vehicles (Mercedes Sedan, Limousine, Sprinter Van, Minibus or Motorcoach Bus) must be received forty-eight (48) hours prior to contracted start time to avoid forfeiture of one hundred percent (100%) of the estimated trip total.

All cancellations for Sedans, SUV's and Vans booked for **two (2) hours or greater** received within 2 hours of contract start time, a cancellation fee of one hundred percent (100%) of the estimated trip total will be charged.

Cancellations for all other vehicles (Mercedes Sedan, Limousine, Sprinter Van, Minibus or Motorcoach Bus) booked for **two (2) hours or greater** require a forty-eight (48) hours prior to contracted start time to avoid forfeiture of one hundred percent (100%) of the estimated trip total.

Late Night / Early Morning Charges and Cancellation: A charge of $25.00 will be applied to the trip total in which the pick up or drop off occurs between the hours of 1:00am and 6:00am. Cancellations must be received no later than 11:00pm for a scheduled late night / early morning pick up that will occur the next day to avoid forfeiture of the one hundred percent (100%) of the estimated trip total.

AMERICAN OVERSIGHT

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/6/2017 1:42:25 AM
To: Marisol Garcia [(b)@frenchangel59.com]
Subject: Re: Car Service - Friday, January 6th at 8:30 AM

Thanks - i just need the ride to the margo lar from the doubletree and then to the west palm beach va afterwards

Va police will take me to the airport
Thanks

Sent from my iPhone

On Jan 5, 2017, at 7:33 PM, Marisol Garcia <(b)@frenchangel59.com> wrote:

January 6, 2017 Transportation: **Park Limousine at 8:30 AM**
561-832-2222
Confirmation # 74326

Pick-up address:
Double Tree Hilton Hotel WPB

Destination:
The Mar-a-Lago Club, L.C.
1100 South Ocean Boulevard
Palm Beach, Florida 33480

(561) 832-2600

*****Driver will wait and take you to the airport*** I will need flight and departure information for driver**

Best,

Marisol

<StandardConfirmation.pdf>

AMERICAN OVERSIGHT

Message

From: Marisol Garcia [(b)@frenchangel59.com]
Sent: 1/6/2017 12:33:22 AM
To: David shulkin [Drshulkin@aol.com]
CC: Bruce Moskowitz [brucem(b) (6) mac.com]
Subject: Car Service - Friday, January 6th at 8:30 AM
Attachments: StandardConfirmation.pdf

January 6, 2017 Transportation: **Park Limousine at 8:30 AM**
561-832-2222
Confirmation # 74326

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Marisol

AMERICAN OVERSIGHT

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139 N. County Road, Palm Beach, FL 33480

Confirmation

Reservation Confirmation #74326

Last Modified On: 01/05/2017 07:25 PM

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Pick-up Date:	01/06/2017 - Friday
Pick-up Time:	08:30 AM
ServiceType:	Charter
Passenger:	Dave Shulkin
Phone Number:	
No. of Pass:	1
Vehicle Type:	Sedan
Primary/Billing Contact:	Accounts Payable
Booking Contact:	Marisol Garcia
Payment Method:	Direct Bill/Invoice

Trip Routing Information:

PU: -- :Double Tree West Palm Beach, 1808 S Australian Avenue, West Palm Beach, FL 33409 - Ph: (561) 689-6888
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AMERICAN OVERSIGHT

Message

From: [(b) (6) [(b) (6) va.gov]
Sent: 1/16/2017 11:44:06 PM
To: 'Darin Selnick' [(b) (6) @gmail.com]
CC: 'David shulkin' [drshulkin@aol.com]
Subject: RE: [EXTERNAL] Re:

Thank you, will have the scheduling team hold for the future.

-----Original Message-----
From: Darin Selnick [(b) (6) @gmail.com]
Sent: Monday, January 16, 2017 06:34 PM Eastern Standard Time
To: [(b) (6)]
Cc: David shulkin
Subject: [EXTERNAL] Re:

Hi [(b) (6)]

Dr. Shulkin would like to have set up a post confirmation meeting with former Secretary Principi.

His contact information is [(b) (6) @yahoo.com.

Thanks so much.

Darin Selnick

On Mon, Jan 16, 2017 at 7:12 AM, David shulkin <Drshulkin@aol.com> wrote:
Darin- [(b) (6)] is best to handle details of my calendar

Thanks

David

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: [redacted] va.gov]
Sent: 1/16/2017 3:03:31 PM
To: 'David shulkin' [Drshulkin@aol.com]
Subject: RE: [EXTERNAL] Fwd: Re:

I'll give two times since your meetings with roe and the congressman from pa are cancelled.

-----Original Message-----
From: David shulkin [Drshulkin@aol.com]
Sent: Monday, January 16, 2017 08:06 AM Eastern Standard Time
To: [redacted]
Subject: Re: [EXTERNAL] Fwd: Re:

Can you work with his office for an hour on wednesday am?

Sent from my iPhone

On Jan 15, 2017, at 11:07 PM, [redacted] va.gov> wrote:

> Tuesday and Wednesday. Wednesday from 8-10.
>
> -----Original Message-----
> **From:** David shulkin [Drshulkin@aol.com]
> **Sent:** Sunday, January 15, 2017 10:30 PM Eastern Standard Time
> **To:** [redacted]
> **Subject:** [EXTERNAL] Fwd: Re:
>
> Lets look for options
>
> Sent from my iPhone
>
> Begin forwarded message:
>
> > **From:** Robert McDonald <[redacted]@gmail.com>
> > **Date:** January 15, 2017 at 10:00:25 PM EST
> > **To:** David shulkin <Drshulkin@aol.com>, "[redacted]
> > [redacted]@va.gov>
> > **Subject: Re:**
> >
> > David, I will spend whatever time you wish. I'm heading back to DC early in the morning, weather permitting. We are having an ice storm in Omaha. If I am lucky and we get out on time, I will be in DC by noon. I can come to the office if you wish. I can also change my schedule for the balance of the week. Just let me know what meets your needs. Thanks. Bob
> >
> > On Sun, Jan 15, 2017 at 9:58 PM, David shulkin <Drshulkin@aol.com> wrote:

AMERICAN OVERSIGHT

Bob- i know you are traveling back but im hoping that we might find sone tine to connect so I can get your advice. I cannot imagine ever being as prepared as you are but knowing that you may be a call away would be a great comfort.

David

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/16/2017 1:05:50 PM
To: (b) (6) ((b) (6) va.gov]
Subject: Re: [EXTERNAL] Fwd: Re:

Can you work with his office for an hour on wednesday am?

Sent from my iPhone

On Jan 15, 2017, at 11:07 PM, (b) (6) (b) (6) R. (b) (6) va.gov> wrote:

> Tuesday and Wednesday. Wednesday from 8-10.
>
> -----Original Message-----
> **From:** David shulkin [Drshulkin@aol.com]
> **Sent:** Sunday, January 15, 2017 10:30 PM Eastern Standard Time
> **To:** (b) (6)
> **Subject:** [EXTERNAL] Fwd: Re:
>
> Lets look for options
>
> Sent from my iPhone
>
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>
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> > **Date:** January 15, 2017 at 10:00:25 PM EST
> > **To:** David shulkin <Drshulkin@aol.com>, "(b) (6)
> > (b) (6) @va.gov>
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> > >
> > > David
> > >
> > > Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: (b) (6) (b) (6) va.gov]
Sent: 1/16/2017 4:07:00 AM
To: 'David shulkin' [Drshulkin@aol.com]
Subject: RE: [EXTERNAL] Fwd: Re:

Tuesday and Wednesday. Wednesday from 8-10.

-----Original Message-----
From: David shulkin [Drshulkin@aol.com]
Sent: Sunday, January 15, 2017 10:30 PM Eastern Standard Time
To: (b) (6)
Subject: [EXTERNAL] Fwd: Re:

Lets look for options

Sent from my iPhone

Begin forwarded message:

> **From:** Robert McDonald <(b) (6) @gmail.com>
> **Date:** January 15, 2017 at 10:00:25 PM EST
> **To:** David shulkin <Drshulkin@aol.com>, "(b) (6) (b) (6) @va.gov>
> **Subject: Re:**
>
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>
> David
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Jennifer Lee [(b) (6) @gmail.com]
Sent: 1/18/2017 8:02:10 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Ride 2 Recovery - (b) (6)

Just met with (b) briefly- I know you are seeing him at 3:30p
great meeting.

-he wants to ask you how committed you are to community partnerships
-he wants to invite you to speak at their conference in June in Miami.
-they have engaged the Conference of Mayors and want to urge us to work with the Mayors

AMERICAN OVERSIGHT

Message

From: Vivieca Simpson [(b) (6) @gmail.com]
Sent: 1/9/2017 10:45:38 PM
To: drshulkin@aol.com
Subject: Fwd: FW: Dr. Shulkin

---------- Forwarded message ----------
From: "Wright, Vivieca (Simpson)" <Vivieca.Wright@va.gov>
Date: Jan 9, 2017 17:20
Subject: FW: Dr. Shulkin
To: "(b) (6) @gmail.com" <(b) (6) @gmail.com>
Cc:

From: (b) (6)
Sent: Monday, January 09, 2017 5:11 PM
To: Wright, Vivieca (Simpson); Stone, Richard A., MD
Subject: Dr. Shulkin

https://www.washingtonpost.com/news/post-politics/wp/2017/01/09/the-full-transcript-from-the-trump-transition-teams-monday-call-to-reporters-5/?utm_term=.a37971bc9537

"The president-elect will then meet with Senator -- Majority Leader Mitch McConnell and then have a meeting with Dr. David Shulkin, that's S-H-U-L-K-I-N, who's the current undersecretary for health at the Department of Veterans Affairs. As Undersecretary Dr. Shulkin leads the nation's largest integrated health care system, currently serving 8.76 million veterans every year, buyers (ph) serving in that -- this current position, Dr. Shulkin has exemplified strong leadership in various roles throughout his career, including chief executive roles, as a doctor, in academia and in entrepreneur roles."

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/16/2017 8:37:05 PM
To: (b) (6) [(b) (6) @gmail.com]
Subject: Fwd: IT issues- Draft plan for first 100 days

Can you print for me

Sent from my iPhone

Begin forwarded message:

> **From:** Jennifer Lee <(b) (6) @gmail.com>
> **Date:** January 16, 2017 at 1:23:59 PM EST
> **To:** David shulkin <Drshulkin@aol.com>
> **Subject: Re: IT issues- Draft plan for first 100 days**
>
> Ok,yes understood. I know you didn't request this- I got a little too excited and ahead of the timeline here. sorry about that!
>
> We are working up papers and TPs for women's health and other issues for confirmation. Those will be ready by tomorrow.
>
> thanks
> Jen
>
> On Mon, Jan 16, 2017 at 1:18 PM, David shulkin <Drshulkin@aol.com> wrote:
> Jennifer- i dont want to consider anythibg till after confirmation- most of this suggests presumption- which would be problematic
>
> Sent from my iPhone
>
> On Jan 16, 2017, at 1:16 PM, Jennifer Lee <(b) (6) @gmail.com> wrote:
>
> > David,
> >
> > We have been hampered in IT by the organizational dysfunction, but in the last 9 months I've learned a lot. Per our discussion yesterday, I'd like to offer a quick summary of my assessment and recommendations and would love to discuss more whenever you would like. I don't expect many in OIT would support this, but I truly believe this is the right path for VHA.
> >
> > **Problem List**:
> >
> > - We cannot succeed in effectively staffing and scheduling, ensuring quality, coordinating care, billing, or in implementing telehealth and other innovative mobile solutions we need for the future until we address the core problems in IT.
> > - The core problems fall into the following areas:
> > - **Technology** – VistA. Our system is outdated and sustainment of the system is killing our budget. Unless we

AMERICAN OVERSIGHT

modernize or convert to a commercial system, we cannot achieve our other access and quality goals in VHA. It is absolutely critical that we address VistA immediately.

- **Governance** –
  - We have to establish who is in the driver seat. The political battles, poor communication and coordination between VHA and OIT are wasting time and money
  - We do not manage our contracts well.
  - We are fragmented even within VHA
- **Leadership** – We don't have the right people in the right seats in VHA or OIT yet.
- **Budget and political support** – VA has wasted literally *billions* of dollars in the last 10 years in failed IT projects. There is little trust. Yet, to fix the problem we will need an investment of funds and political support for our plan.

Assessment/Plan:

- **Technology**:
  - My assessment is that modernizing VistA will mean that we must rebuild an internal IT development capacity that will take too much time, money, and political capital. VA hasn't shown that we can do this effectively. I believe we have no choice and will ultimately need to go to a COTS.
- **Governance**:
  - In my opinion, VHA as the customer must lead. We need to hire the right people and empower them, including at the medical center level.
- **Budget and political support:**
  - We cannot squander political capital in this area. We must move quickly with a definitive plan in the first 30 days and build support on the Hill for it.

Early Action Steps

- **Announce the appointment of a VHA CHIO within first 60 days.**
  (meets the recommendation of the Commission on Care)
- **Announce the appointment of a VHA CIO within 60 days.**
  (meets the recommendation of the Commission on Care; also allows us to move quickly even in absence of a VA CIO appointee confirmed) I can rename the ADUSH (Chuck's) position for this purpose. we have candidates in consideration right now.
- **Select one VAMC to convert to a commercial EHR and prepare for release of RFP.**
  - Success at one VAMC will build confidence and support on the Hill for additional investments going forward.
  - We will also learn valuable lessons that can be applied across the entire system.
  - This will also buy us time to fix more systemic issues within OIT

AMERICAN OVERSIGHT

- **Use existing contracts to immediately begin organizational change management to prepare for EHR conversion at test site.**
    - At same time, we must implement a resource-based scheduling system (i.e. MASS) at test site.
    - VSE is purely a bridge. Not a permanent solution.
- **Convene a blue-ribbon panel to help guide us through the process. This panel of experts will vouch for us when things inevitably get delayed or slowed.**
- **Convene and engage internal field informatics advisory committee to ensure good communication and support from the field.** CPRS is well-liked by providers- there will be concern with a move away from it.
- **Change reporting structure so that VAMC CIOs report primarily to the VAMC director, with a dotted line to the VHA CIO. (**This will generate tremendous support in field)
- **Designate IT dollars for VHA and provide VHA with budgetary control over its own IT funding**
- **Realign existing VHA IT-related programs (including telehealth) in a more efficient structure.** (I already have support for this).

****I believe all of these things could be done administratively, without legislative action. However, we would need to go to the Hill early – within first 30 days- to communicate our plan and build support.****

Thanks for listening,

Jennifer

AMERICAN OVERSIGHT

Message

From: Jennifer Lee [(b) (6) @gmail.com]
Sent: 1/16/2017 6:23:59 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: IT issues- Draft plan for first 100 days

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AMERICAN OVERSIGHT

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  - This will also buy us time to fix more systemic issues within OIT
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  - VSE is purely a bridge. Not a permanent solution.
- **Convene a blue-ribbon panel to help guide us through the process. This panel of experts will vouch for us when things inevitably get delayed or slowed.**
- **Convene and engage internal field informatics advisory committee to ensure good communication and support from the field.** CPRS is well-liked by providers- there will be concern with a move away from it.
- **Change reporting structure so that VAMC CIOs report primarily to the VAMC director, with a dotted line to the VHA CIO. (**This will generate tremendous support in field)
- **Designate IT dollars for VHA and provide VHA with budgetary control over its own IT funding**
- **Realign existing VHA IT-related programs (including telehealth) in a more efficient structure.** (I already have support for this).

AMERICAN OVERSIGHT

****I believe all of these things could be done administratively, without legislative action. However, we would need to go to the Hill early –within first 30 days- to communicate our plan and build support.****

Thanks for listening,

Jennifer

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/16/2017 6:18:57 PM
To: Jennifer Lee [(b) (6) @gmail.com]
Subject: Re: IT issues- Draft plan for first 100 days

Jennifer- i dont want to consider anythibg till after confirmation- most of this suggests presumption- which would be problematic

Sent from my iPhone

On Jan 16, 2017, at 1:16 PM, Jennifer Lee <(b) (6) @gmail.com> wrote:

> David,
>
> We have been hampered in IT by the organizational dysfunction, but in the last 9 months I've learned a lot. Per our discussion yesterday, I'd like to offer a quick summary of my assessment and recommendations and would love to discuss more whenever you would like. I don't expect many in OIT would support this, but I truly believe this is the right path for VHA.
>
> **Problem List**:
>
> - We cannot succeed in effectively staffing and scheduling, ensuring quality, coordinating care, billing, or in implementing telehealth and other innovative mobile solutions we need for the future until we address the core problems in IT.
> - The core problems fall into the following areas:
>   - **Technology** – VistA. Our system is outdated and sustainment of the system is killing our budget. Unless we modernize or convert to a commercial system, we cannot achieve our other access and quality goals in VHA. It is absolutely critical that we address VistA immediately.
>   - **Governance** –
>   - We have to establish who is in the driver seat. The political battles, poor communication and coordination between VHA and OIT are wasting time and money
>   - We do not manage our contracts well.
>   - We are fragmented even within VHA
>   - **Leadership** – We don't have the right people in the right seats in VHA or OIT yet.
>   - **Budget and political support** – VA has wasted literally *billions* of dollars in the last 10 years in failed IT projects. There is little trust. Yet, to fix the problem we will need an investment of funds and political support for our plan.
>
> **Assessment/Plan:**
>
> - **Technology**:
>   - My assessment is that modernizing VistA will mean that we must rebuild an internal IT development capacity that will take too much time, money, and political capital. VA hasn't shown that we can do this effectively. I believe we have no choice and will ultimately need to go to a COTS.
> - **Governance**:

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    - In my opinion, VHA as the customer must lead. We need to hire the right people and empower them, including at the medical center level.
- **Budget and political support:**
    - We cannot squander political capital in this area. We must move quickly with a definitive plan in the first 30 days and build support on the Hill for it.

Early Action Steps

- **Announce the appointment of a VHA CHIO within first 60 days.** (meets the recommendation of the Commission on Care)
- **Announce the appointment of a VHA CIO within 60 days.** (meets the recommendation of the Commission on Care; also allows us to move quickly even in absence of a VA CIO appointee confirmed) I can rename the ADUSH (Chuck's) position for this purpose. we have candidates in consideration right now.
- **Select one VAMC to convert to a commercial EHR and prepare for release of RFP.**
    - Success at one VAMC will build confidence and support on the Hill for additional investments going forward.
    - We will also learn valuable lessons that can be applied across the entire system.
    - This will also buy us time to fix more systemic issues within OIT
- **Use existing contracts to immediately begin organizational change management to prepare for EHR conversion at test site.**
    - At same time, we must implement a resource-based scheduling system (i.e. MASS) at test site.
    - VSE is purely a bridge. Not a permanent solution.
- **Convene a blue-ribbon panel to help guide us through the process. This panel of experts will vouch for us when things inevitably get delayed or slowed.**
- **Convene and engage internal field informatics advisory committee to ensure good communication and support from the field.** CPRS is well-liked by providers- there will be concern with a move away from it.
- **Change reporting structure so that VAMC CIOs report primarily to the VAMC director, with a dotted line to the VHA CIO. (**This will generate tremendous support in field)
- **Designate IT dollars for VHA and provide VHA with budgetary control over its own IT funding**
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****I believe all of these things could be done administratively, without legislative action. However, we would need to go to the Hill early –within first 30 days- to communicate our plan and build support.****

Thanks for listening,

Jennifer

AMERICAN OVERSIGHT

Message

From: Jennifer Lee [(b) (6) @gmail.com]
Sent: 1/16/2017 6:16:02 PM
To: David Shulkin [drshulkin@aol.com]
Subject: IT issues- Draft plan for first 100 days

David,

We have been hampered in IT by the organizational dysfunction, but in the last 9 months I've learned a lot. Per our discussion yesterday, I'd like to offer a quick summary of my assessment and recommendations and would love to discuss more whenever you would like. I don't expect many in OIT would support this, but I truly believe this is the right path for VHA.

Problem List:

- We cannot succeed in effectively staffing and scheduling, ensuring quality, coordinating care, billing, or in implementing telehealth and other innovative mobile solutions we need for the future until we address the core problems in IT.
- The core problems fall into the following areas:
  - **Technology** – VistA. Our system is outdated and sustainment of the system is killing our budget. Unless we modernize or convert to a commercial system, we cannot achieve our other access and quality goals in VHA. It is absolutely critical that we address VistA immediately.
  - **Governance** –
    - We have to establish who is in the driver seat. The political battles, poor communication and coordination between VHA and OIT are wasting time and money
    - We do not manage our contracts well.
    - We are fragmented even within VHA
  - **Leadership** – We don't have the right people in the right seats in VHA or OIT yet.
  - **Budget and political support** – VA has wasted literally *billions* of dollars in the last 10 years in failed IT projects. There is little trust. Yet, to fix the problem we will need an investment of funds and political support for our plan.

Assessment/Plan:

- **Technology**:
  - My assessment is that modernizing VistA will mean that we must rebuild an internal IT development capacity that will take too much time, money, and political capital. VA hasn't shown that we can do this effectively. I believe we have no choice and will ultimately need to go to a COTS.
- **Governance**:
  - In my opinion, VHA as the customer must lead. We need to hire the right people and empower them, including at the medical center level.
- **Budget and political support:**
  - We cannot squander political capital in this area. We must move quickly with a definitive plan in the first 30 days and build support on the Hill for it.

Early Action Steps

- **Announce the appointment of a VHA CHIO within first 60 days.**
  (meets the recommendation of the Commission on Care)

AMERICAN OVERSIGHT

- **Announce the appointment of a VHA CIO within 60 days.** (meets the recommendation of the Commission on Care; also allows us to move quickly even in absence of a VA CIO appointee confirmed) I can rename the ADUSH (Chuck's) position for this purpose. we have candidates in consideration right now.
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- **Designate IT dollars for VHA and provide VHA with budgetary control over its own IT funding**
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****I believe all of these things could be done administratively, without legislative action. However, we would need to go to the Hill early –within first 30 days- to communicate our plan and build support.****

Thanks for listening,

Jennifer

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/9/2017 1:55:15 PM
To: Jennifer Lee [(b) (6) @gmail.com]
Subject: Re: Rumors

Please call vivieca now

Sent from my iPhone

On Jan 9, 2017, at 8:53 AM, Jennifer Lee <(b) (6) @gmail.com> wrote:

> The Rumor Mill is on "hyperdrive" at VA right now!
>
> I think you've connected with (b) (6) recently right? He is a big fan of yours.
>
> p.s. he gets a lot of info from (b) who sits next to Ash

On Mon, Jan 9, 2017 at 8:41 AM, David shulkin <Drshulkin@aol.com> wrote:
At my last hospital we had something on the intranet calked the "Rumor Mill" where people posted suggestions comments and mostly rumors and then admin posted responses- people loved it since everyone loves rumors!

Sent from my iPhone

> On Jan 9, 2017, at 8:33 AM, Jennifer Lee <(b) (6) @gmail.com> wrote:
>
> (b) (6) tells us this am there is now buzz again about keeping bob mcdonald for a year
>
> This must be coming from (b) (6) but not sure who he is talking to
>
> No idea how sound the info is

AMERICAN OVERSIGHT

Message

From: Jennifer Lee [(b) (6) @gmail.com]
Sent: 1/9/2017 1:53:57 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Rumors

The Rumor Mill is on "hyperdrive" at VA right now!

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p.s. he gets a lot of info from (b) who sits next to Ash

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> This must be coming from (b) (6) but not sure who he is talking to
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AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/9/2017 1:41:24 PM
To: Jennifer Lee [(b) (6) @gmail.com]
Subject: Re: Rumors

At my last hospital we had something on the intranet calked the "Rumor Mill" where people posted suggestions comments and mostly rumors and then admin posted responses- people loved it since everyone loves rumors!

Sent from my iPhone

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>
> (b) (6) tells us this am there is now buzz again about keeping bob mcdonald for a year
>
> This must be coming from (b) (6) but not sure who he is talking to
>
> No idea how sound the info is

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/9/2017 1:39:38 PM
To: Jennifer Lee [(b) (6) @gmail.com]
Subject: Re: Rumors

Wow that would be great

But i dont believe it

Sent from my iPhone

> On Jan 9, 2017, at 8:33 AM, Jennifer Lee (b) (6) gmail.com> wrote:
>
> (b) (6) tells us this am there is now buzz again about keeping bob mcdonald for a year
>
> This must be coming from (b) (6) but not sure who he is talking to
>
> No idea how sound the info is

AMERICAN OVERSIGHT

Message

From: Jennifer Lee [(b) (6) @gmail.com]
Sent: 1/9/2017 1:33:42 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Rumors

(b) (6) tells us this am there is now buzz again about keeping bob mcdonald for a year

This must be coming from (b) (6) but not sure who he is talking to

No idea how sound the info is

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/30/2016 12:22:42 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: Laverne

Great

Sent from my iPhone

> On Dec 30, 2016, at 6:38 AM, Poonam Alaigh <(b) (6) n@hotmail.com> wrote:
>
> Confirmed to talk to her Monday at 10am- will dial both of you in
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/30/2016 11:38:51 AM
To: drshulkin@aol.com
Subject: Laverne

Confirmed to talk to her Monday at 10am- will dial both of you in

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Jennifer Lee [(b) (6) @gmail.com]
Sent: 1/6/2017 6:04:09 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: (b)

working on it...

On Fri, Jan 6, 2017 at 12:27 PM, David shulkin <Drshulkin@aol.com> wrote:
Can you get his number for me?

Sent from my iPhone

> On Jan 6, 2017, at 11:17 AM, Jennifer Lee <(b) (6) @gmail.com> wrote:
>
> David,
> Poonam and I spoke this morning. (b) (6) is Rich's main operator and is quite dangerous. If there is anyway to distract or slow her down i think we should.
>
> Another thought: what if you called (b) (6) and told him directly about the RFP.
> I know the transition team has minimal influence but (b) (6) is loud and it could be important to set the record straight.
>

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/6/2017 5:27:30 PM
To: Jennifer Lee [(b) (6)@gmail.com]
Subject: Re: (b)

Can you get his number for me?

Sent from my iPhone

> On Jan 6, 2017, at 11:17 AM, Jennifer Lee (b) (6)@gmail.com> wrote:
>
> David,
> Poonam and I spoke this morning. (b) (6) is Rich's main operator and is quite dangerous. If there is anyway to distract or slow her down I think we should.
>
> Another thought: what if you called (b) and told him directly about the RFP.
> I know the transition team has minimal influence but (b) is loud and it could be important to set the record straight.
>

AMERICAN OVERSIGHT

Message

From: Jennifer Lee [(b) (6) @gmail.com]
Sent: 1/6/2017 4:17:59 PM
To: David Shulkin [drshulkin@aol.com]
Subject: (b)

David,
Poonam and I spoke this morning. (b) (6) is Rich's main operator and is quite dangerous. If there is anyway to distract or slow her down i think we should.

Another thought: what if you called (b) (6) and told him directly about the RFP.
I know the transition team has minimal influence but (b) (6) is loud and it could be important to set the record straight.

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/15/2017 9:43:56 PM
To: (b) [(b) (6) @hotmail.com]
Subject: Fwd: Lunch on Friday, January 20th at 1:15 PM at Trump Hotel

Sent from my iPhone

Begin forwarded message:

From: "Marisol Garcia" <(b) @frenchangel59.com>
Date: January 13, 2017 at 1:21:51 PM EST
To: "David shulkin" <Drshulkin@aol.com>
Subject: Lunch on Friday, January 20th at 1:15 PM at Trump Hotel

Hi Doctor Shulkin,

Laurie and Ike would love to have lunch with you and your wife on Friday after the Swearing-in Ceremony.

Are you available? Mrs. and Doctor Moskowitz and Mr. and Mrs. (b) (6) will join you as well.

Please let me know your wife's name.

Thank you,

Marisol

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/13/2017 6:26:30 PM
To: (b) [(b) (6) @hotmail.com]
Subject: Fwd: Lunch on Friday, January 20th at 1:15 PM at Trump Hotel

Omg we are going to need to be lucille ball

Sent from my iPhone

Begin forwarded message:

> **From:** "Marisol Garcia" <(b) @frenchangel59.com>
> **Date:** January 13, 2017 at 1:21:51 PM EST
> **To:** "David shulkin" <Drshulkin@aol.com>
> **Subject: Lunch on Friday, January 20th at 1:15 PM at Trump Hotel**
>
> Hi Doctor Shulkin,
>
> Laurie and Ike would love to have lunch with you and your wife on Friday after the Swearing-in Ceremony.
>
> Are you available? Mrs. and Doctor Moskowitz and Mr. and Mrs. (b) (6) will join you as well.
>
> Please let me know your wife's name.
>
> Thank you,
>
> Marisol

AMERICAN OVERSIGHT

Message

From: Marisol Garcia [(b)(6)@frenchangel59.com]
Sent: 1/13/2017 6:21:51 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Lunch on Friday, January 20th at 1:15 PM at Trump Hotel

Hi Doctor Shulkin,

Laurie and Ike would love to have lunch with you and your wife on Friday after the Swearing-in Ceremony.

Are you available? Mrs. and Doctor Moskowitz and Mr. and Mrs. (b) (6) will join you as well.

Please let me know your wife's name.

Thank you,

Marisol

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/28/2016 11:55:54 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re:

Yes thst works

Sent from my iPhone

On Dec 28, 2016, at 6:36 PM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:

> I mean 1/5, Thursday dinner in D.C. ?
>
> Sent from my iPhone
>
> On Dec 28, 2016, at 6:35 PM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:
>
> > Unbelievable!
> >
> > Anyway- dinner on 1/6- Thursday when I am in D.C.?
> >
> > Sent from my iPhone
> >
> > On Dec 28, 2016, at 5:14 PM, David Shulkin <drshulkin@aol.com> wrote:
> >
> > > He resigned from Congress under an ethics investigation
> > >
> > > -----Original Message-----
> > > From: Poonam Alaigh <(b) (6) @hotmail.com>
> > > To: David Shulkin <drshulkin@aol.com>
> > > Sent: Wed, Dec 28, 2016 5:11 pm
> > > Subject: Re:
> > >
> > > Wow!!! And being on the transition team will do- you know what!
> > >
> > > Sent from my iPad
> > >
> > > On Dec 28, 2016, at 5:05 PM, David Shulkin <drshulkin@aol.com>
> > > wrote:
> > >
> > > > https://www.opensecrets.org/lobby/firmsum.php?id=F29
> > > > 212

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/28/2016 11:36:36 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Re:

I mean 1/5, Thursday dinner in D.C. ?

Sent from my iPhone

On Dec 28, 2016, at 6:35 PM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:

> Unbelievable!
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> > On Dec 28, 2016, at 5:05 PM, David Shulkin <drshulkin@aol.com> wrote:
> >
> > > https://www.opensecrets.org/lobby/firmsum.php?id=F29212

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 12/28/2016 10:13:01 PM
To: (b) (6) @hotmail.com
Subject: Re:

He resigned from Congress under an ethics investigation

-----Original Message-----
From: Poonam Alaigh <(b) (6) @hotmail.com>
To: David Shulkin <drshulkin@aol.com>
Sent: Wed, Dec 28, 2016 5:11 pm
Subject: Re:

Wow!!! And being on the transition team will do- you know what!

Sent from my iPad

On Dec 28, 2016, at 5:05 PM, David Shulkin <drshulkin@aol.com> wrote:

https://www.opensecrets.org/lobby/firmsum.php?id=F29212

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/28/2016 10:10:46 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Re:

Wow!!! And being on the transition team will do- you know what!

Sent from my iPad

On Dec 28, 2016, at 5:05 PM, David Shulkin <drshulkin@aol.com> wrote:

> https://www.opensecrets.org/lobby/firmsum.php?id=F29212

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 12/28/2016 10:05:55 PM
To: (b) (6) @hotmail.com

https://www.opensecrets.org/lobby/firmsum.php?id=F29212

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/29/2016 6:28:10 PM
To: (b) (6) [(b) (6) ccf.org]
Subject: Brief call

(b) (6) I hope you got some time off over the holidays and I know you may be traveling now.

I was hoping to have a brief call with you on my personal cell if you might have a moment. If not, I understand that these are busy times and we can catch up early next year.

Best Regards,

David Shulkin MD
Cell- (b) (6)

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/24/2016 3:27:48 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re:

Looks good to start outling these goals

Sent from my iPhone

On Dec 24, 2016, at 9:31 AM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:

> I completely agree and we have to lay out our strategy. This is what I think
>
> **Prong 1-** immediately to 3 years- robust consulting practice in both private and public sector. Exit strategy by Year 3 for a minimum of about $50M or more to another large consulting firm. Advantages- gives us immediate revenue, opens up new doors, creates credibility in delivering results, and opportunity for Prong 2 and 3 below
>
> **Prong 2-** immediate to 5 years- health systems strategy where our health solutions services will provide care to institutionalized residents and those needing skilled nursing care- working with the seniors, disabled and the dual population working with both the state and managed care organizations- exit strategy by Year 5 to a managed care company- over $50M
>
> **Prong 3-** Healthclouds- Year 1 to 5- the consumer platform, which we build off of Prong 2, have revenue flow and can get funding to build it up to what it needs to be- either through partnerships with large companies like Amazon or as a result of investors/capital raise. Exit strategy in 5-7 years
>
> Maybe you can build off of some of our thoughts- we have a perfect storm with so much coming together right now. It would be a real shame for us to work for others, we are mature in our professional careers and dont have time to continue to prove ourselves- we need to make all this work for us and be part of BIG change now.
>
> Even with the kids, I am working, so just keep pinging me. I am best with them when I am also working and accomplishing. The kids are already dreading that they will have to deal with an "at home Mom"- over these next few days.

AMERICAN OVERSIGHT

An interesting project/paper that one of my students just did was around "Venture Philanthropy" and setting it up. A lot of academic institutions will need this, so exciting stuff I am learning.

From: David shulkin <Drshulkin@aol.com>
Sent: Saturday, December 24, 2016 7:53 AM
To: Poonam Alaigh
Subject:

I know the kids are home so no need to respond- ive got too much down time waiting for everyone to wake up so my mind is wandering

I still think we want to build something tangible- a real asset- and use consulting as the economic fuel to build it.

The idea i still believe in is healthclouds- which matches a health need with the consumer- The big ideas of the decade have been amazon and uber like services that dont run the service but they match customers and ssrvjces- Noone has dine it yet in heaithcare

Im reading about amazon now offering plumbing, electrical and carpentry. We need to own health or at least home health.

Anyway i suspect consulting will help us get there .....

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/24/2016 1:31:31 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re:

I completely agree and we have to lay out our strategy. This is what I think

Prong 1- immediately to 3 years- robust consulting practice in both private and public sector. Exit strategy by Year 3 for a minimum of about $50M or more to another large consulting firm. Advantages- gives us immediate revenue, opens up new doors, creates credibility in delivering results, and opportunity for Prong 2 and 3 below

Prong 2- immediate to 5 years- health systems strategy where our health solutions services will provide care to institutionalized residents and those needing skilled nursing care- working with the seniors, disabled and the dual population working with both the state and managed care organizations- exit strategy by Year 5 to a managed care company- over $50M

Prong 3- Healthclouds- Year 1 to 5- the consumer platform, which we build off of Prong 2, have revenue flow and can get funding to build it up to what it needs to be- either through partnerships with large companies like Amazon or as a result of investors/capital raise. Exit strategy in 5-7 years

Maybe you can build off of some of our thoughts- we have a perfect storm with so much coming together right now. It would be a real shame for us to work for others, we are mature in our professional careers and dont have time to continue to prove ourselves- we need to make all this work for us and be part of BIG change now.

Even with the kids, I am working, so just keep pinging me. I am best with them when I am also working and accomplishing. The kids are already dreading that they will have to deal with an "at home Mom"- over these next few days.

An interesting project/paper that one of my students just did was around "Venture Philanthropy" and setting it up. A lot of academic institutions will need this, so exciting stuff I am learning.

From: David shulkin <Drshulkin@aol.com>
Sent: Saturday, December 24, 2016 7:53 AM
To: Poonam Alaigh
Subject:

I know the kids are home so no need to respond- ive got too much down time waiting for everyone to wake up so my mind is wandering

I still think we want to build something tangible- a real asset- and use consulting as the economic fuel to build it.

The idea i still believe in is healthclouds- which matches a health need with the consumer- The big ideas of the decade have been amazon and uber like services that dont run the service but they match customers and ssrvjces- Noone has dine it yet in heaithcare

Im reading about amazon now offering plumbing, electrical and carpentry. We need to own health or at least home health.

AMERICAN OVERSIGHT

Anyway i suspect consulting will help us get there .....

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/24/2016 12:53:43 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]

I know the kids are home so no need to respond- ive got too much down time waiting for everyone to wake up so my mind is wandering

I still think we want to build something tangible- a real asset- and use consulting as the economic fuel to build it.

The idea i still believe in is healthclouds- which matches a health need with the consumer- The big ideas of the decade have been amazon and uber like services that dont run the service but they match customers and ssrvjces- Noone has dine it yet in heaithcare

Im reading about amazon now offering plumbing, electrical and carpentry. We need to own health or at least home health.

Anyway i suspect consulting will help us get there .....

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/29/2016 6:29:42 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re:(b)

Let me talk to him- i know him better

Lets see if he responds and what he says

We can reserve your call if we need to clarify something or deliver a message later on

Sent from my iPhone

On Dec 29, 2016, at 1:25 PM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:

> How should we proceed- see below his contact info including cell phone
>
> ---
>
> **From:** Alaigh, Poonam (b) (6) @va.gov>
> **Sent:** Thursday, December 29, 2016 1:24 PM
> **To:** 'Poonam Alaigh'
> **Subject:** FW:(b)
>
> Sent with Good (www.good.com)
>
> -----Original Message-----
> **From:** Blackburn, Scott R.
> **Sent:** Thursday, December 29, 2016 12:06 PM Central Standard Time
> **To:** Alaigh, Poonam
> **Subject:** (b)
>
> See contact information below. Also, please send me the press release link when you have the chance.
>
> (b) (6) contact information:
>
> (b) (6) ccf.org
>
> Personal mobile: 216.570(b)
>
> Phone (b) (6) (I think this is his office phone, answered by his assistant)

AMERICAN OVERSIGHT

(b) (6) M.D.	(b) (6) ccf.org	Chief Executive Officer and President, Cleveland Clinic	9500 Cleveland Clinic, Eudlid Avenue, NA4, Cleveland, OH 44195	(b) (6)	(b) @ccf.org; O: (b) (6)

Scott Blackburn

MyVA

Department of Veterans Affairs

Cell (202) 430-9139



AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6)@hotmail.com]
Sent: 12/29/2016 6:25:39 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Fw: (b)

How should we proceed- see below his contact info including cell phone

---

From: Alaigh, Poonam <Poonam.Alaigh@va.gov>
Sent: Thursday, December 29, 2016 1:24 PM
To: 'Poonam Alaigh'
Subject: FW: (b)

Sent with Good (www.good.com)

-----Original Message-----
From: Blackburn, Scott R.
Sent: Thursday, December 29, 2016 12:06 PM Central Standard Time
To: Alaigh, Poonam
Subject: (b)

See contact information below. Also, please send me the press release link when you have the chance.

(b) (6) contact information:

(b) (6) ccf.org

Personal mobile: 216.570.9507

(b) (6) (I think this is his office phone, answered by his assistant)

(b) (6) M.D.	(b) (6) ccf.org	Chief Executive Officer and President, Cleveland Clinic	9500 Cleveland Clinic, Eudlid Avenue, NA4, Cleveland, OH 44195	(b) (6)	(b) @ccf.org; O:

AMERICAN OVERSIGHT

Scott Blackburn

MyVA

Department of Veterans Affairs

Cell (202) 430-9139



AMERICAN OVERSIGHT

Message

From: Michael Tepper [(b) (6) @yahoo.com]
Sent: 1/9/2017 9:20:46 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Fwd: In the news today that you were meeting with him

Excellent. Great news.

From: David shulkin <Drshulkin@aol.com>
To: Michael Tepper <(b) (6) @yahoo.com>
Sent: Monday, January 9, 2017 4:10 PM
Subject: Fwd: In the news today that you were meeting with him

Sent from my iPhone

Begin forwarded message:

> **From:** Poonam Alaigh <(b) (6) @hotmail.com>
> **Date:** January 9, 2017 at 2:57:05 PM EST
> **To:** David shulkin <drshulkin@aol.com>
> **Subject: In the news today that you were meeting with him**
>
> http://thehill.com/homenews/administration/313309-mcconnell-meets-with-trump-in-new-york
>
> Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/9/2017 9:10:43 PM
To: (b) (6) [(b) @sunnyshulkin.com]; (b) (6) [(b) @sunnyshulkin.com]
Subject: Fwd: In the news today that you were meeting with him

Sent from my iPhone

Begin forwarded message:

> **From:** Poonam Alaigh <(b) (6) @hotmail.com>
> **Date:** January 9, 2017 at 2:57:05 PM EST
> **To:** David shulkin <drshulkin@aol.com>
> **Subject: In the news today that you were meeting with him**
>
> http://thehill.com/homenews/administration/313309-mcconnell-meets-with-trump-in-new-york
>
> Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/9/2017 9:10:27 PM
To: (b) (6) [(b) (6) @aol.com]
Subject: Fwd: In the news today that you were meeting with him

Sent from my iPhone

Begin forwarded message:

> **From:** Poonam Alaigh <(b) (6) @hotmail.com>
> **Date:** January 9, 2017 at 2:57:05 PM EST
> **To:** David shulkin <drshulkin@aol.com>
> **Subject: In the news today that you were meeting with him**
>
> http://thehill.com/homenews/administration/313309-mcconnell-meets-with-trump-in-new-york
>
> Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/9/2017 9:10:04 PM
To: Michael Tepper [(b) (6) @yahoo.com]
Subject: Fwd: In the news today that you were meeting with him

Sent from my iPhone

Begin forwarded message:

> **From:** Poonam Alaigh <(b) (6) @hotmail.com>
> **Date:** January 9, 2017 at 2:57:05 PM EST
> **To:** David shulkin <drshulkin@aol.com>
> **Subject: In the news today that you were meeting with him**
>
> http://thehill.com/homenews/administration/313309-mcconnell-meets-with-trump-in-new-york
>
> Sent from my iPad

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 1/9/2017 7:57:05 PM
To: David shulkin [drshulkin@aol.com]
Subject: In the news today that you were meeting with him

http://thehill.com/homenews/administration/313309-mcconnell-meets-with-trump-in-new-york

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/31/2016 11:18:32 PM
To: Carolyn M Clancy [(b) (6) @gmail.com]
Subject: Re: (b) (6) out as VA Secretary nominee

Yes

Such a strange oddessy

Sent from my iPhone

> On Dec 31, 2016, at 6:13 PM, Carolyn M Clancy <(b) (6) y@gmail.com> wrote:
>
> 'Health reasons' -- and longstanding legal issues re child support
>
>

AMERICAN OVERSIGHT

Message

From: Carolyn M Clancy [(b) (6) @gmail.com]
Sent: 12/31/2016 11:13:42 PM
To: David shulkin [drshulkin@aol.com]
Subject: (b) (6) out as VA Secretary nominee

'Health reasons' -- and longstanding legal issues re child support

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/16/2017 3:30:50 AM
To: (b) (6) [redacted] va.gov]
Subject: Fwd: Re:

Lets look for options

Sent from my iPhone

Begin forwarded message:

> **From:** Robert McDonald <(b) (6) [redacted]@gmail.com>
> **Date:** January 15, 2017 at 10:00:25 PM EST
> **To:** David shulkin <Drshulkin@aol.com>, "(b) (6) [redacted] (b) (6) [redacted]@va.gov>
> **Subject: Re:**
>
> David, I will spend whatever time you wish. I'm heading back to DC early in the morning, weather permitting. We are having an ice storm in Omaha. If I am lucky and we get out on time, I will be in DC by noon. I can come to the office if you wish. I can also change my schedule for the balance of the week. Just let me know what meets your needs. Thanks. Bob
>
> On Sun, Jan 15, 2017 at 9:58 PM, David shulkin <Drshulkin@aol.com> wrote:
> Bob- i know you are traveling back but im hoping that we might find sone tine to connect so I can get your advice. I cannot imagine ever being as prepared as you are but knowing that you may be a call away would be a great comfort.
>
> David
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/16/2017 3:30:33 AM
To: (b) [(b) (6) @hotmail.com]
Subject: Fwd: Re:

Sent from my iPhone

Begin forwarded message:

From: Robert McDonald <(b) (6) @gmail.com>
Date: January 15, 2017 at 10:00:25 PM EST
To: David shulkin <Drshulkin@aol.com>, "(b) (6) (b) (6) @va.gov>
Subject: Re:

David, I will spend whatever time you wish. I'm heading back to DC early in the morning, weather permitting. We are having an ice storm in Omaha. If I am lucky and we get out on time, I will be in DC by noon. I can come to the office if you wish. I can also change my schedule for the balance of the week. Just let me know what meets your needs. Thanks. Bob

On Sun, Jan 15, 2017 at 9:58 PM, David shulkin <Drshulkin@aol.com> wrote:

> Bob- i know you are traveling back but im hoping that we might find sone tine to connect so I can get your advice. I cannot imagine ever being as prepared as you are but knowing that you may be a call away would be a great comfort.
>
> David
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/16/2017 3:29:51 AM
To: Robert McDonald [(b) (6) @gmail.com]
Subject: Re:

Thanks and be safe-

David

Sent from my iPhone

On Jan 15, 2017, at 10:00 PM, Robert McDonald <(b) (6) @gmail.com> wrote:

> David, I will spend whatever time you wish. I'm heading back to DC early in the morning, weather permitting. We are having an ice storm in Omaha. If I am lucky and we get out on time, I will be in DC by noon. I can come to the office if you wish. I can also change my schedule for the balance of the week. Just let me know what meets your needs. Thanks. Bob
>
> On Sun, Jan 15, 2017 at 9:58 PM, David shulkin <Drshulkin@aol.com> wrote:
> Bob- i know you are traveling back but im hoping that we might find sone tine to connect so I can get your advice. I cannot imagine ever being as prepared as you are but knowing that you may be a call away would be a great comfort.
>
> David
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Robert McDonald [(b) (6) @gmail.com]
Sent: 1/16/2017 3:00:25 AM
To: David shulkin [Drshulkin@aol.com]; (b) (6) (b) (6) @va.gov]
Subject: Re:

David, I will spend whatever time you wish. I'm heading back to DC early in the morning, weather permitting. We are having an ice storm in Omaha. If I am lucky and we get out on time, I will be in DC by noon. I can come to the office if you wish. I can also change my schedule for the balance of the week. Just let me know what meets your needs. Thanks. Bob

On Sun, Jan 15, 2017 at 9:58 PM, David shulkin <Drshulkin@aol.com> wrote:

> Bob- i know you are traveling back but im hoping that we might find sone tine to connect so I can get your advice. I cannot imagine ever being as prepared as you are but knowing that you may be a call away would be a great comfort.
>
> David
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/16/2017 2:58:12 AM
To: bob mcDonald [(b) (6) @gmail.com]

Bob- i know you are traveling back but im hoping that we might find sone tine to connect so I can get your advice. I cannot imagine ever being as prepared as you are but knowing that you may be a call away would be a great comfort.

David

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/9/2017 9:33:45 PM
To: bob mcDonald [(b) (6) @gmail.com]; bob mcDonald [Robert.A.McDonald@va.gov]

Bob- if you have a moment could you call me?

David
(b) (6)

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) @gmail.com]
Sent: 12/28/2016 11:02:39 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Re:

Wow.

On Dec 28, 2016 5:06 PM, "David Shulkin" <drshulkin@aol.com> wrote:
https://www.opensecrets.org/lobby/firmsum.php?id=F29212

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 12/28/2016 10:06:15 PM
To: (b) (6) [redacted]@gmail.com

https://www.opensecrets.org/lobby/firmsum.php?id=F29212

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/25/2016 1:31:56 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Re:

Can't wait to hear- thought you didn't remember your dreams, so write it down before you forget

Sent from my iPad

> On Dec 25, 2016, at 7:34 AM, David Shulkin <drshulkin@aol.com> wrote:
>
> I think I just had my best idea yet
>
> Woke up in middle of night with it
>
> Cant wait to tell you when I get back on 28 th
>
> Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 12/25/2016 12:34:30 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]

I think I just had my best idea yet

Woke up in middle of night with it

Cant wait to tell you when I get back on 28 th

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 1/2/2017 6:49:20 PM
To: David shulkin [drshulkin@aol.com]
Subject: (b) (6) and (b) (6) -

http://www.politico.com/story/2016/08/trump-transition-team-227450

See above, both of them were part of George Bush team

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/8/2017 9:12:16 PM
To: (b) (6) [(b) (6) @gmail.com]

Tommorow can you send me on aol the list of vso directors and their phone numbers - please include (b) (6)

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6)@hotmail.com]
Sent: 12/29/2016 3:59:29 PM
To: David Shulkin [drshulkin@aol.com]
Subject: also

Great catching up- glad you are back!

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/19/2016 10:58:48 PM
To: Jennifer Lee [(b) (6) @gmail.com]
Subject: Re: What did you think of (b)

Liked him

Will be good

Sent from my iPhone

> On Dec 19, 2016, at 5:45 PM, Jennifer Lee (b) (6) @gmail.com> wrote:
>
> Thank you for meeting with him.

AMERICAN OVERSIGHT

Message

From: Jennifer Lee [(b) (6) @gmail.com]
Sent: 12/19/2016 10:45:42 PM
To: David Shulkin [drshulkin@aol.com]
Subject: What did you think of (b)

Thank you for meeting with him.

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/24/2016 1:35:43 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Also

If the Bergen stuff comes together- then both of us have the anchor to do our 3 prong strategy- trying very hard for that- still getting good vibes and the our lawyers (both of whom are politically connected with one being an Assemblyman- saying that we have the best and most comprehensive RFP response- but never know.

I will send you the confidential RFP right now

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/22/2016 9:34:50 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Re: Getting closer

Don't worry too much about it- whatever goes around, comes around. That is the law of this universe - and remember our philosophy- Boomerang!!

Sent from my iPhone

> On Dec 22, 2016, at 4:19 PM, David Shulkin <drshulkin@aol.com> wrote:
>
> I really want to stay past transition to get Rich out of there- if he stays it's going to close off many of our relationships simply because he is a nasty guy
>
>
>
> Sent from my iPad
>
>> On Dec 22, 2016, at 5:12 PM, Poonam Alaigh <(b) (6) n@hotmail.com> wrote:
>>
>> I am sold- absolutely love it- SAIL will sail us to success- I am confident
>>
>> To get you out of some boredom, just heard from Steve today that Rich went ballistic because he was not sent the Evaluation Study- I told Steve to punt it to me- I will handle it, gave Vivieca a heads up too. The worst of him is coming out - he just wasn't prepared for your victory lap- I am on top of the world with the report. It validates and cements everything.
>>
>> When I started with you, my politico friends warned me that we could not accomplish much in the short time we had, but together we proved them wrong!!
>>
>> Sent from my iPad
>>
>>> On Dec 22, 2016, at 3:45 PM, David Shulkin <drshulkin@aol.com> wrote:
>>>
>>> Sitting on the beach all day- pretty bored just watching the sailboats drift by
>>> I was think more of names
>>>
>>> SAIL - Shulkin Alaigh Innovative Leadership- The SAIL Group
>>>
>>>
>>>
>>>
>>>
>>> Sent from my iPad
>

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 12/22/2016 9:19:41 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: Getting closer

I really want to stay past transition to get Rich out of there- if he stays it's going to close off many of our relationships simply because he is a nasty guy

Sent from my iPad

> On Dec 22, 2016, at 5:12 PM, Poonam Alaigh <(b) (6) n@hotmail.com> wrote:
>
> I am sold- absolutely love it- SAIL will sail us to success- I am confident
>
> To get you out of some boredom, just heard from Steve today that Rich went ballistic because he was not sent the Evaluation Study- I told Steve to punt it to me- I will handle it, gave Vivieca a heads up too. The worst of him is coming out - he just wasn't prepared for your victory lap- I am on top of the world with the report. It validates and cements everything.
>
> When I started with you, my politico friends warned me that we could not accomplish much in the short time we had, but together we proved them wrong!!
>
> Sent from my iPad
>
>> On Dec 22, 2016, at 3:45 PM, David Shulkin <drshulkin@aol.com> wrote:
>>
>> Sitting on the beach all day- pretty bored just watching the sailboats drift by
>> I was think more of names
>>
>> SAIL - Shulkin Alaigh Innovative Leadership- The SAIL Group
>>
>>
>>
>>
>>
>> Sent from my iPad

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/22/2016 9:12:37 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Re: Getting closer

I am sold- absolutely love it- SAIL will sail us to success- I am confident

To get you out of some boredom, just heard from Steve today that Rich went ballistic because he was not sent the Evaluation Study- I told Steve to punt it to me- I will handle it, gave Vivieca a heads up too. The worst of him is coming out - he just wasn't prepared for your victory lap- I am on top of the world with the report. It validates and cements everything.

When I started with you, my politico friends warned me that we could not accomplish much in the short time we had, but together we proved them wrong!!

Sent from my iPad

> On Dec 22, 2016, at 3:45 PM, David Shulkin <drshulkin@aol.com> wrote:
>
> Sitting on the beach all day- pretty bored just watching the sailboats drift by
> I was think more of names
>
> SAIL - Shulkin Alaigh Innovative Leadership- The SAIL Group
>
>
>
>
>
> Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 12/22/2016 8:45:44 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Getting closer

Sitting on the beach all day- pretty bored just watching the sailboats drift by
I was think more of names

SAIL - Shulkin Alaigh Innovative Leadership- The SAIL Group

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/6/2017 3:01:55 AM
To: Marisol Garcia [(b)@frenchangel59.com]
Subject: Re: Mar-a-Lago

Perfect

Sent from my iPhone

On Jan 5, 2017, at 6:45 PM, Marisol Garcia <(b)@frenchangel59.com> wrote:

> Disregard. I found the address – getting you a car for 8:30 AM pick-up at hotel.
>
> **From:** Marisol Garcia [mailto:(b)@frenchangel59.com]
> **Sent:** Thursday, January 05, 2017 6:32 PM
> **To:** 'David shulkin'
> **Subject:** RE: Mar-a-Lago
>
> You're staying at the Double Tree in Palm Beach?
>
> **From:** David shulkin [mailto:Drshulkin@aol.com]
> **Sent:** Thursday, January 05, 2017 5:25 PM
> **To:** Marisol Garcia
> **Subject:** Re: Mar-a-Lago
>
> No i need to stay at the doubletree- government rates- on Australian avenue
>
> If they can pick me up in the am there thst would be great
>
> Sent from my iPhone
>
> On Jan 5, 2017, at 3:01 PM, Marisol Garcia <(b)@frenchangel59.com> wrote:
>
> > Hi David – are you not able to stay at Mar-a-Lago? I made you a reservation for a room there at $415.00?
> >
> > I will let you know time and date in a few minutes for tomorrow morning.
> >
> > Thank you,
> >
> > Marisol
> >
> > **From:** David shulkin [mailto:Drshulkin@aol.com]
> > **Sent:** Thursday, January 05, 2017 2:32 PM
> > **To:** Marisol Garcia
> > **Subject:** Re: Mar-a-Lago
> >
> > marisol- Im getting in at The airport at 832 pm and staying at the doubletree-
> >
> > Where and what time should i meet for breakfast?

AMERICAN OVERSIGHT

I will handle my own transportation

Thanks so much

David

Sent from my iPhone

On Jan 5, 2017, at 1:31 PM, Marisol Garcia <(b) @frenchangel59.com> wrote:

> Hi Dave,
>
> It was a pleasure speaking to you.
>
> I've booked a hotel room at Mar-a-Lago for tonight checking out tomorrow. I will email you information as soon as I get the email.
>
> Depending on your arrival time – Ike can have dinner with you tonight or Breakfast tomorrow.
>
> Once you get your flight itinerary I can make the car service arrangement.
>
> Look forward to hearing from you or your assistant.
>
> Best,
>
> Marisol
> (b) (6) (Office)
> (b) (6) (Cell)

AMERICAN OVERSIGHT

Message

From: Marisol Garcia [(b)(6)@frenchangel59.com]
Sent: 1/5/2017 11:45:57 PM
To: 'David shulkin' [Drshulkin@aol.com]
Subject: RE: Mar-a-Lago

Disregard. I found the address – getting you a car for 8:30 AM pick-up at hotel.

From: Marisol Garcia [mailto:(b)(6)@frenchangel59.com]
Sent: Thursday, January 05, 2017 6:32 PM
To: 'David shulkin'
Subject: RE: Mar-a-Lago

You're staying at the Double Tree in Palm Beach?

From: David shulkin [mailto:Drshulkin@aol.com]
Sent: Thursday, January 05, 2017 5:25 PM
To: Marisol Garcia
Subject: Re: Mar-a-Lago

No i need to stay at the doubletree- government rates- on Australian avenue

If they can pick me up in the am there thst would be great

Sent from my iPhone

On Jan 5, 2017, at 3:01 PM, Marisol Garcia <(b)(6)@frenchangel59.com> wrote:

> Hi David – are you not able to stay at Mar-a-Lago? I made you a reservation for a room there at $415.00?
>
> I will let you know time and date in a few minutes for tomorrow morning.
>
> Thank you,
>
> Marisol
>
> ---
>
> **From:** David shulkin [mailto:Drshulkin@aol.com]
> **Sent:** Thursday, January 05, 2017 2:32 PM
> **To:** Marisol Garcia
> **Subject:** Re: Mar-a-Lago
>
> marisol- Im getting in at The airport at 832 pm and staying at the doubletree-
>
> Where and what time should i meet for breakfast?
>
> I will handle my own transportation
>
> Thanks so much

AMERICAN OVERSIGHT

David

Sent from my iPhone

On Jan 5, 2017, at 1:31 PM, Marisol Garcia <(b) @frenchangel59.com> wrote:

> Hi Dave,
>
> It was a pleasure speaking to you.
>
> I've booked a hotel room at Mar-a-Lago for tonight checking out tomorrow. I will email you information as soon as I get the email.
>
> Depending on your arrival time – Ike can have dinner with you tonight or Breakfast tomorrow.
>
> Once you get your flight itinerary I can make the car service arrangement.
>
> Look forward to hearing from you or your assistant.
>
> Best,
>
> Marisol
> (b) (6) (Office)
> (b) (6) (Cell)

AMERICAN OVERSIGHT

Message

From: Marisol Garcia [(b)@frenchangel59.com]
Sent: 1/5/2017 11:31:36 PM
To: 'David shulkin' [Drshulkin@aol.com]
Subject: RE: Mar-a-Lago

You're staying at the Double Tree in Palm Beach?

From: David shulkin [mailto:Drshulkin@aol.com]
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AMERICAN OVERSIGHT

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Look forward to hearing from you or your assistant.

Best,

Marisol
(b) (6) (Office)
(b) (6) (Cell)

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/5/2017 10:24:39 PM
To: Marisol Garcia [(b)(6)@frenchangel59.com]
Subject: Re: Mar-a-Lago

No i need to stay at the doubletree- government rates- on Australian avenue

If they can pick me up in the am there thst would be great

Sent from my iPhone

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To: Marisol Garcia
Subject: Re: Mar-a-Lago

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David

Sent from my iPhone

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AMERICAN OVERSIGHT

Once you get your flight itinerary I can make the car service arrangement.

Look forward to hearing from you or your assistant.

Best,

Marisol
[redacted](Office)
[redacted](Cell)

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/5/2017 10:23:31 PM
To: Marisol Garcia [(b)@frenchangel59.com]
Subject: Re: Mar-a-Lago

Im going to handle all hotel and travel to kerp it clean

What time should i be there to meet him and where?

Sent from my iPhone

On Jan 5, 2017, at 3:03 PM, Marisol Garcia <(b)@frenchangel59.com> wrote:

> Please also email flight numbers and times so I can arrange the car service.
>
> ---
>
> **From:** Marisol Garcia [mailto:(b)@frenchangel59.com]
> **Sent:** Thursday, January 05, 2017 3:02 PM
> **To:** 'David shulkin'
> **Subject:** RE: Mar-a-Lago
>
> Hi David – are you not able to stay at Mar-a-Lago? I made you a reservation for a room there at $415.00?
>
> I will let you know time and date in a few minutes for tomorrow morning.
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> **To:** Marisol Garcia
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> Sent from my iPhone
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> > It was a pleasure speaking to you.

AMERICAN OVERSIGHT

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Once you get your flight itinerary I can make the car service arrangement.

Look forward to hearing from you or your assistant.

Best,

Marisol
(b) (6) (Office)
(b) (6) (Cell)

AMERICAN OVERSIGHT

Message

From: Marisol Garcia [(b)(6)@frenchangel59.com]
Sent: 1/5/2017 8:03:12 PM
To: 'David shulkin' [Drshulkin@aol.com]
Subject: RE: Mar-a-Lago

Please also email flight numbers and times so I can arrange the car service.

From: Marisol Garcia [mailto:(b)(6)@frenchangel59.com]
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To: 'David shulkin'
Subject: RE: Mar-a-Lago

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I will let you know time and date in a few minutes for tomorrow morning.

Thank you,

Marisol

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Subject: Re: Mar-a-Lago

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David

Sent from my iPhone

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AMERICAN OVERSIGHT

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(b) (6) (Office)
(b) (6) (Cell)

AMERICAN OVERSIGHT

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From: Marisol Garcia [(b) @frenchangel59.com]
Sent: 1/5/2017 8:01:37 PM
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>
> Best,
>
> Marisol
> (b) (6) (Office)
> (b) (6) (Cell)

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/5/2017 7:32:09 PM
To: Marisol Garcia [(b) @frenchangel59.com]
Subject: Re: Mar-a-Lago

marisol- Im getting in at The airport at 832 pm and staying at the doubletree-

Where and what time should i meet for breakfast?

I will handle my own transportation

Thanks so much

David

Sent from my iPhone

On Jan 5, 2017, at 1:31 PM, Marisol Garcia <(b) @frenchangel59.com> wrote:

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> Once you get your flight itinerary I can make the car service arrangement.
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> Look forward to hearing from you or your assistant.
>
> Best,
>
> Marisol
> (b) (6) (Office)
> (b) (6) (Cell)

AMERICAN OVERSIGHT

Message

From: Jennifer Lee [(b) (6) @gmail.com]
Sent: 1/6/2017 9:30:02 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Bob snyder

David
I got some intel
I think you should have a heart to heart w bob snyder.
He is not supportive of rich. And would like to hear from you

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/22/2016 12:56:45 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Re: Lunch with (b) (6)

Agree- I did tell him to have Milken to push for you as depsec

Sent from my iPhone

> On Dec 21, 2016, at 4:03 PM, David Shulkin <drshulkin@aol.com> wrote:
>
> No not really- He is a good guy
>
> He may be aware of consulting opportunities but I am not sure he is tied in enough
>
> Sent from my iPad
>
>> On Dec 21, 2016, at 11:32 AM, Poonam Alaigh <(b) (6) n@hotmail.com> wrote:
>>
>> Meeting him today in Morristown- anything you want me to bring up?
>>
>> Sent from my iPad
>

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 12/21/2016 8:58:04 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: Lunch with (b) (6)

No not really- He is a good guy

He may be aware of consulting opportunities but I am not sure he is tied in enough

Sent from my iPad

> On Dec 21, 2016, at 11:32 AM, Poonam Alaigh <(b) (6) n@hotmail.com> wrote:
>
> Meeting him today in Morristown- anything you want me to bring up?
>
> Sent from my iPad

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/21/2016 3:32:43 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Lunch with (b) (6)

Meeting him today in Morristown- anything you want me to bring up?

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 12/23/2016 8:48:42 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re:

😀

Sent from my iPad

> On Dec 23, 2016, at 4:12 PM, Poonam Alaigh <(b) (6) n@hotmail.com> wrote:
>
> K- let's keep thinking then - let (b) first approve- I trust her judgement and then we can finalize- definitely not ASS
>
> Sent from my iPhone
>
>> On Dec 23, 2016, at 1:00 PM, David Shulkin <drshulkin@aol.com> wrote:
>>
>> Still working on it- (b) doesn't love SAIL so just playing with others
>>
>> ASCEND
>>
>> Alaigh Shulkin consulting excellence network developers
>>
>>
>> ASK.
>>
>> Alaigh Shulkin Konsultants
>> (Not you usual consultants)
>>
>> SAVE
>>
>> Shulkin Alaigh valuing excellence
>>
>>
>> ASS
>>
>> Alaigh Shulkin Solutions
>>
>> ASPIRE
>>
>> Alaigh shulkin partners in realizing excellence
>>
>> CASH
>>
>> Consultants ALaigh Shulkin Hopefuls
>>
>>
>> Sent from my iPad

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6)@hotmail.com]
Sent: 12/23/2016 8:12:07 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Re:

K- let's keep thinking then - let (b) first approve- I trust her judgement and then we can finalize- definitely not ASS

Sent from my iPhone

> On Dec 23, 2016, at 1:00 PM, David Shulkin <drshulkin@aol.com> wrote:
>
> Still working on it- (b) doesn't love SAIL so just playing with others
>
> ASCEND
>
> Alaigh Shulkin consulting excellence network developers
>
>
> ASK.
>
> Alaigh Shulkin Konsultants
> (Not you usual consultants)
>
> SAVE
>
> Shulkin Alaigh valuing excellence
>
>
> ASS
>
> Alaigh Shulkin Solutions
>
> ASPIRE
>
> Alaigh shulkin partners in realizing excellence
>
> CASH
>
> Consultants ALaigh Shulkin Hopefuls
>
>
> Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 12/23/2016 12:40:32 AM
To: Poonam Alaigh [(b) (6) @hotmail.com]

Still working on it- (b) doesn't love SAIL so just playing with others

ASCEND

Alaigh Shulkin consulting excellence network developers

ASK.

Alaigh Shulkin Konsultants
(Not you usual consultants)

SAVE

Shulkin Alaigh valuing excellence

ASS

Alaigh Shulkin Solutions

ASPIRE

Alaigh shulkin partners in realizing excellence

CASH

Consultants ALaigh Shulkin Hopefuls

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/28/2016 1:36:23 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Fwd: January 6th - Friday

Please see- will go over everything with ryung next Friday when I am in D.C.- and have (b) and (b) attend (in person/phone)

Sent from my iPhone

Begin forwarded message:

> **From:** Poonam Alaigh <(b) (6) @hotmail.com>
> **Date:** December 28, 2016 at 8:35:03 AM EST
> **To:** (b) (6) <(b) @atlasresearch.us>
> **Cc:** (b) (6) <(b) (6) @yahoo.com>
> **Subject: Re: January 6th - Friday**
>
> Then confirmed for 2pm on Friday 1/6. Will have my team attend - thanks
>
> (b) please confirm your attendance- thanks a ton
>
> Sent from my iPhone
>
> On Dec 28, 2016, at 8:24 AM, (b) (6) (b) @atlasresearch.us> wrote:
>
> > Can we do 2 pm or after?
> >
> > If so, Friday works great for me.
> >
> > -------- Original message --------
> > From: Poonam Alaigh <(b) (6) @hotmail.com>
> > Date: 12/28/16 7:50 AM (GMT-05:00)
> > To: (b) (6) <(b) @atlasresearch.us>
> > Cc: (b) (6) <(b) (6) @yahoo.com>
> > Subject: January 6th - Friday
> >
> > (b) - wanted to confirm that we are still meeting in Friday to go over step by step the actions that are needed to set up the SDVOSB. If so, I will have someone from my team attend in person and another over the phone. Sam, can you attend too- not knowing the status with the VA leadership, it's time sensitive so wanted to schedule before the transition.
> >
> > Also, (b) (6) can we block 11am to 1pm on 1/6- will 2 hours be sufficient?
> >
> > Thanks, hope the holidays have been great and wish both of you a happy new year!!
> >
> > Sent from my iPad

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) @gmail.com]
Sent: 1/7/2017 12:35:22 PM
To: David Shulkin [drshulkin@aol.com]

https://www.google.com/amp/s/amp.cnn.com/cnn/2017/01/06/politics/mattis-trump-transition-clash-pentagon-pick/index.html

Why did michele drop out? Sounds like she could've made it.

AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [brucem(b) (6) mac.com]
Sent: 1/15/2017 8:32:36 PM
To: (b) (6) @wharton.upenn.edu
CC: drshulkin@aol.com
Subject: Wharton School

Thank you for your interest in assisting David Shulkin

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/24/2016 1:27:02 AM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: from (b) (6)

Sounds like a good plan

Maybe ill know more then about my situation as well

Sent from my iPhone

On Dec 23, 2016, at 9:04 PM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:

> I have scheduled a 2 hour session at Atlas on Friday 1/6- should I invite him and perhaps have (b) join over the phone?
>
> Will have to invite (b) too just to keep (b) (6) appeased at this time
>
> Sent from my iPhone
>
> Begin forwarded message:
>
> **From:** (b) (6) <(b) (6) @gmail.com>
> **Date:** December 23, 2016 at 7:53:05 PM EST
> **To:** Poonam Alaigh <(b) (6) @hotmail.com>
> **Subject: from** (b) (6)
>
> Poonam,
>
> Thanks for everything. Really, thank you for always asking about me and my family, my son and how things are, before we ever talk about anything else. Believe it or not that is one of the reasons I didn't fall into a cocoon over the last two years. I know that you've always offered to be a resource for my family, and I thank you for that. I sincerely value the relationship we are forming - it means a lot on a personal level.
>
> I wanted to reach out and wish you and your family (and your friends) a happy holiday season - and a very happy, great and terrific New Year.
>
> Let's stay in touch, let's keep pursuing something - and here's looking to a great 2017 and beyond! Happy Holidays and Happy New Year!
>
> ---
> Sincerely,
>
> (b) (6)
> (b) (6) 750@gmail.com
> (b) (6)
> (b) (6) (cell)

AMERICAN OVERSIGHT

www.LinkedIn.com/in/(b) (6) l
www.(b) (6) .com
(b) (6)

Named One of the 10 CMOs to Watch in 2015 by WealthEngine and ranked in the Top CMOs on Twitter by Social Media Marketing Magazine!

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6)@hotmail.com]
Sent: 12/24/2016 1:04:33 AM
To: drshulkin@aol.com
Subject: Fwd: from (b) (6)

I have scheduled a 2 hour session at Atlas on Friday 1/6- should I invite him and perhaps have (b) join over the phone?

Will have to invite (b) too just to keep (b) (6) appeased at this time

Sent from my iPhone

Begin forwarded message:

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>
> Let's stay in touch, let's keep pursuing something - and here's looking to a great 2017 and beyond! Happy Holidays and Happy New Year!
>
> ---
> Sincerely,
>
> (b) (6)
> (b) (6) gmail.com
> (b) (6)
> (cell)
> www.LinkedIn.com/in/(b) (6)
> www.(b) (6).com
> (b) (6)
>
> Named One of the 10 CMOs to Watch in 2015 by WealthEngine and ranked in the Top CMOs on Twitter by Social Media Marketing Magazine!

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 12/21/2016 9:20:44 PM
To: (b) (6) b) (6) @va.gov]
CC: Jennifer Lee [(b) (6) @gmail.com]
Subject: Re: [EXTERNAL] Invitation: January 6th Cancer Moonshot Meeting on Patient Health Data Access

Me and dr Jennifer lee only

Sent from my iPad

On Dec 21, 2016, at 5:13 PM, (b) (6) (b) (6) @va.gov> wrote:

> Sir, the rsvp requires a response as to whether you will be accompanied, before I can close. I have all the requested information for both you and your wife, if necessary. Thanks.
>
> (b) (6)

From: Shulkin, David J., MD
Sent: Wednesday, December 21, 2016 3:40 PM
To: (b) (6)
Subject: FW: [EXTERNAL] Invitation: January 6th Cancer Moonshot Meeting on Patient Health Data Access

can you rsvp yes

-----Original Message-----
From: FN-OVP-CancerMoonshot [(b) (6) @ovp.eop.gov]
Sent: Wednesday, December 21, 2016 02:41 PM Eastern Standard Time
To: Shulkin, David J., MD
Subject: [EXTERNAL] Invitation: January 6th Cancer Moonshot Meeting on Patient Health Data Access

<image001.png>

Dear Dr. Shulkin,

AMERICAN OVERSIGHT

On behalf of the White House Cancer Moonshot℠, I am pleased to invite you to a small group meeting with Vice President Joe Biden to discuss progress to improve our national health information technology and acccelerated efforts to improve patient data access as it relates to the Cancer Moonshot.

We hope you can join us at the White House on Friday, January 6th from 4:00 – 5:30 PM.

Invited to this meeting are public and private sector experts in electronic health records and cancer care. After press pool coverage of remarks from Vice President Biden, the meeting will be closed press to allow for an honest exchange and development of new ideas for action.

Please let us know by Tuesday, December 27 at 3pm if you can attend by completing the security form here. This invitation is non-transferrable.

Should you have any questions about this invitation, please feel free to reach out. We look forward to seeing you on the 6th. Happy holidays!

-The Office of the Vice President and White House Cancer Moonshot

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/7/2017 2:17:52 PM
To: (b) (6) [(b) (6) @gmail.com]

My iphone is not working- can you see if there are any important emails i need and forward to my aol?

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/24/2016 1:27:30 AM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Fwd: from (b) (6)

Very nice

Sent from my iPhone

Begin forwarded message:

From: (b) (6) <(b) (6) @gmail.com>
Date: December 23, 2016 at 8:49:57 PM AST
To: David Shulkin <drshulkin@aol.com>
Subject: from (b) (6)

David,

I wanted to reach out and wish you and your family a very happy holiday season and a very happy new year. I know we haven't spoken much lately, but please know that I'm always hoping to get together, even for a cup of coffee. Thanks for being a resource to me and my family during the hard times with our son in the last two years - and I really hope that our conversations blossom into a greater friendship in time.

Have a great and terrific New Year! And, please stay in touch - let's get together!

Sincerely,

(b) (6)
(b) (6) @gmail.com
(b) (6)
(cell)
www.LinkedIn.com/in/(b) (6)
www(b) (6) .com
(b) (6)

Named One of the 10 CMOs to Watch in 2015 by WealthEngine and ranked in the Top CMOs on Twitter by Social Media Marketing Magazine!

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 1/12/2017 3:02:42 AM
To: (b) [(b) (6) @hotmail.com]
Subject: Fwd: Predictit - Who will be VA Secretary?

Sent from my iPad

Begin forwarded message:

> **From:** David Shulkin <drshulkin@aol.com>
> **Date:** January 11, 2017 at 9:37:30 PM EST
> **To:** Michael Tepper <(b) (6) @yahoo.com>
> **Subject: Fwd: Predictit - Who will be VA Secretary?**
>
> Sent from my iPad
>
> Begin forwarded message:
>
> > **From:** (b) (6) <(b) (6) @gmail.com>
> > **Date:** January 11, 2017 at 9:32:11 PM EST
> > **To:** David Shulkin <drshulkin@aol.com>
> > **Cc:** Vivieca Simpson <(b) (6) @gmail.com>
> > **Subject: Re: Fwd: Predictit - Who will be VA Secretary?**
> >
> > I really liked it!
> >
> > On Jan 11, 2017 9:26 PM, "David Shulkin" <drshulkin@aol.com> wrote:
> > > Look at video
> > >
> > > Sent from my iPad
> > >
> > > Begin forwarded message:
> > >
> > > > **From:** (b) (6) <(b) (6) @hotmail.com>
> > > > **Date:** January 11, 2017 at 7:30:44 PM EST
> > > > **To:** (b) (6) <(b) (6) @gmail.com>
> > > > **Cc:** David shulkin <Drshulkin@aol.com>
> > > > **Subject: Re: Predictit - Who will be VA Secretary?**
> > > >
> > > > Sent from my iPhone
> > > >
> > > > On Jan 11, 2017, at 7:27 PM, (b) (6)
> > > > <(b) (6) @gmail.com> wrote:

AMERICAN OVERSIGHT

https://www.washingtonpost.com/video/politics/trumps-transition-who-is-david-shulkin/2017/01/11/84d1b38e-d82e-11e6-a0e6-d502d6751bc8_video.html
Sent from my iPad

On Jan 11, 2017, at 10:47 AM, (b) (6) <(b) (6) @hotmail.com> wrote:

> Who is scott? Looks like hegseth from this but not sure I understand chart. 13 minutes
>
> Sent from my iPhone
>
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>
> > The link beloaw shows there is a betting market to make money on who is next secretary m It says my chances are low
> >
> > Sent from my iPhone
> >
> > Begin forwarded message:
> >
> > **From:** "Shulkin, David J., MD" <David.Shulkin@va.gov>
> > **Date:** January 11, 2017 at 10:41:24

AMERICAN OVERSIGHT

AM EST
To: 'Dr Shulkin' <drshulkin@aol.com>
Subject: FW: Predictit - Who will be VA Secretary?

Sent with Good (www.good.com)

Original Message----
-
From: Blackburn, Scott R.
Sent: Wednesday, January 11, 2017 10:40 AM Easter

AMERICAN OVERSIGHT

n Standard Time
To: Shulkin, David J., MD
Subject: Predictit - Who will be VA Secretary?

For your scrapbook. It is updated in real time so you can check it every day. It has been amusing to watch.

Sent with Good (www.good.com)

AMERICAN OVERSIGHT

-----Original Message-----
From: Scott Blackburn (b) (6) [redacted] gmail.com]
Sent: Wednesday, January 11, 2017 10:37 AM Eastern Standard Time
To: Blackburn, Scott R.
Subject:

https://www.predictit.org/Market/2635/Who-will-be-Secretary-of-Veterans-

AMERICAN OVERSIGHT

Affair
s-on-
Mar-
31,-
2017

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 1/12/2017 2:37:30 AM
To: Michael Tepper [(b) (6) @yahoo.com]
Subject: Fwd: Predictit - Who will be VA Secretary?

Sent from my iPad

Begin forwarded message:

From: (b) (6) <(b) (6) @gmail.com>
Date: January 11, 2017 at 9:32:11 PM EST
To: David Shulkin <drshulkin@aol.com>
Cc: Vivieca Simpson <(b) (6) @gmail.com>
Subject: Re: Fwd: Predictit - Who will be VA Secretary?

I really liked it!

On Jan 11, 2017 9:26 PM, "David Shulkin" <drshulkin@aol.com> wrote:

> Look at video
>
> Sent from my iPad
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> Begin forwarded message:
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> **To:** (b) (6) <(b) (6) @gmail.com>
> **Cc:** David shulkin <Drshulkin@aol.com>
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> > Sent from my iPad
> >
> > On Jan 11, 2017, at 10:47 AM, (b) (6) <(b) (6) @hotmail.com> wrote:
> >
> > > Who is scott? Looks like hegseth from this but not sure I understand chart. 13 minutes
> > >
> > > Sent from my iPhone

AMERICAN OVERSIGHT

On Jan 11, 2017, at 10:44 AM, David shulkin <Drshulkin@aol.com> wrote:

> The link beloaw shows there is a betting market to make money on who is next secretary m
> It says my chances are low
>
> Sent from my iPhone
>
> Begin forwarded message:
>
> > **From:** "Shulkin, David J., MD" <David.Shulkin@va.gov>
> > **Date:** January 11, 2017 at 10:41:24 AM EST
> > **To:** 'Dr Shulkin' <drshulkin@aol.com>
> > **Subject: FW: Predictit - Who will be VA Secretary?**
> >
> > Sent with Good (www.good.com)
> >
> > -----Original Message-----
> > **From:** Blackburn, Scott R.
> > **Sent:** Wednesday, January 11, 2017 10:40 AM Eastern Standard Time
> > **To:** Shulkin, David J., MD
> > **Subject:** Predictit - Who will be VA Secretary?
> >
> > For your scrapbook. It is updated in real time so you can check it everyday. It has been amusing to

AMERICAN OVERSIGHT

watch.

Sent with Good (www.good.com)

-----Original Message-----
From: Scott Blackburn [(b) (6) @gmail.com]
Sent: Wednesday, January 11, 2017 10:37 AM Eastern Standard Time
To: Blackburn, Scott R.
Subject:

https://www.predictit.org/Market/2635/Who-will-be-Secretary-of-Veterans-Affairs-on-Mar-31,-2017

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) @gmail.com]
Sent: 1/12/2017 2:32:11 AM
To: David Shulkin [drshulkin@aol.com]
CC: Vivieca Simpson [(b) (6) @gmail.com]
Subject: Re: Fwd: Predictit - Who will be VA Secretary?

I really liked it!

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Look at video

Sent from my iPad

Begin forwarded message:

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AMERICAN OVERSIGHT

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Date: January 11, 2017 at 10:41:24 AM EST
To: 'Dr Shulkin' <drshulkin@aol.com>
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From: Scott Blackburn [(b) (6) @gmail.com]
Sent: Wednesday, January 11, 2017 10:37 AM Eastern Standard Time
To: Blackburn, Scott R.
Subject:

https://www.predictit.org/Market/2635/Who-will-be-Secretary-of-Veterans-Affairs-on-Mar-31,-2017

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 1/12/2017 2:32:08 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Re: Predictit - Who will be VA Secretary?

Its a flattering one- gives you so much of credibility- and the pictures definitely are complimentary- yup "you are good looking"

From: David Shulkin <drshulkin@aol.com>
Sent: Wednesday, January 11, 2017 9:25 PM
To: Poonam Alaigh
Subject: Fwd: Predictit - Who will be VA Secretary?

You've got to see this video

Sent from my iPad

Begin forwarded message:

> **From:** (b) (6) <(b) (6) @hotmail.com>
> **Date:** January 11, 2017 at 7:30:44 PM EST
> **To:** (b) (6) <(b) (6) @gmail.com>
> **Cc:** David shulkin <Drshulkin@aol.com>
> **Subject: Re: Predictit - Who will be VA Secretary?**
>
> David u gotta c the salary they list u had,omg
>
> Sent from my iPhone
>
> On Jan 11, 2017, at 7:27 PM, (b) (6) <(b) (6) @gmail.com> wrote:
>
> > https://www.washingtonpost.com/video/politics/trumps-transition-who-is-david-shulkin/2017/01/11/84d1b38e-d82e-11e6-a0e6-d502d6751bc8_video.html
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> > On Jan 11, 2017, at 10:47 AM, (b) (6) <(b) (6) @hotmail.com> wrote:
> >
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> > >
> > > On Jan 11, 2017, at 10:44 AM, David shulkin <Drshulkin@aol.com> wrote:

AMERICAN OVERSIGHT

The link beloaw shows there is a betting market to make money on who is next secretary m
It says my chances are low

Sent from my iPhone

Begin forwarded message:

> **From:** "Shulkin, David J., MD" <David.Shulkin@va.gov>
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> **Subject: FW: Predictit - Who will be VA Secretary?**
>
> Sent with Good (www.good.com)
>
> -----Original Message-----
> **From:** Blackburn, Scott R.
> **Sent:** Wednesday, January 11, 2017 10:40 AM Eastern Standard Time
> **To:** Shulkin, David J., MD
> **Subject:** Predictit - Who will be VA Secretary?
>
> For your scrapbook. It is updated in real time so you can check it everyday. It has been amusing to watch.
>
> Sent with Good (www.good.com)
>
> -----Original Message-----
> **From:** Scott Blackburn [(b) (6) @gmail.com]
> **Sent:** Wednesday, January 11, 2017 10:37 AM Eastern Standard Time
> **To:** Blackburn, Scott R.
> **Subject:**
>
> https://www.predictit.org/Market/2

AMERICAN OVERSIGHT

635/Who-will-be-Secretary-of-Veterans-Affairs-on-Mar-31,-2017

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 1/12/2017 2:25:41 AM
To: (b) (6) [(b) (6) @gmail.com]; Vivieca Simpson [(b) (6) @gmail.com]
Subject: Fwd: Predictit - Who will be VA Secretary?

Look at video

Sent from my iPad

Begin forwarded message:

> **From:** (b) (6) <(b) (6) @hotmail.com>
> **Date:** January 11, 2017 at 7:30:44 PM EST
> **To:** (b) (6) <(b) (6) @gmail.com>
> **Cc:** David shulkin <Drshulkin@aol.com>
> **Subject: Re: Predictit - Who will be VA Secretary?**
>
> Sent from my iPhone
>
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> > > > **Date:** January 11, 2017 at 10:41:24 AM EST
> > > > **To:** 'Dr Shulkin'

AMERICAN OVERSIGHT

<drshulkin@aol.com>
Subject: FW: Predictit - Who will be VA Secretary?

Sent with Good (www.good.com)

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From: Blackburn, Scott R.
Sent: Wednesday, January 11, 2017 10:40 AM Eastern Standard Time
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From: Scott Blackburn [(b) (6) @gmail.com]
Sent: Wednesday, January 11, 2017 10:37 AM Eastern Standard Time
To: Blackburn, Scott R.
Subject:

https://www.predictit.org/Market/2635/Who-will-be-Secretary-of-Veterans-Affairs-on-Mar-31,-2017

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 1/12/2017 2:25:05 AM
To: Poonam Alaigh [(b) (6)@hotmail.com]
Subject: Fwd: Predictit - Who will be VA Secretary?

You've got to see this video

Sent from my iPad

Begin forwarded message:

> **From:** (b) (6) <(b) (6) @hotmail.com>
> **Date:** January 11, 2017 at 7:30:44 PM EST
> **To:** (b) (6) (b) (6) <(b) (6) @gmail.com>
> **Cc:** David shulkin <Drshulkin@aol.com>
> **Subject: Re: Predictit - Who will be VA Secretary?**
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> > https://www.washingtonpost.com/video/politics/trumps-transition-who-is-david-shulkin/2017/01/11/84d1b38e-d82e-11e6-a0e6-d502d6751bc8_video.html
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> > > > **From:** "Shulkin, David J., MD" <David.Shulkin@va.gov>
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AMERICAN OVERSIGHT

To: 'Dr Shulkin'
<drshulkin@aol.com>
Subject: FW: Predictit - Who will be VA Secretary?

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[(b) (6) @gmail.com]
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To: Blackburn, Scott R.
Subject:

https://www.predictit.org/Market/2635/Who-will-be-Secretary-of-Veterans-Affairs-on-Mar-31,-2017

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/17/2017 2:50:21 PM
To: (b) (6) [(b) (6) r@gmail.com]
Subject: Re: Shulkin- VA Nominee Tab 6 - Tax Waiver

Ok i see

Sent from my iPhone

> On Jan 17, 2017, at 9:07 AM, (b) (6) <(b) (6) r@gmail.com> wrote:
>
> Good Morning,
>
> Please find attached David Shukin's tax waiver form - Tab 6.
>
>
> (b) (6)
> <David Shulkin -Nominee Veterans Affairs Tab 6.pdf>

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/17/2017 2:50:02 PM
To: (b) (6) [(b) (6) @gmail.com]
Subject: Re: Shulkin- VA Nominee Tab 6 - Tax Waiver

Do i need to sign?

Sent from my iPhone

> On Jan 17, 2017, at 9:07 AM, (b) (6) <(b) (6) r@gmail.com> wrote:
>
> Good Morning,
>
> Please find attached David Shukin's tax waiver form - Tab 6.
>
>
> (b) (6)
> <David Shulkin -Nominee Veterans Affairs Tab 6.pdf>

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) @gmail.com]
Sent: 1/17/2017 2:07:16 PM
To: (b) (6) @ptt.gov; (b) (6) @ptt.gov
CC: David Shulkin [drshulkin@aol.com]
Subject: Shulkin- VA Nominee Tab 6 - Tax Waiver
Attachments: David Shulkin -Nominee Veterans Affairs Tab 6.pdf

Good Morning,

Please find attached David Shukin's tax waiver form - Tab 6.

(b) (6)

AMERICAN OVERSIGHT

PRIOR TO COMPLETING THIS FORM, PLEASE BE SURE YOU HAVE REVIEWED THE TERMS OF THIS AGREEMENT.

By providing the information herein and by signing this waiver, I voluntarily authorize the Internal Revenue Service to release the tax return and return information indicated below. The return and return information will be used concerning my appointment or employment by the United States Government. This waiver is made pursuant to 26 USC 6103(c), which permits the release of return and return information, which would otherwise be confidential, to my designee.

I designate that the Internal Revenue Service release return and return information to:

DONALD F. MCGAHN II, GENERAL COUNSEL, OFFICE OF THE PRESIDENT-ELECT, 1800 F STREET NW, WASHINGTON, DC

The information I am consenting to release is:

1. Have I failed to file a Federal income tax return for any of the last three (3) years for which filing of a return might have been required? If the filing date for the most recent required return has not yet lapsed on the date the IRS receives this waiver and IRS records do not indicate a return filing for the most recent required return, the "last three years" will mean the three years preceding the year for which returns are currently being filed and processed.
2. Were any of the returns in #1 filed more than forty-five (45) days after the due date for filing, determined with regard to any extension(s) of time for filing?
3. Have I failed to pay any tax, penalty, or interest liability during the current or last three calendar years within forty-five (45) days of the date of which the IRS gave notice of the amount due and request for payment?
4. Am I now or have I ever been under investigation by the IRS for possible criminal offenses?
5. Has any civil penalty for fraud been assessed against me during the current or last three (3) calendar years?

If the information, which is to be released, includes a "*Yes*" answer to any of the above five questions, I authorize the Internal Revenue Service to release any information pertaining to that question.

THE CANDIDATE MUST SIGN AND DATE THE BOTTOM OF THIS FORM.

MY NAME: DAVID SHULKIN

MY SSN: (b) (6), (b) (2) [redacted]

PHONE NUMBER(S): HOME: (b) (6), (b) (2) [redacted] WORK: (202) 461-7000

CURRENT ADDRESS: (b) (6), (b) (2) [redacted]

IF MARRIED AND FILED A JOINT RETURN:

SPOUSE NAME: (b) (6), (b) (2) [redacted]

SPOUSE SSN: (b) (6), (b) (2) [redacted]

NAMES AND ADDRESSES SHOWN ON RETURNS FOR THE LAST THREE (3) YEARS (IF DIFFERENT FROM ABOVE):

YEAR	NAME	(b) (6), (b) (2) [redacted]
2015	DAVID SHULKIN	
2016	DAVID SHULKIN	
2013	DAVID SHULKIN	

DATE: 1/12/17

*WAIVER INVALID UNLESS THE DATE IS **HAND-WRITTEN** BY TAXPAYER AND RECEIVED BY THE IRS WITHIN **120** DAYS OF THIS DATE*

__SIGNATURE OF THE TAXPAYER__ AUTHORIZING THE DISCLOSURE OF RETURN/RETURN INFORMATION

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 1/10/2017 5:57:58 AM
To: (b) (6) [(b) (6) @gmail.com]
Subject: Please print

https://www.stripes.com/news/20-veterans-groups-petition-for-mcdonald-to-remain-va-secretary-1.444451
Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/9/2017 12:26:33 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: Anything I need to know

I am not sure if its ok to say anything publically about it because of hippa

Privately we had seen him for a c and p exam and audiology but no mental health services

Sent from my iPhone

> On Jan 8, 2017, at 10:47 PM, Poonam Alaigh <(b) (6) n@hotmail.com> wrote:
>
> About the Fort Lauderdale shooter- he is a veteran- did he come to the VA? Just in case it comes up tomorrow as part of emotional wellness
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 1/12/2017 4:37:40 PM
To: drshulkin@aol.com
Subject: Article

The kids just sent this -
http://www.nj.com/politics/index.ssf/2017/01/heres_the_obama_administration_holdover_from_nj_wh.html
Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Jennifer Lee [(b) (6) @gmail.com]
Sent: 12/30/2016 7:10:27 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Re: time to catch up?

Thank you!
3pm works- or feel free to call me any time that is convenient for you.
My personal cell is acting up so the work phone is better: (b) (6)
Thanks,
Jen

On Fri, Dec 30, 2016 at 12:55 PM, David Shulkin <drshulkin@aol.com> wrote:
can we talk at 3 PM today or if not tomorrow if fine too

-----Original Message-----
From: Jennifer Lee <(b) (6) @gmail.com>
To: David Shulkin <drshulkin@aol.com>
Sent: Fri, Dec 30, 2016 12:43 pm
Subject: time to catch up?

Hi David,
I hope you're having a nice, well-deserved holiday!
We got back from Puerto Rico yesterday - it was great!
I know it will be a busy week, so am wondering if you have time for a brief phone call this weekend, or if not, time to meet this coming week, maybe for dinner? I just wanted to catch up on a few things with you 1:1.
Thanks so much
Jen

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 12/30/2016 5:55:34 PM
To: (b) (6) @gmail.com
Subject: Re: time to catch up?

can we talk at 3 PM today or if not tomorrow if fine too

-----Original Message-----
From: Jennifer Lee <(b) (6) @gmail.com>
To: David Shulkin <drshulkin@aol.com>
Sent: Fri, Dec 30, 2016 12:43 pm
Subject: time to catch up?

Hi David,
I hope you're having a nice, well-deserved holiday!
We got back from Puerto Rico yesterday - it was great!
I know it will be a busy week, so am wondering if you have time for a brief phone call this weekend, or if not, time to meet this coming week, maybe for dinner? I just wanted to catch up on a few things with you 1:1.
Thanks so much
Jen

AMERICAN OVERSIGHT

Message

From: Jennifer Lee [(b) (6) @gmail.com]
Sent: 12/30/2016 5:43:18 PM
To: David Shulkin [drshulkin@aol.com]
Subject: time to catch up?

Hi David,
I hope you're having a nice, well-deserved holiday!
We got back from Puerto Rico yesterday - it was great!
I know it will be a busy week, so am wondering if you have time for a brief phone call this weekend, or if not, time to meet this coming week, maybe for dinner? I just wanted to catch up on a few things with you 1:1.
Thanks so much
Jen

AMERICAN OVERSIGHT

Message

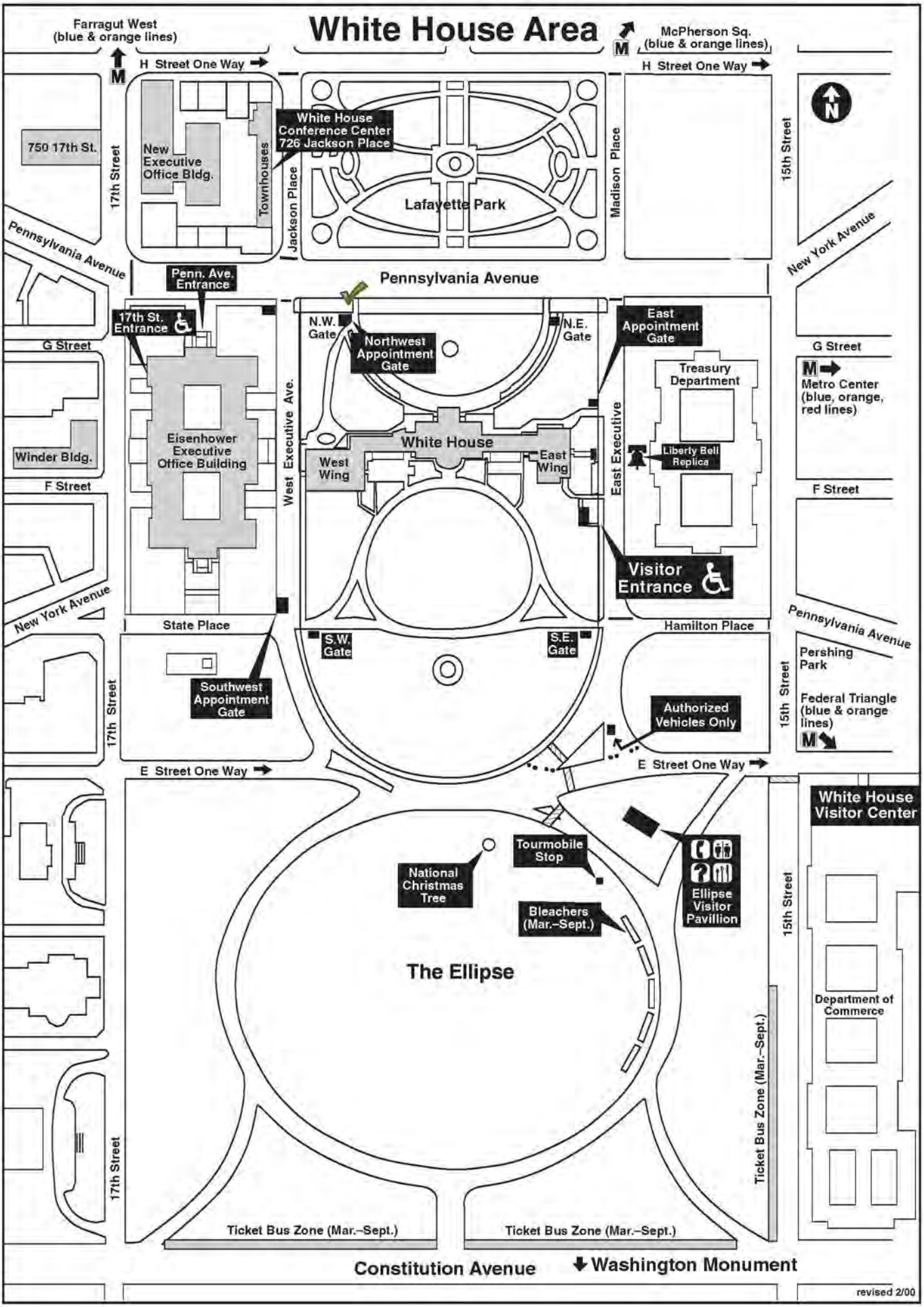
From: David shulkin [Drshulkin@aol.com]
Sent: 12/3/2016 2:39:12 AM
To: (b) (6) [(b) (6) @gmail.com]
Subject: Fwd: Lunch Reservations
Attachments: WH_Complex_Map.pdf; Untitled attachment 18618.htm

Sent from my iPhone

Begin forwarded message:

> **From:** "(b) (6) (b) (6) LT USN WHMO/WHMU" (b) (6) @whmo.mil>
> **Date:** December 2, 2016 at 3:09:38 PM CST
> **To:** "(b) (6) . LT USN WHMO/WHMU" (b) (6) @whmo.mil>
> **Subject: Lunch Reservations**
>
> Good afternoon,
>
> Please see attached map for the day of your lunch reservation. For your ease and convenience, please enter through the Northwest Appointment Gate. Upon your arrival, please give me a call and I will escort you to Dr. (b) (6) office. Please let me know if you have any questions.
>
> V/r,
>
> (b) (6)
> LT, MSC, USN
> White House Medical Unit
> O: (b) (6)
> C: (b) (6)

AMERICAN OVERSIGHT



AMERICAN OVERSIGHT

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/16/2016 2:08:41 AM
To: (b) [(b) (6) @hotmail.com]
Subject: Fwd: Re:

Sent from my iPhone

Begin forwarded message:

From: Robert McDonald <(b) (6) @gmail.com>
Date: December 15, 2016 at 9:00:33 PM EST
To: David Shulkin <drshulkin@aol.com>
Subject: Re:

Thanks David. Please know (b) (6) and I feel the same way about our friendship. Eternal and deep. Best wishes. Bob

On Thu, Dec 15, 2016 at 8:52 PM, David Shulkin <drshulkin@aol.com> wrote:

> Bob- thanks for the message and the heads up- it was so nice of you.
>
> I'm deeply disappointed and was hoping Trump would at the least speak with you-
> But it was not to be- I know you have so much to be proud of and you've made a true lasting difference.
>
> With eternal friendship,
>
> David
>
> Sent from my iPad

AMERICAN OVERSIGHT

Message

From: Robert McDonald [(b) (6) @gmail.com]
Sent: 12/16/2016 2:00:33 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Re:

Thanks David. Please know (b) (6) and I feel the same way about our friendship. Eternal and deep. Best wishes. Bob

On Thu, Dec 15, 2016 at 8:52 PM, David Shulkin <drshulkin@aol.com> wrote:
Bob- thanks for the message and the heads up- it was so nice of you.

I'm deeply disappointed and was hoping Trump would at the least speak with you-
But it was not to be- I know you have so much to be proud of and you've made a true lasting difference.

With eternal friendship,

David

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 12/16/2016 1:52:07 AM
To: bob mcDonald [(b) (6) @gmail.com]

Bob- thanks for the message and the heads up- it was so nice of you.

I'm deeply disappointed and was hoping Trump would at the least speak with you-
But it was not to be- I know you have so much to be proud of and you've made a true lasting difference.

With eternal friendship,

David

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/16/2017 1:59:12 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Fwd: USA Today profile

What is your take on this?

Sent from my iPhone

Begin forwarded message:

From: (b) (6) (b) (6) @ptt.gov>
Date: January 16, 2017 at 8:34:05 AM EST
To: David Shulkin <drshulkin@aol.com>, (b) (6) (b) (6) @comcast.net>, (b) (6)
<(b) (6) @58pic2017.org>
Subject: USA Today profile

https://www.google.com/amp/amp.usatoday.com/story/96566618/?client=safari

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/16/2017 1:56:33 PM
To: (b) (6) [(b) (6) @comcast.net]
BCC: Vivieca Simpson [(b) (6) @gmail.com]; (b) (6) [(b) (6) @gmail.com]
Subject: Fwd: USA Today profile

(b) (6) i think its great- please thank Donovan for me- lets see what the Trump team says

Thank you as always

Sent from my iPhone

Begin forwarded message:

> **From:** (b) (6)) (6) @ptt.gov>
> **Date:** January 16, 2017 at 8:34:05 AM EST
> **To:** David Shulkin <drshulkin@aol.com>, (b) (6) <(b) (6) @comcast.net>, (b) (6) <(b) (6) @58pic2017.org>
> **Subject: USA Today profile**
>
> https://www.google.com/amp/amp.usatoday.com/story/96566618/?client=safari

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/17/2016 1:07:52 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: Next week

If virtual is easier do that- unless you can set up a breakfast or coffee with ellen on the transition team

Sent from my iPhone

On Dec 17, 2016, at 7:14 AM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:

> What do you want me to do- should I work virtually, or I could just come in only if that would be helpful. Rich doesnt want me to be around obviously and I cannot help with the Transition team.
>
> We need to discuss what needs to happen while you are away- which we could do over the phone this weekend or Monday. The only other urgent thing is the Evaluation Study- which they are still fixing, but we could discuss over the phone.

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6)@hotmail.com]
Sent: 12/17/2016 12:14:33 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Next week

What do you want me to do- should I work virtually, or I could just come in only if that would be helpful. Rich doesnt want me to be around obviously and I cannot help with the Transition team.

We need to discuss what needs to happen while you are away- which we could do over the phone this weekend or Monday. The only other urgent thing is the Evaluation Study- which they are still fixing, but we could discuss over the phone.

AMERICAN OVERSIGHT

Message

From: thomas bowman [(b) (6) @yahoo.com]
Sent: 1/14/2017 5:12:38 PM
To: drshulkin@aol.com
Subject: Contact

I am available 24/7....please feel free to contact me at any time....looking forward to meeting up Sunday week from tomorrow.....
R/tom

Personal email (b) (6) @yahoo.com
Cel (b) (6)

Sent from Yahoo Mail on Android

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6)@hotmail.com]
Sent: 12/13/2016 1:23:01 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: So pathetic

Yup- I know there is one person who values me more than anything else- may not be a bad option working with him as his assistant - any yes, it comes with benefits like none other

Sent from my iPhone

> On Dec 12, 2016, at 8:14 PM, David shulkin <Drshulkin@aol.com> wrote:
>
> Thats the right attitude- they dont know what they are missing- their loss
>
> Sent from my iPhone
>
>> On Dec 12, 2016, at 7:42 PM, Poonam Alaigh <(b) (6)n@hotmail.com> wrote:
>>
>> These guys can't even fire anyone- (b) (6) calls me into his office and says "there is no place in the aco for you as of end of January"- so extremely pathetic- good riddens and their loss for not having Poonam on their team. Haven't told anyone (so keep in confidence) as I am still planning to talk to Brian and (b) and maximize my exit- but onto better and bigger things now- most definitely!!
>>
>> Sent from my iPad
>

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/13/2016 1:14:34 AM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: So pathetic

Thats the right attitude- they dont know what they are missing- their loss

Sent from my iPhone

> On Dec 12, 2016, at 7:42 PM, Poonam Alaigh <(b) (6) n@hotmail.com> wrote:
>
> These guys can't even fire anyone- (b) (6) calls me into his office and says "there is no place in the aco for you as of end of January"- so extremely pathetic- good riddens and their loss for not having Poonam on their team. Haven't told anyone (so keep in confidence) as I am still planning to talk to Brian and (b) and maximize my exit- but onto better and bigger things now- most definitely!!
>
> Sent from my iPad

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/13/2016 12:42:23 AM
To: David Shulkin [drshulkin@aol.com]
Subject: So pathetic

These guys can't even fire anyone- (b) (6) calls me into his office and says "there is no place in the aco for you as of end of January"- so extremely pathetic- good riddens and their loss for not having Poonam on their team. Haven't told anyone (so keep in confidence) as I am still planning to talk to Brian and (b) and maximize my exit- but onto better and bigger things now- most definitely!!

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 12/21/2016 9:39:37 PM
To: (b) (6) [(b) (6) @gmail.com]
Subject: Re:

I suspect your right

Sent from my iPad

On Dec 21, 2016, at 5:29 PM, (b) (6) <(b) (6) @gmail.com> wrote:

> Better than the last 30 names, except (b) (6) What do you think?
>
> On Dec 21, 2016 4:24 PM, "David Shulkin" <drshulkin@aol.com> wrote:
> http://www.politico.com/story/2016/12/(b) (b) (6) -veterans-affairs-trump-232894
>
> Sent from my iPad

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) @gmail.com]
Sent: 12/21/2016 9:29:21 PM
To: David Shulkin [drshulkin@aol.com]
CC: Vivieca Wright Simpson [vivieca.Wright@va.gov]
Subject: Re:

Better than the last 30 names, except (b) (6) What do you think?

On Dec 21, 2016 4:24 PM, "David Shulkin" <drshulkin@aol.com> wrote:
http://www.politico.com/story/2016/12/(b) (6) -veterans-affairs-trump-232894

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 12/21/2016 9:19:28 PM
To: Vivieca Wright Simpson [vivieca.Wright@va.gov]; (b) (6) [(b) (6) @gmail.com]

http://www.politico.com/story/2016/12/(b) (b) (6) -veterans-affairs-trump-232894

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 1/18/2017 4:25:51 AM
To: Jennifer Lee [(b) (6) @gmail.com]
Subject: Re: just FYI - from Tom Price's 2015 repeal/replace plan last year

Thanks

Sent from my iPad

On Jan 17, 2017, at 11:19 PM, Jennifer Lee <(b) (6) @gmail.com> wrote:

> • His plan permits individuals eligible for other health benefit programs, including Medicare, Medicaid, CHIP, TRICARE, **Veterans' Affairs**, the Federal Employee Health Benefits Program, and subsidized group coverage to receive a tax credit instead of coverage through the program
>
> Provides a refundable, flat, tax credit for the purchase of health insurance in the individual market ($900 per child, $1,200 age 18-34, $2,100 age 35-49, $3,000 age 50 and over; indexed by CPI.)
>
> I can check to see how this plan scored with CBO last year.
>
> Other aspects of his plan:
>
> - Repeal ACA entirely, including individual and employer mandates, private insurance rules, standards for minimum benefits and maximum cost sharing, and premium and cost sharing subsidies.
> - Provide refundable tax credits of $900 to $3,000 based on age to individuals to purchase insurance in the individual market.
> - Require insurers to offer portability protections for people who maintain continuous coverage. Pre-existing condition exclusions and rate surcharges based on health status can otherwise apply.
> - Implement state high-risk pools with federal grant support for 3 years.
> - Permit enrollees of public programs, and employer-sponsored group health plans to opt out of coverage in favor of private non-group insurance with tax credit subsidy.
> - Repeal Medicaid expansion. Repeal Medicare benefit enhancements, savings provisions, premiums for higher-income beneficiaries, taxes on high earnings, and quality, payment and delivery system provisions.

AMERICAN OVERSIGHT

Message

From: Jennifer Lee [(b) (6) @gmail.com]
Sent: 1/18/2017 4:19:32 AM
To: David Shulkin [drshulkin@aol.com]
Subject: just FYI - from Tom Price's 2015 repeal/replace plan last year

- His plan permits individuals eligible for other health benefit programs, including Medicare, Medicaid, CHIP, TRICARE, **Veterans' Affairs**, the Federal Employee Health Benefits Program, and subsidized group coverage to receive a tax credit instead of coverage through the program

Provides a refundable, flat, tax credit for the purchase of health insurance in the individual market ($900 per child, $1,200 age 18-34, $2,100 age 35-49, $3,000 age 50 and over; indexed by CPI.)

I can check to see how this plan scored with CBO last year.

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- Provide refundable tax credits of $900 to $3,000 based on age to individuals to purchase insurance in the individual market.
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- Repeal Medicaid expansion. Repeal Medicare benefit enhancements, savings provisions, premiums for higher-income beneficiaries, taxes on high earnings, and quality, payment and delivery system provisions.

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/7/2017 2:19:44 PM
To: Jennifer Lee [(b) (6)@gmail.com]
Subject: Re: Re Bob Snyder

Thaanks

Sent from my iPhone

> On Jan 6, 2017, at 11:35 PM, Jennifer Lee (b) (6)@gmail.com> wrote:
>
> From (b) (6), re source of intel relevant to Snyder:
>
> I know that she's very close to Bob, as in speaks with him multiple times a day, and that he has specifically said to her that he is kind of annoyed at being "under utilized." She was personally appalled by stone's actions with the rfp, and my sense is that piece will get back to Bob Snyder even before Dr. Shulkin would choose to speak with him. She said, "He has every right to defend his honor and I hope he does." She felt very strongly that Snyder would be helpful.
>
> From what she said, though, this has to come across as being about what is best for the organization (and of course I know that would be his intent anyway).
> Bottom line: I'm confident she's telling the truth and is right that he's not a fan of or aligned with Stone. This comes down to Dr. Shulkin winning him over by making a bold statement as the best choice for the organization.

AMERICAN OVERSIGHT

Message

From: Jennifer Lee [(b) (6) @gmail.com]
Sent: 1/7/2017 4:35:07 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Re Bob Snyder

From (b) (6), re source of intel relevant to Snyder:

I know that she's very close to Bob, as in speaks with him multiple times a day, and that he has specifically said to her that he is kind of annoyed at being "under utilized." She was personally appalled by stone's actions with the rfp, and my sense is that piece will get back to Bob Snyder even before Dr. Shulkin would choose to speak with him. She said, "He has every right to defend his honor and I hope he does." She felt very strongly that Snyder would be helpful.

From what she said, though, this has to come across as being about what is best for the organization (and of course I know that would be his intent anyway).
Bottom line: I'm confident she's telling the truth and is right that he's not a fan of or aligned with Stone. This comes down to Dr. Shulkin winning him over by making a bold statement as the best choice for the organization.

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 12/16/2016 1:52:41 AM
To: (b) (6) [(b) (6) @gmail.com]
Subject: Re:

Yes she seems like a trailblazer

Sent from my iPad

On Dec 15, 2016, at 8:46 PM, (b) (6) <(b) (6) @gmail.com> wrote:

> Yes sir, I wont. Saw this.
>
> I've watched all her speeches over the last year, she seems awesome
>
> If so, kind of strategic for him to take her out of dod, wonder why. First woman to get 4 stars.
>
> On Dec 15, 2016 8:39 PM, "David Shulkin" <drshulkin@aol.com> wrote:
> I heard this is his choice for secva- she looks like a good choice
> I'm encouraged
>
> Don't talk about it before the official announcement
>
> http://thehill.com/homenews/administration/310553-trump-considering-navy-adm-(b) (6) to-run-va-report
>
> Sent from my iPad

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) @gmail.com]
Sent: 12/16/2016 1:46:58 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Re:

Yes sir, I wont. Saw this.

I've watched all her speeches over the last year, she seems awesome

If so, kind of strategic for him to take her out of dod, wonder why. First woman to get 4 stars.

On Dec 15, 2016 8:39 PM, "David Shulkin" <drshulkin@aol.com> wrote:

> I heard this is his choice for secva- she looks like a good choice
> I'm encouraged
>
> Don't talk about it before the official announcement
>
> http://thehill.com/homenews/administration/310553-trump-considering-navy-adm-(b) (6) -to-run-va-report
>
> Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 12/16/2016 1:39:55 AM
To: Vivieca Wright Simpson[redacted]@va.gov]; [redacted] [redacted]@gmail.com]

I heard this is his choice for secva- she looks like a good choice
I'm encouraged

Don't talk about it before the official announcement

http://thehill.com/homenews/administration/310553-trump-considering-navy-adm[redacted]o-run-va-report

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/15/2016 10:26:02 PM
To: (b) (6) [(b) (6) @gmail.com]
Subject: Re:

He is an impressive kid

Sent from my iPhone

On Dec 15, 2016, at 4:52 PM, (b) (6) <(b) (6) @gmail.com> wrote:

> College dropout, 27 and a billionaire. Yikes. Michigan state didn't help me :-(.

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6)@gmail.com]
Sent: 12/15/2016 9:52:18 PM
To: David Shulkin [drshulkin@aol.com]

College dropout, 27 and a billionaire. Yikes. Michigan state didn't help me :-(.

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6)@hotmail.com]
Sent: 12/24/2016 1:37:54 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Check WhatsApp

Lol- glad it's just a joke - anyway, going to the airport now to pick up (b)

Sent from my iPhone

> On Dec 23, 2016, at 8:34 PM, David shulkin <Drshulkin@aol.com> wrote:
>
> If (b) and scott joined us we call call ourselves the WASP group- with a jew and an indian - (b) (6) alaigh shulkin (b)
>
> Just kidding of course
>
> Sent from my iPhone
>
>> On Dec 23, 2016, at 9:30 PM, Poonam Alaigh <(b) (6) n@hotmail.com> wrote:
>>
>>
>>
>> Sent from my iPhone
>

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/24/2016 1:34:04 AM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: Check WhatsApp

If (b) and (b) joined us we call call ourselves the WASP group- with a jew and an indian - (b) (6) alaigh shulkin (b)

Just kidding of course

Sent from my iPhone

> On Dec 23, 2016, at 9:30 PM, Poonam Alaigh <(b) (6) n@hotmail.com> wrote:
>
>
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/24/2016 1:30:06 AM
To: drshulkin@aol.com
Subject: Check WhatsApp

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/14/2017 2:40:32 AM
To: Vivieca Simpson [(b) (6) @gmail.com]

Your husband is welcome to join you as my guest as well

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) @gmail.com]
Sent: 12/23/2016 2:22:53 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Hub

http://www.foxnews.com/politics/2016/12/15/trump-announces-rep-zinke-as-choice-for-interior-secretary.html

This is (b) (6) husband. (b) is the one with long hair on the transition team.

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/24/2016 3:26:40 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: BRMC RFP - Complete!

Great- that must be a big relief

Sent from my iPhone

On Dec 24, 2016, at 9:36 AM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:

See below

From: (b) (6) (b) (6) @fticonsulting.com>
Sent: Thursday, December 1, 2016 5:50 PM
To: (b) (6) Poonam Alaigh, MD ; (b) (6)
Subject: BRMC RFP - Complete!

Good afternoon, everyone

I am happy to report that the BRMC RFP response is done and out the door! Attached for your files are: 1) Final Word version without Appendix A or the Disclosure exhibits inserted and 2) Final pdf that was sent to Mr. (b) (6) on a USB drive, along with one hard copy original and two printed copies.

If you need it, the Fedex tracking # is 7778 4405 1929

Great team effort – thank you all!

(b)

(b) (6)

+(b) (6) M

(b) (6) @fticonsulting.com

AMERICAN OVERSIGHT

From: (b) (6)
Sent: Thursday, December 01, 2016 11:55 AM
To: (b) (6) Poonam Alaigh, MD ; (b) (6)
Subject: For your final review

Please send me any final changes by 2pm et. There are two remaining open items that I will be adding as soon as I receive them – (b) (6) edits to align the narrative with the final financials and possible edits to the Transaction timeline on printed p69.

Thank you all!

(b) (6)

Director, Health Solutions

FTI Consulting

(b) (6) M

(b) (6) @fticonsulting.com

200 State Street | 8th floor

Boston, MA 02109 USA

www.fticonsulting.com

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This email and any attachments may be confidential and protected by legal privilege. If you are not the intended recipient, be aware that any disclosure, copying, distribution or use of the e-mail or any attachment is prohibited. If you have received this email in error, please notify us immediately by replying to the sender and then delete this copy and the reply from your system. Thank you for your cooperation.

<BSN Response to BCIA-BRMC RFP 12-1-16.pdf>

<BSN Response to BCIA-BRMC RFP - Final without appendix A and exhibits inserted 12-1-16.docx>

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/24/2016 1:36:35 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Fw: BRMC RFP - Complete!
Attachments: BSN Response to BCIA-BRMC RFP 12-1-16.pdf; BSN Response to BCIA-BRMC RFP - Final without appendix A and exhibits inserted 12-1-16.docx

See below

From: (b) (6)) (6) @fticonsulting.com>
Sent: Thursday, December 1, 2016 5:50 PM
To: (b) (6) ; Poonam Alaigh, MD ; (b) (6) John
Subject: BRMC RFP - Complete!

Good afternoon, everyone

I am happy to report that the BRMC RFP response is done and out the door! Attached for your files are: 1) Final Word version without Appendix A or the Disclosure exhibits inserted and 2) Final pdf that was sent to Mr. (b) (6) on a USB drive, along with one hard copy original and two printed copies.

If you need it, the Fedex tracking # is 7778 4405 1929

Great team effort – thank you all!

(b) (6)

(b) (6) M

(b) (6) fticonsulting.com

From: (b) (6)
Sent: Thursday, December 01, 2016 11:55 AM
To: (b) (6) ; Poonam Alaigh, MD ; (b) (6)
Subject: For your final review

AMERICAN OVERSIGHT

Please send me any final changes by 2pm et. There are two remaining open items that I will be adding as soon as I receive them – (b) (6) edits to align the narrative with the final financials and possible edits to the Transaction timeline on printed p69.

Thank you all!

(b) (6)

[redacted]

Director, Health Solutions

FTI Consulting

(b) (6) M

(b) (6) @fticonsulting.com

200 State Street | 8th floor

Boston, MA 02109 USA

www.fticonsulting.com

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AMERICAN OVERSIGHT

Response to Bergen County Improvement Authority Request for Proposal Regarding Bergen Regional Medical Center in Relation to the Lease

Respectfully submitted December 1, 2016
By

(b) (6), MD
President, Bergen Safety Net, Inc.

10 – 14 Saddle River Road
Suite 200
Fair Lawn, NJ 07410

Office (b) (6)
Email (b) (6)@verizon.net

AMERICAN OVERSIGHT

BERGEN SAFETY NET INC.

10 – 14 Saddle River Road
Suite 200
Fair Lawn, NJ 07410

December 1, 2016

Mr. (b) (6) Jr.
Purchasing Agent
Bergen County Improvement Authority
C/o County of Bergen Division of Purchasing
One Bergen County Plaza
3rd floor
Hackensack, NJ 07601-7076

Re: Bergen Safety Net Response to Request for Proposal Regarding Bergen Regional Medical Center in Relation to the Lease

Dear Mr. (b) (6)

On behalf of the Bergen Safety Net ("BSN") team, it is my pleasure to present our response to the Bergen County Improvement Authority's ("BCIA") Request for Proposal regarding Bergen Regional Medical Center ("BRMC") in Relation to the Lease. BSN is committed to the success of BRMC and to the essential safety net services it provides for Bergen County, and our team has the depth and breadth of expertise necessary to revitalize this important community asset.

We thank you for the opportunity to share our capabilities with you and are confident that we can exceed BRMC's expectations for the provision of medical services in Bergen County and surrounding markets. We look forward to the opportunity to partner with you in accomplishing the goals of BCIA to enhance operations and support the ongoing viability of BRMC. Please do not hesitate to contact me at (b) (6) or (b) (6) @verizon.net if you have any questions or would like additional information related to this proposal.

Yours sincerely,

(b) (6)

(b) (6), MD
President

AMERICAN OVERSIGHT

BERGEN SAFETY NET INC.

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I. INTRODUCTION

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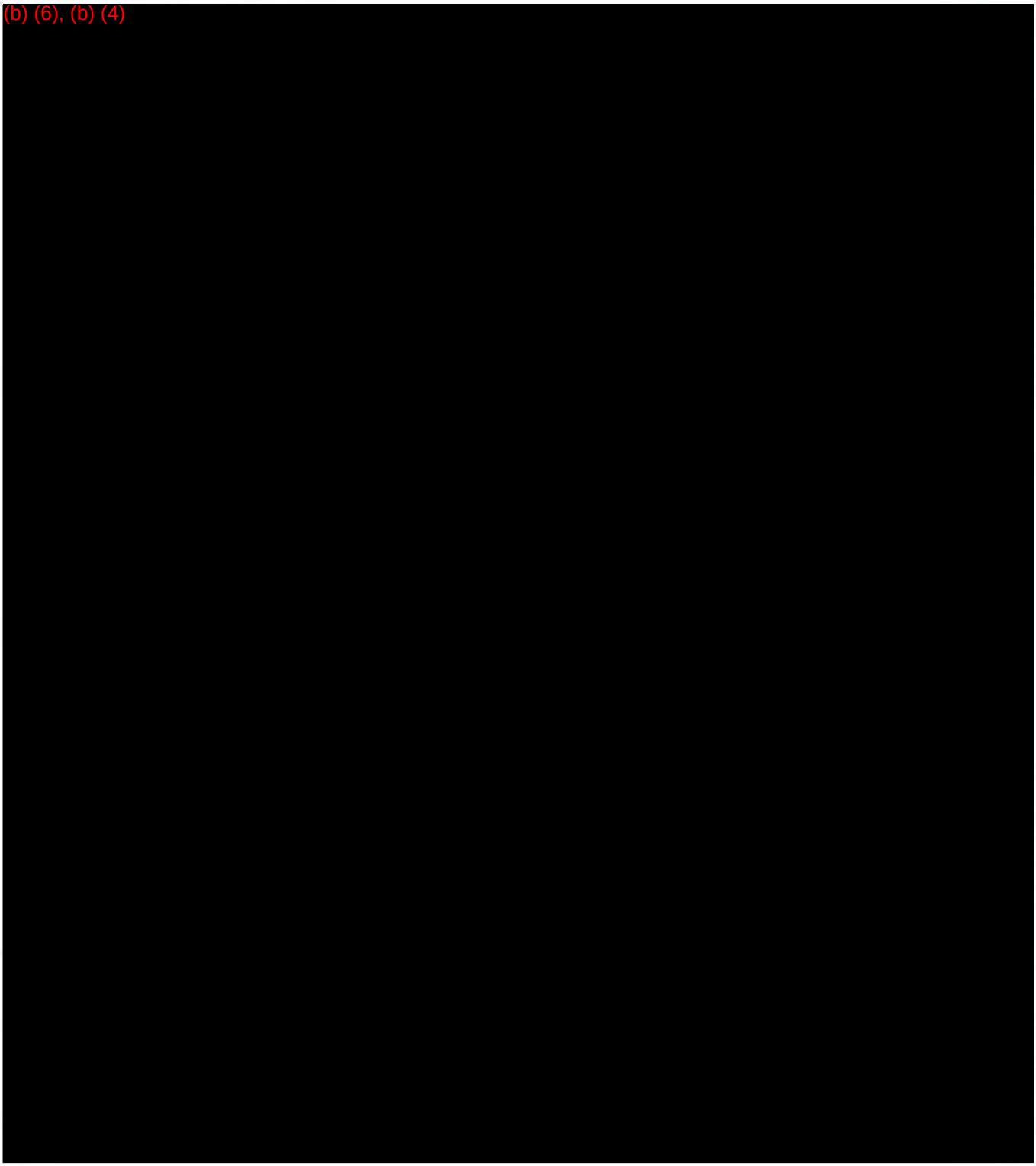

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II. General and Background Information

A. Tenant-Operator and Third-party Operators - General Information

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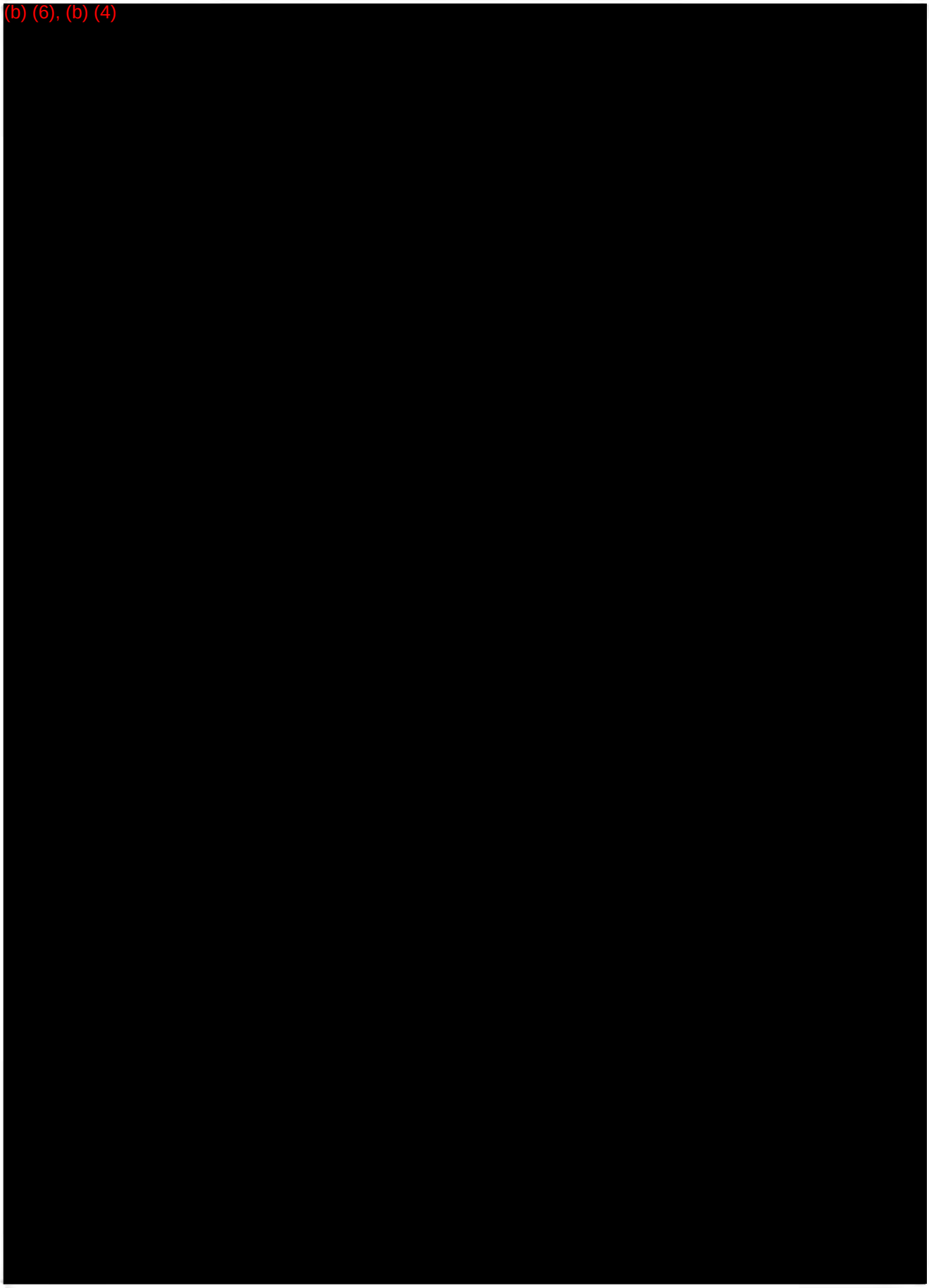

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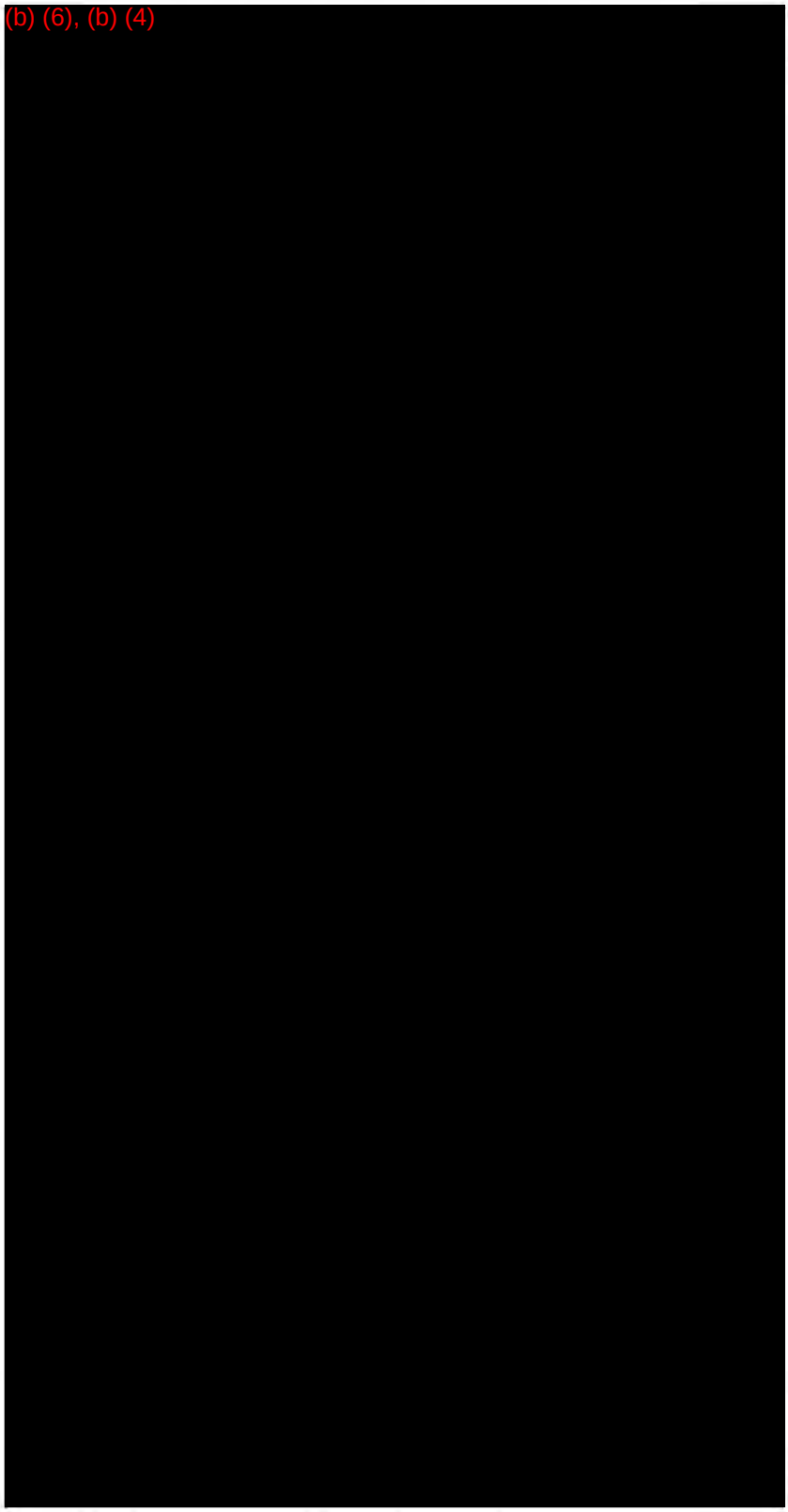

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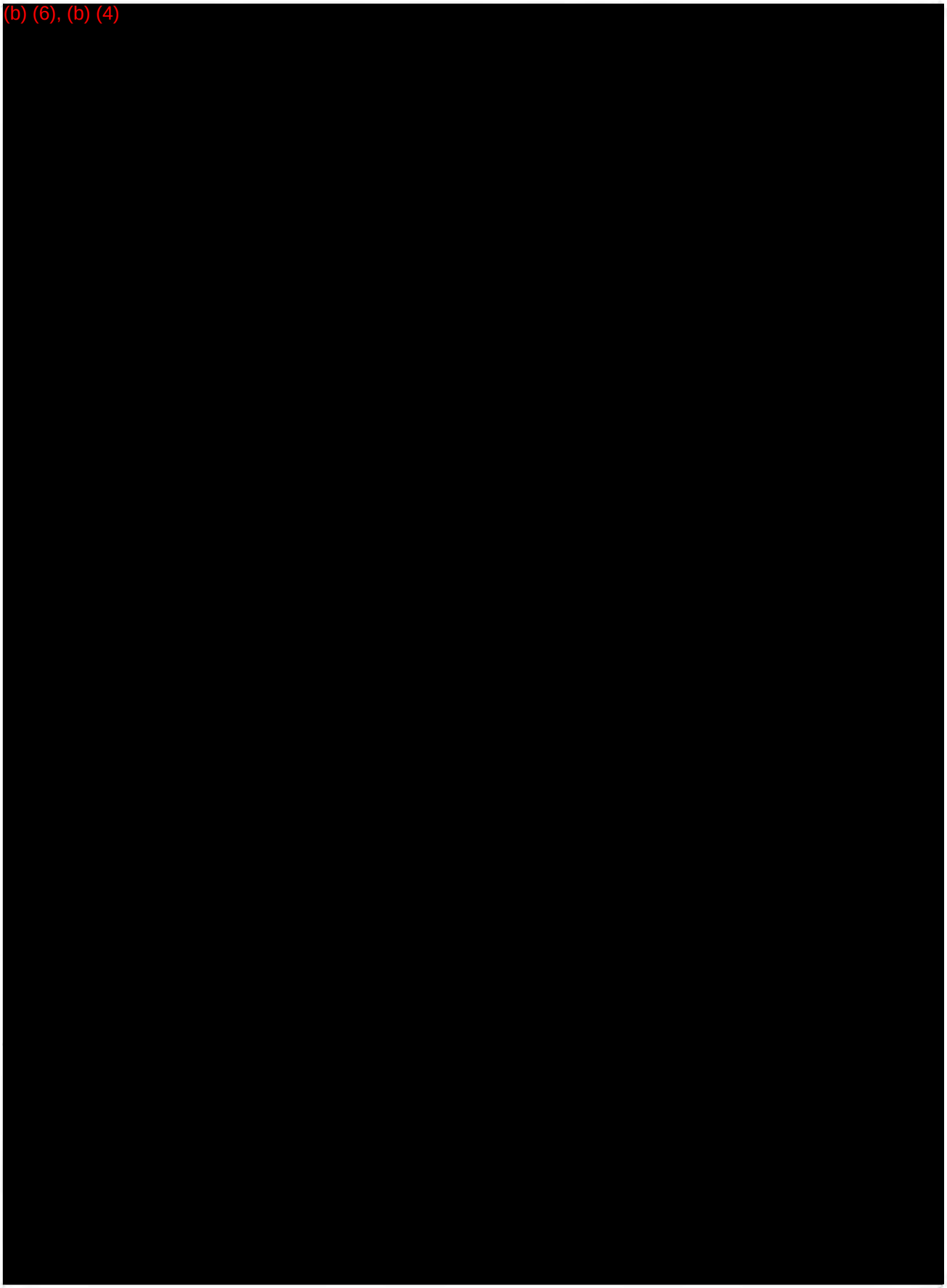

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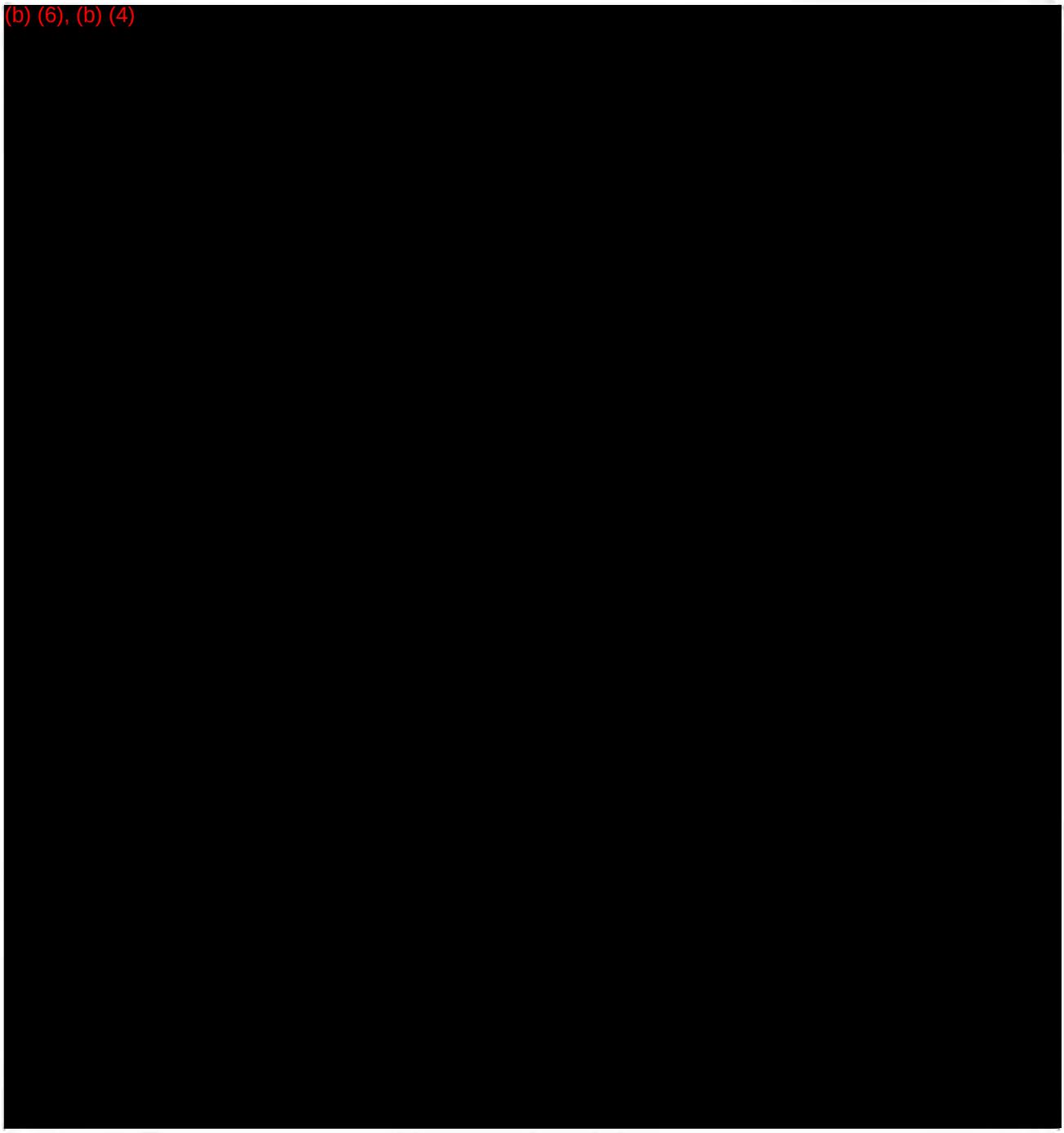

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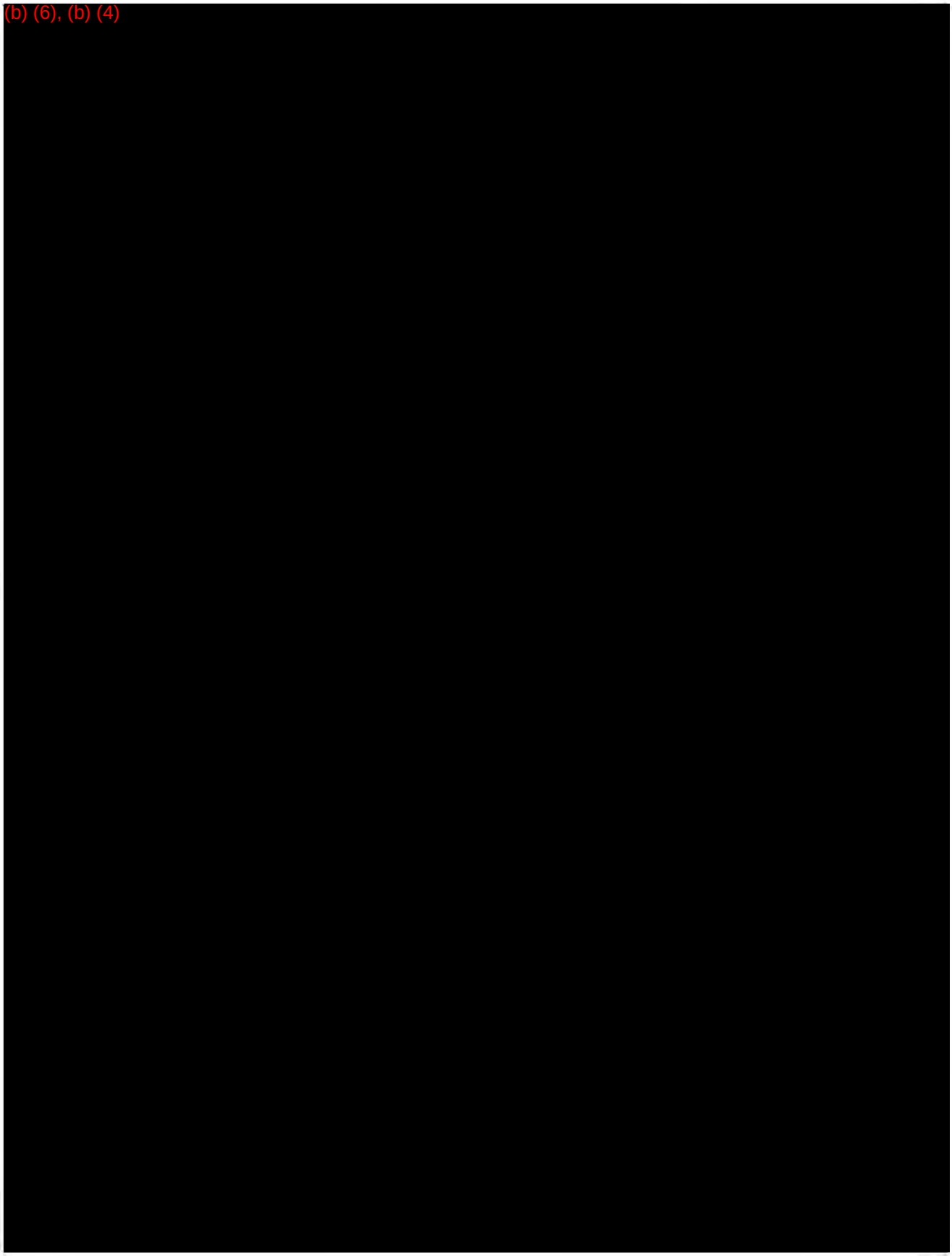

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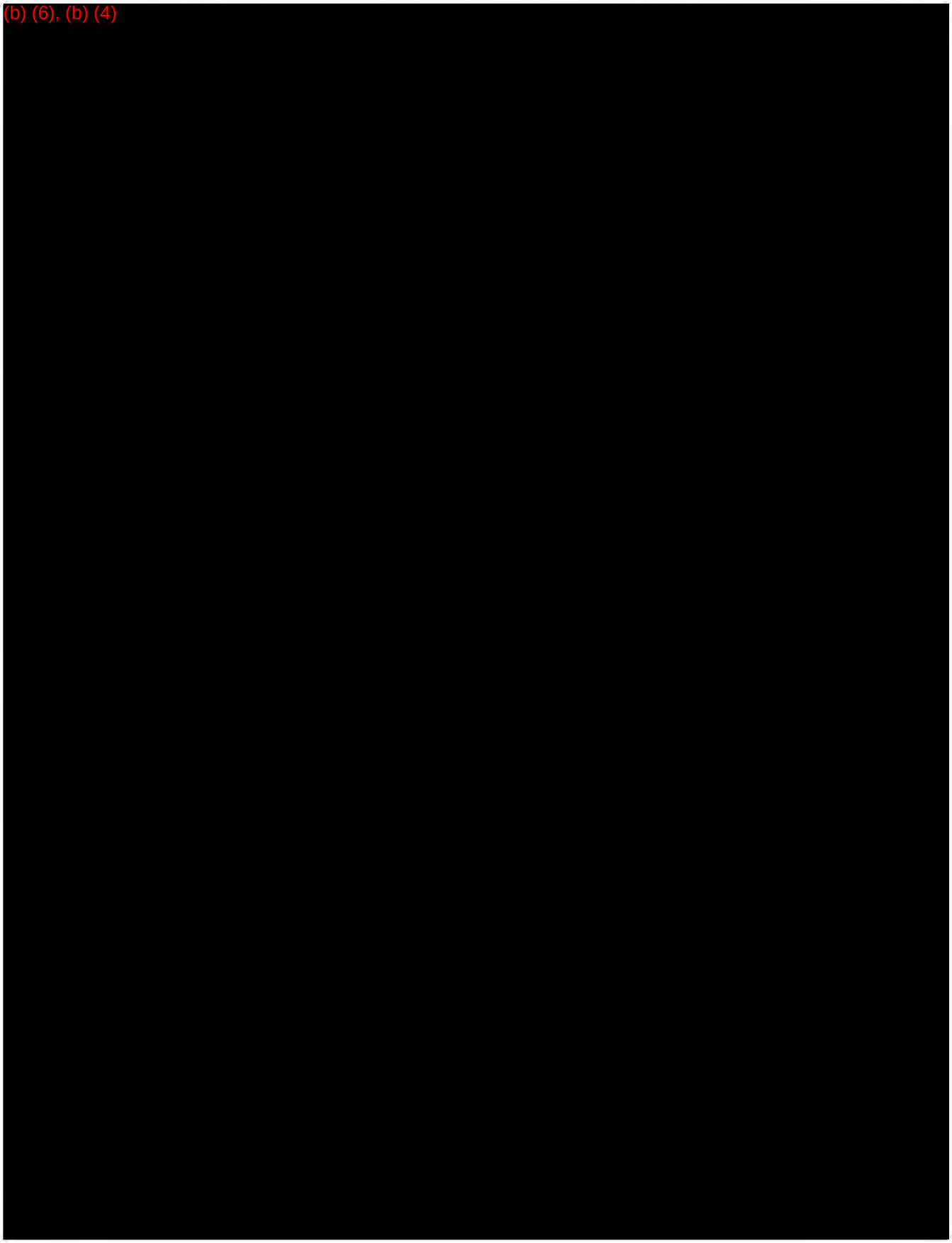

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III. Technical Criteria

A. Proposed Operations

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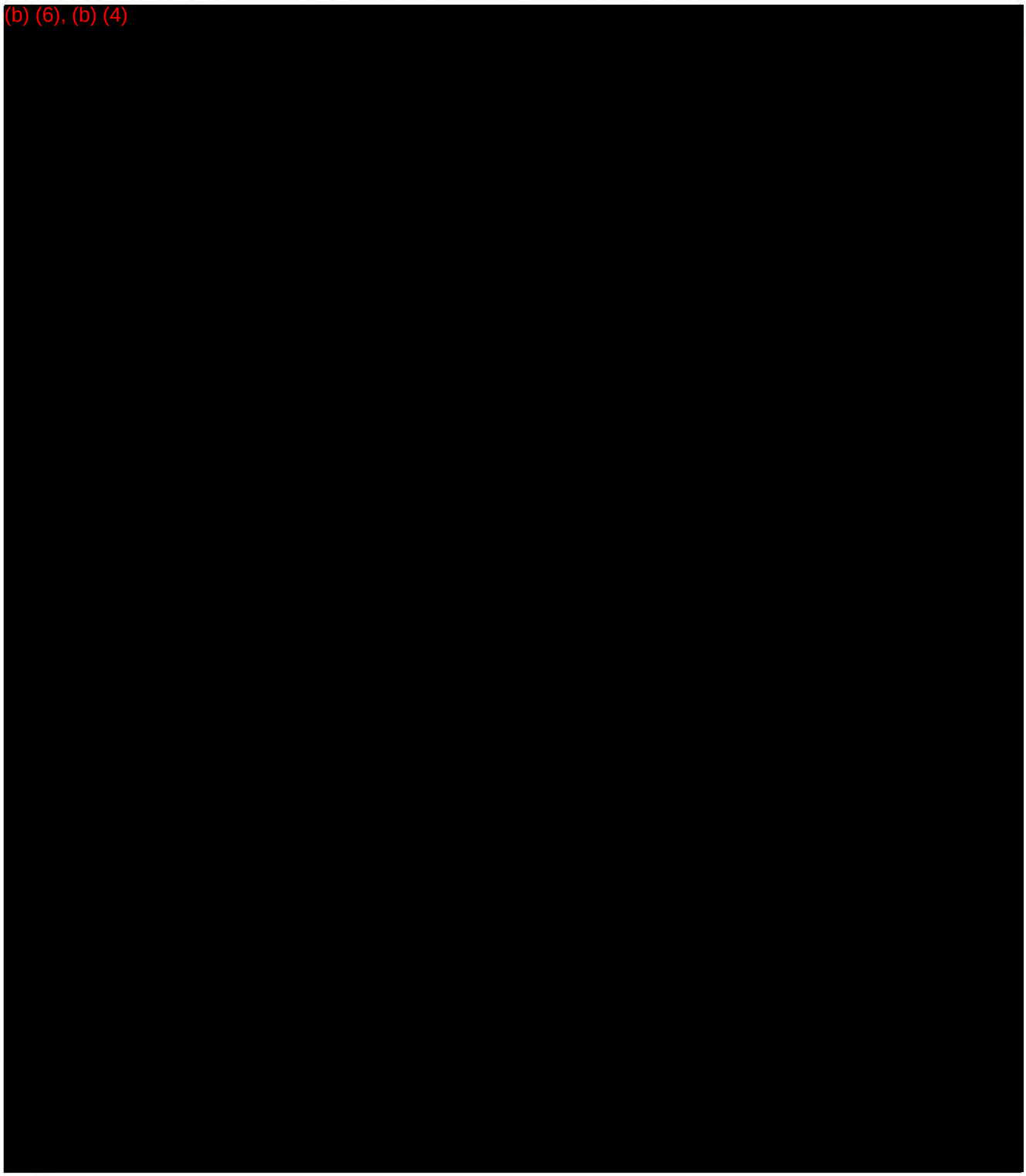

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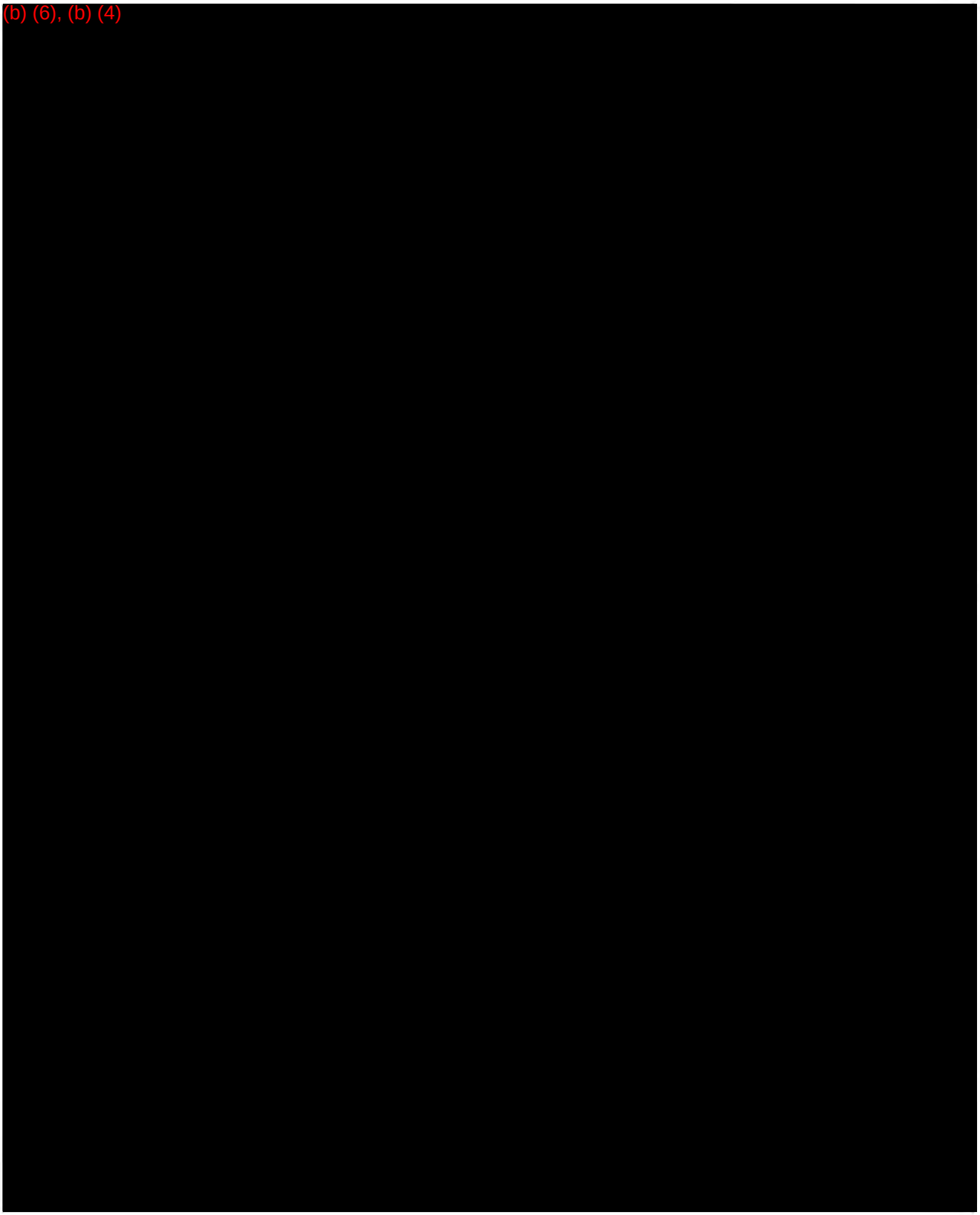

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B. Transaction Structure, Operating and Financial Commitments

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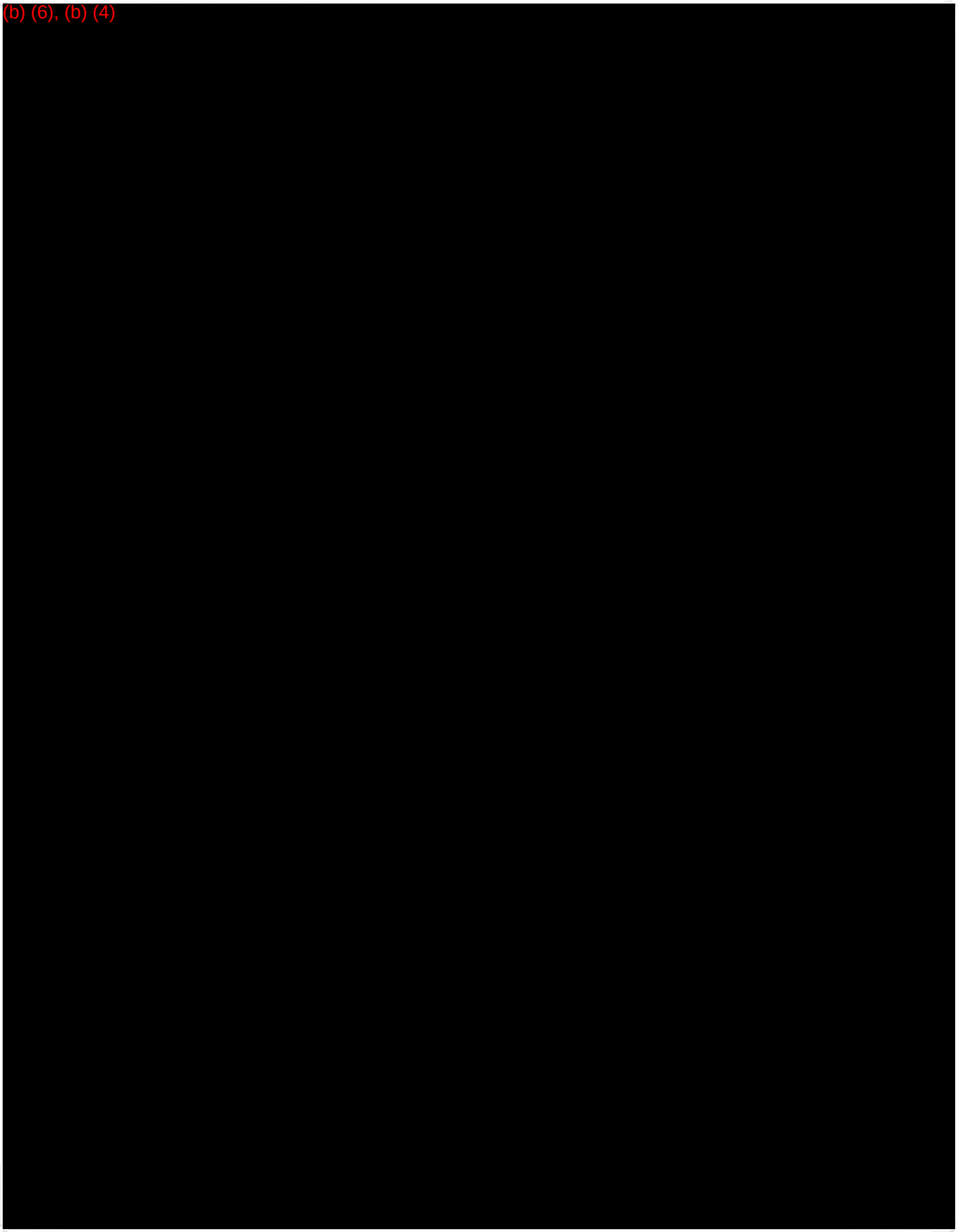

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C. OTHER TRANSACTION CONSIDERATIONS

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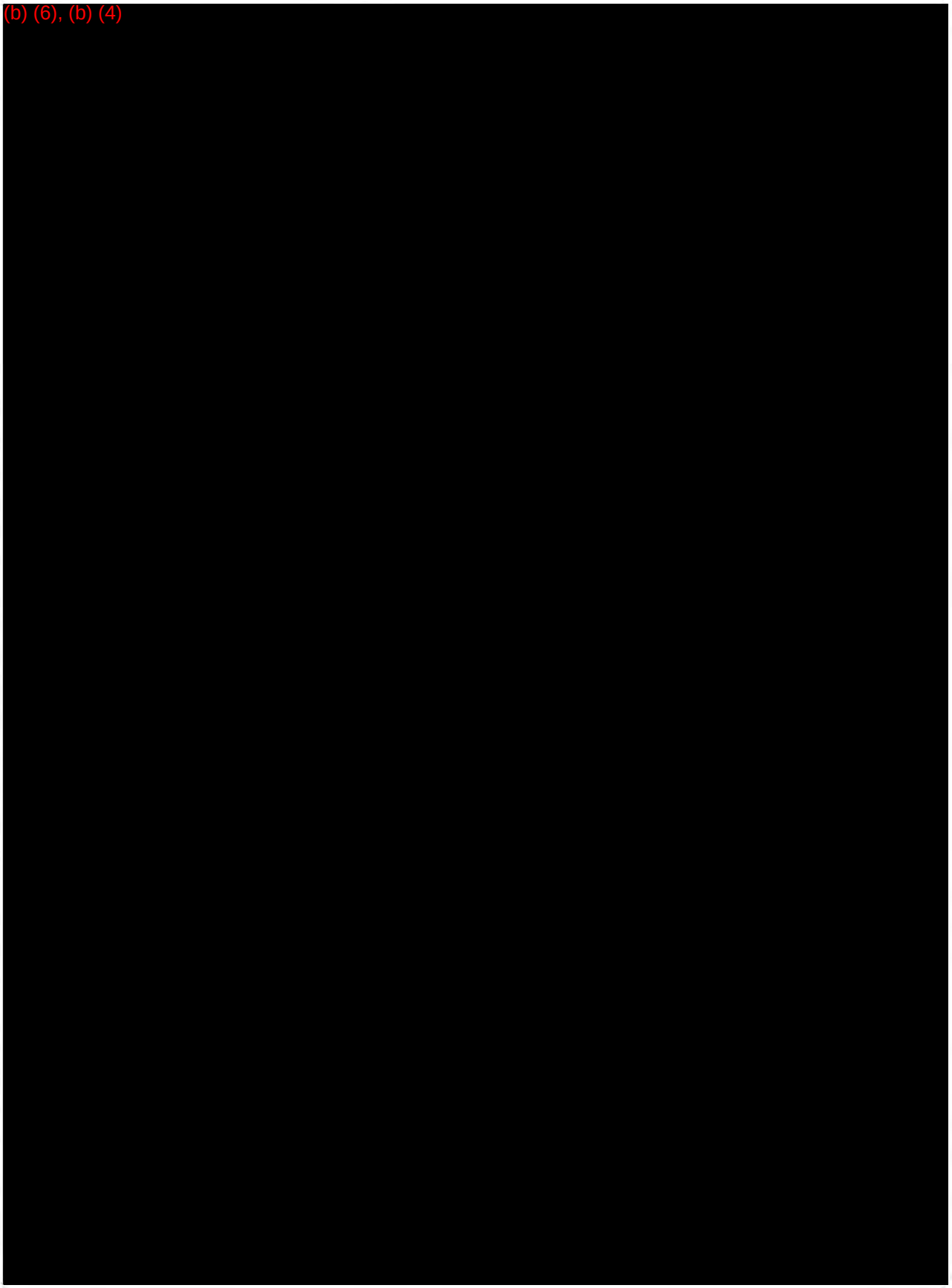

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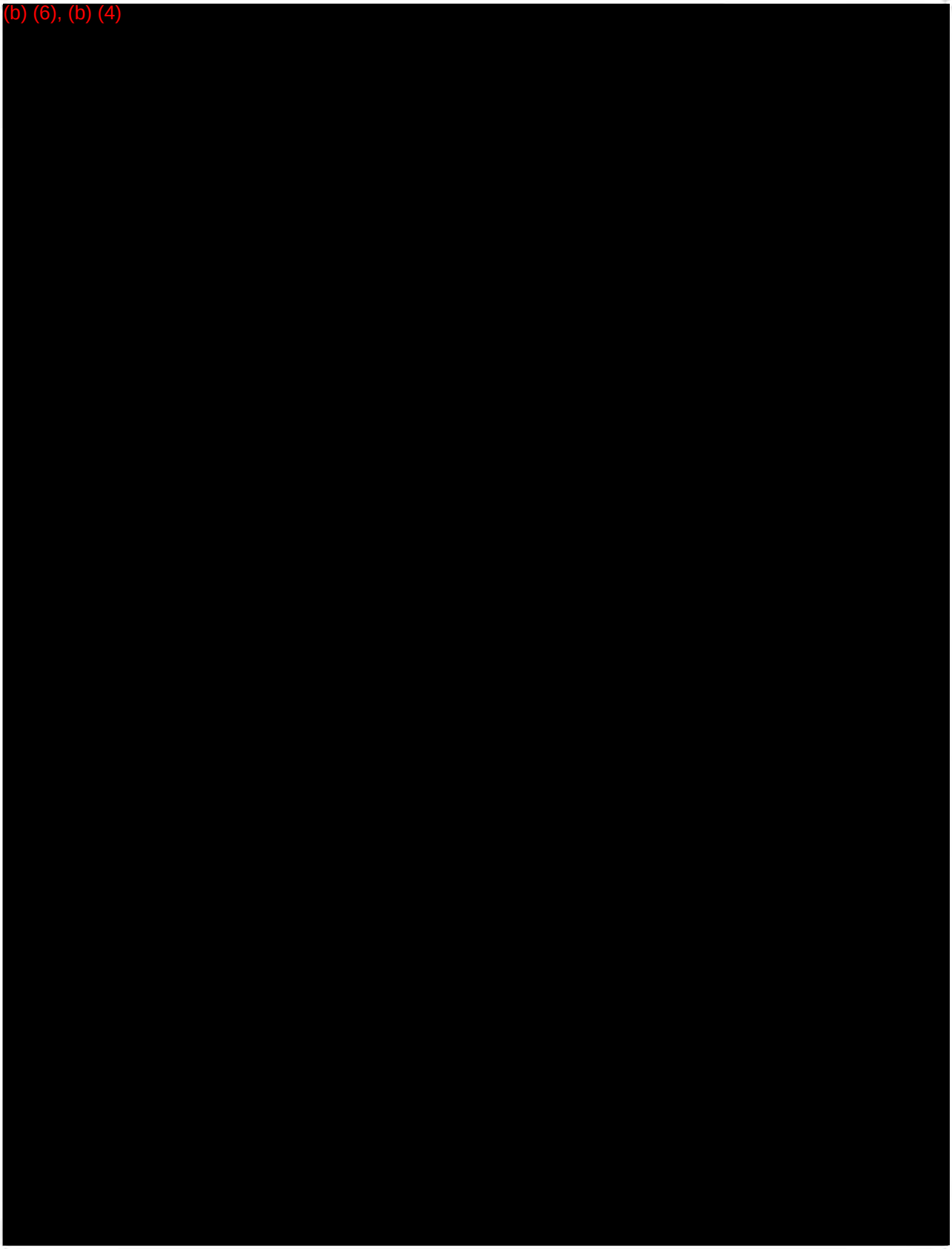

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IV. Required Disclosures

A. Mandatory EEO/Affirmative Action Evidence

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B. Non-Discrimination Affirmation

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[redacted]

C. Disclosure Statement

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[redacted]

D. Statement of Corporate Ownership

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(b) (6), (b) (4)

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E. "Pay To Play" Notice of Disclosure Requirement

(b) (6), (b) (4)

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F. Authority to Audit or Review Contract Records

(b) (6), (b) (4)

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G. Disclosure of Investment Activity in Iran

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V. Other RFP Conditions

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APPENDICES

AMERICAN OVERSIGHT
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APPENDIX A – WINDSOR HEALTHCARE QUALITY AND PATIENT SATISFACTION METRICS

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VA-19-0799-J-001135

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Medicare.gov | Nursing Home Compare

The Official U.S. Government Site for Medicare

General information

	BUCKINGHAM AT NORWOOD, THE	BERGEN REGIONAL MEDICAL CENTER
	Overall rating: 5 out of 5 stars **Much Above Average** 100 MCCLELLAN STREET NORWOOD, NJ 07648 (201) 768-6222 **Distance**: 0.8 miles	**Overall rating**: 2 out of 5 stars **Below Average** 230 E RIDGEWOOD AVE PARAMUS, NJ 07652 (201) 967-[illegible]00 **Distance**: 7.5 miles
Health inspection	5 out of 5 stars **Much Above Average**	2 out of 5 stars **Below Average**
Staffing	3 out of 5 stars **Average**	3 out of 5 stars **Average**
Quality measures	5 out of 5 stars **Much Above Average**	4 out of 5 stars **Above Average**
Health inspections summary	Health Inspections Summary	Health Inspections Summary
Number of certified beds	240	574

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VA-19-0799-J-001136
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Participation: (Medicare/Medicaid)	Medicare and Medicaid	Medicare and Medicaid
Automatic sprinkler systems: in all required areas	Yes	Yes
Within a Continuing Care Retirement Community (CCRC)	No	No
Within a hospital	No	Yes
With a resident and family council	RESIDENT	BOTH
Ownership	For profit - Individual Get More Ownership Information	Government - County Get More Ownership Information

Health & fire safety inspections

	BUCKINGHAM AT NORWOOD, THE	BERGEN REGIONAL MEDICAL CENTER
	Overall rating: 5 out of 5 stars **Much Above Average**	**Overall rating**: 2 out of 5 stars **Below Average**
	100 MCCLELLAN STREET NORWOOD, NJ 07648 (201) 768-6222	230 E RIDGEWOOD AVE PARAMUS, NJ 07652 (201) 967-4000
	Distance: 0.8 miles	**Distance**: 7.5 miles
Health inspection	5 out of 5 stars	2 out of 5 stars

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AMERICAN OVERSIGHT

VA-19-0799-J-001137

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Health inspection	Much Above Average	Below Average
Total number of health deficiencies for this nursing home	1	3
Average number of health deficiencies in New Jersey		
Date of last standard health inspection	06/09/2016	04/26/2016
Health inspection details	Health inspection details	Health inspection details
Number of complaints	1	5
Number of facility-reported incidents	0	0
Fire safety deficiencies		
Total number of fire deficiencies for this nursing home	0	0
Date of last standard fire inspection	06/09/2016	04/19/2016
Range of fire safety deficiencies in New Jersey		
Fire safety inspection details	Fire safety inspection details	Fire safety inspection details

Staffing

	BUCKINGHAM AT NORWOOD, THE	BERGEN REGIONAL MEDICAL CENTER

AMERICAN OVERSIGHT
VA-19-0799-J-001138
DS_00008767

		Overall rating ⓘ: 5 out of 5 stars **Much Above Average** 100 MCCLELLAN STREET NORWOOD, NJ 07648 (201) 768-6222 **Distance** ⓘ: 0.8 miles	**Overall rating** ⓘ: 2 out of 5 stars **Below Average** 230 E RIDGEWOOD AVE PARAMUS, NJ 07652 (201) 967-4000 **Distance** ⓘ: 7.5 miles
Staffing ⓘ		3 out of 5 stars **Average**	3 out of 5 stars **Average**
RN staff only ⓘ		4 out of 5 stars **Above Average**	4 out of 5 stars **Above Average**

	BUCKINGHAM AT NORWOOD, THE	BERGEN REGIONAL MEDICAL CENTER	NEW JERSEY AVERAGE	NATIONAL AVERAGE
Total number of residents	209	560	121.6	86.1
Total number of licensed nurse staff hours per resident per day	1 hour and 37 minutes	1 hour and 12 minutes	1 hour and 49 minutes	1 hour and 41 minutes
RN hours per resident per day	53 minutes	48 minutes	1 hour and 2 minutes	50 minutes
LPN/LVN hours per resident per day	45 minutes	25 minutes	47 minutes	51 minutes
CNA hours per resident per day	2 hours and 20 minutes	2 hours and 18 minutes	2 hours and 16 minutes	2 hours and 28 minutes
Physical therapy staff hours per resident per day	8 minutes	2 minutes	10 minutes	6 minutes

How to read staffing charts | About staff roles

Quality measures

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VA-19-0799-J-001139

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	BUCKINGHAM AT NORWOOD, THE	BERGEN REGIONAL MEDICAL CENTER
	Overall rating: 5 out of 5 stars **Much Above Average** 100 MCCLELLAN STREET NORWOOD, NJ 07648 (201) 768-6222 **Distance**: 0.8 miles	**Overall rating**: 2 out of 5 stars **Below Average** 230 E RIDGEWOOD AVE PARAMUS, NJ 07652 (201) 967-4000 **Distance**: 7.5 miles
Quality measures	5 out of 5 stars **Much Above Average**	4 out of 5 stars **Above Average**

Short-stay residents

Find out why these measures are important.

Get more information about the data.

Get the current data collection period.

	BUCKINGHAM AT NORWOOD, THE	BERGEN REGIONAL MEDICAL CENTER	NEW JERSEY AVERAGE	NATIONAL AVERAGE

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VA-19-0799-J-001140
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NEW **Percentage of short-stay residents who made improvements in function.** *Higher percentages are better.*	76.9%	65.7%	64.3%	63.3%
NEW **Percentage of short-stay residents who were re-hospitalized after a nursing home admission.** *Lower percentages are better.*	20.1%	19.5%	23.2%	22.6%
NEW **Percentage of short-stay residents who have had an outpatient emergency department visit.** *Lower percentages are better.*	7.6%	6.6%	9.8%	12.1%
NEW **Percentage of short-stay residents who were successfully discharged to the community.** *Higher percentages are better.*	58.4%	55.2%	58.1%	56.9%
Percentage of short-stay residents who self-report moderate to severe pain. *Lower percentages are better.*	8.4%	12.2%	9.4%	16.4%
Percentage of short-stay residents with pressure ulcers that are new or worsened. *Lower percentages are better.*	0.4%	1.1%	1.1%	1.2%
Percentage of short-stay residents assessed and given, appropriately, the seasonal influenza vaccine.	92.3%	76.1%	85.9%	80.0%

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VA-19-0799-J-001141
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***Higher** percentages are better.*				
Percentage of short-stay residents assessed and given, appropriately, the pneumococcal vaccine. ***Higher** percentages are better.*	99.4%	75.4%	87.2%	81.5%
Percentage of short-stay residents who newly received an antipsychotic medication. ***Lower** percentages are better.*	0.4%	3.9%	1.5%	2.1%

Long-stay residents

Find out why these measures are important.

Get more information about the data.

Get the current data collection period.

	BUCKINGHAM AT NORWOOD, THE	BERGEN REGIONAL MEDICAL CENTER	NEW JERSEY AVERAGE	NATIONAL AVERAGE
Percentage of long-stay residents experiencing one or more falls with major injury. ***Lower** percentages are better.*	4.3%	3.4%	2.4%	3.3%
Percentage of long-stay residents with a	2.1%	2.2%	3.1%	4.6%

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urinary tract infection. *Lower percentages are better.*				
Percentage of long-stay residents who self-report moderate to severe pain. *Lower percentages are better.*	1.3%	6.9%	3.3%	7.8%
Percentage of long-stay high-risk residents with pressure ulcers. *Lower percentages are better.*	4.4%	7.9%	6.5%	5.7%
Percentage of long-stay low-risk residents who lose control of their bowels or bladder. *Lower percentages are better.*	6.5%	32.9%	39.5%	46.8%
Percentage of long-stay residents who have/had a catheter inserted and left in their bladder. *Lower percentages are better.*	2.8%	1.5%	2.3%	2.8%
Percentage of long-stay residents who were physically restrained. *Lower percentages are better.*	0.0%	0.7%	1.0%	0.7%
NEW **Percentage of long-stay residents whose ability to move independently worsened.** *Lower percentages are better.*	8.9%	13.0%	15.1%	18.2%
Percentage of long-stay residents whose need for help with daily activities has increased. *Lower percentages are better.*	6.9%	10.8%	12.4%	15.3%
Percentage of long-stay residents who	7.1%	6.8%	6.9%	7.1%

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VA-19-0799-J-001143
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lose too much weight. *Lower percentages are better.*				
Percentage of long-stay residents who have depressive symptoms. *Lower percentages are better.*	1.1%	0.3%	2.7%	5.4%
Percentage of long-stay residents who received an antianxiety or hypnotic medication. *Lower percentages are better.*	8.7%	34.9%	21.4%	23.5%
Percentage of long-stay residents assessed and given, appropriately, the seasonal influenza vaccine. *Higher percentages are better.*	99.2%	97.0%	96.1%	94.5%
Percentage of long-stay residents assessed and given, appropriately, the pneumococcal vaccine. *Higher percentages are better.*	99.9%	98.5%	95.2%	93.4%
Percentage of long-stay residents who received an antipsychotic medication. *Lower percentages are better.*	0.6%	15.3%	12.6%	16.9%

Penalties

	BUCKINGHAM AT NORWOOD, THE	BERGEN REGIONAL MEDICAL CENTER
	Overall rating: 5 out of 5 stars **Much Above**	**Overall rating**: 2 out of 5 stars

AMERICAN OVERSIGHT
84
VA-19-0799-J-001144
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	Average 100 MCCLELLAN STREET NORWOOD, NJ 07648 (201) 768-6222 **Distance**: 0.8 miles	**Below Average** 230 E RIDGEWOOD AVE PARAMUS, NJ 07652 (201) 967-4000 **Distance**: 7.5 miles
Federal fines in the last 3 years	0	0
Federal payment denials in the last 3 years	0	0

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BENCHMARK CORE Q SCORE = 84%

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VA-19-0799-J-001146

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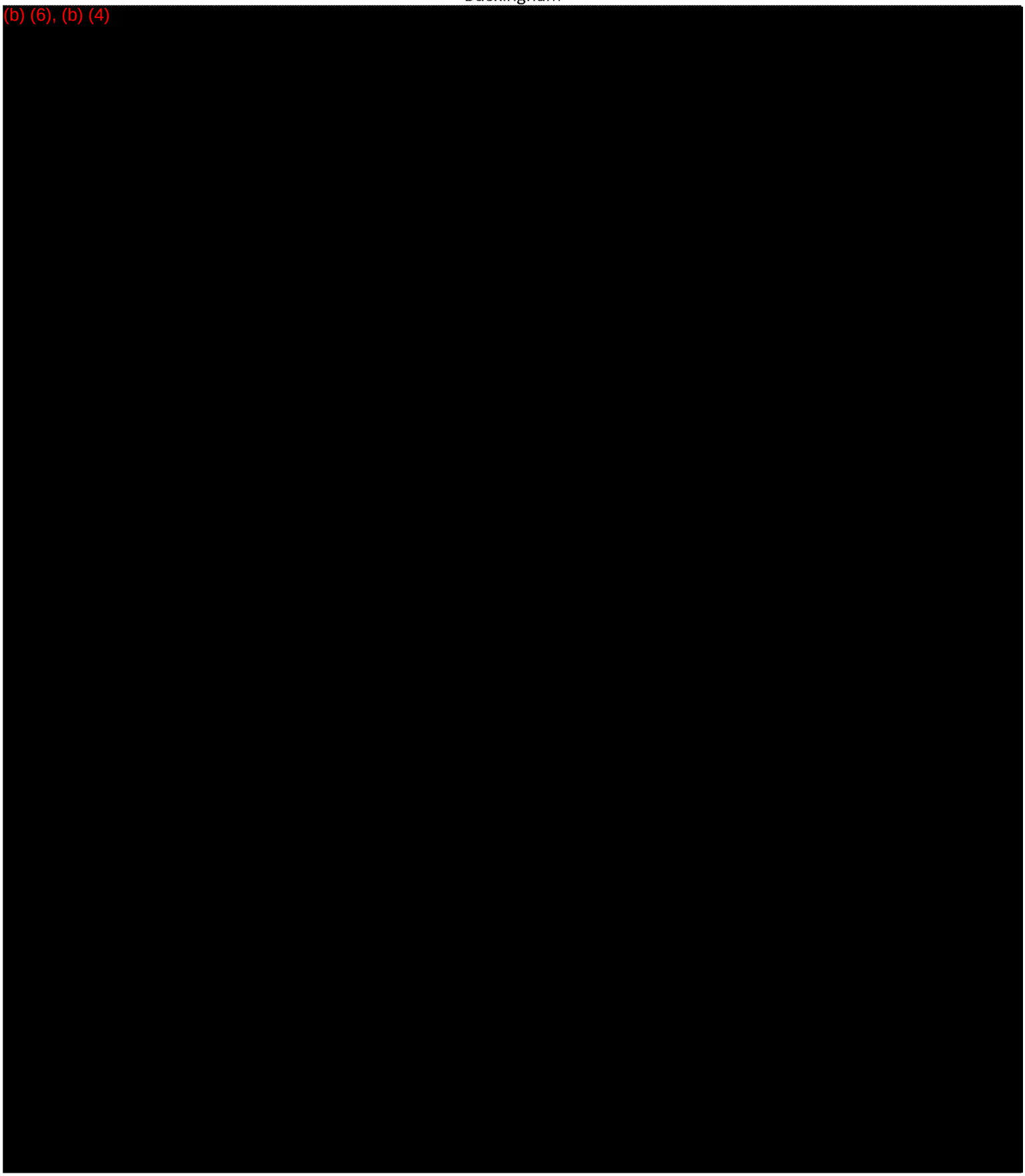

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APPENDIX B – DRAFT TRANSITION CHECKLIST

GENERAL ACTIVITIES FOR TRANSITION

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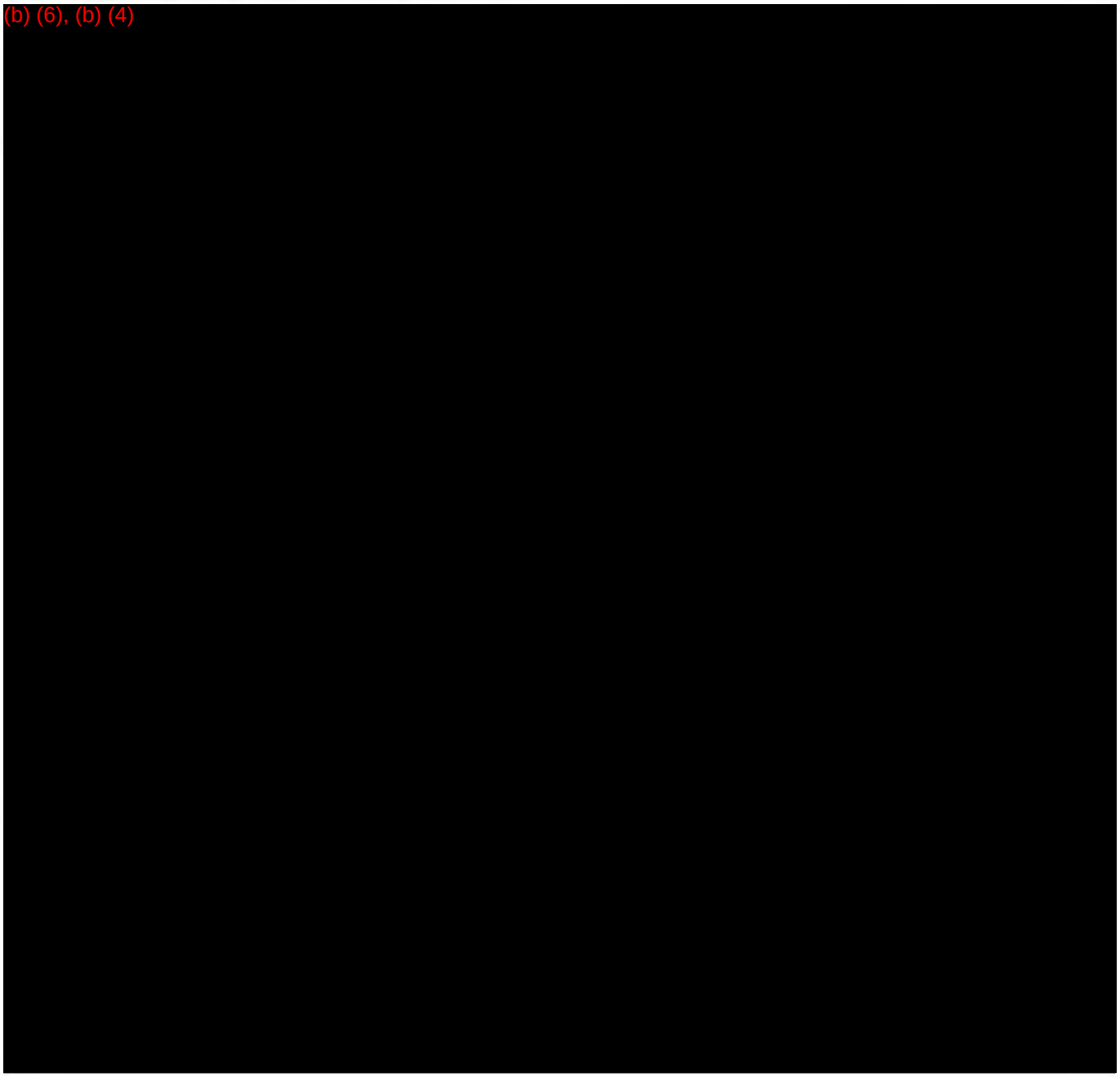

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VA-19-0799-J-001149

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COMMUNICATIONS

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AMERICAN OVERSIGHT

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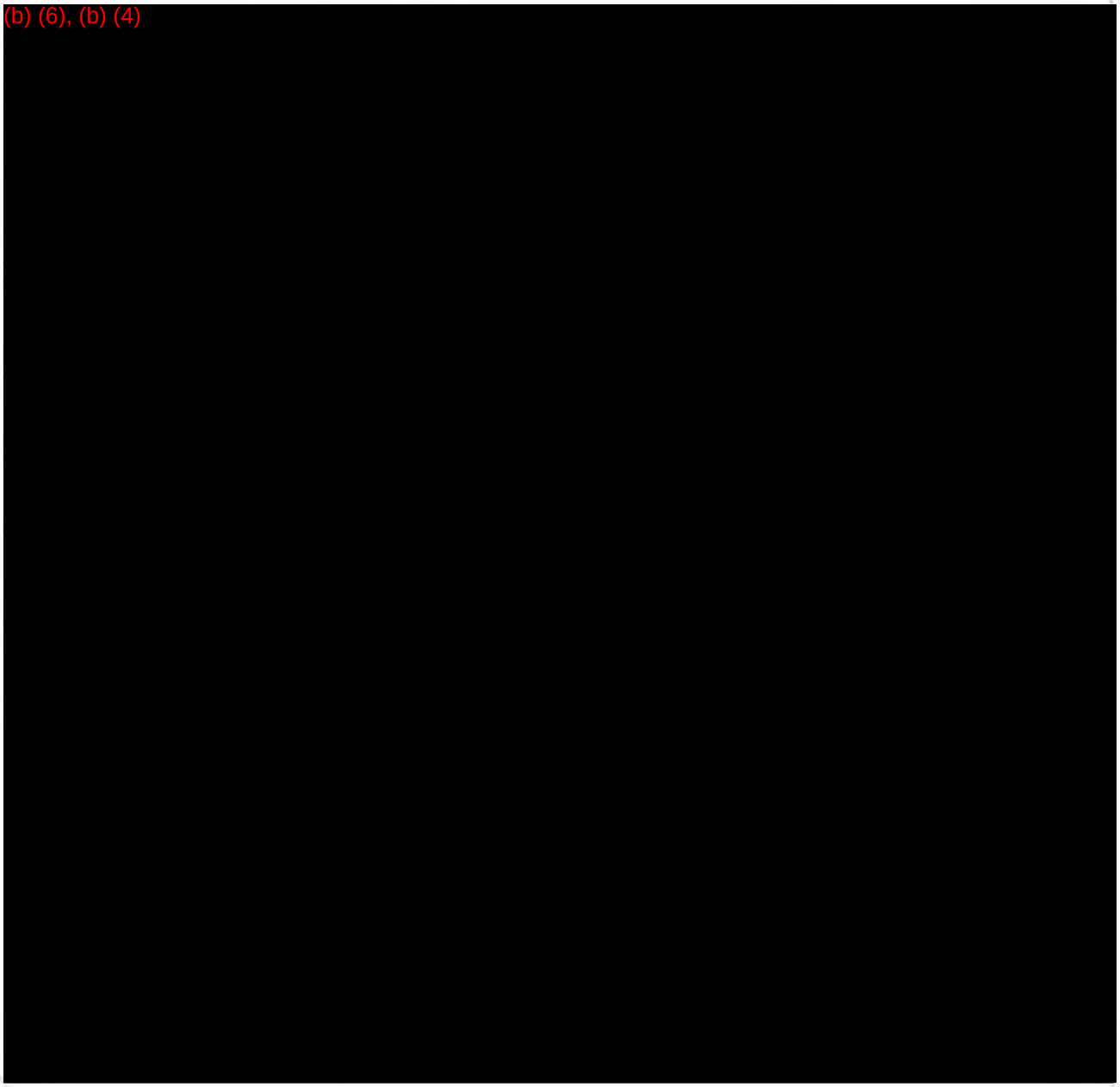

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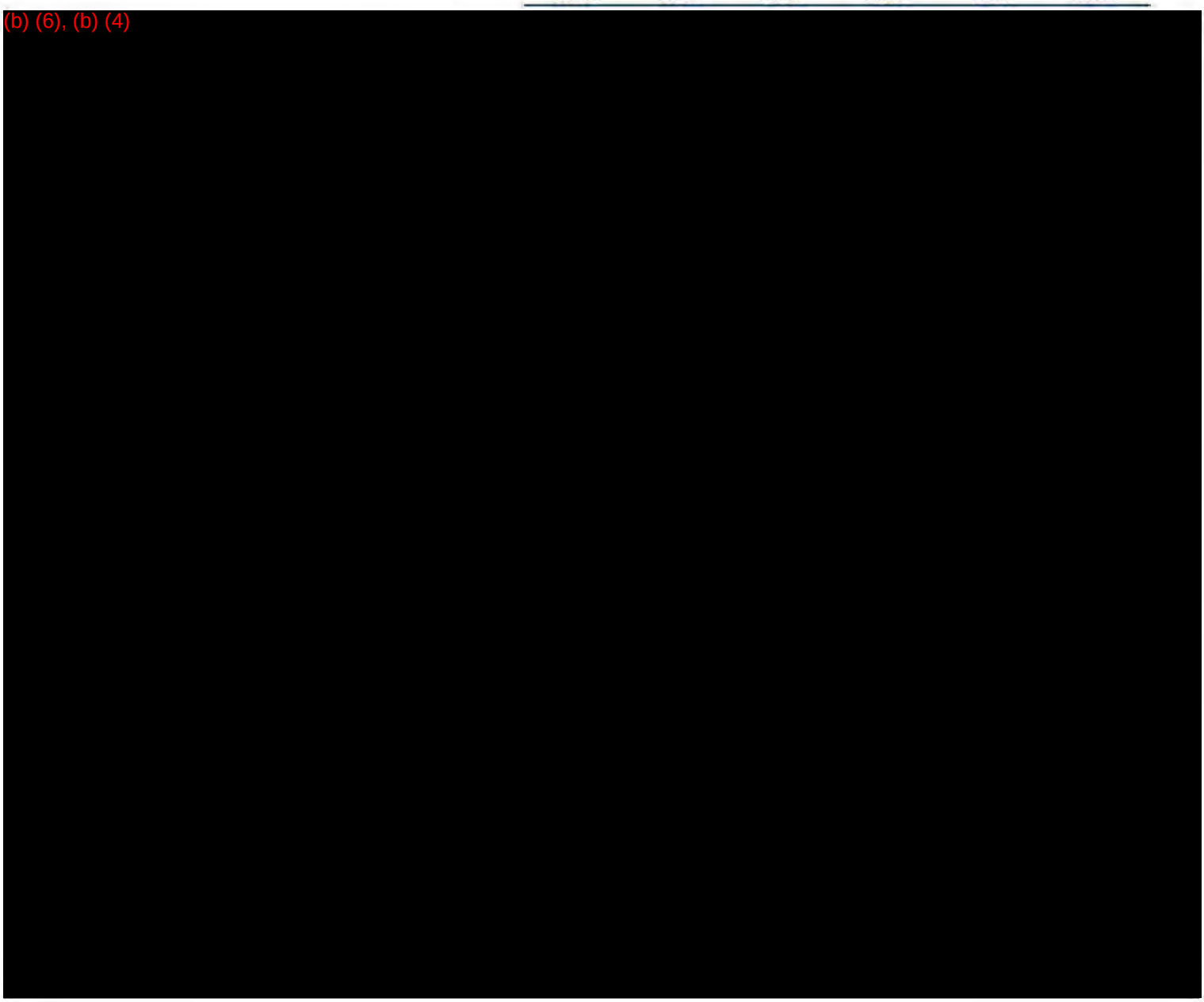
APPENDIX C – DETAILED FINANCIAL PROJECTIONS

Summary Financial Projections					
9 Months Ending Dec 2017E	2018E	2019E	2020E	2021E	2022E

(b) (6), (b) (4)



AMERICAN OVERSIGHT

VA-19-0799-J-001153

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Annual Income Statement					
9 Months Ending Dec 2017E	2018E	2019E	2020E	2021E	2022E
(b) (6), (b) (4)					

AMERICAN OVERSIGHT
VA-19-0799-J-001154
DS_00008783

	Annual Balance Sheet					
	2017E	2018E	2019E	2020E	2021E	2022E
(b) (6), (b) (4)						

AMERICAN OVERSIGHT

Annual Statement of Cash Flows					
9 Months Ending Dec 2017E	2018E	2019E	2020E	2021E	2022E

(b) (6), (b) (4)

[redacted]

AMERICAN OVERSIGHT

VA-19-0799-J-001156

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RFP EXHIBITS

AMERICAN OVERSIGHT

EXHIBIT 5 – DISCLOSURE STATEMENT

AMERICAN OVERSIGHT
VA-19-0799-J-001158
DS_00008787

DISCLOSURE STATEMENT

The attention of Respondents are drawn to the provisions of the Local Government Ethics Law (N.J.S.A. 40A:9-22-1, et seq.) which prohibits a County Officer or employee or member of his/her immediate family from having an interest in a business organization or engaging in any business transaction, or professional activity which is in substantial conflict with the proper discharge of his duties in the public interest.

In furtherance thereof, please list any individuals (or all immediate relatives of such individuals) who is an officer, a Board member of Respondent, or has an interest in Respondent who are Bergen County or BCIA employees or elected officials of Bergen County. For purposes of the above, "immediate relative" means a spouse, parent, stepparent, brother, sister, child, stepchild, direct-line aunt or uncle, grandparent, grandchild, and in-laws by reason of relation. If there are none, please mark the line below affirmatively.

None XXXXX

If there are any such individuals that meet the aforementioned criteria, provide the name of the individual and identify the position held at Bergen County (employee or elected official) or the BCIA

Name _____ Position Held _____

Name _____ Position Held _____

Name _____ Position Held _____

(b) (6) [redacted] 11/30/16

S[redacted]

President, Vice President or Signature of Authorized Representative

(b) (6) [redacted] M.D.

Print Name

President and Chief Operating Officer

Title

NOTE: All terms used herein are to be construed in accordance with their meaning under the Local Government Ethics Law, cited above.

AMERICAN OVERSIGHT
VA-19-0799-J-001159
DS 00008788

EXHIBIT 6 – STOCKHOLDER DISCLOSURE CERTIFICATION

AMERICAN OVERSIGHT
VA-19-0799-J-001160
DS_00008789

Exhibit 6

STOCKHOLDER DISCLOSURE CERTIFICATION

To be completed by Respondents and submitted as part of the RFP Response
Respondents must continue to disclose stockholders to the extent which individuals are identified. For example, if XYZ company is owned 100% by ABC company, the Respondent must identify ABC company and so on until all individuals are identified who own 10% or more.

Legal Name: _____

☒ I certify that the list below contains the names and home addresses of all stockholders holding 10% or more of the issued and outstanding stock of the undersigned.

OR

☐ I certify that no one stockholder owns 10% or more of the issued and outstanding stock of the undersigned.

Check the box that represents the type of business organization:

☐ Partnership ☒ Corporation ☐ Sole Proprietorship

☐ Limited Partnership ☐ Limited Liability Corporation ☐ Limited Liability Partnership

☐ Subchapter S Corporation ☐ Other, Please List_____

Sign and notarize the form on the subsequent page, and, if necessary, complete the stockholder list below.

AMERICAN OVERSIGHT

VA-19-0799-J-001161

DS_00008790

Exhibit 6 (continued)

Stockholders:

Name: (b) (6) M.D.

Home Address: (b) (6)

(b) (6)

Name: (b) (6)

Home Address: (b) (6)

(b) (6)

Name: Poonam Alaigh, M.D.

Home Address: (b) (6)

(b) (6)

Name: (b) (6) M.D.

Home Address: (b) (6)

(b) (6)

(b) (6)

(b) (6)

Subscribed and sworn before me this 30th **day of** November, 2016

(Notary Public)

My Commission expires: 6-3-18

MICALE BIANCA BAPTISTE
Notary Public
State of New Jersey
My Commission Expires June 3, 2018
I.D.# 2434719

M.D.

President

(Corporate Seal)

AMERICAN OVERSIGHT

VA-19-0799-J-001162

DS_00008791

EXHIBIT 7 – DIRECT FINANCIAL DISCLOSURE OF CAMPAIGN CONTRIBUTIONS

AMERICAN OVERSIGHT

VA-19-0799-J-001163

DS_00008792

Exhibit 7

To be completed by Respondents and submitted as part of the RFP Response

County of Bergen
"Sunshine Form" for Disclosure of Political Contributions
***Please fill out and attach to each resolution**
DIRECT FINANCIAL DISCLOSURE OF CAMPAIGN CONTRIBUTIONS

(A) VENDOR NAME or SPECIAL COUNSEL NAME Bergen Safety Net, Inc.

VENDOR ADDRESS or SPECIAL COUNSEL ADDRESS 10-14 Saddle River Road
Suite 200, Fairlawn, New Jersey 07410

VENDOR TELEPHONE NUMBER (201) 794-3256 FAX # (___) ___-____

VENDOR REPRESENTATIVE [redacted]

VENDOR EMAIL ADDRESS [redacted]

VENDOR REPRESENTATIVE [redacted]

(B) THE NAME OF THE PARTNERS OR SHAREHOLDERS OR, IF A PUBLIC CORPORATION, THE NAME OF THE CORPORATE OFFICERS AND DIRECTORS AS FOUND ON THE 10K OR 10Q FORMS REQUIRED TO BE FILED WITH THE FEDERAL SECURITIES AND EXCHANGE COMMISSION

[redacted] Poonam Alaigh, M.D.,

[redacted]

(C) CAMPAIGN CONTRIBUTIONS MADE, BY ANY INDIVIDUAL(S) AND/OR BUSINESS ENTITY LISTED IN (A) OR (B) (ABOVE) DURING THE PRIOR AND CURRENT CALENDAR YEAR TO THE FOLLOWING NAMED ELECTED OFFICIALS AND CONSTITUTIONAL OFFICERS:

(D) ● No contributions (sign directly below and return, nothing else required except signature/date this page only).

Signature: [redacted] 30/16

Print your [redacted]

OFFICIAL POSITION/ NAME (* Denotes Incumbent)

COUNTY EXECUTIVE [redacted]
SHERIFF
SHERIFF
SURROGATE
SURROGATE
COUNTY CLERK
COUNTY CLERK

[1] This form shall be updated periodically to reflect new elected officials and candidates for office. However, it shall maintain the format and required disclosures contained herein. 06/28/2016

AMERICAN OVERSIGHT

VA-19-0799-J-001164

DS_00008793

Exhibit 7 (continued)

FREEHOLDERS:

(b) (6), (b) (4)

COUNTY POLITICAL PARTY COMMITTEE (Within Bergen County, Organization as listed below or its successor)

(b) (6), (b) (4)

MUNICIPAL POLITICAL PARTY COMMITTEES (Within Bergen County)
Name of Organization – (e.g. Hackensack Republican/Democrat Organization)

OTHER POLITICAL CONTRIBUTIONS (i.e. Federal, State, Local, School Board)
(You may attach additional sheets if necessary)

☐ Please check if contributions listed above (sign below and return with signature/date).

Signature: X_____ **Date:** _____

Print your name: _____

[1] This form shall be updated periodically to reflect new elected officials and candidates for office. However, it shall maintain the format and required disclosures contained herein.
Edited: June 28, 2016

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VA-19-0799-J-001165

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EXHIBIT 8 – DISCLOSURE OF INVESTMENT ACTIVITIES IN IRAN

AMERICAN OVERSIGHT

VA-19-0799-J-001166

DS_00008795

Exhibit 8

To be completed by Tenant-Operators and submitted as part of the RFP Response

Disclosure of Investment Activities in IRAN

BID/RFP/Solicitation Number: RFP for BRMC Lease **Bidder/Offeror:** Bergen Safety Net

Part 1: Certification

BIDDERS ARE TO COMPLETE PART 1 BY CHECKING EITHER BOX.

Pursuant to Public Law 2012, c. 25, any person or entity that submits a bid or proposal or otherwise proposes to enter into or renew a contract must complete the certification below to attest, under penalty of perjury, that neither the person or entity, nor any of its parents, subsidiaries, or affiliates, is identified on the Department of Treasury's Chapter 25 list as a person or entity engaging in investment activities in Iran. The Chapter 25 list is found on the Division's website at http://www.state.nj.us/treasury/purchase/pdf/Chapter25List.pdf. Bidders must review this list prior to completing the below certification. Failure to complete the certification will render a bidder's proposal non-responsive. If the Director finds a person or entity to be in violation of law, s/he shall take action as may be appropriate and provided by law, rule or contract, including but not limited to, imposing sanctions, seeking compliance, recovering damages, declaring the party in default and seeking debarment or suspension of the party

PLEASE CHECK THE APPROPRIATE BOX:

(b) (6), (b) (4) [redacted]

I certify, pursuant to Public Law 012, c. 25, that neither the bidder listed above nor any of the bidder's parents, subsidiaries, or affiliates is listed on the N.J. Department of the Treasury's list of entities determined to be engaged in prohibited activities in Iran pursuant to P.L. 2012, c. 25 ("Chapter 25 List"). I further certify that I am the person listed above, or I am an officer or representative of the entity listed above and am authorized to make this certification on its behalf. I will skip Part 2 and sign and complete the Certification below.

OR

I am unable to certify as above because the bidder and/or one or more of its parents, subsidiaries, or affiliates is listed on the Department's Chapter 25 list. I will provide a detailed, accurate and precise description of the activities in Part 2 below and sign and complete the Certification below.

Part 2: PLEASE PROVIDE FURTHER INFORMATION RELATED TO INVESTMENT ACTIVITIES IN IRAN You must provide a detailed, accurate and precise description of the activities of the bidding person/entity, or one of its parents, subsidiaries or affiliates, engaging in the investment activates in Iran on additional sheets provided by you.

Certification: I, being duly sworn upon my oath, hereby represent and state that the foregoing information and any attachments thereto to the best of my knowledge are true and complete. I attest that I am authorized to execute this certification on behalf of the above-referenced person or entity. I acknowledge that the State of New Jersey is relying on the information contained herein and thereby acknowledge that I am under a continuing obligation from the date of this certification through the completion of any contracts with the State to notify the State in writing of any changes to the answers of information contained herein. I acknowledge that I am aware that it is a criminal offense to make a false statement or misrepresentation in this certification, and if I do so, I recognize that I am subject to criminal prosecution under the law and that it will also constitute a material breach of my agreement(s) with the State of New Jersey and that the State at its option may declare any contract(s) resulting from this certification void and unenforceable.

Full Na(b) (6), (b) (4) [redacted] gnature: (b) (6) [redacted]

Title: President C.E.O Bergen Safety Net Inc Date: 11/2/16

AMERICAN OVERSIGHT

VA-19-0799-J-001167

DS_00008796

Response to Bergen County Improvement Authority Request for Proposal Regarding Bergen Regional Medical Center in Relation to the Lease

Respectfully submitted December 1, 2016
By

(b) (6), MD
President, Bergen Safety Net, Inc.

10 – 14 Saddle River Road
Suite 200
Fair Lawn, NJ 07410

Office (b) (6)
Email (b) (6)@verizon.net

AMERICAN OVERSIGHT

BERGEN SAFETY NET INC

10 – 14 Saddle River Road
Suite 200
Fair Lawn, NJ 07410

December 1, 2016

Mr. (b) (6)
Purchasing Agent
Bergen County Improvement Authority
C/o County of Bergen Division of Purchasing
One Bergen County Plaza
3rd floor
Hackensack, NJ 07601-7076

Re: Bergen Safety Net Response to Request for Proposal Regarding Bergen Regional Medical Center in Relation to the Lease

Dear Mr. (b) (6)

On behalf of the Bergen Safety Net ("BSN") team, it is my pleasure to present our response to the Bergen County Improvement Authority's ("BCIA") Request for Proposal regarding Bergen Regional Medical Center ("BRMC") in Relation to the Lease. BSN is committed to the success of BRMC and to the essential safety net services it provides for Bergen County, and our team has the depth and breadth of expertise necessary to revitalize this important community asset.

We thank you for the opportunity to share our capabilities with you and are confident that we can exceed BRMC's expectations for the provision of medical services in Bergen County and surrounding markets. We look forward to the opportunity to partner with you in accomplishing the goals of BCIA to enhance operations and support the ongoing viability of BRMC. Please do not hesitate to contact me at (b) (6) or (b) (6) @verizon.net if you have any questions or would like additional information related to this proposal.

Yours sincerely,

(b) (6)

(b) (6), MD
President

AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

I. INTRODUCTION

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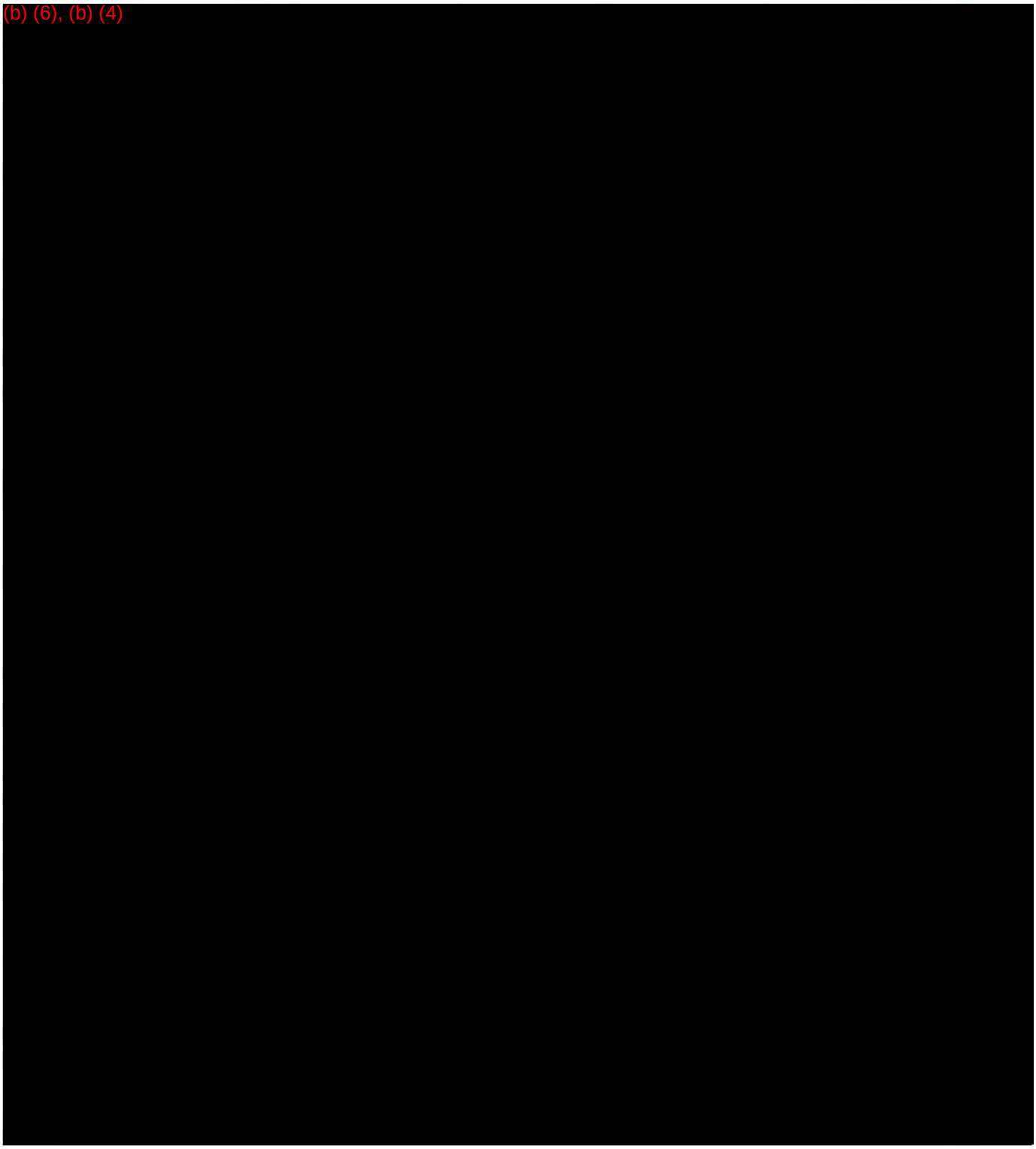

AMERICAN OVERSIGHT

II. General and Background Information

A. Tenant-Operator and Third-party Operators - General Information

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AMERICAN OVERSIGHT

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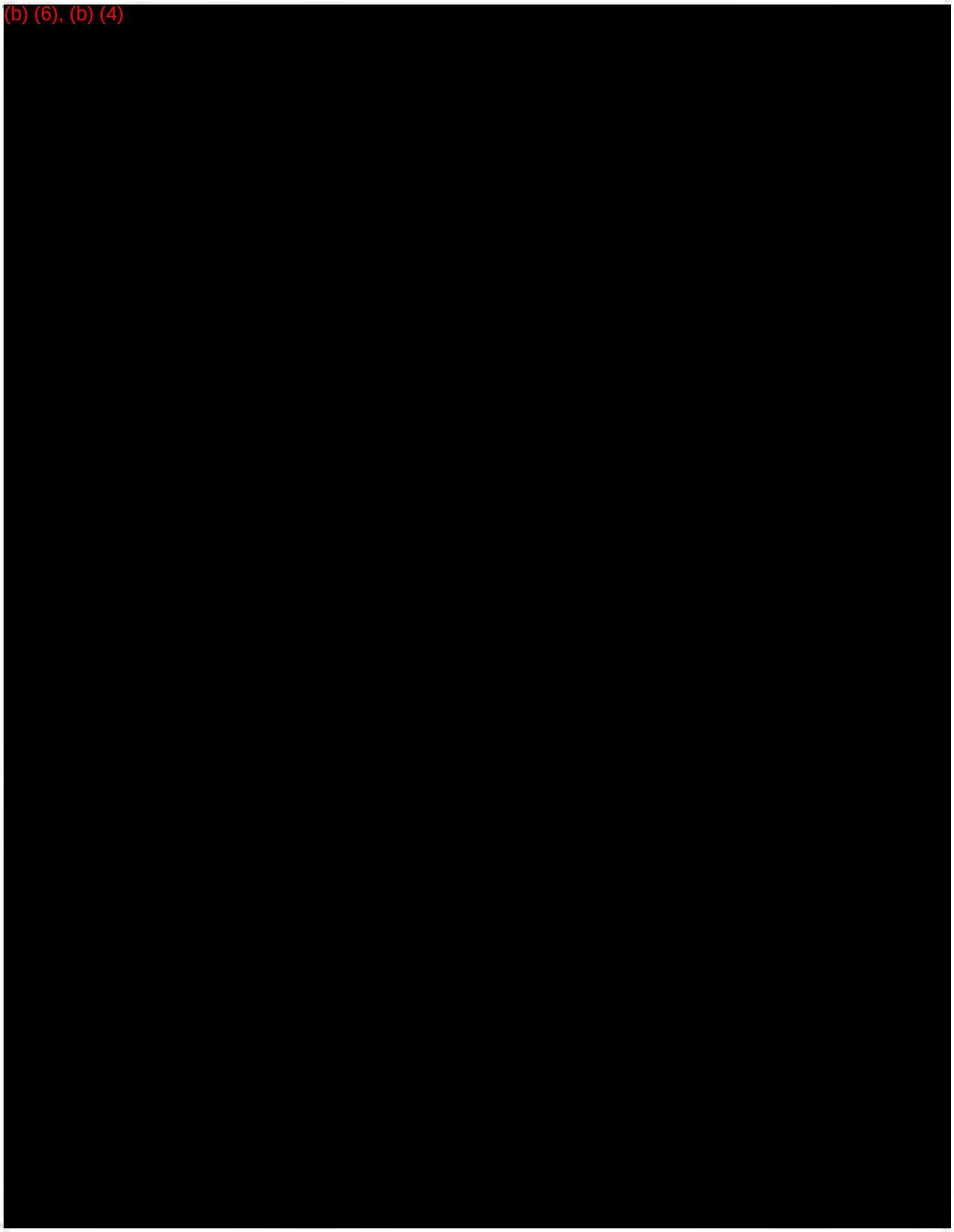

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B. Background Information – Tenant-Operator and Third-Party Operators

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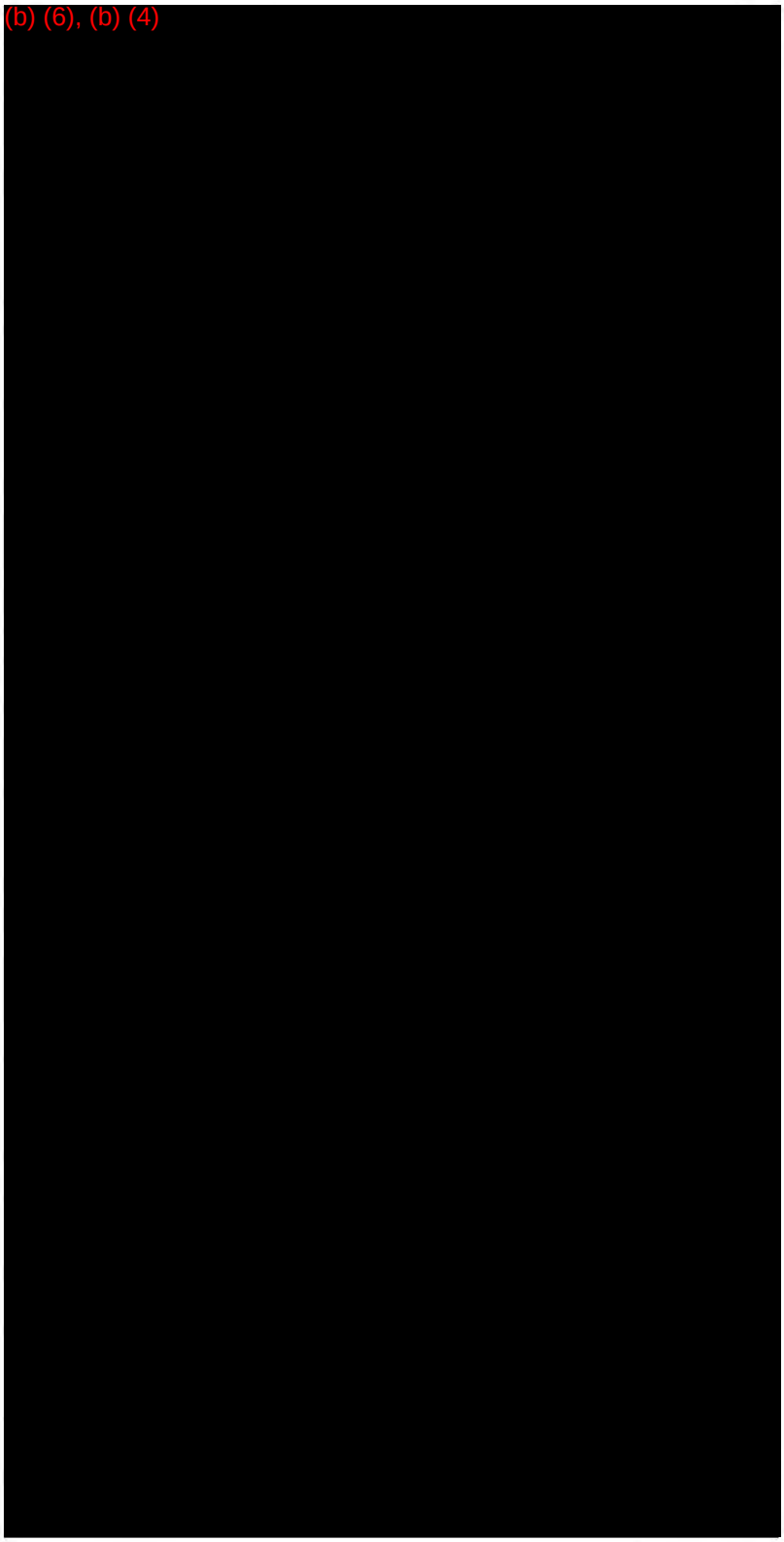

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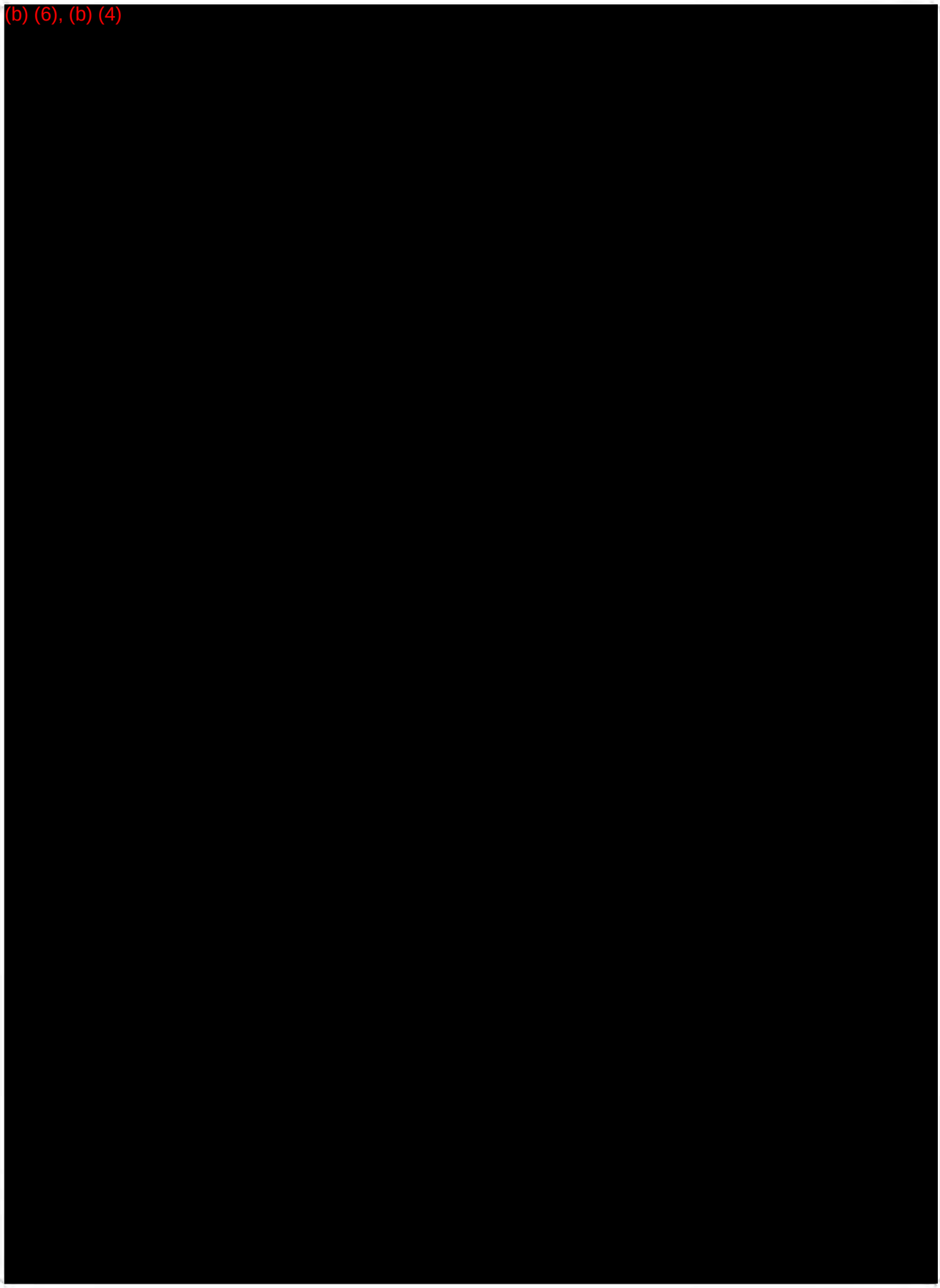

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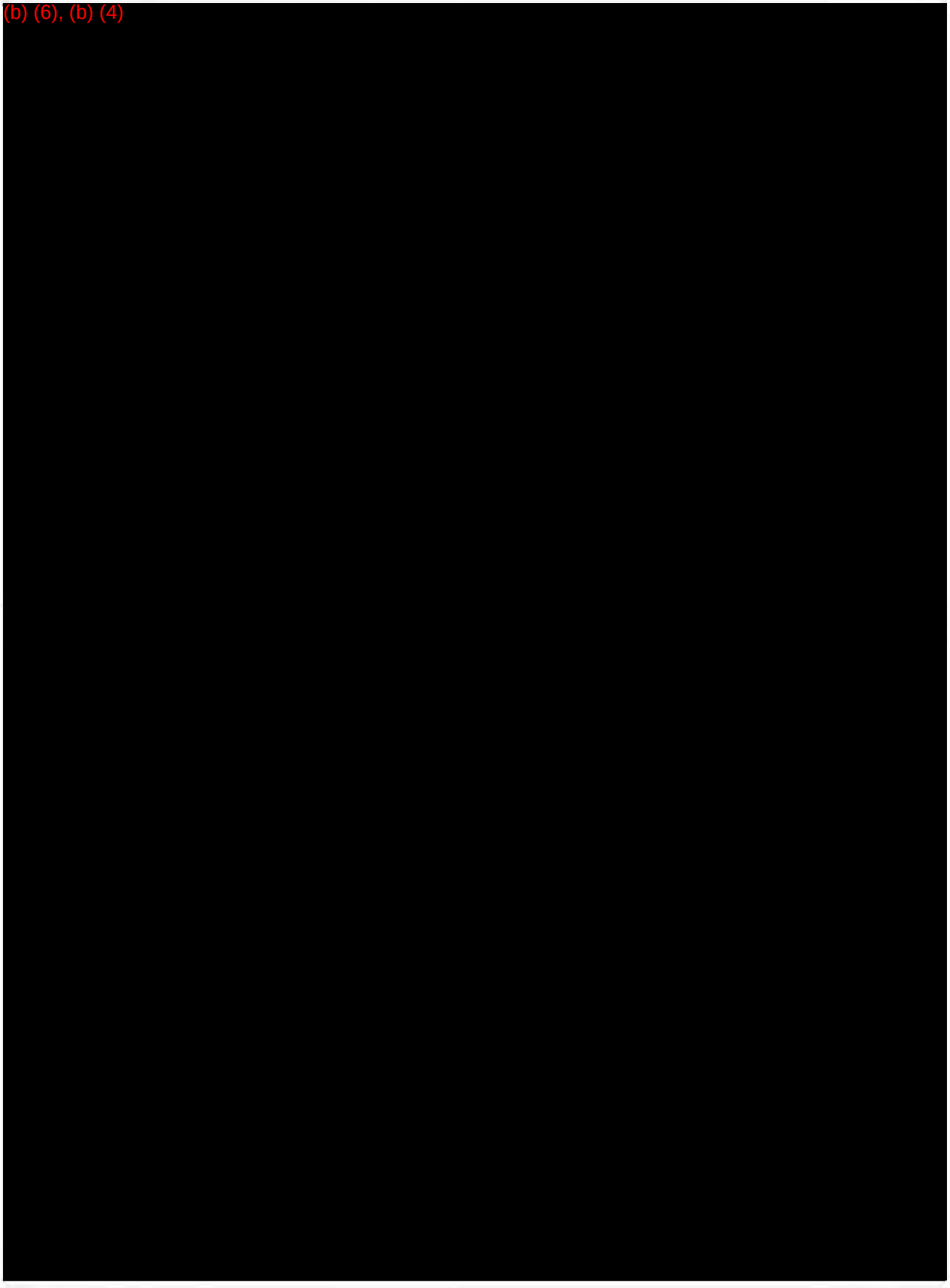

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AMERICAN OVERSIGHT

III. Technical Criteria

A. Proposed Operations

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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

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B. Transaction Structure, Operating and Financial Commitments

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[redacted]

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AMERICAN OVERSIGHT

c. (b) (6), (b) (4)

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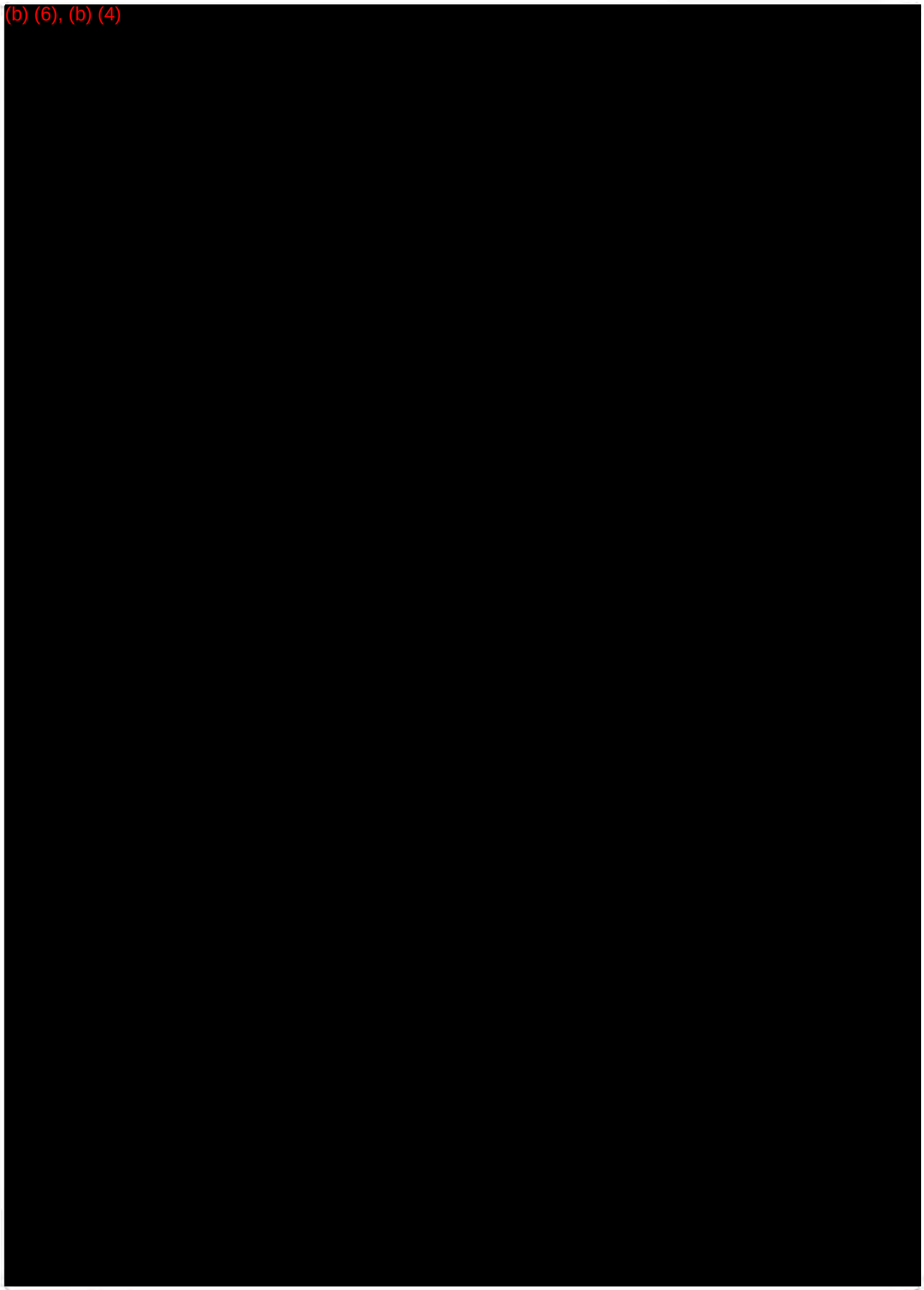

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AMERICAN OVERSIGHT

C. Other Transaction Considerations

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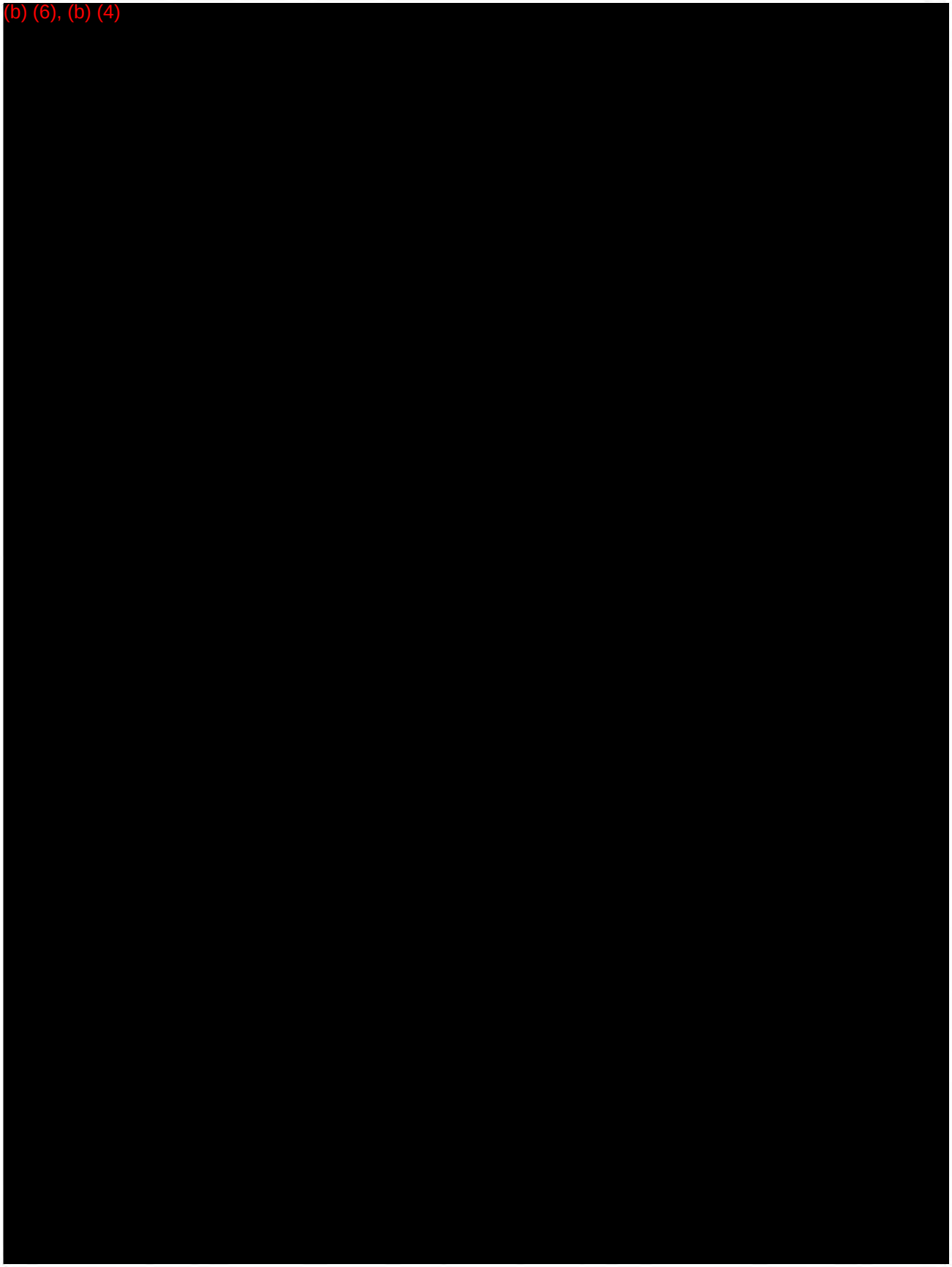

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AMERICAN OVERSIGHT

(b) (6), (b) (4)

c.

d.

AMERICAN OVERSIGHT

Summary Financial Projections					
9 Months Ending Dec 2017E	2018E	2019E	2020E	2021E	2022E

(b) (6), (b) (4)

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AMERICAN OVERSIGHT

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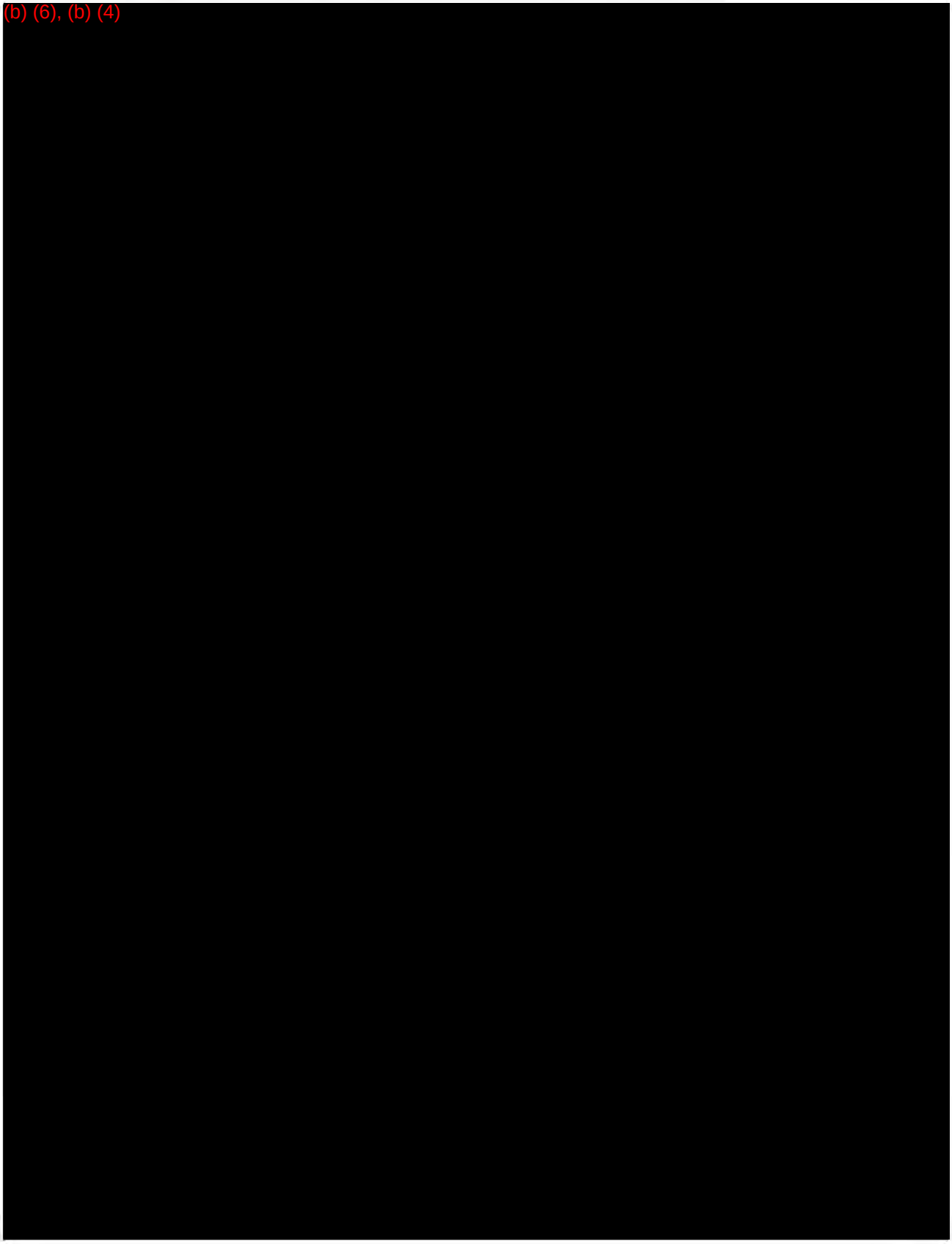

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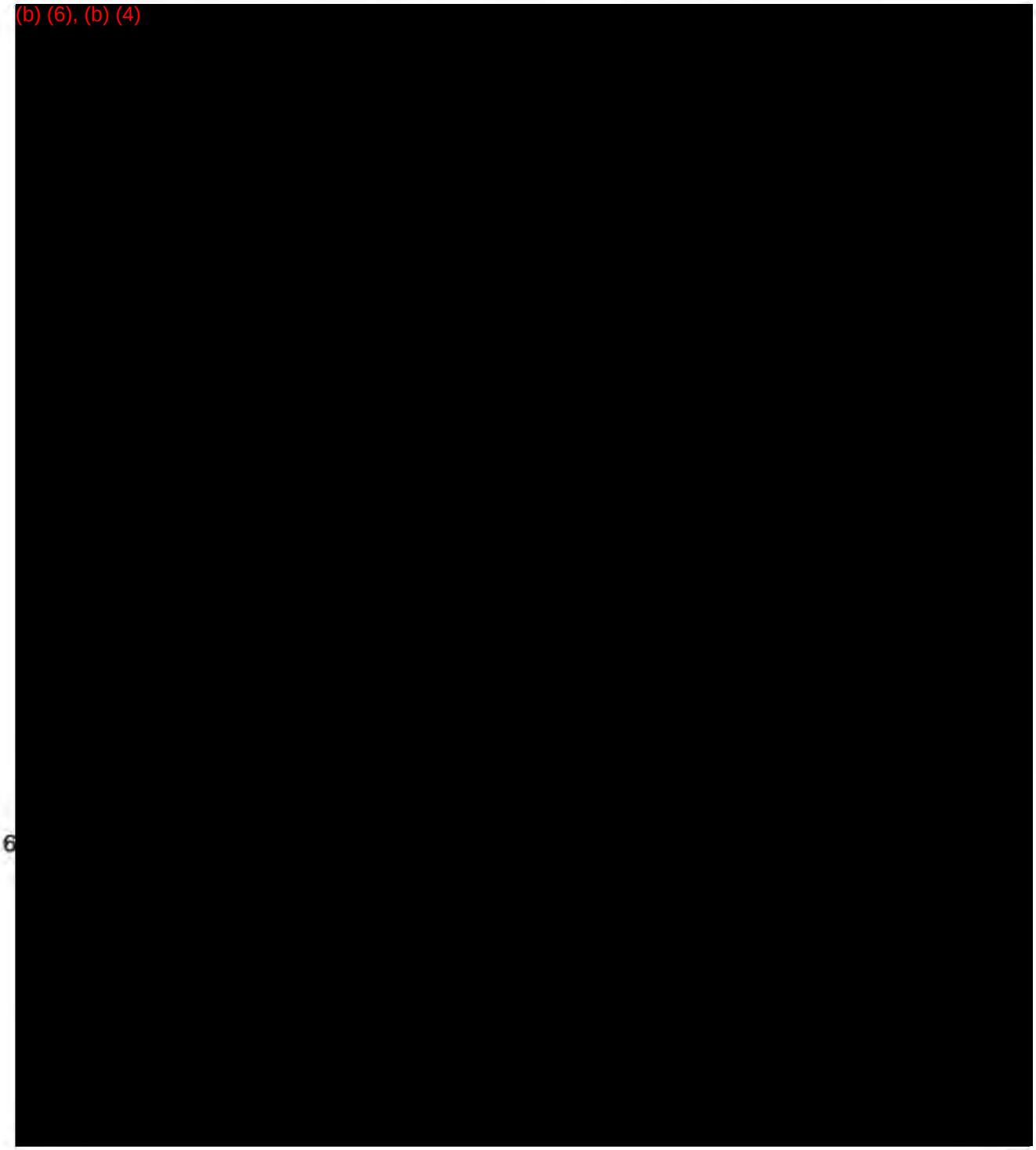

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AMERICAN OVERSIGHT

IV. Required Disclosures

A. Mandatory EEO/Affirmative Action Evidence

(b) (6), (b) (4)

[redacted]

B. Non-Discrimination Affirmation

(b) (6), (b) (4)

[redacted]

C. Disclosure Statement

(b) (6), (b) (4)

[redacted]

D. Statement of Corporate Ownership

(b) (6), (b) (4)

[redacted]

AMERICAN OVERSIGHT

VA-19-0799-J-001241

DS_00008870

(b) (6), (b) (4)

[redacted]

E. "Pay To Play" Notice of Disclosure Requirement

(b) (6), (b) (4)

[redacted]

F. Authority to Audit or Review Contract Records

(b) (6), (b) (4)

[redacted]

G. Disclosure of Investment Activity in Iran

(b) (6), (b) (4)

[redacted]

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V. OTHER RFP CONDITIONS

(b) (6), (b) (4)



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VA-19-0799-J-001243

DS_00008872

APPENDICES

AMERICAN OVERSIGHT

APPENDIX A – WINDSOR HEALTHCARE QUALITY AND PATIENT SATISFACTION METRICS

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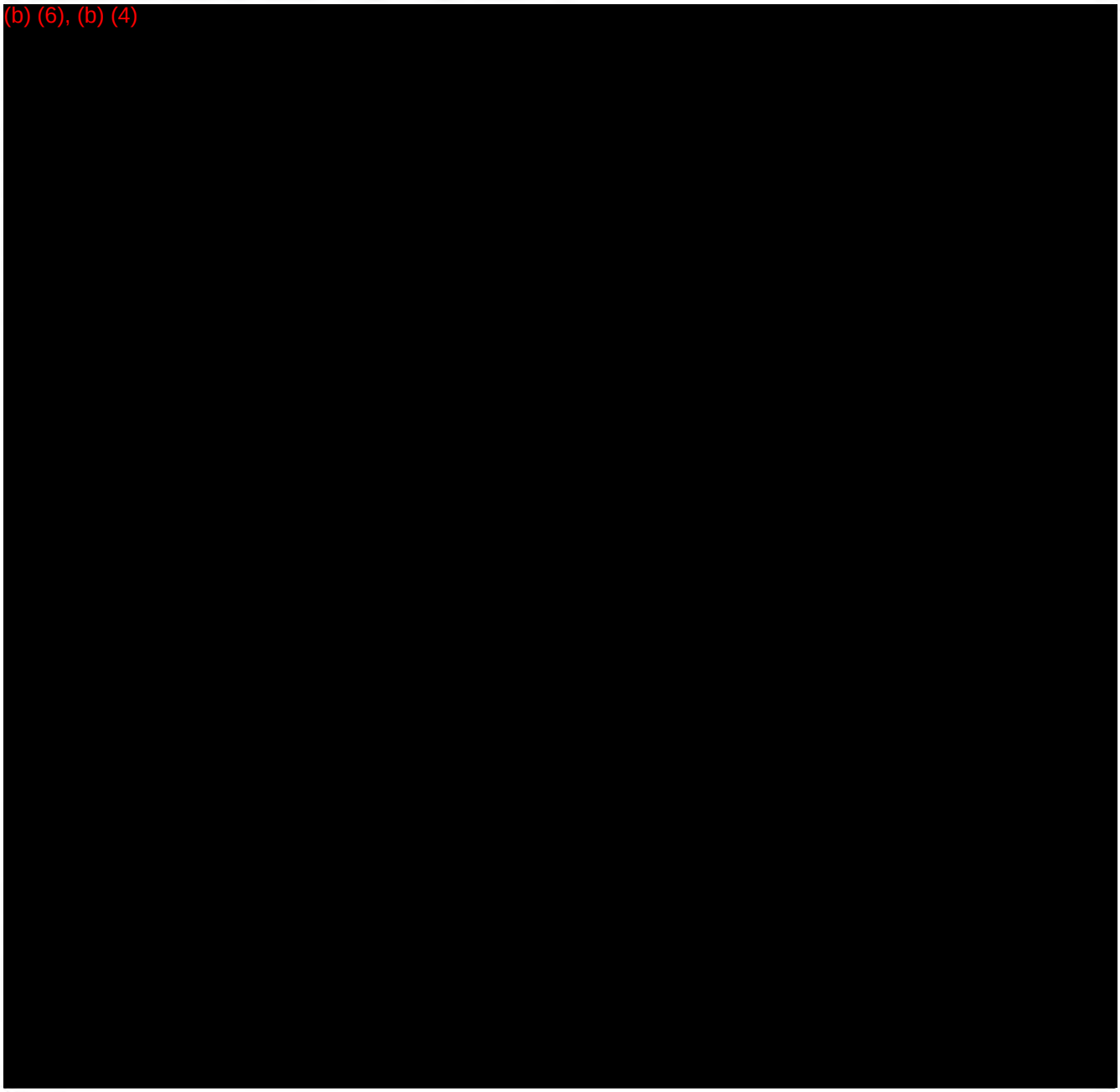
VA-19-0799-J-001245
DS_00008874

APPENDIX B – DRAFT TRANSITION CHECKLIST

GENERAL ACTIVITIES FOR TRANSITION

(b) (6), (b) (4)



AMERICAN OVERSIGHT
VA-19-0799-J-001246
DS_00008875

FINANCE

(b) (6), (b) (4)

[redacted]

COMMUNICATIONS

(b) (6), (b) (4)

[redacted]

AMERICAN OVERSIGHT

VA-19-0799-J-001247

DS_00008876

(b) (6), (b) (4)

[redacted]

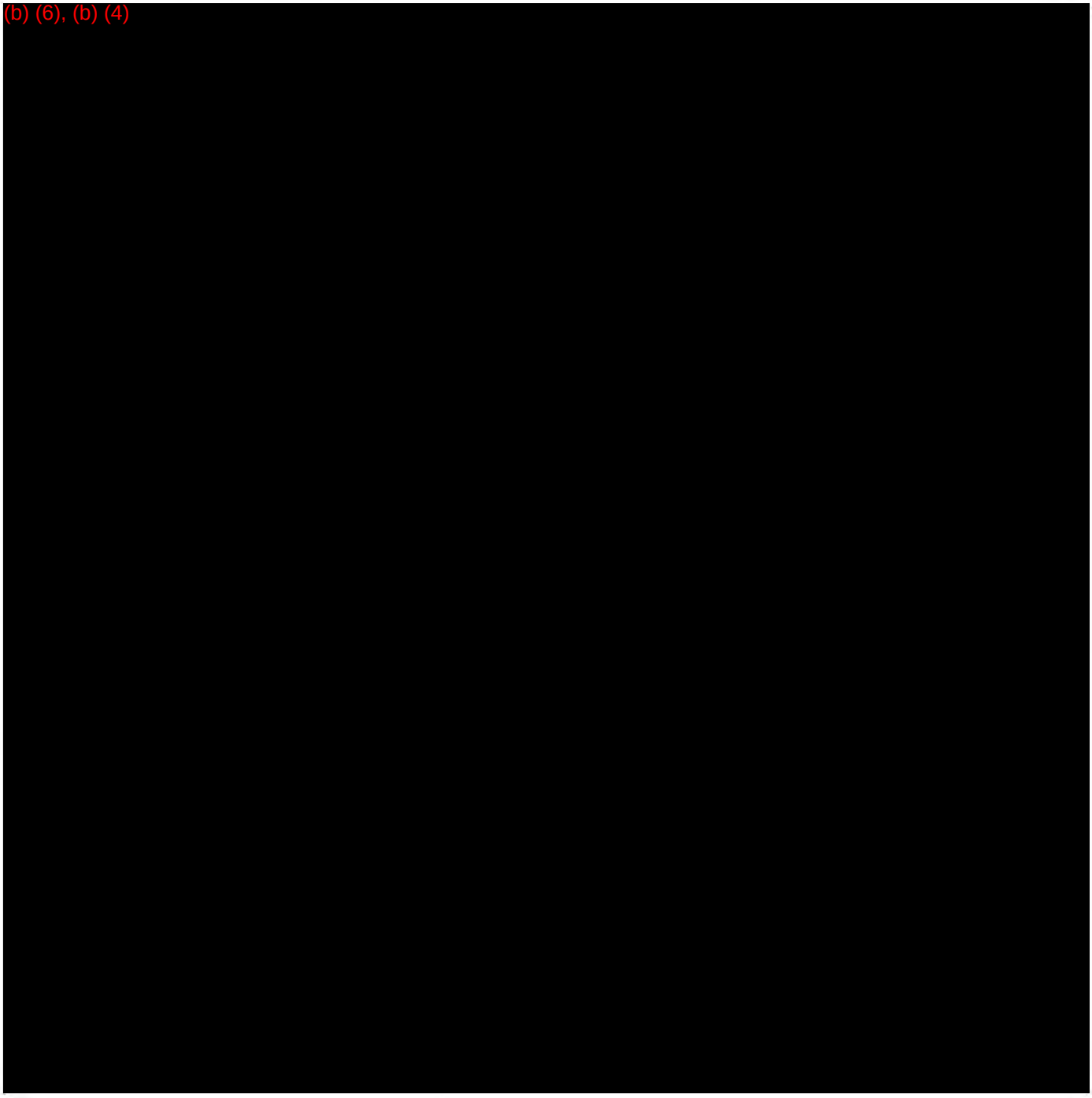
ADDITIONAL ITEMS FOR REVIEW

(b) (6), (b) (4)

[redacted]

AMERICAN OVERSIGHT

(b) (6), (b) (4)



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APPENDIX C – DETAILED FINANCIAL PROJECTIONS

Summary Financial Projections					
9 Months Ending Dec 2017E	2018E	2019E	2020E	2021E	2022E

(b) (6), (b) (4)

[redacted]

AMERICAN OVERSIGHT

Annual Income Statement					
9 Months Ending Dec 2017E	2018E	2019E	2020E	2021E	2022E

(b) (6), (b) (4)

[redacted]

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VA-19-0799-J-001251

DS_00008880

	Annual Balance Sheet					
	2017E	2018E	2019E	2020E	2021E	2022E
(b) (6), (b) (4)						

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Annual Statement of Cash Flows					
9 Months Ending Dec 2017E	2018E	2019E	2020E	2021E	2022E

(b) (6), (b) (4)

[redacted]

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VA-19-0799-J-001253

DS_00008882

RFP EXHIBITS

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VA-19-0799-J-001254
DS_00008883

EXHIBIT 5 – DISCLOSURE STATEMENT

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VA-19-0799-J-001255
DS_00008884

EXHIBIT 6 – STOCKHOLDER DISCLOSURE CERTIFICATION

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VA-19-0799-J-001256
DS_00008885

EXHIBIT 7 – DIRECT FINANCIAL DISCLOSURE OF CAMPAIGN CONTRIBUTIONS

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VA-19-0799-J-001257

DS_00008886

EXHIBIT 8 – DISCLOSURE OF INVESTMENT ACTIVITIES IN IRAN

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VA-19-0799-J-001258

DS_00008887

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/6/2017 3:00:21 AM
To: (b) (6) [(b) (6) @gmail.com]
Subject: Re: Here you go

Please call her office at henry ford tommorow and get her email or phone number- just like we did for (b) use i am ush and her friend

Sent from my iPhone

On Jan 5, 2017, at 7:05 PM, (b) (6) <(b) (6) @gmail.com> wrote:

> http://www.fiercehealthcare.com/healthcare/former-henry-ford-ceo-may-be-under-consideration-for-va-secretary-post

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) @gmail.com]
Sent: 1/6/2017 12:05:41 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Here you go

http://www.fiercehealthcare.com/healthcare/former-henry-ford-ceo-may-be-under-consideration-for-va-secretary-post

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/16/2016 2:19:58 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Re:

dont worry- take your time, though I will likely sleep by 10- have to get up at 5am since (b) has an early flight

---

From: David Shulkin <drshulkin@aol.com>
Sent: Thursday, December 15, 2016 9:16 PM
To: Poonam Alaigh
Subject:

Sorry- my sister is having an issue- I'll call you as soon as I can get off

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 12/16/2016 2:16:56 AM
To: Poonam Alaigh [(b) (6) @hotmail.com]

Sorry- my sister is having an issue- I'll call you as soon as I can get off

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/17/2016 10:03:56 PM
To: (b) (6) [(b) (6) @gmail.com]
Subject: Re:

I have some extras if they have the addresses

Sent from my iPhone

On Dec 17, 2016, at 3:46 PM, (b) (6) <(b) (6) @gmail.com> wrote:

> Hi, no, totally forgot about this group. Will ask the team if they have extra on Monday to give to you.
>
> (b) (6)
>
> On Dec 17, 2016 1:41 PM, "David shulkin" <Drshulkin@aol.com> wrote:
> (b) (6) i forget - did we send cards to smag members?
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) @gmail.com]
Sent: 12/17/2016 8:46:26 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re:

Hi, no, totally forgot about this group. Will ask the team if they have extra on Monday to give to you.

(b) (6)

On Dec 17, 2016 1:41 PM, "David shulkin" <Drshulkin@aol.com> wrote:
(b) (6) i forget - did we send cards to smag members?

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/17/2016 6:41:04 PM
To: (b) (6) [(b) (6) @gmail.com]

(b) (6) i forget - did we send cards to smag members?

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/30/2016 12:25:40 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Fwd: speaking with (b)
Attachments: (b) (6) pdf; Untitled attachment 19004.htm

The guy i was talking about for (b)

But i dont see web skills etc

Sent from my iPhone

Begin forwarded message:

> **From:** (b) (6) <(b) (6) @gmail.com>
> **Date:** December 29, 2016 at 8:41:26 PM EST
> **To:** (b) (6) (b) (6) (b) (6) gmail.com>, David Shulkin <drshulkin@aol.com>
> **Subject: speaking with** (b) (6)
>
> Dad,
>
> I'm sending you (b) (6) email so you two can set up a time to talk sometime soon.
>
> His resume is attached to give you an idea of what he's done. His interests are HR, General Management, and Marketing.
>
> (b) (6)

AMERICAN OVERSIGHT

(b) (6)
(b) (6)
(b) (6) @umich.edu • (b) (6)

EDUCATION

(b) (6), (b) (2)

EXPERIENCE

2016

(b) (6), (b) (2)

2016

2014-2015

2014

2012-2014

2005-2008

ADDITIONAL

AMERICAN OVERSIGHT

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 12/27/2016 8:46:44 PM
To: (b) (6) @hotmail.com
Subject: Re: (b) (6) piece (not in the clips)- so accurate and appropriate- send him a note

send

Sent from AOL Mobile Mail

-----Original Message-----
From: Poonam Alaigh <(b) (6) @hotmail.com>
To: David Shulkin <drshulkin@aol.com>
Sent: Tue, Dec 27, 2016 03:48 PM
Subject: Re: (b) (6) piece (not in the clips)- so accurate and appropriate- send him a note

Do you want me to go ahead and send him a note or do you want to discuss first

---

From: David Shulkin <drshulkin@aol.com>
Sent: Tuesday, December 27, 2016 2:43 PM
To: (b) (6) @hotmail.com
Subject: Re: (b) (6) piece (not in the clips)- so accurate and appropriate- send him a note

ok that might help

Sent from AOL Mobile Mail

-----Original Message-----
From: Poonam Alaigh <(b) (6) @hotmail.com>
To: David Shulkin <drshulkin@aol.com>
Sent: Tue, Dec 27, 2016 03:10 PM
Subject: Re: (b) (6) piece (not in the clips)- so accurate and appropriate- send him a note

I can send him a note that you and I would like to meet/talk to him- we can discuss further when we talk- also check your whatsapp- Laverne can speak on the 1st or 2nd on the phone once she returns

---

From: David Shulkin <drshulkin@aol.com>
Sent: Tuesday, December 27, 2016 2:05 PM
To: (b) (6) @hotmail.com
Subject: Re: (b) (6) piece (not in the clips)- so accurate and appropriate- send him a note

AMERICAN OVERSIGHT

i agree- i want to discuss how to deal with him- he is on the attack and i think he is a good guy but its not productive now

Sent from AOL Mobile Mail

-----Original Message-----
From: Poonam Alaigh <(b) (6) @hotmail.com>
To: David Shulkin <drshulkin@aol.com>
Sent: Tue, Dec 27, 2016 03:01 PM
Subject: (b) (6) piece (not in the clips)- so accurate and appropriate- send him a note

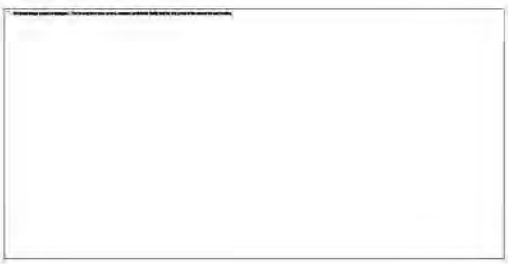
http://taskandpurpose.com/one-problem-will-make-break-trumps-pick-va-secretary/



The One Problem That Will Make Or Break Trump's Pick For VA Secretary

taskandpurpose.com

The problems in the VA don't stem from the top, but from middle management, which is entrenched in bureaucracy and plausible deniability.



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Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/27/2016 7:48:36 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Re: (b) (6) piece (not in the clips)- so accurate and appropriate- send him a note

Do you want me to go ahead and send him a note or do you want to discuss first

---

From: David Shulkin <drshulkin@aol.com>
Sent: Tuesday, December 27, 2016 2:43 PM
To: (b) (6) @hotmail.com
Subject: Re: (b) (6) piece (not in the clips)- so accurate and appropriate- send him a note

ok that might help

Sent from AOL Mobile Mail

-----Original Message-----
From: Poonam Alaigh <(b) (6) @hotmail.com>
To: David Shulkin <drshulkin@aol.com>
Sent: Tue, Dec 27, 2016 03:10 PM
Subject: Re: (b) (6) piece (not in the clips)- so accurate and appropriate- send him a note

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From: David Shulkin <drshulkin@aol.com>
Sent: Tuesday, December 27, 2016 2:05 PM
To: (b) (6) @hotmail.com
Subject: Re: (b) (6) piece (not in the clips)- so accurate and appropriate- send him a note

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Sent from AOL Mobile Mail

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Message

From: David Shulkin [drshulkin@aol.com]
Sent: 12/27/2016 7:43:20 PM
To: (b) (6) @hotmail.com
Subject: Re: (b) (6) piece (not in the clips)- so accurate and appropriate- send him a note

ok that might help

Sent from AOL Mobile Mail

-----Original Message-----
From: Poonam Alaigh <(b) (6) @hotmail.com>
To: David Shulkin <drshulkin@aol.com>
Sent: Tue, Dec 27, 2016 03:10 PM
Subject: Re: (b) (6) piece (not in the clips)- so accurate and appropriate- send him a note

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---

From: David Shulkin <drshulkin@aol.com>
Sent: Tuesday, December 27, 2016 2:05 PM
To: (b) (6) @hotmail.com
Subject: Re: (b) (6) piece (not in the clips)- so accurate and appropriate- send him a note

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To: David Shulkin <drshulkin@aol.com>
Sent: Tue, Dec 27, 2016 03:01 PM
Subject: (b) (6) piece (not in the clips)- so accurate and appropriate- send him a note

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Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/27/2016 7:08:53 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Re: (b) (6) piece (not in the clips)- so accurate and appropriate- send him a note

I can send him a note that you and I would like to meet/talk to him- we can discuss further when we talk- also check your whatsapp- Laverne can speak on the 1st or 2nd on the phone once she returns

---

From: David Shulkin <drshulkin@aol.com>
Sent: Tuesday, December 27, 2016 2:05 PM
To: (b) (6) @hotmail.com
Subject: Re: (b) (6) piece (not in the clips)- so accurate and appropriate- send him a note

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Sent from AOL Mobile Mail

-----Original Message-----
From: Poonam Alaigh <(b) (6) @hotmail.com>
To: David Shulkin <drshulkin@aol.com>
Sent: Tue, Dec 27, 2016 03:01 PM
Subject: (b) (6) piece (not in the clips)- so accurate and appropriate- send him a note

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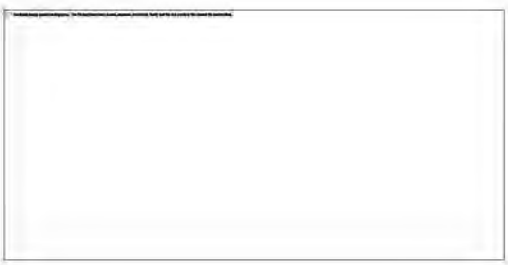

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Message

From: David Shulkin [drshulkin@aol.com]
Sent: 12/27/2016 7:05:58 PM
To: (b) (6) @hotmail.com
Subject: Re: (b) (6) piece (not in the clips)- so accurate and appropriate- send him a note

i agree- i want to discuss how to deal with him- he is on the attack and i think he is a good guy but its not productive now

Sent from AOL Mobile Mail

-----Original Message-----
From: Poonam Alaigh <(b) (6) @hotmail.com>
To: David Shulkin <drshulkin@aol.com>
Sent: Tue, Dec 27, 2016 03:01 PM
Subject: (b) (6) piece (not in the clips)- so accurate and appropriate- send him a note

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Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/27/2016 7:01:09 PM
To: David Shulkin [drshulkin@aol.com]
Subject: (b) (6) piece (not in the clips)- so accurate and appropriate- send him a note

http://taskandpurpose.com/one-problem-will-make-break-trumps-pick-va-secretary/

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taskandpurpose.com

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Message

From: [redacted] [redacted]@gmail.com]
Sent: 1/20/2017 11:22:15 AM
To: David shulkin [Drshulkin@aol.com]
CC: [redacted] [redacted]@58pic2017.org]
Subject: Re:

Reread, can mail on Monday. Let me know the address.

On Jan 20, 2017 6:20 AM, "[redacted] <[redacted]@gmail.com> wrote:
Yes, in my office.

Hi [redacted] are you referring to the svac forms? We have the original in my office. Do the forms get mailed or will electrons pages we sent work.

Or are you referring to another set of forms to be notarized?

On Jan 20, 2017 6:13 AM, "David shulkin" <Drshulkin@aol.com> wrote:
I had the form notarized already- [redacted] do you know where the notarized original is?

Sent from my iPhone

On Jan 20, 2017, at 12:02 AM, [redacted] <[redacted]@58PIC2017.org> wrote:

Sir:

Yes Sir. Just got the approval of the form this evening. Do you have a notary that can motorized the original copy? Once that's done we can get the original over to them. I am transmitting an electronic version to the clerk in the next ten minutes.

As an FYI, as far as the 31st goes, the SVAC legal counsel informed me that that date was a place holder but nothing was in stone. She gave me the impression that the hearing could slide to the right a few days.

[redacted]

Get Outlook for iOS

From: David shulkin <Drshulkin@aol.com>
Sent: Thursday, January 19, 2017 11:51:35 PM
To: [redacted]
Subject:

AMERICAN OVERSIGHT

(b) my forms have been done for a number of days now. Have you communicate with OGE to see when they are turning it around? If we want to keep the hearing on the 31st i think we need to get everything to the senate on Monday. Can you work with OGE to make sure we stay on schedule?

David Shulkin

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) @gmail.com]
Sent: 1/20/2017 11:20:11 AM
To: David shulkin [Drshulkin@aol.com]
CC: (b) (6) [(b) (6) @58pic2017.org]
Subject: Re:

Yes, in my office.

Hi (b) are you referring to the svac forms? We have the original in my office. Do the forms get mailed or will electrons pages we sent work.

Or are you referring to another set of forms to be notarized?

On Jan 20, 2017 6:13 AM, "David shulkin" <Drshulkin@aol.com> wrote:
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Sent from my iPhone

On Jan 20, 2017, at 12:02 AM, (b) (6) <(b) (6) @58PIC2017.org> wrote:

> Sir:
>
> Yes Sir. Just got the approval of the form this evening. Do you have a notary that can motorized the original copy? Once that's done we can get the original over to them. I am transmitting an electronic version to the clerk in the next ten minutes.
>
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>
> (b)
>
> Get Outlook for iOS
>
> ---
> **From:** David shulkin <Drshulkin@aol.com>
> **Sent:** Thursday, January 19, 2017 11:51:35 PM
> **To:** (b) (6)
> **Subject:**
>
> (b) my forms have been done for a number of days now. Have you communicate with OGE to see when they are turning it around? If we want to keep the hearing on the 31st i think we need to get everything to the senate on Monday. Can you work with OGE to make sure we stay on schedule?

AMERICAN OVERSIGHT

David Shulkin

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/20/2017 11:13:28 AM
To: (b) (6) [(b) (6)@58PIC2017.org]
CC: (b) (6) [(b) (6) @gmail.com]; (b) (6) R. (b) (6) [(b) (6) va.gov]
Subject: Re:

I had the form notarized already- (b) (6) do you know where the notarized original is?

Sent from my iPhone

On Jan 20, 2017, at 12:02 AM, (b) (6) <(b) (6) @58PIC2017.org> wrote:

> Sir:
>
> Yes Sir. Just got the approval of the form this evening. Do you have a notary that can motorized the original copy? Once that's done we can get the original over to them. I am transmitting an electronic version to the clerk in the next ten minutes.
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>
> Get Outlook for iOS
>
> ---
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> **Sent:** Thursday, January 19, 2017 11:51:35 PM
> **To:** (b) (6)
> **Subject:**
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>
> David Shulkin
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/8/2016 1:08:28 AM
To: Jennifer Lee [(b) (6) @gmail.com]
Subject: Re: CHIO

Sure

Sent from my iPhone

> On Dec 7, 2016, at 6:20 PM, Jennifer Lee (b) (6) @gmail.com> wrote:
>
> Good news!
> I think I found the CHIO! but I need some help convincing him to come...
> Would you be willing to meet with him?
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AMERICAN OVERSIGHT

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From: Jennifer Lee [(b) (6) @gmail.com]
Sent: 12/7/2016 11:20:02 PM
To: David Shulkin [drshulkin@aol.com]
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AMERICAN OVERSIGHT

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From: (b) (6) [(b) (6)@gmail.com]
Sent: 12/21/2016 10:36:32 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Tmrw , Friday, Monday

(b) (6) is ooo Thursday - Tuesday, you can send your print request and rsvps to me and I'll make they get printed by (b) (6)

(b)

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/24/2016 8:22:43 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: [EXTERNAL] RE: MyVA Access Evaluation Final Report

It clearly shows his colors and agenda

We knew this - we need to see how things play out in the next two weeks

Sent from my iPhone

On Dec 24, 2016, at 11:55 AM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:

> nice response, but still cant get over how this great news for us- and he is putting his personal agenda ahead of what is good for the VA and the veterans- totally disgusted. He even suggests not using it in the last para "Should you use it"

From: David shulkin <Drshulkin@aol.com>
Sent: Saturday, December 24, 2016 10:30 AM
To: Stone, Richard A., MD
Subject: Re: [EXTERNAL] RE: MyVA Access Evaluation Final Report

Really good insights

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> **To:** Shulkin, David J., MD
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AMERICAN OVERSIGHT

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To: (b) (6) Alaigh, Poonam
Cc: (b) (6)
(b) (6)
Subject: [EXTERNAL] RE: MyVA Access Evaluation Final Report

Hello Dr. Alaigh,

Please find attached the MyVA Access Evaluation Final Report.

Happy Holidays!

Thank you,

(b) (6)

Research Administrator

Program Evaluation and Research Unit-PERU

The Offices at Baum #300B

5607 Baum Boulevard

Pittsburgh, PA 15206

Phone: (b) (6) Fax: (b) (6)

(b) (6) @pitt.edu

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<(b) 1@katz.pitt.edu>; (b) (6) <(b) (6) @pitt.edu>;
(b) (6) <(b) (6) @pitt.edu>; Fawcett, Jaime
<(b) (6) @pitt.edu>
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(b) (6) @pitt.edu

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/24/2016 3:52:43 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: [EXTERNAL] RE: MyVA Access Evaluation Final Report

See below my comments- I think since he wasnt part of it, he wants to undermine it- but see my responses in bold, which you can copy and paste and send to him as appropriate- that way he knows that you are paying attention to him.

Also, just do it in a gentler manner than the way I wrote it

From: David shulkin <Drshulkin@aol.com>
Sent: Saturday, December 24, 2016 10:25 AM
To: Poonam Alaigh
Subject: Fwd: [EXTERNAL] RE: MyVA Access Evaluation Final Report

Thoughts?

Sent from my iPhone

Begin forwarded message:

> **From:** "Stone, Richard A., MD" <Richard.Stone2@va.gov>
> **Date:** December 24, 2016 at 10:40:33 AM AST
> **To:** 'David Shulkin' <drshulkin@aol.com>
> **Subject: RE: [EXTERNAL] RE: MyVA Access Evaluation Final Report**
>
> David
> Have read the report.
>
> Weaknesses:
> 1. Completed before we completely implemented 12/31 goals across the system-
> **The My VA Access 3 pronged approach to improving access in a sustainable way started in April 2016- this is what we are measuring, As a result of the strong foundation we are creating, we have been able to achieve the aspirational goal of same day access in primary care and mental health. The goal of the study is not to see if we achieved same day access, but to see if our strategy of focusing on the most urgent veteran needs has been successful in a sustainable way.**
>
> 2. Unclear how the Nov 15 stand down effected metric improvement. Is this a endorsement of the "access" strategy or "stand down" strategy?
> **It is an endorsement of the success of the strategy we used around identifying our most urgent patients, having the field start focusing on them, consolidating our scheduling systems and empowering the field so that they are able to deal with the access crisis in a meaningful and impactful way**

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3. It is heavily weighted to satisfaction and perception data. It makes little reference to predicting if this is a sustainable improvement. This relates to my concern that it was completed while we are still implementing the process-
We asked them to identify the best way to measure improvement in access knowing the limitations of our scheduling systems and that there was no way of measuring it against private sector standards. So the gold standard based on their review is patient satisfaction

4. It identifies no improvement for new patients access (pg 63)-
Correct, this is a journey and our focus is on the urgent needs of veterans. There was no way of identifying if these patients had urgent or routine needs. But with same day access now available, these patients, whether new or returning have access to same day services in primary and mental health

5. "The average wait time for routine consults and the percentage of same day appointments in mental health and in primary care clinics has worsened, on average, post myVA Access....." I know this wasn't our focus but you can envision the headline. (Pg 63)-
With our resources diverted to urgent needs, the routine care wait times did go up. THis is expected and further validates our study which shows that we have made a tremendous impact on urgent care needs while we are willing for patients to wait for routine care. These routine care patients are part of the PACT teams and know how to access care with their care teams as needed even though the numbers look worse, but appropriately worse.

6. Page 45 first full paragraph second half, sentence beginning with "However both metric for primary care showed no improvement." - out of context could create same risk as number 5 above-
I dont quite understand his concern, the two PC metrics for new patients routine appointments includes measuring trend and change in mean that shows no improvement. ITs for routine care, and we acknowledge this. In a matter of less than a year, we have made monumental change in a complex organization with the focus being on urgent needs. We have seen significant improvement in that with improving wait times, veteran perception and same day appointments for urgent needs.

This study creates significant risk for the above reasons. Should we use it, we should concentrate on Veteran perception measures of satisfaction. In addition, the hard metric analysis should be reworked to clearly separate improvement based on the late 2015 stand down and those related to process improvement instituted following the February 2016 Access declaration release.

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Back- should be there

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> On Dec 13, 2016, at 6:35 AM, David shulkin <Drshulkin@aol.com> wrote:
>
> Oh no- No problem- dont worry
>
> Sent from my iPhone
>
>> On Dec 13, 2016, at 5:26 AM, Poonam Alaigh <(b) (6) n@hotmail.com> wrote:
>>
>> Not a false alarm- finally warming up at the Ritz- will be a few hours I think- don't know if I will make it to morning report - battery is running low too
>>
>> <IMG_1922.JPG>
>>
>>
>>
>> Sent from my iPhone
>

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/13/2016 11:35:42 AM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: Since 4am - and the adventure continues

Oh no- No problem- dont worry

Sent from my iPhone

> On Dec 13, 2016, at 5:26 AM, Poonam Alaigh <(b) (6) n@hotmail.com> wrote:
>
> Not a false alarm- finally warming up at the Ritz- will be a few hours I think- don't know if I will make it to morning report - battery is running low too
>
> <IMG_1922.JPG>
>
>
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/13/2016 10:26:14 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Since 4am - and the adventure continues
Attachments: IMG_1922.JPG; ATT00001.txt

Not a false alarm- finally warming up at the Ritz- will be a few hours I think- don't know if I will make it to morning report - battery is running low too

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AMERICAN OVERSIGHT

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 12/11/2016 9:11:12 PM
To: (b) (6) [redacted]@gmail.com
Subject: print for monday call with Senator Udall
Attachments: Albuquerque SAIL One Pager Q3 2016pla.pptx

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Albuquerque, NM

New Mexico VA Health Care System

Strategic Analytics for Improvement and Learning (SAIL) Report Highlights

Q3 FY 2016

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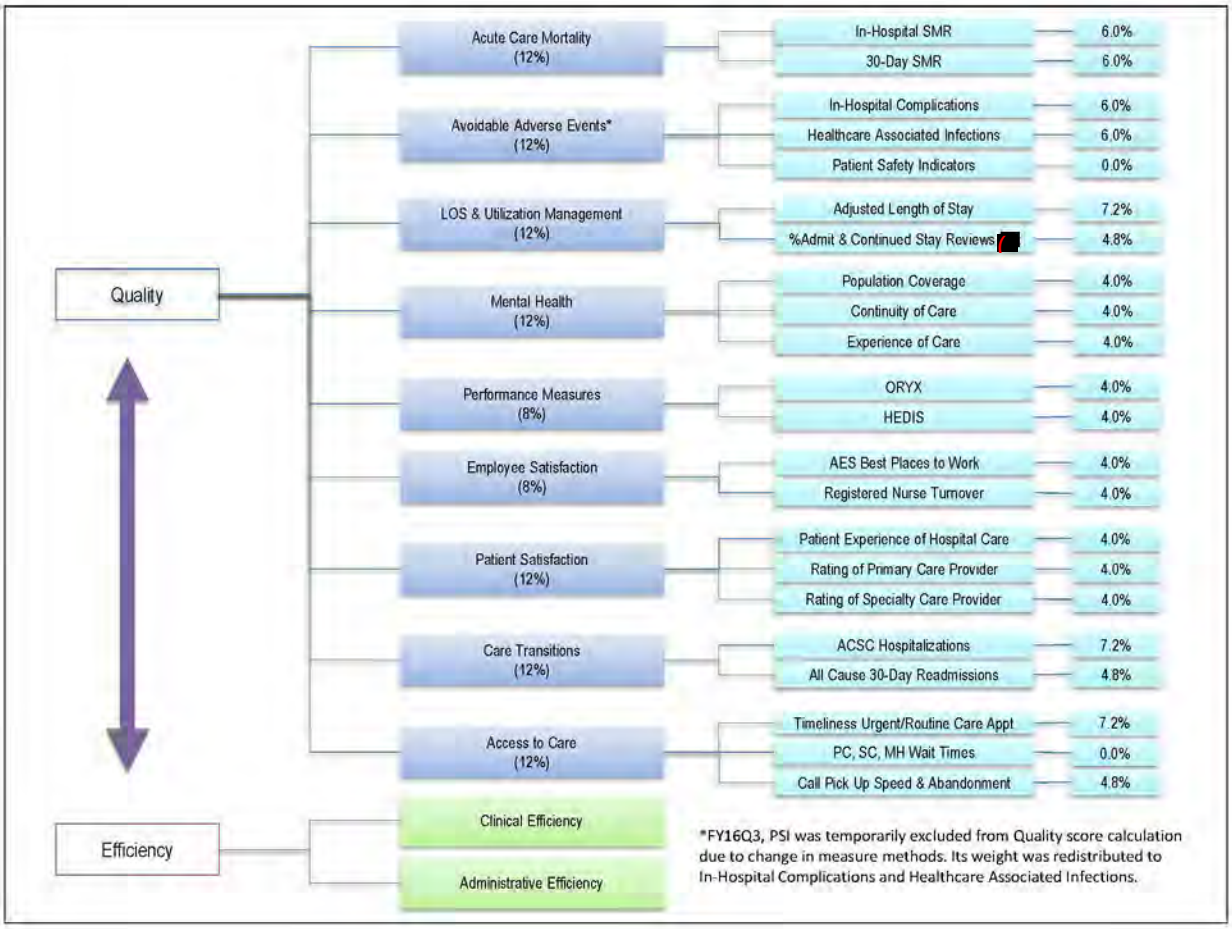

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Albuquerque VA Medical Center Private Sector Comparisions

- Medical/Surgical Patients
  - 30-day mortality rates for AMI, heart failure and pneumonia are lower or similar to regional and national rates
  - Deaths among patients with serious treatable complications after surgery is lower than regional and national rates
  - MRSA infection rate is similar to regional and national rates
- Hospital Based Inpatient Psychiatric Services
  - Use of physical restraints is similar to regional and national rates (lower is better)
  - Proportion of patients with Post discharge continuing care plan created is higher than national rate (higher is better)
  - Proportion of patient with post discharge continuing care plan transmitted to next level of care provider upon discharge is higher than national rate (higher is better)
- Patient Satisfaction (HCAHPS – inpatient)
  - Proportion of patients who gave top rating (score of 9 and 10 on a scale from 0 to 10) to the hospital is higher than regional and national rates (higher is better)

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Albuquerque
VHA Comparisons

- In 2016 Q3, Albuquerque is a 1-star healthcare system.
- Compared to VHA, Albuquerque is a top performer in the patient satisfaction measure, in which they've consistently ranked in the top quintiles for the past four quarters.
- In the past year, Albuquerque made large absolute performance improvements in patient satisfaction, primary care appointment wait times, SMR and adjusted length of stay.
- In the past year, Albuquerque also made absolute performance improvements in Best Place to Work, access to urgent specialty care appointments, SMR-30, HEDIS and **overall quality**
- In the past year, Albuquerque saw large absolute performance deteriorations in telephone answering speed, wait time for mental health appointments, percent of admission reviews that met criteria, readmission rates for cardiovascular cohorts, access to routine primary care appointments, telephone abandonment and access to urgent primary care appointments. In these areas, Albuquerque ranks in the bottom 50% of VHA facilities.
- Compared to VHA, Albuquerque has opportunities to improve in the avoidable adverse events, mental health, employee satisfaction, access, performance measures and care transitions domains.

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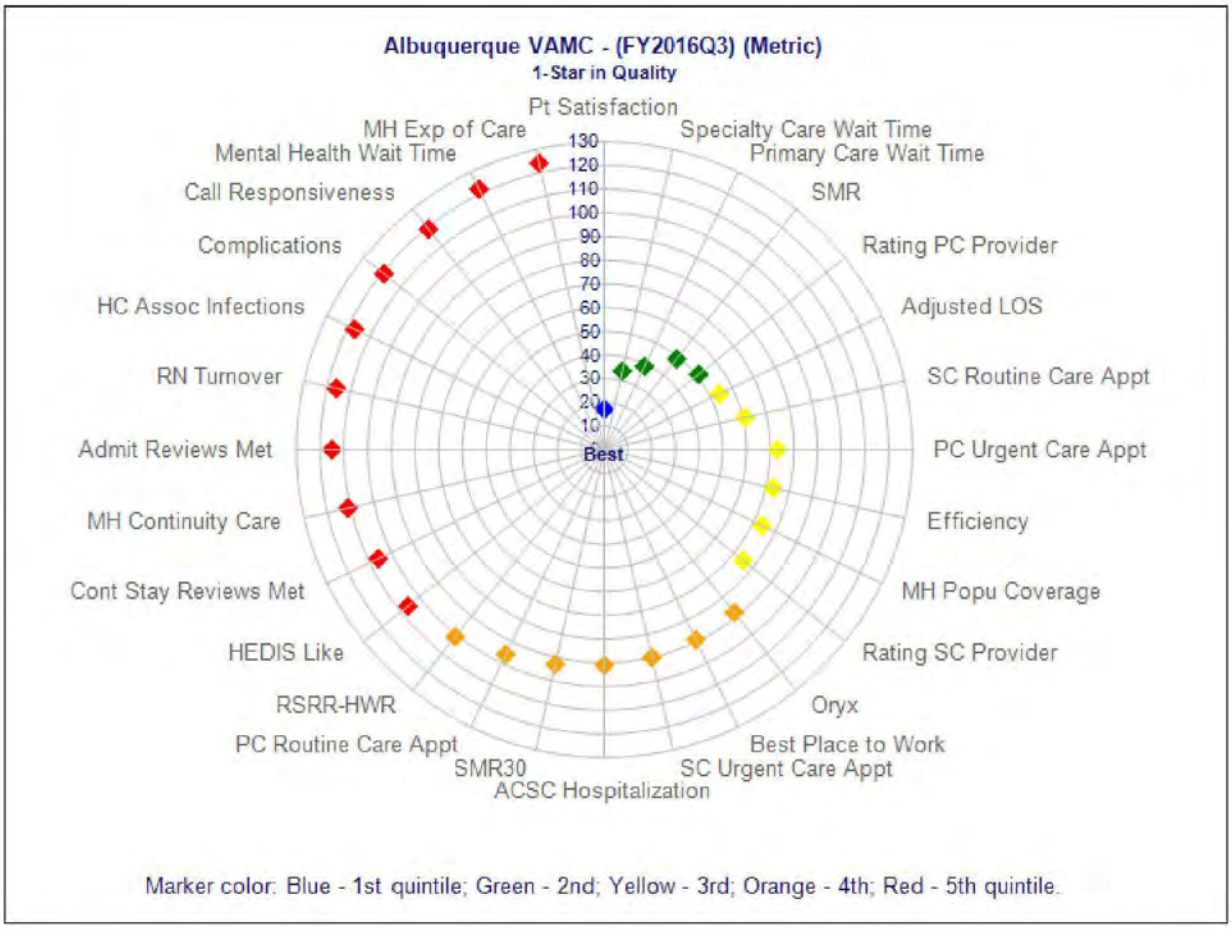

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/20/2016 2:50:52 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: On a call with (b) (6)

(b) (6) knows about thus or someone at bush institute?

Sent from my iPhone

> On Dec 20, 2016, at 9:23 AM, Poonam Alaigh <(b) (6) n@hotmail.com> wrote:
>
> We are planning the Bush Institute follow up and he mentioned treatment with Prazocin and Ketamine infusion and Propanolol- in studies as option for TBI/depression/pain syndromes - maybe you should connect with him for Jennie
>
> Sent from my iPad

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6)@gmail.com]
Sent: 12/10/2016 10:36:22 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Did you know this

Yep, I'll say.

On Dec 10, 2016 1:00 PM, "David shulkin" <Drshulkin@aol.com> wrote:

Wow thats a good deal

Sent from my iPhone

On Dec 10, 2016, at 12:00 PM, (b) (6) <(b) (6)@gmail.com> wrote:

https://www.archives.gov/about/laws/former-presidents.html

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/10/2016 6:00:16 PM
To: (b) (6) [(b) (6) @gmail.com]
Subject: Re: Did you know this

Wow thats a good deal

Sent from my iPhone

On Dec 10, 2016, at 12:00 PM, (b) (6) <(b) (6) @gmail.com> wrote:

> https://www.archives.gov/about/laws/former-presidents.html

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) @gmail.com]
Sent: 12/10/2016 5:00:59 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Did you know this

https://www.archives.gov/about/laws/former-presidents.html

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 12/17/2016 3:49:06 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: Quick 15 min call

Ok

Sent from my iPad

On Dec 17, 2016, at 9:58 AM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:

> I think we should talk to Vivek about transition stuff too- (b) (6) called me (Vivek person who we had dinner with). Call me a little before 3:30 if you can and I can give you the download
>
> Sent from my iPad
>
> On Dec 16, 2016, at 10:40 PM, David Shulkin <drshulkin@aol.com> wrote:
>
> > Saturday at 330?
> >
> > Sent from my iPad
> >
> > On Dec 16, 2016, at 10:06 PM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:
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> > > On Dec 16, 2016, at 10:03 PM, Vivek Murthy <(b) (6) @gmail.com> wrote:
> > >
> > > > Hi Poonam and David,
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> > > > On Thursday, December 15, 2016, David shulkin <Drshulkin@aol.com> wrote:
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> > > > Sent from my iPhone
> > > >
> > > > > On Dec 15, 2016, at 2:01 PM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:
> > > > >
> > > > > Can we just have a quick huddle and make sure we are all in sync with the January 9th event- anytime before next Tuesday (David starts

AMERICAN OVERSIGHT

vacation) or after the 28th would work- I could just patch the 3 of us at any point in the evening or weekend. Let me know if this would work or it you want to arrange for a more formal meeting through your respective offices, which is not always easy. Thanks

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> Sent from my iPad

AMERICAN OVERSIGHT

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From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/17/2016 2:58:06 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Re: Quick 15 min call

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Sent from my iPad

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> > > >
> > > > Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/17/2016 1:08:29 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
CC: Vivek Murthy [(b) (6) @gmail.com]
Subject: Re: Quick 15 min call

Ok

Sent from my iPhone

On Dec 17, 2016, at 5:32 AM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:

> Let's speak at 3:30pm today- I will patch both of you in on your cell phones- thanks
>
> Sent from my iPhone
>
> On Dec 16, 2016, at 10:03 PM, Vivek Murthy <(b) (6) @gmail.com> wrote:
>
> > Hi Poonam and David,
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> > > > Sent from my iPad

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From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/17/2016 10:32:37 AM
To: Vivek Murthy [(b) (6) @gmail.com]
CC: David shulkin [Drshulkin@aol.com]
Subject: Re: Quick 15 min call

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Sent from my iPhone

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From: David Shulkin [drshulkin@aol.com]
Sent: 12/17/2016 3:40:53 AM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: Quick 15 min call

Saturday at 330?

Sent from my iPad

On Dec 16, 2016, at 10:06 PM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:

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> > > > Thanks
> > > >
> > > > Sent from my iPad

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/17/2016 3:06:42 AM
To: Vivek Murthy [(b) (6) @gmail.com]
CC: David shulkin [Drshulkin@aol.com]
Subject: Re: Quick 15 min call

David, what works for you, just pick a time- I can make either work

Sent from my iPad

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> > Sent from my iPad

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/15/2016 9:11:40 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
CC: (b) (6) @gmail.com
Subject: Re: Quick 15 min call

This weekend works for me

Sent from my iPhone

> On Dec 15, 2016, at 2:01 PM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:
>
> Can we just have a quick huddle and make sure we are all in sync with the January 9th event- anytime before next Tuesday (David starts vacation) or after the 28th would work- I could just patch the 3 of us at any point in the evening or weekend. Let me know if this would work or it you want to arrange for a more formal meeting through your respective offices, which is not always easy. Thanks
>
> Sent from my iPad

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Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/15/2016 7:01:42 PM
To: (b) (6) @gmail.com; drshulkin@aol.com
Subject: Quick 15 min call

Can we just have a quick huddle and make sure we are all in sync with the January 9th event- anytime before next Tuesday (David starts vacation) or after the 28th would work- I could just patch the 3 of us at any point in the evening or weekend. Let me know if this would work or it you want to arrange for a more formal meeting through your respective offices, which is not always easy. Thanks

Sent from my iPad

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Message

From: David Shulkin [drshulkin@aol.com]
Sent: 12/22/2016 1:01:29 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: (b) (6)

Yes I agree

Sent from my iPad

On Dec 22, 2016, at 8:15 AM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:

> She told me and suggested I file an EEO complaint and that there would be many witnesses but I don't like doing that kind of stuff- it goes against my grain, never consider myself to be a victim - I agree, he will self implode
>
> Sent from my iPhone
>
> On Dec 21, 2016, at 4:23 PM, David Shulkin <drshulkin@aol.com> wrote:
>
> > I got it open
> >
> > It looks much much better and is really exactly what you hoped for at the beginning
> >
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> >
> > > Ecstatic!!
> > >
> > > Sent from my iPhone
> > >
> > > On Dec 21, 2016, at 3:58 PM, David Shulkin <drshulkin@aol.com> wrote:
> > >
> > > > Doing it now

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Are you pleased?
Sent from my iPad

On Dec 21, 2016, at 4:37 PM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:

> can you check the evaluation study please and let me know what you want me to do

---

From: David Shulkin <drshulkin@aol.com>
Sent: Wednesday, December 21, 2016 7:34 AM
To: Poonam Alaigh
Subject: Re: (b) (6)

Sounds like a good plan- again it's good to have options and they see the value in having you there

Sent from my iPad

On Dec 20, 2016, at 10:37 PM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:

> You know him better- I dont know him at all, I was just making my own assessment. Anyway, let all the chips fall where they may- we have many options, which is always the best position to be in.
>
> Also heard from AHS- they are ready to consider me for a part time employment role but want to cut my salary.

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I told them to have a market valuation based on my experience and qualifications and then to give me two options- one as a part time employment and the other as a consultant. I have made it clear that I would not consider any cut in my salary. This buys me time- they wont work on it until after the holidays and hopefully we hear from Bergen by then- at which point will be able to make a calculated and informed decision.

From: David Shulkin <drshulkin@aol.com>
Sent: Tuesday, December 20, 2016 9:06 PM
To: Poonam Alaigh
Subject: Re: (b) (6)

I was thinking the opposite- he is a know it all - has all the answers and would run VHA from VA

Sent from my iPad

On Dec 20, 2016, at 9:11 PM, Poonam Alaigh

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<(b) (6) @hotmail.com> wrote:

wow- would nt that be good for you- maybe to step into the DepSec positio n- he knows you and respec ts you

---

From: David Shulkin <drshulkin@aol.com>
Sent: Tuesday, December 20, 2016 8:09 PM
To: Poonam Alaigh
Subject: (b) (6)

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http://abcnews.go.com/Politics/wireStory/trump-blames-islamic-terrorists-turkey-germany-killings-44296537



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Sent
from
my
iPad

AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

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Sent: Tuesday, December 20, 2016 8:09 PM
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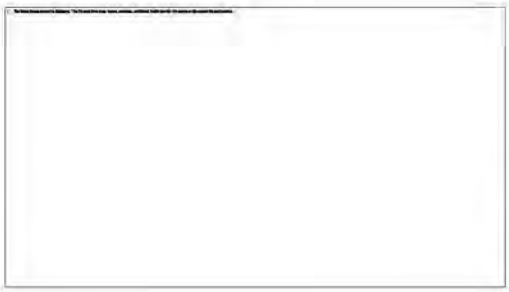
Subject: (b) (6)

http://abcnews.go.com/Politics/wireStory/trump-blames-islamic-terrorists-turkey-germany-killings-44296537



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Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 12/21/2016 9:07:50 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: (b) (6)

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> On Dec 21, 2016, at 3:58 PM, David Shulkin <drshulkin@aol.com> wrote:
>
> > Doing it now
> >
> > Are you pleased?
> > Sent from my iPad
> >
> > On Dec 21, 2016, at 4:37 PM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:
> >
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> >
> > ---
> > **From:** David Shulkin <drshulkin@aol.com>
> > **Sent:** Wednesday, December 21, 2016 7:34 AM
> > **To:** Poonam Alaigh
> > **Subject:** Re: (b) (6)

AMERICAN OVERSIGHT

Sounds like a good plan- again it's good to have options and they see the value in having you there

Sent from my iPad

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From: David Shulkin <drshulkin@aol.com>
Sent: Tuesday, December 20, 2016 9:06 PM
To: Poonam Alaigh
Subject: Re: (b) (6)

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Sent from my iPad

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From: David Shulkin <drshulkin@aol.com>
Sent: Tuesday, December 20, 2016 8:09 PM
To: Poonam Alaigh
Subject: (b) (6)

http://abcnews.go.com/Politics/wireStory/trump-blames-islamic-terrorists-turkey-germany-killings-44296537



AMERICAN OVERSIGHT

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 12/21/2016 9:00:10 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: (b) (6)

Can you resend the report to aol

I'm having trouble downloading on va phone

Sent from my iPad

On Dec 21, 2016, at 4:37 PM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:

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Subject: Re: (b) (6)

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Sent: Tuesday, December 20, 2016 9:06 PM
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http://abcnews.go.com/Politics/wireStory/trump-blames-islamic-terrorists-turkey-germany-killings-44296537



Trump Hosts Candidates for Ke
Affairs Post

abcnews.go.com

President-elect Donald Trump met Tuesday n
candidates for his unfilled Cabinet positions,
prospective hires to run the Department of V
a beleaguered agency that the Republican bu
vowed to overhaul. Vice President-elect Mike
with...

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/21/2016 8:58:59 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Re: (b) (6)

Ecstatic!!

Sent from my iPhone

On Dec 21, 2016, at 3:58 PM, David Shulkin <drshulkin@aol.com> wrote:

> Doing it now
>
> Are you pleased?
> Sent from my iPad
>
> On Dec 21, 2016, at 4:37 PM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:
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>
> ---
>
> **From:** David Shulkin <drshulkin@aol.com>
> **Sent:** Wednesday, December 21, 2016 7:34 AM
> **To:** Poonam Alaigh
> **Subject:** Re: (b) (6)
>
> Sounds like a good plan- again it's good to have options and they see the value in having you there
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Sent: Tuesday, December 20, 2016 9:06 PM
To: Poonam Alaigh
Subject: Re: (b) (6)

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Sent from my iPad

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Trump Hosts Candidates f
Affairs Post

abcnews.go.com

President-elect Donald Trump met Tu
candidates for his unfilled Cabinet po

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prospective hires to run the Departm
a beleaguered agency that the Reput
vowed to overhaul. Vice President-ele
with...

Sent from my iPad

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Message

From: David Shulkin [drshulkin@aol.com]
Sent: 12/21/2016 8:51:53 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: (b) (6)

Doing it now

Are you pleased?
Sent from my iPad

On Dec 21, 2016, at 4:37 PM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:

> can you check the evaluation study please and let me know what you want me to do

---

From: David Shulkin <drshulkin@aol.com>
Sent: Wednesday, December 21, 2016 7:34 AM
To: Poonam Alaigh
Subject: Re: (b) (6)

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Sent: Tuesday, December 20, 2016 9:06 PM
To: Poonam Alaigh
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prospective hires to run the Department of V
a beleaguered agency that the Republican bu
vowed to overhaul. Vice President-elect Mike
with...

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/21/2016 8:37:27 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Re: (b) (6)

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---

From: David Shulkin <drshulkin@aol.com>
Sent: Wednesday, December 21, 2016 7:34 AM
To: Poonam Alaigh
Subject: Re: (b) (6)

Sounds like a good plan- again it's good to have options and they see the value in having you there

Sent from my iPad

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To: Poonam Alaigh
Subject: (b) (6)

http://abcnews.go.com/Politics/wireStory/trump-blames-islamic-terrorists-turkey-germany-killings-44296537



Trump Hosts Candidates for Key Vet Affairs Post

abcnews.go.com

President-elect Donald Trump met Tuesday met with candidates for his unfilled Cabinet positions, includin prospective hires to run the Department of Veterans a beleaguered agency that the Republican businessm vowed to overhaul. Vice President-elect Mike Pence with...

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 12/21/2016 12:34:28 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: (b) (6)

Sounds like a good plan- again it's good to have options and they see the value in having you there

Sent from my iPad

On Dec 20, 2016, at 10:37 PM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:

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>
> **From:** David Shulkin <drshulkin@aol.com>
> **Sent:** Tuesday, December 20, 2016 9:06 PM
> **To:** Poonam Alaigh
> **Subject:** Re: (b) (6)
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> I was thinking the opposite- he is a know it all - has all the answers and would run VHA from VA
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> > ---
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> > **From:** David Shulkin <drshulkin@aol.com>
> > **Sent:** Tuesday, December 20, 2016 8:09 PM
> > **To:** Poonam Alaigh
> > **Subject:** (b) (6)

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http://abcnews.go.com/Politics/wireStory/trump-blames-islamic-terrorists-turkey-germany-killings-44296537



Trump Hosts Candidates for Key Vet Affairs Post

abcnews.go.com

President-elect Donald Trump met Tuesday met with candidates for his unfilled Cabinet positions, includin prospective hires to run the Department of Veterans a beleaguered agency that the Republican businessm vowed to overhaul. Vice President-elect Mike Pence with...

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/21/2016 2:37:07 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Re: (b) (6)

You know him better- I dont know him at all, I was just making my own assessment. Anyway, let all the chips fall where they may- we have many options, which is always the best position to be in.

Also heard from AHS- they are ready to consider me for a part time employment role but want to cut my salary. I told them to have a market valuation based on my experience and qualifications and then to give me two options- one as a part time employment and the other as a consultant. I have made it clear that I would not consider any cut in my salary. This buys me time- they wont work on it until after the holidays and hopefully we hear from Bergen by then- at which point will be able to make a calculated and informed decision.

From: David Shulkin <drshulkin@aol.com>
Sent: Tuesday, December 20, 2016 9:06 PM
To: Poonam Alaigh
Subject: Re: (b) (6)

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Sent from my iPad

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>
> **From:** David Shulkin <drshulkin@aol.com>
> **Sent:** Tuesday, December 20, 2016 8:09 PM
> **To:** Poonam Alaigh
> **Subject:** (b) (6)
>
> http://abcnews.go.com/Politics/wireStory/trump-blames-islamic-terrorists-turkey-germany-killings-44296537

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Trump Hosts Candidates for Key Veterans Affairs Post

abcnews.go.com

President-elect Donald Trump met Tuesday met with candidates for his unfilled Cabinet positions, including prospective hires to run the Department of Veterans Affairs, a beleaguered agency that the Republican businessman has vowed to overhaul. Vice President-elect Mike Pence met with...

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 12/21/2016 2:06:34 AM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: (b) (6)

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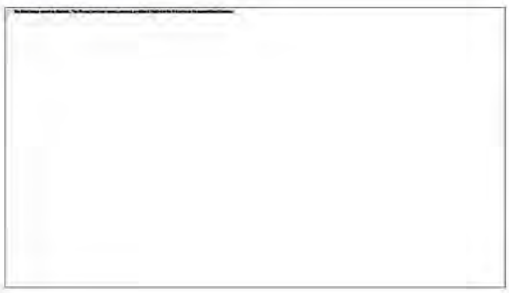
Sent: Tuesday, December 20, 2016 8:09 PM
To: Poonam Alaigh
Subject: (b) (6)

http://abcnews.go.com/Politics/wireStory/trump-blames-islamic-terrorists-turkey-germany-killings-44296537



Trump Hosts Candidates for Key Veterans Affairs Post

abcnews.go.com

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Sent from my iPad

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/21/2016 1:11:37 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Re: (b) (6)

wow- wouldnt that be good for you- maybe to step into the DepSec position- he knows you and respects you

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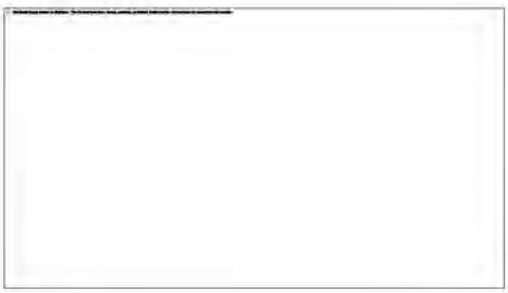
From: David Shulkin <drshulkin@aol.com>
Sent: Tuesday, December 20, 2016 8:09 PM
To: Poonam Alaigh
Subject: (b) (6)

http://abcnews.go.com/Politics/wireStory/trump-blames-islamic-terrorists-turkey-germany-killings-44296537



Trump Hosts Candidates for Key Veterans Affairs Post

abcnews.go.com

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Sent from my iPad

AMERICAN OVERSIGHT

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From: David Shulkin [drshulkin@aol.com]
Sent: 12/21/2016 1:09:10 AM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: (b) (6)

http://abcnews.go.com/Politics/wireStory/trump-blames-islamic-terrorists-turkey-germany-killings-44296537

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/19/2017 4:02:22 AM
To: Poonam Alaigh [(b) (6)@hotmail.com]
Subject: Re: Fellowship: Communications, VA

Ok - i may have timethursday late afternoon or friday late afternoon

Sent from my iPhone

On Jan 18, 2017, at 10:13 PM, Poonam Alaigh <(b) (6)@hotmail.com> wrote:

> Spoke to him today- more when we connect
>
> Sent from my iPad
>
> Begin forwarded message:
>
> **From:** "(b) (6) <(b) (6)@mayo.edu>
> **Date:** January 16, 2017 at 12:14:00 PM EST
> **To:** Poonam Alaigh <(b) (6)@hotmail.com>
> **Subject: Fellowship: Communications, VA**
>
> Thanks v. much Poonam....appreciate it; traveling tomorrow (Salzburg to Davos); best time for me will be noon or later EST; quite flexible EST on Wednesday.
>
> Best, (b)
>
> ---
>
> **From:** Poonam Alaigh [mailto:(b) (6)@hotmail.com]
> **Sent:** Monday, January 16, 2017 10:55 AM
> **To:** (b) (6)
> **Cc:** David shulkin; Bruce Moskowitz; Marc Sherman
> **Subject:** Re: Fellowship: Communications, VA
>
> Dr Moskowitz, Marc and (b) - good to meet all of you. We look forward to continuing this dialogue and exploring further this exciting way to ensure both the success of VA and the ability to communicate it.
>
> (b) (6) my personal cell phone number is (b) (6) - lets plan on speaking this week- either tomorrow or Wednesday. Will text you some times that work on my end and we can confirm.
>
> Thanks
>
> Poonam
>
> Sent from my iPad
>
> On Jan 16, 2017, at 9:58 AM, (b) (6) (b) (6)@mayo.edu> wrote:

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Thanks very much Dr. Shulkin. Dr. Alaigh, feel free to reach as it's convenient for you. Best option this week is my cell phone (b) (6) I will be connected throughout this week.

Best,

(b) (6)
Chair | Mayo Clinic Department of Public Affairs
(c) (b) (6)

On Jan 16, 2017, at 2:06 PM, David shulkin <Drshulkin@aol.com> wrote:

> (b) (6) this makes a great deal of sense. Im going to ask Dr Poonam Alaigh, my senior advisor to work through the details with you.
>
> I understand youll be busy in Davos but she is very responsive to email
>
> David
>
> Sent from my iPhone
>
> On Jan 16, 2017, at 12:32 AM, (b) (6) <(b) (6)@mayo.edu> wrote:
>
> > Hi -- comfortable w/ that approach; will be important to gain a better understanding of what skills are needed (social media; media relations; issues management; etc.); role the person would have relative to the existing staff/the Secretary; details of this person's "on boarding" into the role (logistics of office details, etc.).
> >
> > Apologize for "diving into the details," but would need to address these to tee up for success; happy to work these through w/ whomever you designate/recommend Dr. Shulkin. Away, traveling this week (World Economic Forum, Davos), but available to "dive in" next week and accomplish some of this remotely in the interim.
> >
> > Thanks,

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(b) (6)
Chair | Mayo Clinic Department of Public Affairs
(c) (b) (6)

On Jan 15, 2017, at 11:06 PM, Bruce Moskowitz <brucem(b) (6) mac.com> wrote:

> Agree
>
> Sent from my iPad
> Bruce Moskowitz
> M.D.
>
> On Jan 15, 2017, at 5:04 PM, David shulkin <Drshulkin@aol.com> wrote:
>
> > I like this!
> >
> > Sent from my iPhone
> >
> > On Jan 15, 2017, at 4:50 PM, Marc Sherman <mbsh(b) (6) @gmail.com> wrote:
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tatyourdiscretion.

OnSun,Jan15,2017at4:42PM,Davidsh

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ulkin<Drshulkin@aol.com>wrote:[redacted]-ithinkktheissueis

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whether the "executive sabbatical" should be publicly announ

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OnJanl5,2017,at3.58PM

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(b) (6)

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(b) (6)

@mayo.edu> wrote:

Hi Dr. Shulkin – thanks for your time

AMERICAN OVERSIGHT

is after noon; I'm keenly interested in assisting w/ your idea

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of a fellowship to support the VA Communications – please let me

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Best,

(b)(6)

Chair | Mayo Clinic Department of Public Affai

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Message

From: Poonam Alaigh [(b) (6)@hotmail.com]
Sent: 1/19/2017 3:13:24 AM
To: David shulkin [drshulkin@aol.com]
Subject: Fwd: Fellowship: Communications, VA

Spoke to him today- more when we connect

Sent from my iPad

Begin forwarded message:

> **From:** "(b) (6) <(b) (6)@mayo.edu>
> **Date:** January 16, 2017 at 12:14:00 PM EST
> **To:** Poonam Alaigh <(b) (6)@hotmail.com>
> **Subject: Fellowship: Communications, VA**
>
> Thanks v. much Poonam....appreciate it; traveling tomorrow (Salzburg to Davos); best time for me will be noon or later EST; quite flexible EST on Wednesday.
>
> Best, (b)
>
> ---
>
> **From:** Poonam Alaigh [mailto:(b) (6)@hotmail.com]
> **Sent:** Monday, January 16, 2017 10:55 AM
> **To:** (b) (6)
> **Cc:** David shulkin; Bruce Moskowitz; Marc Sherman
> **Subject:** Re: Fellowship: Communications, VA
>
> Dr Moskowitz, Marc and (b) - good to meet all of you. We look forward to continuing this dialogue and exploring further this exciting way to ensure both the success of VA and the ability to communicate it.
>
> (b) (6), my personal cell phone number is (b) (6) lets plan on speaking this week- either tomorrow or Wednesday. Will text you some times that work on my end and we can confirm.
>
> Thanks
>
> Poonam
>
> Sent from my iPad
>
> On Jan 16, 2017, at 9:58 AM, (b) (6) (b) (6)@mayo.edu> wrote:
>
> > Thanks very much Dr. Shulkin. Dr. Alaigh, feel free to reach as it's convenient for you. Best option this week is my cell phone ((b) (6) I will be connected throughout this week.
> >
> > Best,
> >
> > (b) (6)

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(c) (b) (6)

On Jan 16, 2017, at 2:06 PM, David shulkin <Drshulkin@aol.com> wrote:

> (b) (6) this makes a great deal of sense. Im going to ask Dr Poonam Alaigh, my senior advisor to work through the details with you.
>
> I understand youll be busy in Davos but she is very responsive to email
>
> David
>
> Sent from my iPhone
>
> On Jan 16, 2017, at 12:32 AM, (b) (6) <(b) (6)@mayo.edu> wrote:
>
> > Hi -- comfortable w/ that approach; will be important to gain a better understanding of what skills are needed (social media; media relations; issues management; etc.); role the person would have relative to the existing staff/the Secretary; details of this person's "on boarding" into the role (logistics of office details, etc.).
> >
> > Apologize for "diving into the details," but would need to address these to tee up for success; happy to work these through w/ whomever you designate/recommend Dr. Shulkin. Away, traveling this week (World Economic Forum, Davos), but available to "dive in" next week and accomplish some of this remotely in the interim.
> >
> > Thanks,
> >
> > (b) (6)
> > Chair | Mayo Clinic Department of Public Affairs
> > (c) (b) (6)
> >
> > On Jan 15, 2017, at 11:06 PM, Bruce Moskowitz <brucem(b) (6) mac.com> wrote:
> >
> > > Agree
> > >
> > > Sent from my iPad
> > > Bruce Moskowitz M.D.
> > >
> > > On Jan 15, 2017, at 5:04 PM, David

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shulkin <Drshulkin@aol.com> wrote:

> I like this!
>
> Sent from my iPhone
>
> On Jan 15, 2017, at 4:50 PM, Marc Sherman <mbs(b) (6) gmail.com> wrote:
>
> > Are those two options mutually exclusive? What if it were closely offered in the beginning (because you know who you are getting), and then once implemented, widely publicized to deliver the message that the VA is cutting edge and the

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place to be for prestige (which (b) can speak to as a member of the program...enhanced by the PR that (b) (6) Mayo pedigree adds) which will then start to draw other market-wide talent and get you top talent, but at your discretion.

On Sun, Jan 15, 2017 at 4:42 PM, David shulkin <Drshulkin@aol.com> wrote:

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(b) (6)

i think the issue is whether the "executive sabbatical" should be publicly announced and widely disseminated or if it should be selectively offered to members of our group and a few hand picked others?

Sent from my iPhone

On Jan 15, 2017, at 3:58 PM, (b) (6) <(b) (6)

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@may
o.edu>
wrote:

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son "next steps" to advance this idea; happy to talk w/ whomever

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B e s t ,



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[redacted]

Chair | Mayo Clinic Department of Public Affairs

200 First Street S.

AMERICAN OVERSIGHT

W
| Rochester, MN 55905
cell -
(b) (6)
| office
(b) (6)
e-mail -
(b) (6)

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(b)
(6)

@mayo.edu

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Message

From: (b) (6) [(b) (6) @gmail.com]
Sent: 12/8/2016 12:33:16 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Read her tweets

That or the senior advisor for strategic communications, Rob nabors old job before he became va chief of staff.

On Dec 8, 2016 7:24 AM, "David shulkin" <Drshulkin@aol.com> wrote:
Rosemarys job?

Sent from my iPhone

On Dec 7, 2016, at 11:03 PM, (b) (6) <(b) (6) @gmail.com> wrote:

12/6 best possible pick for va.

She likely will get a senior advisor role of some sort for communications

https://mobile.twitter.com/AmberSmithUSA?ref_src=twsrc%5Egoogle%7Ctwcamp%5Eserp%7Ctwgr%5Eauthor

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/8/2016 12:13:25 PM
To: (b) (6) [(b) (6) @gmail.com]
Subject: Re: Read her tweets

(b) (6) job?

Sent from my iPhone

On Dec 7, 2016, at 11:03 PM, (b) (6) <(b) (6) @gmail.com> wrote:

> 12/6 best possible pick for va.
>
> She likely will get a senior advisor role of some sort for communications
>
> https://mobile.twitter.com/AmberSmithUSA?ref_src=twsrc%5Egoogle%7Ctwcamp%5Eserp%7Ctwgr%5Eauthor

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Message

From: (b) (6) [(b) (6) @gmail.com]
Sent: 12/8/2016 4:03:29 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Read her tweets

12/6 best possible pick for va.

She likely will get a senior advisor role of some sort for communications

https://mobile.twitter.com/AmberSmithUSA?ref_src=twsrc%5Egoogle%7Ctwcamp%5Eserp%7Ctwgr%5Eauthor

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Message

From: (b) (6) [(b) (6) @gmail.com]
Sent: 12/15/2016 10:45:17 PM
To: David Shulkin [drshulkin@aol.com]

https://www.suny.edu/about/leadership/chancellor-nancy-zimpher/biography/

Here's the former UC president that's a really good family friend. She really helped shaped my university experience views as a first generation college student. She's amazing. I love her.

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Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/17/2016 4:08:55 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Re: SDVSB designation

I am so excited for this next phase of life- so much to do, so much opportunity and so much to accomplish. I am so blessed to have you as my partner- picked up my mom to be with me this weekend since (b) is away and I have been talking about you and our partnership. David you give me strength to deal with the future and the confidence to know that we can realize the full potential of possibilities. Thank you

Sent from my iPad

On Dec 17, 2016, at 10:51 AM, David Shulkin <drshulkin@aol.com> wrote:

> Ok I'm going through all my contacts now on who to a good contact for our consulting- I'm up to 157 now and only up to letter C- I have 2600 linked in to go through
>
> Sent from my iPad
>
> On Dec 17, 2016, at 8:12 AM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:
>
> > I was trying to get something going with (b) (6) next week but he is away- we are trujnf for the first week of January now
> >
> > Sent from my iPhone
> >
> > On Dec 17, 2016, at 8:08 AM, David shulkin <Drshulkin@aol.com> wrote:
> >
> > > This is good
> > >
> > > Sent from my iPhone
> > >
> > > On Dec 17, 2016, at 6:26 AM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:
> > >
> > > > See this- https://www.sba.gov/contracting/government-contracting-programs/service-disabled-veteran-owned-businesses
> > > >
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> > > >
> > > > Service-Disabled Veteran-Own Business Concerns ...

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www.sba.gov

The Veterans Entrepreneurship and Small Bu
Act of 1999 (Public Law 106-50) established a
wide goal of not less than 3% of the ...

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Message

From: David Shulkin [drshulkin@aol.com]
Sent: 12/17/2016 3:51:04 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: SDVSB designation

Ok I'm going through all my contacts now on who to a good contact for our consulting- I'm up to 157 now and only up to letter C- I have 2600 linked in to go through

Sent from my iPad

On Dec 17, 2016, at 8:12 AM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:

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> >
> > See this- https://www.sba.gov/contracting/government-contracting-programs/service-disabled-veteran-owned-businesses



Service-Disabled Veteran-Own
Business Concerns ...

www.sba.gov

The Veterans Entrepreneurship and Small Bu
Development Act of 1999 (Public Law 106-50
an annual government-wide goal of not less
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AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/17/2016 1:12:12 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: SDVSB designation

I was trying to get something going with (b) (6) next week but he is away- we are trujnf for the first week of January now

Sent from my iPhone

On Dec 17, 2016, at 8:08 AM, David shulkin <Drshulkin@aol.com> wrote:

> This is good
>
> Sent from my iPhone
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> On Dec 17, 2016, at 6:26 AM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:
>
> > See this- https://www.sba.gov/contracting/government-contracting-programs/service-disabled-veteran-owned-businesses



Service-Disabled Veteran-Owned Sm
Business Concerns ...

www.sba.gov

The Veterans Entrepreneurship and Small Business Development Act of 1999 (Public Law 106-50) establ an annual government-wide goal of not less than 3%

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/17/2016 1:08:14 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: SDVSB designation

This is good

Sent from my iPhone

On Dec 17, 2016, at 6:26 AM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:

> See this- https://www.sba.gov/contracting/government-contracting-programs/service-disabled-veteran-owned-businesses



Service-Disabled Veteran-Owned Small Business Concerns ...

www.sba.gov

The Veterans Entrepreneurship and Small Business Development Act of 1999 (Public Law 106-50) established an annual government-wide goal of not less than 3% of the ...

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Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/17/2016 11:26:02 AM
To: David Shulkin [drshulkin@aol.com]
Subject: SDVSB designation

See this- https://www.sba.gov/contracting/government-contracting-programs/service-disabled-veteran-owned-businesses



Service-Disabled Veteran-Owned Small Business Concerns ...

www.sba.gov

The Veterans Entrepreneurship and Small Business Development Act of 1999 (Public Law 106-50) established an annual government-wide goal of not less than 3% of the ...

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/28/2016 1:40:21 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: Are you back

Ok im going out about 4 - i cracked my iphone screen on vacation and have an appoi tment to fix it

Pick a time tommorow- im pretty open

Sent from my iPhone

> On Dec 28, 2016, at 8:33 AM, Poonam Alaigh <(b) (6) n@hotmail.com> wrote:
>
> Today after 3:30pm- in back to back all day until then.
>
> Tomorrow, a lot of flexibility as of now, but can change. Friday- 12 to 3pm. And yes, available over the holiday weekend- Saturday thru Monday
>
> Sent from my iPhone
>
>> On Dec 28, 2016, at 8:08 AM, David shulkin <Drshulkin@aol.com> wrote:
>>
>> Whats your schedule over the next few days?
>>
>> Sent from my iPhone
>>
>>> On Dec 28, 2016, at 7:33 AM, Poonam Alaigh <(b) (6) n@hotmail.com> wrote:
>>>
>>> Can't wait for you to share your epiphany
>>>
>>> Sent from my iPad

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Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/28/2016 1:33:17 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Are you back

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Sent from my iPhone

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>
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> Sent from my iPhone
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>>
>> Can't wait for you to share your epiphany
>>
>> Sent from my iPad

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/28/2016 1:08:29 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: Are you back

Whats your schedule over the next few days?

Sent from my iPhone

> On Dec 28, 2016, at 7:33 AM, Poonam Alaigh <(b) (6) n@hotmail.com> wrote:
>
> Can't wait for you to share your epiphany
>
> Sent from my iPad

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/28/2016 12:33:33 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Are you back

Can't wait for you to share your epiphany

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 12/21/2016 9:11:01 PM
To: Poonam Alaigh [(b) (6)]@hotmail.com]
Subject: Fwd: Google Alert - shulkin

I have no idea if this could lead to connections but I thought it might be worthwhile

Sent from my iPad

Begin forwarded message:

From: Google Alerts <googlealerts-noreply@google.com>
Date: December 21, 2016 at 4:00:28 PM AST
To: drshulkin@aol.com
Subject: Google Alert - shulkin

Google Alerts

shulkin

Daily update · December 21, 2016

NEWS

NFL Doing More For Research On Concussions

Football Insiders

The Honorable Dr. David J. **Shulkin** is Under Secretary for Health for the United States Department of Veterans Affairs. As the Chief Executive of the ...

Flag as irrelevant

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/18/2017 1:02:14 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: Laverne

I agree

Sent from my iPhone

> On Jan 18, 2017, at 7:22 AM, Poonam Alaigh <(b) (6) n@hotmail.com> wrote:
>
> Were you planning to out her in acting secretary role- I would strongly advice against that- I like the idea of Ron much better
>
> Sent from my iPhone

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Message

From: Poonam Alaigh [(b) (6)@hotmail.com]
Sent: 1/18/2017 12:22:14 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Laverne

Were you planning to out her in acting secretary role- I would strongly advice against that- I like the idea of Ron much better

Sent from my iPhone

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Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/6/2016 3:40:45 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: "Poonam is back"

To you too PARTNER- although as my Dad would always say- "there are many slips between the cup and the lips" - but enjoying a small win in the interim - the journey!! High five to you!

Sent from my iPad

On Dec 6, 2016, at 10:25 AM, David shulkin <Drshulkin@aol.com> wrote:

> Wow! When you cone back- thats coning back! Congrats
>
> Sent from my iPhone
>
> On Dec 6, 2016, at 9:59 AM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:
>
> > Again, apologies, but was just so down yesterday with stuff! Feeling back in control of my destiny and know that I will drive forward ***for the both of us***, so don't worry on this end, just take care of (b) (6) (b) (6) and everything else.
> >
> > Just finished a meeting with the nursing home group- they have agreed tentatively on the pricing plan for our initiative and will take it to the board.
> >
> > It will be $10K for initial assessment and $1200/month for each facility. If all the facilities in her network agree- it will mean gross annual revenues of $1.5M
> >
> > We will talk later!

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/6/2016 3:25:50 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: "Poonam is back"

Wow! When you cone back- thats coning back! Congrats

Sent from my iPhone

On Dec 6, 2016, at 9:59 AM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:

> Again, apologies, but was just so down yesterday with stuff! Feeling back in control of my destiny and know that I will drive forward ***for the both of us***, so don't worry on this end, just take care of (b) (6) , (b) (6) and everything else.
>
> Just finished a meeting with the nursing home group- they have agreed tentatively on the pricing plan for our initiative and will take it to the board.
>
> It will be $10K for initial assessment and $1200/month for each facility. If all the facilities in her network agree- it will mean gross annual revenues of $1.5M
>
> We will talk later!

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/6/2016 2:59:55 PM
To: David Shulkin [drshulkin@aol.com]
Subject: "Poonam is back"

Again, apologies, but was just so down yesterday with stuff! Feeling back in control of my destiny and know that I will drive forward ***for the both of us***, so don't worry on this end, just take care of (b) (6) (b) (6) and everything else.

Just finished a meeting with the nursing home group- they have agreed tentatively on the pricing plan for our initiative and will take it to the board.

It will be $10K for initial assessment and $1200/month for each facility. If all the facilities in her network agree- it will mean gross annual revenues of $1.5M

We will talk later!

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 1/13/2017 1:55:45 AM
To: (b) (6) @ptt.gov
CC: (b) (6) @gmail.com
Subject: Re: Confirmation follow-up

sure- (b) (6) can we track this down through (b) (6)

-----Original Message-----
From: (b) (6)) (6) @ptt.gov>
To: David Shulkin <drshulkin@aol.com>; d(b) (6) (b) (6) @ptt.gov>
Cc: (b) (6) (b) (6) @ptt.gov>; (b) (6) t@ptt.gov>; (b) (6)
<(b) (6) @yahoo.com>
Sent: Thu, Jan 12, 2017 7:48 pm
Subject: Re: Confirmation follow-up

Dr Shulkin,

I did not get an email about 60 minutes. Could you please have that sent to me so we can track.

Donovan isn't filing her piece until tomorrow afternoon. I know that (b) is working on the accomplishments document we discussed this morning. I want to be sure to get the key pieces of that to Donovan by Noon.

On Thu, Jan 12, 2017 at 7:43 PM David Shulkin <drshulkin@aol.com> wrote:

I realized my cell number had a typo in it. It should be 610 453 (b)

Also David I wanted to make sure that you received an email that 60 minutes has requested an interview with me.

We have told them that we would not speak prior to confirmation but I wanted to make sure you were aware

thanks

AMERICAN OVERSIGHT

David Shulkin MD

-----Original Message-----

From: (b) (6) (b) (6) @ptt.gov>

To: drshulkin <drshulkin@aol.com>

Cc: (b) (6) <(b) (6) ptt.gov>; (b) (6) <(b) (6) ptt.gov>(b) (6) (b) (6) @ptt.gov>; (b) (6) <(b) (6) @yahoo.com>

Sent: Thu, Jan 12, 2017 12:19 pm

Subject: Confirmation follow-up

Hi David,

Congrats again.

AMERICAN OVERSIGHT

Attached are the three documents we discussed.

Contacts:

(b) (6) - White House Senior Advisor - (b) (6) @yahoo.com - (b) (6)

(b) (6) - Media Sherpa (b) (6) @ptt.gov - (b) (6)

(b) (6) - Cabinet Affairs - (b) (6) @ptt.gov - (b) (6)

My information is below - I am heading up the confirmations team.

Let us know if you have any questions.

AMERICAN OVERSIGHT

And, most importantly - good luck on the paperwork. It is the driver in your process. I understand that the Veteran's Affairs committee had tentatively targeted Jan. 29 for a hearing. While it is unlikely we can get paperwork cleared by then, it does show that they are eager to move the nomination.

Cheers,

(b) (6)

--

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(b) (6) [redacted]

PTT Confirmations

(b) (6) [redacted]

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/16/2016 11:02:33 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Fwd: [EXTERNAL] An Invitation: Emotional Well-Being Convening - January 9, 2017

Sent from my iPhone

Begin forwarded message:

From: "Shulkin, David J., MD" <David.Shulkin@va.gov>
Date: December 16, 2016 at 4:47:54 PM EST
To: 'Dr Shulkin' <drshulkin@aol.com>, "Shulkin, David J., MD" <David.Shulkin@va.gov>
Subject: FW: [EXTERNAL] An Invitation: Emotional Well-Being Convening - January 9, 2017

-----Original Message-----
From: OS Surgeon.General (HHS\OASH) (b) (6) @HHS.GOV]
Sent: Friday, December 16, 2016 02:58 PM Eastern Standard Time
To: OS Surgeon.General (HHS\OASH)
Subject: [EXTERNAL] An Invitation: Emotional Well-Being Convening - January 9, 2017



A joint convening of the Office of the Surgeon General
& Veterans Health Administration

Please join

VADM Vivek H. Murthy

19th U.S. Surgeon General

AMERICAN OVERSIGHT

&

Honorable Dr. David Shulkin

VA Under Secretary for Health

For an unprecedented gathering of thought leaders from science, policy, and practice to inform a national agenda on emotional well-being.

The convening will provide a forum to share diverse perspectives, foster forward-thinking dialogue, and facilitate collaboration & partnerships among participants. Through snapshots of current work and personal stories, this small group will engage in deep discussion about the path towards making emotional well-being a pillar of health in America.

We look forward to creating this future with you.

~

Monday, January 9, 2017

IBM Corporation

Center for Cognitive Government

600 14th Street, NW | Washington, DC 20005

Second Floor

8:30am – 5:30pm

Optional evening reception to follow

Please RSVP with your name, email, and brief bio & photo to

(b) (6) .(b) (6) @hhs.gov by **December 23, 2016.**

For more information on the convening please email

AMERICAN OVERSIGHT

(b) (6) @hhs.gov or (b) (6) @va.gov

~

Travel and Lodging

For your convenience, there will be a discounted block of rooms held at the Washington Hilton for out of town attendees - booking information to follow. Funding will not be provided for travel and lodging.

This invitation is non-transferable.

AMERICAN OVERSIGHT

Message

From: Jennifer Lee [(b) (6) @gmail.com]
Sent: 1/10/2017 7:30:11 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Rapid Updates from today

Roger. Will do

On Jan 10, 2017 2:28 PM, "David shulkin" <Drshulkin@aol.com> wrote:
Yes please send to them

Sent from my iPhone

> On Jan 10, 2017, at 1:57 PM, Jennifer Lee <(b) (6) @gmail.com> wrote:
>
> I have a few updates for you- call me if you want to talk- but wanted you to know:
>
> - Ash was called by Ron Thomas again today. He asked for a high level org chart with names filled in. she is unsure whether to provide it or not, but is thinking we probably should because he can just get it from someone else. He said the team was meeting and wanted it. what do you think? should we send?
>
> (b) (6) found out that the ART team is planning for a RFP for change management for VACO very soon - not surprising I suppose. and not first time it has happened.
> this probably explains why they want org charts
>
> -(b) called Snyder and gave him the feedback (just now by phone) he had gathered. He said Snyder told him DEPSEC was likely to be the continuity and that folks on 10th floor were a bit edgy that you got called to NY and not SECVA. just FYI.
>
> -various people (lower level staff) here at VACO are buzzing that you went to NY. they are asking whether you are being considered for SECVA. I just smile.
>
>
>

AMERICAN OVERSIGHT

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>
>
>

AMERICAN OVERSIGHT

Message

From: Jennifer Lee [(b) (6) @gmail.com]
Sent: 12/16/2016 3:19:17 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Thank you!

Hi David,
I love my mug!! thank you!!
Am so grateful to be part of your team.
Thank you for bringing me on board.
I'm excited for everything we will accomplish together next year.
Jen :)

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) @gmail.com]
Sent: 12/7/2016 4:50:34 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Previous NPR Interview Recording Here
Attachments: Shulkin And Quil.m4a

Recording attached.

(b) (6)

AMERICAN OVERSIGHT

Message

From: Michael Tepper [(b) (6) @yahoo.com]
Sent: 1/12/2017 3:01:22 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Re: GPO-PLUMBOOK-2016-8-30.pdf

Thank you so much David. I'll go through this.

On Jan 11, 2017, at 21:36, David Shulkin <drshulkin@aol.com> wrote:

> Sent from my iPad
>
> Begin forwarded message:
>
> **From:** (b) (6) <(b) (6) @gmail.com>
> **Date:** January 11, 2017 at 9:16:56 PM EST
> **To:** David Shulkin <drshulkin@aol.com>, "Wright, Vivieca (Simpson) (SES)" <Vivieca.wright@va.gov>
> **Subject: GPO-PLUMBOOK-2016-8-30.pdf**
>
> Appointees take a look.
> <GPO-PLUMBOOK-2016-8-30.pdf>

AMERICAN OVERSIGHT

Message

From: [(b) (6) (t(b) (6) va.gov]
Sent: 1/12/2017 2:40:49 AM
To: 'David Shulkin' [drshulkin@aol.com]
Subject: RE: [EXTERNAL] GPO-PLUMBOOK-2016-8-30.pdf

Yes

-----Original Message-----
From: David Shulkin [drshulkin@aol.com]
Sent: Wednesday, January 11, 2017 09:29 PM Eastern Standard Time
To: Wright, Vivieca (Simpson)
Cc: (b) (6)
Subject: Re: [EXTERNAL] GPO-PLUMBOOK-2016-8-30.pdf

Can you show me tommorow

I don't see any attachment

Sent from my iPad

On Jan 11, 2017, at 9:21 PM, Wright, Vivieca (Simpson) <Vivieca.Wright@va.gov> wrote:

> Very helpful
>
> -----Original Message-----
> **From:** (b) (6) [(b) (6) @gmail.com]
> **Sent:** Wednesday, January 11, 2017 09:17 PM Eastern Standard Time
> **To:** David Shulkin; Wright, Vivieca (Simpson)
> **Subject:** [EXTERNAL] GPO-PLUMBOOK-2016-8-30.pdf
>
> Appointees take a look.

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 1/12/2017 2:36:16 AM
To: Michael Tepper [(b) (6) @yahoo.com]
Subject: Fwd: GPO-PLUMBOOK-2016-8-30.pdf
Attachments: GPO-PLUMBOOK-2016-8-30.pdf; Untitled attachment 19611.htm

Sent from my iPad

Begin forwarded message:

From: (b) (6) <(b) (6) @gmail.com>
Date: January 11, 2017 at 9:16:56 PM EST
To: David Shulkin <drshulkin@aol.com>, "Wright, Vivieca (Simpson) (SES)" <Vivieca.wright@va.gov>
Subject: GPO-PLUMBOOK-2016-8-30.pdf

Appointees take a look.

AMERICAN OVERSIGHT

AUTHENTICATED U.S. GOVERNMENT INFORMATION GPO

DEPARTMENT OF VETERANS AFFAIRS

Location	Position Title	Name of Incumbent	Type of Appt.	Pay Plan	Level, Grade, or Pay	Tenure	Expires
	OFFICE OF THE SECRETARY AND DEPUTY						
Washington, DC	Secretary of Veterans Affairs	Robert A. McDonald	PAS	EX	I		
Do	Deputy Secretary of Veterans Affairs	Sloan D. Gibson IV	PAS	EX	II		
Do	Chief of Staff	Vacant		ES			
Do	Deputy Chief of Staff	Career Incumbent	CA	ES			
Do	Executive Secretary to the Department	.....do	CA	ES			
Do	Director, Center for Minority Veterans	Barbara A. Ward	NA	ES			
Do	Director, Center for Women Veterans	Kayla M. Williams	NA	ES			
Do	Senior Advisor, Strategic Engagement	Brandon L. Fureigh	NA	ES			
Do	Senior Advisor	Vacant		ES			
Do	.....do	Marina Stone Martin	NA	ES			
Do	.....do	Vacant		ES			
Do	.....do	Joshua David Jacobs	NA	ES			
Do	.....do	Vacant		ES			
Do	Senior Advisor for Appeals Modernization	Carol Ann DiBattiste	TA	ES			04/30/19
Do	Special Assistant	Charlyn A. Isaac	SC	GS	13		
Do	Senior Advisor for Management Initiatives and White House Liaison.	Carrie A. Kagawa	SC	GS	14		
Do	Director, Center for Faith Based Community Initiatives.	Evna T. Lavelle	SC	GS	15		
	OFFICE OF ACQUISITIONS, LOGISTICS AND CONSTRUCTION						
Frederick, MD	Chancellor, VA Acquisition Academy	Vacant		ES			
	Office of Acquisition and Materiel Management						
Washington, DC	Associate Deputy Assistant Secretary Logistics and Supply Chain Management.	Career Incumbent	CA	ES			
	BOARD OF VETERANS' APPEALS						
Do	Chairman, Board of Veterans' Appeals	Vacant	PAS	EX	IV		
	OFFICE OF THE GENERAL COUNSEL						
Do	General Counsel	Leigh A. Bradley	PAS	EX	IV		
Do	Principal Deputy General Counsel	Career Incumbent	CA	ES			
Do	Special Counsel	Vacant		ES			
Do	Assistant General Counsel-Group II	Career Incumbent	CA	ES			
Do	Assistant General Counsel, Group IV	.....do	CA	ES			
Do	Assistant General Counsel Group VII	.....do	CA	ES			
Do	Chief Counsel Health Law Group	.....do	CA	ES			
Do	Chief Counsel, Procurement Law Group	.....do	CA	ES			
Do	Special Assistant	Jennifer Harkin	SC	GS	14		
Do	Associate Chief Counsel	Kimberly P. McLeod	XS	SL	$156,775		
	OFFICE OF THE ASSISTANT SECRETARY FOR MANAGEMENT						
Do	Assistant Secretary for Management	Vacant	PA	EX	IV		
Do	Director, Programming Analysis and Evaluation.	.....do		ES			
Do	Executive Director	.....do		ES			
Do	Chief Financial Officer	.....do	PAS	EX	IV		
	Office of Budget						
Do	Deputy Assistant Secretary for Budget	Career Incumbent	CA	ES			
Do	Associate Deputy Assistant Secretary, Budget Operations.	.....do	CA	ES			
Do	Associate Deputy Assistant Secretary, Program Budgets.	Vacant		ES			
	Office of Finance						
Do	Associate Deputy Assistant Secretary for Financial Policy.	Career Incumbent	CA	ES			
Do	Associate Deputy Assistant Secretary for Financial Process Improvement and Audit Readiness.	.....do	CA	ES			
Do	Director, Corporate Travel and Management Reporting.	.....do	CA	ES			
	Office of Asset Enterprise Management						
Do	Director, Asset Enterprise Management	.....do	CA	ES			
	OFFICE OF THE ASSISTANT SECRETARY FOR POLICY AND PLANNING						
Do	Assistant Secretary for Policy and Planning	Linda A. Schwartz	PAS	EX	IV		
Do	Director, National Center for Veterans Analysis and Statistics.	Career Incumbent	CA	ES			

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DEPARTMENT OF VETERANS AFFAIRS—Continued

Location	Position Title	Name of Incumbent	Type of Appt.	Pay Plan	Level, Grade, or Pay	Tenure	Expires
Washington, DC	Deputy Assistant Secretary for Data Governance and Analysis.	Career Incumbent	CA	ES	.....	.....	
Do	Director, Office of Performance Management	.....do	CA	ES	.....	.....	
Do	Principal Deputy Assistant Secretary	.....do	CA	ES	.....	.....	
Do	Executive Director	Vacant	.....	ES	.....	.....	
Do	Director Enterprise Risk Management	.....do	.....	ES	.....	.....	
Do	Senior Advisor/Chief Veteran Experience Officer.	Thomas B. Allin	NA	ES	.....	.....	
Do	Director, Support Services	Career Incumbent	CA	ES	.....	.....	
Do	Executive Director, MyVA Program Management Office.	.....do	CA	ES	.....	.....	
Do	Deputy Chief Veterans Experience Officer	.....do	CA	ES	.....	.....	
Do	Senior Call Center Advisor, Architecture and Design.	Rosetta Lue	TA	ES	.....	.....	11/29/18
Do	Executive Director	Career Incumbent	CA	ES	.....	.....	
Do	Senior Advisor, VEO (Implementation)	.....do	CA	ES	.....	.....	
Do	Director Navigation and Advocacy	.....do	CA	ES	.....	.....	
Do	Senior Advisor for Strategic Partnerships	Matthew S. Collier	NA	ES	.....	.....	
New York New York, NY.	District Veterans Experience Officer	James Z. Wartski	NA	ES	.....	.....	
Washington, DC	Director Enterprise Access and Integration	Vacant	.....	ES	.....	.....	
Atlanta, GA	District Veterans Experience Officer (Southeast).	Career Incumbent	CA	ES	.....	.....	
Chicago, IL	District Veterans Experience Officer (Midwest).	Vacant	.....	ES	.....	.....	
Los Angeles, CA	District Veterans Experience Officer (Pacific)	.....do	.....	ES	.....	.....	
Washington, DC	Director Insight and Design	Sarah B. Brooks	SC	GS	15	.....	
Do	District Veterans Experience Officer (Continental).	Career Incumbent	CA	ES	.....	.....	
Do	Director Special Programs	Julia M. Kim	SC	GS	15	.....	
	Office of Policy						
Do	Deputy Assistant Secretary for Policy	Vacant	.....	ES	.....	.....	
Do	Executive Director	Career Incumbent	CA	ES	.....	.....	
Do	.....do	.....do	CA	ES	.....	.....	
	OFFICE OF THE ASSISTANT SECRETARY FOR HUMAN RESOURCES AND ADMINISTRATION						
Do	Assistant Secretary for Human Resources and Administration.	Vacant	PA	EX	IV	.....	
Do	Principal Deputy Assistant Secretary for Human Resources and Administration.	Career Incumbent	CA	ES	.....	.....	
Do	Deputy Assistant Secretary for Labor-Management Relations.	.....do	CA	ES	.....	.....	
	Office of Human Resources Management						
Do	Deputy Assistant Secretary for Human Resources Management.	Vacant	.....	ES	.....	.....	
Do	Associate Deputy Assistant Secretary (ADAS) for HR Automation, Systems, and Analytics.	Career Incumbent	CA	ES	.....	.....	
Do	Associate Deputy Assistant Secretary for Human Resources Management Operations.	.....do	CA	ES	.....	.....	
	Office of Diversity Management and Equal Employment Opportunity						
Do	Deputy Assistant Secretary for Diversity Management and Equal Employment Opportunity.	.....do	CA	ES	.....	.....	
	Office of Administration						
Do	Executive Director	.....do	CA	ES	.....	.....	
Do	Associate Deputy Assistant Secretary for Administration.	.....do	CA	ES	.....	.....	
	Office of Resolution Management						
Do	Deputy Assistant Secretary for Resolution Management.	.....do	CA	ES	.....	.....	
Do	Associate Deputy Assistant Secretary for Resolution Management.	.....do	CA	ES	.....	.....	
	VA Learning University						
Do	Dean, Veterans Affairs Learning University ..	.....do	CA	ES	.....	.....	
	OFFICE OF THE ASSISTANT SECRETARY FOR PUBLIC AND INTERGOVERNMENTAL AFFAIRS						
Do	Assistant Secretary for Public and Intergovernmental Affairs.	Rosemary J. Williams	PA	EX	IV	.....	

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DEPARTMENT OF VETERANS AFFAIRS—Continued

Location	Position Title	Name of Incumbent	Type of Appt.	Pay Plan	Level, Grade, or Pay	Tenure	Expires
Washington, DC	Executive Director Public and Intergovernmental Affairs.	Vacant	.....	ES	.....	.....	
Do	Press Secretary	Victoria N. Dillon	SC	GS	15	.....	
Do	Special Assistant	Raleigh R H Contreras	SC	GS	12	.....	
	Office of Public Affairs						
Do	Director for Public Affairs	Vacant	.....	ES	.....	.....	
Do	Special Advisor	Brian A. Hawthorne	SC	GS	14	.....	
	Office of Intergovernmental Affairs						
Do	Deputy Assistant Secretary for Intergovernmental Affairs.	James Albino	NA	ES	.....	.....	
Do	Director, Office of Tribal Government Relations.	Career Incumbent	CA	ES	.....	.....	
	OFFICE OF THE ASSISTANT SECRETARY FOR GOVERNMENT RELATIONS						
Do	Assistant Secretary for Congressional and Legislative Affairs.	Vacant	PAS	EX	IV	.....	
Do	Deputy Assistant Secretary for Congressional Affairs.	Michelle Dominguez	NA	ES	.....	.....	
Do	Principal Deputy Assistant Secretary for Congressional and Legislative Affairs.	Career Incumbent	CA	ES	.....	.....	
Do	Director Oversight	Ryan Keith Hedgepeth	SC	GS	15	.....	
Do	Special Assistant	Mark A. Howell	SC	GS	12	.....	
	OFFICE OF THE ASSISTANT SECRETARY FOR INFORMATION AND TECHNOLOGY						
Do	Assistant Secretary for Information and Technology.	Laverne H. Council	PAS	EX	IV	.....	
Do	Principal Deputy Assistant Secretary for Information and Technology.	Career Incumbent	CA	ES	.....	.....	
Do	Executive Director (Field Operations)	Vacant	.....	ES	.....	.....	
Do	Executive Director (Systems Engineering)	Career Incumbent	CA	ES	.....	.....	
Do	Deputy Chief Information Officer for Architecture, Strategy, and Design.	.....do	CA	ES	.....	.....	
Do	Deputy Director	Vacant	.....	ES	.....	.....	
Do	Executive Director, Application Support	.....do	.....	ES	.....	.....	
Do	Executive Director, Development Management Service.	.....do	.....	ES	.....	.....	
Do	Deputy Chief Information Officer	Career Incumbent	CA	ES	.....	.....	
Do	Director	.....do	CA	ES	.....	.....	
Do	Chief Learning Officer	.....do	CA	ES	.....	.....	
Do	Deputy Chief Information Officer, Account Manager for Health.	.....do	CA	ES	.....	.....	
Do	Deputy Chief Information Officer, Account Manager for Benefits.	.....do	CA	ES	.....	.....	
Do	Deputy Chief Information Officer, Enterprise Data Management.	Vacant	.....	ES	.....	.....	
Do	Deputy Assistant Secretary, Enterprise Program Management Officer.	Career Incumbent	CA	ES	.....	.....	
Do	Executive Director, Enterprise Project Manager.	.....do	CA	ES	.....	.....	
Do	Deputy Chief Information Officer, Account Manager for Corporate.	.....do	CA	ES	.....	.....	
Eatontown, NJ	Executive Director, Leans Systems Engineering.	.....do	CA	ES	.....	.....	
Washington, DC	Executive Director, OI&T Enterprise Cybersecurity Strategy.	Dominic Cussatt	TA	ES	.....	.....	05/14/19
	OFFICE OF THE ASSISTANT SECRETARY FOR OPERATIONS, SECURITY AND PREPAREDNESS						
Do	Assistant Secretary for Operations, Security and Preparedness.	Kevin Hanretta	PA	EX	IV	.....	
Do	Director, Office of Personnel Security and Identity Management.	Career Incumbent	CA	ES	.....	.....	
	NATIONAL CEMETERY ADMINISTRATION						
Do	Under Secretary for Memorial Affairs	Vacant	PAS	EX	III	.....	
Do	Deputy Under Secretary For Field Programs	Career Incumbent	CA	ES	.....	.....	
Do	Deputy Under Secretary for Memorial Affairs	.....do	CA	ES	.....	.....	
Do	Associate Director, Office of Field Programs ..	.....do	CA	ES	.....	.....	
Do	Associate Deputy Under Secretary for Management.	.....do	CA	ES	.....	.....	

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VA-19-0799-J-001444
DS_00009074

DEPARTMENT OF VETERANS AFFAIRS—Continued

Location	Position Title	Name of Incumbent	Type of Appt.	Pay Plan	Level, Grade, or Pay	Tenure	Expires
Washington, DC	Executive Director, Memorial Programs	Vacant	.....	ES	.....	.....	
Philadelphia, PA	Memorial Service Network Director	Career Incumbent	CA	ES	.....	.....	
Decatur, GA	.....do	.....do	CA	ES	.....	.....	
Indianapolis, IN	.....do	.....do	CA	ES	.....	.....	
Lakewood, CO	.....do	.....do	CA	ES	.....	.....	
Oakland, CA	.....do	.....do	CA	ES	.....	.....	
Washington, DC	Executive Director	.....do	CA	ES	.....	.....	
	VETERANS BENEFITS ADMINISTRATION						
Do	Under Secretary for Benefits	Vacant	PAS	EX	III	.....	
Do	Principal Deputy Under Secretary for Benefits.	Career Incumbent	CA	ES	.....	.....	
Do	Director, Compensation and Pension Service	Vacant	.....	ES	.....	.....	
Do	Director, Loan Guaranty Service	Career Incumbent	CA	ES	.....	.....	
Do	Director Vocational Rehabilitation and Employment.	.....do	CA	ES	.....	.....	
Do	Director Education Service	.....do	CA	ES	.....	.....	
Do	Chief of Staff	.....do	CA	ES	.....	.....	
Do	Director, Employee Development and Training.	.....do	CA	ES	.....	.....	
Do	Associate Deputy Under Secretary for Field Operations.	.....do	CA	ES	.....	.....	
Do	Director, Office of Management	.....do	CA	ES	.....	.....	
Do	Director, Office of Performance Analysis and Integrity.	.....do	CA	ES	.....	.....	
Do	Director, Office of Facilities, Access and Administration.	.....do	CA	ES	.....	.....	
Do	Director Benefits Assistance Service	.....do	CA	ES	.....	.....	
Do	Director, Veterans Benefits Management System Program Management Office.	Vacant	.....	ES	.....	.....	
Do	Director, Office of Veterans Relationship Management Program Office.	.....do	.....	ES	.....	.....	
Do	Deputy Under Secretary for Disability Assistance.	Career Incumbent	CA	ES	.....	.....	
Do	Director, Office of Strategic Planning	.....do	CA	ES	.....	.....	
Do	Deputy Under Secretary for Economic Opportunity.	.....do	CA	ES	.....	.....	
Do	Director, Pension and Fiduciary Service	.....do	CA	ES	.....	.....	
Philadelphia, PA	Director Insurance Service	.....do	CA	ES	.....	.....	
Washington, DC	Director, VBA/DoD Programs	Vacant	.....	ES	.....	.....	
Do	Director Appeals Management Center	Career Incumbent	CA	ES	.....	.....	
Do	Assistant Deputy Under Secretary for Field Operations.	.....do	CA	ES	.....	.....	
Do	Assistant Deputy Under Secretary for Field Operations - National Work Queue.	.....do	CA	ES	.....	.....	
Austin, TX	Director, Office of Business Process Integration.	.....do	CA	ES	.....	.....	
	Area Directors						
St. Louis, MO	Area Director - Region 3	.....do	CA	ES	.....	.....	
Nashville, TN	Area Director - Region 2	.....do	CA	ES	.....	.....	
Phoenix, AZ	Area Director - Region 5	.....do	CA	ES	.....	.....	
Philadelphia, PA	Area Director - Region 1	.....do	CA	ES	.....	.....	
Denver, CO	Area Director - Region 4	.....do	CA	ES	.....	.....	
	Regional Office Directors						
New York New York, NY.	Director Regional Office New York	.....do	CA	ES	.....	.....	
Atlanta, GA	Director Regional Office Atlanta	.....do	CA	ES	.....	.....	
St. Petersburg, FL	Director Regional Office Saint Petersburg	Vacant	.....	ES	.....	.....	
Winston Salem, NC	Director Regional Office Winston-Salem	Career Incumbent	CA	ES	.....	.....	
Cleveland, OH	Director Regional Office Cleveland	.....do	CA	ES	.....	.....	
Chicago, IL	Director Regional Office Chicago	Vacant	.....	ES	.....	.....	
Detroit, MI	Director Regional Office Detroit	.....do	.....	ES	.....	.....	
Oakland, CA	Director Regional Office Oakland	Career Incumbent	CA	ES	.....	.....	
Los Angeles, CA	Director Regional Office Los Angeles	.....do	CA	ES	.....	.....	
Waco, TX	Director Regional Office Waco	.....do	CA	ES	.....	.....	
Houston, TX	Director Regional Office Houston	.....do	CA	ES	.....	.....	
Salt Lake City, UT	Director Regional Office Salt Lake City	.....do	CA	ES	.....	.....	
Philadelphia, PA	Director Regional Office Insurance Center Philadelphia.	.....do	CA	ES	.....	.....	
St. Paul, MN	Director Regional Office Saint Paul	.....do	CA	ES	.....	.....	
St. Louis, MO	Director Regional Office Saint Louis	.....do	CA	ES	.....	.....	
Seattle, WA	Director Regional Office Seattle	.....do	CA	ES	.....	.....	
Lakewood, CO	Director Regional Office Denver	.....do	CA	ES	.....	.....	
Montgomery, AL	Director Regional Office Montgomery	.....do	CA	ES	.....	.....	

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DEPARTMENT OF VETERANS AFFAIRS—Continued

Location	Position Title	Name of Incumbent	Type of Appt.	Pay Plan	Level, Grade, or Pay	Tenure	Expires
Roanoke, VA	Director Regional Office Roanoke	Career Incumbent	CA	ES			
Nashville, TN	Director Regional Office Nashville	do	CA	ES			
Indianapolis, IN	Director Regional Office Indianapolis	do	CA	ES			
New Orleans, LA	Director Regional Office New Orleans	do	CA	ES			
Muskogee, OK	Director Regional Office Muskogee	do	CA	ES			
Buffalo, NY	Director Regional Office Buffalo	do	CA	ES			
Phoenix, AZ	Director Regional Office Phoenix	Vacant		ES			
Milwaukee, WI	Director Regional Office Milwaukee	Career Incumbent	CA	ES			
Pittsburgh, PA	Director Regional Office Pittsburgh	do	CA	ES			
Manila, Philippines	Director Regional Office and Outpatient Clinic Manila.	do	CA	ES			
Columbia, SC	Director Regional Office Columbia	do	CA	ES			
Louisville, KY	Director Regional Office Louisville	do	CA	ES			
Little Rock, AR	Director Regional Office Little Rock	do	CA	ES			
San Juan, Puerto Rico.	Director Regional Office San Juan	do	CA	ES			
Portland, OR	Director Regional Office Portland	do	CA	ES			
Baltimore, MD	Director Regional Office Baltimore	do	CA	ES			
Jackson, MS	Director Regional Office Jackson	do	CA	ES			
San Diego, CA	Director Regional Office San Diego	do	CA	ES			
Lincoln, NE	Director Regional Office Lincoln	do	CA	ES			
Boston, MA	Director Regional Office Boston	do	CA	ES			
	VETERANS HEALTH ADMINISTRATION						
Washington, DC	Under Secretary for Health	David J. Shulkin M.D.	PAS	EX	III		
Do	Chief Workforce Management and Consulting Officer.	Vacant		ES			
Do	Chief of Staff	Career Incumbent	CA	ES			
Do	Deputy Under Secretary for Health for Operations and Management.	Vacant		ES			
Do	Director, Policy, Analysis, and Forecasting	Career Incumbent	CA	ES			
Denver, CO	Veterans Integrated Service Network Director	Vacant		ES			
Washington, DC	Assistant Deputy Under Secretary for Health for Administrative Operations.	do		ES			
Do	Associate Chief Financial Officer for Resource Management.	do		ES			
Do	Executive Director Office of Communication	Career Incumbent	CA	ES			
Do	Chief Readjustment Counseling Service Officer.	do	CA	ES			
Do	Executive Director, Office of Strategic Planning and Analysis.	Vacant		ES			
Do	Chief, Business Officer	Career Incumbent	CA	ES			
Denver, CO	Deputy Chief Business Officer for Revenue Operations.	do	CA	ES			
Washington, DC	Executive Director, Network Support	Vacant		ES			
Do	Deputy Chief Business Officer for Purchased Care.	Career Incumbent	CA	ES			
Topeka, KS	Deputy Chief Business Officer for Member Services.	Vacant		ES			
Washington, DC	Deputy Chief Officer, Workforce Management and Consulting Office.	Career Incumbent	CA	ES			
Orlando, FL	Director Veterans Affairs Medical Center Orlando.	do	CA	ES			
Washington, DC	Assistant Deputy Under Secretary for Health for Organizational Integration.	Vacant		ES			
Do	Assistant Deputy Under Secretary for Health for Policy and Planning.	Career Incumbent	CA	ES			
Ann Arbor, MI	Director, Organizational Health Initiative	Vacant		ES			
Washington, DC	Deputy Chief of Staff	do		ES			
Vallejo, CA	Deputy Director, Consulting Services	Career Incumbent	CA	ES			
Washington, DC	Deputy Chief Learning Officer	do	CA	ES			
Do	Director, Office of Rural Health	do	CA	ES			
Do	Chief Learning Officer	do	CA	ES			
Do	Executive Director, Homeless Veterans Program.	do	CA	ES			
Do	Special Assistant	Vacant		ES			
Do	Director, Consolidated Patient Account Center Program.	Career Incumbent	CA	ES			
Cincinnati, OH	Director, National Center for Organizational Development.	do	CA	ES			
St. Cloud, MN	Medical Center Director	do	CA	ES			
Washington, DC	Assistant Deputy Under Secretary of Health for Workforce Services.	Vacant		ES			
Do	Project Executive	Career Incumbent	CA	ES			
Do	Assistant Deputy Under Secretary for Health for Informatics and Analytics.	do	CA	ES			

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DEPARTMENT OF VETERANS AFFAIRS—Continued

Location	Position Title	Name of Incumbent	Type of Appt.	Pay Plan	Level, Grade, or Pay	Tenure	Expires
Washington, DC	Chief Health Technology Officer	Career Incumbent	CA	ES	.....	.....	
Los Angeles, CA	Executive Director of Clinical Care	.....do	CA	ES	.....	.....	
Washington, DC	Deputy Under Secretary for Health for Community Care.	Vacant	.....	ES	.....	.....	
Do	Director, Healthcare Leadership Talent Institute.	.....do	.....	ES	.....	.....	
Do	Executive Director, Administration and Support Services.	.....do	.....	ES	.....	.....	
Bay Pines, FL	Senior Advisor on Legislative and Congressional Affairs.	.....do	XS	OT	.....	.....	
Washington, DC	Senior Advisor	.....do	XS	SL	.....	.....	
Do	Executive Director, Delivery Operations, Office of Community Care.	.....do	.....	ES	.....	.....	
	Veterans Integrated Service Network Directors						
Albany, NY	Director Veterans Affairs Medical Center Albany.	.....do	.....	ES	.....	.....	
Albuquerque, NM ..	Director New Mexico Veterans Affairs Healthcare System.	Career Incumbent	CA	ES	.....	.....	
Alexandria, LA	Director Veterans Affairs Medical Center Alexandria.	.....do	CA	ES	.....	.....	
Altoona, PA	Director Veterans Affairs Medical Center Altoona.	.....do	CA	ES	.....	.....	
Amarillo, TX	Director, Amarillo Veterans Affairs Health Care System.	.....do	CA	ES	.....	.....	
Hines, IL	Veterans Integrated Service Network Director	Vacant	.....	ES	.....	.....	
Ann Arbor, MI	Director Veterans Affairs Medical Center Ann Arbor.	Career Incumbent	CA	ES	.....	.....	
Asheville, NC	Director Veterans Affairs Medical Center Asheville.	.....do	CA	ES	.....	.....	
Atlanta, GA	Director Veterans Affairs Medical Center Atlanta.	Vacant	.....	ES	.....	.....	
Augusta, GA	Director Veterans Affairs Medical Center Augusta.	Career Incumbent	CA	ES	.....	.....	
Bath, NY	Director Veterans Affairs Medical Center, Bath, NY.	.....do	CA	ES	.....	.....	
Battle Creek, MI ...	Director Veterans Affairs Medical Center Battle Creek.	.....do	CA	ES	.....	.....	
Bay Pines, FL	Director Veterans Affairs Medical Center Bay Pines.	.....do	CA	ES	.....	.....	
Beckley, WV	Director Veterans Affairs Medical Center Beckley.	Vacant	.....	ES	.....	.....	
Bedford, MA	Director Veterans Affairs Medical Center Bedford.	Career Incumbent	CA	ES	.....	.....	
Big Spring, TX	Director, West Texas Veterans Affairs Healthcare System.	Vacant	.....	ES	.....	.....	
Biloxi, MS	Director Veterans Affairs Medical Center Biloxi.	Career Incumbent	CA	ES	.....	.....	
Birmingham, AL	Director Veterans Affairs Medical Center Birmingham.	.....do	CA	ES	.....	.....	
Boise, ID	Director Veterans Affairs Medical Center Boise.	.....do	CA	ES	.....	.....	
Boston, MA	Director, Veterans Affairs Boston Healthcare System.	.....do	CA	ES	.....	.....	
New York -Bronx, NY.	Director Veterans Affairs Medical Center Bronx.	Vacant	.....	ES	.....	.....	
New York New York, NY.	Director, Veterans Affairs New York Harbor Health Care System.	Career Incumbent	CA	ES	.....	.....	
Buffalo, NY	Director Veterans Affairs Western New York Healthcare System.	.....do	CA	ES	.....	.....	
Dallas, TX	Director Veterans Affairs Medical Center Dallas.	.....do	CA	ES	.....	.....	
Butler, PA	Director Veterans Affairs Medical Center Butler.	.....do	CA	ES	.....	.....	
Canandaigua, NY ..	Director Veterans Affairs Medical Center Canandaigua.	Vacant	.....	ES	.....	.....	
Charleston, SC	Director Veterans Affairs Medical Center Charleston.	Career Incumbent	CA	ES	.....	.....	
Cheyenne, WY	Director VAM and ROC Cheyenne	Vacant	.....	ES	.....	.....	
Chicago, IL	Director, Veterans Affairs Medical Center Chicago.	.....do	.....	ES	.....	.....	
Chillicothe, OH	Director Veterans Affairs Medical Center Chillicothe.	Career Incumbent	CA	ES	.....	.....	
Cincinnati, OH	Director Veterans Affairs Medical Center Cincinnati.	Vacant	.....	ES	.....	.....	

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DEPARTMENT OF VETERANS AFFAIRS—Continued

Location	Position Title	Name of Incumbent	Type of Appt.	Pay Plan	Level, Grade, or Pay	Tenure	Expires
Cleveland, OH	Director Veterans Affairs Medical Center Cleveland.	Career Incumbent	CA	ES			
Columbia, MO	Director Veterans Affairs Medical Center Columbia, Missouri.	...do	CA	ES			
Columbia, SC	Director Veterans Affairs Medical Center Columbia, South Carolina.	...do	CA	ES			
Columbus, OH	Director Veterans Affairs Medical Center Columbus, OH.	...do	CA	ES			
Dallas, TX	Veterans Administration North Texas Health Care System.	...do	CA	ES			
Dayton, OH	Director Veterans Affairs Medical Center Dayton.	...do	CA	ES			
Des Moines, IA	Director, Veterans Affairs Central Iowa Healthcare System.	...do	CA	ES			
Dublin, GA	Director Veterans Affairs Medical Center Dublin.	...do	CA	ES			
Durham, NC	Director Veterans Affairs Medical Center Durham.	...do	CA	ES			
East Orange, NJ	Director Veterans Affairs Medical Center East Orange.	...do	CA	ES			
El Paso, TX	El Paso Department of Veterans Affairs Health Care System.	Vacant		ES			
Erie, PA	Director Veterans Affairs Medical Center Erie	Career Incumbent	CA	ES			
Fargo, ND	Director Veterans Affairs Medical and Regional Office Center Fargo.	...do	CA	ES			
Nashville, TN	Chief Medical Officer, VISN 9	Maria C. Farina-Morin	XS	OT	$305,302		
Fayetteville, AR	Director Veterans Affairs Medical Center Fayetteville, Arkansas.	Career Incumbent	CA	ES			
Fayetteville, NC	Director Veterans Affairs Medical Center Fayetteville, North Carolina.	...do	CA	ES			
Fort Harrison, MT	Director Veterans Affairs Medical and Regional Office Center Fort Harrison.	Vacant		ES			
Fort Meade, SD	Director Veterans Affairs Black Hills Health Care System.	Career Incumbent	CA	ES			
Fresno, CA	Director, Veterans Affairs Central California Health Care System.	Vacant		ES			
Grand Junction, CO.	Director Veterans Affairs Medical Center Grand Junction.	Career Incumbent	CA	ES			
Hampton, VA	Director Veterans Affairs Medical Center Hampton.	...do	CA	ES			
Hines, IL	Director Veterans Affairs Medical Center Hines.	Vacant	XS	OT			
Houston, TX	Director Veterans Affairs Medical Center Houston.	...do		ES			
Huntington, WV	Director Veterans Affairs Medical Center Huntington.	Career Incumbent	CA	ES			
Indianapolis, IN	Director Veterans Affairs Medical Center Indianapolis.	Vacant		ES			
Iowa City, IA	Director Veterans Affairs Medical Center Iowa City.	...do		ES			
Iron Mountain, MI	Director Veterans Affairs Medical Center Iron Mountain.	Career Incumbent	CA	ES			
Jackson, MS	Director Veterans Affairs Medical Center Jackson.	Vacant		ES			
Kansas City, MO	Director Veterans Affairs Medical Center Kansas City.	Career Incumbent	CA	ES			
Gainesville, FL	Director Veterans Affairs Medical Center Gainesville.	...do	CA	ES			
Las Vegas, NV	Director, Veterans Affairs Southern Nevada Health Care System, Las Vegas, Nevada.	...do	CA	ES			
Lebanon, PA	Director Veterans Affairs Medical Center Lebanon.	...do	CA	ES			
Lexington, KY	Director Veterans Affairs Medical Center Lexington.	...do	CA	ES			
Little Rock, AR	Director Veterans Affairs Medical Center Little Rock.	Vacant		ES			
Loma Linda, CA	Director Veterans Affairs Medical Center Loma Linda.	Career Incumbent	CA	ES			
Long Beach, CA	Director Veterans Affairs Long Beach Healthcare System.	...do	CA	ES			
Louisville, KY	Director Veterans Affairs Medical Center Louisville.	...do	CA	ES			
Manchester, NH	Director Veterans Affairs Medical Center Manchester.	...do	CA	ES			
Marion, IL	Director Veterans Affairs Medical Center Marion.	Vacant		ES			

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DEPARTMENT OF VETERANS AFFAIRS—Continued

Location	Position Title	Name of Incumbent	Type of Appt.	Pay Plan	Level, Grade, or Pay	Tenure	Expires
Fort Wayne, IN	Director Veterans Affairs Medical Center Ft. Wayne.	Vacant		ES			
Martinsburg, WV	Director Veterans Affairs Medical Center Martinsburg.	Career Incumbent	CA	ES			
Memphis, TN	Director Veterans Affairs Medical Center Memphis.	Vacant		ES			
Miami, FL	Director Veterans Affairs Medical Center Miami.	Career Incumbent	CA	ES			
Montrose, NY	Director, Veterans Affairs Hudson Valley Health Care System.	do	CA	ES			
Johnson City, TN	Director Veterans Affairs Medical Center Mountain Home.	Vacant		ES			
Nashville, TN	Director Veterans Affairs Medical Center Nashville.	do		ES			
Muskogee, OK	Director Veterans Affairs Medical Center Muskogee.	Career Incumbent	CA	ES			
New Orleans, LA	Director Veterans Affairs Medical Center New Orleans.	do	CA	ES			
North Chicago, IL	Director Veterans Affairs Medical Center North Chicago.	Vacant		ES			
Coatesville, PA	Director Veterans Affairs Medical Center Coatesville.	do		ES			
Northport, NY	Director Veterans Affairs Medical Center Northport.	Career Incumbent	CA	ES			
Omaha, NE	Director, Veterans Affairs Nebraska-Western Iowa Health Care System.	do	CA	ES			
Palo Alto, CA	Director Veterans Affairs Palo Alto Health Care System.	Vacant		ES			
Philadelphia, PA	Director Veterans Affairs Medical Center Philadelphia.	Career Incumbent	CA	ES			
Pittsburgh, PA	Director, Veterans Affairs Pittsburgh Health Care System.	do	CA	ES			
Poplar Bluff, MO	Director Veterans Affairs Medical Center Poplar Bluff.	do	CA	ES			
Portland, OR	Director Veterans Affairs Medical Center Portland.	Vacant		ES			
Prescott, AZ	Director Northern Arizona Veterans Affairs Health Care System.	do		ES			
Providence, RI	Director Veterans Affairs Medical Center Providence.	Career Incumbent	CA	ES			
Reno, NV	Director Veterans Affairs Medical Center Reno.	do	CA	ES			
Richmond, VA	Director Veterans Affairs Medical Center Richmond.	do	CA	ES			
Roseburg, OR	Director Veterans Affairs Medical Center Roseburg.	do	CA	ES			
Saginaw, MI	Director Veterans Affairs Medical Center Saginaw.	Vacant		ES			
Salem, VA	Director Veterans Affairs Medical Center Salem.	do		ES			
Salisbury, NC	Director Veterans Affairs Medical Center Salisbury.	Career Incumbent	CA	ES			
Salt Lake City, UT	Director Veterans Affairs Medial Center Salt Lake City.	do	CA	ES			
San Antonio, TX	Director Veterans Affairs Medical Center San Antonio.	Vacant		ES			
Danville, IL	Director Veterans Affairs Medical Center Danville.	do		ES			
San Juan, Puerto Rico.	Director Veterans Affairs Medical Center, San Juan Puerto Rico.	Career Incumbent	CA	ES			
Seattle, WA	Director Veterans Affairs Medical Center Seattle.	do	CA	ES			
Los Angeles, CA	Director, Veterans Affairs Greater Los Angeles Health Care System.	do	CA	ES			
Sheridan, WY	Director Veterans Affairs Medical Center Sheridan.	do	CA	ES			
Shreveport, LA	Director Veterans Affairs Medical Center Shreveport.	do	CA	ES			
Sioux Falls, SD	Director, Veterans Affairs Medical Center	do	CA	ES			
Spokane, WA	Director Veterans Affairs Medical Center Spokane.	do	CA	ES			
St. Louis, MO	Director Veterans Affairs Medical Center Saint Louis.	Vacant		ES			
Syracuse, NY	Director Veterans Affairs Medical Center Syracuse.	Career Incumbent	CA	ES			

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DEPARTMENT OF VETERANS AFFAIRS—Continued

Location	Position Title	Name of Incumbent	Type of Appt.	Pay Plan	Level, Grade, or Pay	Tenure	Expires
Temple, TX	Director, Veterans Affairs Central Texas Health Care System.	Vacant		ES			
Togus, ME	Director Veterans Affairs Medical and Regional Office Center Togus.	...do		ES			
Tomah, WI	Director Veterans Affairs Medical Center Tomah.	...do		ES			
Topeka, KS	Director Veterans Affairs Medical Center Topeka.	Career Incumbent	CA	ES			
Tucson, AZ	Director Veterans Affairs Medical Center Tucson.	Vacant		ES			
Tuscaloosa, AL	Director Veterans Affairs Medical Center Tuscaloosa.	Career Incumbent	CA	ES			
Walla Walla, WA	Director Veterans Affairs Medical Center, Walla Walla.	...do	CA	ES			
Washington, DC	Director Veterans Affairs Medical Center Washington.	...do	CA	ES			
West Haven, CT	Director, Veterans Affairs Connecticut Healthcare System.	...do	CA	ES			
White City, OR	Director Veterans Affairs Medical Center White City.	...do	CA	ES			
White River Junction, VT.	Director Veterans Affairs Medical and Regional Office Center White River Junction.	...do	CA	ES			
Wichita, KS	Director Veterans Affairs Medical Center Wichita.	Vacant		ES			
Wilkes Barre, PA	Director Veterans Affairs Medical Center Wilkes Barre.	...do		ES			
Wilmington, DE	Director Veterans Affairs Medical Center Wilmington.	Career Incumbent	CA	ES			
Milwaukee, WI	Director Veterans Affairs Medical Center Milwaukee.	...do	CA	ES			
Northampton, MA	Director Veterans Affairs Medical Center Northampton.	...do	CA	ES			
Tampa, FL	Director Veterans Affairs Medical Center Tampa.	...do	CA	ES			
Madison, WI	Director Veterans Affairs Medical Center Madison.	...do	CA	ES			
Phoenix, AZ	Director Veterans Affairs Medical Center Phoenix.	...do	CA	ES			
San Diego, CA	Director Veterans Affairs Medical Center San Diego.	Vacant		ES			
Oklahoma City, OK	Director Veterans Affairs Medical Center Oklahoma City.	Career Incumbent	CA	ES			
Tuskegee, AL	Director Central Alabama Healthcare System	Vacant		ES			
San Francisco, CA	Director Veterans Affairs Medical Center San Francisco.	Career Incumbent	CA	ES			
West Palm Beach, FL.	Director Veterans Affairs Medical Center West Palm Beach.	Vacant		ES			
Honolulu, HI	Director Veterans Affairs Medical and Regional Office Center Honolulu, Hawaii.	...do		ES			
Anchorage, AK	Director, Veterans Affairs Operations Clinic and Regional Office Anchorage, Alaska.	...do		ES			
Martinez, CA	Director, Veterans Affairs Northern California Health Care System.	Career Incumbent	CA	ES			
Albany, NY	Director, Veterans Integrated Service Network Albany, New York.	Vacant		ES			
New York -Bronx, NY.	Director, Veterans Integrated Service Network Bronx, New York.	...do		ES			
Pittsburgh, PA	Director, Veterans Integrated Service Network Pittsburg, Pennsylvania.	...do		ES			
Linthicum Hghts, MD.	Director, Veterans Integrated Service Network Linthicum, Maryland.	Career Incumbent	CA	ES			
Durham, NC	Director, Veterans Integrated Service Network Durham, North Carolina.	...do	CA	ES			
Atlanta, GA	Director, Veterans Integrated Service Network Atlanta, Georgia.	...do	CA	ES			
St. Petersburg, FL	Director Veterans Integrated Service Network	Vacant		ES			
Nashville, TN	...do	Career Incumbent	CA	ES			
Cincinnati, OH	Director, Veterans Integrated Service Network.	Vacant		ES			
Ann Arbor, MI	...do	Career Incumbent	CA	ES			
Kansas City, MO	...do	Vacant		ES			
Ridgeland, MS	Director Veterans Integrated Service Network	Career Incumbent	CA	ES			
Dallas, TX	Director, Veterans Integrated Service Network.	...do	CA	ES			
Phoenix, AZ	...do	Vacant		ES			
Portland, OR	Director Veterans Integrated Service Network	...do		ES			

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DEPARTMENT OF VETERANS AFFAIRS—Continued

Location	Position Title	Name of Incumbent	Type of Appt.	Pay Plan	Level, Grade, or Pay	Tenure	Expires
San Francisco, CA	Director Veterans Integrated Service Network	Career Incumbent	CA	ES			
Long Beach, CA	Director, Veterans Integrated Service Network.	do	CA	ES			
Minneapolis, MN	Health System Administrator	do	CA	ES			
Do	Director Veterans Integrated Service Network	do	CA	ES			
Denver, CO	Director, Veterans Affairs Eastern Colorado Health Care System.	do	CA	ES			
Harlingen, TX	Director Veterans Affairs Medical Center Harlingen.	Vacant		ES			
Washington, DC	Deputy Network Director	Career Incumbent	CA	ES			
St. Petersburg, FL	Deputy Veterans Integrated Service Network Director.	Vacant		ES			
Clarksburg, WV	Director Veterans Affairs Medical Center Clarksburg.	Glenn R. Snider Jr.	XS	OT	$265,000		
Indianapolis, IN	Director Veterans Affairs Medical Center Indianapolis.	James Brian Hancock	XS	OT	$275,120		
Jackson, MS	Director Veterans Affairs Medical Center Jackson.	David Walker	XS	OT	$280,000		
Little Rock, AR	Director Veterans Affairs Medical Center Little Rock.	Margie A. Scott	XS	OT	$304,596		
Baltimore, MD	Director Veterans Affairs Medical Center Baltimore.	Adam M. Robinson M.D.	XS	OT	$285,000		
New York -Bronx, NY.	Health System Administration (Medical Center Director).	Erik Langhoff M.D.	XS	OT	$250,000		
	Title 38 Positions						
Washington, DC	National Director, Nutrition and Food Service	Vacant	XS	OT			
Do	Chief Nursing Officer	do	XS	OT			
Do	Chief Consultant, Pharmacy Benefits Management Services.	Michael A. Valentino	XS	OT	$198,360		
Do	Chief Consultant, Primary Care Services	Gordon Schectman	XS	OT	$229,137		
Linthicum Hghts, MD.	Chief Medical Officer	Vacant	XS	OT			
Pittsburgh, PA	do	Timothy R. Burke M.D.	XS	OT	$271,231		
Washington, DC	Deputy Director, Clinical Science Research and Development Service.	Vacant	XS	OT			
Ann Arbor, MI	National Program Director, Nuclear Medicine and Radiation Safety Service.	do	XS	OT			
Washington, DC	Deputy Chief Research and Development Officer (Field Operations).	do	XS	OT			
Do	National Director, Anesthesia Services	Sam T. Sum-Ping	XS	OT	$334,929		
Seattle, WA	Chief Consultant, Spinal Cord Injury and Disorders Services.	Sophia N. Chun	XS	OT	$272,000		
Washington, DC	Chief Consultant Women Veterans Health Strategic Health Care Group.	Patricia M. Hayes	XS	OT	$149,989		
New Orleans, LA	Director, Healthcare Retention and Recruitment Office.	Vacant	XS	OT			
Washington, DC	Principal Deputy Under Secretary for Health	Richard Stone	XS	OT	$315,000		
Detroit, MI	Director, Veterans Affairs Medical Center Detroit.	Pamela J. Reeves	XS	OT	$217,836		
Baltimore, MD	Director, Biomedical Research and Development Service.	Christopher T. Bever Jr.	XS	OT	$275,000		
Kansas City, MO	Chief Medical Officer, VISN 15	Kanan Chatterjee	XS	OT	$253,108		
Sacramento, CA	Health System Administrator	Vacant	XS	OT			
Boston, MA	Director Veterans Integrated Service Network	Michael F. Mayo-Smith M.D..	XS	OT	$228,215		
Pittsburgh, PA	do	Michael D. Adelman	XS	OT	$250,044		
St. Petersburg, FL	do	Miguel H. Lapuz M.D.	XS	OT	$256,142		
North Chicago, IL	Director Veterans Affairs Medical Center North Chicago, Il.	Stephen R. Holt	XS	OT	$256,343		
Vancouver, WA	Chief Medical Officer, VISN 20	Vacant	XS	OT			
Hampton, VA	National Director, Chaplain Services	Michael L. McCoy	XS	OT	$141,045		
Washington, DC	Deputy Under Secretary for Health for Organizational Excellence.	Carolyn M. Clancy	XS	OT	$250,302		
Atlanta, GA	Chief Medical Officer	Ajay K. Dhawan M.D.	XS	OT	$281,188		
Washington, DC	Deputy Chief Academics Officer	Karen Sanders	XS	OT	$230,839		
Do	Chief Consultant, Mental Health Services	Harold S. Kudler	XS	OT	$260,000		
Do	Chief Consultant, Geriatrics and Extended Care Services.	Richard M. Allman	XS	OT	$261,364		
Do	Chief Public Health and Environmental Hazards Officer.	Vacant	XS	OT			
Kansas City, MO	Director Veterans Integrated Service Network	William Patterson	XS	OT	$239,390		
Washington, DC	Deputy Chief Consultant for Mental Health Standards of Care.	Marsden H. McGuire	XS	OT	$250,000		
Do	Deputy Chief Officer Office of Research Oversight.	Peter N. Poon	XS	OT	$158,000		

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DEPARTMENT OF VETERANS AFFAIRS—Continued

Location	Position Title	Name of Incumbent	Type of Appt.	Pay Plan	Level, Grade, or Pay	Tenure	Expires
Washington, DC	Associate Chief Patient Care Services Officer	Barbara L. Hyduke	XS	OT	$135,018	.....	
Do	Chief Consultant, Telehealth Services	Vacant	XS	OT	.....	.....	
Martinsburg, WV ...	Chief Consultant, Emergency Management ...	Daniel J. Bochicchio M.D.	XS	OT	$235,000	.....	
Boston, MA	Director, Performance and Measurement	Steven M. Wright	XS	OT	$150,767	.....	
Kansas City, MO ...	Director Operational Analytics and Reporting	Peter L. Almenoff	XS	OT	$236,924	.....	
Washington, DC	Chief Consultant for Human Resources	Vacant	XS	OT	.....	.....	
Do	Director, Human Resources and Staffing Services.	Makki Mohamad	XS	OT	$149,590	.....	
Do	Director, Healthcare Talent Management Office.	Vacant	XS	OT	.....	.....	
Hines, IL	Chief Medical Officer	.....do	XS	OT	.....	.....	
Washington, DC	Director, Rehabilitation Research and Development Service.	Patricia Dorn	XS	OT	$165,300	.....	
Do	Chief Academic Affiliations Officer	Robert L. Jesse	XS	OT	$277,820	.....	
Bedford, MA	Chief Medical Officer	Vacant	XS	OT	.....	.....	
Washington, DC	Director, Health Information Governance	Marcia Insley	XS	OT	$154,828	.....	
Do	Director, Clinical Analytics and Reporting	Joseph Francis M.D.	XS	OT	$238,325	.....	
Do	Chief Officer, Office of Research Oversight	John T. Puglisi	XS	OT	$165,300	.....	
Silver Spring, MD	Director - Veterans Affairs / Department of Defense Health Information Sharing Service.	Vacant	XS	OT	.....	.....	
Washington, DC	Director, Organizational Integrity and Information Synchronization.	Caitlin A. O'Brien	XS	OT	$179,700	.....	
Do	Deputy Director, Office of Patient Care Services and Cultural Transformation.	Ann C. Patterson	XS	OT	$173,600	.....	
Durham, NC	Chief Diagnostics Services and National Director, Radiology Services.	Robert H. Sherrier	XS	OT	$394,388	.....	
Washington, DC	Assistant Deputy Under Secretary for Health for Policy and Services.	Vacant	XS	OT	.....	.....	
Do	Deputy Chief Patient Care Services Officer (Office of Public Health).	Richard A. Kaslow	XS	OT	$245,000	.....	
Do	Director, Health Services Research and Development.	David Atkins	XS	OT	$222,703	.....	
Do	Associate Chief Officer	Terry A. Ross	XS	OT	$149,989	.....	
Ann Arbor, MI	Chief Safety and Risk Awareness Officer	Robin R. Hemphill M.D.	XS	OT	$227,500	.....	
Washington, DC	Assistant Under Secretary for Health for Dentistry.	Patricia E. Arola	XS	OT	$218,085	.....	
Do	Chief Officer, Office of Disability and Medical Assessment.	Patricia Murray	XS	OT	.....	.....	
Do	Deputy Chief Nursing Officer	B. Alan Bernstein	XS	OT	$168,700	.....	
Palo Alto, CA	Chief Consultant, Population Health	Larry A. Mole	XS	OT	$163,275	.....	
Washington, DC	Executive Director, Mental Health Operations	J. David Carroll	XS	OT	$171,500	.....	
Do	Director, Clinical Programs and Administrative Operations.	Vacant	XS	OT	$169,000	.....	
Do	Senior Medical Officer (Office Quality, Safety and Value).	.....do	XS	OT	.....	.....	
Do	Director, National Surgery Office (Physician)	William P. Gunnar	XS	OT	$360,000	.....	
Do	Chief Consultant, Specialty Care Services	Vacant	XS	OT	.....	.....	
Iowa City, IA	National Director, Pathology and Laboratory Medicine Service.	Michael S. Icardi	XS	OT	$208,000	.....	
Richmond, VA	National Director, Radiation Oncology Program (Physician).	Michael P. Hagan	XS	OT	$267,141	.....	
Washington, DC	Special Operations Officer	Vacant	XS	OT	.....	.....	
Do	Chief Consultant Occupational Health	Kathleen McPhaul	XS	OT	$140,671	.....	
Do	Executive Director, National Center for Ethics in Health Care.	Lisa S. Lehmann	XS	OT	$260,000	.....	
Do	National Director, Veterans Health Administration Homeless Programs.	Vacant	XS	OT	.....	.....	
Do	Chief Consultant, Care Management and Social Work Services.	Michael T. Kilmer	XS	OT	$149,000	.....	
Do	Executive Director for Connected Health	Kathleen L. Frisbee	XS	OT	$163,319	.....	
Durham, NC	Chief Consultant for Preventive Medicine	Vacant	XS	OT	.....	.....	
Washington, DC	Executive Director, Interagency Health Affairs.	Karen T. Malebranche	XS	OT	$173,600	.....	
Do	Executive Director, Office of Strategic Integration.	Katheleen Z B Andrews	XS	OT	$245,000	.....	
Do	Assistant Deputy Under Secretary for Health for Quality, Safety, and Value.	Vacant	XS	OT	.....	.....	
Do	National Director, Prosthetic and Sensory Aids Service, Rehabilitation and Prosthetic Services.	Penny L. Nechanicky	XS	OT	$160,235	.....	
Do	Deputy Director, Office of Strategic Integration.	Vacant	XS	OT	.....	.....	
Do	Chief Consultant, Post Deployment Health	Ralph L. Erickson	XS	OT	$244,970	.....	
Do	Deputy Chief, Research and Development Officer.	Vacant	XS	OT	.....	.....	

AMERICAN OVERSIGHT
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DEPARTMENT OF VETERANS AFFAIRS—Continued

Location	Position Title	Name of Incumbent	Type of Appt.	Pay Plan	Level, Grade, or Pay	Tenure	Expires
Washington, DC	Deputy Director, Office of Mental Health Operations.	Vacant	XS	OT	$250,000	.....	
Do	Deputy Chief Patient Care Services, Office for Rehabilitation and Prosthetic.	Lucille B. Beck	XS	OT	$173,600	.....	
Do	National Director of Neurology	Donald S. Higgins Jr.	XS	OT	$261,056	.....	
Do	Senior Medical Advisor, Office of the Assistant Deputy Under Secretary for Clinical Operations.	Gavin West	XS	OT	$220,000	.....	
Do	National Program Director, Ophthalmology ...	Glenn Cockerham	XS	OT	$280,562	.....	
Do	National Director, Physical Medicine and Rehabilitation Services.	Joel Scholten	XS	OT	$259,024	.....	
Do	Deputy Principal Deputy Under Secretary for Health.	Deborah W. Dort	XS	OT	$284,530	.....	
Orlando, FL	Deputy Chief Learning Officer for Business Operations.	Manuel Dominguez	XS	OT	$173,600	.....	
Washington, DC	Chief Officer, Office of Health Equity	Uchenna S. Uchendu	XS	OT	$226,140	.....	
Do	Assistant Deputy Under Secretary for Health for Community Care.	Baligh R. Yehia M.D.	XS	OT	$217,500	.....	
Do	Assistant Deputy Under Secretary for Health for Integrity.	Gerard R. Cox	XS	OT	$255,355	.....	
Do	Assistant Deputy Under Secretary for Clinical Operations.	Robert E. Lynch M.D.	XS	OT	$275,000	.....	
Do	Deputy Assistant Deputy Under Secretary for Health for Clinical Operations.	Tammy Czarnecki	XS	OT	$151,435	.....	
Do	Executive Director, Office of Patient Centered Care and Cultural Transformation.	Tracy W. Gaudet	XS	OT	$275,980	.....	
Do	Deputy Under Secretary for Health for Policy and Services.	Jennifer S. Lee	XS	OT	$220,000	.....	
Do	Director, Strategic Investment Management ..	Charles C. Hume	XS	OT	$165,300	.....	
Do	Director, HIV, Hepatitis and Public Health Pathogens Program.	David B. Ross	XS	OT	$230,521	.....	
Do	Assistant Deputy Under Secretary for Health for Patient Care Services.	Maureen McCarthy	XS	OT	$277,315	.....	
Do	Deputy Chief Consultant for Specialty Mental Health.	Wendy N. Tenhula	XS	OT	$165,540	.....	
Do	Director of Physician Assistant Services	Denni J. Woodmansee	XS	OT	$127,910	.....	
Do	Chief Officer, Office of Connected Care	Neil Evans	XS	OT	$265,000	.....	
Do	Director, Bioinformatics	James L. Breeling	XS	OT	$227,070	.....	
Do	Assistant Deputy Chief Patient Care Services	Vacant	XS	OT	.....	.....	
Fort Howard, MD ..	National Director Optometry Service	John C. Townsend	XS	AD	$165,300	.....	
Cleveland, OH	Director Podiatry Service	Jeffrey M. Robbins	XS	AD	$160,829	.....	
Cheyenne, WY	Director Regional Office Medical Center Cheyenne.	Vacant	XS	AD	.....	.....	
Albany, NY	Director Veterans Integrated Service Network	Joan McInerney	XS	AD	$258,170	.....	

DEPARTMENT OF VETERANS AFFAIRS OFFICE OF THE INSPECTOR GENERAL

Location	Position Title	Name of Incumbent	Type of Appt.	Pay Plan	Level, Grade, or Pay	Tenure	Expires
	IMMEDIATE OFFICE OF THE INSPECTOR GENERAL						
Washington, DC	Inspector General	Michael Joseph Missal	PAS	EX	III	.....	

AMERICAN OVERSIGHT

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Message

From: David Shulkin [drshulkin@aol.com]
Sent: 1/12/2017 2:29:53 AM
To: Wright, Vivieca (Simpson) [Vivieca.Wright@va.gov]
CC: (b) (6) [(b) (6) ((b) (6) va.gov]
Subject: Re: [EXTERNAL] GPO-PLUMBOOK-2016-8-30.pdf

Can you show me tommorow

I don't see any attachment

Sent from my iPad

On Jan 11, 2017, at 9:21 PM, Wright, Vivieca (Simpson) <Vivieca.Wright@va.gov> wrote:

> Very helpful
>
> -----Original Message-----
> **From:** (b) (6) [(b) (6) @gmail.com]
> **Sent:** Wednesday, January 11, 2017 09:17 PM Eastern Standard Time
> **To:** David Shulkin; Wright, Vivieca (Simpson)
> **Subject:** [EXTERNAL] GPO-PLUMBOOK-2016-8-30.pdf
>
> Appointees take a look.

AMERICAN OVERSIGHT

Message

From: Wright, Vivieca (Simpson) [Vivieca.Wright@va.gov]
Sent: 1/12/2017 2:21:16 AM
To: (b) (6) [(b) (6) @gmail.com]; 'David Shulkin' [drshulkin@aol.com]
Subject: RE: [EXTERNAL] GPO-PLUMBOOK-2016-8-30.pdf

Very helpful

-----Original Message-----
From: (b) (6) [(b) (6) @gmail.com]
Sent: Wednesday, January 11, 2017 09:17 PM Eastern Standard Time
To: David Shulkin; Wright, Vivieca (Simpson)
Subject: [EXTERNAL] GPO-PLUMBOOK-2016-8-30.pdf

Appointees take a look.

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6)@gmail.com]
Sent: 1/12/2017 2:16:56 AM
To: David Shulkin [drshulkin@aol.com]; Wright, Vivieca (Simpson) (SES) [Vivieca.wright@va.gov]
Subject: GPO-PLUMBOOK-2016-8-30.pdf
Attachments: GPO-PLUMBOOK-2016-8-30.pdf

Appointees take a look.

AMERICAN OVERSIGHT

AUTHENTICATED U.S. GOVERNMENT INFORMATION GPO

DEPARTMENT OF VETERANS AFFAIRS

Location	Position Title	Name of Incumbent	Type of Appt.	Pay Plan	Level, Grade, or Pay	Tenure	Expires
	OFFICE OF THE SECRETARY AND DEPUTY						
Washington, DC	Secretary of Veterans Affairs	Robert A. McDonald	PAS	EX	I		
Do	Deputy Secretary of Veterans Affairs	Sloan D. Gibson IV	PAS	EX	II		
Do	Chief of Staff	Vacant		ES			
Do	Deputy Chief of Staff	Career Incumbent	CA	ES			
Do	Executive Secretary to the Department	.....do	CA	ES			
Do	Director, Center for Minority Veterans	Barbara A. Ward	NA	ES			
Do	Director, Center for Women Veterans	Kayla M. Williams	NA	ES			
Do	Senior Advisor, Strategic Engagement	Brandon L. Fureigh	NA	ES			
Do	Senior Advisor	Vacant		ES			
Do	.....do	Marina Stone Martin	NA	ES			
Do	.....do	Vacant		ES			
Do	.....do	Joshua David Jacobs	NA	ES			
Do	.....do	Vacant		ES			
Do	Senior Advisor for Appeals Modernization	Carol Ann DiBattiste	TA	ES			04/30/19
Do	Special Assistant	Charlyn A. Isaac	SC	GS	13		
Do	Senior Advisor for Management Initiatives and White House Liaison.	Carrie A. Kagawa	SC	GS	14		
Do	Director, Center for Faith Based Community Initiatives.	Evna T. Lavelle	SC	GS	15		
	OFFICE OF ACQUISITIONS, LOGISTICS AND CONSTRUCTION						
Frederick, MD	Chancellor, VA Acquisition Academy	Vacant		ES			
	Office of Acquisition and Materiel Management						
Washington, DC	Associate Deputy Assistant Secretary Logistics and Supply Chain Management.	Career Incumbent	CA	ES			
	BOARD OF VETERANS' APPEALS						
Do	Chairman, Board of Veterans' Appeals	Vacant	PAS	EX	IV		
	OFFICE OF THE GENERAL COUNSEL						
Do	General Counsel	Leigh A. Bradley	PAS	EX	IV		
Do	Principal Deputy General Counsel	Career Incumbent	CA	ES			
Do	Special Counsel	Vacant		ES			
Do	Assistant General Counsel-Group II	Career Incumbent	CA	ES			
Do	Assistant General Counsel, Group IV	.....do	CA	ES			
Do	Assistant General Counsel Group VII	.....do	CA	ES			
Do	Chief Counsel Health Law Group	.....do	CA	ES			
Do	Chief Counsel, Procurement Law Group	.....do	CA	ES			
Do	Special Assistant	Jennifer Harkin	SC	GS	14		
Do	Associate Chief Counsel	Kimberly P. McLeod	XS	SL	$156,775		
	OFFICE OF THE ASSISTANT SECRETARY FOR MANAGEMENT						
Do	Assistant Secretary for Management	Vacant	PA	EX	IV		
Do	Director, Programming Analysis and Evaluation.	.....do		ES			
Do	Executive Director	.....do		ES			
Do	Chief Financial Officer	.....do	PAS	EX	IV		
	Office of Budget						
Do	Deputy Assistant Secretary for Budget	Career Incumbent	CA	ES			
Do	Associate Deputy Assistant Secretary, Budget Operations.	.....do	CA	ES			
Do	Associate Deputy Assistant Secretary, Program Budgets.	Vacant		ES			
	Office of Finance						
Do	Associate Deputy Assistant Secretary for Financial Policy.	Career Incumbent	CA	ES			
Do	Associate Deputy Assistant Secretary for Financial Process Improvement and Audit Readiness.	.....do	CA	ES			
Do	Director, Corporate Travel and Management Reporting.	.....do	CA	ES			
	Office of Asset Enterprise Management						
Do	Director, Asset Enterprise Management	.....do	CA	ES			
	OFFICE OF THE ASSISTANT SECRETARY FOR POLICY AND PLANNING						
Do	Assistant Secretary for Policy and Planning	Linda A. Schwartz	PAS	EX	IV		
Do	Director, National Center for Veterans Analysis and Statistics.	Career Incumbent	CA	ES			

AMERICAN OVERSIGHT

DEPARTMENT OF VETERANS AFFAIRS—Continued

Location	Position Title	Name of Incumbent	Type of Appt.	Pay Plan	Level, Grade, or Pay	Tenure	Expires
Washington, DC	Deputy Assistant Secretary for Data Governance and Analysis.	Career Incumbent	CA	ES	.....	.....	
Do	Director, Office of Performance Management	.....do	CA	ES	.....	.....	
Do	Principal Deputy Assistant Secretary	.....do	CA	ES	.....	.....	
Do	Executive Director	Vacant	.....	ES	.....	.....	
Do	Director Enterprise Risk Management	.....do	.....	ES	.....	.....	
Do	Senior Advisor/Chief Veteran Experience Officer.	Thomas B. Allin	NA	ES	.....	.....	
Do	Director, Support Services	Career Incumbent	CA	ES	.....	.....	
Do	Executive Director, MyVA Program Management Office.	.....do	CA	ES	.....	.....	
Do	Deputy Chief Veterans Experience Officer	.....do	CA	ES	.....	.....	
Do	Senior Call Center Advisor, Architecture and Design.	Rosetta Lue	TA	ES	.....	.....	11/29/18
Do	Executive Director	Career Incumbent	CA	ES	.....	.....	
Do	Senior Advisor, VEO (Implementation)	.....do	CA	ES	.....	.....	
Do	Director Navigation and Advocacy	.....do	CA	ES	.....	.....	
Do	Senior Advisor for Strategic Partnerships	Matthew S. Collier	NA	ES	.....	.....	
New York New York, NY.	District Veterans Experience Officer	James Z. Wartski	NA	ES	.....	.....	
Washington, DC	Director Enterprise Access and Integration	Vacant	.....	ES	.....	.....	
Atlanta, GA	District Veterans Experience Officer (Southeast).	Career Incumbent	CA	ES	.....	.....	
Chicago, IL	District Veterans Experience Officer (Midwest).	Vacant	.....	ES	.....	.....	
Los Angeles, CA	District Veterans Experience Officer (Pacific)	.....do	.....	ES	.....	.....	
Washington, DC	Director Insight and Design	Sarah B. Brooks	SC	GS	15	.....	
Do	District Veterans Experience Officer (Continental).	Career Incumbent	CA	ES	.....	.....	
Do	Director Special Programs	Julia M. Kim	SC	GS	15	.....	
	Office of Policy						
Do	Deputy Assistant Secretary for Policy	Vacant	.....	ES	.....	.....	
Do	Executive Director	Career Incumbent	CA	ES	.....	.....	
Do	.....do	.....do	CA	ES	.....	.....	
	OFFICE OF THE ASSISTANT SECRETARY FOR HUMAN RESOURCES AND ADMINISTRATION						
Do	Assistant Secretary for Human Resources and Administration.	Vacant	PA	EX	IV	.....	
Do	Principal Deputy Assistant Secretary for Human Resources and Administration.	Career Incumbent	CA	ES	.....	.....	
Do	Deputy Assistant Secretary for Labor-Management Relations.	.....do	CA	ES	.....	.....	
	Office of Human Resources Management						
Do	Deputy Assistant Secretary for Human Resources Management.	Vacant	.....	ES	.....	.....	
Do	Associate Deputy Assistant Secretary (ADAS) for HR Automation, Systems, and Analytics.	Career Incumbent	CA	ES	.....	.....	
Do	Associate Deputy Assistant Secretary for Human Resources Management Operations.	.....do	CA	ES	.....	.....	
	Office of Diversity Management and Equal Employment Opportunity						
Do	Deputy Assistant Secretary for Diversity Management and Equal Employment Opportunity.	.....do	CA	ES	.....	.....	
	Office of Administration						
Do	Executive Director	.....do	CA	ES	.....	.....	
Do	Associate Deputy Assistant Secretary for Administration.	.....do	CA	ES	.....	.....	
	Office of Resolution Management						
Do	Deputy Assistant Secretary for Resolution Management.	.....do	CA	ES	.....	.....	
Do	Associate Deputy Assistant Secretary for Resolution Management.	.....do	CA	ES	.....	.....	
	VA Learning University						
Do	Dean, Veterans Affairs Learning University ..	.....do	CA	ES	.....	.....	
	OFFICE OF THE ASSISTANT SECRETARY FOR PUBLIC AND INTERGOVERNMENTAL AFFAIRS						
Do	Assistant Secretary for Public and Intergovernmental Affairs.	Rosemary J. Williams	PA	EX	IV	.....	

AMERICAN OVERSIGHT
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DEPARTMENT OF VETERANS AFFAIRS—Continued

Location	Position Title	Name of Incumbent	Type of Appt.	Pay Plan	Level, Grade, or Pay	Tenure	Expires
Washington, DC	Executive Director Public and Intergovernmental Affairs.	Vacant	.....	ES	.....	.....	
Do	Press Secretary	Victoria N. Dillon	SC	GS	15	.....	
Do	Special Assistant	Raleigh R H Contreras	SC	GS	12	.....	
	Office of Public Affairs						
Do	Director for Public Affairs	Vacant	.....	ES	.....	.....	
Do	Special Advisor	Brian A. Hawthorne	SC	GS	14	.....	
	Office of Intergovernmental Affairs						
Do	Deputy Assistant Secretary for Intergovernmental Affairs.	James Albino	NA	ES	.....	.....	
Do	Director, Office of Tribal Government Relations.	Career Incumbent	CA	ES	.....	.....	
	OFFICE OF THE ASSISTANT SECRETARY FOR GOVERNMENT RELATIONS						
Do	Assistant Secretary for Congressional and Legislative Affairs.	Vacant	PAS	EX	IV	.....	
Do	Deputy Assistant Secretary for Congressional Affairs.	Michelle Dominguez	NA	ES	.....	.....	
Do	Principal Deputy Assistant Secretary for Congressional and Legislative Affairs.	Career Incumbent	CA	ES	.....	.....	
Do	Director Oversight	Ryan Keith Hedgepeth	SC	GS	15	.....	
Do	Special Assistant	Mark A. Howell	SC	GS	12	.....	
	OFFICE OF THE ASSISTANT SECRETARY FOR INFORMATION AND TECHNOLOGY						
Do	Assistant Secretary for Information and Technology.	Laverne H. Council	PAS	EX	IV	.....	
Do	Principal Deputy Assistant Secretary for Information and Technology.	Career Incumbent	CA	ES	.....	.....	
Do	Executive Director (Field Operations)	Vacant	.....	ES	.....	.....	
Do	Executive Director (Systems Engineering)	Career Incumbent	CA	ES	.....	.....	
Do	Deputy Chief Information Officer for Architecture, Strategy, and Design.	.....do	CA	ES	.....	.....	
Do	Deputy Director	Vacant	.....	ES	.....	.....	
Do	Executive Director, Application Support	.....do	.....	ES	.....	.....	
Do	Executive Director, Development Management Service.	.....do	.....	ES	.....	.....	
Do	Deputy Chief Information Officer	Career Incumbent	CA	ES	.....	.....	
Do	Director	.....do	CA	ES	.....	.....	
Do	Chief Learning Officer	.....do	CA	ES	.....	.....	
Do	Deputy Chief Information Officer, Account Manager for Health.	.....do	CA	ES	.....	.....	
Do	Deputy Chief Information Officer, Account Manager for Benefits.	.....do	CA	ES	.....	.....	
Do	Deputy Chief Information Officer, Enterprise Data Management.	Vacant	.....	ES	.....	.....	
Do	Deputy Assistant Secretary, Enterprise Program Management Officer.	Career Incumbent	CA	ES	.....	.....	
Do	Executive Director, Enterprise Project Manager.	.....do	CA	ES	.....	.....	
Do	Deputy Chief Information Officer, Account Manager for Corporate.	.....do	CA	ES	.....	.....	
Eatontown, NJ	Executive Director, Leans Systems Engineering.	.....do	CA	ES	.....	.....	
Washington, DC	Executive Director, OI&T Enterprise Cybersecurity Strategy.	Dominic Cussatt	TA	ES	.....	.....	05/14/19
	OFFICE OF THE ASSISTANT SECRETARY FOR OPERATIONS, SECURITY AND PREPAREDNESS						
Do	Assistant Secretary for Operations, Security and Preparedness.	Kevin Hanretta	PA	EX	IV	.....	
Do	Director, Office of Personnel Security and Identity Management.	Career Incumbent	CA	ES	.....	.....	
	NATIONAL CEMETERY ADMINISTRATION						
Do	Under Secretary for Memorial Affairs	Vacant	PAS	EX	III	.....	
Do	Deputy Under Secretary For Field Programs	Career Incumbent	CA	ES	.....	.....	
Do	Deputy Under Secretary for Memorial Affairs	.....do	CA	ES	.....	.....	
Do	Associate Director, Office of Field Programs ..	.....do	CA	ES	.....	.....	
Do	Associate Deputy Under Secretary for Management.	.....do	CA	ES	.....	.....	

AMERICAN OVERSIGHT

DEPARTMENT OF VETERANS AFFAIRS—Continued

Location	Position Title	Name of Incumbent	Type of Appt.	Pay Plan	Level, Grade, or Pay	Tenure	Expires
Washington, DC	Executive Director, Memorial Programs	Vacant	.....	ES	.....	.....	
Philadelphia, PA	Memorial Service Network Director	Career Incumbent	CA	ES	.....	.....	
Decatur, GA	.....do	.....do	CA	ES	.....	.....	
Indianapolis, IN	.....do	.....do	CA	ES	.....	.....	
Lakewood, CO	.....do	.....do	CA	ES	.....	.....	
Oakland, CA	.....do	.....do	CA	ES	.....	.....	
Washington, DC	Executive Director	.....do	CA	ES	.....	.....	
	VETERANS BENEFITS ADMINISTRATION						
Do	Under Secretary for Benefits	Vacant	PAS	EX	III	.....	
Do	Principal Deputy Under Secretary for Benefits.	Career Incumbent	CA	ES	.....	.....	
Do	Director, Compensation and Pension Service	Vacant	.....	ES	.....	.....	
Do	Director, Loan Guaranty Service	Career Incumbent	CA	ES	.....	.....	
Do	Director Vocational Rehabilitation and Employment.	.....do	CA	ES	.....	.....	
Do	Director Education Service	.....do	CA	ES	.....	.....	
Do	Chief of Staff	.....do	CA	ES	.....	.....	
Do	Director, Employee Development and Training.	.....do	CA	ES	.....	.....	
Do	Associate Deputy Under Secretary for Field Operations.	.....do	CA	ES	.....	.....	
Do	Director, Office of Management	.....do	CA	ES	.....	.....	
Do	Director, Office of Performance Analysis and Integrity.	.....do	CA	ES	.....	.....	
Do	Director, Office of Facilities, Access and Administration.	.....do	CA	ES	.....	.....	
Do	Director Benefits Assistance Service	.....do	CA	ES	.....	.....	
Do	Director, Veterans Benefits Management System Program Management Office.	Vacant	.....	ES	.....	.....	
Do	Director, Office of Veterans Relationship Management Program Office.	.....do	.....	ES	.....	.....	
Do	Deputy Under Secretary for Disability Assistance.	Career Incumbent	CA	ES	.....	.....	
Do	Director, Office of Strategic Planning	.....do	CA	ES	.....	.....	
Do	Deputy Under Secretary for Economic Opportunity.	.....do	CA	ES	.....	.....	
Do	Director, Pension and Fiduciary Service	.....do	CA	ES	.....	.....	
Philadelphia, PA	Director Insurance Service	.....do	CA	ES	.....	.....	
Washington, DC	Director, VBA/DoD Programs	Vacant	.....	ES	.....	.....	
Do	Director Appeals Management Center	Career Incumbent	CA	ES	.....	.....	
Do	Assistant Deputy Under Secretary for Field Operations.	.....do	CA	ES	.....	.....	
Do	Assistant Deputy Under Secretary for Field Operations - National Work Queue.	.....do	CA	ES	.....	.....	
Austin, TX	Director, Office of Business Process Integration.	.....do	CA	ES	.....	.....	
	Area Directors						
St. Louis, MO	Area Director - Region 3	.....do	CA	ES	.....	.....	
Nashville, TN	Area Director - Region 2	.....do	CA	ES	.....	.....	
Phoenix, AZ	Area Director - Region 5	.....do	CA	ES	.....	.....	
Philadelphia, PA	Area Director - Region 1	.....do	CA	ES	.....	.....	
Denver, CO	Area Director - Region 4	.....do	CA	ES	.....	.....	
	Regional Office Directors						
New York New York, NY.	Director Regional Office New York	.....do	CA	ES	.....	.....	
Atlanta, GA	Director Regional Office Atlanta	.....do	CA	ES	.....	.....	
St. Petersburg, FL	Director Regional Office Saint Petersburg	Vacant	.....	ES	.....	.....	
Winston Salem, NC	Director Regional Office Winston-Salem	Career Incumbent	CA	ES	.....	.....	
Cleveland, OH	Director Regional Office Cleveland	.....do	CA	ES	.....	.....	
Chicago, IL	Director Regional Office Chicago	Vacant	.....	ES	.....	.....	
Detroit, MI	Director Regional Office Detroit	.....do	.....	ES	.....	.....	
Oakland, CA	Director Regional Office Oakland	Career Incumbent	CA	ES	.....	.....	
Los Angeles, CA	Director Regional Office Los Angeles	.....do	CA	ES	.....	.....	
Waco, TX	Director Regional Office Waco	.....do	CA	ES	.....	.....	
Houston, TX	Director Regional Office Houston	.....do	CA	ES	.....	.....	
Salt Lake City, UT	Director Regional Office Salt Lake City	.....do	CA	ES	.....	.....	
Philadelphia, PA	Director Regional Office Insurance Center Philadelphia.	.....do	CA	ES	.....	.....	
St. Paul, MN	Director Regional Office Saint Paul	.....do	CA	ES	.....	.....	
St. Louis, MO	Director Regional Office Saint Louis	.....do	CA	ES	.....	.....	
Seattle, WA	Director Regional Office Seattle	.....do	CA	ES	.....	.....	
Lakewood, CO	Director Regional Office Denver	.....do	CA	ES	.....	.....	
Montgomery, AL	Director Regional Office Montgomery	.....do	CA	ES	.....	.....	

AMERICAN OVERSIGHT
VA-19-0799-J-001461
DS_00009091

DEPARTMENT OF VETERANS AFFAIRS—Continued

Location	Position Title	Name of Incumbent	Type of Appt.	Pay Plan	Level, Grade, or Pay	Tenure	Expires
Roanoke, VA	Director Regional Office Roanoke	Career Incumbent	CA	ES			
Nashville, TN	Director Regional Office Nashville	do	CA	ES			
Indianapolis, IN	Director Regional Office Indianapolis	do	CA	ES			
New Orleans, LA	Director Regional Office New Orleans	do	CA	ES			
Muskogee, OK	Director Regional Office Muskogee	do	CA	ES			
Buffalo, NY	Director Regional Office Buffalo	do	CA	ES			
Phoenix, AZ	Director Regional Office Phoenix	Vacant		ES			
Milwaukee, WI	Director Regional Office Milwaukee	Career Incumbent	CA	ES			
Pittsburgh, PA	Director Regional Office Pittsburgh	do	CA	ES			
Manila, Philippines	Director Regional Office and Outpatient Clinic Manila.	do	CA	ES			
Columbia, SC	Director Regional Office Columbia	do	CA	ES			
Louisville, KY	Director Regional Office Louisville	do	CA	ES			
Little Rock, AR	Director Regional Office Little Rock	do	CA	ES			
San Juan, Puerto Rico.	Director Regional Office San Juan	do	CA	ES			
Portland, OR	Director Regional Office Portland	do	CA	ES			
Baltimore, MD	Director Regional Office Baltimore	do	CA	ES			
Jackson, MS	Director Regional Office Jackson	do	CA	ES			
San Diego, CA	Director Regional Office San Diego	do	CA	ES			
Lincoln, NE	Director Regional Office Lincoln	do	CA	ES			
Boston, MA	Director Regional Office Boston	do	CA	ES			
	VETERANS HEALTH ADMINISTRATION						
Washington, DC	Under Secretary for Health	David J. Shulkin M.D.	PAS	EX	III		
Do	Chief Workforce Management and Consulting Officer.	Vacant		ES			
Do	Chief of Staff	Career Incumbent	CA	ES			
Do	Deputy Under Secretary for Health for Operations and Management.	Vacant		ES			
Do	Director, Policy, Analysis, and Forecasting	Career Incumbent	CA	ES			
Denver, CO	Veterans Integrated Service Network Director	Vacant		ES			
Washington, DC	Assistant Deputy Under Secretary for Health for Administrative Operations.	do		ES			
Do	Associate Chief Financial Officer for Resource Management.	do		ES			
Do	Executive Director Office of Communication	Career Incumbent	CA	ES			
Do	Chief Readjustment Counseling Service Officer.	do	CA	ES			
Do	Executive Director, Office of Strategic Planning and Analysis.	Vacant		ES			
Do	Chief, Business Officer	Career Incumbent	CA	ES			
Denver, CO	Deputy Chief Business Officer for Revenue Operations.	do	CA	ES			
Washington, DC	Executive Director, Network Support	Vacant		ES			
Do	Deputy Chief Business Officer for Purchased Care.	Career Incumbent	CA	ES			
Topeka, KS	Deputy Chief Business Officer for Member Services.	Vacant		ES			
Washington, DC	Deputy Chief Officer, Workforce Management and Consulting Office.	Career Incumbent	CA	ES			
Orlando, FL	Director Veterans Affairs Medical Center Orlando.	do	CA	ES			
Washington, DC	Assistant Deputy Under Secretary for Health for Organizational Integration.	Vacant		ES			
Do	Assistant Deputy Under Secretary for Health for Policy and Planning.	Career Incumbent	CA	ES			
Ann Arbor, MI	Director, Organizational Health Initiative	Vacant		ES			
Washington, DC	Deputy Chief of Staff	do		ES			
Vallejo, CA	Deputy Director, Consulting Services	Career Incumbent	CA	ES			
Washington, DC	Deputy Chief Learning Officer	do	CA	ES			
Do	Director, Office of Rural Health	do	CA	ES			
Do	Chief Learning Officer	do	CA	ES			
Do	Executive Director, Homeless Veterans Program.	do	CA	ES			
Do	Special Assistant	Vacant		ES			
Do	Director, Consolidated Patient Account Center Program.	Career Incumbent	CA	ES			
Cincinnati, OH	Director, National Center for Organizational Development.	do	CA	ES			
St. Cloud, MN	Medical Center Director	do	CA	ES			
Washington, DC	Assistant Deputy Under Secretary of Health for Workforce Services.	Vacant		ES			
Do	Project Executive	Career Incumbent	CA	ES			
Do	Assistant Deputy Under Secretary for Health for Informatics and Analytics.	do	CA	ES			

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DEPARTMENT OF VETERANS AFFAIRS—Continued

Location	Position Title	Name of Incumbent	Type of Appt.	Pay Plan	Level, Grade, or Pay	Tenure	Expires
Washington, DC	Chief Health Technology Officer	Career Incumbent	CA	ES	.....	.....	
Los Angeles, CA	Executive Director of Clinical Care	.....do	CA	ES	.....	.....	
Washington, DC	Deputy Under Secretary for Health for Community Care.	Vacant	.....	ES	.....	.....	
Do	Director, Healthcare Leadership Talent Institute.	.....do	.....	ES	.....	.....	
Do	Executive Director, Administration and Support Services.	.....do	.....	ES	.....	.....	
Bay Pines, FL	Senior Advisor on Legislative and Congressional Affairs.	.....do	XS	OT	.....	.....	
Washington, DC	Senior Advisor	.....do	XS	SL	.....	.....	
Do	Executive Director, Delivery Operations, Office of Community Care.	.....do	.....	ES	.....	.....	
	Veterans Integrated Service Network Directors						
Albany, NY	Director Veterans Affairs Medical Center Albany.	.....do	.....	ES	.....	.....	
Albuquerque, NM ..	Director New Mexico Veterans Affairs Healthcare System.	Career Incumbent	CA	ES	.....	.....	
Alexandria, LA	Director Veterans Affairs Medical Center Alexandria.	.....do	CA	ES	.....	.....	
Altoona, PA	Director Veterans Affairs Medical Center Altoona.	.....do	CA	ES	.....	.....	
Amarillo, TX	Director, Amarillo Veterans Affairs Health Care System.	.....do	CA	ES	.....	.....	
Hines, IL	Veterans Integrated Service Network Director	Vacant	.....	ES	.....	.....	
Ann Arbor, MI	Director Veterans Affairs Medical Center Ann Arbor.	Career Incumbent	CA	ES	.....	.....	
Asheville, NC	Director Veterans Affairs Medical Center Asheville.	.....do	CA	ES	.....	.....	
Atlanta, GA	Director Veterans Affairs Medical Center Atlanta.	Vacant	.....	ES	.....	.....	
Augusta, GA	Director Veterans Affairs Medical Center Augusta.	Career Incumbent	CA	ES	.....	.....	
Bath, NY	Director Veterans Affairs Medical Center, Bath, NY.	.....do	CA	ES	.....	.....	
Battle Creek, MI ...	Director Veterans Affairs Medical Center Battle Creek.	.....do	CA	ES	.....	.....	
Bay Pines, FL	Director Veterans Affairs Medical Center Bay Pines.	.....do	CA	ES	.....	.....	
Beckley, WV	Director Veterans Affairs Medical Center Beckley.	Vacant	.....	ES	.....	.....	
Bedford, MA	Director Veterans Affairs Medical Center Bedford.	Career Incumbent	CA	ES	.....	.....	
Big Spring, TX	Director, West Texas Veterans Affairs Healthcare System.	Vacant	.....	ES	.....	.....	
Biloxi, MS	Director Veterans Affairs Medical Center Biloxi.	Career Incumbent	CA	ES	.....	.....	
Birmingham, AL	Director Veterans Affairs Medical Center Birmingham.	.....do	CA	ES	.....	.....	
Boise, ID	Director Veterans Affairs Medical Center Boise.	.....do	CA	ES	.....	.....	
Boston, MA	Director, Veterans Affairs Boston Healthcare System.	.....do	CA	ES	.....	.....	
New York -Bronx, NY.	Director Veterans Affairs Medical Center Bronx.	Vacant	.....	ES	.....	.....	
New York New York, NY.	Director, Veterans Affairs New York Harbor Health Care System.	Career Incumbent	CA	ES	.....	.....	
Buffalo, NY	Director Veterans Affairs Western New York Healthcare System.	.....do	CA	ES	.....	.....	
Dallas, TX	Director Veterans Affairs Medical Center Dallas.	.....do	CA	ES	.....	.....	
Butler, PA	Director Veterans Affairs Medical Center Butler.	.....do	CA	ES	.....	.....	
Canandaigua, NY ..	Director Veterans Affairs Medical Center Canandaigua.	Vacant	.....	ES	.....	.....	
Charleston, SC	Director Veterans Affairs Medical Center Charleston.	Career Incumbent	CA	ES	.....	.....	
Cheyenne, WY	Director VAM and ROC Cheyenne	Vacant	.....	ES	.....	.....	
Chicago, IL	Director, Veterans Affairs Medical Center Chicago.	.....do	.....	ES	.....	.....	
Chillicothe, OH	Director Veterans Affairs Medical Center Chillicothe.	Career Incumbent	CA	ES	.....	.....	
Cincinnati, OH	Director Veterans Affairs Medical Center Cincinnati.	Vacant	.....	ES	.....	.....	

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DEPARTMENT OF VETERANS AFFAIRS—Continued

Location	Position Title	Name of Incumbent	Type of Appt.	Pay Plan	Level, Grade, or Pay	Tenure	Expires
Cleveland, OH	Director Veterans Affairs Medical Center Cleveland.	Career Incumbent	CA	ES			
Columbia, MO	Director Veterans Affairs Medical Center Columbia, Missouri.	...do	CA	ES			
Columbia, SC	Director Veterans Affairs Medical Center Columbia, South Carolina.	...do	CA	ES			
Columbus, OH	Director Veterans Affairs Medical Center Columbus, OH.	...do	CA	ES			
Dallas, TX	Veterans Administration North Texas Health Care System.	...do	CA	ES			
Dayton, OH	Director Veterans Affairs Medical Center Dayton.	...do	CA	ES			
Des Moines, IA	Director, Veterans Affairs Central Iowa Healthcare System.	...do	CA	ES			
Dublin, GA	Director Veterans Affairs Medical Center Dublin.	...do	CA	ES			
Durham, NC	Director Veterans Affairs Medical Center Durham.	...do	CA	ES			
East Orange, NJ	Director Veterans Affairs Medical Center East Orange.	...do	CA	ES			
El Paso, TX	El Paso Department of Veterans Affairs Health Care System.	Vacant		ES			
Erie, PA	Director Veterans Affairs Medical Center Erie	Career Incumbent	CA	ES			
Fargo, ND	Director Veterans Affairs Medical and Regional Office Center Fargo.	...do	CA	ES			
Nashville, TN	Chief Medical Officer, VISN 9	Maria C. Farina-Morin	XS	OT	$305,302		
Fayetteville, AR	Director Veterans Affairs Medical Center Fayetteville, Arkansas.	Career Incumbent	CA	ES			
Fayetteville, NC	Director Veterans Affairs Medical Center Fayetteville, North Carolina.	...do	CA	ES			
Fort Harrison, MT	Director Veterans Affairs Medical and Regional Office Center Fort Harrison.	Vacant		ES			
Fort Meade, SD	Director Veterans Affairs Black Hills Health Care System.	Career Incumbent	CA	ES			
Fresno, CA	Director, Veterans Affairs Central California Health Care System.	Vacant		ES			
Grand Junction, CO.	Director Veterans Affairs Medical Center Grand Junction.	Career Incumbent	CA	ES			
Hampton, VA	Director Veterans Affairs Medical Center Hampton.	...do	CA	ES			
Hines, IL	Director Veterans Affairs Medical Center Hines.	Vacant	XS	OT			
Houston, TX	Director Veterans Affairs Medical Center Houston.	...do		ES			
Huntington, WV	Director Veterans Affairs Medical Center Huntington.	Career Incumbent	CA	ES			
Indianapolis, IN	Director Veterans Affairs Medical Center Indianapolis.	Vacant		ES			
Iowa City, IA	Director Veterans Affairs Medical Center Iowa City.	...do		ES			
Iron Mountain, MI	Director Veterans Affairs Medical Center Iron Mountain.	Career Incumbent	CA	ES			
Jackson, MS	Director Veterans Affairs Medical Center Jackson.	Vacant		ES			
Kansas City, MO	Director Veterans Affairs Medical Center Kansas City.	Career Incumbent	CA	ES			
Gainesville, FL	Director Veterans Affairs Medical Center Gainesville.	...do	CA	ES			
Las Vegas, NV	Director, Veterans Affairs Southern Nevada Health Care System, Las Vegas, Nevada.	...do	CA	ES			
Lebanon, PA	Director Veterans Affairs Medical Center Lebanon.	...do	CA	ES			
Lexington, KY	Director Veterans Affairs Medical Center Lexington.	...do	CA	ES			
Little Rock, AR	Director Veterans Affairs Medical Center Little Rock.	Vacant		ES			
Loma Linda, CA	Director Veterans Affairs Medical Center Loma Linda.	Career Incumbent	CA	ES			
Long Beach, CA	Director Veterans Affairs Long Beach Healthcare System.	...do	CA	ES			
Louisville, KY	Director Veterans Affairs Medical Center Louisville.	...do	CA	ES			
Manchester, NH	Director Veterans Affairs Medical Center Manchester.	...do	CA	ES			
Marion, IL	Director Veterans Affairs Medical Center Marion.	Vacant		ES			

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DEPARTMENT OF VETERANS AFFAIRS—Continued

Location	Position Title	Name of Incumbent	Type of Appt.	Pay Plan	Level, Grade, or Pay	Tenure	Expires
Fort Wayne, IN	Director Veterans Affairs Medical Center Ft. Wayne.	Vacant		ES			
Martinsburg, WV	Director Veterans Affairs Medical Center Martinsburg.	Career Incumbent	CA	ES			
Memphis, TN	Director Veterans Affairs Medical Center Memphis.	Vacant		ES			
Miami, FL	Director Veterans Affairs Medical Center Miami.	Career Incumbent	CA	ES			
Montrose, NY	Director, Veterans Affairs Hudson Valley Health Care System.	do	CA	ES			
Johnson City, TN	Director Veterans Affairs Medical Center Mountain Home.	Vacant		ES			
Nashville, TN	Director Veterans Affairs Medical Center Nashville.	do		ES			
Muskogee, OK	Director Veterans Affairs Medical Center Muskogee.	Career Incumbent	CA	ES			
New Orleans, LA	Director Veterans Affairs Medical Center New Orleans.	do	CA	ES			
North Chicago, IL	Director Veterans Affairs Medical Center North Chicago.	Vacant		ES			
Coatesville, PA	Director Veterans Affairs Medical Center Coatesville.	do		ES			
Northport, NY	Director Veterans Affairs Medical Center Northport.	Career Incumbent	CA	ES			
Omaha, NE	Director, Veterans Affairs Nebraska-Western Iowa Health Care System.	do	CA	ES			
Palo Alto, CA	Director Veterans Affairs Palo Alto Health Care System.	Vacant		ES			
Philadelphia, PA	Director Veterans Affairs Medical Center Philadelphia.	Career Incumbent	CA	ES			
Pittsburgh, PA	Director, Veterans Affairs Pittsburgh Health Care System.	do	CA	ES			
Poplar Bluff, MO	Director Veterans Affairs Medical Center Poplar Bluff.	do	CA	ES			
Portland, OR	Director Veterans Affairs Medical Center Portland.	Vacant		ES			
Prescott, AZ	Director Northern Arizona Veterans Affairs Health Care System.	do		ES			
Providence, RI	Director Veterans Affairs Medical Center Providence.	Career Incumbent	CA	ES			
Reno, NV	Director Veterans Affairs Medical Center Reno.	do	CA	ES			
Richmond, VA	Director Veterans Affairs Medical Center Richmond.	do	CA	ES			
Roseburg, OR	Director Veterans Affairs Medical Center Roseburg.	do	CA	ES			
Saginaw, MI	Director Veterans Affairs Medical Center Saginaw.	Vacant		ES			
Salem, VA	Director Veterans Affairs Medical Center Salem.	do		ES			
Salisbury, NC	Director Veterans Affairs Medical Center Salisbury.	Career Incumbent	CA	ES			
Salt Lake City, UT	Director Veterans Affairs Medial Center Salt Lake City.	do	CA	ES			
San Antonio, TX	Director Veterans Affairs Medical Center San Antonio.	Vacant		ES			
Danville, IL	Director Veterans Affairs Medical Center Danville.	do		ES			
San Juan, Puerto Rico.	Director Veterans Affairs Medical Center, San Juan Puerto Rico.	Career Incumbent	CA	ES			
Seattle, WA	Director Veterans Affairs Medical Center Seattle.	do	CA	ES			
Los Angeles, CA	Director, Veterans Affairs Greater Los Angeles Health Care System.	do	CA	ES			
Sheridan, WY	Director Veterans Affairs Medical Center Sheridan.	do	CA	ES			
Shreveport, LA	Director Veterans Affairs Medical Center Shreveport.	do	CA	ES			
Sioux Falls, SD	Director, Veterans Affairs Medical Center	do	CA	ES			
Spokane, WA	Director Veterans Affairs Medical Center Spokane.	do	CA	ES			
St. Louis, MO	Director Veterans Affairs Medical Center Saint Louis.	Vacant		ES			
Syracuse, NY	Director Veterans Affairs Medical Center Syracuse.	Career Incumbent	CA	ES			

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DEPARTMENT OF VETERANS AFFAIRS—Continued

Location	Position Title	Name of Incumbent	Type of Appt.	Pay Plan	Level, Grade, or Pay	Tenure	Expires
Temple, TX	Director, Veterans Affairs Central Texas Health Care System.	Vacant		ES			
Togus, ME	Director Veterans Affairs Medical and Regional Office Center Togus.	....do		ES			
Tomah, WI	Director Veterans Affairs Medical Center Tomah.	....do		ES			
Topeka, KS	Director Veterans Affairs Medical Center Topeka.	Career Incumbent	CA	ES			
Tucson, AZ	Director Veterans Affairs Medical Center Tucson.	Vacant		ES			
Tuscaloosa, AL	Director Veterans Affairs Medical Center Tuscaloosa.	Career Incumbent	CA	ES			
Walla Walla, WA	Director Veterans Affairs Medical Center, Walla Walla.	....do	CA	ES			
Washington, DC	Director Veterans Affairs Medical Center Washington.	....do	CA	ES			
West Haven, CT	Director, Veterans Affairs Connecticut Healthcare System.	....do	CA	ES			
White City, OR	Director Veterans Affairs Medical Center White City.	....do	CA	ES			
White River Junction, VT.	Director Veterans Affairs Medical and Regional Office Center White River Junction.	....do	CA	ES			
Wichita, KS	Director Veterans Affairs Medical Center Wichita.	Vacant		ES			
Wilkes Barre, PA	Director Veterans Affairs Medical Center Wilkes Barre.	....do		ES			
Wilmington, DE	Director Veterans Affairs Medical Center Wilmington.	Career Incumbent	CA	ES			
Milwaukee, WI	Director Veterans Affairs Medical Center Milwaukee.	....do	CA	ES			
Northampton, MA	Director Veterans Affairs Medical Center Northampton.	....do	CA	ES			
Tampa, FL	Director Veterans Affairs Medical Center Tampa.	....do	CA	ES			
Madison, WI	Director Veterans Affairs Medical Center Madison.	....do	CA	ES			
Phoenix, AZ	Director Veterans Affairs Medical Center Phoenix.	....do	CA	ES			
San Diego, CA	Director Veterans Affairs Medical Center San Diego.	Vacant		ES			
Oklahoma City, OK	Director Veterans Affairs Medical Center Oklahoma City.	Career Incumbent	CA	ES			
Tuskegee, AL	Director Central Alabama Healthcare System	Vacant		ES			
San Francisco, CA	Director Veterans Affairs Medical Center San Francisco.	Career Incumbent	CA	ES			
West Palm Beach, FL.	Director Veterans Affairs Medical Center West Palm Beach.	Vacant		ES			
Honolulu, HI	Director Veterans Affairs Medical and Regional Office Center Honolulu, Hawaii.	....do		ES			
Anchorage, AK	Director, Veterans Affairs Operations Clinic and Regional Office Anchorage, Alaska.	....do		ES			
Martinez, CA	Director, Veterans Affairs Northern California Health Care System.	Career Incumbent	CA	ES			
Albany, NY	Director, Veterans Integrated Service Network Albany, New York.	Vacant		ES			
New York -Bronx, NY.	Director, Veterans Integrated Service Network Bronx, New York.	....do		ES			
Pittsburgh, PA	Director, Veterans Integrated Service Network Pittsburg, Pennsylvania.	....do		ES			
Linthicum Hghts, MD.	Director, Veterans Integrated Service Network Linthicum, Maryland.	Career Incumbent	CA	ES			
Durham, NC	Director, Veterans Integrated Service Network Durham, North Carolina.	....do	CA	ES			
Atlanta, GA	Director, Veterans Integrated Service Network Atlanta, Georgia.	....do	CA	ES			
St. Petersburg, FL	Director Veterans Integrated Service Network	Vacant		ES			
Nashville, TN	....do	Career Incumbent	CA	ES			
Cincinnati, OH	Director, Veterans Integrated Service Network.	Vacant		ES			
Ann Arbor, MI	....do	Career Incumbent	CA	ES			
Kansas City, MO	....do	Vacant		ES			
Ridgeland, MS	Director Veterans Integrated Service Network	Career Incumbent	CA	ES			
Dallas, TX	Director, Veterans Integrated Service Network.	....do	CA	ES			
Phoenix, AZ	....do	Vacant		ES			
Portland, OR	Director Veterans Integrated Service Network	....do		ES			

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DEPARTMENT OF VETERANS AFFAIRS—Continued

Location	Position Title	Name of Incumbent	Type of Appt.	Pay Plan	Level, Grade, or Pay	Tenure	Expires
San Francisco, CA	Director Veterans Integrated Service Network	Career Incumbent	CA	ES			
Long Beach, CA	Director, Veterans Integrated Service Network.	do	CA	ES			
Minneapolis, MN	Health System Administrator	do	CA	ES			
Do	Director Veterans Integrated Service Network	do	CA	ES			
Denver, CO	Director, Veterans Affairs Eastern Colorado Health Care System.	do	CA	ES			
Harlingen, TX	Director Veterans Affairs Medical Center Harlingen.	Vacant		ES			
Washington, DC	Deputy Network Director	Career Incumbent	CA	ES			
St. Petersburg, FL	Deputy Veterans Integrated Service Network Director.	Vacant		ES			
Clarksburg, WV	Director Veterans Affairs Medical Center Clarksburg.	Glenn R. Snider Jr.	XS	OT	$265,000		
Indianapolis, IN	Director Veterans Affairs Medical Center Indianapolis.	James Brian Hancock	XS	OT	$275,120		
Jackson, MS	Director Veterans Affairs Medical Center Jackson.	David Walker	XS	OT	$280,000		
Little Rock, AR	Director Veterans Affairs Medical Center Little Rock.	Margie A. Scott	XS	OT	$304,596		
Baltimore, MD	Director Veterans Affairs Medical Center Baltimore.	Adam M. Robinson M.D.	XS	OT	$285,000		
New York -Bronx, NY.	Health System Administration (Medical Center Director).	Erik Langhoff M.D.	XS	OT	$250,000		
	Title 38 Positions						
Washington, DC	National Director, Nutrition and Food Service	Vacant	XS	OT			
Do	Chief Nursing Officer	do	XS	OT			
Do	Chief Consultant, Pharmacy Benefits Management Services.	Michael A. Valentino	XS	OT	$198,360		
Do	Chief Consultant, Primary Care Services	Gordon Schectman	XS	OT	$229,137		
Linthicum Hghts, MD.	Chief Medical Officer	Vacant	XS	OT			
Pittsburgh, PA	do	Timothy R. Burke M.D.	XS	OT	$271,231		
Washington, DC	Deputy Director, Clinical Science Research and Development Service.	Vacant	XS	OT			
Ann Arbor, MI	National Program Director, Nuclear Medicine and Radiation Safety Service.	do	XS	OT			
Washington, DC	Deputy Chief Research and Development Officer (Field Operations).	do	XS	OT			
Do	National Director, Anesthesia Services	Sam T. Sum-Ping	XS	OT	$334,929		
Seattle, WA	Chief Consultant, Spinal Cord Injury and Disorders Services.	Sophia N. Chun	XS	OT	$272,000		
Washington, DC	Chief Consultant Women Veterans Health Strategic Health Care Group.	Patricia M. Hayes	XS	OT	$149,989		
New Orleans, LA	Director, Healthcare Retention and Recruitment Office.	Vacant	XS	OT			
Washington, DC	Principal Deputy Under Secretary for Health	Richard Stone	XS	OT	$315,000		
Detroit, MI	Director, Veterans Affairs Medical Center Detroit.	Pamela J. Reeves	XS	OT	$217,836		
Baltimore, MD	Director, Biomedical Research and Development Service.	Christopher T. Bever Jr.	XS	OT	$275,000		
Kansas City, MO	Chief Medical Officer, VISN 15	Kanan Chatterjee	XS	OT	$253,108		
Sacramento, CA	Health System Administrator	Vacant	XS	OT			
Boston, MA	Director Veterans Integrated Service Network	Michael F. Mayo-Smith M.D..	XS	OT	$228,215		
Pittsburgh, PA	do	Michael D. Adelman	XS	OT	$250,044		
St. Petersburg, FL	do	Miguel H. Lapuz M.D.	XS	OT	$256,142		
North Chicago, IL	Director Veterans Affairs Medical Center North Chicago, Il.	Stephen R. Holt	XS	OT	$256,343		
Vancouver, WA	Chief Medical Officer, VISN 20	Vacant	XS	OT			
Hampton, VA	National Director, Chaplain Services	Michael L. McCoy	XS	OT	$141,045		
Washington, DC	Deputy Under Secretary for Health for Organizational Excellence.	Carolyn M. Clancy	XS	OT	$250,302		
Atlanta, GA	Chief Medical Officer	Ajay K. Dhawan M.D.	XS	OT	$281,188		
Washington, DC	Deputy Chief Academics Officer	Karen Sanders	XS	OT	$230,839		
Do	Chief Consultant, Mental Health Services	Harold S. Kudler	XS	OT	$260,000		
Do	Chief Consultant, Geriatrics and Extended Care Services.	Richard M. Allman	XS	OT	$261,364		
Do	Chief Public Health and Environmental Hazards Officer.	Vacant	XS	OT			
Kansas City, MO	Director Veterans Integrated Service Network	William Patterson	XS	OT	$239,390		
Washington, DC	Deputy Chief Consultant for Mental Health Standards of Care.	Marsden H. McGuire	XS	OT	$250,000		
Do	Deputy Chief Officer Office of Research Oversight.	Peter N. Poon	XS	OT	$158,000		

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DEPARTMENT OF VETERANS AFFAIRS—Continued

Location	Position Title	Name of Incumbent	Type of Appt.	Pay Plan	Level, Grade, or Pay	Tenure	Expires
Washington, DC	Associate Chief Patient Care Services Officer	Barbara L. Hyduke	XS	OT	$135,018		
Do	Chief Consultant, Telehealth Services	Vacant	XS	OT			
Martinsburg, WV	Chief Consultant, Emergency Management	Daniel J. Bochicchio M.D.	XS	OT	$235,000		
Boston, MA	Director, Performance and Measurement	Steven M. Wright	XS	OT	$150,767		
Kansas City, MO	Director Operational Analytics and Reporting	Peter L. Almenoff	XS	OT	$236,924		
Washington, DC	Chief Consultant for Human Resources	Vacant	XS	OT			
Do	Director, Human Resources and Staffing Services.	Makki Mohamad	XS	OT	$149,590		
Do	Director, Healthcare Talent Management Office.	Vacant	XS	OT			
Hines, IL	Chief Medical Officer	.....do	XS	OT			
Washington, DC	Director, Rehabilitation Research and Development Service.	Patricia Dorn	XS	OT	$165,300		
Do	Chief Academic Affiliations Officer	Robert L. Jesse	XS	OT	$277,820		
Bedford, MA	Chief Medical Officer	Vacant	XS	OT			
Washington, DC	Director, Health Information Governance	Marcia Insley	XS	OT	$154,828		
Do	Director, Clinical Analytics and Reporting	Joseph Francis M.D.	XS	OT	$238,325		
Do	Chief Officer, Office of Research Oversight	John T. Puglisi	XS	OT	$165,300		
Silver Spring, MD	Director - Veterans Affairs / Department of Defense Health Information Sharing Service.	Vacant	XS	OT			
Washington, DC	Director, Organizational Integrity and Information Synchronization.	Caitlin A. O'Brien	XS	OT	$179,700		
Do	Deputy Director, Office of Patient Care Services and Cultural Transformation.	Ann C. Patterson	XS	OT	$173,600		
Durham, NC	Chief Diagnostics Services and National Director, Radiology Services.	Robert H. Sherrier	XS	OT	$394,388		
Washington, DC	Assistant Deputy Under Secretary for Health for Policy and Services.	Vacant	XS	OT			
Do	Deputy Chief Patient Care Services Officer (Office of Public Health).	Richard A. Kaslow	XS	OT	$245,000		
Do	Director, Health Services Research and Development.	David Atkins	XS	OT	$222,703		
Do	Associate Chief Officer	Terry A. Ross	XS	OT	$149,989		
Ann Arbor, MI	Chief Safety and Risk Awareness Officer	Robin R. Hemphill M.D.	XS	OT	$227,500		
Washington, DC	Assistant Under Secretary for Health for Dentistry.	Patricia E. Arola	XS	OT	$218,085		
Do	Chief Officer, Office of Disability and Medical Assessment.	Patricia Murray	XS	OT			
Do	Deputy Chief Nursing Officer	B. Alan Bernstein	XS	OT	$168,700		
Palo Alto, CA	Chief Consultant, Population Health	Larry A. Mole	XS	OT	$163,275		
Washington, DC	Executive Director, Mental Health Operations	J. David Carroll	XS	OT	$171,500		
Do	Director, Clinical Programs and Administrative Operations.	Vacant	XS	OT	$169,000		
Do	Senior Medical Officer (Office Quality, Safety and Value).	.....do	XS	OT			
Do	Director, National Surgery Office (Physician)	William P. Gunnar	XS	OT	$360,000		
Do	Chief Consultant, Specialty Care Services	Vacant	XS	OT			
Iowa City, IA	National Director, Pathology and Laboratory Medicine Service.	Michael S. Icardi	XS	OT	$208,000		
Richmond, VA	National Director, Radiation Oncology Program (Physician).	Michael P. Hagan	XS	OT	$267,141		
Washington, DC	Special Operations Officer	Vacant	XS	OT			
Do	Chief Consultant Occupational Health	Kathleen McPhaul	XS	OT	$140,671		
Do	Executive Director, National Center for Ethics in Health Care.	Lisa S. Lehmann	XS	OT	$260,000		
Do	National Director, Veterans Health Administration Homeless Programs.	Vacant	XS	OT			
Do	Chief Consultant, Care Management and Social Work Services.	Michael T. Kilmer	XS	OT	$149,000		
Do	Executive Director for Connected Health	Kathleen L. Frisbee	XS	OT	$163,319		
Durham, NC	Chief Consultant for Preventive Medicine	Vacant	XS	OT			
Washington, DC	Executive Director, Interagency Health Affairs.	Karen T. Malebranche	XS	OT	$173,600		
Do	Executive Director, Office of Strategic Integration.	Katheleen Z B Andrews	XS	OT	$245,000		
Do	Assistant Deputy Under Secretary for Health for Quality, Safety, and Value.	Vacant	XS	OT			
Do	National Director, Prosthetic and Sensory Aids Service, Rehabilitation and Prosthetic Services.	Penny L. Nechanicky	XS	OT	$160,235		
Do	Deputy Director, Office of Strategic Integration.	Vacant	XS	OT			
Do	Chief Consultant, Post Deployment Health	Ralph L. Erickson	XS	OT	$244,970		
Do	Deputy Chief, Research and Development Officer.	Vacant	XS	OT			

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DEPARTMENT OF VETERANS AFFAIRS—Continued

Location	Position Title	Name of Incumbent	Type of Appt.	Pay Plan	Level, Grade, or Pay	Tenure	Expires
Washington, DC	Deputy Director, Office of Mental Health Operations.	Vacant	XS	OT	$250,000	.....	
Do	Deputy Chief Patient Care Services, Office for Rehabilitation and Prosthetic.	Lucille B. Beck	XS	OT	$173,600	.....	
Do	National Director of Neurology	Donald S. Higgins Jr.	XS	OT	$261,056	.....	
Do	Senior Medical Advisor, Office of the Assistant Deputy Under Secretary for Clinical Operations.	Gavin West	XS	OT	$220,000	.....	
Do	National Program Director, Ophthalmology ...	Glenn Cockerham	XS	OT	$280,562	.....	
Do	National Director, Physical Medicine and Rehabilitation Services.	Joel Scholten	XS	OT	$259,024	.....	
Do	Deputy Principal Deputy Under Secretary for Health.	Deborah W. Dort	XS	OT	$284,530	.....	
Orlando, FL	Deputy Chief Learning Officer for Business Operations.	Manuel Dominguez	XS	OT	$173,600	.....	
Washington, DC	Chief Officer, Office of Health Equity	Uchenna S. Uchendu	XS	OT	$226,140	.....	
Do	Assistant Deputy Under Secretary for Health for Community Care.	Baligh R. Yehia M.D.	XS	OT	$217,500	.....	
Do	Assistant Deputy Under Secretary for Health for Integrity.	Gerard R. Cox	XS	OT	$255,355	.....	
Do	Assistant Deputy Under Secretary for Clinical Operations.	Robert E. Lynch M.D.	XS	OT	$275,000	.....	
Do	Deputy Assistant Deputy Under Secretary for Health for Clinical Operations.	Tammy Czarnecki	XS	OT	$151,435	.....	
Do	Executive Director, Office of Patient Centered Care and Cultural Transformation.	Tracy W. Gaudet	XS	OT	$275,980	.....	
Do	Deputy Under Secretary for Health for Policy and Services.	Jennifer S. Lee	XS	OT	$220,000	.....	
Do	Director, Strategic Investment Management ..	Charles C. Hume	XS	OT	$165,300	.....	
Do	Director, HIV, Hepatitis and Public Health Pathogens Program.	David B. Ross	XS	OT	$230,521	.....	
Do	Assistant Deputy Under Secretary for Health for Patient Care Services.	Maureen McCarthy	XS	OT	$277,315	.....	
Do	Deputy Chief Consultant for Specialty Mental Health.	Wendy N. Tenhula	XS	OT	$165,540	.....	
Do	Director of Physician Assistant Services	Denni J. Woodmansee	XS	OT	$127,910	.....	
Do	Chief Officer, Office of Connected Care	Neil Evans	XS	OT	$265,000	.....	
Do	Director, Bioinformatics	James L. Breeling	XS	OT	$227,070	.....	
Do	Assistant Deputy Chief Patient Care Services	Vacant	XS	OT	.....	.....	
Fort Howard, MD ..	National Director Optometry Service	John C. Townsend	XS	AD	$165,300	.....	
Cleveland, OH	Director Podiatry Service	Jeffrey M. Robbins	XS	AD	$160,829	.....	
Cheyenne, WY	Director Regional Office Medical Center Cheyenne.	Vacant	XS	AD	.....	.....	
Albany, NY	Director Veterans Integrated Service Network	Joan McInerney	XS	AD	$258,170	.....	

DEPARTMENT OF VETERANS AFFAIRS OFFICE OF THE INSPECTOR GENERAL

Location	Position Title	Name of Incumbent	Type of Appt.	Pay Plan	Level, Grade, or Pay	Tenure	Expires
	IMMEDIATE OFFICE OF THE INSPECTOR GENERAL						
Washington, DC	Inspector General	Michael Joseph Missal	PAS	EX	III	.....	

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 12/11/2016 8:50:47 PM
To: [redacted] [redacted]@gmail.com]; Poonam Alaigh [redacted]@hotmail.com]

This says trump offered Christie secretary of VA

http://www.cnn.com/2016/12/11/politics/chris-christie-turned-down-donald-trump/index.html

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/4/2016 4:56:55 PM
To: Allison Hickey (b) (6) @allin-solutions.com]
BCC: (b) (6) [(b) (6) @gmail.com]
Subject: Re: RE:

(b) (6)

Sent from my iPhone

On Dec 4, 2016, at 11:48 AM, Allison Hickey (b) (6) @allin-solutions.com> wrote:

> Yes. See you there. Do you have a cell number?
>
> (b) (6)
>
> Sent via the Samsung Galaxy S7, an AT&T 4G LTE smartphone
>
> -------- Original message --------
> From: David Shulkin <drshulkin@aol.com>
> Date: 12/4/16 10:17 AM (GMT-05:00)
> To: Allison Hickey (b) (6) @allin-solutions.com>
> Subject: Re:
>
> Would getting together for a drink work Monday at 430 PM at BLK on I street near vaco?
>
> -----Original Message-----
> From: Allison Hickey (b) (6) @allin-solutions.com>
> To: David shulkin <Drshulkin@aol.com>; allison.a.hickey (b) (6) @gmail.com>
> Sent: Sun, Dec 4, 2016 10:12 am
> Subject: RE:
>
> Monday or Friday this week?
>
> Sent via the Samsung Galaxy S7, an AT&T 4G LTE smartphone
>
> -------- Original message --------
> From: David shulkin <Drshulkin@aol.com>
> Date: 12/4/16 10:08 AM (GMT-05:00)
> To: (b) (6) @gmail.com
> Subject:
>
> Allison- I was thinking of you and wanted to check in and see how you are doing-
>
> Anytime to catch up for a cup of coffee or lunch before the holidays?

AMERICAN OVERSIGHT

David

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/10/2016 4:03:07 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: We need to coordinate

Yes we will be lockstep

Sent from my iPhone

> On Dec 10, 2016, at 10:59 AM, Poonam Alaigh <(b) (6) n@hotmail.com> wrote:
>
> Didn't get a chance to discuss, but in the event that you do leave next month, I want to leave before you and hand in my resignation to you. Hopefully we will get clarity over the next couple of weeks- but I am not staying here for an extra second without you being here.
>
> Sent from my iPad

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/10/2016 3:59:43 PM
To: David shulkin [drshulkin@aol.com]
Subject: We need to coordinate

Didn't get a chance to discuss, but in the event that you do leave next month, I want to leave before you and hand in my resignation to you. Hopefully we will get clarity over the next couple of weeks- but I am not staying here for an extra second without you being here.

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/6/2016 11:48:13 AM
To: Darin Selnick(b) (6) @gmail.com]
Subject: Re:

Great - how is teaism on h street near vaco?

Sent from my iPhone

On Dec 6, 2016, at 1:53 AM, Darin Selnick (b) (6) @gmail.com> wrote:

> How does breakfast on the 14th at 8am work for you.
>
> Darin
>
> On Mon, Dec 5, 2016 at 7:05 PM, David shulkin <Drshulkin@aol.com> wrote:
> Unfortunately i cant do the 14 th - i could do dinner on the 12 th or the 15th or early in thr morning on the 12th, 14 th or 15 th
>
> Sent from my iPhone
>
> On Dec 5, 2016, at 7:30 PM, Darin Selnick (b) (6) @gmail.com> wrote:
>
> > How about Wed, Dec 14, at 6pm, we could do dinner if you like.
> >
> > Darin
> >
> > On Mon, Dec 5, 2016 at 2:51 PM, David shulkin <Drshulkin@aol.com> wrote:
> > Next week would be great Darin-
> >
> > Im flexible
> >
> > David
> >
> > Sent from my iPhone
> >
> > On Dec 5, 2016, at 4:16 PM, Darin Selnick (b) (6) @gmail.com> wrote:
> >
> > > Hi David
> > >
> > > I am back in Oceanside this week, will be back in DC next week. Happy to talk either week.
> > >
> > > I know we will be setting up follow up VHA meetings for next week, Dec 13-16. So let me know if you want to talk on the phone later this week or in person next week.
> > >
> > > Best
> > >
> > > Darin

AMERICAN OVERSIGHT

On Mon, Dec 5, 2016 at 1:08 PM, David shulkin <Drshulkin@aol.com> wrote:

Darin- i dont want to break protocol
So let me know if you are not comfortable- but i would very much appreciate the opportunity to get together informally at a convenient time to share thoughts on the process. Id be glad to meet for lunch or after hours- whatever is best for you

Thanks

David

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Darin Selnick [(b) (6)@gmail.com]
Sent: 12/6/2016 6:53:10 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re:

How does breakfast on the 14th at 8am work for you.

Darin

On Mon, Dec 5, 2016 at 7:05 PM, David shulkin <Drshulkin@aol.com> wrote:
Unfortunately i cant do the 14 th - i could do dinner on the 12 th or the 15th or early in thr morning on the 12th, 14 th or 15 th

Sent from my iPhone

On Dec 5, 2016, at 7:30 PM, Darin Selnick (b) (6)@gmail.com> wrote:

> How about Wed, Dec 14, at 6pm, we could do dinner if you like.
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> Darin
>
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> >
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> > So let me know if you are not comfortable- but i would very much appreciate the opportunity to get together informally at a convenient time to share

AMERICAN OVERSIGHT

thoughts on the process. Id be glad to meet for lunch or after hours- whatever is best for you

Thanks

David

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/6/2016 3:05:33 AM
To: Darin Selnick (b) (6) @gmail.com]
Subject: Re:

Unfortunately i cant do the 14 th - i could do dinner on the 12 th or the 15th or early in thr morning on the 12th, 14 th or 15 th

Sent from my iPhone

On Dec 5, 2016, at 7:30 PM, Darin Selnick (b) (6) @gmail.com> wrote:

> How about Wed, Dec 14, at 6pm, we could do dinner if you like.
>
> Darin
>
> On Mon, Dec 5, 2016 at 2:51 PM, David shulkin <Drshulkin@aol.com> wrote:
> Next week would be great Darin-
>
> Im flexible
>
> David
>
> Sent from my iPhone
>
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>
> > Hi David
> >
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> >
> > I know we will be setting up follow up VHA meetings for next week, Dec 13-16. So let me know if you want to talk on the phone later this week or in person next week.
> >
> > Best
> >
> > Darin
> >
> > On Mon, Dec 5, 2016 at 1:08 PM, David shulkin <Drshulkin@aol.com> wrote:
> > Darin- i dont want to break protocol
> > So let me know if you are not comfortable- but i would very much appreciate the opportunity to get together informally at a convenient time to share thoughts on the process. Id be glad to meet for lunch or after hours- whatever is best for you
> >
> > Thanks

AMERICAN OVERSIGHT

David

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Darin Selnick[(b) (6) @gmail.com]
Sent: 12/6/2016 12:30:03 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re:

How about Wed, Dec 14, at 6pm, we could do dinner if you like.

Darin

On Mon, Dec 5, 2016 at 2:51 PM, David shulkin <Drshulkin@aol.com> wrote:
Next week would be great Darin-

Im flexible

David

Sent from my iPhone

On Dec 5, 2016, at 4:16 PM, Darin Selnick (b) (6) @gmail.com> wrote:

> Hi David
>
> I am back in Oceanside this week, will be back in DC next week. Happy to talk either week.
>
> I know we will be setting up follow up VHA meetings for next week, Dec 13-16. So let me know if you want to talk on the phone later this week or in person next week.
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>
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> So let me know if you are not comfortable- but i would very much appreciate the opportunity to get together informally at a convenient time to share thoughts on the process. Id be glad to meet for lunch or after hours- whatever is best for you
>
> Thanks
>
> David
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/5/2016 10:51:56 PM
To: Darin Selnick (b) (6) @gmail.com]
Subject: Re:

Next week would be great Darin-

Im flexible

David

Sent from my iPhone

On Dec 5, 2016, at 4:16 PM, Darin Selnick (b) (6) @gmail.com> wrote:

> Hi David
>
> I am back in Oceanside this week, will be back in DC next week. Happy to talk either week.
>
> I know we will be setting up follow up VHA meetings for next week, Dec 13-16. So let me know if you want to talk on the phone later this week or in person next week.
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>
> Thanks
>
> David
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Darin Selnick [(b) (6) @gmail.com]
Sent: 12/5/2016 9:16:39 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re:

Hi David

I am back in Oceanside this week, will be back in DC next week. Happy to talk either week.

I know we will be setting up follow up VHA meetings for next week, Dec 13-16. So let me know if you want to talk on the phone later this week or in person next week.

Best

Darin

On Mon, Dec 5, 2016 at 1:08 PM, David shulkin <Drshulkin@aol.com> wrote:

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> So let me know if you are not comfortable- but i would very much appreciate the opportunity to get together informally at a convenient time to share thoughts on the process. Id be glad to meet for lunch or after hours- whatever is best for you
>
> Thanks
>
> David
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/5/2016 9:08:36 PM
To: (b) (6) @gmail.com

Darin- i dont want to break protocol
So let me know if you are not comfortable- but i would very much appreciate the opportunity to get together informally at a convenient time to share thoughts on the process. Id be glad to meet for lunch or after hours- whatever is best for you

Thanks

David

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Jennifer Lee [(b) (6) @gmail.com]
Sent: 12/3/2016 7:03:49 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re:

Ok great idea! will do

On Dec 3, 2016 2:02 PM, "David shulkin" <Drshulkin@aol.com> wrote:
You can always say we are frozen during transition

Sent from my iPhone

On Dec 3, 2016, at 1:18 PM, Jennifer Lee <(b) (6) @gmail.com> wrote:

I think I know what it is-- that company that made the videos (Mytonomy) for DC VAMC wants us to fund more of their videos...
They asked me for a follow up meeting to identify funding sources

On Dec 3, 2016 1:01 PM, "David shulkin" <Drshulkin@aol.com> wrote:
Jen- (b) (6) is texting me to have you call him- not sure what he wants or if younwant to call- just passing it along

David

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/3/2016 7:02:15 PM
To: Jennifer Lee [(b) (6) @gmail.com]
Subject: Re:

You can always say we are frozen during transition

Sent from my iPhone

On Dec 3, 2016, at 1:18 PM, Jennifer Lee <(b) (6) @gmail.com> wrote:

> I think I know what it is-- that company that made the videos (Mytonomy) for DC VAMC wants us to fund more of their videos...
> They asked me for a follow up meeting to identify funding sources
>
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> Jen- (b) (6) is texting me to have you call him- not sure what he wants or if younwant to call- just passing it along
>
> David
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/3/2016 4:08:25 PM
To: Jennifer Lee [(b) (6)@gmail.com]

Jen- (b) (6) is texting me to have you call him- not sure what he wants or if younwant to call- just passing it along

David

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/6/2016 12:36:09 PM
To: David shulkin [drshulkin@aol.com]
Subject: Also

I am feeling much better this morning- don't worry about me, was just in a bad state of mind with so much hitting me too. All is well now that (b) is coming home today so he will be able to deal with all my "venting" and will help clear my mind before heading to D.C. tomorrow

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/29/2016 1:25:36 PM
To: (b) (6) [(b) (6) @gmail.com]
Subject: Re: Do you want to go to this ?

Yes

Sent from my iPhone

> On Dec 29, 2016, at 7:45 AM, (b) (6) <(b) (6) r@gmail.com> wrote:
>
> Medal of Honor Recipients VFW
> <20161229_074753.jpg>

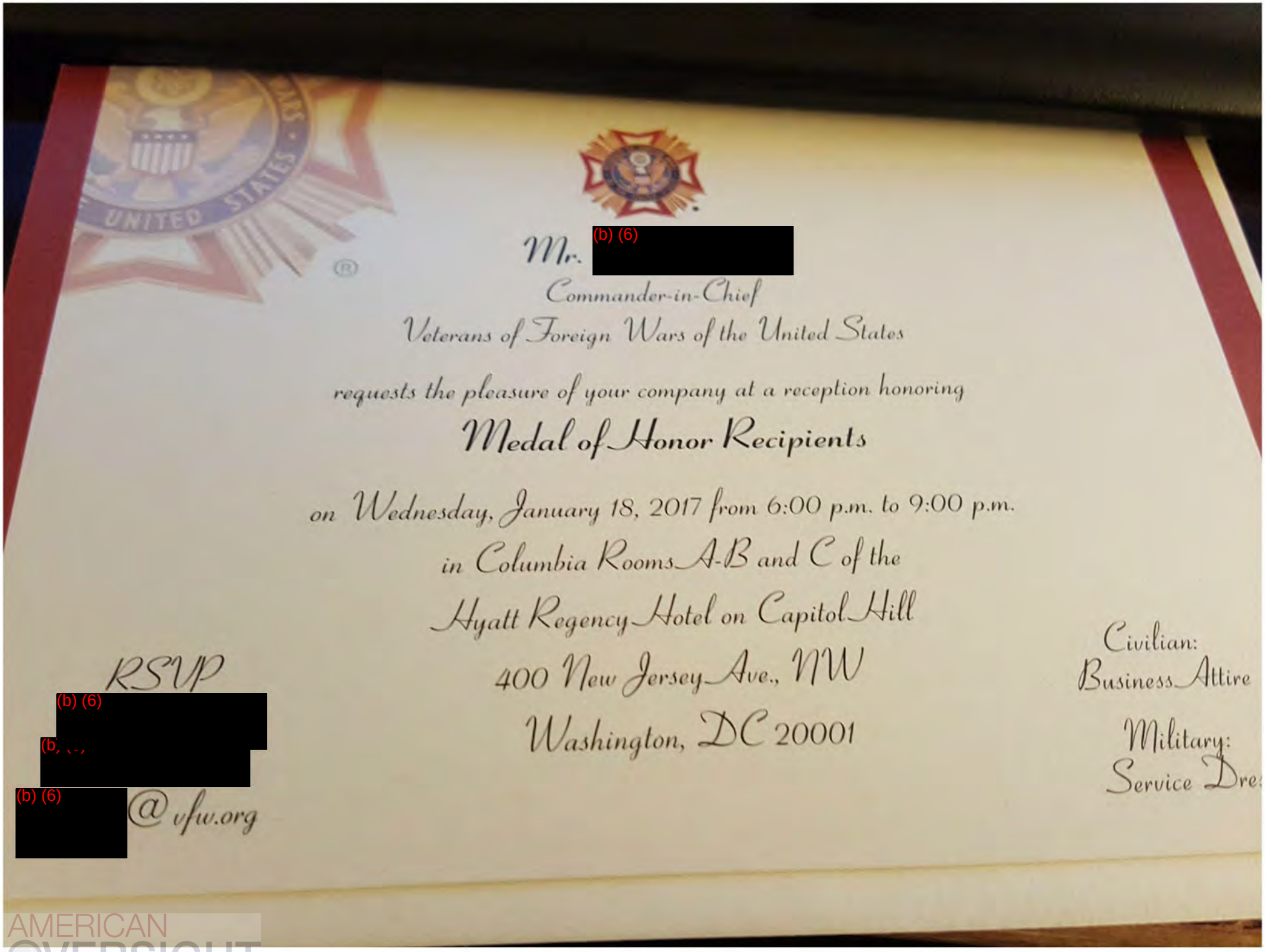
AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6)@gmail.com]
Sent: 12/29/2016 12:45:56 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Do you want to go to this ?
Attachments: 20161229_074753.jpg

Medal of Honor Recipients VFW

AMERICAN OVERSIGHT



AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) @me.com]
Sent: 1/19/2017 1:43:25 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: [EXTERNAL] Fwd: Re: Request

Thanks! and good luck!
(b) (6)

From: David Shulkin <Drshulkin@aol.com>
Date: Wednesday, January 18, 2017 at 8:09 PM
To: (b) (6) <(b) (6) @me.com>
Subject: Re: [EXTERNAL] Fwd: Re: Request

(b) our ethics counsel said no but ill go back and push why this has changed but after i get through my hearings of course

Sent from my iPhone

On Jan 18, 2017, at 7:49 PM, (b) (6) <(b) (6) @me.com> wrote:

> David,
>
> Obviously very disappointed with this since we have never had a problem before.
> SecVA Principi and Peake, DepSecVA Gould, USB Hickey, and ASecVA Baker and Council as well as myself as DAS and AASec for 6 years running served in the role with approvals from ethics counsel.
> In addition we have had DOD representatives at the ASec level and representatives from other agencies all clear ethics consideration.
> This is our 13th year and VA has always been represented.
> I know you have much more pressing issues in front of you but still a big disappointment.
> Life goes on and my offer stands to be of service in any way I can.
> BTW (b) (6) asked me to convey his congratulations and best wishes.
>
> Regards
>
> (b) (6)

AMERICAN OVERSIGHT

From: "(b) (6) (b) (6) R." (b) (6) va.gov>
Date: Wednesday, January 18, 2017 at 1:24 PM
To: (b) (6) <(b) (6) @me.com>
Subject: RE: [EXTERNAL] Fwd: Re: Request

Good Afternoon,

Thank you so much for asking Dr. Shulkin to serve as the Honorary Chairman of the 13th Annual Operation Jumpstart. Unfortunately, our Ethics counsel has determined he is unable to serve in this capacity. Please except our sincere regrets.

(b) (6)
Chief Administrative Officer
Office of the Under Secretary for Health
Veterans Health Administration
(b) (6)
(b) (6) (Blackberry)
Request a meeting: https://vets.force.com/USH/s

---------- Forwarded message ----------
From: "David shulkin" <Drshulkin@aol.com>
Date: Nov 30, 2016 2:11 PM
Subject: Re: Request
To: "(b) (6) <(b) (6) @me.com>
Cc: "(b) (6) <(b) (6) @gmail.com>

Id be honored- let me submit for clearance

Sent from my iPhone

On Nov 30, 2016, at 12:32 PM, (b) (6) <(b) (6) @me.com> wrote:

> David,
>
> I hope you will consider serving as Honorary Chairman of our 13th Annual Operation Jumpstart on February 6, 2017 at the Army Navy Country Club in Arlington, Virginia.
> There is nothing you would have to do other than show up.
> This is the event you attended last year when LaVerne was the honorary chairperson.
> Over the years several other VA officials have served in this capacity so there should be no problem clearing this with the ethics folks.
> Thanks for considering it.

AMERICAN OVERSIGHT

http://1105govinfocustom.1105cms01.com/events/operation-jump-start/home.aspx

Regards
(b)

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/19/2017 1:09:51 AM
To: (b) (6) [(b) (6) @me.com]
Subject: Re: [EXTERNAL] Fwd: Re: Request

(b) our ethics counsel said no but ill go back and push why this has changed but after i get through my hearings of course

Sent from my iPhone

On Jan 18, 2017, at 7:49 PM, (b) (6) <(b) (6) @me.com> wrote:

> David,
>
> Obviously very disappointed with this since we have never had a problem before.
> SecVA Principi and Peake, DepSecVA Gould, USB Hickey, and ASecVA Baker and Council as well as myself as DAS and AASec for 6 years running served in the role with approvals from ethics counsel.
> In addition we have had DOD representatives at the ASec level and representatives from other agencies all clear ethics consideration.
> This is our 13th year and VA has always been represented.
> I know you have much more pressing issues in front of you but still a big disappointment.
> Life goes on and my offer stands to be of service in any way I can.
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> Regards
>
> (b) (6)
>
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> **Date:** Wednesday, January 18, 2017 at 1:24 PM
> **To:** (b) (6) <(b) (6) @me.com>
> **Subject:** RE: [EXTERNAL] Fwd: Re: Request
>
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AMERICAN OVERSIGHT

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(b) (6)
Chief Administrative Officer
Office of the Under Secretary for Health
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Request a meeting: https://vets.force.com/USH/s

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Subject: Re: Request
To: "(b) (6) <(b) (6) @me.com>
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> http://1105govinfocustom.1105cms01.com/events/operation-jump-start/home.aspx
>
> Regards
> (b)

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) @me.com]
Sent: 1/19/2017 12:49:39 AM
To: David Shulkin [Drshulkin@aol.com]
Subject: FW: [EXTERNAL] Fwd: Re: Request

David,

Obviously very disappointed with this since we have never had a problem before. SecVA Principi and Peake, DepSecVA Gould, USB Hickey, and ASecVA Baker and Council as well as myself as DAS and AASec for 6 years running served in the role with approvals from ethics counsel.
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BTW (b) (6) asked me to convey his congratulations and best wishes.

Regards

(b) (6)

From: "(b) (6) (b) (6) R." (b) (6) va.gov>
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(b) (6)
Chief Administrative Officer
Office of the Under Secretary for Health
Veterans Health Administration
(b) (6)
(b) (6) (Blackberry)
Request a meeting: https://vets.force.com/USH/s

AMERICAN OVERSIGHT

---------- Forwarded message ----------
From: "David shulkin" <Drshulkin@aol.com>
Date: Nov 30, 2016 2:11 PM
Subject: Re: Request
To: "(b) (6) <(b) (6) @me.com>
Cc: "(b) (6) (b) (6) @gmail.com>

Id be honored- let me submit for clearance

Sent from my iPhone

On Nov 30, 2016, at 12:32 PM, (b) (6) <(b) (6) @me.com> wrote:

> David,
>
> I hope you will consider serving as Honorary Chairman of our 13th Annual Operation Jumpstart on February 6, 2017 at the Army Navy Country Club in Arlington, Virginia.
> There is nothing you would have to do other than show up.
> This is the event you attended last year when LaVerne was the honorary chairperson.
> Over the years several other VA officials have served in this capacity so there should be no problem clearing this with the ethics folks.
> Thanks for considering it.
>
> http://1105govinfocustom.1105cms01.com/events/operation-jump-start/home.aspx
>
> Regards
> (b)

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 11/30/2016 7:11:42 PM
To: (b) (6) [(b) (6) @me.com]
CC: (b) (6) [(b) (6) @gmail.com]
Subject: Re: Request

Id be honored- let me submit for clearance

Sent from my iPhone

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> http://1105govinfocustom.1105cms01.com/events/operation-jump-start/home.aspx
>
> Regards
> (b)

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/15/2016 6:52:37 PM
To: David Shulkin [drshulkin@aol.com]
Subject: You and I HAVE to connect end of the day today

Need to speak to you about my Bush Institute meeting and the Evaluation. report

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: Wright, Vivieca (Simpson) [(b) (6) @va.gov]
Sent: 12/1/2016 10:21:49 PM
To: 'David shulkin' [Drshulkin@aol.com]
Subject: RE: [EXTERNAL] Fwd: CJM Letter to SecVA

(b) (6) is reviewing.

From: David shulkin [mailto:Drshulkin@aol.com]
Sent: Thursday, December 01, 2016 5:16 PM
To: Wright, Vivieca (Simpson)
Subject: [EXTERNAL] Fwd: CJM Letter to SecVA

Fyi

Sent from my iPhone

Begin forwarded message:

> **From:** Carolyn M Clancy <(b) (6) @gmail.com>
> **Date:** December 1, 2016 at 1:23:59 PM EST
> **To:** David Shulkin <drshulkin@aol.com>
> **Subject: Fwd: CJM Letter to SecVA**
>
> FYI
>
> Begin forwarded message:
>
> > **From:** "Clancy, Carolyn" <Carolyn.Clancy@va.gov>
> > **Date:** December 1, 2016 at 12:03:38 PM EST
> > **To:** 'Carolyn Clancy HOME' <(b) (6) @gmail.com>
> > **Subject: FW: CJM Letter to SecVA**
> >
> > Carolyn M Clancy, MD
> > Deputy Under Secretary for Health
> > Organizational Excellence
> > 810 Vermont Ave NW
> > Washington DC 20420
> > 202-461-0370
> >
> > -----Original Message-----
> > **From:** Jensen, Jon M.
> > **Sent:** Thursday, December 01, 2016 11:10 AM Eastern Standard Time
> > **To:** Clancy, Carolyn; Wright, Vivieca (Simpson)

AMERICAN OVERSIGHT

Subject: FW: CJM Letter to SecVA

I wanted to give you a heads up on this.

Jon M. Jensen

Director (Acting)

VHA Congressional & Legislative Affairs (10B3)

Washington, DC 20420

Office: 202-461-6410

BB: 202-769-6129

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/1/2016 10:16:16 PM
To: Vivieca Wright Simpson [vivieca.Wright@va.gov]
Subject: Fwd: CJM Letter to SecVA
Attachments: CJM Letter to SecVA Re Dr. (b) (6) pdf; Untitled attachment 19803.htm

Fyi

Sent from my iPhone

Begin forwarded message:

> **From:** Carolyn M Clancy <(b) (6) @gmail.com>
> **Date:** December 1, 2016 at 1:23:59 PM EST
> **To:** David Shulkin <drshulkin@aol.com>
> **Subject: Fwd: CJM Letter to SecVA**
>
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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

REPUBLICANS
JEFF MILLER, FLORIDA, CHAIRMAN
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GUS M. BILIRAKIS, FLORIDA
DAVID P. ROE, TENNESSEE
DAN BENISHEK, MICHIGAN
TIM HUELSKAMP, KANSAS
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RALPH ABRAHAM, LOUISIANA
LEE ZELDIN, NEW YORK
RYAN COSTELLO, PENNSYLVANIA
AMATA RADEWAGEN, AMERICAN SAMOA
MIKE BOST, ILLINOIS
(b) (6) STAFF DIRECTOR

DEMOCRATS
CORRINE BROWN, FLORIDA, RANKING
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JULIA BROWNLEY, CALIFORNIA
DINA TITUS, NEVADA
RAUL RUIZ, CALIFORNIA
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KATHLEEN RICE, NEW YORK
TIMOTHY J. WALZ, MINNESOTA
JERRY MCNERNEY, CALIFORNIA
DON PHILLIPS
DEMOCRATIC STAFF DIRECTOR

U.S. House of Representatives

COMMITTEE ON VETERANS' AFFAIRS

ONE HUNDRED FOURTEENTH CONGRESS
335 CANNON HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
http://veterans.house.gov

November 30, 2016

The Honorable Robert A. McDonald
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary McDonald,

This letter is regarding Dr. (b) (6) who was recently selected as Assistant Deputy Under Secretary for Health for Quality, Safety, and Value. According to whistleblowers, the Professional Standards Board (PSB) did not recommend Dr. (b) (6) for the position because he failed to meet the minimum requirements for the position. The Committee was also informed that, after the PSB's finding that Dr. (b) (6) did not meet the minimum requirements, the position was reposted under a different hiring authority, thereby removing the PSB from the hiring process. Additionally, the original applicants for the position were apparently not informed that the position was reposted and with changes to the hiring criteria.

One job posting for this position required "at least ten years of professional practice in positions with progressively more complex leadership and policy making assignments including planning, directing and administering clinical organizations and programs in private and public sector." Notably, Dr. (b) (6) 's public online profile highlights that he completed medical school in 2012 and was on leave from his oncology residency to engage in a White House Fellowship. His experience includes being a resident, researcher, consultant, advisor, and analyst, none of which amount to ten years of professional practice experience or health care leadership.

As such, I am requesting the following information regarding the hiring of Dr. (b) (6)

1. How many times and under what hiring authority was the Assistant Deputy Under Secretary for Health for Quality, Safety, and Value position posted from January 2015 to November 2016?
2. If the position was posted multiple times throughout this time period, please list what dates the posting opened and closed as well as the reasons necessitating the position to be reposted.
3. How many applicants applied for the Assistant Deputy Under Secretary for Health for Quality, Safety, and Value each time it was posted?
4. Did the PSB make a recommendation regarding Dr. (b) (6) 's candidacy for the position? Please send all documentation indicating that recommendation.
5. How many applicants for the position were VA employees with the ten years of professional practice experience required by the position posting? Similarly, how many applicants were non-VA employees with the required ten years of professional practice experience required by the position posting?

AMERICAN OVERSIGHT

6. When responding to the previous question, please also denote which applicants, if any, were veterans.

We all agree that our Veterans deserve safe, quality health care. While I am not questioning Dr. (b) (6) 's capabilities as a doctor, I am deeply concerned that the person now selected to lead the quality and safety of the VHA has no post-residency experience apart from his service as a White House Fellow.

Please provide answers to these questions, along with all requested documentation in unredacted form, by close of business on December 13, 2016. If you have any questions, please contact Mr. (b) (6), Majority Staff Director of the House Committee on Veterans' Affairs, at (202) 225-(b) (6)

Sincerely,

JEFF MILLER
Chairman

JM:(b)

AMERICAN OVERSIGHT

AMERICAN OVERSIGHT

Message

From: Carolyn M Clancy [(b) (6) @gmail.com]
Sent: 12/1/2016 6:23:59 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Fwd: CJM Letter to SecVA
Attachments: CJM Letter to SecVA Re Dr. (b) (6) pdf; Untitled attachment 19808.htm

FYI

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Carolyn M Clancy, MD
Deputy Under Secretary for Health
Organizational Excellence
810 Vermont Ave NW
Washington DC 20420
202-461-0370

-----Original Message-----
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Sent: Thursday, December 01, 2016 11:10 AM Eastern Standard Time
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Jon M. Jensen

Director (Acting)

VHA Congressional & Legislative Affairs (10B3)

Washington, DC 20420

AMERICAN OVERSIGHT

Office: 202-461-6410

BB: 202-769-6129

AMERICAN OVERSIGHT

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DEMOCRATIC STAFF DIRECTOR

November 30, 2016

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810 Vermont Avenue, NW
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AMERICAN OVERSIGHT

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Sincerely,

JEFF MILLER
Chairman

JM(b)

AMERICAN OVERSIGHT

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 11/30/2016 7:46:35 PM
To: bob mcDonald [(b) (6) @gmail.com]
Subject: In case you missed it

http://www.cnbc.com/2016/11/30/trump-may-consider-sarah-palin-for-va-secretary-source-tells-nbc.html

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 11/30/2016 3:16:25 AM
To: (b) (6) @gmail.com]
Subject: Re: Fwd: Re: Fwd: Re:

She is married to Mitch McConnell the senate leader

Sent from my iPad

On Nov 29, 2016, at 9:47 PM, (b) (6) @gmail.com> wrote:

> The new secretary of transportation on the board of Ny presbyterian and elizabeth dole foundation caring for military families
> http://www.chaofamilyfoundations.com/elaine-chao/
>
> Sent from my iPhone
>
> On Nov 29, 2016, at 10:30 AM, David shulkin <Drshulkin@aol.com> wrote:
>
>> Sent from my iPhone
>>
>> Begin forwarded message:
>>
>> **From:** Poonam Alaigh <(b) (6) @hotmail.com>
>> **Date:** November 29, 2016 at 8:38:53 AM EST
>> **To:** David shulkin <Drshulkin@aol.com>
>> **Subject: Re: Fwd: Re:**
>>
>> She worked with Pence- not surprising
>>
>> Sent from my iPad
>>
>> On Nov 29, 2016, at 7:36 AM, David shulkin <Drshulkin@aol.com> wrote:
>>
>>> Sent from my iPhone
>>>
>>> Begin forwarded message:
>>>
>>> **From:** (b) (6) @gmail.com>
>>> **Date:** November 29, 2016 at 6:54:56 AM EST
>>> **To:** David shulkin <Drshulkin@aol.com>
>>> **Subject: Re:**

AMERICAN OVERSIGHT

U.S. President-elect Donald Trump is set to name Indiana health policy consultant Seema Verma as his pick for administrator of the Centers for Medicare and Medicaid Services, a transition official told Reuters on Monday

Sent from my iPhone

On Nov 28, 2016, at 8:17 PM, David shulkin <Drshulkin@aol.com> wrote:

> http://www.cbsnews.com/news/veterans-protest-hampshire-college-stopped-flying-us-flag/?ftag=CNM-00-10aab6j&linkId=31627065
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 11/30/2016 3:09:37 AM
To: (b) (6) @gmail.com]
Subject: Re: Fwd: Re: Fwd: Re:

Interesting

Sent from my iPad

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AMERICAN OVERSIGHT

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From: (b) (6) @gmail.com]
Sent: 11/30/2016 2:47:32 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Fwd: Re: Fwd: Re:

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AMERICAN OVERSIGHT

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From: David shulkin [Drshulkin@aol.com]
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> > >
> > > Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Bowman, Thomas (Veterans Affairs) [(b) (6) @vetaff.senate.gov]
Sent: 1/18/2017 8:26:07 PM
To: David Shulkin [drshulkin@aol.com]
CC: (b) (6) @yahoo.com
Subject: Update

Dr. Shulkin: Wanted to let you know that I spoke confidentially with Chairman Isakson yesterday about our earlier call and that we were going to meet next weekend. He was good with it. I told him this was an exploratory discussion and no commitments were made by either you or me.....
I look forward to our discussion next Sunday.....please again confirm for me where and at what time is convenient for you....anytime works for me.....thanks.
R/tom
Cell: (b) (6)

From: David Shulkin [mailto:drshulkin@aol.com]
Sent: Saturday, January 14, 2017 10:39 AM
To: Bowman, Thomas (Veterans Affairs) (b) (6) @vetaff.senate.gov>
Subject: Fwd:

Tom- i never got an email- but then again my account has been rejecting a few- but now you have my correct email

Now that ive seen the full calendar of events I dont think ill have any time in friday to get together. But here are some options

Breakfast or lunch sunday the 22nd or the week of the 23 rd any evening after work would work

David
(b) (6)

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/1/2016 3:44:41 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Fwd: For example, at the first networking activity I met David Shulkin

Networking

Sent from my iPhone

Begin forwarded message:

From: Michael Tepper <(b) (6) @yahoo.com>
Date: December 1, 2016 at 10:11:12 AM EST
To: "David J. Shulkin" <DrShulkin@aol.com>
Subject: For example, at the first networking activity I met David Shulkin
Reply-To: (b) (6) 1@yahoo.com

http://www.lifescienceleader.com/doc/why-partnering-for-cures-is-a-highly-differentiated-experience-0001

Why "Partnering For Cures" Is A Highly Differentiated Experience

Source: Life Science Leader



By Rob Wright, Chief Editor, Life Science Leader
Follow Me On Twitter @RfwrightLSL



Two weeks ago I went to the Partnering For Cures (Nov. 13 – 15) conference at the Grand Hyatt in New York. After the experience, it is almost painful to admit that this was my first time attending. Developed by Faster Cures and the Milken Institute, the conference (now in existence for over eight years) brings together nearly 1,000 leaders from across the research ecosystem. The event's goal is to forge partnerships dedicated to reducing death and suffering. And while I have attended other conferences that preach partnering, this conference, for some reason, felt distinctly different.

Like many other conferences, it began with networking and was formally kicked off by a patient advocate presentation. Also similar to other conferences it included well-rounded panels with high-caliber participants. So what makes Partnering For Cures distinctly different? Is it the fact

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that the initiative is being driven by a billionaire (i.e., Mike Milken) with a vision for positively disrupting the status quo, as well as a penchant for having successfully done so? Could it be an expectation that the material will be top shelf, and thus why so many conference organizers (from other shows) not only attend Partnering For Cures, but share it as being one of their favorites (even amongst their own offerings)? Yes and yes. But the differences don't stop there.

In fact, what I thought was the biggest differentiator — and real value —of this show, was the breadth of attendees, especially as it pertained to networking. At biopharmaceutical conferences built around a specific discipline (e.g., manufacturing, clinical), most networking conversations focus on discipline expertise. But because "Partnering" succeeds in bringing together a wider range of potential collaborators, networkers have to find a common ground all on their own.

For example, at the first networking activity I met David Shulkin, whose name badge listed him as working for the U.S. Department of Veterans Affairs. I admit, I didn't recognize his name at first, but I quickly realized that this was the Under Secretary of Health for the U.S. Department of Veterans Affairs, a man who had been appointed by the President and who had suffered a number of challenges this past year. During our conversation, we were joined by Bill Fair, director of life sciences at the Lake Nona Medical City. Fair explained about Orlando Florida's medical city — a 7,000-acre community that is already home to the University of Central Florida's College of Medicine, Nemours Children's Hospital, the Sanford-Burnham Medical Institute, and the future Orlando VA Medical Center. The medical city is expected to have created more than 30,000 jobs and bring in $7.6 billion in annual economic activity. These are just two examples of the diverse group of people this event seems to bring together.

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/2/2016 5:26:19 PM
To: Vivieca Wright Simpson [vivieca.Wright@va.gov]
CC: (b) (6) [(b) (6) @gmail.com]
Subject: Fwd: Re:

Can we work on this next week

Sent from my iPhone

Begin forwarded message:

From: (b) (6) @yahoo.com>
Date: December 2, 2016 at 7:37:54 AM CST
To: "+(b) (6) @tmomail.net" <+(b) (6) @tmomail.net>, "DrShulkin@aol.com" <DrShulkin@aol.com>, "(b) (6) @tmomail.net" <(b) (6) @tmomail.net>, "(b) (6) @tmomail.net" <(b) (6) @tmomail.net>
Subject: Re:
Reply-To: Joni Aldrich <(b) (6) @yahoo.com>

Hello, Dr. Shulkin, this is (b) (6). I still have a few scheduled shows available before the end of the year, so please contact me as soon as possible so we can get your interview scheduled on Treatment SOS.

Treatment SOS is simulcast on three Internet radio networks, and then programs are made available on UKHealthRadio.com and iHeart.com. This would be a call in or Skype 50-minute interview. Pre-records are available if 2:00 p.m. ET, 11:00 a.m. PT on Thursday does not work in your schedule.

Best, (b)

From: "+(b) (6) @tmomail.net" <+(b) (6) @tmomail.net>
To: DrShulkin@aol.com; (b) (6) @yahoo.com; (b) (6) @tmomail.net; (b) (6) @tmomail.net
Sent: Wednesday, November 23, 2016 9:38 AM
Subject:

David, we don't know of your future professional endeavors/plans however the invitation is still open regarding being on the I-Heart Radio Show, if U like. Please let us know so we can schedule? It would be our honor/prevelige for U to share the accomplishments during your tenure. So please let us know your thoughts to schedule. FYI-Our-group is translating into a company soon & will update as we proceed. Appreciate your service to our veterans in serving as the Undersecretary of Health.

Thanks
(b) (6), MHA, USAF-Veteran
(b) (6)
(b) (6) @yahoo.com

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T··Mobile·

This message was sent to you by a T-Mobile wireless phone.

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This message was sent to you by a T-Mobile wireless phone.

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 11/30/2016 1:53:50 AM
To: bob mcDonald [(b) (6) @gmail.com]
Subject: Fwd: POTUS Signing table

How cool!

Sent from my iPhone

Begin forwarded message:

> **From:** "(b) (6) L. RDML USN WHMO/WHMU" (b) (6) @whmo.mil>
> **Date:** November 29, 2016 at 8:22:18 PM EST
> **To:** "drshulkin@aol.com" <drshulkin@aol.com>
> **Subject: POTUS Signing table**
>
> David,
> Look what I found on the POTUS signing table. POTUS just finished his last wounded warrior visit.
> (b) (6)

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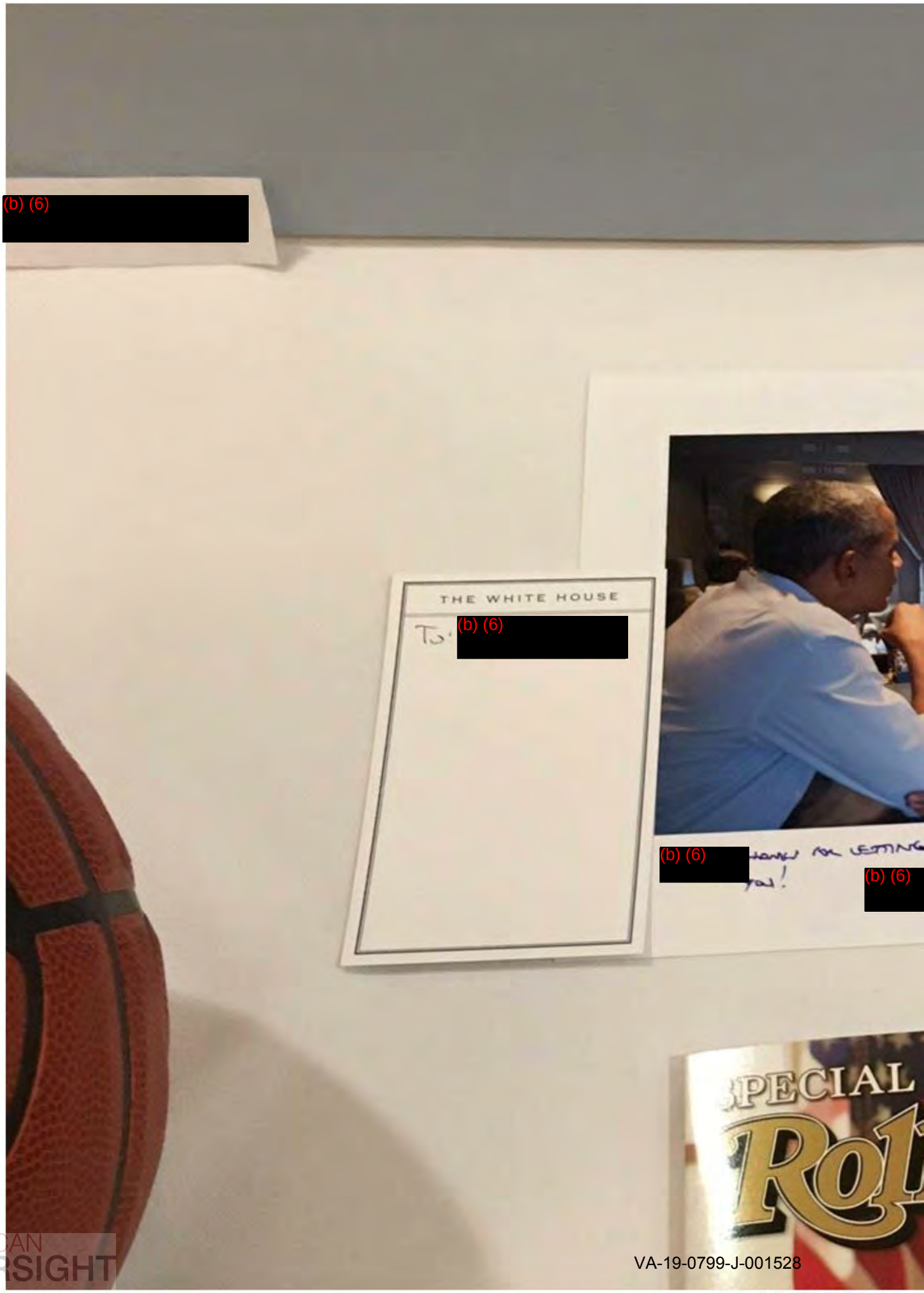

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Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 12/5/2016 3:17:46 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Just for a few days

I need to regroup because I am feeling like a real failure right now. Between having to justify my value after being part of AHS for over 5 years for the umpteenth time and putting my very best at the VA but having no identity/not even a place in the org structure- I feel that all my efforts have been futile. I have no energy to fight anymore. Right now I need to be simply a worker bee and not have these fluffy dreams and grandiose feelings of having made a positive impact/change. So unless it's about my tactical work related directly to the VA- let's not really talk about anything else. I am just feeling extremely tired and burdened right now

Sent from my iPhone

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/5/2016 12:24:04 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: Didn't get your thoughts verbally

Sorry- i overlooked

Sent from my iPhone

> On Dec 5, 2016, at 7:09 AM, Poonam Alaigh <(b) (6) n@hotmail.com> wrote:
>
> But I do think we need a preamble that we can use for the Pitt piece- I will use what we developed for HBS and we can talk about creating a more comprehensive version for the article. The more we can get out right now in different ways the better it is - also want to make sure we include/acknowledge some key folks internally in this piece. Quick turn around and inclusion is of the essence, so whenever you want to speak its fine- if you don't- it's fine too, I will just continue along, unless you tell me to stop
>
> Sent from my iPad

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/5/2016 12:20:52 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
Subject: Re: Didn't get your thoughts verbally

Keep driving!

Sent from my iPhone

> On Dec 5, 2016, at 7:09 AM, Poonam Alaigh <(b) (6) n@hotmail.com> wrote:
>
> But I do think we need a preamble that we can use for the Pitt piece- I will use what we developed for HBS and we can talk about creating a more comprehensive version for the article. The more we can get out right now in different ways the better it is - also want to make sure we include/acknowledge some key folks internally in this piece. Quick turn around and inclusion is of the essence, so whenever you want to speak its fine- if you don't- it's fine too, I will just continue along, unless you tell me to stop
>
> Sent from my iPad

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Message

From: Poonam Alaigh [(b) (6)@hotmail.com]
Sent: 12/5/2016 12:09:41 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Didn't get your thoughts verbally

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Sent from my iPad

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Message

From: David Shulkin [drshulkin@aol.com]
Sent: 11/26/2016 2:03:43 PM
To: (b) (6) @hotmail.com
Subject: Re: Transition presentation

Ok - I really like it

-----Original Message-----
From: Poonam Alaigh <(b) (6) @hotmail.com>
To: David shulkin <Drshulkin@aol.com>
Sent: Sat, Nov 26, 2016 9:02 am
Subject: Re: Transition presentation

K- let me try to do it first and if it doesn't work will have them do it- I worked on the last version that I sent to you since it was just easier for me to do it rather than going back and forth

Sent from my iPhone

On Nov 26, 2016, at 8:57 AM, David shulkin <Drshulkin@aol.com> wrote:

> I still can only open on my phone- it seems to be saved as a type of file that my computer does not recognize. I wonder if someone on the team could resave it as a powerpoint file and try to resend to my aol ?
>
> Sent from my iPhone
>
> On Nov 26, 2016, at 1:08 AM, Poonam Alaigh <(b) (6) @hotmail.com> wrote:
>
> > Does this work now
> >
> > Sent from my iPhone
> >
> > Begin forwarded message:
> >
> > **From:** Poonam Alaigh <(b) (6) @hotmail.com>
> > **Date:** November 25, 2016 at 5:08:55 PM EST
> > **To:** David Shulkin <drshulkin@aol.com>, "Shulkin, David J. , MD" <david.shulkin@va.gov>
> > **Subject: Transition presentation**
> >
> > David, please see attached that the team worked on. There are some place holder slides that still need to be populated (#16 and 36).
> >
> > - I am assuming that Jen will give you slide #16
> > - you will complete slide #36
> > - we are waiting for a revised slide from (b) (6) on Best Practices- slide #22 unless you think its fine.
> >
> > All of your original content has been captured in this presentation.

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Let me know if you want to catch up over the weekend to discuss- have to get ready for the evening now, (b) is getting impatient.

<VHAOrgBrief-PresidentialTransition-(b) (6) _v2 (002) REVISED Access Team v7 compressed.pptx>

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Message

From: Poonam Alaigh [(b) (6) @hotmail.com]
Sent: 11/26/2016 2:01:35 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Transition presentation

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Sent from my iPhone

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<VHAOrgBrief-PresidentialTransition-(b) (6) _v2 (002) REVISED Access Team v7 compressed.pptx>

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From: David shulkin [Drshulkin@aol.com]
Sent: 11/26/2016 1:57:02 PM
To: Poonam Alaigh [(b) (6) @hotmail.com]
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> > <VHAOrgBrief-PresidentialTransition-(b) (6) _v2 (002) REVISED Access Team v7 compressed.pptx>

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 11/26/2016 1:53:16 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Fwd: Transition presentation
Attachments: Untitled attachment 20254.pptx; Untitled attachment 20257.htm

Sent from my iPhone

Begin forwarded message:

> **From:** Poonam Alaigh <(b) (6) @hotmail.com>
> **Date:** November 26, 2016 at 1:08:47 AM EST
> **To:** David Shulkin <drshulkin@aol.com>
> **Subject: Fwd: Transition presentation**
>
> Does this work now
>
> Sent from my iPhone
>
> Begin forwarded message:
>
> > **From:** Poonam Alaigh <(b) (6) @hotmail.com>
> > **Date:** November 25, 2016 at 5:08:55 PM EST
> > **To:** David Shulkin <drshulkin@aol.com>, "Shulkin, David J. , MD" <david.shulkin@va.gov>
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Purpose and Agenda

- **Purpose:** To provide an overview of the Veterans Health Administration (VHA) and highlight major priorities and challenges
- **Overview:**
  - Organization, Budget and FTEs
  - Our Mission and Who We Serve
  - Assessment of VHA's Situation
    - Priorities
    - Performance
  - Accomplishments in FY 2016
  - Future Direction, Priorities and Opportunities for VHA

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Relevant Questions

- Is VHA making progress?
- What do Veterans think of VHA care?
- How does VHA compare to the private sector?
- What services should be provided in the community and what services within VHA?
- What are costs associated with moving more care out into the community?
- What is the impact of changes to ACA to VHA?
- Are there sustainable fixes to funding future VHA care?

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Organization, Budget and FTEs

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Organizational Leadership



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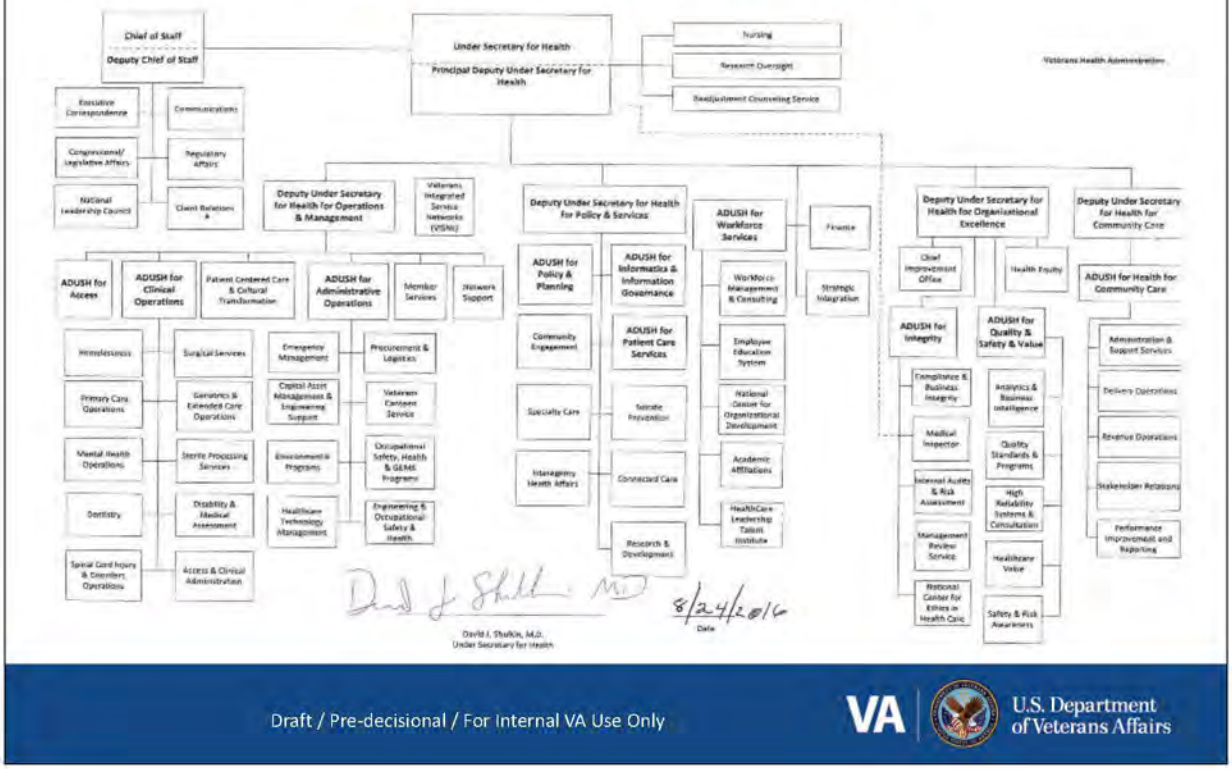
Organization Chart



Draft / Pre-decisional / For Internal VA Use Only

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Budget and FTEs

FY 17 Enacted Budget	FY 18 Enacted Budget	Change (% Change)
$72,835,537	$70,012, 287	-2,823,250 (-3.9%)

Employees in VHA- 320,795 FTEs

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How We Are Different:
Our Mission and Who We Serve

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The Largest Healthcare System in the United States

- 1,234 health care facilities
  - 168 VA Medical Centers
  - 1,055 outpatient sites
- 25,000 physicians and
- 93,600 nurses (RN, LPN & NA)

- Over four times as many hospitals as Kaiser
- Over twice as many hospitals as DoD

Annual Workload Snapshot



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Annual Financial Report source file for graphic

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Who We Serve

- Veterans who rely most on the VA
  - Veterans with lower income
  - Veterans living in rural areas
  - Veterans without other access to health insurance coverage
  - Veterans with poorer self-reported health status
  - Veterans with higher rates of comorbidities
- The prevalence of many common conditions is projected to increase among Veterans over the next 10 years
- In the event of a potential future conflict, even moderate levels of deployment could substantially increase the size of the incoming cohort of VA patients

Findings from the independent assessment (section 201) Appendix A Demographics

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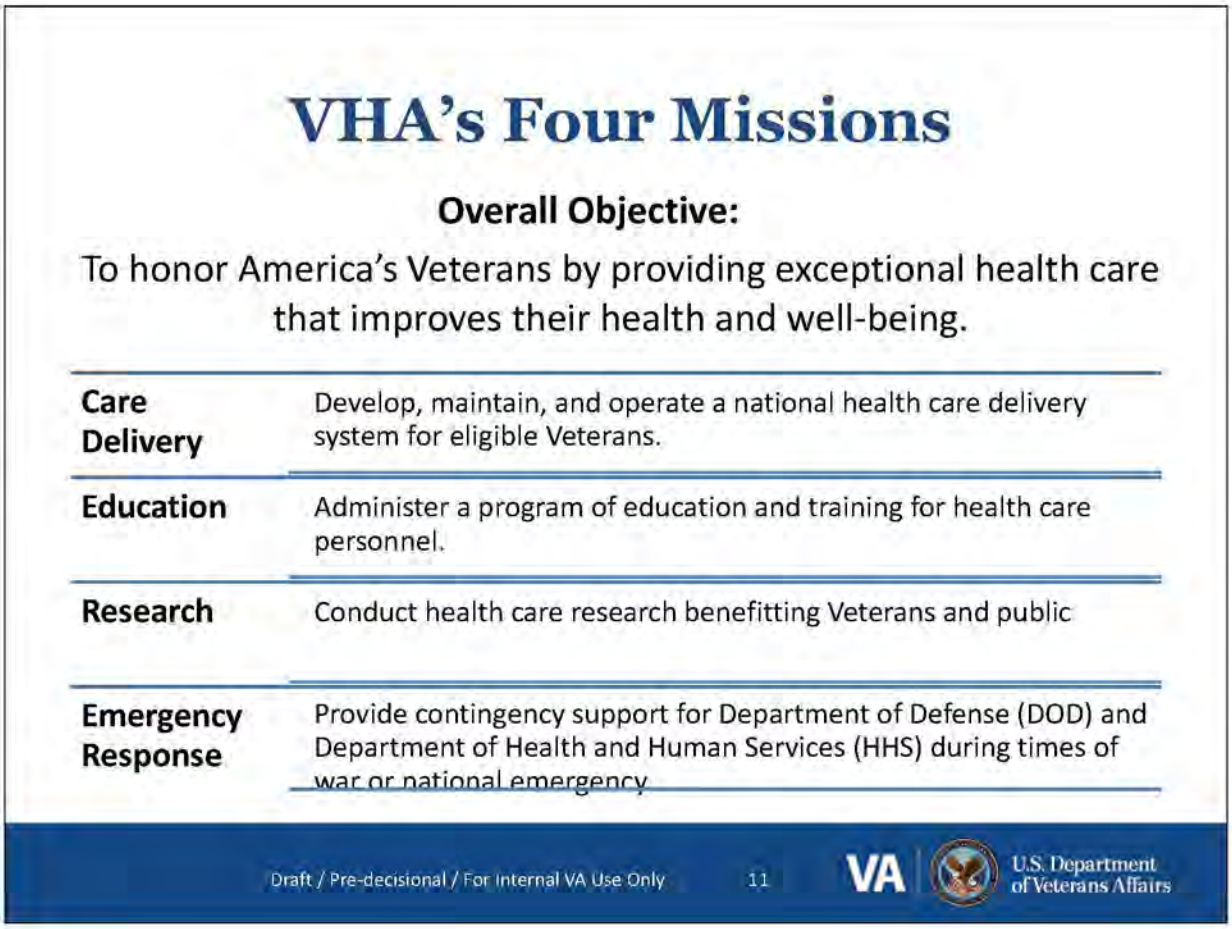

Our mission extends beyond healthcare for Veterans

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VA Healthcare Services Not Found in the Private Sector

- Caregivers
- Travel
- Dental
- Homeless Programs
- Long Term Care
- Readjustment Counseling
- Rural Health Outreach
- Special Populations- Spina Bifida, Camp Lejeune
- Comprehensive Emergency Medical Program
- Health Professions Educational Assistance
- Income Verification Match
- Hepatitis C Treatments
- Prosthetics
- Comprehensive Behavioral Health Programs
- Blind Rehabilitation
- Veterans Crisis Line
- Beneficiary Travel

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VA Healthcare Costs Not Found in the Private Sector

$Millions	FY 2015	FY 2016	FY 2017
Beneficiary Travel	$853	$888	$924
Camp Lejeune	$10	$24	$21
Caregivers	$454	$623	$725
CHAMPVA, Spina Bifida, FMP, CWVV	$1,547	$1,817	$1,920
Comprehensive Emergency Medical Program	$147	$135	$139
Dental Care	$1,005	$1,035	$1,433
Health Professions Educational Assistance programs	$37	$56	$70
Homeless Programs	$1,507	$1,477	$1,591
Income Verification Match	$17	$19	$19
Long Term Care	$7,702	$8,223	$8,588
Readjustment Counseling	$221	$258	$244
Rural Health Outreach Initiatives	$219	$270	$250
Sharing Agreements - Services Provided by VA	$157	$157	$166
Subtotal	$13,875	$14,980	$16,090
Hepatitis C (assume 50% greater benefit)	$406.1	$500.0	$500.0
Mental Health (assume 50% greater benefit)	$2,283.9	$2,494.9	$2,610.6
Prosthetics (assume 50% greater benefit)	$909.0	$950.3	$1,215.2
Subtotal	$3,599.0	$3,945.2	$4,325.9
Total	$17,473.9	$18,924.9	$20,415.8

Educational
Employment Services

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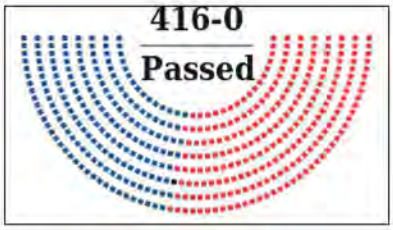
20 Years of Increasing Demand for Services

- 1996 "Veterans Eligibility Reform Act"
- Conflicts in Afghanistan and Iraq continued
  - Congress provided eligibility for care for five years after discharge
- From 2002 to 2015, VHA outpatient volume increased from 46.5M to almost 97M visits
- 2014 "The Veterans Access, Choice and Accountability Act"



IRAQ AND AFGHANISTAN VETERANS OF AMERICA

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- Enactment of Public Law 104-262, "Veterans Eligibility Reform Act" in 1996 allowed VA to provide full continuum of care for all Veterans who chose to enroll for care

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Myths vs. Reality

Myth	Reality
Veterans cared for by VHA have similar issues to most other Americans	Users of VHA are older and have more complex medical issues than non-users (almost 50% of users have a mental health diagnosis)
Care in VHA is poor quality	Numerous independent studies have shown that quality or equal or better
VHA does not want to utilize private sector health providers	22% of all care currently is done in the community- Close to 4 million Choice Act Authorizations has been utilized
Veteran Suicides are only a VHA problem	Of the 20 Veterans who take their own life a day- 14 do not get care in VHA
The private sector offers the same services as in VHA	More than 16 billion dollars in care a year goes towards services not provided by private sector
Access to services is worse than the private sector	96.5% of veterans were seen within 30 days of their clinical indicated or preferred date. Similar data is not readily available from the private sector
Veterans want to use private sector providers and not VA services	Of the 1 million veterans that used Choice, less than 5000 veterans did not also receive their care in VHA

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Impact of VHA Research

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VHA Priorities

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USH 5 Priorities for Strategic Action

Access

We will provide timely access to Veterans as determined by their clinical needs.

PSA: We pledge that any Veteran with the requirement for urgent care will receive care at the right time appropriate to his or her clinical needs

Employee Engagement

We seek a work environment where employees are valued, supported, and encouraged to do their best for Veterans.

PSA: We will work to allow staff to have greater input into their work environment.



High Performance Network

We will ensure that Veterans receive the highest level of coordinated care within VA or from participating providers.

PSA: We will build a high performance network of care to best serve Veterans.

Best Practices

We will use best clinical practices. We also seek best practices in research, education, and management.

PSA: We seek to identify and disseminate best practices throughout VA.

Veterans First: Trust in VA Care

We will be there for our Veterans when they need us.

PSA: We will share our results on the quality and timeliness of how we care for Veterans.

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Priority 1: Access
Transformative Changes



MyVA Access Declaration

Prong 1

Prong 2

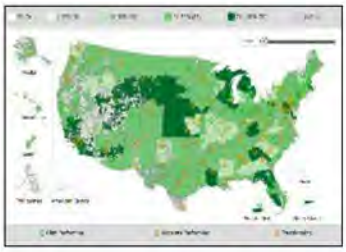
Access Improvement Solutions

National Deployment Strategy

Prong 3



Dr. David Shulkin signing the MyVA Declaration Statement on 4/7/2016



Transformative changes heading
Prong
Guidebook
Map

Same day Services for urgent needs
Path to SDA

Third slide is Results and impact that improve access

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Priority 1: Access

Same Day Access in Primary Care and Mental Health

By the end of this year, we may be the most accessible healthcare system in the United States

September
52 sites (31%)

October
85 Sites (51%)

November
123 Sites (74%)

December
166 Sites (100%)

Same Day Services:

If you need care right away during regular business hours, you are able to get services the same day, or if after hours, by the next day from a VA Medical Center or Health Care Center.

- Options for how that care might be provided include in person, via telephone, smart phone, through video care, secure messaging ,or other options.
- This care may be delivered by your provider or another appropriate clinical staff member based on availability and your care needs.
- *For a medical emergency always call 911 or report to the emergency room closest to where you are located.*

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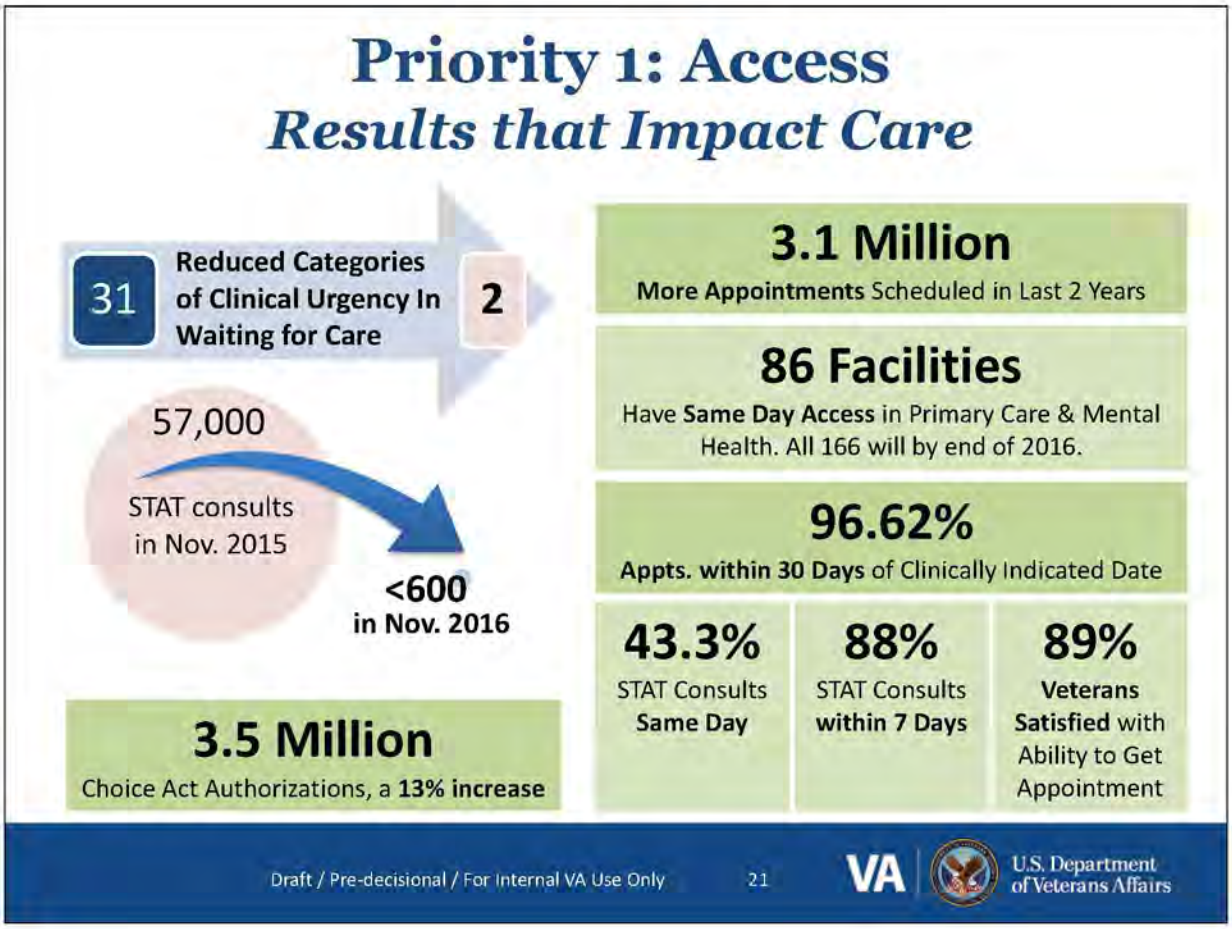

Second bullet is discussing STAT consults over 30 days

Categorized veterans waiting for care into clinical urgency (from 31 categories to 2)
57,000 stat consults in Nov 2015 to <600 in November 2016
3.1 Million more appointments scheduled in the last 2 years
86 facilities have Same Day Access in Primary Care and Mental Health. All 166 facilities will be able to offer these services by the end of 2016
89% of veterans satisfied with the ability to get an appointment (2.1 M veterans)
In October 2016, 96.62% of appointments were within 30 days of the clinically indicated or Veteran's preferred date
43.3% of stat consults were completed same day and 88% were seen within 7 days (a 22% increase from the start of the fiscal year)
Map of veterans evaluation of waiting times by site placed on internet on 11/11/16
Expanded scheduled hours on weekends and evenings, productivity, people, and space
More than 3.5 million authorizations through Choice from September 1, 2015 through August 31, 2016. This represents a 13% increase in authorizations when compared to the same period in 2014/2015

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Priority 2: Best Practices
& Performing as an Integrated Enterprise

- Successfully replicating **13 USH Gold Status best practices 386 times** throughout the system:
  - ➢**85** of those replications have been completed **within 9 months**
  - ➢**301** of those replication projects are **ongoing and on track**
  - ➢**Over 100 facilities** are replicating at least one of the best practices
- Examples would be using Pharmacists to manage medications and a Virtual Tumor Board



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Priority 3: High Performance Network

- As of the end of FY 2016, the Veterans Choice provider network has grown by **85%** and includes more than **350,000** network providers.
- Clinical workload is up **12%** over the past two years—**9%** within VA and **31%** in the community. The **12%** increase translates into roughly **7.5 million** additional hours of care for Veterans.
- New Choice Plan submitted to Congress in October 2015
- RFP planned to be released at end of month for revisions to Community Care program



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When Congress passed the Veterans Access, Choice and Accountability Act in 2014 (the Act), which established the Veterans Choice Program (VCP), the Act specified that the program may not furnish care or services after the expiration date of the program on August 7, 2017, or when the funding allocated ($10 billion) was exhausted.
Without further action by Congress before August 7, 2017, those Veterans that receive care through the current VCP (approximately one million unique Veterans have sought care through VCP since its implementation) will have to discontinue VCP care, and those Veterans newly authorized to receive VCP care will have to make alternative arrangements to receive care.
Other VA community care programs may not have the capacity to handle the entirety of patients who will come off of the current VCP. Wait times for appointments at VA facilities will likely rise if large numbers of Veterans return to VA to seek care.

Our goal for VA Community Care is to deliver a program that is easy to understand, simple to administer, and meets the needs of Veterans, community providers, and VA staff. How will we get there? Our approach consists of five components:
1. Eligibility: We want to provide easy to understand eligibility information to Veterans, community providers, and VA staff.
2. Referral and Authorizations: We want to streamline referral and authorizations, providing Veterans timely access to a community provider of their choice.
3. Care Coordination: We want to solidify care coordination through seamless health information exchanges.
4. Community Care Network: We plan to implement a Community Care Network that provides access to high-quality care inside and outside of VA.
5. Provider Payment (Claims): We want to become better partners to our community providers by paying them promptly and correctly.

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Other VA community care programs may not have the capacity to handle the entirety of patients who will come off of the current VCP. Wait times for appointments at VA facilities will likely rise if large numbers of Veterans return to VA to seek care.

Second bullet references a comparison of FY 14 to FY 15 and was originally completed by Finance in March 2016

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Priority 4: Employee Engagement

- VA Pulse - **94,339 unique users**
- Holding **Quarterly Town Hall Meetings** and site based employee open forums
- **AES scores improved** from 3.45 (2014) to 3.58 (2016)



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Priority 5: Restoring Trust

		VE Measure	% Agree or Strongly Agree Jan-Mar 2016 (Q2) (n=24,415)	%Agree or Strongly Agree Apr-Jun 2016 (Q3) (n=29,873)	%Agree or Strongly Agree Jul-Sep 2016 (Q4) (n=27,758)
	BRAND	**"I trust VA to fulfill our country's commitment to Veterans"**	**55%**	**59%**	**60%**
VETERANS EXPERIENCE	EFFECTIVE	"I got the care or service I needed"	72%	74%	75%
	EASE	"It was easy to get the care or services I needed"	61%	65%	66%
	EMOTION	"I felt like a valued customer"	63%	67%	68%

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This survey was conducted by an independent contractor and validated by survey subject matter experts from Research Triangle International.

Acknowledgements to National Center for Organizational Development Dr Scott Moore and VHA Operational Excellence Dr Steven Wright.

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VHA Accomplishments in 2016

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Suicide Prevention

- **Elevated Office** of Suicide Prevention
- Completed and released a **landmark, comprehensive data analyses of Veteran suicide rates**, examining over 50 million Veteran records from 1979 to 2014 from every state in the nation, providing critical insights to help inform and shape our policies and efforts
- Reach Vet Program initiated to **proactively reach out** to those at highest risk
- **Added 163 responders** to the Veterans crisis line and added direct connections from the phone system to VCL
- Hugely successful Suicide Prevention Month 2016 campaign **#BeThere** garnered **over 73 million social media impressions** across various platforms, over 420 million impressions from TV, radio, and out of home placements (earned and paid), and was supported via Twitter by Joe Mantegna and Senators McCain and Sanders



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Innovative Healthcare

Telehealth

- In FY 2016, 12% of all Veterans enrolled for VA care received telehealth-based care. This includes **2.17 million telehealth visits, touching 702,000 Veterans**.
- Upcoming expanded services through VAR and VA Video Connect in 2017.

Million Veterans Program

- Program to incorporate **precision medicine** to improve Veterans' health by establishing large database containing genetic, military exposure, lifestyle, and health information with over **520,000 enrollees** as of Oct. 2016

Office of Compassionate Innovation

- Launched **Mental Health Service Dog** pilot to assist Veterans with mental health conditions that impede their mobility
- Since Center for Compassionate Innovation announced in April 2016, 38 proposals received; **8 proposals have moved to field implementation or warm hand-off** and **3 have been closed**

New

VA / Watson Cancer Partnership for Precision Oncology

Connect Care

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Complex Care Needs

Homelessness

- There was a **17 percent decline in Veteran homelessness** between 2015 and 2016, quadruple the previous year's annual rate of decline
- Since 2010**, over 480,000 Veterans and their family members have been permanently housed**, rapidly rehoused, or prevented from falling into homelessness by HUD's targeted housing vouchers and VA's homelessness programs

We've cut Veteran homelessness nationwide by 47% since 2010

Providing Counseling Services where Veterans are Comfortable

- More than **1 million primary care/mental health integration visits**
- More than **1.5 million visits** to Vet Centers providing readjustment, Military Sexual Trauma and bereavement counseling services



Hep C Management Notes

VA follows CDC recommendations to screen everyone born between 1945-1965 as they are at the highest risk of having HCV. Screening is also recommended for those born outside of this cohort who have other risk factors.

Source: VA's National Center for Health Promotion and Disease Prevention (NCP) HCV Screening recommendations: http://vaww.prevention.va.gov/CPS/Screening_for_Hepatitis_C.asp

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Public Health Issues

Hepatitis C Management

- In FY15 & 16, **VA treated a total of 69,294 Veterans with Hepatitis C** with an anticipated cure rate of over 90%.
- In CY2015, **69.9%** of the birth cohort (Veterans born between 1945-1965) were **screened for Hepatitis C**.



Reducing Opioid Abuse and Dependency

- 22% reduction in opioid use
- 42% reduction in use of opioids and benzodiazepines
- 32% reduction in dosages



Prevention Programs

- 42,000 Veteran Flu Shots at Walgreens
- MOVE! has helped over 600,000 patients lose weight, keep it off, and improve their health

Walgreens

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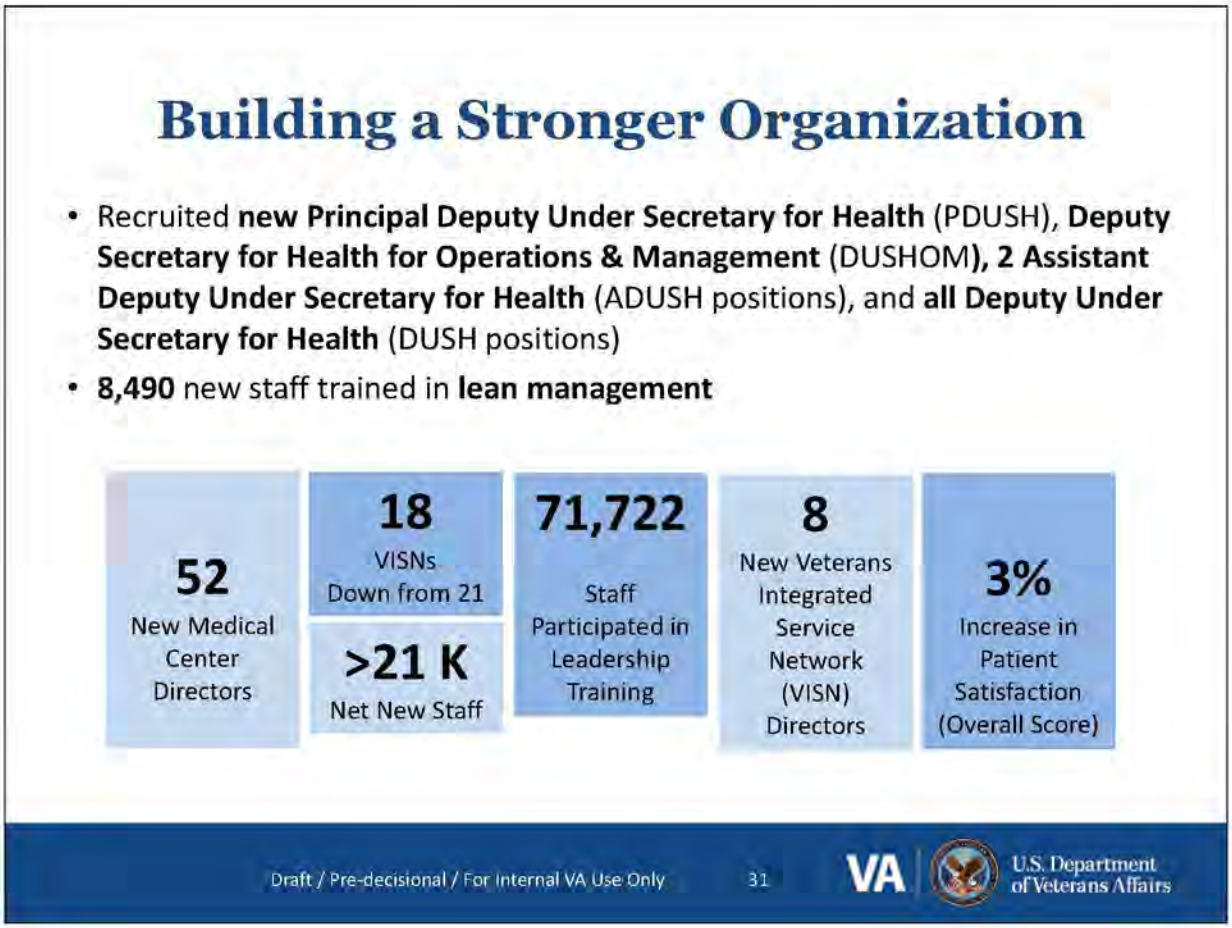

5th bullet notes:

Precision Oncology is the targeting of cancer therapy to the molecular profile of the cancer. This is not new – for many years we have been tailoring cancer therapy for some cancers. An easy example is assessing breast cancer for the presence of estrogen receptors, then using medications that block the effect of estrogen, thus blunting the effect of hormones which drive breast cancer growth. However, in the last 10 years the ability to sequence many genes simultaneously has led to an understanding of the specific mutations that drive cancer growth in many tumor types. This has gone in parallel with the development of medications that target and inhibit the effect of these specific driver mutations. Use of these targeted therapies has resulted in dramatic responses in some cases that previously had very poor outcomes. Unfortunately, only a small minority of cancers have identifiable mutations and targeted therapy available. The VA is currently expanding a program of sequencing a large number of genes in solid cancers, with several aims: to identify mutations in cancers for which there is available targeted therapy and treat these Veterans with the best available therapy; to identify mutations in cancers that might make them susceptible to an approved drug as an off label use; and to identify Veterans with molecular profiles in their cancer that would allow them to consider enrolling in clinical trials. To address the analysis of the molecular data, the VHA has a partnership with IBM Watson Health. This partnership will enhance our ability to both ensure Veterans receive the best available care now, and that clinical and basic research will improve care in the future.

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Serving our Veterans and the Nation

Culture of Improvement

- 6th year – **VA's pharmacy benefits ranked among best in class**
- **24 million in cost avoidance** through our supply chain efforts
- An Integrated operations center to **proactively monitor and identify** issues in quality or access
- **23,000 pounds of used medications** returned and **destroyed** this year

Service to the Nation

- **9,860 research publications** in 2016
- Added **547.4 graduate medical education positions**
- Responded and deployed to **6 national emergencies**



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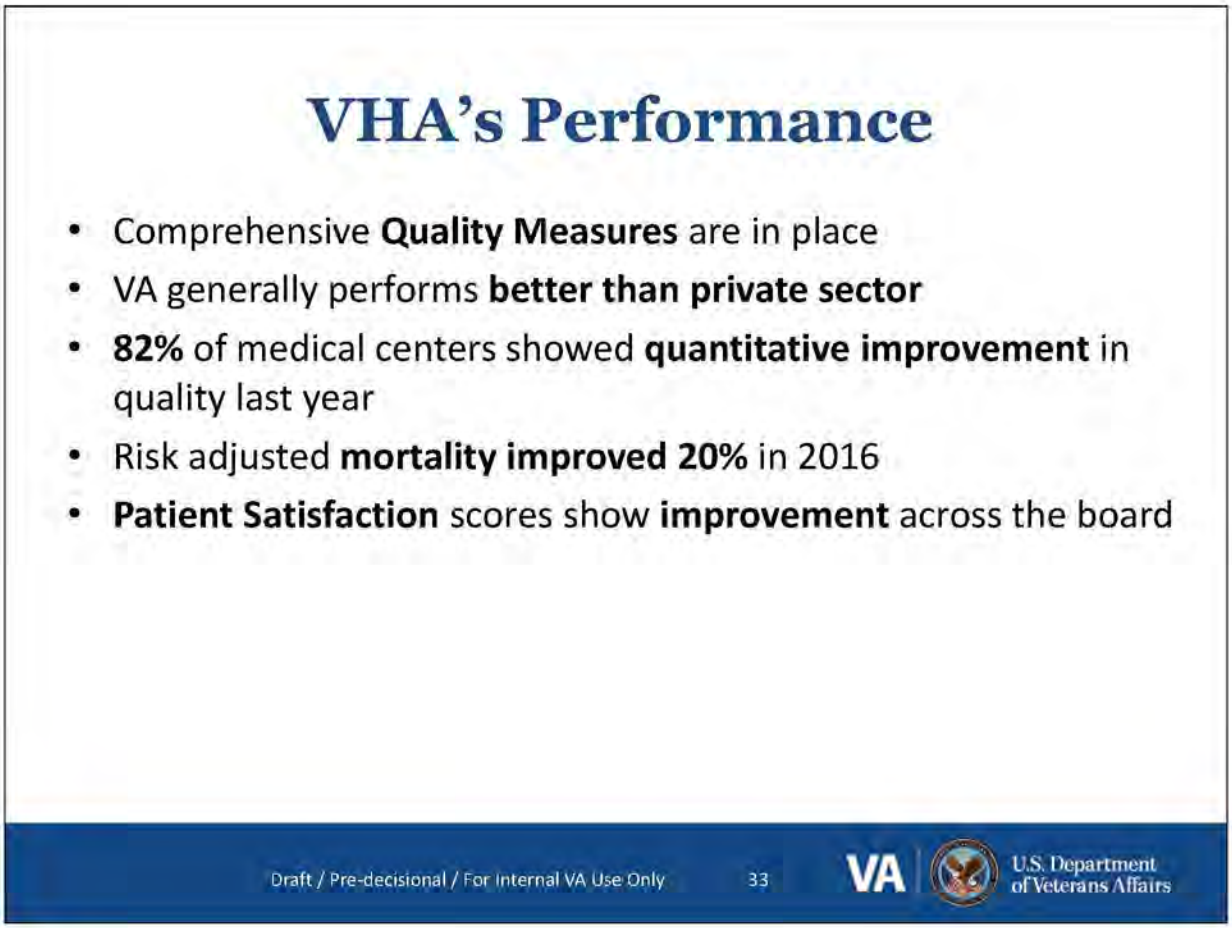

1st bullet:
Regarding Strategic Analytics for Improvement and Learning (SAIL) Model

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82% of VAMCs with Improvement
SAIL Quality Measures in Past Year

	FY16Q3 SAIL Quality Star Percentile Cut-Off					
Overall Quality FY15Q4-FY16Q3[1]	Top10% 5-Star	11-30th% 4-Star	31-70th% 3-Star	71-90th% 2-Star	Bottom10% 1-Star	Total
Large Improvement	8	18	35	20	9	90
Small Improvement	3	7	13	5	2	30
Trivial Improvement	1	3	3	3	1	11
Trivial Decline	3	1	0	0	1	5
Small Decline	1	1	2	0	1	5
Meaningful Decline	1	1	2	0	1	5
Total	17[2]	31[2]	55	28[3]	15[3]	146[4]

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Most Challenged Sites Making Improvements

Site	Indicator	FY14	FY16 (YTD)
Phoenix	CAPHS - Routine Care	66	74
	CAPHS - Urgent Care	51	56
Hines	CAPHS - Routine Care	83	88
	CAPHS - Urgent Care	74	78
Shreveport	CAPHS - Routine Care	79	82
	CAPHS - Urgent Care	65	70
Spokane	CAPHS - Routine Care	81	82
	CAPHS - Urgent Care	64	68
Greater LA	CAPHS - Routine Care	82	83

Note: a 4 to 5 point change is considered "clinically significant"

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Comparative Data

	VHA	Private Sector
Quality		
Satisfaction		
Access		
Employee Engagement		
HEDIS		

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Studies showing better outcomes
JAMA

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Comparing VA Care to Private Sector

- 30-day risk-standardized **mortality rates are lower** in VA than those of non-VA hospitals for acute myocardial infarction and heart failure
- **MRSA infections declined** 69 percent in VA acute care facilities and 81 percent in spinal cord injury units over 5 years thanks to VA's aggressive MRSA prevention plan.
- VA performed the **same or significantly better** than non-VA providers on 12 of 14 **effectiveness measures in the inpatient setting**
- VA performed **significantly better** on 16 **outpatient HEDIS measures** compared with commercial HMOs and significantly better on 15 outpatient HEDIS measures compared with Medicare HMOs
- VA mental health care was **better than private-sector care by at least 30 percent on all seven performance measures**, with VA patients with depression more than twice as likely as private-sector patients to get effective long-term treatment
- **Outcomes for VA patients compared favorably** to patients with non-VA health insurance, with VA patients more likely to receive recommended evidence-based treatment

More data in press release: http://www.va.gov/opa/pressrel/includes/viewPDF.cfm?id=2778

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Future Direction, Priorities and Opportunities

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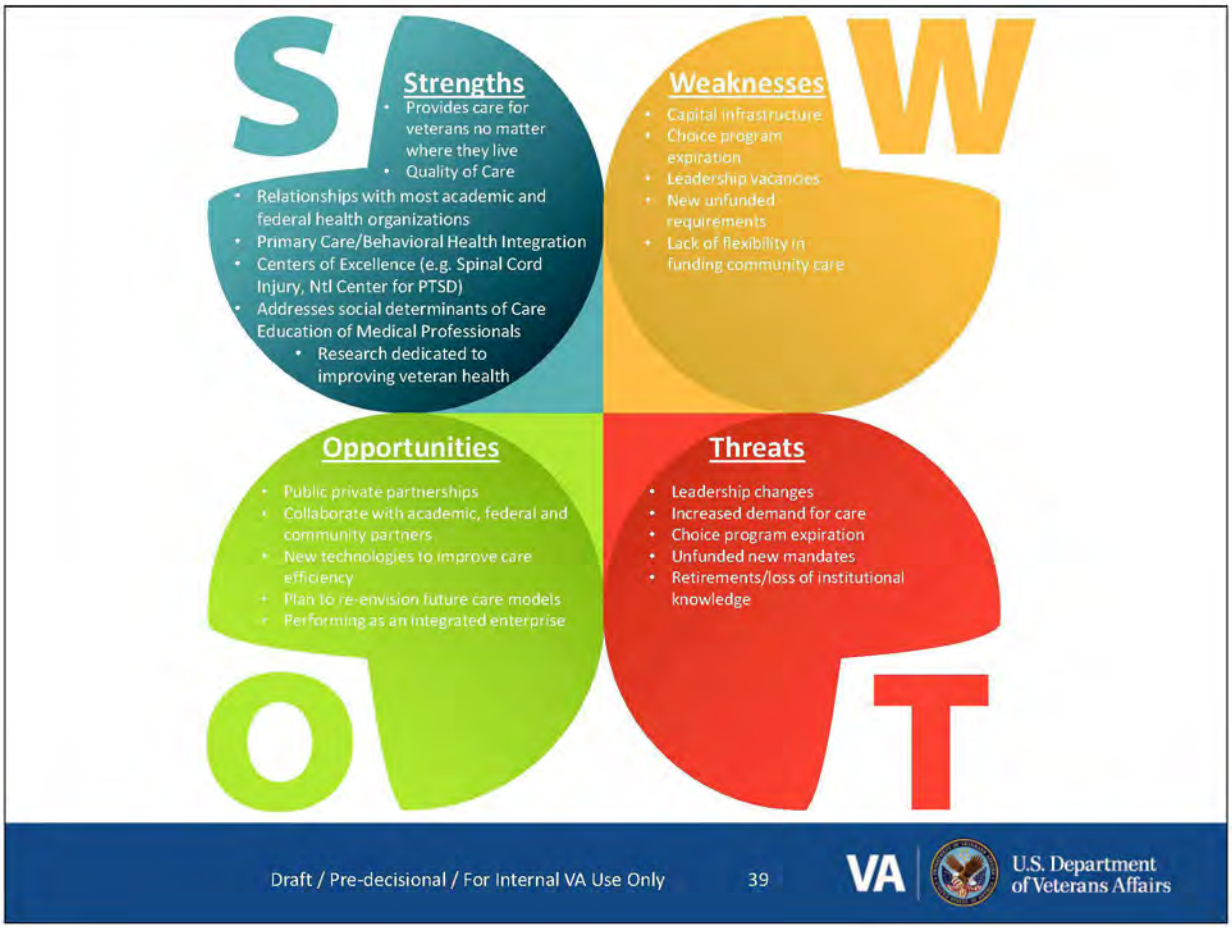

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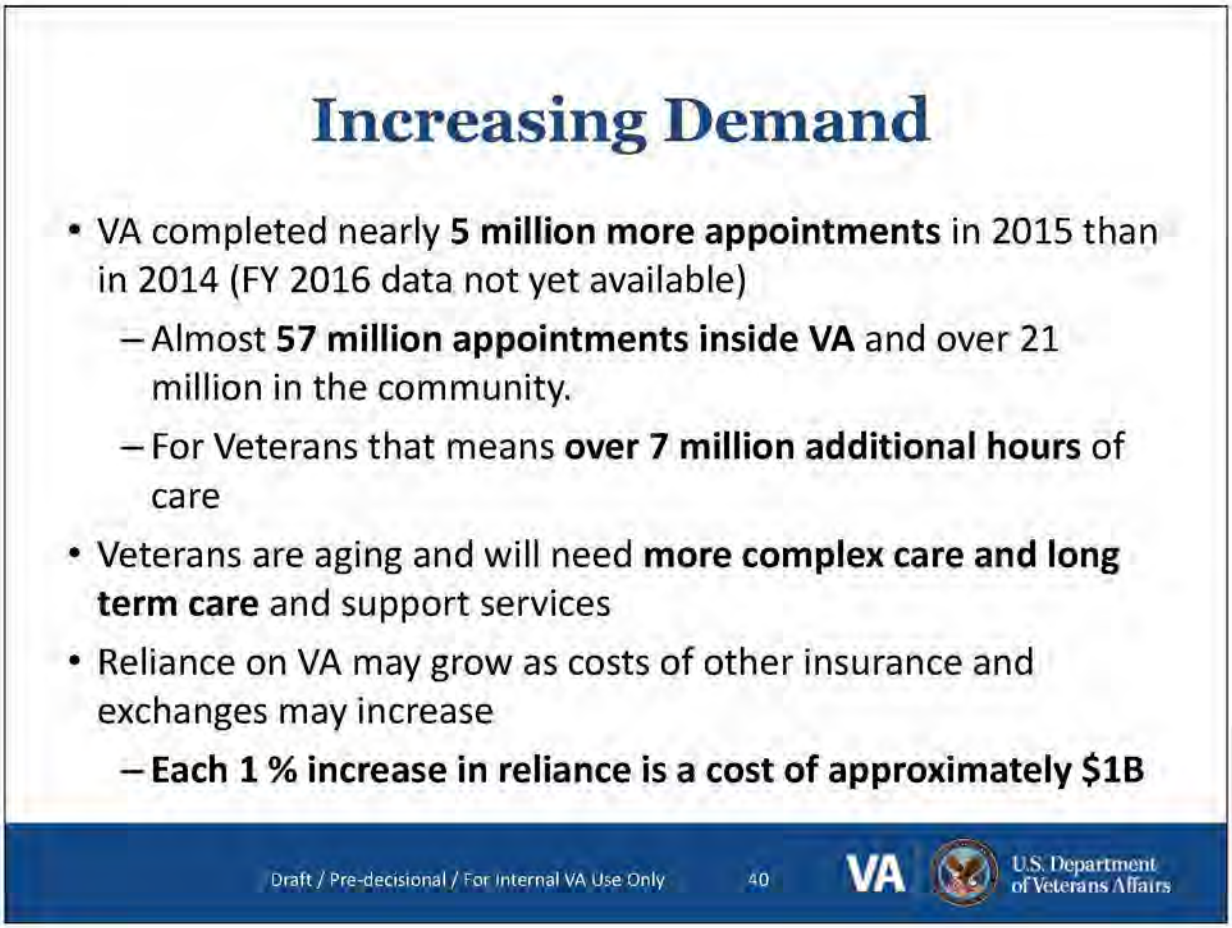

3rd bullet notes:
In 2014, enrollee reliance was estimated to be approximately 34%. We are currently updating reliance analysis with more recent Medicare data, but it is not available at this time. Reliance reflects the portion of health care services that an enrollee needs that we expect VA to provide or pay for. Some enrollees will get all of their health care from the VA and some will get none of their care, but most receive some portion of their care in the VA. For example, based on his/her morbidity, if an enrollee needs 10 office visits in a year and gets 4 of those office visits in VA. This enrollee is said to be 40 percent reliant on VA for office visits.

(b) (6) mentioned wanting to get graphs for this slide and the next from Mark Yow. As such, I haven't edited.

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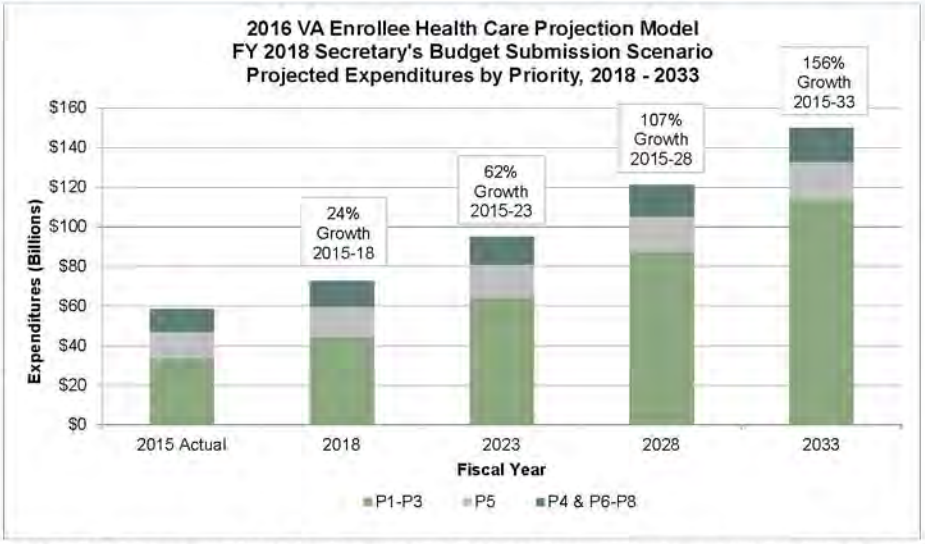
VA's Resource Requirements
Projected to Grow Significantly Over Time



2016 VA EHCPM, Budget Scenario (BAF) Note: The projections do not include requirements for several activities/ programs that are not projected by the VA EHCPM, including non-recurring maintenance, readjustment counseling, state-based long term services and supports programs, and some components of the CHAMPVA program.

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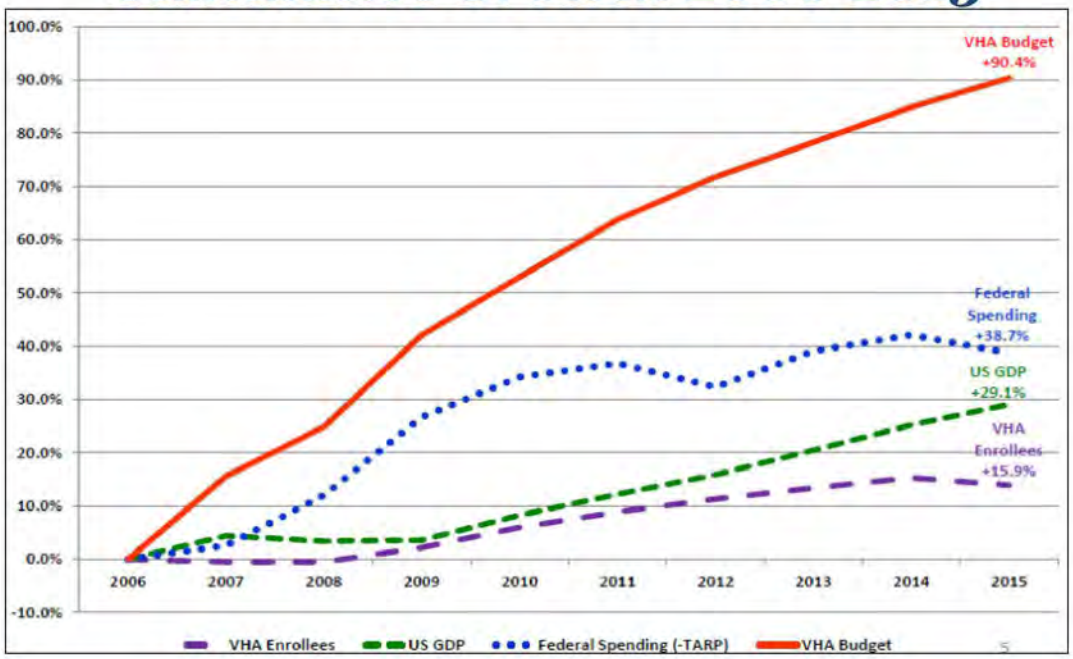
VA Medical Care Budget Challenge:
Cumulative Growth 2006-2015



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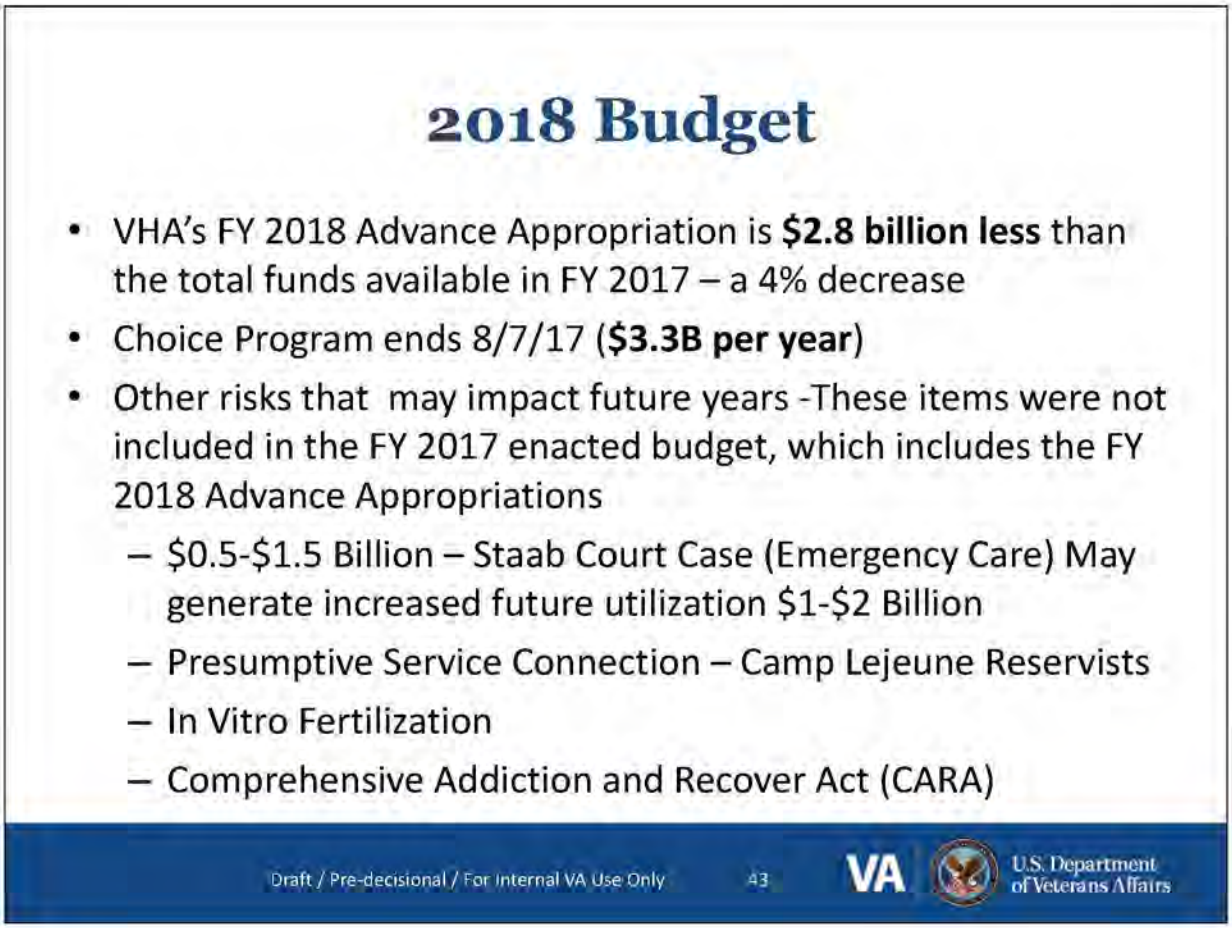

Bullet 3: Estimated budget numbers:
IVF6.5 Million FY 17, 13. million Fy18 --Maximum estimate Non VA Care funds
Adoption: 500K FY 17, 1.5 million FY 18—Maximum estimate
CARA = $153 million – crude estimate, some of which has already been incurred

Camp Lejeune.

Based on evidence there is sufficient scientific and medical evidence available to establish a presumption of connection between exposure to contaminants in the water supply at Camp Lejeune and the occurrence of eight health conditions

The proposed eight presumptive diseases are:
adult leukemia
aplastic anemia and other myelodysplastic syndromes
bladder cancer
kidney cancer
liver cancer
multiple myeloma
non-Hodgkin's lymphoma
Parkinson's disease

VA will not limit entitlement to active duty military personnel. Rather, VA proposes to presume exposure for all active duty, reserve and National Guard personnel who served at Camp Lejeune for no less than 30 cumulative days from August 1,

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1953, through December 31, 1987.

In addition, VA proposes to establish a presumption that individuals who served at Camp Lejeune during this period and later developed one of the presumptive diseases were disabled during the relevant period of service, thus establishing active military service for benefit purposes.

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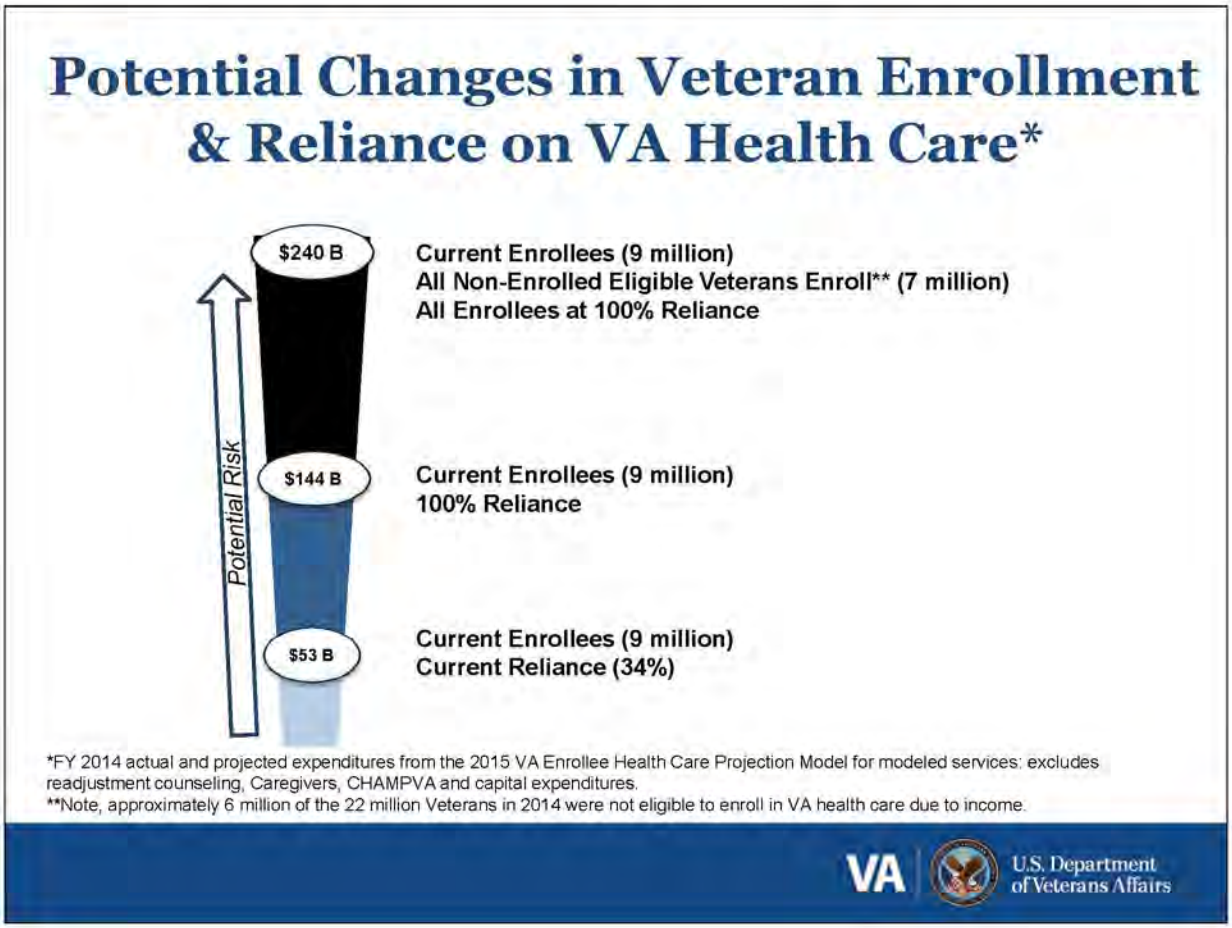

In 2014, costs for modeled services for 9 million enrollees at 34% reliance was $53 billion.

If all those 9 million enrollees used VA for all their health care, the cost in 2014 would have been $144 billion.

If all eligible but unenrolled veterans enrolled in VA and used VA for all their health care, the cost in 2014 would have been $240 billion.

All policy changes move this lever up and down as they impact either reliance on VA for health care, enrollment in VA, or both.

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Continuity of Leadership during a Crisis
Leadership vacancies and succession planning
Maintaining and Strengthening the Gains in Access (including Community Care), Quality, Engagement, and Trust
Direction of the Commission on Care Recommendations
Supporting VHA's Course for a Future Vision

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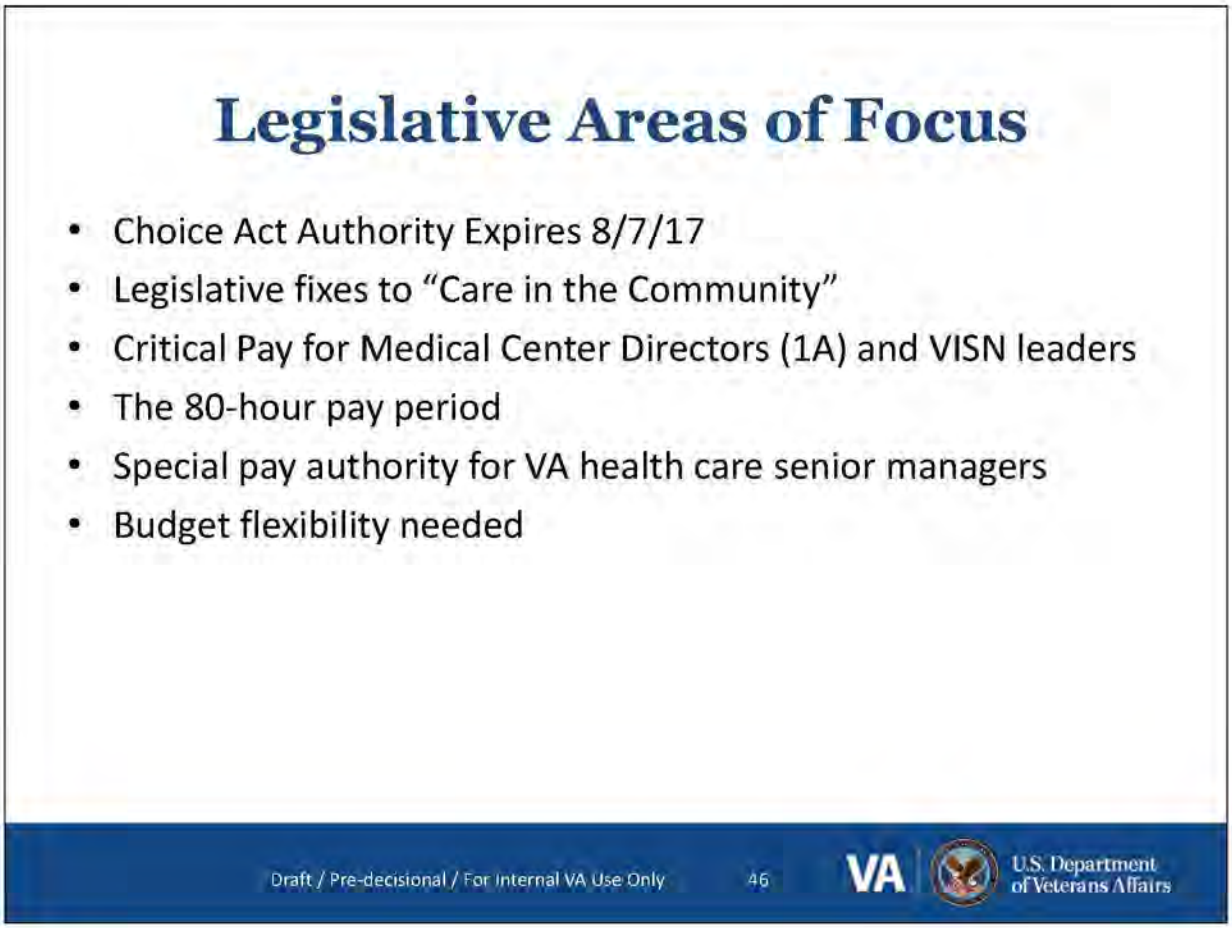

3RD BULLET:
The critical position pay authority (CPPA) allows the Secretary (or designee) to approve higher rates of pay for employees in positions that require expertise of an extremely high level in a scientific, technical, professional or administrative field critical to the Department's successful accomplishment of an important mission to the extent necessary to recruit or retain an individual exceptionally well-qualified for the critical position. Medical Center Directors and other Senior Executive Services (SES) VA health care senior managers would be eligible for CPPA.

Critical position pay requests must be submitted in writing only after it has been determined that the position in question cannot be filled with an exceptionally well-qualified individual through the use of other human resources flexibilities and pay authorities (e.g. recruitment, relocation and retention incentives, special salary rates, above minimum entrance rates).

The Secretary (or designee) must review and approve each critical position pay authority request before forwarding it to the Office of Personnel Management (OPM), who in consultation with the Office of Management and Budget (OMB) will issue final approval.

On September 22, 2016 OPM approved VA's request for CPPA for the Deputy Under Secretary for Health for Operations, 18 VISN Directors, 39 Level 1A Medical Center Directors, and 10 additional positions. 2 employees are in receipt of critical position pay and a plan is being developed for the additional positions.

Currently there is no special pay authority to compensate Medical Center Directors and other SES VA health care senior managers.

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Attached for reference is the signed/dated letter from OPM regarding critical pay.

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Organizational Areas of Focus

- Streamline Hiring/Onboarding Process
- Space: Leasing restrictions
- Facility Modernization: VHA aging Infrastructure
- Implement Full Practice Authority for Advance Practice Nurses: would increase VA ability to increase access
- Expand telehealth capability
- Implement scheduling system for medical appointments
- Examining intermediate and long term funding options for VA healthcare

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Our Commitment to Veterans

- ✓ Veterans should be at the center of what we do and how we deliver care at VHA
- ✓ No veteran with an urgent care need that may cause harm should wait for care
- ✓ VA must act like an integrated enterprise and a learning health system to benefit veterans most
- ✓ We will work closely with our academic, federal and community providers to deliver the highest outcomes to veterans
- ✓ VA leadership and staff must feel proud, fulfilled and empowered to deliver services to Veterans
- ✓ We must regain the trust and confidence of Veterans and the American public
- ✓ VA mission of research, education, and emergency preparedness must continue to contribute to improving the health of Veterans and all Americans

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A Future Vision for VHA

- **Public Private Partnerships** to serve Veterans
- **Digital Health Platform**
- **Whole Health Medicine** (empowering veteran well-being)
- Develop the **High Performance Network** (role of VISNs)
- **Center of Excellence** and Foundational Care
- **Value Based Management** and Efficiency Strategies
- Strengthen VA as a **Learning Healthcare System**
- Accelerate **Precision Medicine** and foster innovation
- Provide access to **VA Research Data** for non VA researchers with appropriate safeguards
- **Train More** primary care and behavioral health students

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Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 11/26/2016 6:08:47 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Fwd: Transition presentation
Attachments: VHAOrgBrief-PresidentialTransition(b) (6) _v2 (002) REVISED Access Team v7 compressed.pptx; ATT00001.htm

Does this work now

Sent from my iPhone

Begin forwarded message:

> **From:** Poonam Alaigh <(b) (6) hotmail.com>
> **Date:** November 25, 2016 at 5:08:55 PM EST
> **To:** David Shulkin <drshulkin@aol.com>, "Shulkin, David J. , MD" <david.shulkin@va.gov>
> **Subject: Transition presentation**
>
> David, please see attached that the team worked on. There are some place holder slides that still need to be populated (#16 and 36).
>
> - I am assuming that Jen will give you slide #16
> - you will complete slide #36
> - we are waiting for a revised slide from (b) (6) on Best Practices- slide #22 unless you think its fine.
>
> All of your original content has been captured in this presentation.
>
> Let me know if you want to catch up over the weekend to discuss- have to get ready for the evening now, (b) is getting impatient.

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U.S. Department of Veterans Affairs Presidential Transition Briefing

Veterans Health Administration

Prepared for:
Agency Review Team

Briefed by:
David J. Shulkin, MD
Under Secretary of Health, Veterans Health Administration

November 2016

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Purpose and Agenda

- **Purpose:** To provide an overview of the Veterans Health Administration (VHA) and highlight major priorities and challenges
- **Overview:**
  - Organization, Budget and FTEs
  - Our Mission and Who We Serve
  - Assessment of VHA's Situation
    - Priorities
    - Performance
  - Accomplishments in FY 2016
  - Future Direction, Priorities and Opportunities for VHA

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Relevant Questions

- Is VHA making progress?
- What do Veterans think of VHA care?
- How does VHA compare to the private sector?
- What services should be provided in the community and what services within VHA?
- What are costs associated with moving more care out into the community?
- What is the impact of changes to ACA to VHA?
- Are there sustainable fixes to funding future VHA care?

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Organization, Budget and FTEs

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Organizational Leadership



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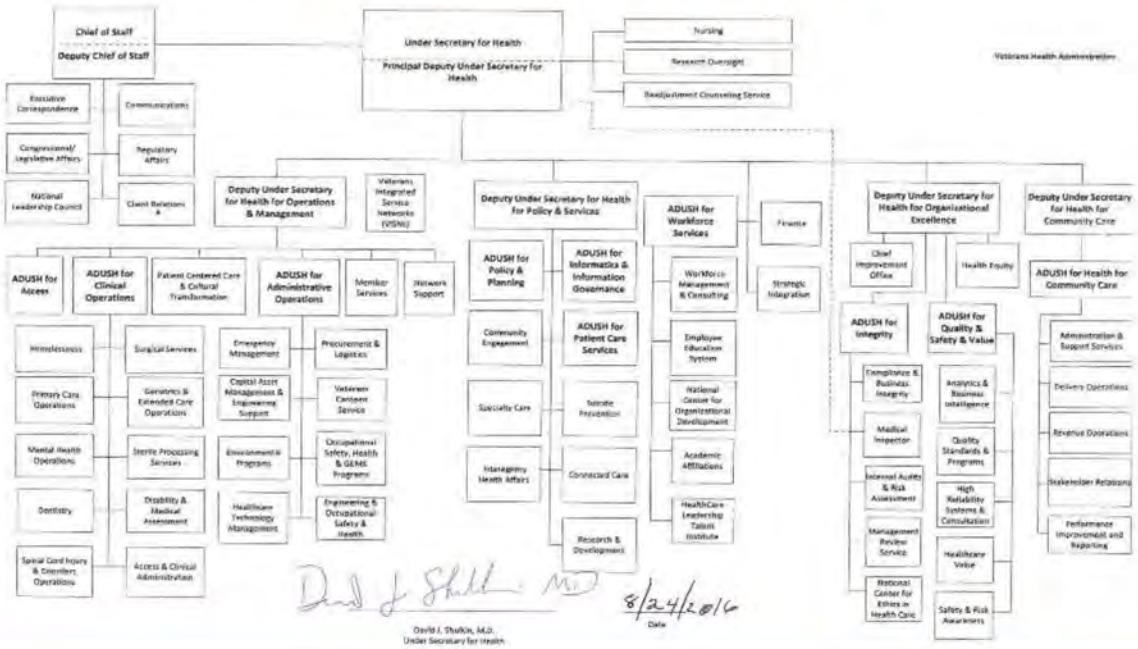
Organization Chart



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Budget and FTEs

FY 17 Enacted Budget	FY 18 Enacted Budget	Change (% Change)
$72,835,537	$70,012, 287	-2,823,250 (-3.9%)

Employees in VHA- 320,795 FTEs

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How We Are Different:
Our Mission and Who We Serve

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The Largest Healthcare System in the United States

- 1,234 health care facilities
  - 168 VA Medical Centers
  - 1,055 outpatient sites
- 25,000 physicians and
- 93,600 nurses (RN, LPN & NA)

- Over four times as many hospitals as Kaiser
- Over twice as many hospitals as DoD

Annual Workload Snapshot



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Annual Financial Report source file for graphic

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Who We Serve

- Veterans who rely most on the VA
  - Veterans with lower income
  - Veterans living in rural areas
  - Veterans without other access to health insurance coverage
  - Veterans with poorer self-reported health status
  - Veterans with higher rates of comorbidities
- The prevalence of many common conditions is projected to increase among Veterans over the next 10 years
- In the event of a potential future conflict, even moderate levels of deployment could substantially increase the size of the incoming cohort of VA patients

Findings from the independent assessment (section 201) Appendix A Demographics

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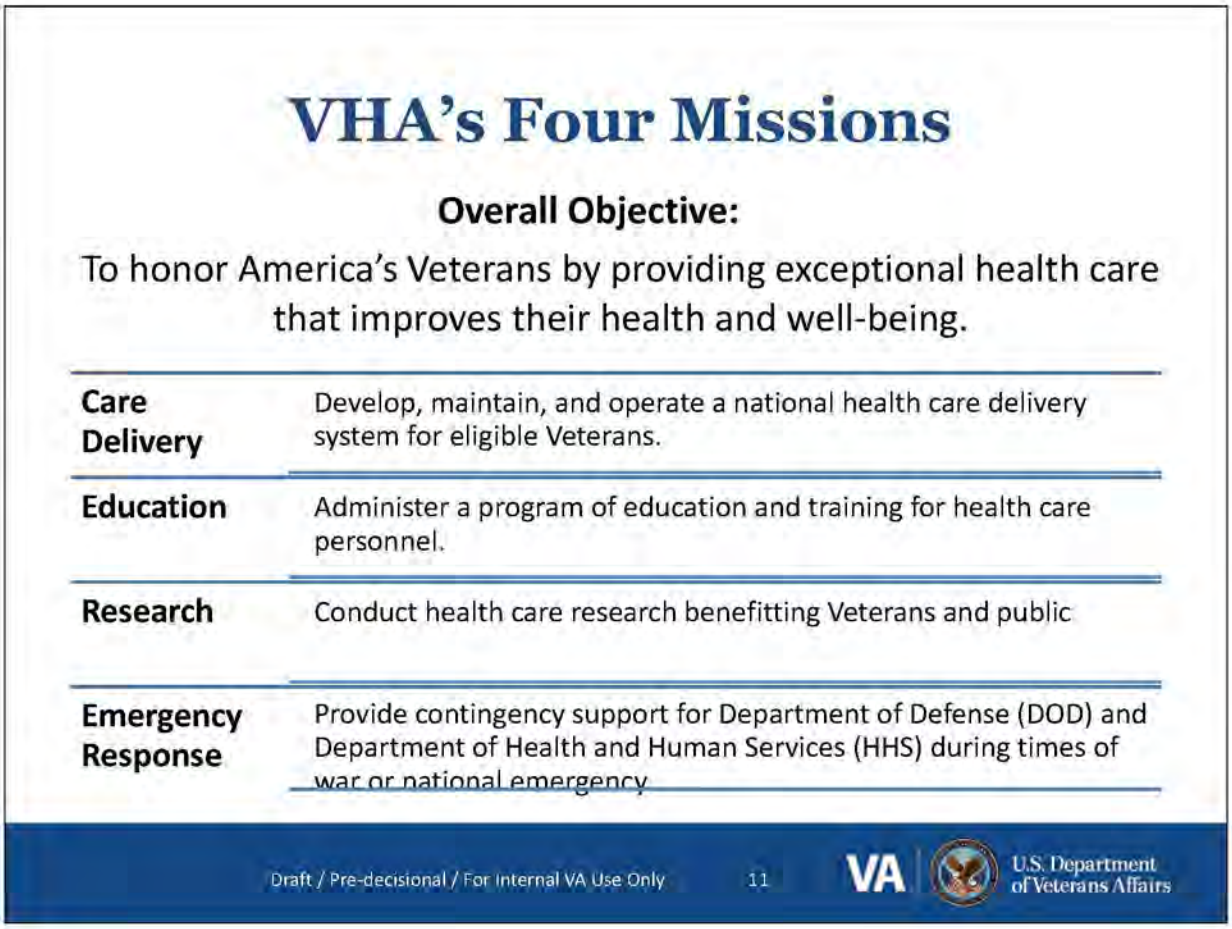

Our mission extends beyond healthcare for Veterans

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VA Healthcare Services Not Found in the Private Sector

- Caregivers
- Travel
- Dental
- Homeless Programs
- Long Term Care
- Readjustment Counseling
- Rural Health Outreach
- Special Populations- Spina Bifida, Camp Lejeune
- Comprehensive Emergency Medical Program
- Health Professions Educational Assistance
- Income Verification Match
- Hepatitis C Treatments
- Prosthetics
- Comprehensive Behavioral Health Programs
- Blind Rehabilitation
- Veterans Crisis Line
- Beneficiary Travel

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VA Healthcare Costs Not Found in the Private Sector

$Millions	FY 2015	FY 2016	FY 2017
Beneficiary Travel	$853	$888	$924
Camp Lejeune	$10	$24	$21
Caregivers	$454	$623	$725
CHAMPVA, Spina Bifida, FMP, CWVV	$1,547	$1,817	$1,920
Comprehensive Emergency Medical Program	$147	$135	$139
Dental Care	$1,005	$1,035	$1,433
Health Professions Educational Assistance programs	$37	$56	$70
Homeless Programs	$1,507	$1,477	$1,591
Income Verification Match	$17	$19	$19
Long Term Care	$7,702	$8,223	$8,588
Readjustment Counseling	$221	$258	$244
Rural Health Outreach Initiatives	$219	$270	$250
Sharing Agreements - Services Provided by VA	$157	$157	$166
Subtotal	$13,875	$14,980	$16,090
Hepatitis C (assume 50% greater benefit)	$406.1	$500.0	$500.0
Mental Health (assume 50% greater benefit)	$2,283.9	$2,494.9	$2,610.6
Prosthetics (assume 50% greater benefit)	$909.0	$950.3	$1,215.2
Subtotal	$3,599.0	$3,945.2	$4,325.9
Total	$17,473.9	$18,924.9	$20,415.8

Educational
Employment Services

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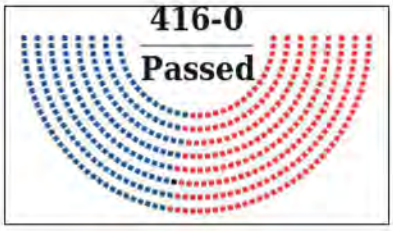
20 Years of Increasing Demand for Services

- 1996 "Veterans Eligibility Reform Act"
- Conflicts in Afghanistan and Iraq continued
  - Congress provided eligibility for care for five years after discharge
- From 2002 to 2015, VHA outpatient volume increased from 46.5M to almost 97M visits
- 2014 "The Veterans Access, Choice and Accountability Act"



IRAQ AND AFGHANISTAN VETERANS OF AMERICA

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- Enactment of Public Law 104-262, "Veterans Eligibility Reform Act" in 1996 allowed VA to provide full continuum of care for all Veterans who chose to enroll for care

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Myths vs. Reality

Myth	Reality
Veterans cared for by VHA have similar issues to most other Americans	Users of VHA are older and have more complex medical issues than non-users (almost 50% of users have a mental health diagnosis)
Care in VHA is poor quality	Numerous independent studies have shown that quality or equal or better
VHA does not want to utilize private sector health providers	22% of all care currently is done in the community- Close to 4 million Choice Act Authorizations has been utilized
Veteran Suicides are only a VHA problem	Of the 20 Veterans who take their own life a day- 14 do not get care in VHA
The private sector offers the same services as in VHA	More than 16 billion dollars in care a year goes towards services not provided by private sector
Access to services is worse than the private sector	96.5% of veterans were seen within 30 days of their clinical indicated or preferred date. Similar data is not readily available from the private sector
Veterans want to use private sector providers and not VA services	Of the 1 million veterans that used Choice, less than 5000 veterans did not also receive their care in VHA

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Impact of VHA Research

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VHA Priorities

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USH 5 Priorities for Strategic Action

Access

We will provide timely access to Veterans as determined by their clinical needs.

PSA: We pledge that any Veteran with the requirement for urgent care will receive care at the right time appropriate to his or her clinical needs

Employee Engagement

We seek a work environment where employees are valued, supported, and encouraged to do their best for Veterans.

PSA: We will work to allow staff to have greater input into their work environment.



High Performance Network

We will ensure that Veterans receive the highest level of coordinated care within VA or from participating providers.

PSA: We will build a high performance network of care to best serve Veterans.

Best Practices

We will use best clinical practices. We also seek best practices in research, education, and management.

PSA: We seek to identify and disseminate best practices throughout VA.

Veterans First: Trust in VA Care

We will be there for our Veterans when they need us.

PSA: We will share our results on the quality and timeliness of how we care for Veterans.

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Priority 1: Access
Transformative Changes



MyVA Access Declaration

Prong 1

Prong 2

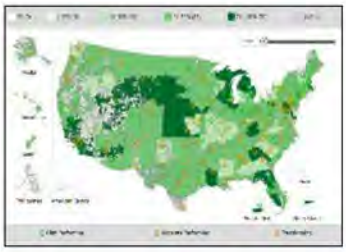
Access Improvement Solutions

National Deployment Strategy

Prong 3



Dr. David Shulkin signing the MyVA Declaration Statement on 4/7/2016



Transformative changes heading
Prong
Guidebook
Map

Same day Services for urgent needs
Path to SDA

Third slide is Results and impact that improve access

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Priority 1: Access

Same Day Access in Primary Care and Mental Health

By the end of this year, we may be the most accessible healthcare system in the United States

September
52 sites (31%)

October
85 Sites (51%)

November
123 Sites (74%)

December
166 Sites (100%)

Same Day Services:

If you need care right away during regular business hours, you are able to get services the same day, or if after hours, by the next day from a VA Medical Center or Health Care Center.

- Options for how that care might be provided include in person, via telephone, smart phone, through video care, secure messaging ,or other options.
- This care may be delivered by your provider or another appropriate clinical staff member based on availability and your care needs.
- *For a medical emergency always call 911 or report to the emergency room closest to where you are located.*

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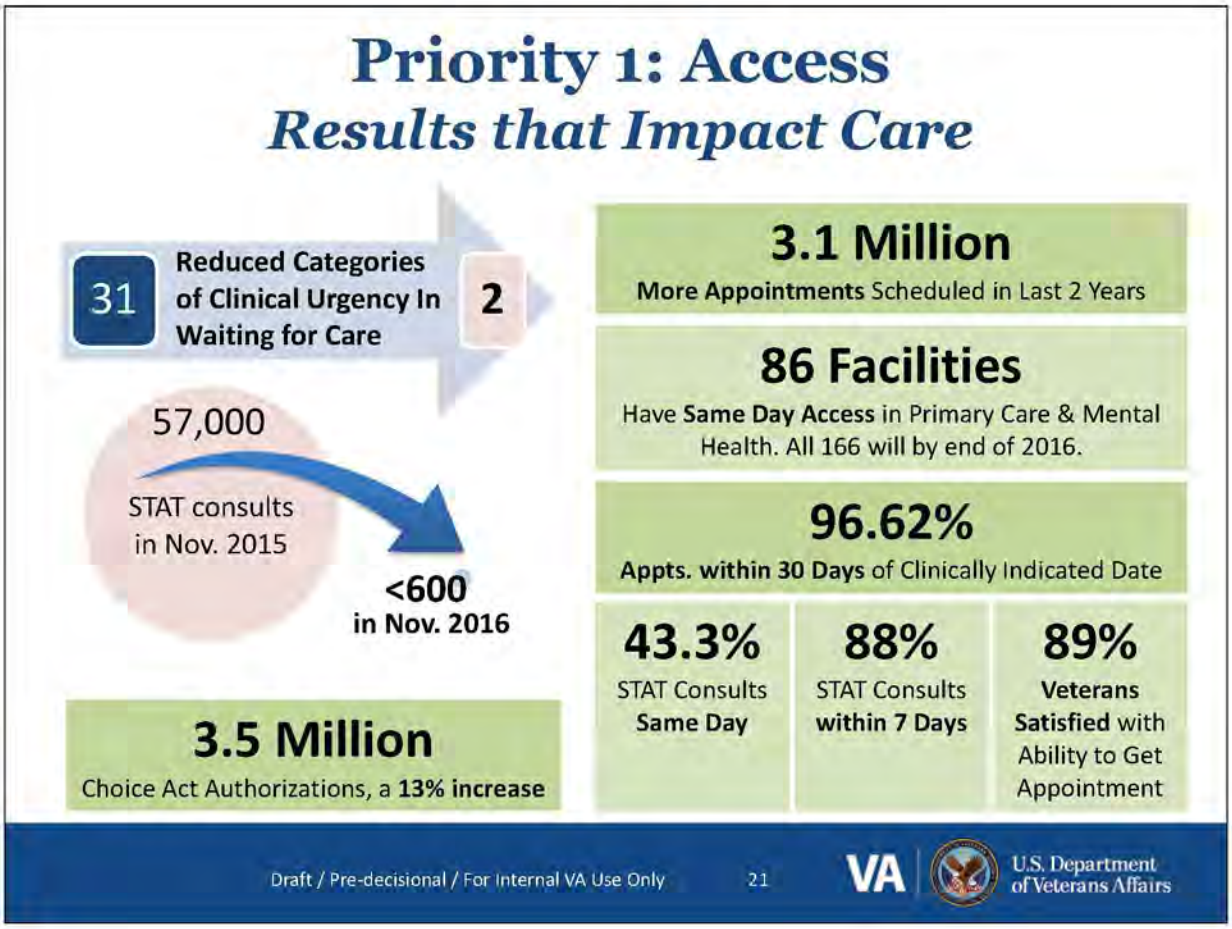

Second bullet is discussing STAT consults over 30 days

Categorized veterans waiting for care into clinical urgency (from 31 categories to 2)
57,000 stat consults in Nov 2015 to <600 in November 2016
3.1 Million more appointments scheduled in the last 2 years
86 facilities have Same Day Access in Primary Care and Mental Health. All 166 facilities will be able to offer these services by the end of 2016
89% of veterans satisfied with the ability to get an appointment (2.1 M veterans)
In October 2016, 96.62% of appointments were within 30 days of the clinically indicated or Veteran's preferred date
43.3% of stat consults were completed same day and 88% were seen within 7 days (a 22% increase from the start of the fiscal year)
Map of veterans evaluation of waiting times by site placed on internet on 11/11/16
Expanded scheduled hours on weekends and evenings, productivity, people, and space
More than 3.5 million authorizations through Choice from September 1, 2015 through August 31, 2016. This represents a 13% increase in authorizations when compared to the same period in 2014/2015

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Priority 2: Best Practices
& Performing as an Integrated Enterprise

- Successfully replicating **13 USH Gold Status best practices 386 times** throughout the system:
  - ➢**85** of those replications have been completed **within 9 months**
  - ➢**301** of those replication projects are **ongoing and on track**
  - ➢**Over 100 facilities** are replicating at least one of the best practices
- Examples would be using Pharmacists to manage medications and a Virtual Tumor Board



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Priority 3: High Performance Network

- As of the end of FY 2016, the Veterans Choice provider network has grown by **85%** and includes more than **350,000** network providers.
- Clinical workload is up **12%** over the past two years—**9%** within VA and **31%** in the community. The **12%** increase translates into roughly **7.5 million** additional hours of care for Veterans.
- New Choice Plan submitted to Congress in October 2015
- RFP planned to be released at end of month for revisions to Community Care program



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When Congress passed the Veterans Access, Choice and Accountability Act in 2014 (the Act), which established the Veterans Choice Program (VCP), the Act specified that the program may not furnish care or services after the expiration date of the program on August 7, 2017, or when the funding allocated ($10 billion) was exhausted.
Without further action by Congress before August 7, 2017, those Veterans that receive care through the current VCP (approximately one million unique Veterans have sought care through VCP since its implementation) will have to discontinue VCP care, and those Veterans newly authorized to receive VCP care will have to make alternative arrangements to receive care.
Other VA community care programs may not have the capacity to handle the entirety of patients who will come off of the current VCP. Wait times for appointments at VA facilities will likely rise if large numbers of Veterans return to VA to seek care.

Our goal for VA Community Care is to deliver a program that is easy to understand, simple to administer, and meets the needs of Veterans, community providers, and VA staff. How will we get there? Our approach consists of five components:
1. Eligibility: We want to provide easy to understand eligibility information to Veterans, community providers, and VA staff.
2. Referral and Authorizations: We want to streamline referral and authorizations, providing Veterans timely access to a community provider of their choice.
3. Care Coordination: We want to solidify care coordination through seamless health information exchanges.
4. Community Care Network: We plan to implement a Community Care Network that provides access to high-quality care inside and outside of VA.
5. Provider Payment (Claims): We want to become better partners to our community providers by paying them promptly and correctly.

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Second bullet references a comparison of FY 14 to FY 15 and was originally completed by Finance in March 2016

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Priority 4: Employee Engagement

- VA Pulse - **94,339 unique users**
- Holding **Quarterly Town Hall Meetings** and site based employee open forums
- **AES scores improved** from 3.45 (2014) to 3.58 (2016)



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Priority 5: Restoring Trust

		VE Measure	% Agree or Strongly Agree Jan-Mar 2016 (Q2) (n=24,415)	%Agree or Strongly Agree Apr-Jun 2016 (Q3) (n=29,873)	%Agree or Strongly Agree Jul-Sep 2016 (Q4) (n=27,758)
	BRAND	**"I trust VA to fulfill our country's commitment to Veterans"**	**55%**	**59%**	**60%**
VETERANS EXPERIENCE	EFFECTIVE	"I got the care or service I needed"	72%	74%	75%
	EASE	"It was easy to get the care or services I needed"	61%	65%	66%
	EMOTION	"I felt like a valued customer"	63%	67%	68%

This survey was conducted by an independent contractor and validated by survey subject matter experts from Research Triangle International.

Acknowledgements to National Center for Organizational Development Dr Scott Moore and VHA Operational Excellence Dr Steven Wright.

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VHA Accomplishments in 2016

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Suicide Prevention

- **Elevated Office** of Suicide Prevention
- Completed and released a **landmark, comprehensive data analyses of Veteran suicide rates**, examining over 50 million Veteran records from 1979 to 2014 from every state in the nation, providing critical insights to help inform and shape our policies and efforts
- Reach Vet Program initiated to **proactively reach out** to those at highest risk
- **Added 163 responders** to the Veterans crisis line and added direct connections from the phone system to VCL
- Hugely successful Suicide Prevention Month 2016 campaign **#BeThere** garnered **over 73 million social media impressions** across various platforms, over 420 million impressions from TV, radio, and out of home placements (earned and paid), and was supported via Twitter by Joe Mantegna and Senators McCain and Sanders



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Innovative Healthcare

Telehealth

- In FY 2016, 12% of all Veterans enrolled for VA care received telehealth-based care. This includes **2.17 million telehealth visits, touching 702,000 Veterans**.
- Upcoming expanded services through VAR and VA Video Connect in 2017.

Million Veterans Program

- Program to incorporate **precision medicine** to improve Veterans' health by establishing large database containing genetic, military exposure, lifestyle, and health information with over **520,000 enrollees** as of Oct. 2016

Office of Compassionate Innovation

- Launched **Mental Health Service Dog** pilot to assist Veterans with mental health conditions that impede their mobility
- Since Center for Compassionate Innovation announced in April 2016, 38 proposals received; **8 proposals have moved to field implementation or warm hand-off** and **3 have been closed**

New

VA / Watson Cancer Partnership for Precision Oncology

Connect Care

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Complex Care Needs

Homelessness

- There was a **17 percent decline in Veteran homelessness** between 2015 and 2016, quadruple the previous year's annual rate of decline
- Since 2010**, over 480,000 Veterans and their family members have been permanently housed**, rapidly rehoused, or prevented from falling into homelessness by HUD's targeted housing vouchers and VA's homelessness programs

We've cut Veteran homelessness nationwide by 47% since 2010

Providing Counseling Services where Veterans are Comfortable

- More than **1 million primary care/mental health integration visits**
- More than **1.5 million visits** to Vet Centers providing readjustment, Military Sexual Trauma and bereavement counseling services



Hep C Management Notes

VA follows CDC recommendations to screen everyone born between 1945-1965 as they are at the highest risk of having HCV. Screening is also recommended for those born outside of this cohort who have other risk factors.

Source: VA's National Center for Health Promotion and Disease Prevention (NCP) HCV Screening recommendations: http://vaww.prevention.va.gov/CPS/Screening_for_Hepatitis_C.asp

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Public Health Issues

Hepatitis C Management

- In FY15 & 16, **VA treated a total of 69,294 Veterans with Hepatitis C** with an anticipated cure rate of over 90%.
- In CY2015, **69.9%** of the birth cohort (Veterans born between 1945-1965) were **screened for Hepatitis C**.



Reducing Opioid Abuse and Dependency

- 22% reduction in opioid use
- 42% reduction in use of opioids and benzodiazepines
- 32% reduction in dosages



Prevention Programs

- 42,000 Veteran Flu Shots at Walgreens
- MOVE! has helped over 600,000 patients lose weight, keep it off, and improve their health

Walgreens

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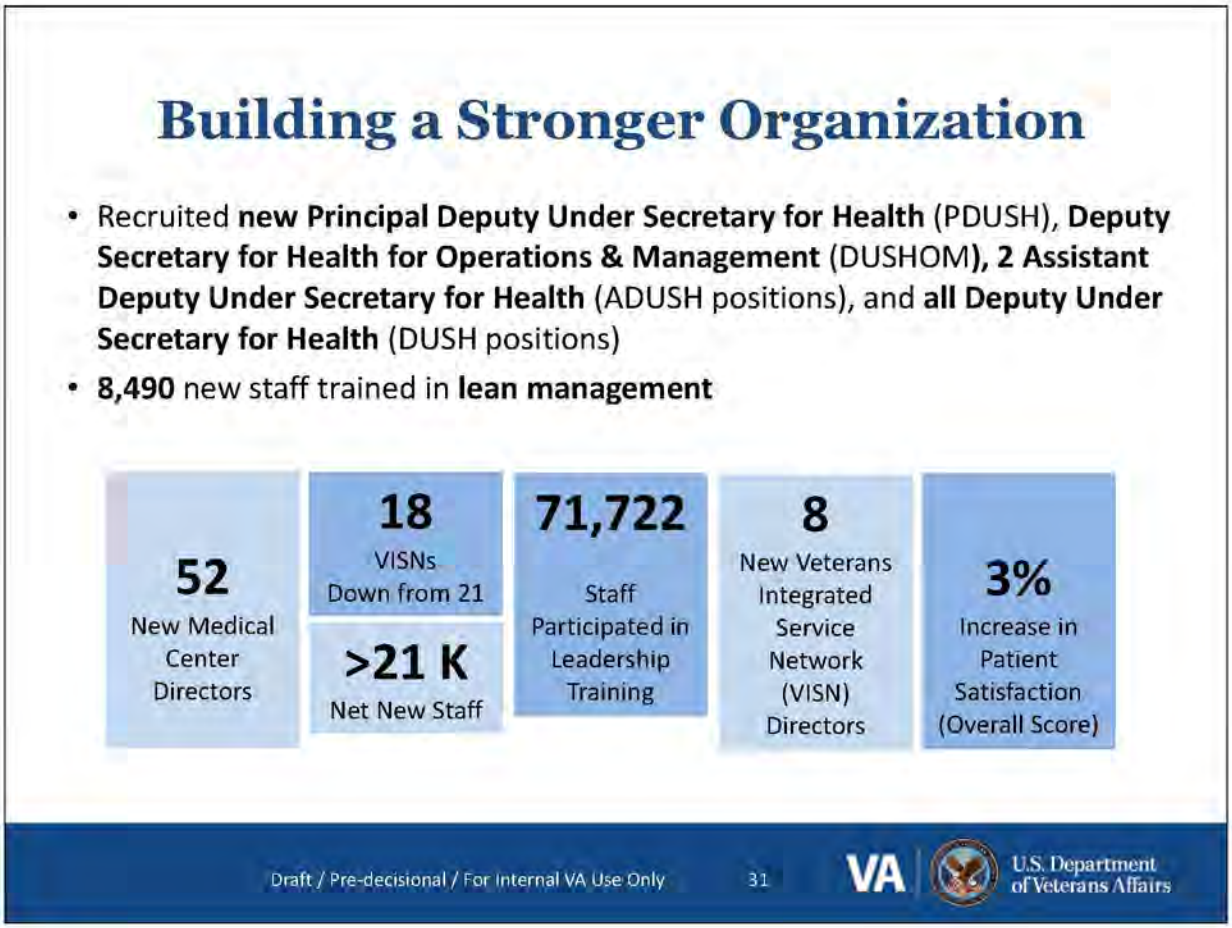

5th bullet notes:

Precision Oncology is the targeting of cancer therapy to the molecular profile of the cancer. This is not new – for many years we have been tailoring cancer therapy for some cancers. An easy example is assessing breast cancer for the presence of estrogen receptors, then using medications that block the effect of estrogen, thus blunting the effect of hormones which drive breast cancer growth. However, in the last 10 years the ability to sequence many genes simultaneously has led to an understanding of the specific mutations that drive cancer growth in many tumor types. This has gone in parallel with the development of medications that target and inhibit the effect of these specific driver mutations. Use of these targeted therapies has resulted in dramatic responses in some cases that previously had very poor outcomes. Unfortunately, only a small minority of cancers have identifiable mutations and targeted therapy available. The VA is currently expanding a program of sequencing a large number of genes in solid cancers, with several aims: to identify mutations in cancers for which there is available targeted therapy and treat these Veterans with the best available therapy; to identify mutations in cancers that might make them susceptible to an approved drug as an off label use; and to identify Veterans with molecular profiles in their cancer that would allow them to consider enrolling in clinical trials. To address the analysis of the molecular data, the VHA has a partnership with IBM Watson Health. This partnership will enhance our ability to both ensure Veterans receive the best available care now, and that clinical and basic research will improve care in the future.

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Serving our Veterans and the Nation

Culture of Improvement

- 6th year – **VA's pharmacy benefits ranked among best in class**
- **24 million in cost avoidance** through our supply chain efforts
- An Integrated operations center to **proactively monitor and identify** issues in quality or access
- **23,000 pounds of used medications** returned and **destroyed** this year

Service to the Nation

- **9,860 research publications** in 2016
- Added **547.4 graduate medical education positions**
- Responded and deployed to **6 national emergencies**



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VHA's Performance

- Comprehensive **Quality Measures** are in place
- VA generally performs **better than private sector**
- **82%** of medical centers showed **quantitative improvement** in quality last year
- Risk adjusted **mortality improved 20%** in 2016
- **Patient Satisfaction** scores show **improvement** across the board

1st bullet:
Regarding Strategic Analytics for Improvement and Learning (SAIL) Model

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82% of VAMCs with Improvement
SAIL Quality Measures in Past Year

	FY16Q3 SAIL Quality Star Percentile Cut-Off					
Overall Quality FY15Q4-FY16Q3[1]	Top10% 5-Star	11-30th% 4-Star	31-70th% 3-Star	71-90th% 2-Star	Bottom10% 1-Star	Total
Large Improvement	8	18	35	20	9	90
Small Improvement	3	7	13	5	2	30
Trivial Improvement	1	3	3	3	1	11
Trivial Decline	3	1	0	0	1	5
Small Decline	1	1	2	0	1	5
Meaningful Decline	1	1	2	0	1	5
Total	17[2]	31[2]	55	28[3]	15[3]	146[4]

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Most Challenged Sites Making Improvements

Site	Indicator	FY14	FY16 (YTD)
Phoenix	CAPHS - Routine Care	66	74
	CAPHS - Urgent Care	51	56
Hines	CAPHS - Routine Care	83	88
	CAPHS - Urgent Care	74	78
Shreveport	CAPHS - Routine Care	79	82
	CAPHS - Urgent Care	65	70
Spokane	CAPHS - Routine Care	81	82
	CAPHS - Urgent Care	64	68
Greater LA	CAPHS - Routine Care	82	83

Note: a 4 to 5 point change is considered "clinically significant"

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Comparative Data

	VHA	Private Sector
Quality		
Satisfaction		
Access		
Employee Engagement		
HEDIS		

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Studies showing better outcomes
JAMA

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Comparing VA Care to Private Sector

- 30-day risk-standardized **mortality rates are lower** in VA than those of non-VA hospitals for acute myocardial infarction and heart failure
- **MRSA infections declined** 69 percent in VA acute care facilities and 81 percent in spinal cord injury units over 5 years thanks to VA's aggressive MRSA prevention plan.
- VA performed the **same or significantly better** than non-VA providers on 12 of 14 **effectiveness measures in the inpatient setting**
- VA performed **significantly better** on 16 **outpatient HEDIS measures** compared with commercial HMOs and significantly better on 15 outpatient HEDIS measures compared with Medicare HMOs
- VA mental health care was **better than private-sector care by at least 30 percent on all seven performance measures**, with VA patients with depression more than twice as likely as private-sector patients to get effective long-term treatment
- **Outcomes for VA patients compared favorably** to patients with non-VA health insurance, with VA patients more likely to receive recommended evidence-based treatment

More data in press release: http://www.va.gov/opa/pressrel/includes/viewPDF.cfm?id=2778

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Future Direction, Priorities and Opportunities

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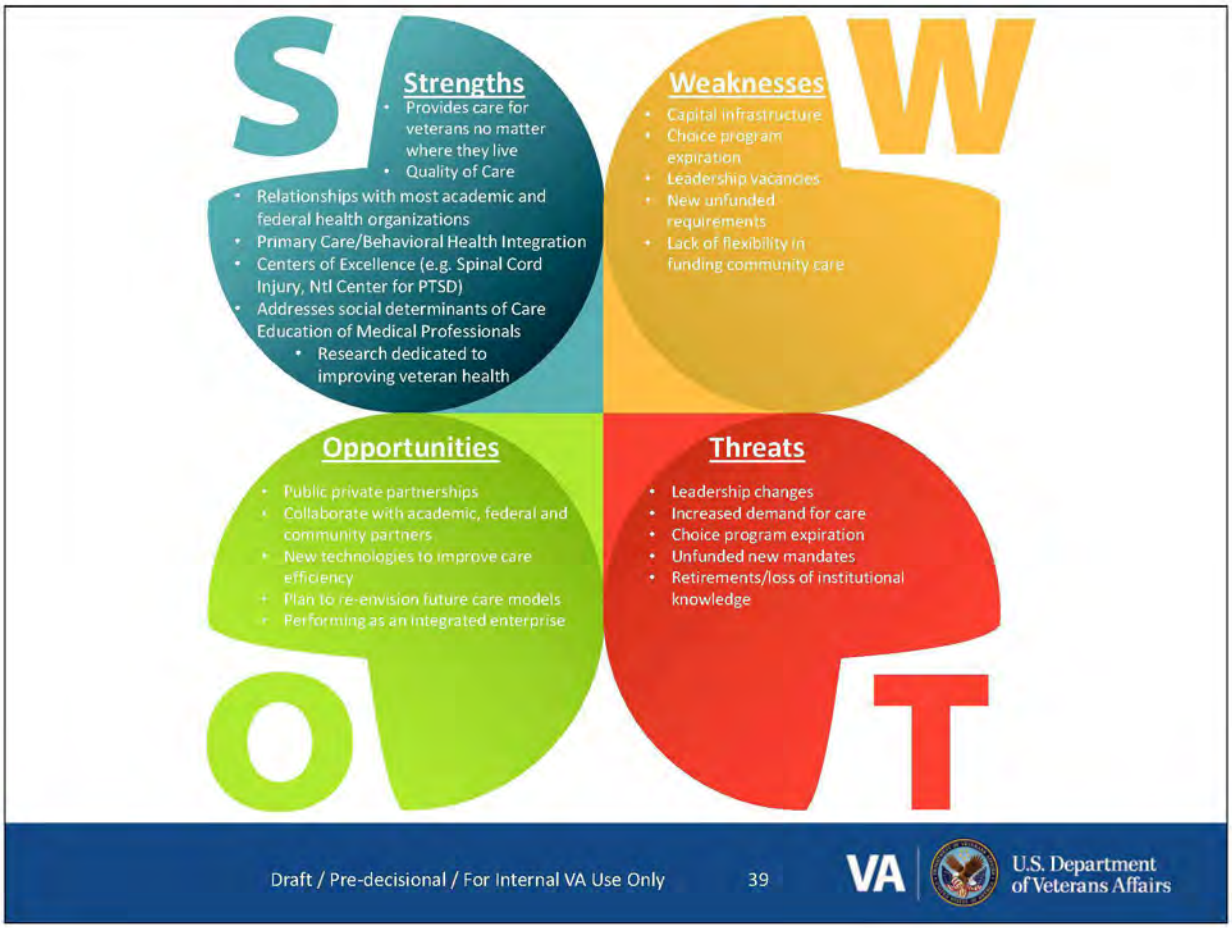

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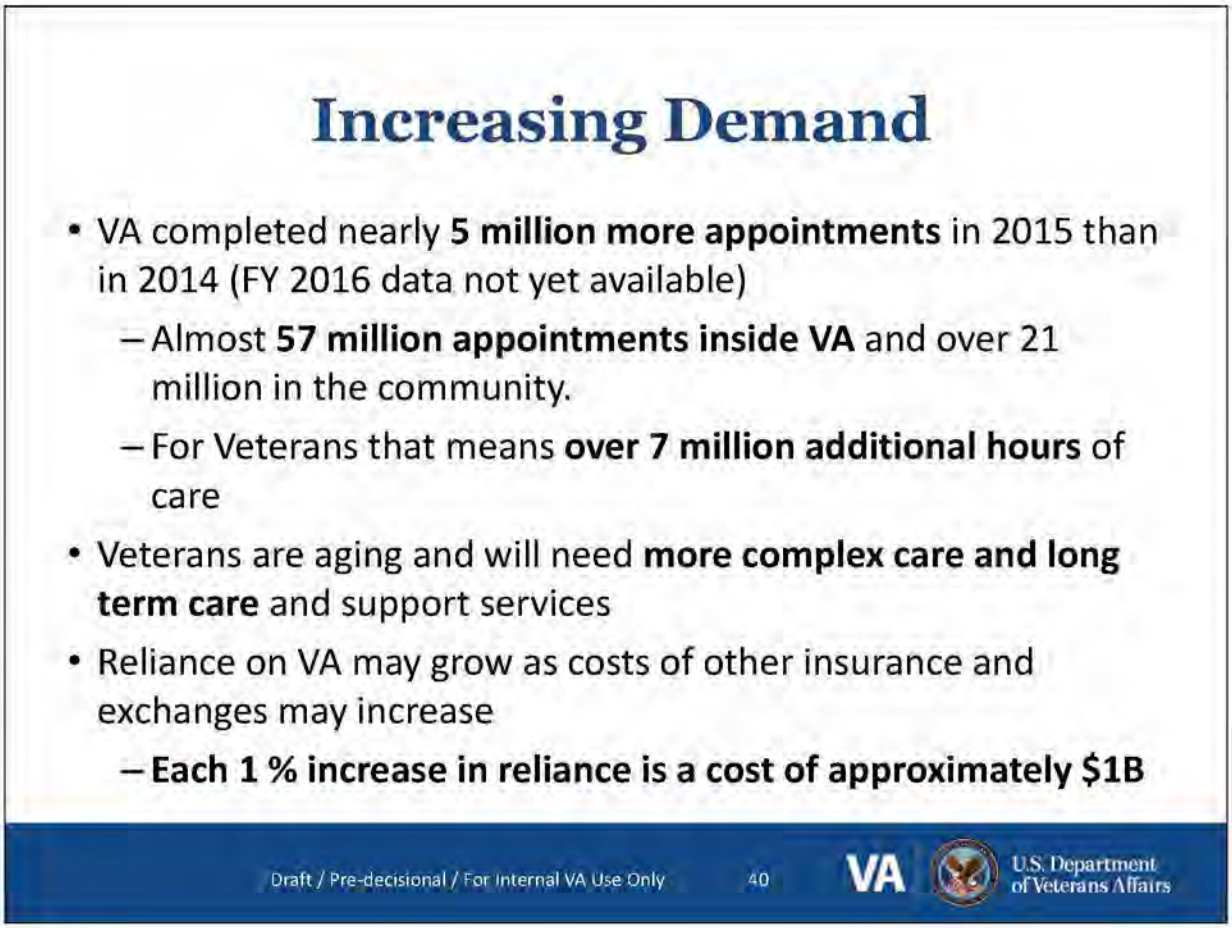

3rd bullet notes:
In 2014, enrollee reliance was estimated to be approximately 34%. We are currently updating reliance analysis with more recent Medicare data, but it is not available at this time. Reliance reflects the portion of health care services that an enrollee needs that we expect VA to provide or pay for. Some enrollees will get all of their health care from the VA and some will get none of their care, but most receive some portion of their care in the VA. For example, based on his/her morbidity, if an enrollee needs 10 office visits in a year and gets 4 of those office visits in VA. This enrollee is said to be 40 percent reliant on VA for office visits.

(b) (6) mentioned wanting to get graphs for this slide and the next from Mark Yow. As such, I haven't edited.

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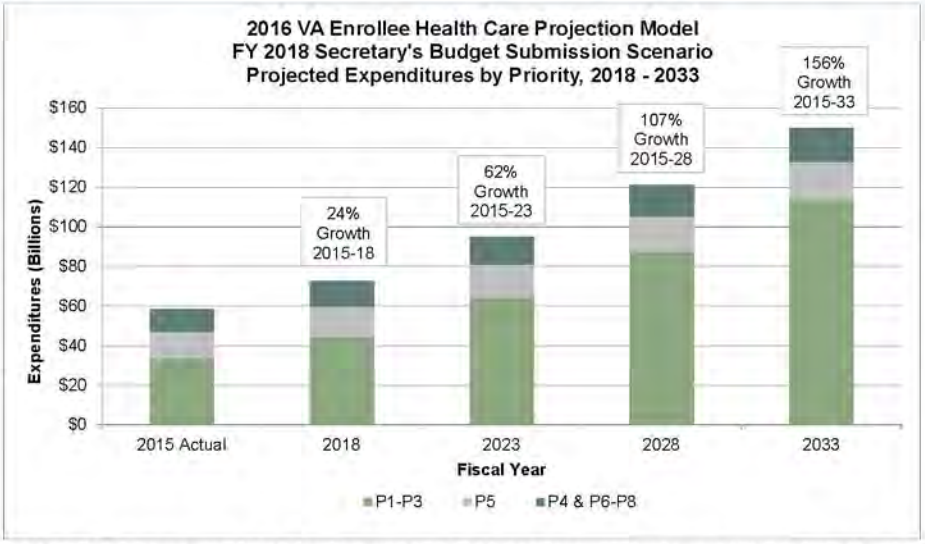
VA's Resource Requirements
Projected to Grow Significantly Over Time



2016 VA EHCPM, Budget Scenario (BAF) Note: The projections do not include requirements for several activities/ programs that are not projected by the VA EHCPM, including non-recurring maintenance, readjustment counseling, state-based long term services and supports programs, and some components of the CHAMPVA program.

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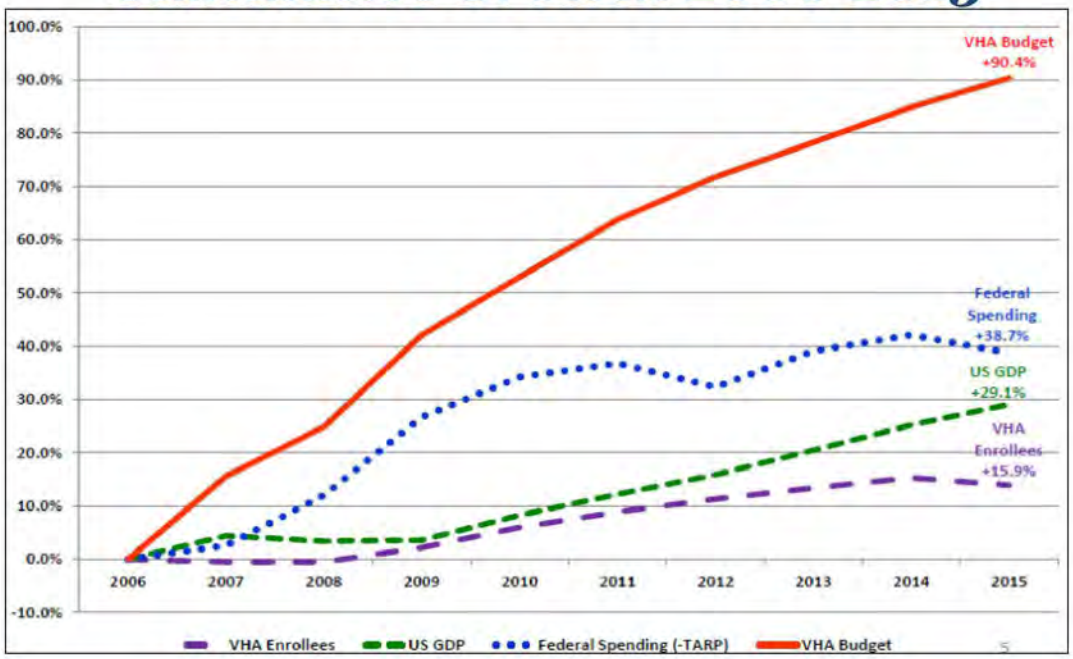
VA Medical Care Budget Challenge:
Cumulative Growth 2006-2015



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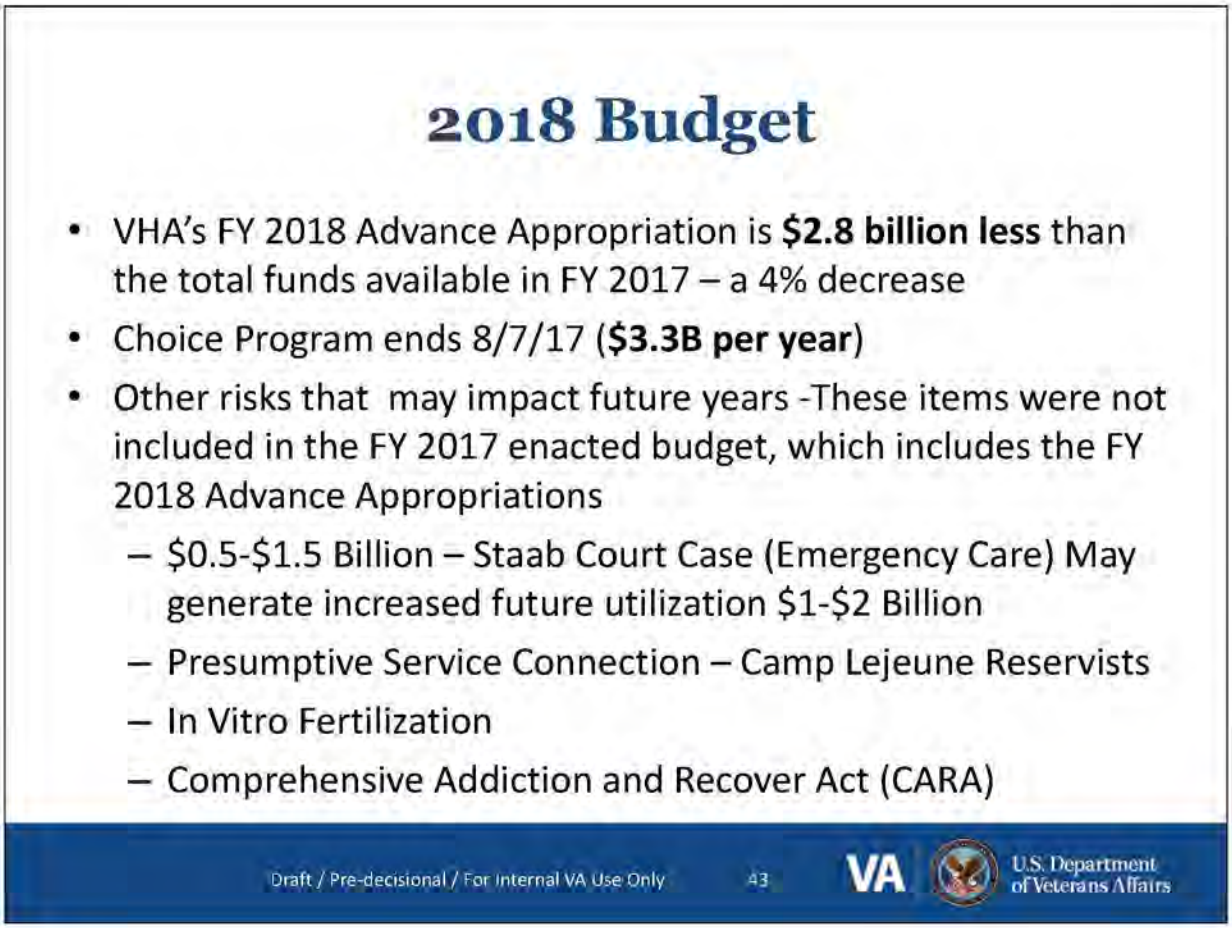

Bullet 3: Estimated budget numbers:
IVF6.5 Million FY 17, 13. million Fy18 --Maximum estimate Non VA Care funds
Adoption: 500K FY 17, 1.5 million FY 18—Maximum estimate
CARA = $153 million – crude estimate, some of which has already been incurred

Camp Lejeune.

Based on evidence there is sufficient scientific and medical evidence available to establish a presumption of connection between exposure to contaminants in the water supply at Camp Lejeune and the occurrence of eight health conditions

The proposed eight presumptive diseases are:
adult leukemia
aplastic anemia and other myelodysplastic syndromes
bladder cancer
kidney cancer
liver cancer
multiple myeloma
non-Hodgkin's lymphoma
Parkinson's disease

VA will not limit entitlement to active duty military personnel. Rather, VA proposes to presume exposure for all active duty, reserve and National Guard personnel who served at Camp Lejeune for no less than 30 cumulative days from August 1,

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1953, through December 31, 1987.

In addition, VA proposes to establish a presumption that individuals who served at Camp Lejeune during this period and later developed one of the presumptive diseases were disabled during the relevant period of service, thus establishing active military service for benefit purposes.

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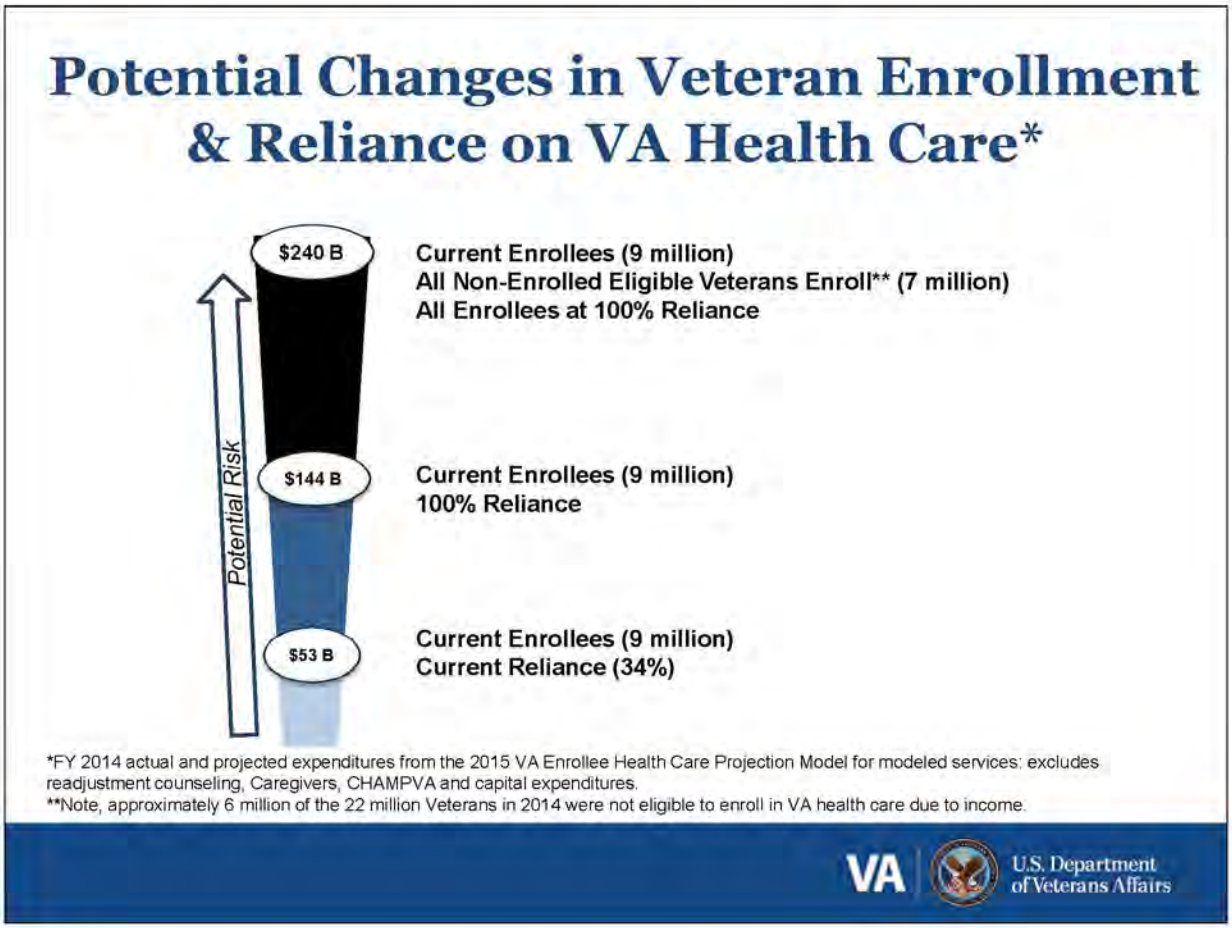

In 2014, costs for modeled services for 9 million enrollees at 34% reliance was $53 billion.

If all those 9 million enrollees used VA for all their health care, the cost in 2014 would have been $144 billion.

If all eligible but unenrolled veterans enrolled in VA and used VA for all their health care, the cost in 2014 would have been $240 billion.

All policy changes move this lever up and down as they impact either reliance on VA for health care, enrollment in VA, or both.

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Continuity of Leadership during a Crisis
Leadership vacancies and succession planning
Maintaining and Strengthening the Gains in Access (including Community Care), Quality, Engagement, and Trust
Direction of the Commission on Care Recommendations
Supporting VHA's Course for a Future Vision

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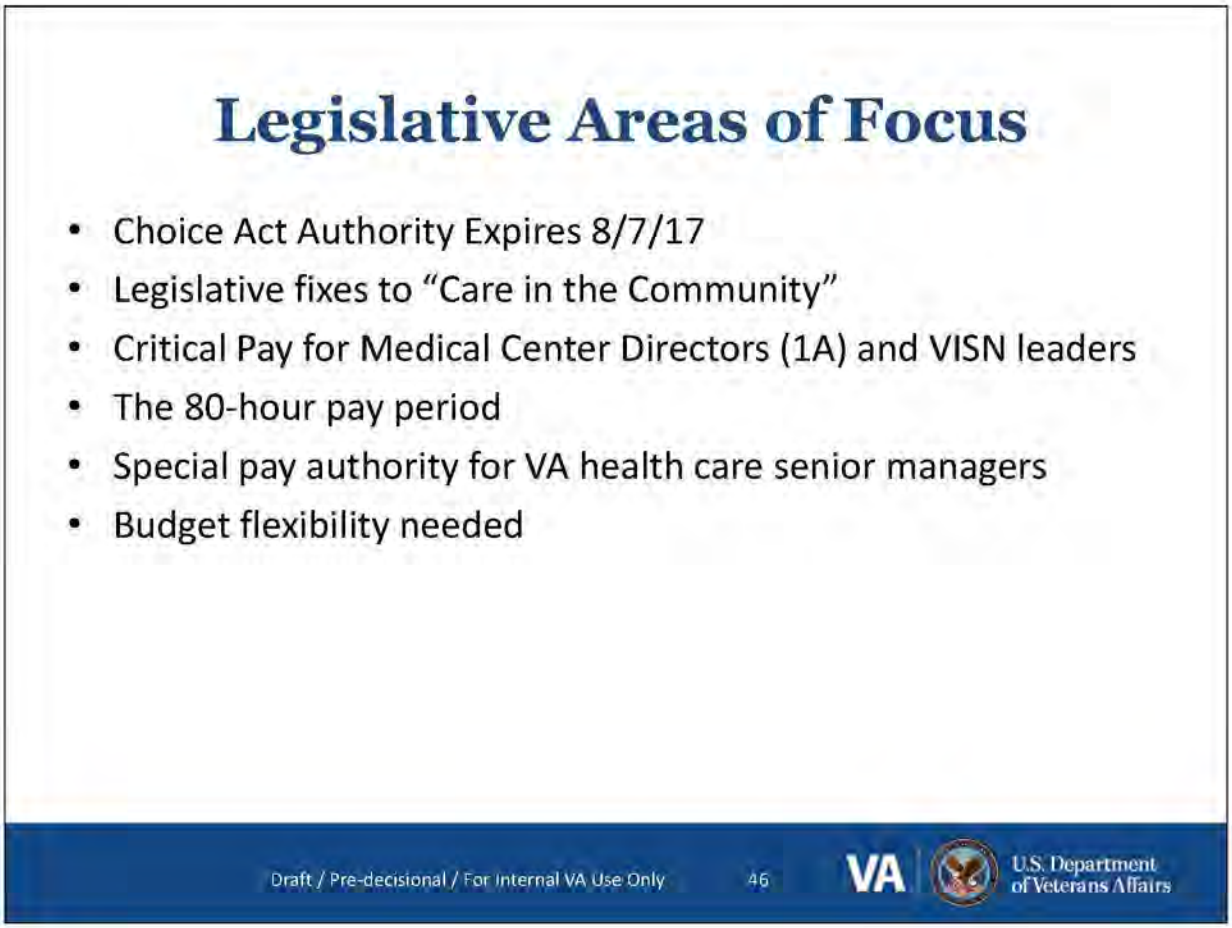

3RD BULLET:
The critical position pay authority (CPPA) allows the Secretary (or designee) to approve higher rates of pay for employees in positions that require expertise of an extremely high level in a scientific, technical, professional or administrative field critical to the Department's successful accomplishment of an important mission to the extent necessary to recruit or retain an individual exceptionally well-qualified for the critical position. Medical Center Directors and other Senior Executive Services (SES) VA health care senior managers would be eligible for CPPA.

Critical position pay requests must be submitted in writing only after it has been determined that the position in question cannot be filled with an exceptionally well-qualified individual through the use of other human resources flexibilities and pay authorities (e.g. recruitment, relocation and retention incentives, special salary rates, above minimum entrance rates).

The Secretary (or designee) must review and approve each critical position pay authority request before forwarding it to the Office of Personnel Management (OPM), who in consultation with the Office of Management and Budget (OMB) will issue final approval.

On September 22, 2016 OPM approved VA's request for CPPA for the Deputy Under Secretary for Health for Operations, 18 VISN Directors, 39 Level 1A Medical Center Directors, and 10 additional positions. 2 employees are in receipt of critical position pay and a plan is being developed for the additional positions.

Currently there is no special pay authority to compensate Medical Center Directors and other SES VA health care senior managers.

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Attached for reference is the signed/dated letter from OPM regarding critical pay.

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Organizational Areas of Focus

- Streamline Hiring/Onboarding Process
- Space: Leasing restrictions
- Facility Modernization: VHA aging Infrastructure
- Implement Full Practice Authority for Advance Practice Nurses: would increase VA ability to increase access
- Expand telehealth capability
- Implement scheduling system for medical appointments
- Examining intermediate and long term funding options for VA healthcare

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Our Commitment to Veterans

- ✓ Veterans should be at the center of what we do and how we deliver care at VHA
- ✓ No veteran with an urgent care need that may cause harm should wait for care
- ✓ VA must act like an integrated enterprise and a learning health system to benefit veterans most
- ✓ We will work closely with our academic, federal and community providers to deliver the highest outcomes to veterans
- ✓ VA leadership and staff must feel proud, fulfilled and empowered to deliver services to Veterans
- ✓ We must regain the trust and confidence of Veterans and the American public
- ✓ VA mission of research, education, and emergency preparedness must continue to contribute to improving the health of Veterans and all Americans

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A Future Vision for VHA

- **Public Private Partnerships** to serve Veterans
- **Digital Health Platform**
- **Whole Health Medicine** (empowering veteran well-being)
- Develop the **High Performance Network** (role of VISNs)
- **Center of Excellence** and Foundational Care
- **Value Based Management** and Efficiency Strategies
- Strengthen VA as a **Learning Healthcare System**
- Accelerate **Precision Medicine** and foster innovation
- Provide access to **VA Research Data** for non VA researchers with appropriate safeguards
- **Train More** primary care and behavioral health students

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Message

From: Shulkin, David J., MD [David.Shulkin@va.gov]
Sent: 11/26/2016 12:17:24 AM
To: 'Dr Shulkin' [drshulkin@aol.com]
Subject: FW: [EXTERNAL] Transition presentation
Attachments: VHAOrgBrief-PresidentialTransition(b) (6) _v2 (002) REVISED Access Team v7 compressed.pptx

-----Original Message-----
From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: Friday, November 25, 2016 05:09 PM Eastern Standard Time
To: David Shulkin; Shulkin, David J., MD
Subject: [EXTERNAL] Transition presentation

David, please see attached that the team worked on. There are some place holder slides that still need to be populated (#16 and 36).

- I am assuming that Jen will give you slide #16
- you will complete slide #36
- we are waiting for a revised slide from (b) (6) on Best Practices- slide #22 unless you think its fine.

All of your original content has been captured in this presentation.

Let me know if you want to catch up over the weekend to discuss- have to get ready for the evening now, (b) is getting impatient.

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U.S. Department of Veterans Affairs Presidential Transition Briefing

Veterans Health Administration

Prepared for:
Agency Review Team

Briefed by:
David J. Shulkin, MD
Under Secretary of Health, Veterans Health Administration

November 2016

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Purpose and Agenda

- **Purpose:** To provide an overview of the Veterans Health Administration (VHA) and highlight major priorities and challenges
- **Overview:**
  - Organization, Budget and FTEs
  - Our Mission and Who We Serve
  - Assessment of VHA's Situation
    - Priorities
    - Performance
  - Accomplishments in FY 2016
  - Future Direction, Priorities and Opportunities for VHA

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Relevant Questions

- Is VHA making progress?
- What do Veterans think of VHA care?
- How does VHA compare to the private sector?
- What services should be provided in the community and what services within VHA?
- What are costs associated with moving more care out into the community?
- What is the impact of changes to ACA to VHA?
- Are there sustainable fixes to funding future VHA care?

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Organization, Budget and FTEs

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Organizational Leadership



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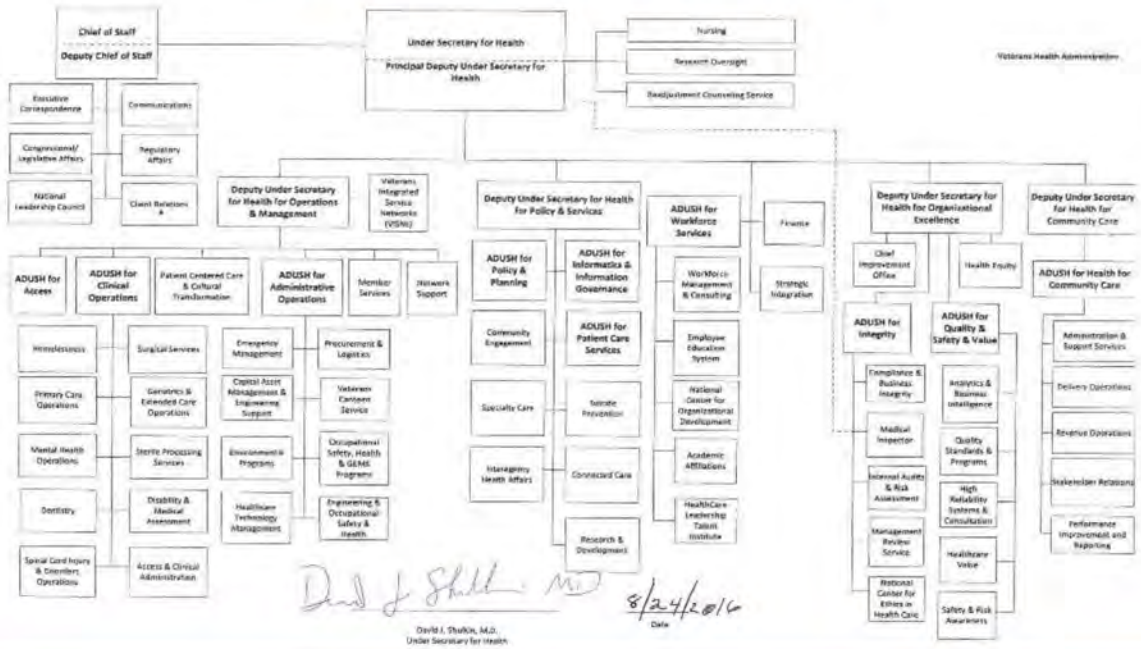
Organization Chart



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Budget and FTEs

FY 17 Enacted Budget	FY 18 Enacted Budget	Change (% Change)
$72,835,537	$70,012, 287	-2,823,250 (-3.9%)

Employees in VHA- 320,795 FTEs

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How We Are Different:
Our Mission and Who We Serve

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The Largest Healthcare System in the United States

- 1,234 health care facilities
  - 168 VA Medical Centers
  - 1,055 outpatient sites
- 25,000 physicians and
- 93,600 nurses (RN, LPN & NA)

- Over four times as many hospitals as Kaiser
- Over twice as many hospitals as DoD

Annual Workload Snapshot



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Annual Financial Report source file for graphic

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Who We Serve

- Veterans who rely most on the VA
  - Veterans with lower income
  - Veterans living in rural areas
  - Veterans without other access to health insurance coverage
  - Veterans with poorer self-reported health status
  - Veterans with higher rates of comorbidities
- The prevalence of many common conditions is projected to increase among Veterans over the next 10 years
- In the event of a potential future conflict, even moderate levels of deployment could substantially increase the size of the incoming cohort of VA patients

Findings from the independent assessment (section 201) Appendix A Demographics

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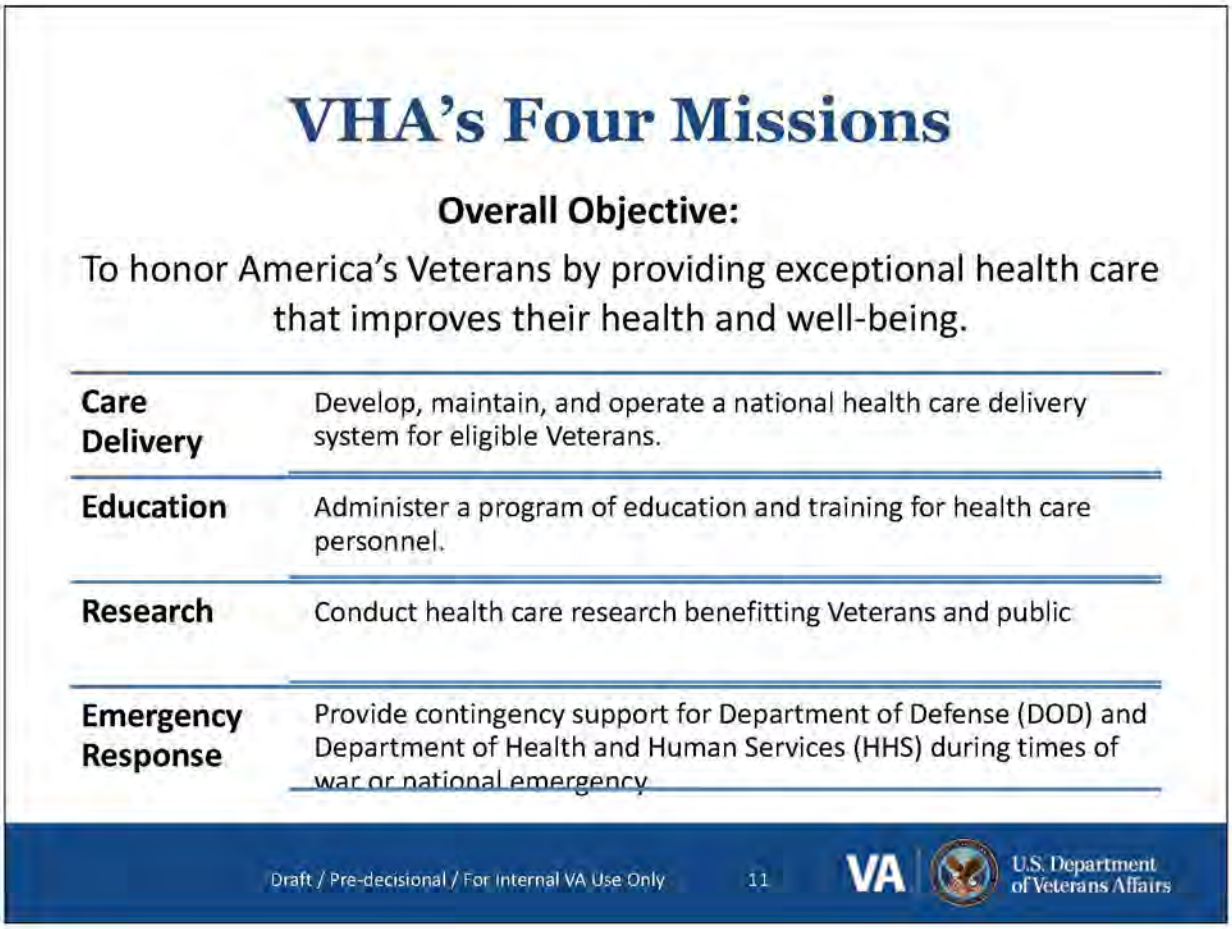

Our mission extends beyond healthcare for Veterans

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VA Healthcare Services Not Found in the Private Sector

- Caregivers
- Travel
- Dental
- Homeless Programs
- Long Term Care
- Readjustment Counseling
- Rural Health Outreach
- Special Populations- Spina Bifida, Camp Lejeune
- Comprehensive Emergency Medical Program
- Health Professions Educational Assistance
- Income Verification Match
- Hepatitis C Treatments
- Prosthetics
- Comprehensive Behavioral Health Programs
- Blind Rehabilitation
- Veterans Crisis Line
- Beneficiary Travel

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VA Healthcare Costs Not Found in the Private Sector

$Millions	FY 2015	FY 2016	FY 2017
Beneficiary Travel	$853	$888	$924
Camp Lejeune	$10	$24	$21
Caregivers	$454	$623	$725
CHAMPVA, Spina Bifida, FMP, CWVV	$1,547	$1,817	$1,920
Comprehensive Emergency Medical Program	$147	$135	$139
Dental Care	$1,005	$1,035	$1,433
Health Professions Educational Assistance programs	$37	$56	$70
Homeless Programs	$1,507	$1,477	$1,591
Income Verification Match	$17	$19	$19
Long Term Care	$7,702	$8,223	$8,588
Readjustment Counseling	$221	$258	$244
Rural Health Outreach Initiatives	$219	$270	$250
Sharing Agreements - Services Provided by VA	$157	$157	$166
Subtotal	$13,875	$14,980	$16,090
Hepatitis C (assume 50% greater benefit)	$406.1	$500.0	$500.0
Mental Health (assume 50% greater benefit)	$2,283.9	$2,494.9	$2,610.6
Prosthetics (assume 50% greater benefit)	$909.0	$950.3	$1,215.2
Subtotal	$3,599.0	$3,945.2	$4,325.9
Total	$17,473.9	$18,924.9	$20,415.8

Educational
Employment Services

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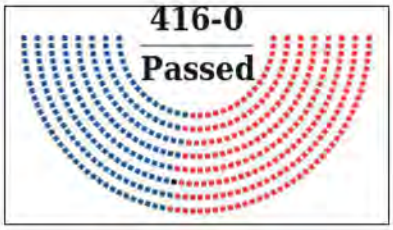
20 Years of Increasing Demand for Services

- 1996 "Veterans Eligibility Reform Act"
- Conflicts in Afghanistan and Iraq continued
  - Congress provided eligibility for care for five years after discharge
- From 2002 to 2015, VHA outpatient volume increased from 46.5M to almost 97M visits
- 2014 "The Veterans Access, Choice and Accountability Act"



IRAQ AND AFGHANISTAN VETERANS OF AMERICA

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- Enactment of Public Law 104-262, "Veterans Eligibility Reform Act" in 1996 allowed VA to provide full continuum of care for all Veterans who chose to enroll for care

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Myths vs. Reality

Myth	Reality
Veterans cared for by VHA have similar issues to most other Americans	Users of VHA are older and have more complex medical issues than non-users (almost 50% of users have a mental health diagnosis)
Care in VHA is poor quality	Numerous independent studies have shown that quality or equal or better
VHA does not want to utilize private sector health providers	22% of all care currently is done in the community- Close to 4 million Choice Act Authorizations has been utilized
Veteran Suicides are only a VHA problem	Of the 20 Veterans who take their own life a day- 14 do not get care in VHA
The private sector offers the same services as in VHA	More than 16 billion dollars in care a year goes towards services not provided by private sector
Access to services is worse than the private sector	96.5% of veterans were seen within 30 days of their clinical indicated or preferred date. Similar data is not readily available from the private sector
Veterans want to use private sector providers and not VA services	Of the 1 million veterans that used Choice, less than 5000 veterans did not also receive their care in VHA

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Impact of VHA Research

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VHA Priorities

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USH 5 Priorities for Strategic Action

Access

We will provide timely access to Veterans as determined by their clinical needs.

PSA: We pledge that any Veteran with the requirement for urgent care will receive care at the right time appropriate to his or her clinical needs

Employee Engagement

We seek a work environment where employees are valued, supported, and encouraged to do their best for Veterans.

PSA: We will work to allow staff to have greater input into their work environment.



High Performance Network

We will ensure that Veterans receive the highest level of coordinated care within VA or from participating providers.

PSA: We will build a high performance network of care to best serve Veterans.

Best Practices

We will use best clinical practices. We also seek best practices in research, education, and management.

PSA: We seek to identify and disseminate best practices throughout VA.

Veterans First: Trust in VA Care

We will be there for our Veterans when they need us.

PSA: We will share our results on the quality and timeliness of how we care for Veterans.

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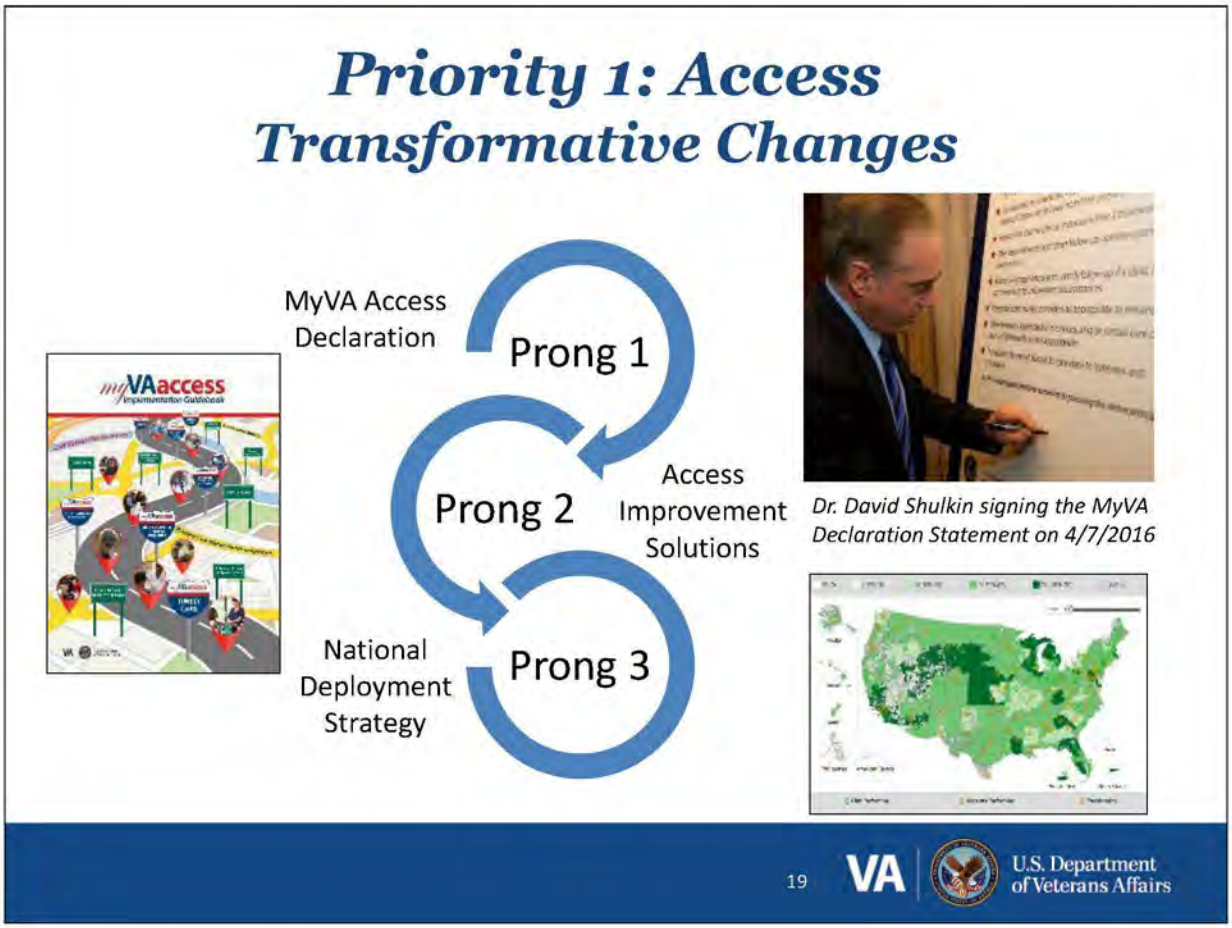

Transformative changes heading
Prong
Guidebook
Map

Same day Services for urgent needs
Path to SDA

Third slide is Results and impact that improve access

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Priority 1: Access

Same Day Access in Primary Care and Mental Health

By the end of this year, we may be the most accessible healthcare system in the United States

September
52 sites (31%)

October
85 Sites (51%)

November
123 Sites (74%)

December
166 Sites (100%)

Same Day Services:

If you need care right away during regular business hours, you are able to get services the same day, or if after hours, by the next day from a VA Medical Center or Health Care Center.

- Options for how that care might be provided include in person, via telephone, smart phone, through video care, secure messaging ,or other options.
- This care may be delivered by your provider or another appropriate clinical staff member based on availability and your care needs.
- *For a medical emergency always call 911 or report to the emergency room closest to where you are located.*

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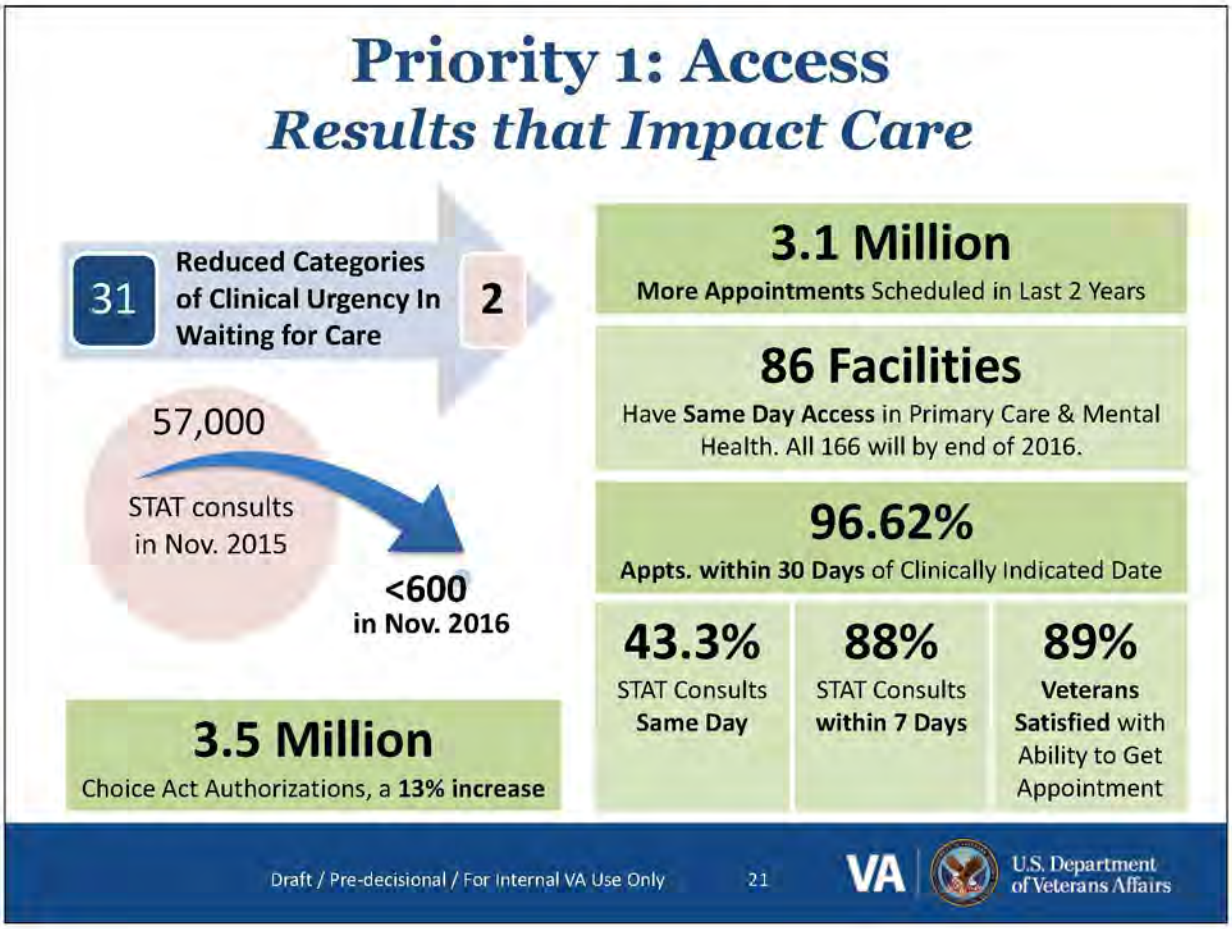

Second bullet is discussing STAT consults over 30 days

Categorized veterans waiting for care into clinical urgency (from 31 categories to 2)
57,000 stat consults in Nov 2015 to <600 in November 2016
3.1 Million more appointments scheduled in the last 2 years
86 facilities have Same Day Access in Primary Care and Mental Health. All 166 facilities will be able to offer these services by the end of 2016
89% of veterans satisfied with the ability to get an appointment (2.1 M veterans)
In October 2016, 96.62% of appointments were within 30 days of the clinically indicated or Veteran's preferred date
43.3% of stat consults were completed same day and 88% were seen within 7 days (a 22% increase from the start of the fiscal year)
Map of veterans evaluation of waiting times by site placed on internet on 11/11/16
Expanded scheduled hours on weekends and evenings, productivity, people, and space
More than 3.5 million authorizations through Choice from September 1, 2015 through August 31, 2016. This represents a 13% increase in authorizations when compared to the same period in 2014/2015

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Priority 2: Best Practices
& Performing as an Integrated Enterprise

- Successfully replicating **13 USH Gold Status best practices 386 times** throughout the system:
  - ➢**85** of those replications have been completed **within 9 months**
  - ➢**301** of those replication projects are **ongoing and on track**
  - ➢**Over 100 facilities** are replicating at least one of the best practices
- Examples would be using Pharmacists to manage medications and a Virtual Tumor Board



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Priority 3: High Performance Network

- As of the end of FY 2016, the Veterans Choice provider network has grown by **85%** and includes more than **350,000** network providers.
- Clinical workload is up **12%** over the past two years—**9%** within VA and **31%** in the community. The **12%** increase translates into roughly **7.5 million** additional hours of care for Veterans.
- New Choice Plan submitted to Congress in October 2015
- RFP planned to be released at end of month for revisions to Community Care program



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When Congress passed the Veterans Access, Choice and Accountability Act in 2014 (the Act), which established the Veterans Choice Program (VCP), the Act specified that the program may not furnish care or services after the expiration date of the program on August 7, 2017, or when the funding allocated ($10 billion) was exhausted.
Without further action by Congress before August 7, 2017, those Veterans that receive care through the current VCP (approximately one million unique Veterans have sought care through VCP since its implementation) will have to discontinue VCP care, and those Veterans newly authorized to receive VCP care will have to make alternative arrangements to receive care.
Other VA community care programs may not have the capacity to handle the entirety of patients who will come off of the current VCP. Wait times for appointments at VA facilities will likely rise if large numbers of Veterans return to VA to seek care.

Our goal for VA Community Care is to deliver a program that is easy to understand, simple to administer, and meets the needs of Veterans, community providers, and VA staff. How will we get there? Our approach consists of five components:
1. Eligibility: We want to provide easy to understand eligibility information to Veterans, community providers, and VA staff.
2. Referral and Authorizations: We want to streamline referral and authorizations, providing Veterans timely access to a community provider of their choice.
3. Care Coordination: We want to solidify care coordination through seamless health information exchanges.
4. Community Care Network: We plan to implement a Community Care Network that provides access to high-quality care inside and outside of VA.
5. Provider Payment (Claims): We want to become better partners to our community providers by paying them promptly and correctly.

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When Congress passed the Veterans Access, Choice and Accountability Act in 2014 (the Act), which established the Veterans Choice Program (VCP), the Act specified that the program may not furnish care or services after the expiration date of the program on August 7, 2017, or when the funding allocated ($10 billion) was exhausted.

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Other VA community care programs may not have the capacity to handle the entirety of patients who will come off of the current VCP. Wait times for appointments at VA facilities will likely rise if large numbers of Veterans return to VA to seek care.

Second bullet references a comparison of FY 14 to FY 15 and was originally completed by Finance in March 2016

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Priority 4: Employee Engagement

- VA Pulse - **94,339 unique users**
- Holding **Quarterly Town Hall Meetings** and site based employee open forums
- **AES scores improved** from 3.45 (2014) to 3.58 (2016)



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Priority 5: Restoring Trust

	VE Measure	% Agree or Strongly Agree Jan-Mar 2016 (Q2) (n=24,415)	%Agree or Strongly Agree Apr-Jun 2016 (Q3) (n=29,873)	%Agree or Strongly Agree Jul-Sep 2016 (Q4) (n=27,758)
BRAND	**"I trust VA to fulfill our country's commitment to Veterans"**	**55%**	**59%**	**60%**
VETERANS EXPERIENCE – EFFECTIVE	"I got the care or service I needed"	72%	74%	75%
VETERANS EXPERIENCE – EASE	"It was easy to get the care or services I needed"	61%	65%	66%
VETERANS EXPERIENCE – EMOTION	"I felt like a valued customer"	63%	67%	68%

This survey was conducted by an independent contractor and validated by survey subject matter experts from Research Triangle International.

Acknowledgements to National Center for Organizational Development Dr Scott Moore and VHA Operational Excellence Dr Steven Wright.

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VHA Accomplishments in 2016

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Suicide Prevention

- **Elevated Office** of Suicide Prevention
- Completed and released a **landmark, comprehensive data analyses of Veteran suicide rates**, examining over 50 million Veteran records from 1979 to 2014 from every state in the nation, providing critical insights to help inform and shape our policies and efforts
- Reach Vet Program initiated to **proactively reach out** to those at highest risk
- **Added 163 responders** to the Veterans crisis line and added direct connections from the phone system to VCL
- Hugely successful Suicide Prevention Month 2016 campaign **#BeThere** garnered **over 73 million social media impressions** across various platforms, over 420 million impressions from TV, radio, and out of home placements (earned and paid), and was supported via Twitter by Joe Mantegna and Senators McCain and Sanders



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Innovative Healthcare

Telehealth

- In FY 2016, 12% of all Veterans enrolled for VA care received telehealth-based care. This includes **2.17 million telehealth visits, touching 702,000 Veterans**.
- Upcoming expanded services through VAR and VA Video Connect in 2017.

Million Veterans Program

- Program to incorporate **precision medicine** to improve Veterans' health by establishing large database containing genetic, military exposure, lifestyle, and health information with over **520,000 enrollees** as of Oct. 2016

Office of Compassionate Innovation

- Launched **Mental Health Service Dog** pilot to assist Veterans with mental health conditions that impede their mobility
- Since Center for Compassionate Innovation announced in April 2016, 38 proposals received; **8 proposals have moved to field implementation or warm hand-off** and **3 have been closed**

New

VA / Watson Cancer Partnership for Precision Oncology

Connect Care

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Complex Care Needs

Homelessness

- There was a **17 percent decline in Veteran homelessness** between 2015 and 2016, quadruple the previous year's annual rate of decline
- Since 2010**, over 480,000 Veterans and their family members have been permanently housed**, rapidly rehoused, or prevented from falling into homelessness by HUD's targeted housing vouchers and VA's homelessness programs

We've cut Veteran homelessness nationwide by 47% since 2010

Providing Counseling Services where Veterans are Comfortable

- More than **1 million primary care/mental health integration visits**
- More than **1.5 million visits** to Vet Centers providing readjustment, Military Sexual Trauma and bereavement counseling services



Hep C Management Notes

VA follows CDC recommendations to screen everyone born between 1945-1965 as they are at the highest risk of having HCV. Screening is also recommended for those born outside of this cohort who have other risk factors.

Source: VA's National Center for Health Promotion and Disease Prevention (NCP) HCV Screening recommendations: http://vaww.prevention.va.gov/CPS/Screening_for_Hepatitis_C.asp

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Public Health Issues

Hepatitis C Management

- In FY15 & 16, **VA treated a total of 69,294 Veterans with Hepatitis C** with an anticipated cure rate of over 90%.
- In CY2015, **69.9%** of the birth cohort (Veterans born between 1945-1965) were **screened for Hepatitis C**.



Reducing Opioid Abuse and Dependency

- 22% reduction in opioid use
- 42% reduction in use of opioids and benzodiazepines
- 32% reduction in dosages



Prevention Programs

- 42,000 Veteran Flu Shots at Walgreens
- MOVE! has helped over 600,000 patients lose weight, keep it off, and improve their health

Walgreens

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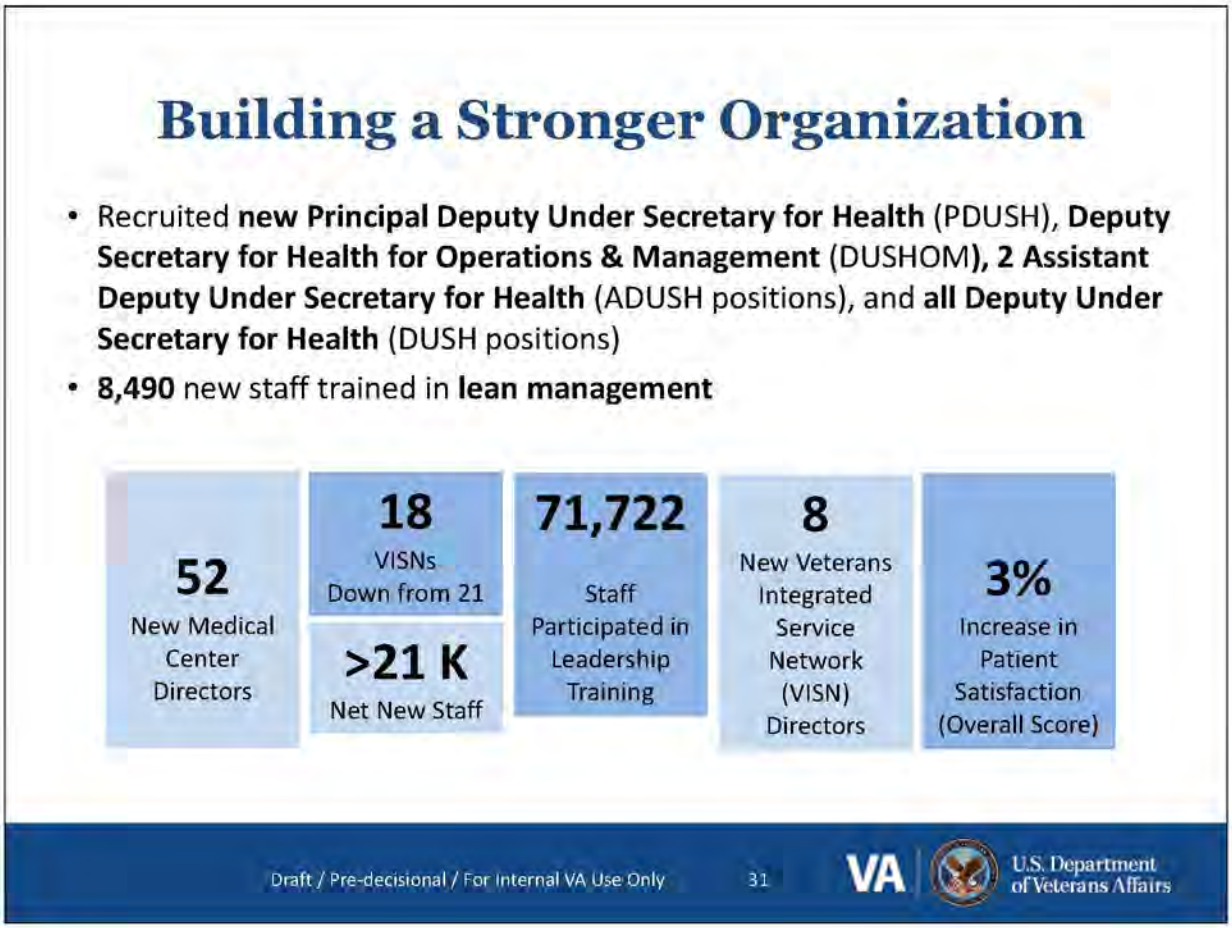

5th bullet notes:

Precision Oncology is the targeting of cancer therapy to the molecular profile of the cancer. This is not new – for many years we have been tailoring cancer therapy for some cancers. An easy example is assessing breast cancer for the presence of estrogen receptors, then using medications that block the effect of estrogen, thus blunting the effect of hormones which drive breast cancer growth. However, in the last 10 years the ability to sequence many genes simultaneously has led to an understanding of the specific mutations that drive cancer growth in many tumor types. This has gone in parallel with the development of medications that target and inhibit the effect of these specific driver mutations. Use of these targeted therapies has resulted in dramatic responses in some cases that previously had very poor outcomes. Unfortunately, only a small minority of cancers have identifiable mutations and targeted therapy available. The VA is currently expanding a program of sequencing a large number of genes in solid cancers, with several aims: to identify mutations in cancers for which there is available targeted therapy and treat these Veterans with the best available therapy; to identify mutations in cancers that might make them susceptible to an approved drug as an off label use; and to identify Veterans with molecular profiles in their cancer that would allow them to consider enrolling in clinical trials. To address the analysis of the molecular data, the VHA has a partnership with IBM Watson Health. This partnership will enhance our ability to both ensure Veterans receive the best available care now, and that clinical and basic research will improve care in the future.

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Serving our Veterans and the Nation

Culture of Improvement

- 6th year – **VA's pharmacy benefits ranked among best in class**
- **24 million in cost avoidance** through our supply chain efforts
- An Integrated operations center to **proactively monitor and identify** issues in quality or access
- **23,000 pounds of used medications** returned and **destroyed** this year

Service to the Nation

- **9,860 research publications** in 2016
- Added **547.4 graduate medical education positions**
- Responded and deployed to **6 national emergencies**



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VHA's Performance

- Comprehensive **Quality Measures** are in place
- VA generally performs **better than private sector**
- **82%** of medical centers showed **quantitative improvement** in quality last year
- Risk adjusted **mortality improved 20%** in 2016
- **Patient Satisfaction** scores show **improvement** across the board

1st bullet:
Regarding Strategic Analytics for Improvement and Learning (SAIL) Model

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82% of VAMCs with Improvement
SAIL Quality Measures in Past Year

	FY16Q3 SAIL Quality Star Percentile Cut-Off					
Overall Quality FY15Q4-FY16Q3[1]	Top10% 5-Star	11-30th% 4-Star	31-70th% 3-Star	71-90th% 2-Star	Bottom10% 1-Star	Total
Large Improvement	8	18	35	20	9	90
Small Improvement	3	7	13	5	2	30
Trivial Improvement	1	3	3	3	1	11
Trivial Decline	3	1	0	0	1	5
Small Decline	1	1	2	0	1	5
Meaningful Decline	1	1	2	0	1	5
Total	17[2]	31[2]	55	28[3]	15[3]	146[4]

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Most Challenged Sites Making Improvements

Site	Indicator	FY14	FY16 (YTD)
Phoenix	CAPHS - Routine Care	66	74
	CAPHS - Urgent Care	51	56
Hines	CAPHS - Routine Care	83	88
	CAPHS - Urgent Care	74	78
Shreveport	CAPHS - Routine Care	79	82
	CAPHS - Urgent Care	65	70
Spokane	CAPHS - Routine Care	81	82
	CAPHS - Urgent Care	64	68
Greater LA	CAPHS - Routine Care	82	83

Note: a 4 to 5 point change is considered "clinically significant"

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Comparative Data

	VHA	Private Sector
Quality		
Satisfaction		
Access		
Employee Engagement		
HEDIS		

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Studies showing better outcomes
JAMA

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Comparing VA Care to Private Sector

- 30-day risk-standardized **mortality rates are lower** in VA than those of non-VA hospitals for acute myocardial infarction and heart failure
- **MRSA infections declined** 69 percent in VA acute care facilities and 81 percent in spinal cord injury units over 5 years thanks to VA's aggressive MRSA prevention plan.
- VA performed the **same or significantly better** than non-VA providers on 12 of 14 **effectiveness measures in the inpatient setting**
- VA performed **significantly better** on 16 **outpatient HEDIS measures** compared with commercial HMOs and significantly better on 15 outpatient HEDIS measures compared with Medicare HMOs
- VA mental health care was **better than private-sector care by at least 30 percent on all seven performance measures**, with VA patients with depression more than twice as likely as private-sector patients to get effective long-term treatment
- **Outcomes for VA patients compared favorably** to patients with non-VA health insurance, with VA patients more likely to receive recommended evidence-based treatment

More data in press release: http://www.va.gov/opa/pressrel/includes/viewPDF.cfm?id=2778

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Future Direction, Priorities and Opportunities

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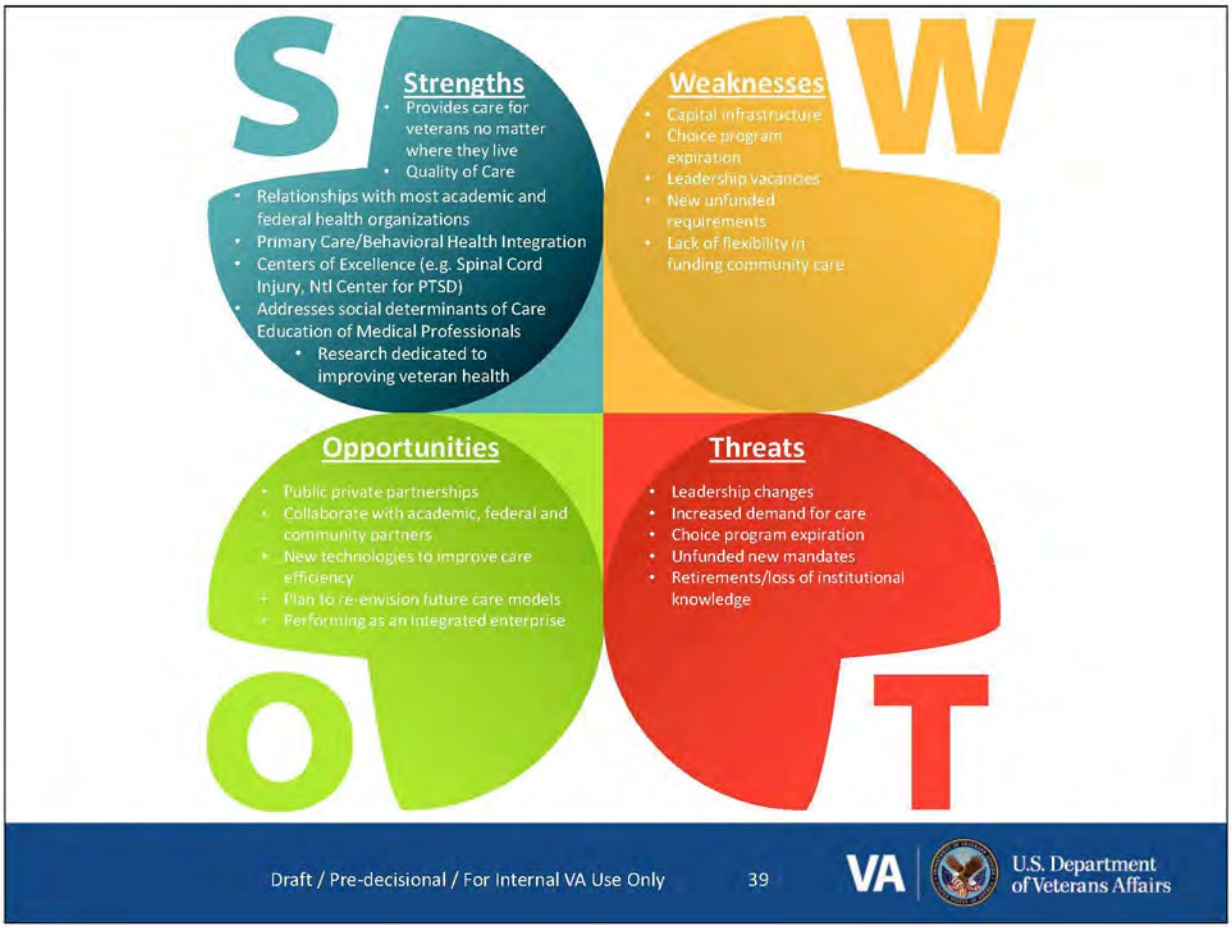

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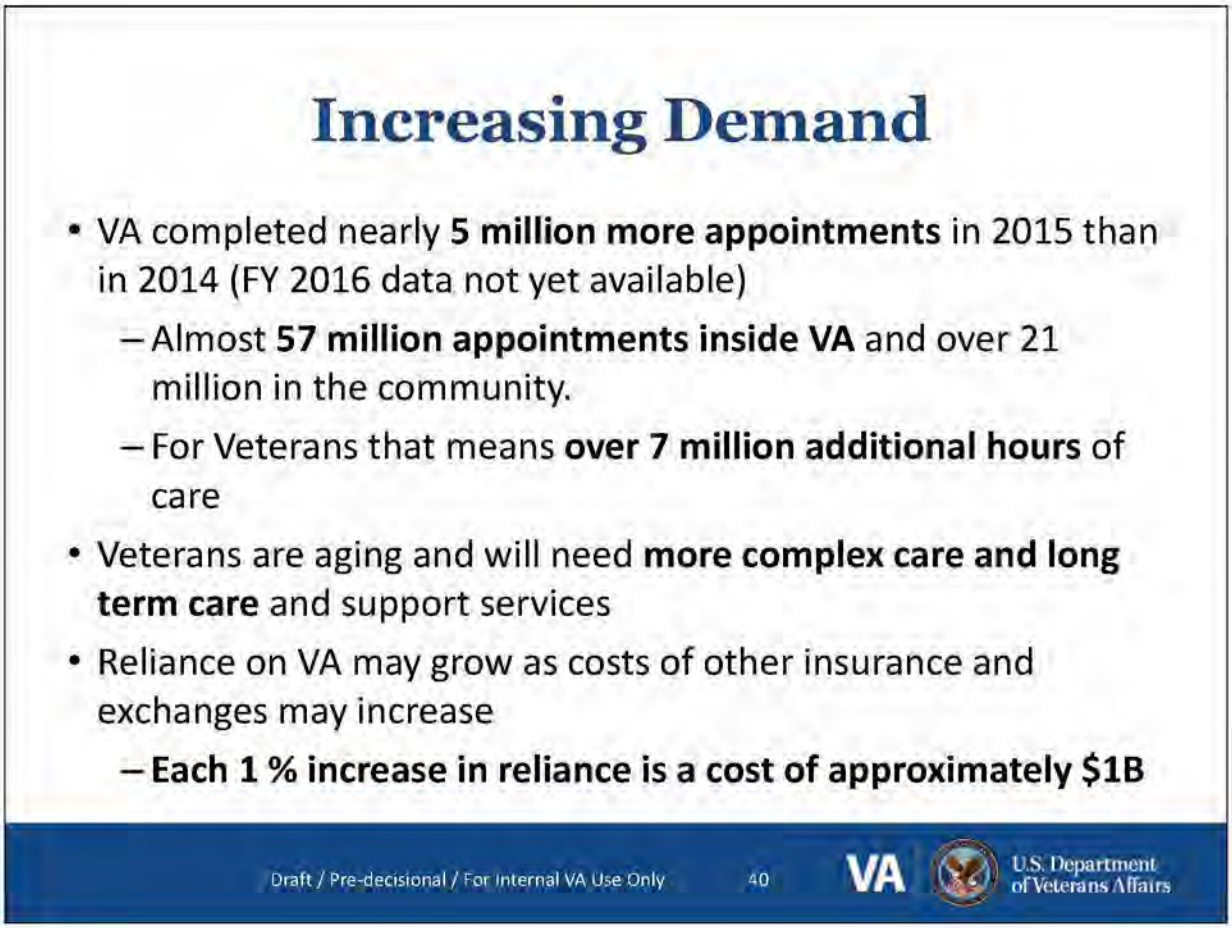

3rd bullet notes:
In 2014, enrollee reliance was estimated to be approximately 34%. We are currently updating reliance analysis with more recent Medicare data, but it is not available at this time. Reliance reflects the portion of health care services that an enrollee needs that we expect VA to provide or pay for. Some enrollees will get all of their health care from the VA and some will get none of their care, but most receive some portion of their care in the VA. For example, based on his/her morbidity, if an enrollee needs 10 office visits in a year and gets 4 of those office visits in VA. This enrollee is said to be 40 percent reliant on VA for office visits.

(b) (6) mentioned wanting to get graphs for this slide and the next from Mark Yow. As such, I haven't edited.

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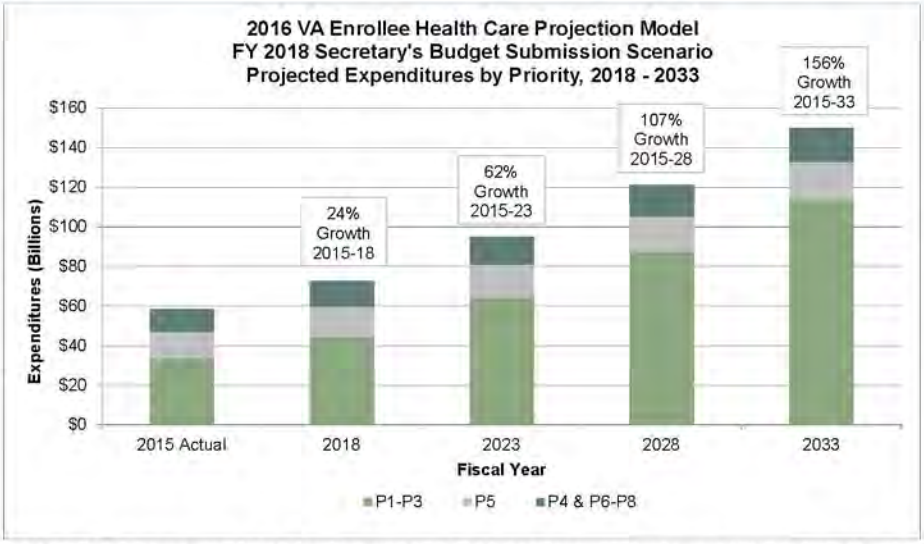
VA's Resource Requirements
Projected to Grow Significantly Over Time



2016 VA EHCPM, Budget Scenario (BAF) Note: The projections do not include requirements for several activities/ programs that are not projected by the VA EHCPM, including non-recurring maintenance, readjustment counseling, state-based long term services and supports programs, and some components of the CHAMPVA program.

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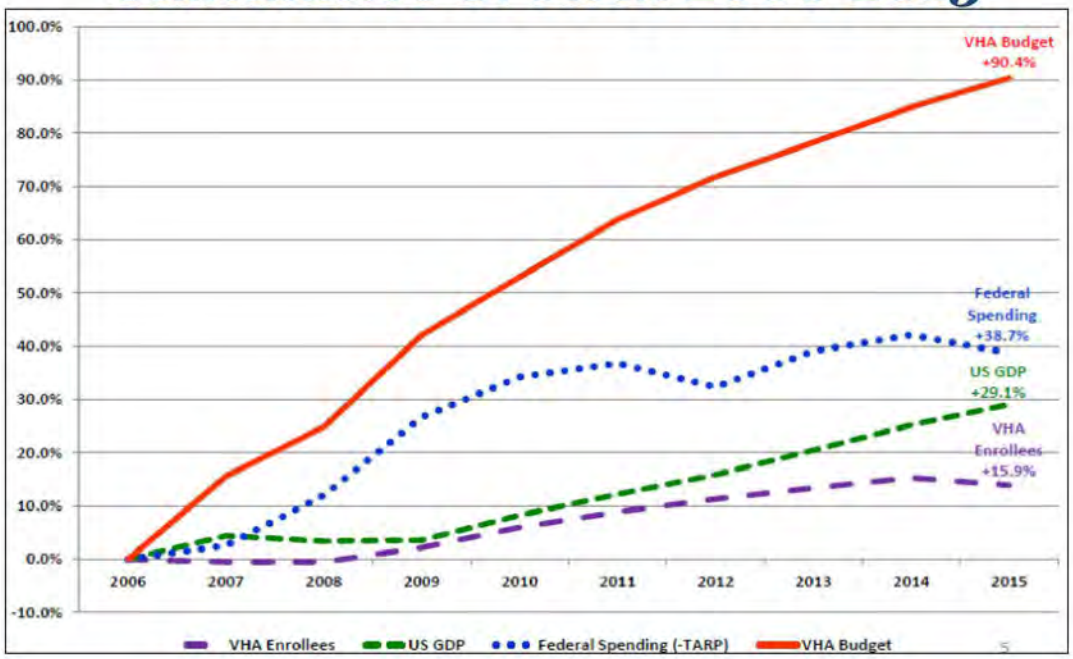
VA Medical Care Budget Challenge:
Cumulative Growth 2006-2015



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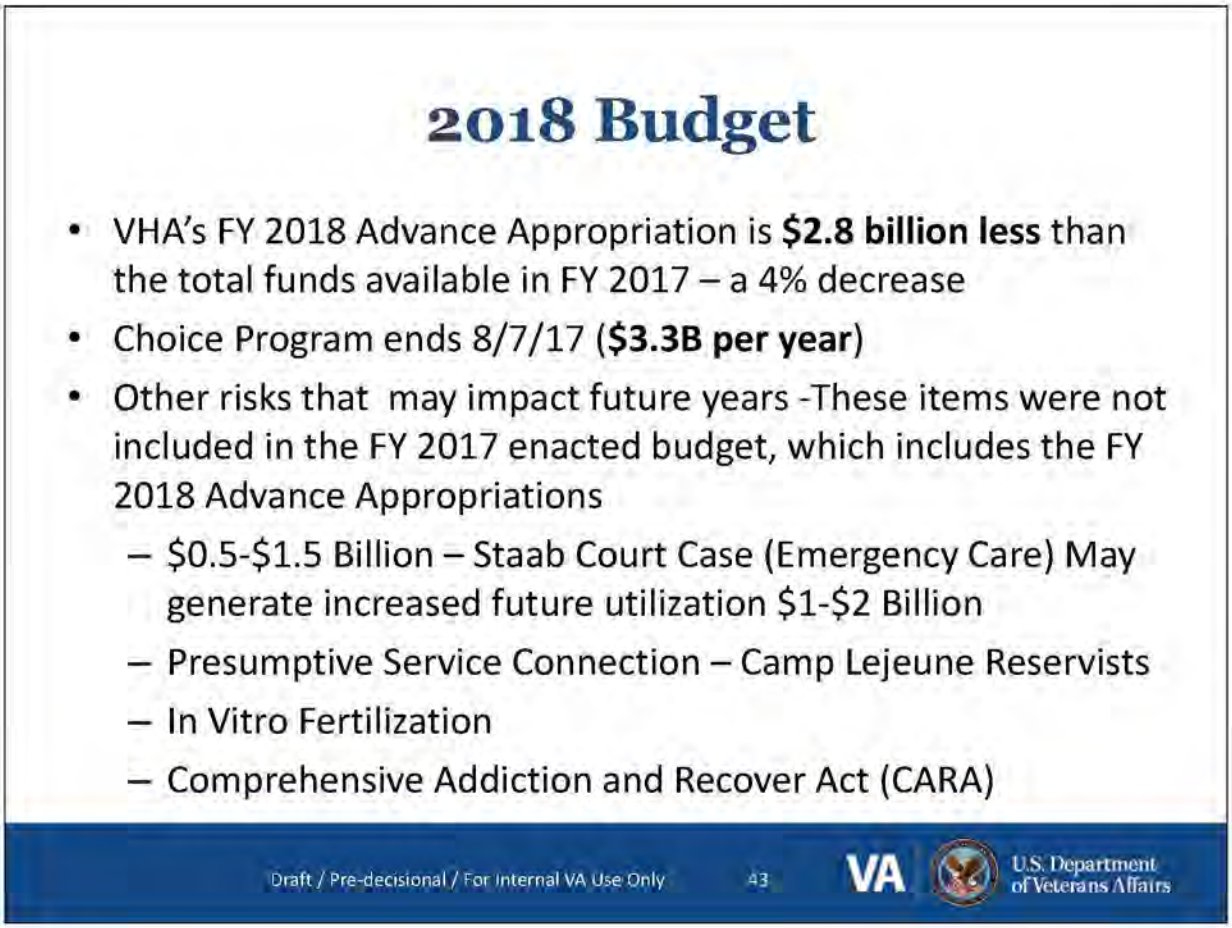

Bullet 3: Estimated budget numbers:
IVF6.5 Million FY 17, 13. million Fy18 --Maximum estimate Non VA Care funds
Adoption: 500K FY 17, 1.5 million FY 18—Maximum estimate
CARA = $153 million – crude estimate, some of which has already been incurred

Camp Lejeune.

Based on evidence there is sufficient scientific and medical evidence available to establish a presumption of connection between exposure to contaminants in the water supply at Camp Lejeune and the occurrence of eight health conditions

The proposed eight presumptive diseases are:
adult leukemia
aplastic anemia and other myelodysplastic syndromes
bladder cancer
kidney cancer
liver cancer
multiple myeloma
non-Hodgkin's lymphoma
Parkinson's disease

VA will not limit entitlement to active duty military personnel. Rather, VA proposes to presume exposure for all active duty, reserve and National Guard personnel who served at Camp Lejeune for no less than 30 cumulative days from August 1,

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1953, through December 31, 1987.

In addition, VA proposes to establish a presumption that individuals who served at Camp Lejeune during this period and later developed one of the presumptive diseases were disabled during the relevant period of service, thus establishing active military service for benefit purposes.

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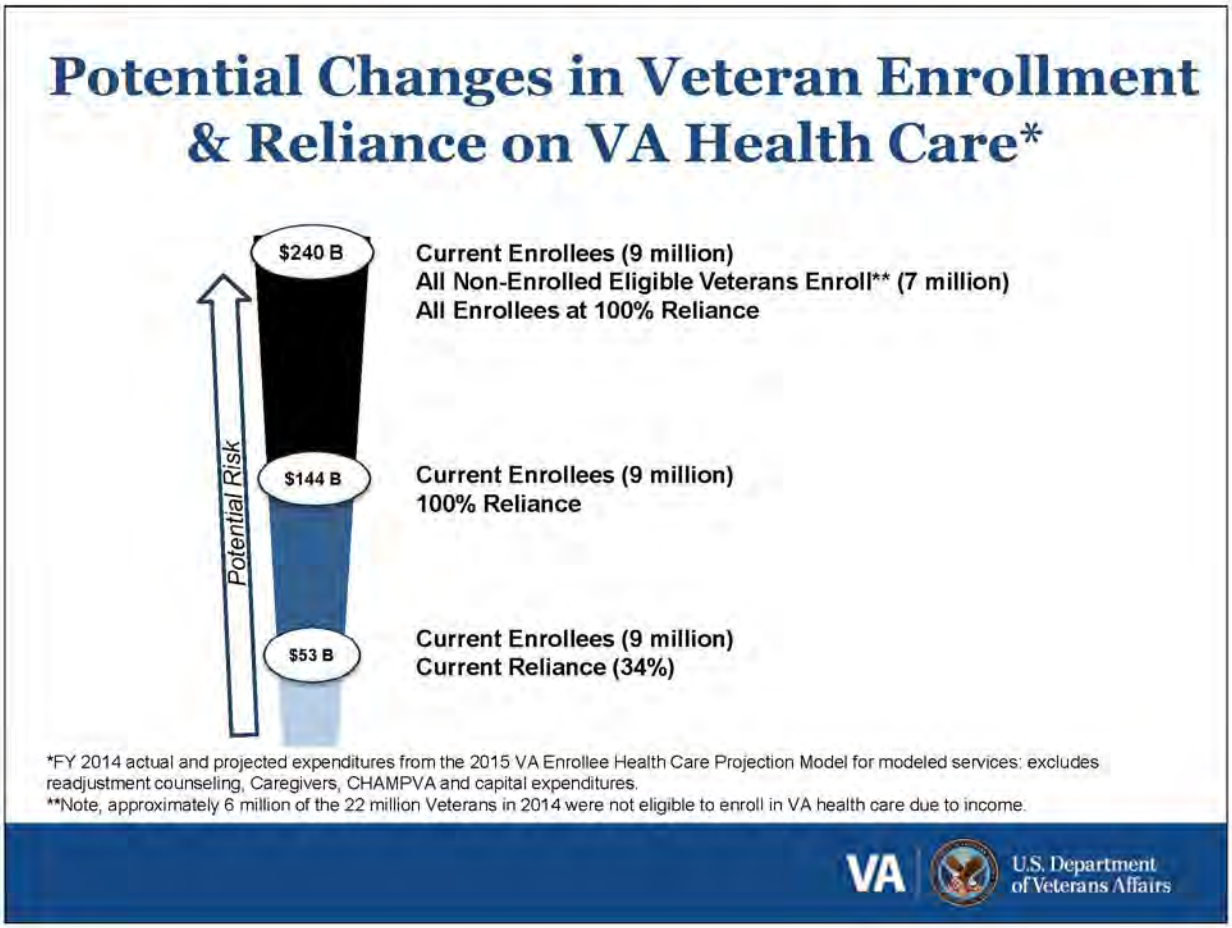

In 2014, costs for modeled services for 9 million enrollees at 34% reliance was $53 billion.

If all those 9 million enrollees used VA for all their health care, the cost in 2014 would have been $144 billion.

If all eligible but unenrolled veterans enrolled in VA and used VA for all their health care, the cost in 2014 would have been $240 billion.

All policy changes move this lever up and down as they impact either reliance on VA for health care, enrollment in VA, or both.

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Continuity of Leadership during a Crisis
Leadership vacancies and succession planning
Maintaining and Strengthening the Gains in Access (including Community Care), Quality, Engagement, and Trust
Direction of the Commission on Care Recommendations
Supporting VHA's Course for a Future Vision

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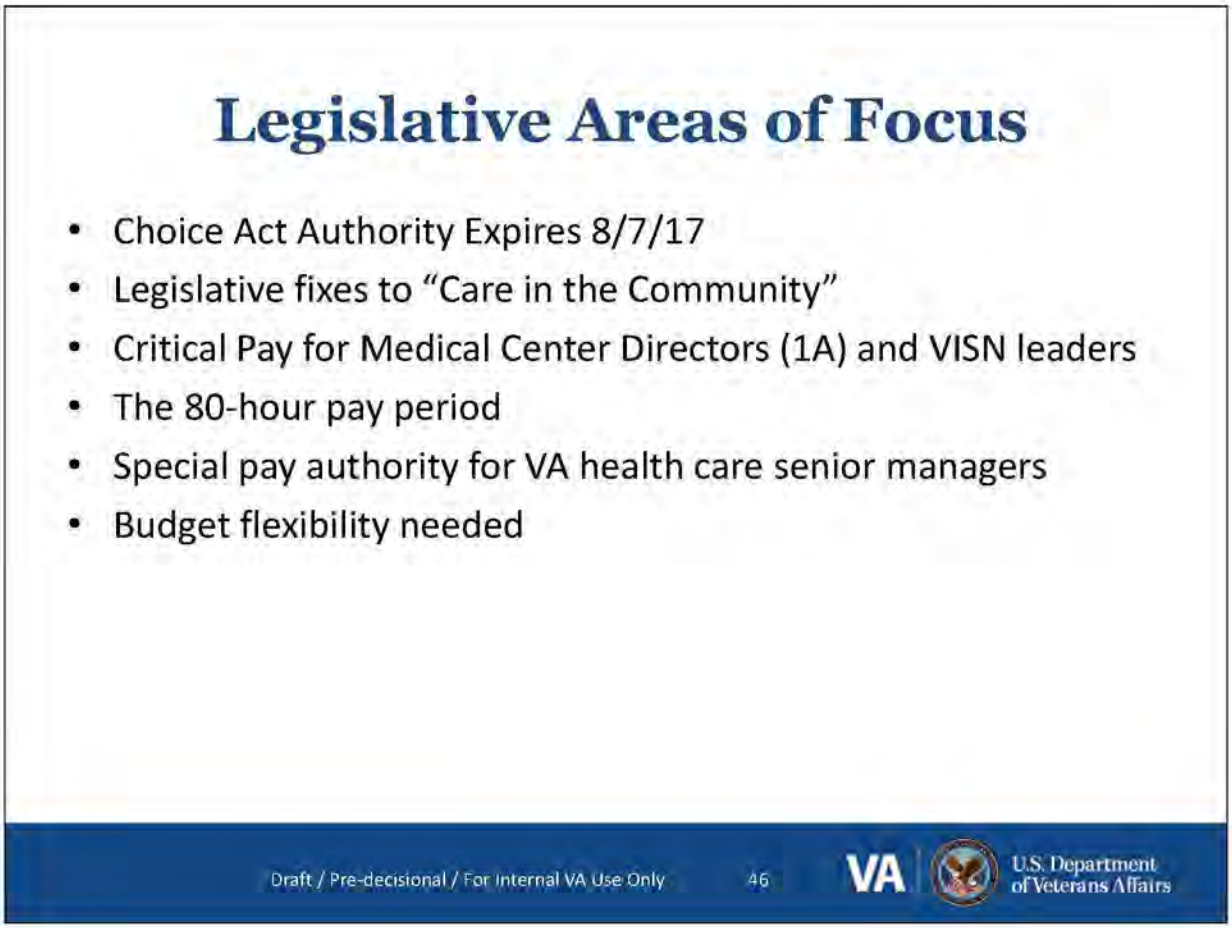

3RD BULLET:
The critical position pay authority (CPPA) allows the Secretary (or designee) to approve higher rates of pay for employees in positions that require expertise of an extremely high level in a scientific, technical, professional or administrative field critical to the Department's successful accomplishment of an important mission to the extent necessary to recruit or retain an individual exceptionally well-qualified for the critical position. Medical Center Directors and other Senior Executive Services (SES) VA health care senior managers would be eligible for CPPA.

Critical position pay requests must be submitted in writing only after it has been determined that the position in question cannot be filled with an exceptionally well-qualified individual through the use of other human resources flexibilities and pay authorities (e.g. recruitment, relocation and retention incentives, special salary rates, above minimum entrance rates).

The Secretary (or designee) must review and approve each critical position pay authority request before forwarding it to the Office of Personnel Management (OPM), who in consultation with the Office of Management and Budget (OMB) will issue final approval.

On September 22, 2016 OPM approved VA's request for CPPA for the Deputy Under Secretary for Health for Operations, 18 VISN Directors, 39 Level 1A Medical Center Directors, and 10 additional positions. 2 employees are in receipt of critical position pay and a plan is being developed for the additional positions.

Currently there is no special pay authority to compensate Medical Center Directors and other SES VA health care senior managers.

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Attached for reference is the signed/dated letter from OPM regarding critical pay.

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Organizational Areas of Focus

- Streamline Hiring/Onboarding Process
- Space: Leasing restrictions
- Facility Modernization: VHA aging Infrastructure
- Implement Full Practice Authority for Advance Practice Nurses: would increase VA ability to increase access
- Expand telehealth capability
- Implement scheduling system for medical appointments
- Examining intermediate and long term funding options for VA healthcare

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Our Commitment to Veterans

- ✓ Veterans should be at the center of what we do and how we deliver care at VHA
- ✓ No veteran with an urgent care need that may cause harm should wait for care
- ✓ VA must act like an integrated enterprise and a learning health system to benefit veterans most
- ✓ We will work closely with our academic, federal and community providers to deliver the highest outcomes to veterans
- ✓ VA leadership and staff must feel proud, fulfilled and empowered to deliver services to Veterans
- ✓ We must regain the trust and confidence of Veterans and the American public
- ✓ VA mission of research, education, and emergency preparedness must continue to contribute to improving the health of Veterans and all Americans

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A Future Vision for VHA

- **Public Private Partnerships** to serve Veterans
- **Digital Health Platform**
- **Whole Health Medicine** (empowering veteran well-being)
- Develop the **High Performance Network** (role of VISNs)
- **Center of Excellence** and Foundational Care
- **Value Based Management** and Efficiency Strategies
- Strengthen VA as a **Learning Healthcare System**
- Accelerate **Precision Medicine** and foster innovation
- Provide access to **VA Research Data** for non VA researchers with appropriate safeguards
- **Train More** primary care and behavioral health students

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Message

From: Shulkin, David J., MD [David.Shulkin@va.gov]
Sent: 11/25/2016 10:12:43 PM
To: 'Dr Shulkin' [drshulkin@aol.com]
Subject: FW: [EXTERNAL] Transition presentation
Attachments: VHAOrgBrief-PresidentialTransition(b) (6) _v2 (002) REVISED Access Team v7 compressed.pptx

-----Original Message-----
From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: Friday, November 25, 2016 05:09 PM Eastern Standard Time
To: David Shulkin; Shulkin, David J., MD
Subject: [EXTERNAL] Transition presentation

David, please see attached that the team worked on. There are some place holder slides that still need to be populated (#16 and 36).

- I am assuming that Jen will give you slide #16
- you will complete slide #36
- we are waiting for a revised slide from (b) (6) on Best Practices- slide #22 unless you think its fine.

All of your original content has been captured in this presentation.

Let me know if you want to catch up over the weekend to discuss- have to get ready for the evening now, (b) is getting impatient.

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Purpose and Agenda

- **Purpose:** To provide an overview of the Veterans Health Administration (VHA) and highlight major priorities and challenges
- **Overview:**
  - Organization, Budget and FTEs
  - Our Mission and Who We Serve
  - Assessment of VHA's Situation
    - Priorities
    - Performance
  - Accomplishments in FY 2016
  - Future Direction, Priorities and Opportunities for VHA

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Relevant Questions

- Is VHA making progress?
- What do Veterans think of VHA care?
- How does VHA compare to the private sector?
- What services should be provided in the community and what services within VHA?
- What are costs associated with moving more care out into the community?
- What is the impact of changes to ACA to VHA?
- Are there sustainable fixes to funding future VHA care?

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Organization, Budget and FTEs

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Organizational Leadership



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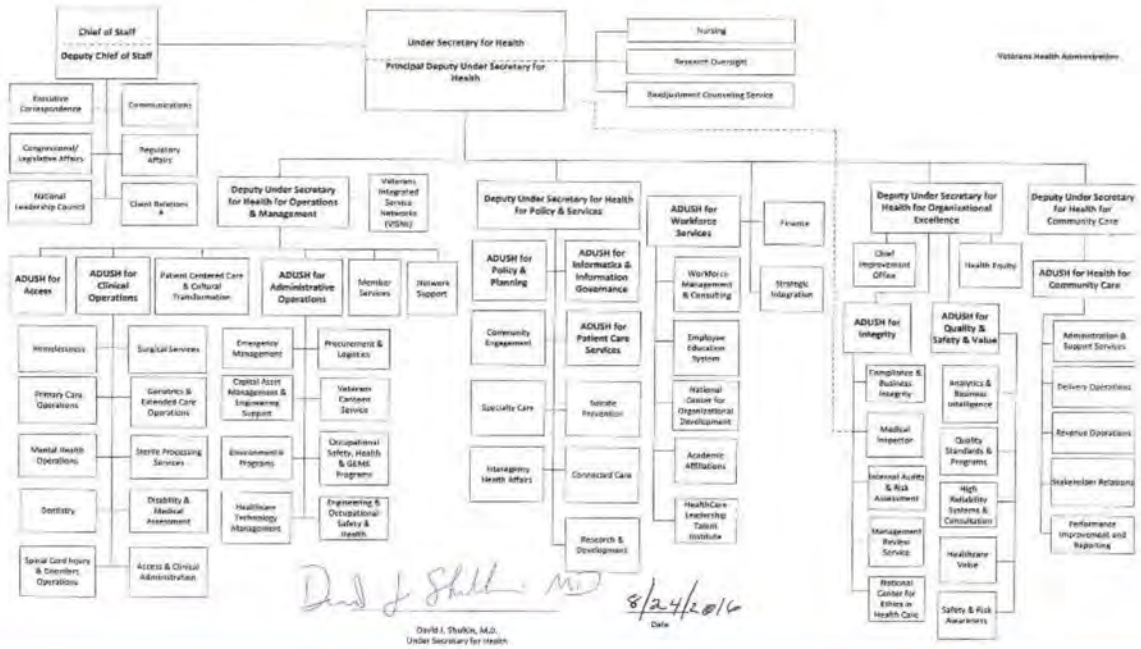
Organization Chart



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Budget and FTEs

FY 17 Enacted Budget	FY 18 Enacted Budget	Change (% Change)
$72,835,537	$70,012, 287	-2,823,250 (-3.9%)

Employees in VHA- 320,795 FTEs

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How We Are Different:
Our Mission and Who We Serve

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The Largest Healthcare System in the United States

- 1,234 health care facilities
  - 168 VA Medical Centers
  - 1,055 outpatient sites
- 25,000 physicians and
- 93,600 nurses (RN, LPN & NA)

- Over four times as many hospitals as Kaiser
- Over twice as many hospitals as DoD

Annual Workload Snapshot



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Annual Financial Report source file for graphic

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Who We Serve

- Veterans who rely most on the VA
  - Veterans with lower income
  - Veterans living in rural areas
  - Veterans without other access to health insurance coverage
  - Veterans with poorer self-reported health status
  - Veterans with higher rates of comorbidities
- The prevalence of many common conditions is projected to increase among Veterans over the next 10 years
- In the event of a potential future conflict, even moderate levels of deployment could substantially increase the size of the incoming cohort of VA patients

Findings from the independent assessment (section 201) Appendix A Demographics

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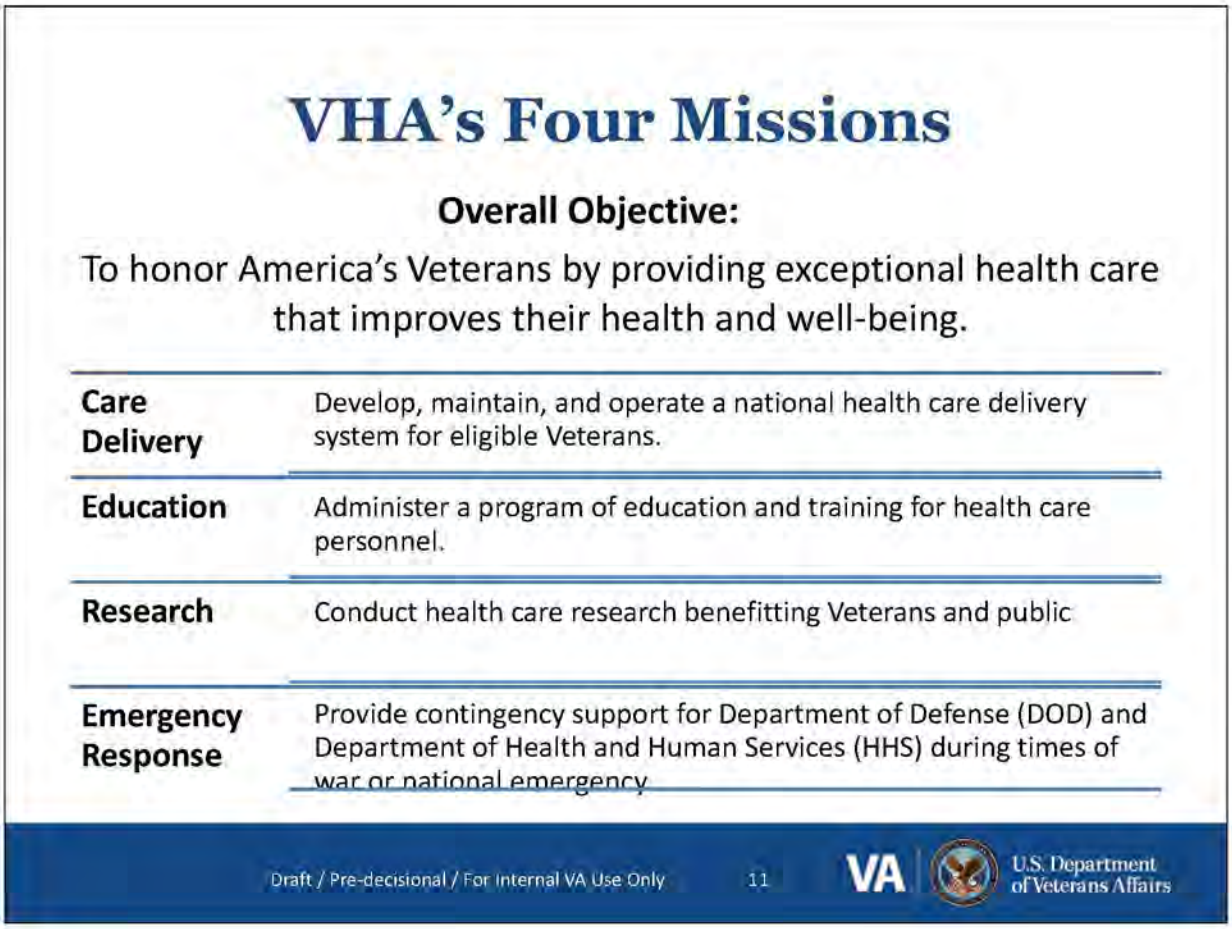

Our mission extends beyond healthcare for Veterans

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VA Healthcare Services Not Found in the Private Sector

- Caregivers
- Travel
- Dental
- Homeless Programs
- Long Term Care
- Readjustment Counseling
- Rural Health Outreach
- Special Populations- Spina Bifida, Camp Lejeune
- Comprehensive Emergency Medical Program
- Health Professions Educational Assistance
- Income Verification Match
- Hepatitis C Treatments
- Prosthetics
- Comprehensive Behavioral Health Programs
- Blind Rehabilitation
- Veterans Crisis Line
- Beneficiary Travel

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VA Healthcare Costs Not Found in the Private Sector

$Millions	FY 2015	FY 2016	FY 2017
Beneficiary Travel	$853	$888	$924
Camp Lejeune	$10	$24	$21
Caregivers	$454	$623	$725
CHAMPVA, Spina Bifida, FMP, CWVV	$1,547	$1,817	$1,920
Comprehensive Emergency Medical Program	$147	$135	$139
Dental Care	$1,005	$1,035	$1,433
Health Professions Educational Assistance programs	$37	$56	$70
Homeless Programs	$1,507	$1,477	$1,591
Income Verification Match	$17	$19	$19
Long Term Care	$7,702	$8,223	$8,588
Readjustment Counseling	$221	$258	$244
Rural Health Outreach Initiatives	$219	$270	$250
Sharing Agreements - Services Provided by VA	$157	$157	$166
Subtotal	$13,875	$14,980	$16,090
Hepatitis C (assume 50% greater benefit)	$406.1	$500.0	$500.0
Mental Health (assume 50% greater benefit)	$2,283.9	$2,494.9	$2,610.6
Prosthetics (assume 50% greater benefit)	$909.0	$950.3	$1,215.2
Subtotal	$3,599.0	$3,945.2	$4,325.9
Total	$17,473.9	$18,924.9	$20,415.8

Educational
Employment Services

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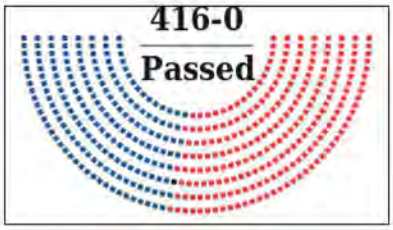
20 Years of Increasing Demand for Services

- 1996 "Veterans Eligibility Reform Act"
- Conflicts in Afghanistan and Iraq continued
  - Congress provided eligibility for care for five years after discharge
- From 2002 to 2015, VHA outpatient volume increased from 46.5M to almost 97M visits
- 2014 "The Veterans Access, Choice and Accountability Act"



IRAQ AND AFGHANISTAN VETERANS OF AMERICA

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- Enactment of Public Law 104-262, "Veterans Eligibility Reform Act" in 1996 allowed VA to provide full continuum of care for all Veterans who chose to enroll for care

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Myths vs. Reality

Myth	Reality
Veterans cared for by VHA have similar issues to most other Americans	Users of VHA are older and have more complex medical issues than non-users (almost 50% of users have a mental health diagnosis)
Care in VHA is poor quality	Numerous independent studies have shown that quality or equal or better
VHA does not want to utilize private sector health providers	22% of all care currently is done in the community- Close to 4 million Choice Act Authorizations has been utilized
Veteran Suicides are only a VHA problem	Of the 20 Veterans who take their own life a day- 14 do not get care in VHA
The private sector offers the same services as in VHA	More than 16 billion dollars in care a year goes towards services not provided by private sector
Access to services is worse than the private sector	96.5% of veterans were seen within 30 days of their clinical indicated or preferred date. Similar data is not readily available from the private sector
Veterans want to use private sector providers and not VA services	Of the 1 million veterans that used Choice, less than 5000 veterans did not also receive their care in VHA

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Impact of VHA Research



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VHA Priorities

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USH 5 Priorities for Strategic Action

Access

We will provide timely access to Veterans as determined by their clinical needs.

PSA: We pledge that any Veteran with the requirement for urgent care will receive care at the right time appropriate to his or her clinical needs

Employee Engagement

We seek a work environment where employees are valued, supported, and encouraged to do their best for Veterans.

PSA: We will work to allow staff to have greater input into their work environment.



High Performance Network

We will ensure that Veterans receive the highest level of coordinated care within VA or from participating providers.

PSA: We will build a high performance network of care to best serve Veterans.

Best Practices

We will use best clinical practices. We also seek best practices in research, education, and management.

PSA: We seek to identify and disseminate best practices throughout VA.

Veterans First: Trust in VA Care

We will be there for our Veterans when they need us.

PSA: We will share our results on the quality and timeliness of how we care for Veterans.

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Priority 1: Access
Transformative Changes



MyVA Access Declaration

Prong 1

Prong 2

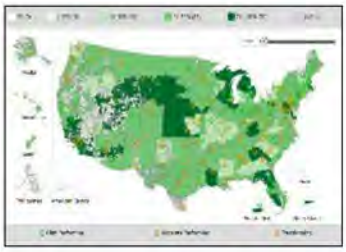
Access Improvement Solutions

National Deployment Strategy

Prong 3



Dr. David Shulkin signing the MyVA Declaration Statement on 4/7/2016



Transformative changes heading
Prong
Guidebook
Map

Same day Services for urgent needs
Path to SDA

Third slide is Results and impact that improve access

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Priority 1: Access

Same Day Access in Primary Care and Mental Health

By the end of this year, we may be the most accessible healthcare system in the United States

September
52 sites (31%)

October
85 Sites (51%)

November
123 Sites (74%)

December
166 Sites (100%)

Same Day Services:

If you need care right away during regular business hours, you are able to get services the same day, or if after hours, by the next day from a VA Medical Center or Health Care Center.

- Options for how that care might be provided include in person, via telephone, smart phone, through video care, secure messaging ,or other options.
- This care may be delivered by your provider or another appropriate clinical staff member based on availability and your care needs.
- *For a medical emergency always call 911 or report to the emergency room closest to where you are located.*

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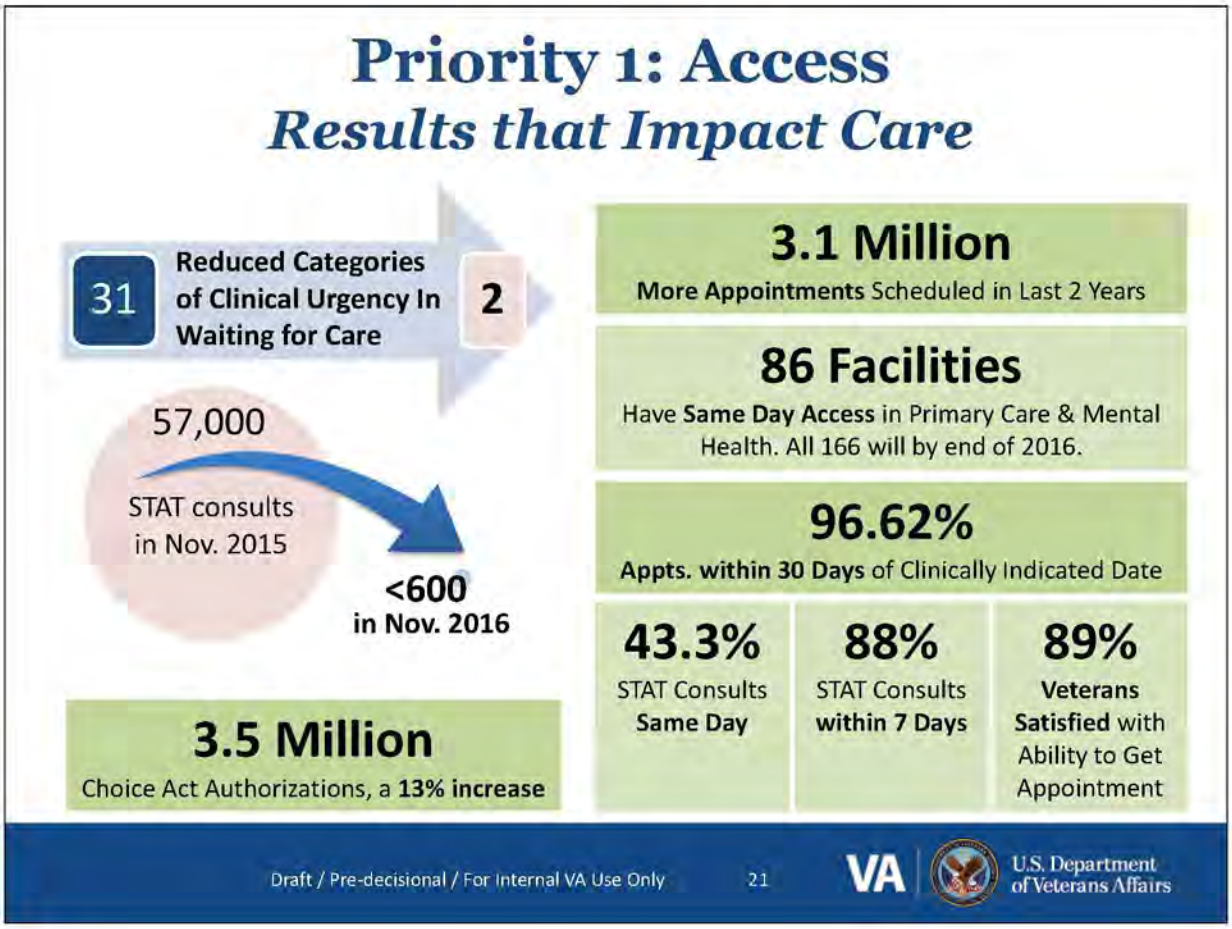

Second bullet is discussing STAT consults over 30 days

Categorized veterans waiting for care into clinical urgency (from 31 categories to 2)
57,000 stat consults in Nov 2015 to <600 in November 2016
3.1 Million more appointments scheduled in the last 2 years
86 facilities have Same Day Access in Primary Care and Mental Health. All 166 facilities will be able to offer these services by the end of 2016
89% of veterans satisfied with the ability to get an appointment (2.1 M veterans)
In October 2016, 96.62% of appointments were within 30 days of the clinically indicated or Veteran's preferred date
43.3% of stat consults were completed same day and 88% were seen within 7 days (a 22% increase from the start of the fiscal year)
Map of veterans evaluation of waiting times by site placed on internet on 11/11/16
Expanded scheduled hours on weekends and evenings, productivity, people, and space
More than 3.5 million authorizations through Choice from September 1, 2015 through August 31, 2016. This represents a 13% increase in authorizations when compared to the same period in 2014/2015

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Priority 2: Best Practices
& Performing as an Integrated Enterprise

- Successfully replicating **13 USH Gold Status best practices 386 times** throughout the system:
  - ➢**85** of those replications have been completed **within 9 months**
  - ➢**301** of those replication projects are **ongoing and on track**
  - ➢**Over 100 facilities** are replicating at least one of the best practices
- Examples would be using Pharmacists to manage medications and a Virtual Tumor Board



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Priority 3: High Performance Network

- As of the end of FY 2016, the Veterans Choice provider network has grown by **85%** and includes more than **350,000** network providers.
- Clinical workload is up **12%** over the past two years—**9%** within VA and **31%** in the community. The **12%** increase translates into roughly **7.5 million** additional hours of care for Veterans.
- New Choice Plan submitted to Congress in October 2015
- RFP planned to be released at end of month for revisions to Community Care program



Draft / Pre-decisional / For Internal VA Use Only 23 VA U.S. Department of Veterans Affairs

When Congress passed the Veterans Access, Choice and Accountability Act in 2014 (the Act), which established the Veterans Choice Program (VCP), the Act specified that the program may not furnish care or services after the expiration date of the program on August 7, 2017, or when the funding allocated ($10 billion) was exhausted.
Without further action by Congress before August 7, 2017, those Veterans that receive care through the current VCP (approximately one million unique Veterans have sought care through VCP since its implementation) will have to discontinue VCP care, and those Veterans newly authorized to receive VCP care will have to make alternative arrangements to receive care.
Other VA community care programs may not have the capacity to handle the entirety of patients who will come off of the current VCP. Wait times for appointments at VA facilities will likely rise if large numbers of Veterans return to VA to seek care.

Our goal for VA Community Care is to deliver a program that is easy to understand, simple to administer, and meets the needs of Veterans, community providers, and VA staff. How will we get there? Our approach consists of five components:
1. Eligibility: We want to provide easy to understand eligibility information to Veterans, community providers, and VA staff.
2. Referral and Authorizations: We want to streamline referral and authorizations, providing Veterans timely access to a community provider of their choice.
3. Care Coordination: We want to solidify care coordination through seamless health information exchanges.
4. Community Care Network: We plan to implement a Community Care Network that provides access to high-quality care inside and outside of VA.
5. Provider Payment (Claims): We want to become better partners to our community providers by paying them promptly and correctly.

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When Congress passed the Veterans Access, Choice and Accountability Act in 2014 (the Act), which established the Veterans Choice Program (VCP), the Act specified that the program may not furnish care or services after the expiration date of the program on August 7, 2017, or when the funding allocated ($10 billion) was exhausted.

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Other VA community care programs may not have the capacity to handle the entirety of patients who will come off of the current VCP. Wait times for appointments at VA facilities will likely rise if large numbers of Veterans return to VA to seek care.

Second bullet references a comparison of FY 14 to FY 15 and was originally completed by Finance in March 2016

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Priority 4: Employee Engagement

- VA Pulse - **94,339 unique users**
- Holding **Quarterly Town Hall Meetings** and site based employee open forums
- **AES scores improved** from 3.45 (2014) to 3.58 (2016)



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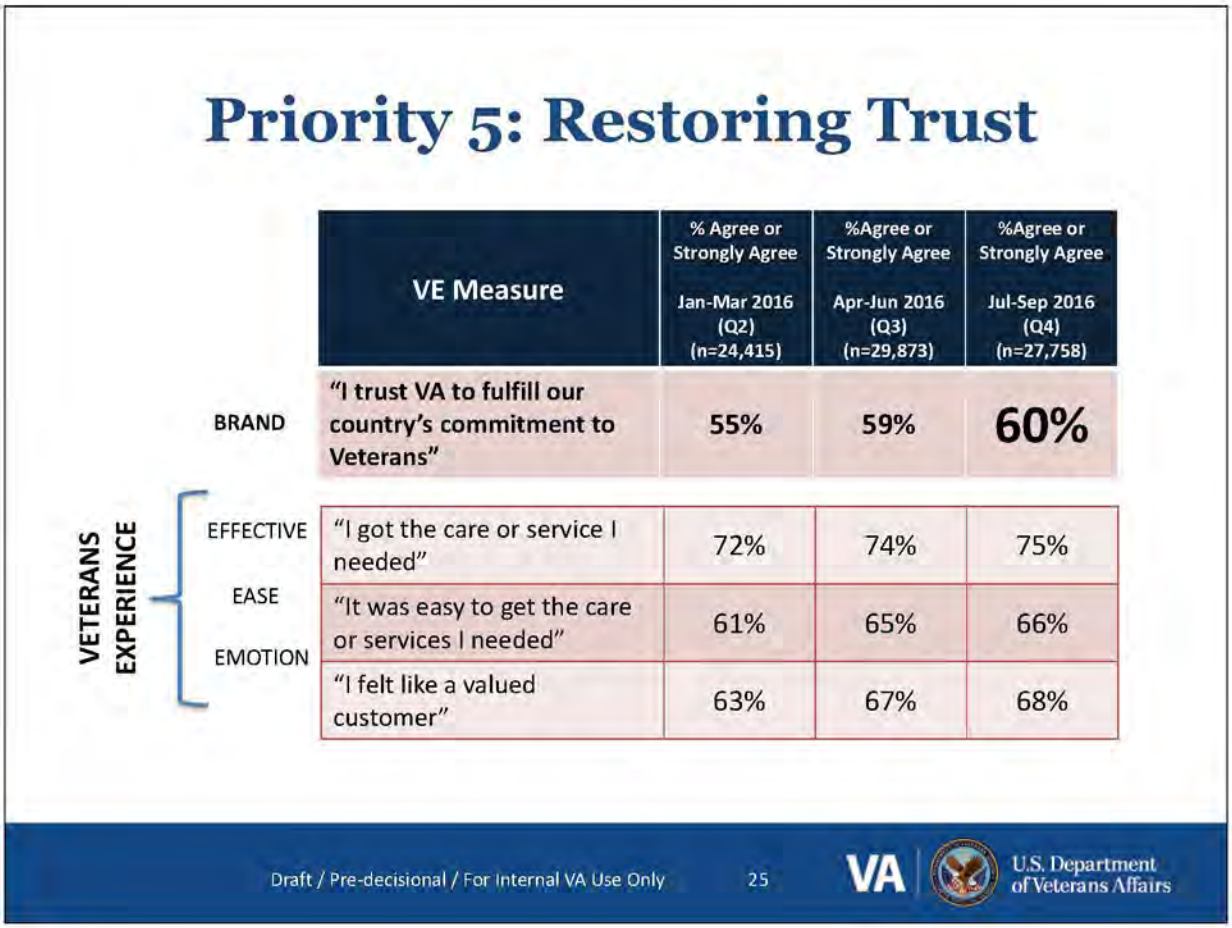

This survey was conducted by an independent contractor and validated by survey subject matter experts from Research Triangle International.

Acknowledgements to National Center for Organizational Development Dr Scott Moore and VHA Operational Excellence Dr Steven Wright.

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VHA Accomplishments in 2016

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Suicide Prevention

- **Elevated Office** of Suicide Prevention
- Completed and released a **landmark, comprehensive data analyses of Veteran suicide rates**, examining over 50 million Veteran records from 1979 to 2014 from every state in the nation, providing critical insights to help inform and shape our policies and efforts
- Reach Vet Program initiated to **proactively reach out** to those at highest risk
- **Added 163 responders** to the Veterans crisis line and added direct connections from the phone system to VCL
- Hugely successful Suicide Prevention Month 2016 campaign **#BeThere** garnered **over 73 million social media impressions** across various platforms, over 420 million impressions from TV, radio, and out of home placements (earned and paid), and was supported via Twitter by Joe Mantegna and Senators McCain and Sanders



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Innovative Healthcare

Telehealth

- In FY 2016, 12% of all Veterans enrolled for VA care received telehealth-based care. This includes **2.17 million telehealth visits, touching 702,000 Veterans**.
- Upcoming expanded services through VAR and VA Video Connect in 2017.

Million Veterans Program

- Program to incorporate **precision medicine** to improve Veterans' health by establishing large database containing genetic, military exposure, lifestyle, and health information with over **520,000 enrollees** as of Oct. 2016

Office of Compassionate Innovation

- Launched **Mental Health Service Dog** pilot to assist Veterans with mental health conditions that impede their mobility
- Since Center for Compassionate Innovation announced in April 2016, 38 proposals received; **8 proposals have moved to field implementation or warm hand-off** and **3 have been closed**

New

VA / Watson Cancer Partnership for Precision Oncology

Connect Care

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Complex Care Needs

Homelessness

- There was a **17 percent decline in Veteran homelessness** between 2015 and 2016, quadruple the previous year's annual rate of decline
- Since 2010**, over 480,000 Veterans and their family members have been permanently housed**, rapidly rehoused, or prevented from falling into homelessness by HUD's targeted housing vouchers and VA's homelessness programs

We've cut Veteran homelessness nationwide by 47% since 2010

Providing Counseling Services where Veterans are Comfortable

- More than **1 million primary care/mental health integration visits**
- More than **1.5 million visits** to Vet Centers providing readjustment, Military Sexual Trauma and bereavement counseling services



Hep C Management Notes

VA follows CDC recommendations to screen everyone born between 1945-1965 as they are at the highest risk of having HCV. Screening is also recommended for those born outside of this cohort who have other risk factors.

Source: VA's National Center for Health Promotion and Disease Prevention (NCP) HCV Screening recommendations: http://vaww.prevention.va.gov/CPS/Screening_for_Hepatitis_C.asp

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Public Health Issues

Hepatitis C Management

- In FY15 & 16, **VA treated a total of 69,294 Veterans with Hepatitis C** with an anticipated cure rate of over 90%.
- In CY2015, **69.9%** of the birth cohort (Veterans born between 1945-1965) were **screened for Hepatitis C**.



Reducing Opioid Abuse and Dependency

- 22% reduction in opioid use
- 42% reduction in use of opioids and benzodiazepines
- 32% reduction in dosages



Prevention Programs

- 42,000 Veteran Flu Shots at Walgreens
- MOVE! has helped over 600,000 patients lose weight, keep it off, and improve their health

Walgreens

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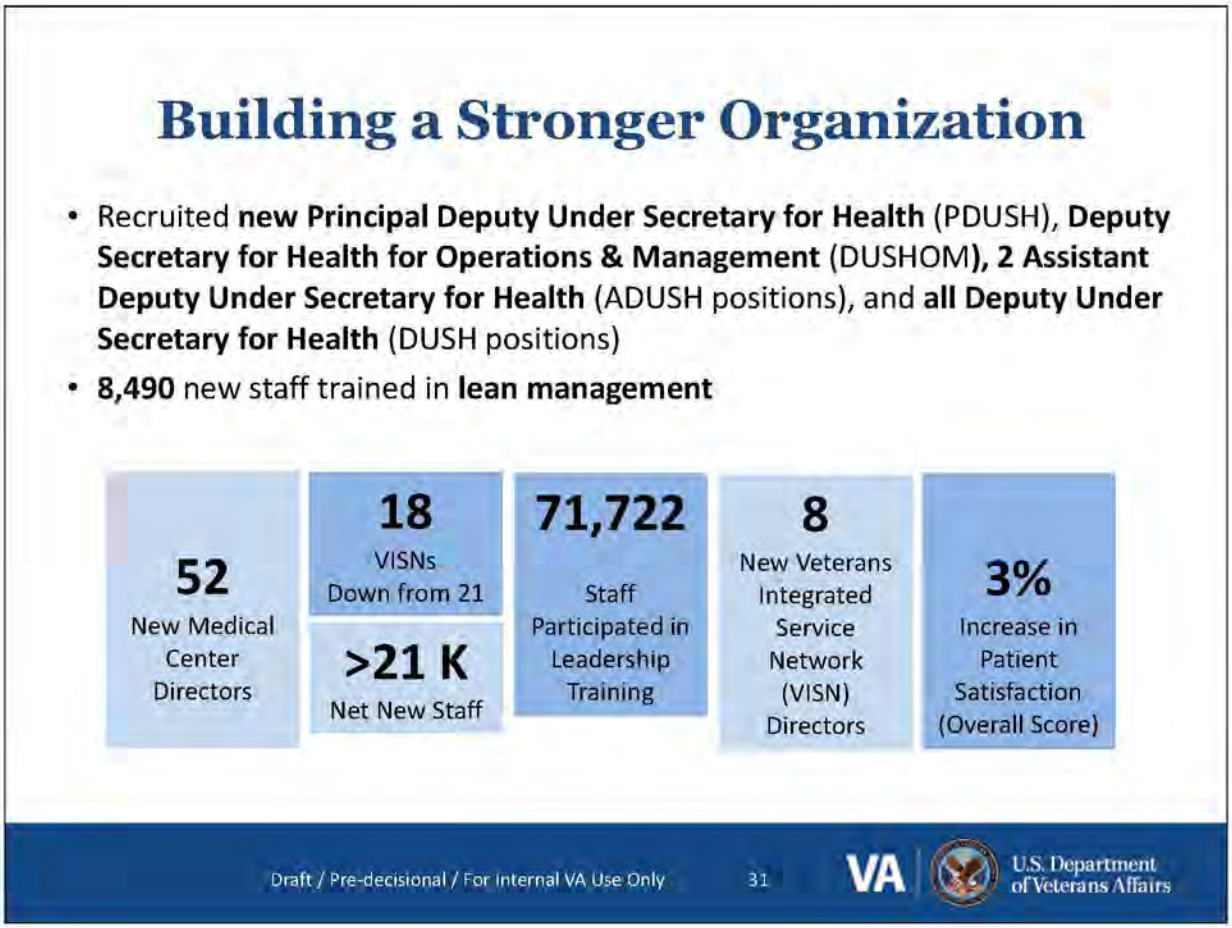

5th bullet notes:

Precision Oncology is the targeting of cancer therapy to the molecular profile of the cancer. This is not new – for many years we have been tailoring cancer therapy for some cancers. An easy example is assessing breast cancer for the presence of estrogen receptors, then using medications that block the effect of estrogen, thus blunting the effect of hormones which drive breast cancer growth. However, in the last 10 years the ability to sequence many genes simultaneously has led to an understanding of the specific mutations that drive cancer growth in many tumor types. This has gone in parallel with the development of medications that target and inhibit the effect of these specific driver mutations. Use of these targeted therapies has resulted in dramatic responses in some cases that previously had very poor outcomes. Unfortunately, only a small minority of cancers have identifiable mutations and targeted therapy available. The VA is currently expanding a program of sequencing a large number of genes in solid cancers, with several aims: to identify mutations in cancers for which there is available targeted therapy and treat these Veterans with the best available therapy; to identify mutations in cancers that might make them susceptible to an approved drug as an off label use; and to identify Veterans with molecular profiles in their cancer that would allow them to consider enrolling in clinical trials. To address the analysis of the molecular data, the VHA has a partnership with IBM Watson Health. This partnership will enhance our ability to both ensure Veterans receive the best available care now, and that clinical and basic research will improve care in the future.

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Serving our Veterans and the Nation

Culture of Improvement

- 6th year – **VA's pharmacy benefits ranked among best in class**
- **24 million in cost avoidance** through our supply chain efforts
- An Integrated operations center to **proactively monitor and identify** issues in quality or access
- **23,000 pounds of used medications** returned and **destroyed** this year

Service to the Nation

- **9,860 research publications** in 2016
- Added **547.4 graduate medical education positions**
- Responded and deployed to **6 national emergencies**



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VHA's Performance

- Comprehensive **Quality Measures** are in place
- VA generally performs **better than private sector**
- **82%** of medical centers showed **quantitative improvement** in quality last year
- Risk adjusted **mortality improved 20%** in 2016
- **Patient Satisfaction** scores show **improvement** across the board

1st bullet:
Regarding Strategic Analytics for Improvement and Learning (SAIL) Model

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82% of VAMCs with Improvement
SAIL Quality Measures in Past Year

	FY16Q3 SAIL Quality Star Percentile Cut-Off					
Overall Quality FY15Q4-FY16Q3[1]	Top10% 5-Star	11-30th% 4-Star	31-70th% 3-Star	71-90th% 2-Star	Bottom10% 1-Star	Total
Large Improvement	8	18	35	20	9	90
Small Improvement	3	7	13	5	2	30
Trivial Improvement	1	3	3	3	1	11
Trivial Decline	3	1	0	0	1	5
Small Decline	1	1	2	0	1	5
Meaningful Decline	1	1	2	0	1	5
Total	17[2]	31[2]	55	28[3]	15[3]	146[4]

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Most Challenged Sites Making Improvements

Site	Indicator	FY14	FY16 (YTD)
Phoenix	CAPHS - Routine Care	66	74
	CAPHS - Urgent Care	51	56
Hines	CAPHS - Routine Care	83	88
	CAPHS - Urgent Care	74	78
Shreveport	CAPHS - Routine Care	79	82
	CAPHS - Urgent Care	65	70
Spokane	CAPHS - Routine Care	81	82
	CAPHS - Urgent Care	64	68
Greater LA	CAPHS - Routine Care	82	83

Note: a 4 to 5 point change is considered "clinically significant"

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Comparative Data

	VHA	Private Sector
Quality		
Satisfaction		
Access		
Employee Engagement		
HEDIS		

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Studies showing better outcomes
JAMA

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Comparing VA Care to Private Sector

- 30-day risk-standardized **mortality rates are lower** in VA than those of non-VA hospitals for acute myocardial infarction and heart failure
- **MRSA infections declined** 69 percent in VA acute care facilities and 81 percent in spinal cord injury units over 5 years thanks to VA's aggressive MRSA prevention plan.
- VA performed the **same or significantly better** than non-VA providers on 12 of 14 **effectiveness measures in the inpatient setting**
- VA performed **significantly better** on 16 **outpatient HEDIS measures** compared with commercial HMOs and significantly better on 15 outpatient HEDIS measures compared with Medicare HMOs
- VA mental health care was **better than private-sector care by at least 30 percent on all seven performance measures**, with VA patients with depression more than twice as likely as private-sector patients to get effective long-term treatment
- **Outcomes for VA patients compared favorably** to patients with non-VA health insurance, with VA patients more likely to receive recommended evidence-based treatment

More data in press release: http://www.va.gov/opa/pressrel/includes/viewPDF.cfm?id=2778

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Future Direction, Priorities and Opportunities

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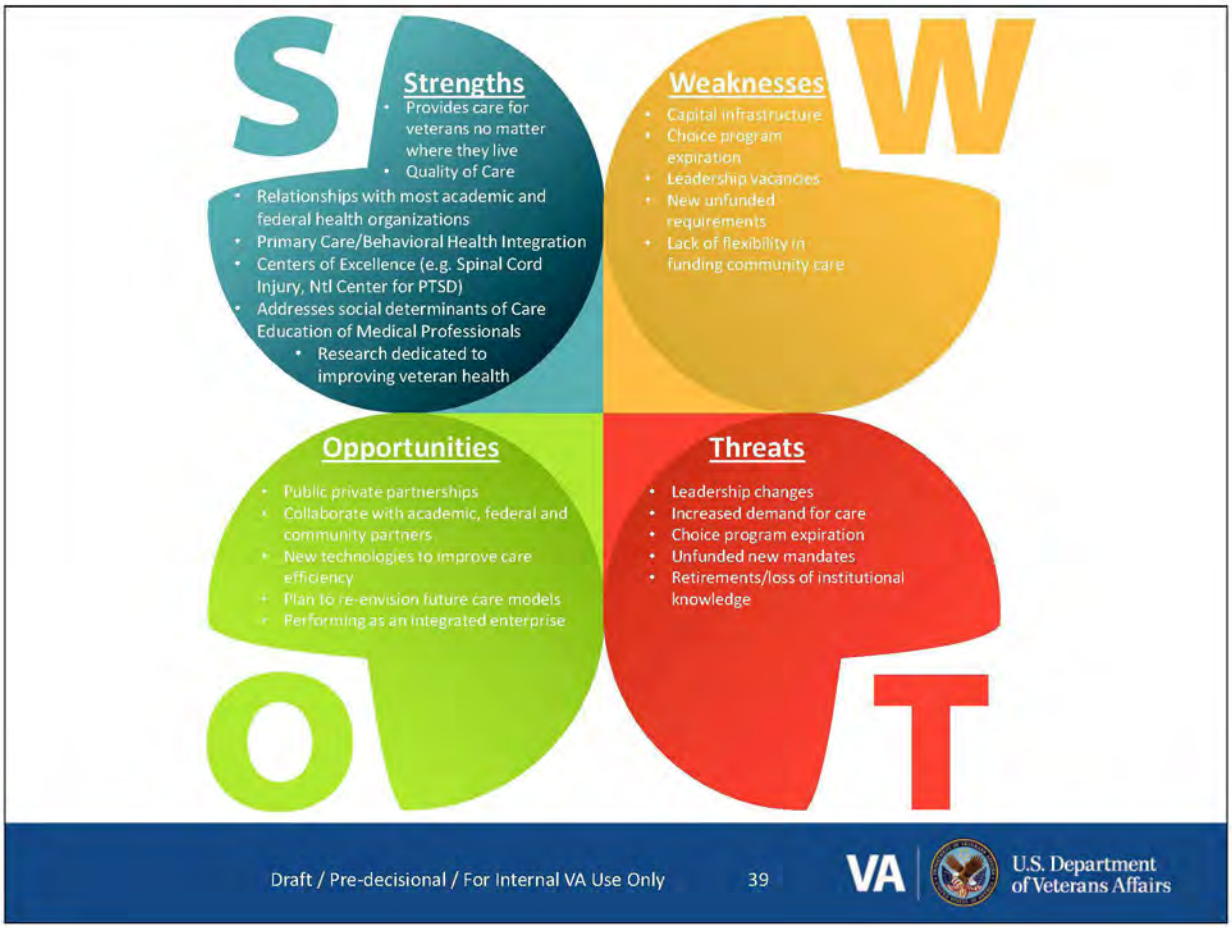

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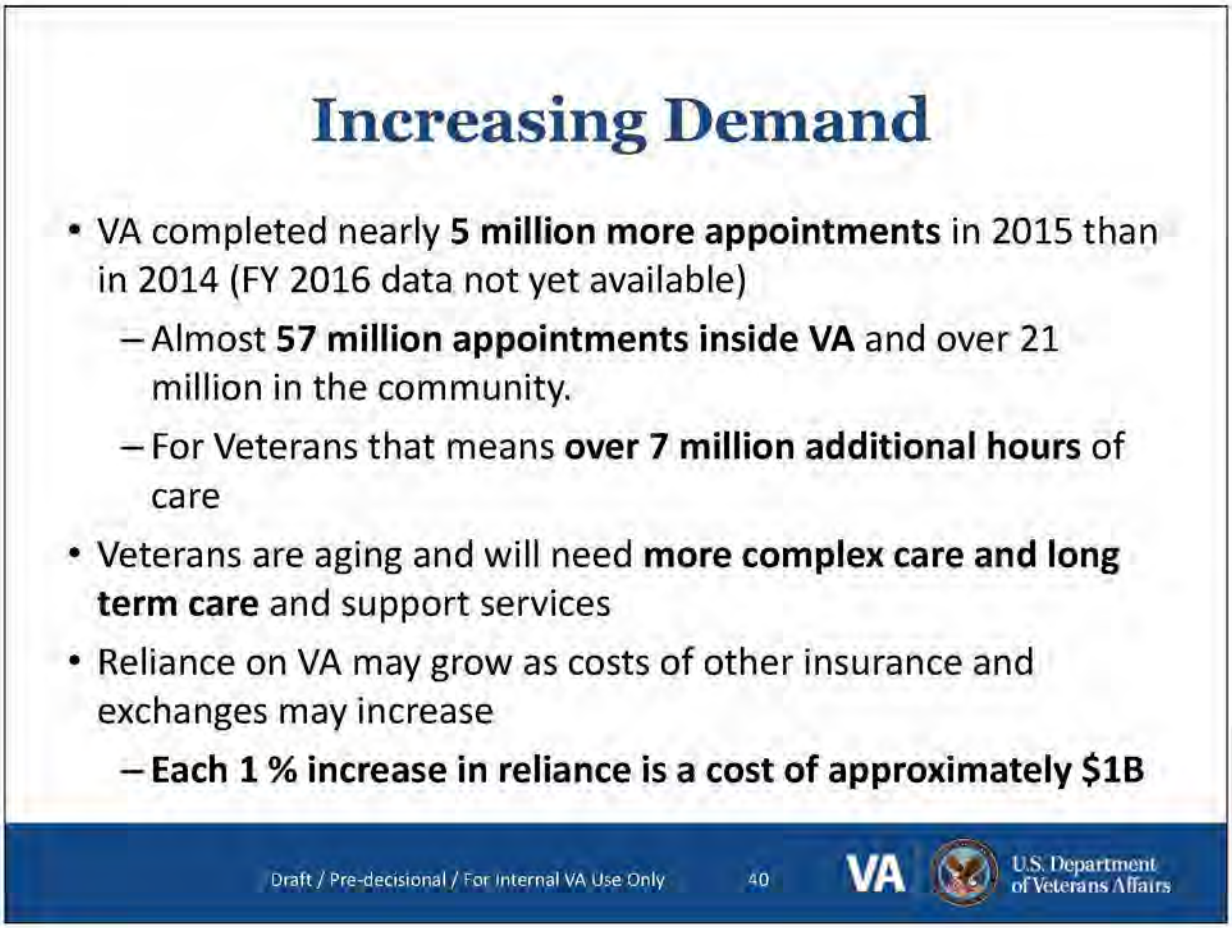

3rd bullet notes:
In 2014, enrollee reliance was estimated to be approximately 34%. We are currently updating reliance analysis with more recent Medicare data, but it is not available at this time. Reliance reflects the portion of health care services that an enrollee needs that we expect VA to provide or pay for. Some enrollees will get all of their health care from the VA and some will get none of their care, but most receive some portion of their care in the VA. For example, based on his/her morbidity, if an enrollee needs 10 office visits in a year and gets 4 of those office visits in VA. This enrollee is said to be 40 percent reliant on VA for office visits.

(b) (6) mentioned wanting to get graphs for this slide and the next from Mark Yow. As such, I haven't edited.

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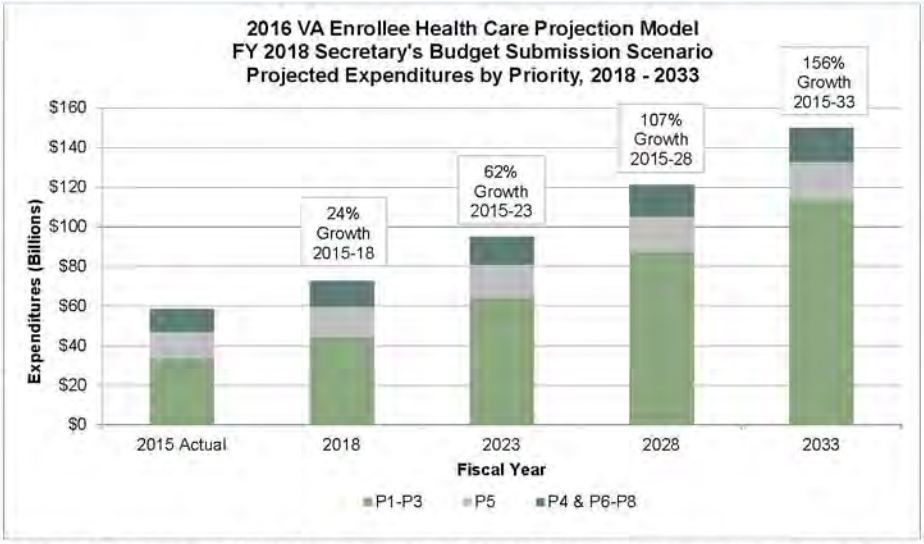
VA's Resource Requirements
Projected to Grow Significantly Over Time



2016 VA EHCPM, Budget Scenario (BAF) Note: The projections do not include requirements for several activities/ programs that are not projected by the VA EHCPM, including non-recurring maintenance, readjustment counseling, state-based long term services and supports programs, and some components of the CHAMPVA program.

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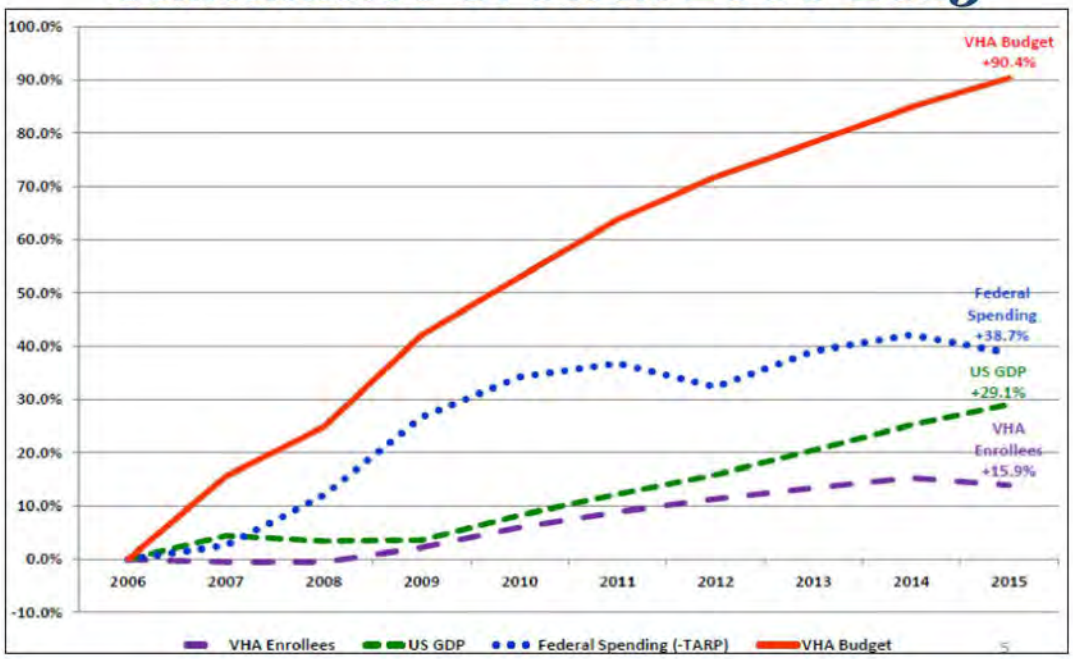
VA Medical Care Budget Challenge:
Cumulative Growth 2006-2015



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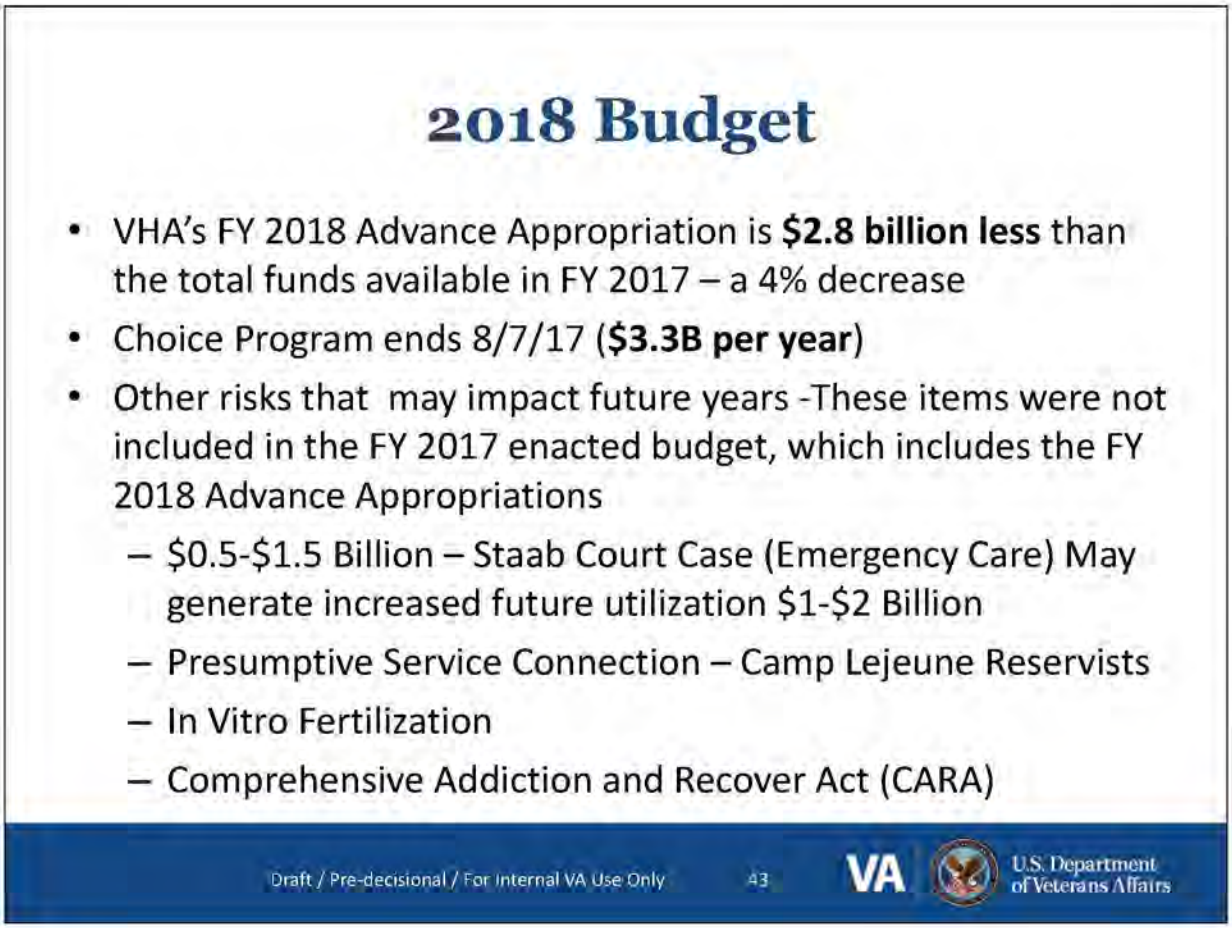

Bullet 3: Estimated budget numbers:
IVF6.5 Million FY 17, 13. million Fy18 --Maximum estimate Non VA Care funds
Adoption: 500K FY 17, 1.5 million FY 18—Maximum estimate
CARA = $153 million – crude estimate, some of which has already been incurred

Camp Lejeune.

Based on evidence there is sufficient scientific and medical evidence available to establish a presumption of connection between exposure to contaminants in the water supply at Camp Lejeune and the occurrence of eight health conditions

The proposed eight presumptive diseases are:
adult leukemia
aplastic anemia and other myelodysplastic syndromes
bladder cancer
kidney cancer
liver cancer
multiple myeloma
non-Hodgkin's lymphoma
Parkinson's disease

VA will not limit entitlement to active duty military personnel. Rather, VA proposes to presume exposure for all active duty, reserve and National Guard personnel who served at Camp Lejeune for no less than 30 cumulative days from August 1,

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1953, through December 31, 1987.

In addition, VA proposes to establish a presumption that individuals who served at Camp Lejeune during this period and later developed one of the presumptive diseases were disabled during the relevant period of service, thus establishing active military service for benefit purposes.

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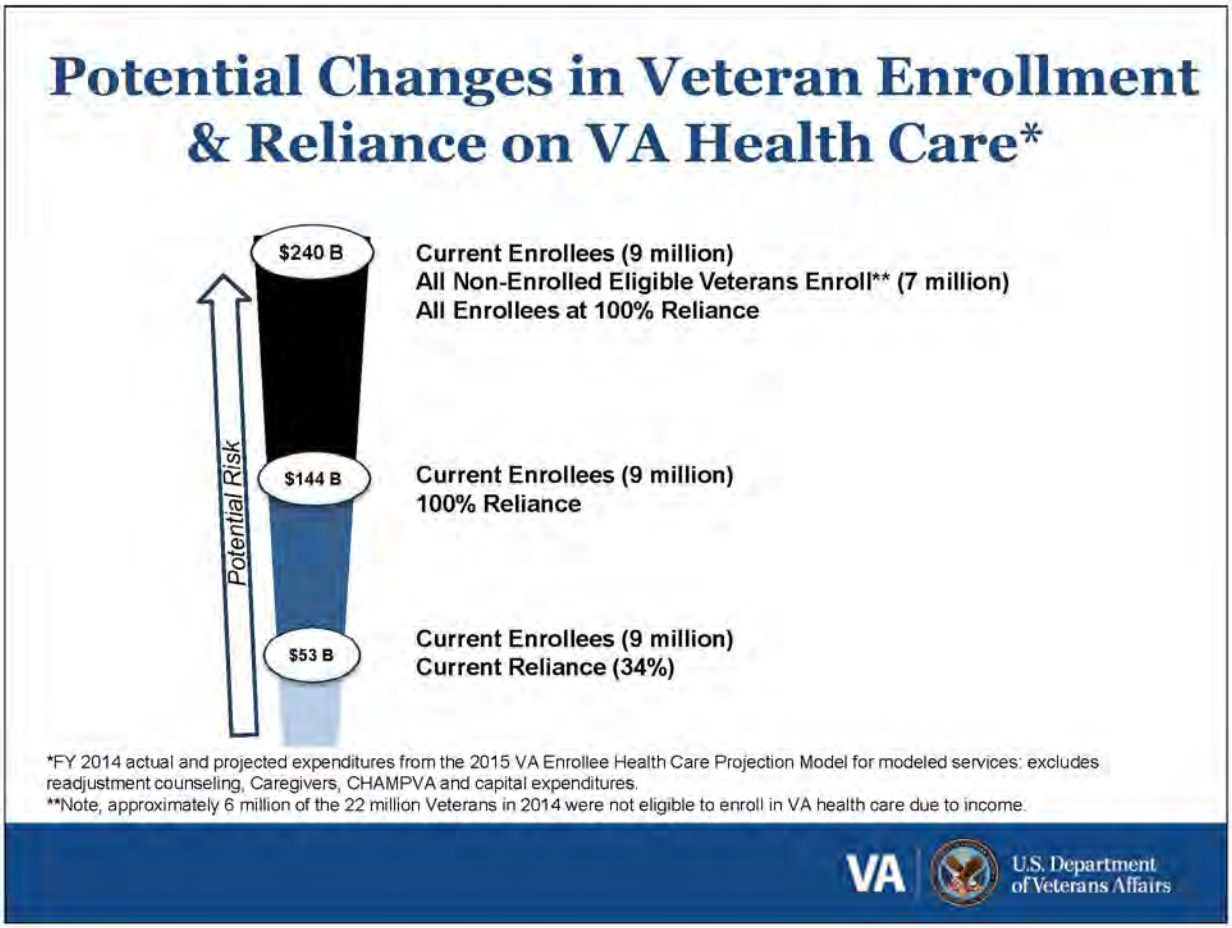

In 2014, costs for modeled services for 9 million enrollees at 34% reliance was $53 billion.

If all those 9 million enrollees used VA for all their health care, the cost in 2014 would have been $144 billion.

If all eligible but unenrolled veterans enrolled in VA and used VA for all their health care, the cost in 2014 would have been $240 billion.

All policy changes move this lever up and down as they impact either reliance on VA for health care, enrollment in VA, or both.

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Continuity of Leadership during a Crisis
Leadership vacancies and succession planning
Maintaining and Strengthening the Gains in Access (including Community Care), Quality, Engagement, and Trust
Direction of the Commission on Care Recommendations
Supporting VHA's Course for a Future Vision

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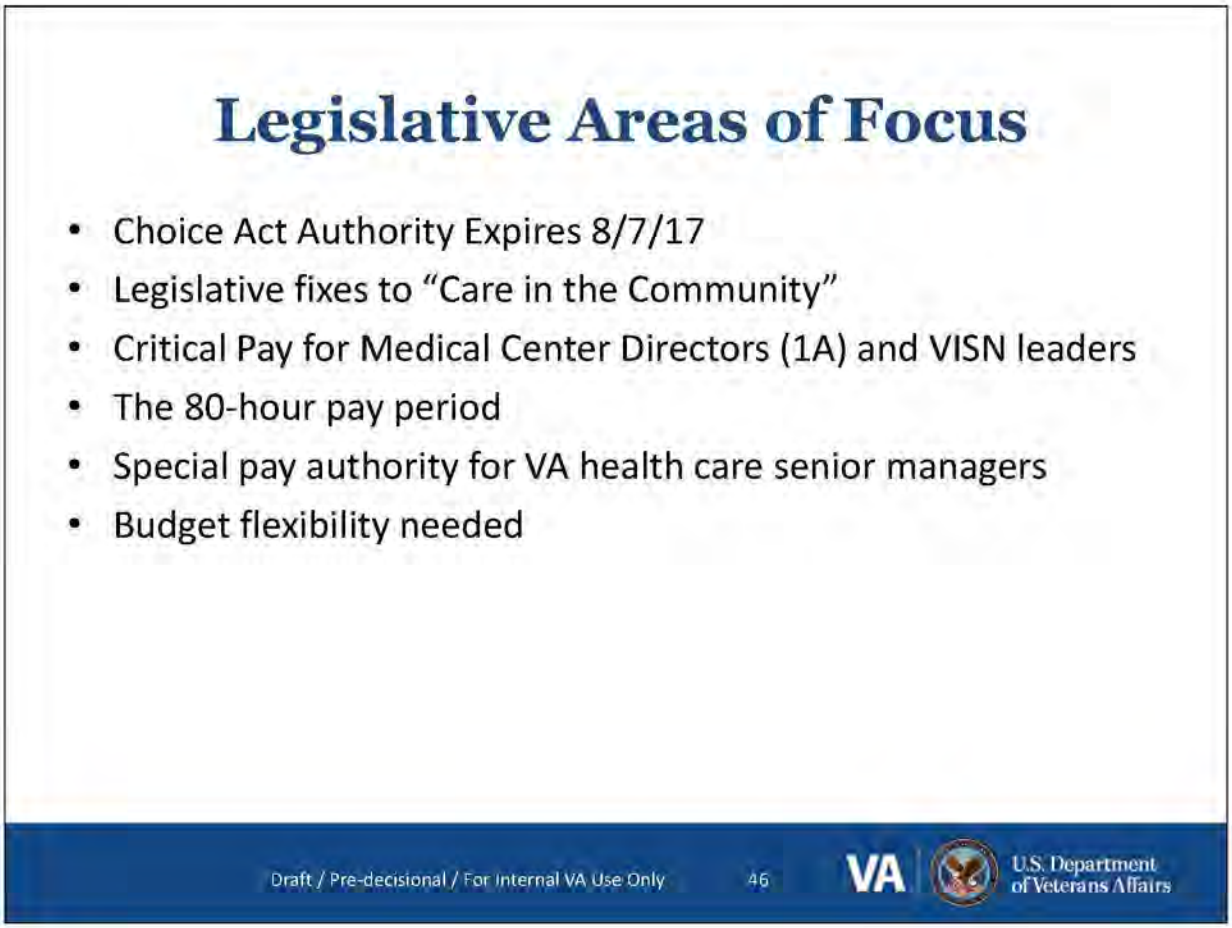

3RD BULLET:
The critical position pay authority (CPPA) allows the Secretary (or designee) to approve higher rates of pay for employees in positions that require expertise of an extremely high level in a scientific, technical, professional or administrative field critical to the Department's successful accomplishment of an important mission to the extent necessary to recruit or retain an individual exceptionally well-qualified for the critical position. Medical Center Directors and other Senior Executive Services (SES) VA health care senior managers would be eligible for CPPA.

Critical position pay requests must be submitted in writing only after it has been determined that the position in question cannot be filled with an exceptionally well-qualified individual through the use of other human resources flexibilities and pay authorities (e.g. recruitment, relocation and retention incentives, special salary rates, above minimum entrance rates).

The Secretary (or designee) must review and approve each critical position pay authority request before forwarding it to the Office of Personnel Management (OPM), who in consultation with the Office of Management and Budget (OMB) will issue final approval.

On September 22, 2016 OPM approved VA's request for CPPA for the Deputy Under Secretary for Health for Operations, 18 VISN Directors, 39 Level 1A Medical Center Directors, and 10 additional positions. 2 employees are in receipt of critical position pay and a plan is being developed for the additional positions.

Currently there is no special pay authority to compensate Medical Center Directors and other SES VA health care senior managers.

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Attached for reference is the signed/dated letter from OPM regarding critical pay.

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Organizational Areas of Focus

- Streamline Hiring/Onboarding Process
- Space: Leasing restrictions
- Facility Modernization: VHA aging Infrastructure
- Implement Full Practice Authority for Advance Practice Nurses: would increase VA ability to increase access
- Expand telehealth capability
- Implement scheduling system for medical appointments
- Examining intermediate and long term funding options for VA healthcare

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Our Commitment to Veterans

- ✓ Veterans should be at the center of what we do and how we deliver care at VHA
- ✓ No veteran with an urgent care need that may cause harm should wait for care
- ✓ VA must act like an integrated enterprise and a learning health system to benefit veterans most
- ✓ We will work closely with our academic, federal and community providers to deliver the highest outcomes to veterans
- ✓ VA leadership and staff must feel proud, fulfilled and empowered to deliver services to Veterans
- ✓ We must regain the trust and confidence of Veterans and the American public
- ✓ VA mission of research, education, and emergency preparedness must continue to contribute to improving the health of Veterans and all Americans

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A Future Vision for VHA

- **Public Private Partnerships** to serve Veterans
- **Digital Health Platform**
- **Whole Health Medicine** (empowering veteran well-being)
- Develop the **High Performance Network** (role of VISNs)
- **Center of Excellence** and Foundational Care
- **Value Based Management** and Efficiency Strategies
- Strengthen VA as a **Learning Healthcare System**
- Accelerate **Precision Medicine** and foster innovation
- Provide access to **VA Research Data** for non VA researchers with appropriate safeguards
- **Train More** primary care and behavioral health students

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Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 11/25/2016 10:08:55 PM
To: David Shulkin [drshulkin@aol.com]; Shulkin, David J. , MD [david.shulkin@va.gov]
Subject: Transition presentation
Attachments: VHAOrgBrief-PresidentialTransition(b) (6) _v2 (002) REVISED Access Team v7 compressed.pptx

David, please see attached that the team worked on. There are some place holder slides that still need to be populated (#16 and 36).

- I am assuming that Jen will give you slide #16
- you will complete slide #36
- we are waiting for a revised slide from (b) (6) on Best Practices- slide #22 unless you think its fine.

All of your original content has been captured in this presentation.

Let me know if you want to catch up over the weekend to discuss- have to get ready for the evening now, (b) is getting impatient.

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U.S. Department of Veterans Affairs Presidential Transition Briefing

Veterans Health Administration

Prepared for:
Agency Review Team

Briefed by:
David J. Shulkin, MD
Under Secretary of Health, Veterans Health Administration

November 2016

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Purpose and Agenda

- **Purpose:** To provide an overview of the Veterans Health Administration (VHA) and highlight major priorities and challenges
- **Overview:**
  - Organization, Budget and FTEs
  - Our Mission and Who We Serve
  - Assessment of VHA's Situation
    - Priorities
    - Performance
  - Accomplishments in FY 2016
  - Future Direction, Priorities and Opportunities for VHA

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Relevant Questions

- Is VHA making progress?
- What do Veterans think of VHA care?
- How does VHA compare to the private sector?
- What services should be provided in the community and what services within VHA?
- What are costs associated with moving more care out into the community?
- What is the impact of changes to ACA to VHA?
- Are there sustainable fixes to funding future VHA care?

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Organization, Budget and FTEs

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Organizational Leadership



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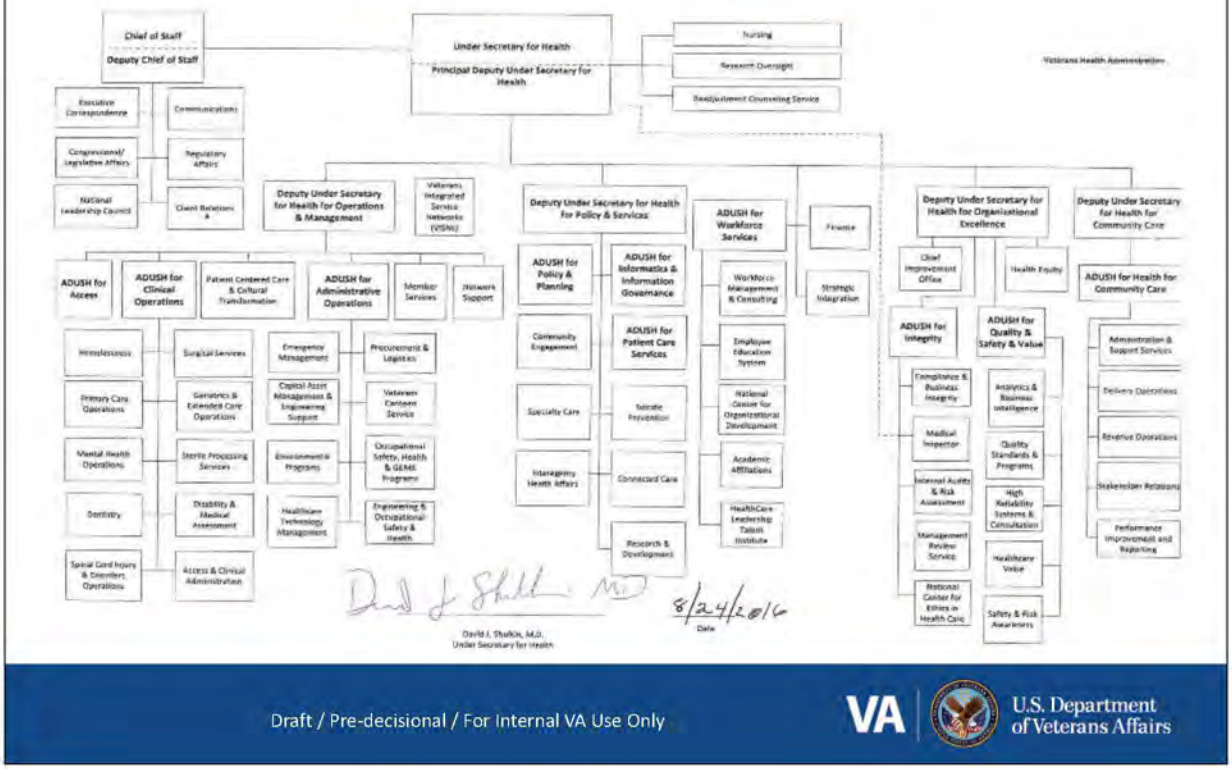
Organization Chart



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Budget and FTEs

FY 17 Enacted Budget	FY 18 Enacted Budget	Change (% Change)
$72,835,537	$70,012, 287	-2,823,250 (-3.9%)

Employees in VHA- 320,795 FTEs

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How We Are Different:
Our Mission and Who We Serve

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The Largest Healthcare System in the United States

- 1,234 health care facilities
  - 168 VA Medical Centers
  - 1,055 outpatient sites
- 25,000 physicians and
- 93,600 nurses (RN, LPN & NA)

- Over four times as many hospitals as Kaiser
- Over twice as many hospitals as DoD

Annual Workload Snapshot



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Annual Financial Report source file for graphic

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Who We Serve

- Veterans who rely most on the VA
  - Veterans with lower income
  - Veterans living in rural areas
  - Veterans without other access to health insurance coverage
  - Veterans with poorer self-reported health status
  - Veterans with higher rates of comorbidities
- The prevalence of many common conditions is projected to increase among Veterans over the next 10 years
- In the event of a potential future conflict, even moderate levels of deployment could substantially increase the size of the incoming cohort of VA patients

Findings from the independent assessment (section 201) Appendix A Demographics

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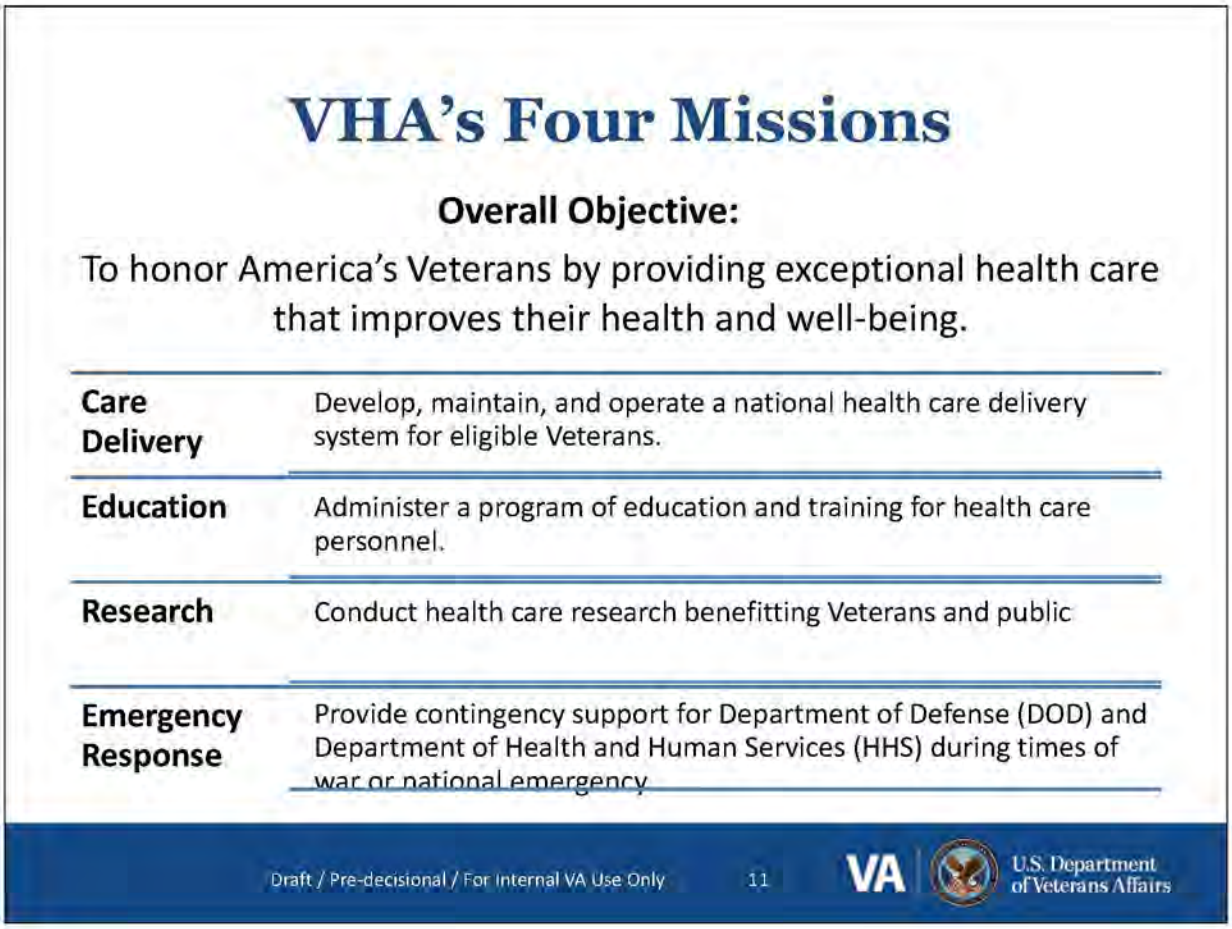

Our mission extends beyond healthcare for Veterans

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VA Healthcare Services Not Found in the Private Sector

- Caregivers
- Travel
- Dental
- Homeless Programs
- Long Term Care
- Readjustment Counseling
- Rural Health Outreach
- Special Populations- Spina Bifida, Camp Lejeune
- Comprehensive Emergency Medical Program
- Health Professions Educational Assistance
- Income Verification Match
- Hepatitis C Treatments
- Prosthetics
- Comprehensive Behavioral Health Programs
- Blind Rehabilitation
- Veterans Crisis Line
- Beneficiary Travel

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VA Healthcare Costs Not Found in the Private Sector

$Millions	FY 2015	FY 2016	FY 2017
Beneficiary Travel	$853	$888	$924
Camp Lejeune	$10	$24	$21
Caregivers	$454	$623	$725
CHAMPVA, Spina Bifida, FMP, CWVV	$1,547	$1,817	$1,920
Comprehensive Emergency Medical Program	$147	$135	$139
Dental Care	$1,005	$1,035	$1,433
Health Professions Educational Assistance programs	$37	$56	$70
Homeless Programs	$1,507	$1,477	$1,591
Income Verification Match	$17	$19	$19
Long Term Care	$7,702	$8,223	$8,588
Readjustment Counseling	$221	$258	$244
Rural Health Outreach Initiatives	$219	$270	$250
Sharing Agreements - Services Provided by VA	$157	$157	$166
Subtotal	$13,875	$14,980	$16,090
Hepatitis C (assume 50% greater benefit)	$406.1	$500.0	$500.0
Mental Health (assume 50% greater benefit)	$2,283.9	$2,494.9	$2,610.6
Prosthetics (assume 50% greater benefit)	$909.0	$950.3	$1,215.2
Subtotal	$3,599.0	$3,945.2	$4,325.9
Total	$17,473.9	$18,924.9	$20,415.8

Educational
Employment Services

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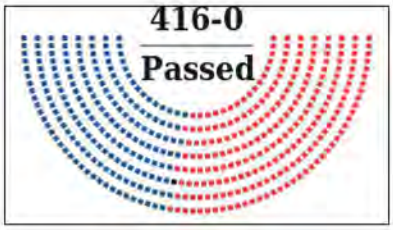
20 Years of Increasing Demand for Services

- 1996 "Veterans Eligibility Reform Act"
- Conflicts in Afghanistan and Iraq continued
  - Congress provided eligibility for care for five years after discharge
- From 2002 to 2015, VHA outpatient volume increased from 46.5M to almost 97M visits
- 2014 "The Veterans Access, Choice and Accountability Act"



IRAQ AND AFGHANISTAN VETERANS OF AMERICA

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- Enactment of Public Law 104-262, "Veterans Eligibility Reform Act" in 1996 allowed VA to provide full continuum of care for all Veterans who chose to enroll for care

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Myths vs. Reality

Myth	Reality
Veterans cared for by VHA have similar issues to most other Americans	Users of VHA are older and have more complex medical issues than non-users (almost 50% of users have a mental health diagnosis)
Care in VHA is poor quality	Numerous independent studies have shown that quality or equal or better
VHA does not want to utilize private sector health providers	22% of all care currently is done in the community- Close to 4 million Choice Act Authorizations has been utilized
Veteran Suicides are only a VHA problem	Of the 20 Veterans who take their own life a day- 14 do not get care in VHA
The private sector offers the same services as in VHA	More than 16 billion dollars in care a year goes towards services not provided by private sector
Access to services is worse than the private sector	96.5% of veterans were seen within 30 days of their clinical indicated or preferred date. Similar data is not readily available from the private sector
Veterans want to use private sector providers and not VA services	Of the 1 million veterans that used Choice, less than 5000 veterans did not also receive their care in VHA

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Impact of VHA Research

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VHA Priorities

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USH 5 Priorities for Strategic Action

Access

We will provide timely access to Veterans as determined by their clinical needs.

PSA: We pledge that any Veteran with the requirement for urgent care will receive care at the right time appropriate to his or her clinical needs

Employee Engagement

We seek a work environment where employees are valued, supported, and encouraged to do their best for Veterans.

PSA: We will work to allow staff to have greater input into their work environment.



High Performance Network

We will ensure that Veterans receive the highest level of coordinated care within VA or from participating providers.

PSA: We will build a high performance network of care to best serve Veterans.

Best Practices

We will use best clinical practices. We also seek best practices in research, education, and management.

PSA: We seek to identify and disseminate best practices throughout VA.

Veterans First: Trust in VA Care

We will be there for our Veterans when they need us.

PSA: We will share our results on the quality and timeliness of how we care for Veterans.

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Priority 1: Access
Transformative Changes



MyVA Access Declaration

Prong 1

Prong 2

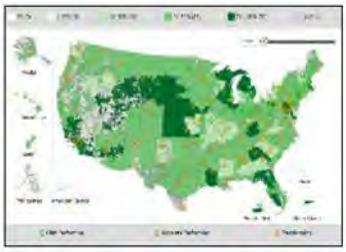
Access Improvement Solutions

National Deployment Strategy

Prong 3



Dr. David Shulkin signing the MyVA Declaration Statement on 4/7/2016



Transformative changes heading
Prong
Guidebook
Map

Same day Services for urgent needs
Path to SDA

Third slide is Results and impact that improve access

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Priority 1: Access

Same Day Access in Primary Care and Mental Health

By the end of this year, we may be the most accessible healthcare system in the United States

September
52 sites (31%)

October
85 Sites (51%)

November
123 Sites (74%)

December
166 Sites (100%)

Same Day Services:

If you need care right away during regular business hours, you are able to get services the same day, or if after hours, by the next day from a VA Medical Center or Health Care Center.

- Options for how that care might be provided include in person, via telephone, smart phone, through video care, secure messaging ,or other options.
- This care may be delivered by your provider or another appropriate clinical staff member based on availability and your care needs.
- *For a medical emergency always call 911 or report to the emergency room closest to where you are located.*

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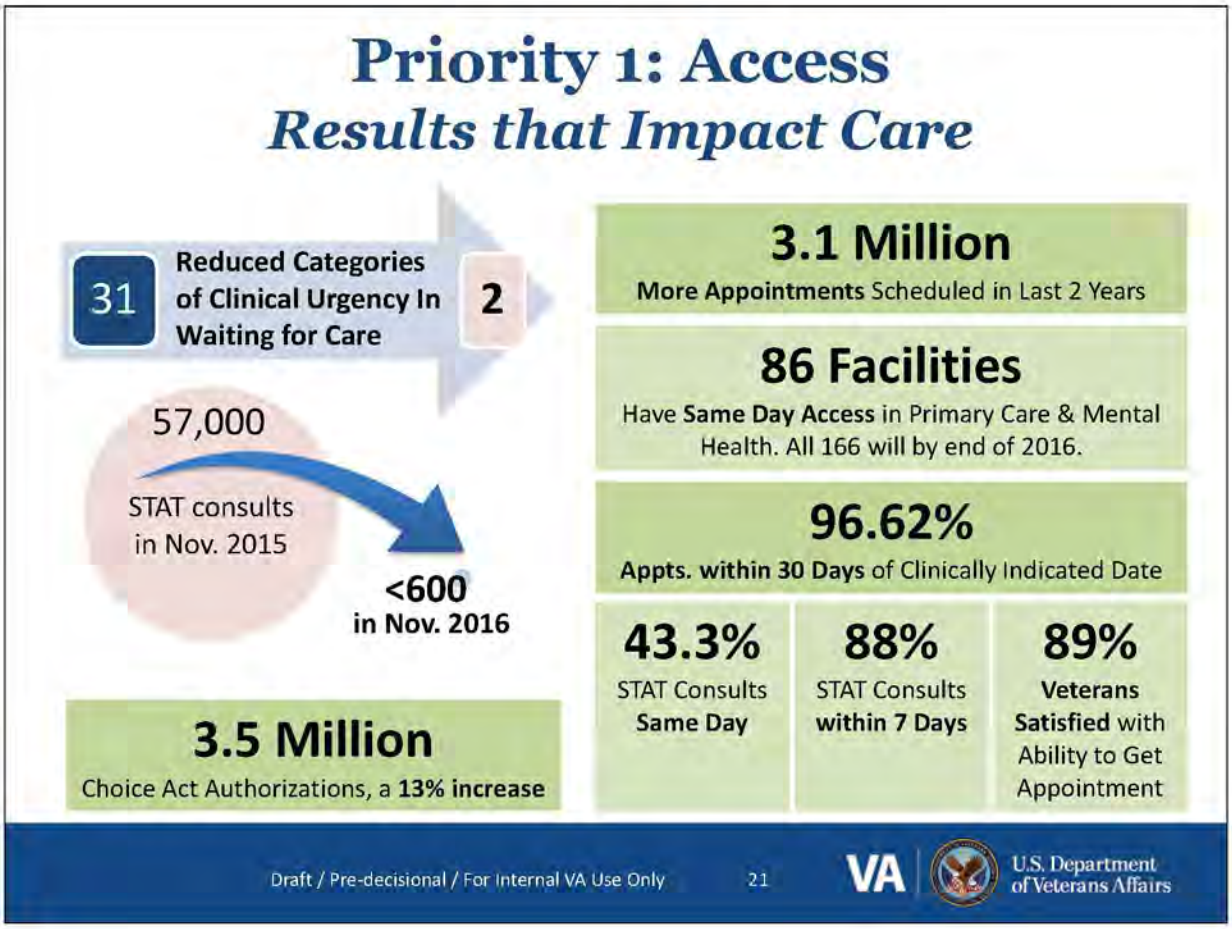

Second bullet is discussing STAT consults over 30 days

Categorized veterans waiting for care into clinical urgency (from 31 categories to 2)
57,000 stat consults in Nov 2015 to <600 in November 2016
3.1 Million more appointments scheduled in the last 2 years
86 facilities have Same Day Access in Primary Care and Mental Health. All 166 facilities will be able to offer these services by the end of 2016
89% of veterans satisfied with the ability to get an appointment (2.1 M veterans)
In October 2016, 96.62% of appointments were within 30 days of the clinically indicated or Veteran's preferred date
43.3% of stat consults were completed same day and 88% were seen within 7 days (a 22% increase from the start of the fiscal year)
Map of veterans evaluation of waiting times by site placed on internet on 11/11/16
Expanded scheduled hours on weekends and evenings, productivity, people, and space
More than 3.5 million authorizations through Choice from September 1, 2015 through August 31, 2016. This represents a 13% increase in authorizations when compared to the same period in 2014/2015

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Priority 2: Best Practices
& Performing as an Integrated Enterprise

- Successfully replicating **13 USH Gold Status best practices 386 times** throughout the system:
  - ➢**85** of those replications have been completed **within 9 months**
  - ➢**301** of those replication projects are **ongoing and on track**
  - ➢**Over 100 facilities** are replicating at least one of the best practices
- Examples would be using Pharmacists to manage medications and a Virtual Tumor Board



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Priority 3: High Performance Network

- As of the end of FY 2016, the Veterans Choice provider network has grown by **85%** and includes more than **350,000** network providers.
- Clinical workload is up **12%** over the past two years—**9%** within VA and **31%** in the community. The **12%** increase translates into roughly **7.5 million** additional hours of care for Veterans.
- New Choice Plan submitted to Congress in October 2015
- RFP planned to be released at end of month for revisions to Community Care program



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When Congress passed the Veterans Access, Choice and Accountability Act in 2014 (the Act), which established the Veterans Choice Program (VCP), the Act specified that the program may not furnish care or services after the expiration date of the program on August 7, 2017, or when the funding allocated ($10 billion) was exhausted.
Without further action by Congress before August 7, 2017, those Veterans that receive care through the current VCP (approximately one million unique Veterans have sought care through VCP since its implementation) will have to discontinue VCP care, and those Veterans newly authorized to receive VCP care will have to make alternative arrangements to receive care.
Other VA community care programs may not have the capacity to handle the entirety of patients who will come off of the current VCP. Wait times for appointments at VA facilities will likely rise if large numbers of Veterans return to VA to seek care.

Our goal for VA Community Care is to deliver a program that is easy to understand, simple to administer, and meets the needs of Veterans, community providers, and VA staff. How will we get there? Our approach consists of five components:
1. Eligibility: We want to provide easy to understand eligibility information to Veterans, community providers, and VA staff.
2. Referral and Authorizations: We want to streamline referral and authorizations, providing Veterans timely access to a community provider of their choice.
3. Care Coordination: We want to solidify care coordination through seamless health information exchanges.
4. Community Care Network: We plan to implement a Community Care Network that provides access to high-quality care inside and outside of VA.
5. Provider Payment (Claims): We want to become better partners to our community providers by paying them promptly and correctly.

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When Congress passed the Veterans Access, Choice and Accountability Act in 2014 (the Act), which established the Veterans Choice Program (VCP), the Act specified that the program may not furnish care or services after the expiration date of the program on August 7, 2017, or when the funding allocated ($10 billion) was exhausted.

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Other VA community care programs may not have the capacity to handle the entirety of patients who will come off of the current VCP. Wait times for appointments at VA facilities will likely rise if large numbers of Veterans return to VA to seek care.

Second bullet references a comparison of FY 14 to FY 15 and was originally completed by Finance in March 2016

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Priority 4: Employee Engagement

- VA Pulse - **94,339 unique users**
- Holding **Quarterly Town Hall Meetings** and site based employee open forums
- **AES scores improved** from 3.45 (2014) to 3.58 (2016)



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Priority 5: Restoring Trust

	VE Measure	% Agree or Strongly Agree Jan-Mar 2016 (Q2) (n=24,415)	%Agree or Strongly Agree Apr-Jun 2016 (Q3) (n=29,873)	%Agree or Strongly Agree Jul-Sep 2016 (Q4) (n=27,758)
BRAND	**"I trust VA to fulfill our country's commitment to Veterans"**	**55%**	**59%**	**60%**
VETERANS EXPERIENCE – EFFECTIVE	"I got the care or service I needed"	72%	74%	75%
VETERANS EXPERIENCE – EASE	"It was easy to get the care or services I needed"	61%	65%	66%
VETERANS EXPERIENCE – EMOTION	"I felt like a valued customer"	63%	67%	68%

This survey was conducted by an independent contractor and validated by survey subject matter experts from Research Triangle International.

Acknowledgements to National Center for Organizational Development Dr Scott Moore and VHA Operational Excellence Dr Steven Wright.

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VHA Accomplishments in 2016

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Suicide Prevention

- **Elevated Office** of Suicide Prevention
- Completed and released a **landmark, comprehensive data analyses of Veteran suicide rates**, examining over 50 million Veteran records from 1979 to 2014 from every state in the nation, providing critical insights to help inform and shape our policies and efforts
- Reach Vet Program initiated to **proactively reach out** to those at highest risk
- **Added 163 responders** to the Veterans crisis line and added direct connections from the phone system to VCL
- Hugely successful Suicide Prevention Month 2016 campaign **#BeThere** garnered **over 73 million social media impressions** across various platforms, over 420 million impressions from TV, radio, and out of home placements (earned and paid), and was supported via Twitter by Joe Mantegna and Senators McCain and Sanders



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Innovative Healthcare

Telehealth

- In FY 2016, 12% of all Veterans enrolled for VA care received telehealth-based care. This includes **2.17 million telehealth visits, touching 702,000 Veterans**.
- Upcoming expanded services through VAR and VA Video Connect in 2017.

Million Veterans Program

- Program to incorporate **precision medicine** to improve Veterans' health by establishing large database containing genetic, military exposure, lifestyle, and health information with over **520,000 enrollees** as of Oct. 2016

Office of Compassionate Innovation

- Launched **Mental Health Service Dog** pilot to assist Veterans with mental health conditions that impede their mobility
- Since Center for Compassionate Innovation announced in April 2016, 38 proposals received; **8 proposals have moved to field implementation or warm hand-off** and **3 have been closed**

New

VA / Watson Cancer Partnership for Precision Oncology

Connect Care

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Complex Care Needs

Homelessness

- There was a **17 percent decline in Veteran homelessness** between 2015 and 2016, quadruple the previous year's annual rate of decline
- Since 2010**, over 480,000 Veterans and their family members have been permanently housed**, rapidly rehoused, or prevented from falling into homelessness by HUD's targeted housing vouchers and VA's homelessness programs

We've cut Veteran homelessness nationwide by 47% since 2010

Providing Counseling Services where Veterans are Comfortable

- More than **1 million primary care/mental health integration visits**
- More than **1.5 million visits** to Vet Centers providing readjustment, Military Sexual Trauma and bereavement counseling services



Hep C Management Notes

VA follows CDC recommendations to screen everyone born between 1945-1965 as they are at the highest risk of having HCV. Screening is also recommended for those born outside of this cohort who have other risk factors.

Source: VA's National Center for Health Promotion and Disease Prevention (NCP) HCV Screening recommendations: http://vaww.prevention.va.gov/CPS/Screening_for_Hepatitis_C.asp

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Public Health Issues

Hepatitis C Management

- In FY15 & 16, **VA treated a total of 69,294 Veterans with Hepatitis C** with an anticipated cure rate of over 90%.
- In CY2015, **69.9%** of the birth cohort (Veterans born between 1945-1965) were **screened for Hepatitis C**.



Reducing Opioid Abuse and Dependency

- 22% reduction in opioid use
- 42% reduction in use of opioids and benzodiazepines
- 32% reduction in dosages



Prevention Programs

- 42,000 Veteran Flu Shots at Walgreens
- MOVE! has helped over 600,000 patients lose weight, keep it off, and improve their health

Walgreens

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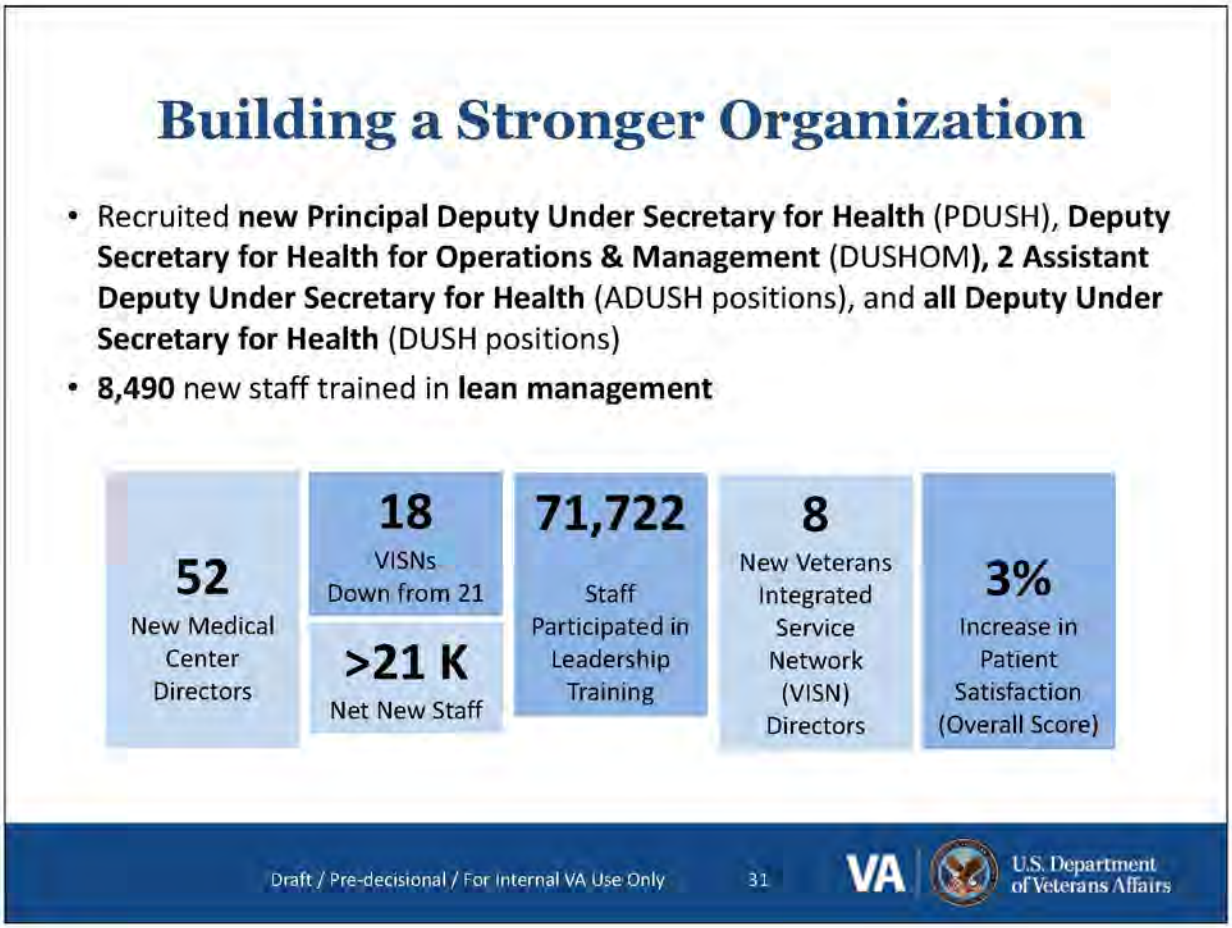

5th bullet notes:

Precision Oncology is the targeting of cancer therapy to the molecular profile of the cancer. This is not new – for many years we have been tailoring cancer therapy for some cancers. An easy example is assessing breast cancer for the presence of estrogen receptors, then using medications that block the effect of estrogen, thus blunting the effect of hormones which drive breast cancer growth. However, in the last 10 years the ability to sequence many genes simultaneously has led to an understanding of the specific mutations that drive cancer growth in many tumor types. This has gone in parallel with the development of medications that target and inhibit the effect of these specific driver mutations. Use of these targeted therapies has resulted in dramatic responses in some cases that previously had very poor outcomes. Unfortunately, only a small minority of cancers have identifiable mutations and targeted therapy available. The VA is currently expanding a program of sequencing a large number of genes in solid cancers, with several aims: to identify mutations in cancers for which there is available targeted therapy and treat these Veterans with the best available therapy; to identify mutations in cancers that might make them susceptible to an approved drug as an off label use; and to identify Veterans with molecular profiles in their cancer that would allow them to consider enrolling in clinical trials. To address the analysis of the molecular data, the VHA has a partnership with IBM Watson Health. This partnership will enhance our ability to both ensure Veterans receive the best available care now, and that clinical and basic research will improve care in the future.

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Serving our Veterans and the Nation

Culture of Improvement

- 6th year – **VA's pharmacy benefits ranked among best in class**
- **24 million in cost avoidance** through our supply chain efforts
- An Integrated operations center to **proactively monitor and identify** issues in quality or access
- **23,000 pounds of used medications** returned and **destroyed** this year

Service to the Nation

- **9,860 research publications** in 2016
- Added **547.4 graduate medical education positions**
- Responded and deployed to **6 national emergencies**



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VHA's Performance

- Comprehensive **Quality Measures** are in place
- VA generally performs **better than private sector**
- **82%** of medical centers showed **quantitative improvement** in quality last year
- Risk adjusted **mortality improved 20%** in 2016
- **Patient Satisfaction** scores show **improvement** across the board

1st bullet:
Regarding Strategic Analytics for Improvement and Learning (SAIL) Model

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82% of VAMCs with Improvement
SAIL Quality Measures in Past Year

	FY16Q3 SAIL Quality Star Percentile Cut-Off					
Overall Quality FY15Q4-FY16Q3[1]	Top10% 5-Star	11-30th% 4-Star	31-70th% 3-Star	71-90th% 2-Star	Bottom10% 1-Star	Total
Large Improvement	8	18	35	20	9	90
Small Improvement	3	7	13	5	2	30
Trivial Improvement	1	3	3	3	1	11
Trivial Decline	3	1	0	0	1	5
Small Decline	1	1	2	0	1	5
Meaningful Decline	1	1	2	0	1	5
Total	17[2]	31[2]	55	28[3]	15[3]	146[4]

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Most Challenged Sites Making Improvements

Site	Indicator	FY14	FY16 (YTD)
Phoenix	CAPHS - Routine Care	66	74
	CAPHS - Urgent Care	51	56
Hines	CAPHS - Routine Care	83	88
	CAPHS - Urgent Care	74	78
Shreveport	CAPHS - Routine Care	79	82
	CAPHS - Urgent Care	65	70
Spokane	CAPHS - Routine Care	81	82
	CAPHS - Urgent Care	64	68
Greater LA	CAPHS - Routine Care	82	83

Note: a 4 to 5 point change is considered "clinically significant"

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Comparative Data

	VHA	Private Sector
Quality		
Satisfaction		
Access		
Employee Engagement		
HEDIS		

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Studies showing better outcomes
JAMA

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Comparing VA Care to Private Sector

- 30-day risk-standardized **mortality rates are lower** in VA than those of non-VA hospitals for acute myocardial infarction and heart failure
- **MRSA infections declined** 69 percent in VA acute care facilities and 81 percent in spinal cord injury units over 5 years thanks to VA's aggressive MRSA prevention plan.
- VA performed the **same or significantly better** than non-VA providers on 12 of 14 **effectiveness measures in the inpatient setting**
- VA performed **significantly better** on 16 **outpatient HEDIS measures** compared with commercial HMOs and significantly better on 15 outpatient HEDIS measures compared with Medicare HMOs
- VA mental health care was **better than private-sector care by at least 30 percent on all seven performance measures**, with VA patients with depression more than twice as likely as private-sector patients to get effective long-term treatment
- **Outcomes for VA patients compared favorably** to patients with non-VA health insurance, with VA patients more likely to receive recommended evidence-based treatment

More data in press release: http://www.va.gov/opa/pressrel/includes/viewPDF.cfm?id=2778

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Future Direction, Priorities and Opportunities

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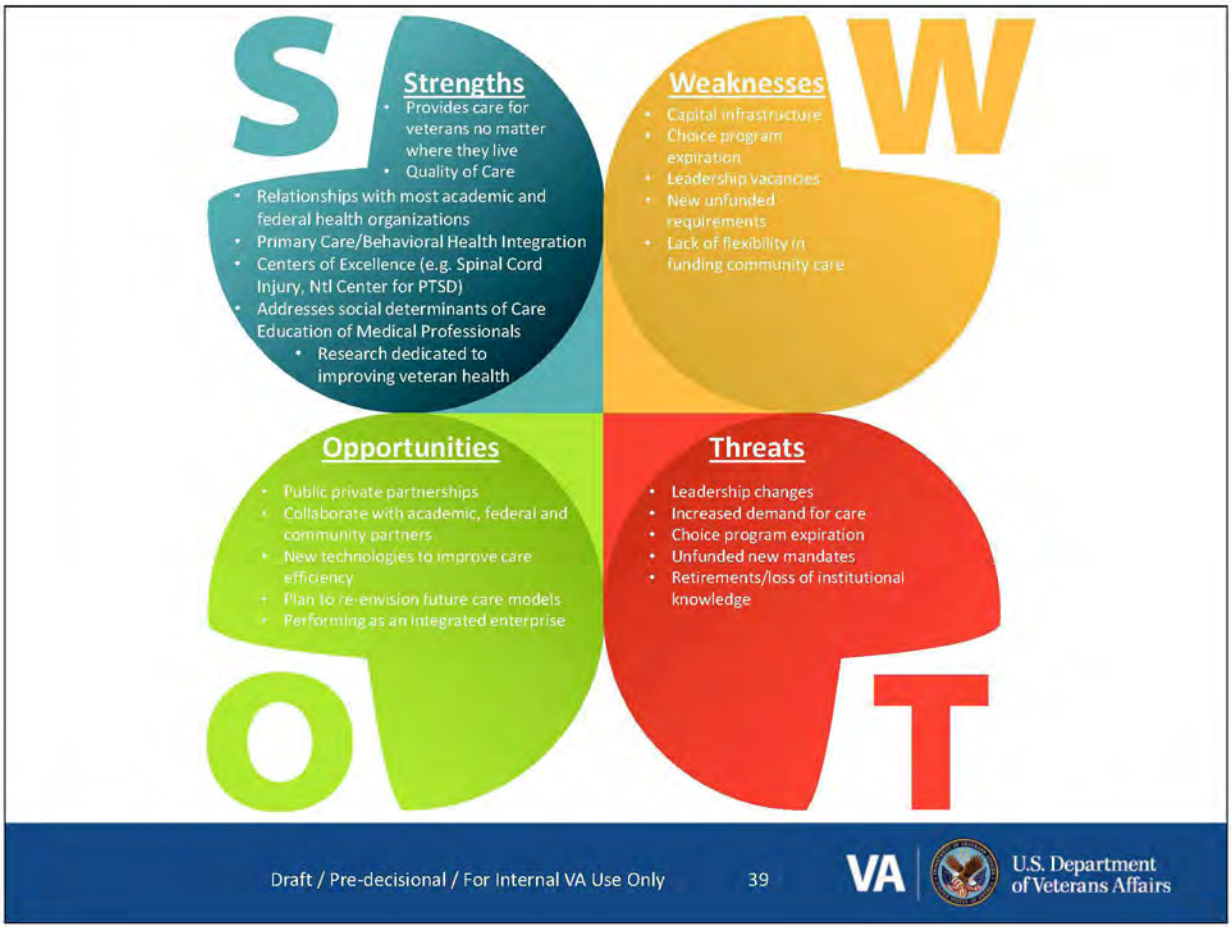

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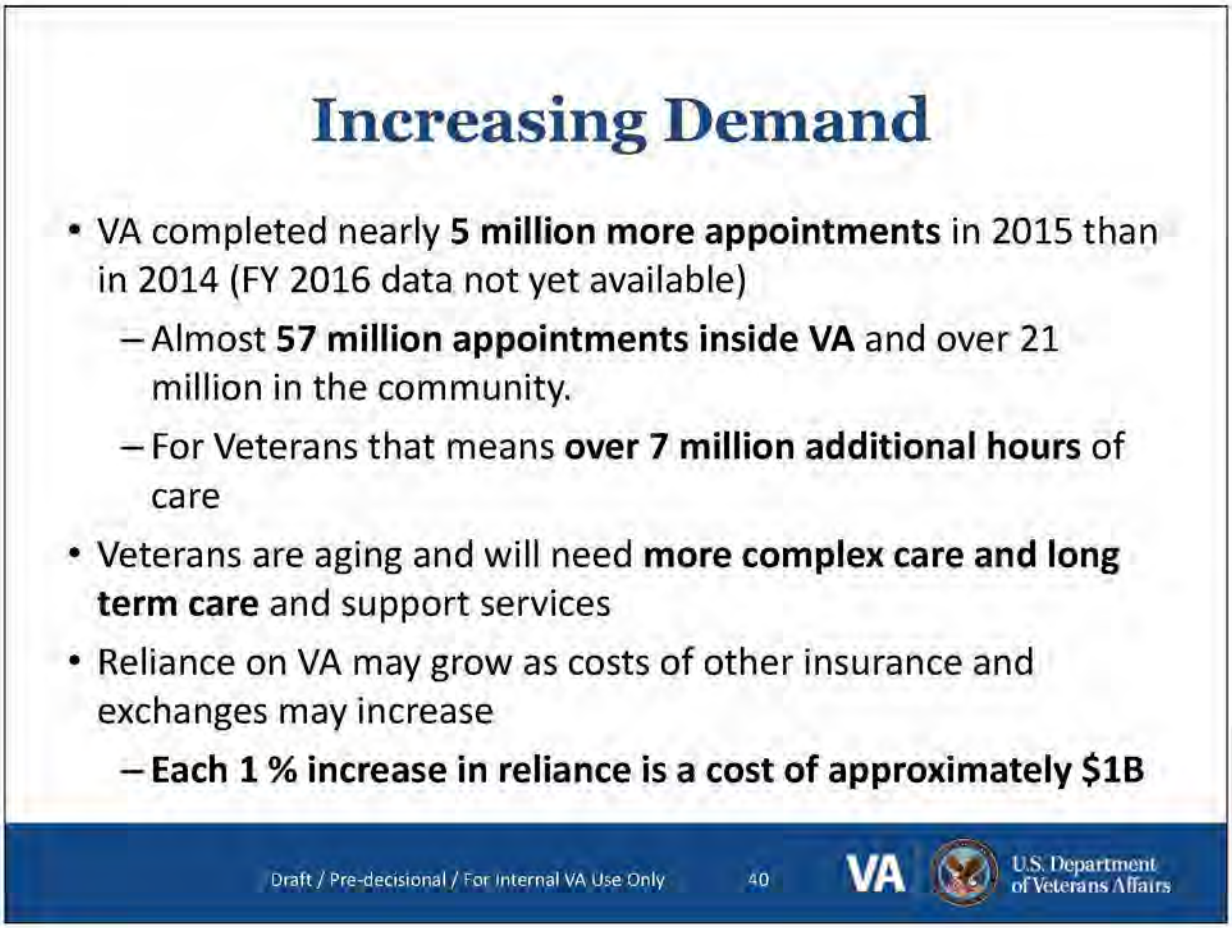

3rd bullet notes:
In 2014, enrollee reliance was estimated to be approximately 34%. We are currently updating reliance analysis with more recent Medicare data, but it is not available at this time. Reliance reflects the portion of health care services that an enrollee needs that we expect VA to provide or pay for. Some enrollees will get all of their health care from the VA and some will get none of their care, but most receive some portion of their care in the VA. For example, based on his/her morbidity, if an enrollee needs 10 office visits in a year and gets 4 of those office visits in VA. This enrollee is said to be 40 percent reliant on VA for office visits.

(b) (6) mentioned wanting to get graphs for this slide and the next from Mark Yow. As such, I haven't edited.

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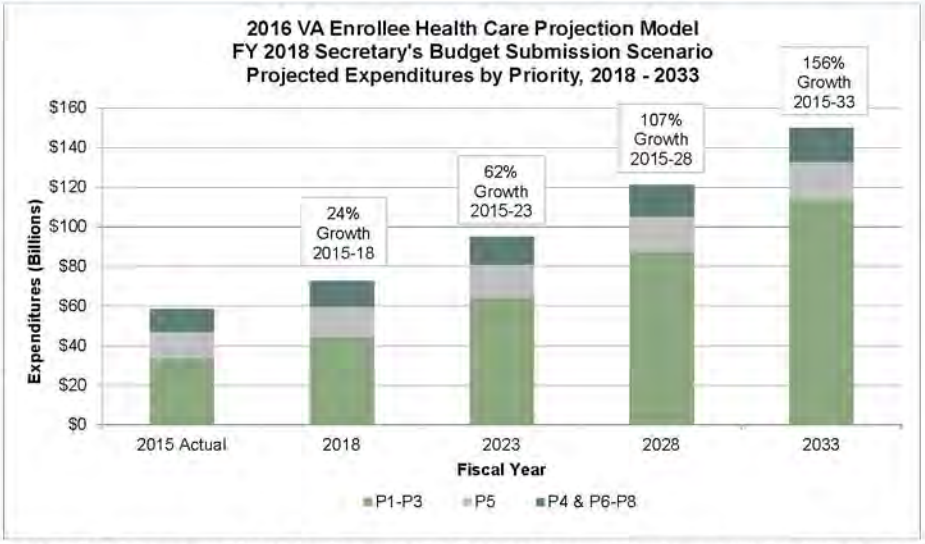
VA's Resource Requirements
Projected to Grow Significantly Over Time



2016 VA EHCPM, Budget Scenario (BAF) Note: The projections do not include requirements for several activities/ programs that are not projected by the VA EHCPM, including non-recurring maintenance, readjustment counseling, state-based long term services and supports programs, and some components of the CHAMPVA program.

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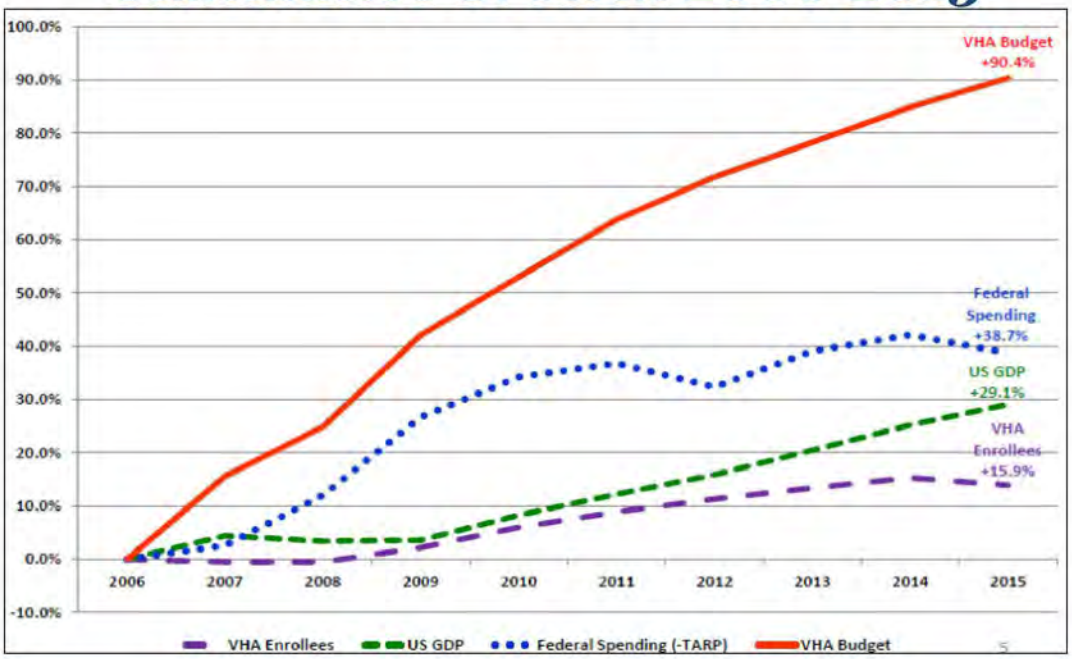
VA Medical Care Budget Challenge:
Cumulative Growth 2006-2015



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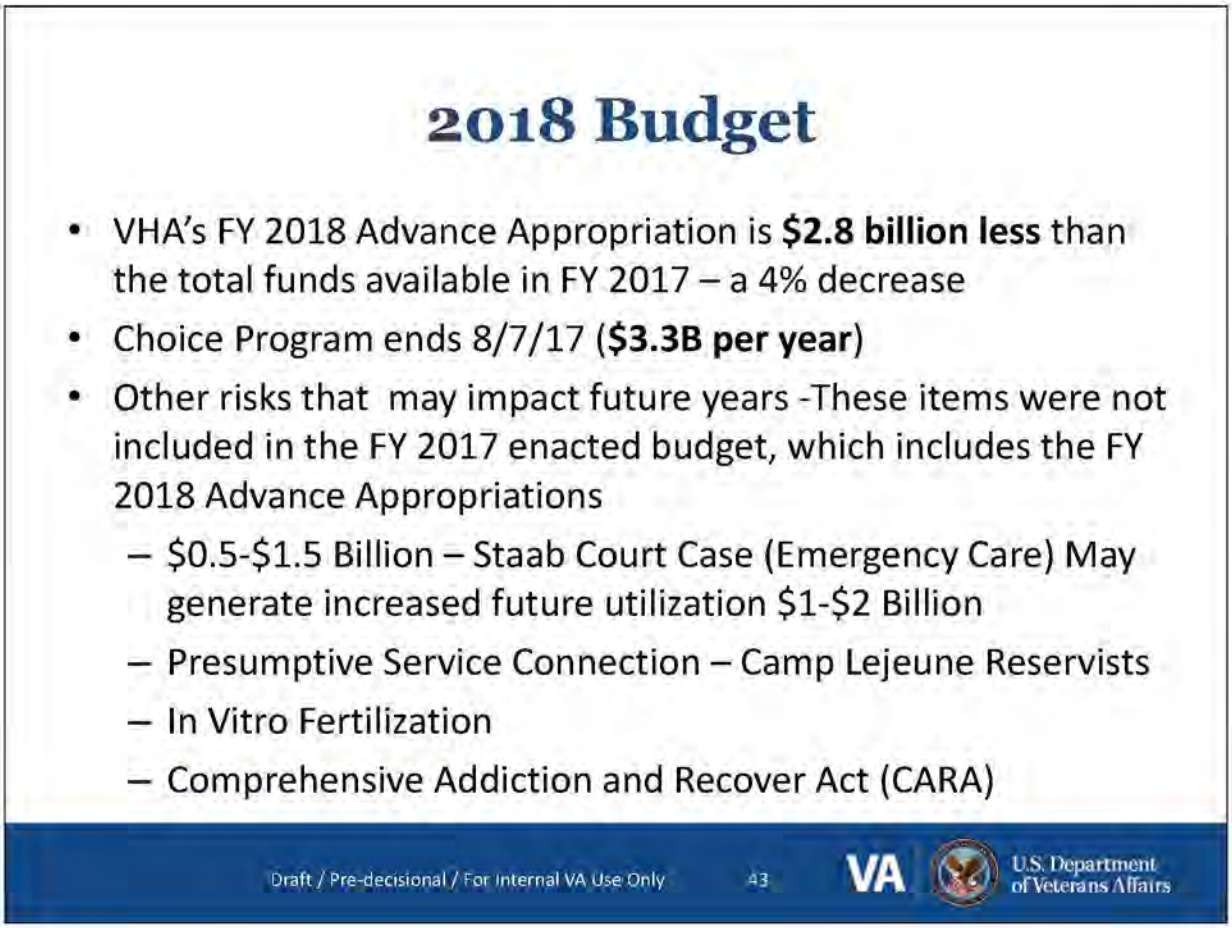

Bullet 3: Estimated budget numbers:
IVF6.5 Million FY 17, 13. million Fy18 --Maximum estimate Non VA Care funds
Adoption: 500K FY 17, 1.5 million FY 18—Maximum estimate
CARA = $153 million – crude estimate, some of which has already been incurred

Camp Lejeune.

Based on evidence there is sufficient scientific and medical evidence available to establish a presumption of connection between exposure to contaminants in the water supply at Camp Lejeune and the occurrence of eight health conditions

The proposed eight presumptive diseases are:
adult leukemia
aplastic anemia and other myelodysplastic syndromes
bladder cancer
kidney cancer
liver cancer
multiple myeloma
non-Hodgkin's lymphoma
Parkinson's disease

VA will not limit entitlement to active duty military personnel. Rather, VA proposes to presume exposure for all active duty, reserve and National Guard personnel who served at Camp Lejeune for no less than 30 cumulative days from August 1,

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1953, through December 31, 1987.

In addition, VA proposes to establish a presumption that individuals who served at Camp Lejeune during this period and later developed one of the presumptive diseases were disabled during the relevant period of service, thus establishing active military service for benefit purposes.

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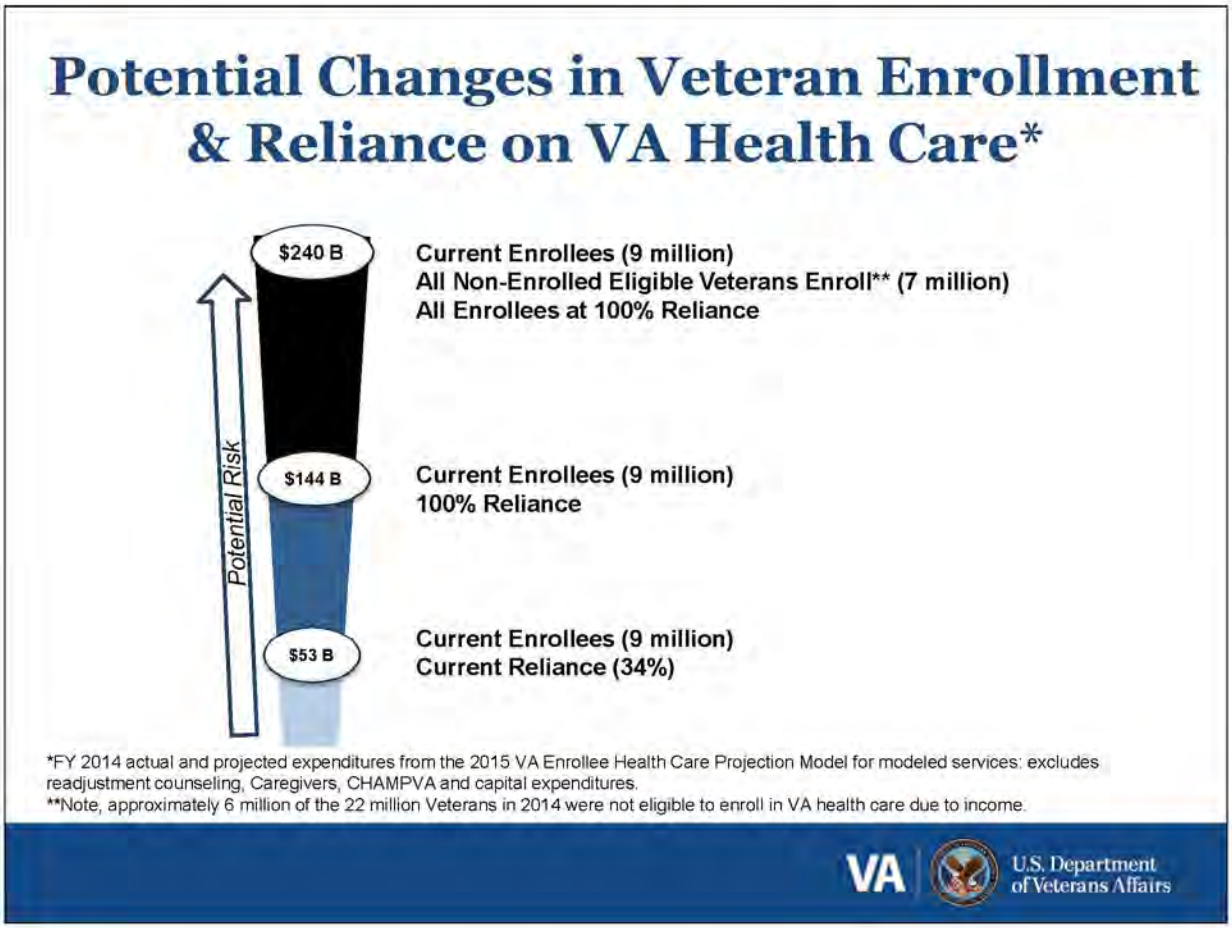

In 2014, costs for modeled services for 9 million enrollees at 34% reliance was $53 billion.

If all those 9 million enrollees used VA for all their health care, the cost in 2014 would have been $144 billion.

If all eligible but unenrolled veterans enrolled in VA and used VA for all their health care, the cost in 2014 would have been $240 billion.

All policy changes move this lever up and down as they impact either reliance on VA for health care, enrollment in VA, or both.

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Continuity of Leadership during a Crisis
Leadership vacancies and succession planning
Maintaining and Strengthening the Gains in Access (including Community Care), Quality, Engagement, and Trust
Direction of the Commission on Care Recommendations
Supporting VHA's Course for a Future Vision

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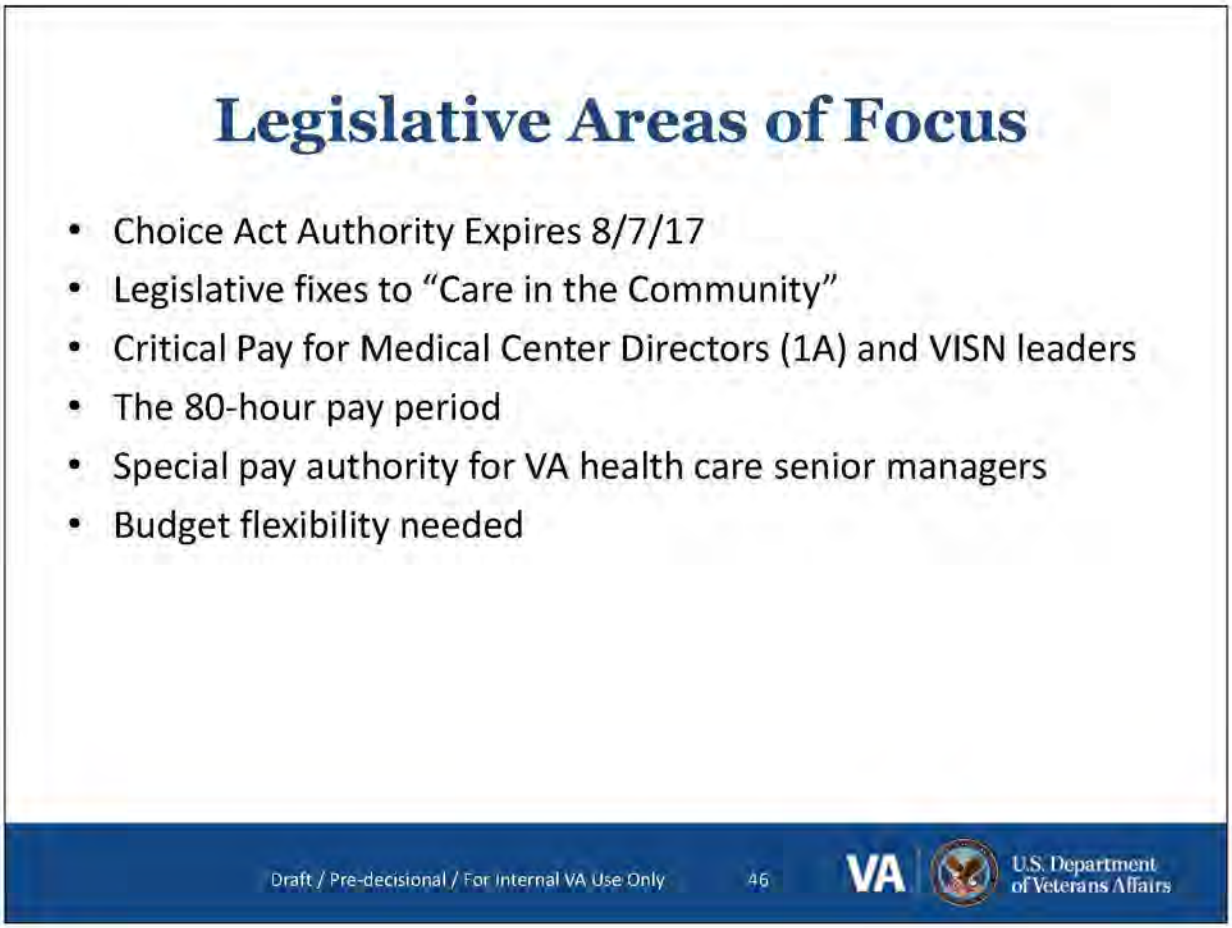

3RD BULLET:
The critical position pay authority (CPPA) allows the Secretary (or designee) to approve higher rates of pay for employees in positions that require expertise of an extremely high level in a scientific, technical, professional or administrative field critical to the Department's successful accomplishment of an important mission to the extent necessary to recruit or retain an individual exceptionally well-qualified for the critical position. Medical Center Directors and other Senior Executive Services (SES) VA health care senior managers would be eligible for CPPA.

Critical position pay requests must be submitted in writing only after it has been determined that the position in question cannot be filled with an exceptionally well-qualified individual through the use of other human resources flexibilities and pay authorities (e.g. recruitment, relocation and retention incentives, special salary rates, above minimum entrance rates).

The Secretary (or designee) must review and approve each critical position pay authority request before forwarding it to the Office of Personnel Management (OPM), who in consultation with the Office of Management and Budget (OMB) will issue final approval.

On September 22, 2016 OPM approved VA's request for CPPA for the Deputy Under Secretary for Health for Operations, 18 VISN Directors, 39 Level 1A Medical Center Directors, and 10 additional positions. 2 employees are in receipt of critical position pay and a plan is being developed for the additional positions.

Currently there is no special pay authority to compensate Medical Center Directors and other SES VA health care senior managers.

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Attached for reference is the signed/dated letter from OPM regarding critical pay.

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Organizational Areas of Focus

- Streamline Hiring/Onboarding Process
- Space: Leasing restrictions
- Facility Modernization: VHA aging Infrastructure
- Implement Full Practice Authority for Advance Practice Nurses: would increase VA ability to increase access
- Expand telehealth capability
- Implement scheduling system for medical appointments
- Examining intermediate and long term funding options for VA healthcare

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Our Commitment to Veterans

- ✓ Veterans should be at the center of what we do and how we deliver care at VHA
- ✓ No veteran with an urgent care need that may cause harm should wait for care
- ✓ VA must act like an integrated enterprise and a learning health system to benefit veterans most
- ✓ We will work closely with our academic, federal and community providers to deliver the highest outcomes to veterans
- ✓ VA leadership and staff must feel proud, fulfilled and empowered to deliver services to Veterans
- ✓ We must regain the trust and confidence of Veterans and the American public
- ✓ VA mission of research, education, and emergency preparedness must continue to contribute to improving the health of Veterans and all Americans

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A Future Vision for VHA

- **Public Private Partnerships** to serve Veterans
- **Digital Health Platform**
- **Whole Health Medicine** (empowering veteran well-being)
- Develop the **High Performance Network** (role of VISNs)
- **Center of Excellence** and Foundational Care
- **Value Based Management** and Efficiency Strategies
- Strengthen VA as a **Learning Healthcare System**
- Accelerate **Precision Medicine** and foster innovation
- Provide access to **VA Research Data** for non VA researchers with appropriate safeguards
- **Train More** primary care and behavioral health students

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Message

From: David Shulkin [drshulkin@aol.com]
Sent: 12/17/2016 4:58:07 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: NJII Services Presentation

Is this a big company? Looks like they have a lot of revenue?

Would we use them for Bergen ? Or are you thinking just general hospital consulting?

Sent from my iPad

On Dec 17, 2016, at 11:11 AM, Poonam Alaigh <(b) (6) hotmail.com> wrote:

> I met with these guys on Friday from NJII at njit and they want to do provide services around physician quality reporting, MIPS and practice transformation in our consulting practice - see slide deck- we can subcontract to them and they have been able to increase revenue for practices by 30% as part of the PQRS reporting
>
> Sent from my iPad
>
> Begin forwarded message:
>
> **From:** (b) (6) (b) (6) @njii.com>
> **Date:** December 16, 2016 at 10:22:01 AM EST
> **To:** (b) (6) hotmail.com
> **Subject: NJII Services Presentation**
>
> (b) , M.S.
>
> Director of Business Development and Measures Management
>
> Healthcare Delivery Systems iLab
>
> New Jersey Innovation Institute (NJII)
>
> University Heights, Newark, NJ 07103
>
> (b) @NJII.com
>
> (b) (6) O
>
> (b) (6) M
>
> (b) (6) F
>
> **NJII Wins $49.6 Million Federal Grant to Improve Clinical Care Practices in NJ**
>
> **Visit Us @** www.NJII.com

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<Services Introduction Slide Presentation.pdf>

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Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 12/17/2016 4:11:52 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Fwd: NJII Services Presentation
Attachments: Services Introduction Slide Presentation.pdf

I met with these guys on Friday from NJII at njit and they want to do provide services around physician quality reporting, MIPS and practice transformation in our consulting practice - see slide deck- we can subcontract to them and they have been able to increase revenue for practices by 30% as part of the PQRS reporting

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(b) , M.S.

Director of Business Development and Measures Management

Healthcare Delivery Systems iLab

New Jersey Innovation Institute (NJII)

University Heights, Newark, NJ 07103

(b) @NJII.com

(b) (6) O

(b) (6) M

(b) (6) F

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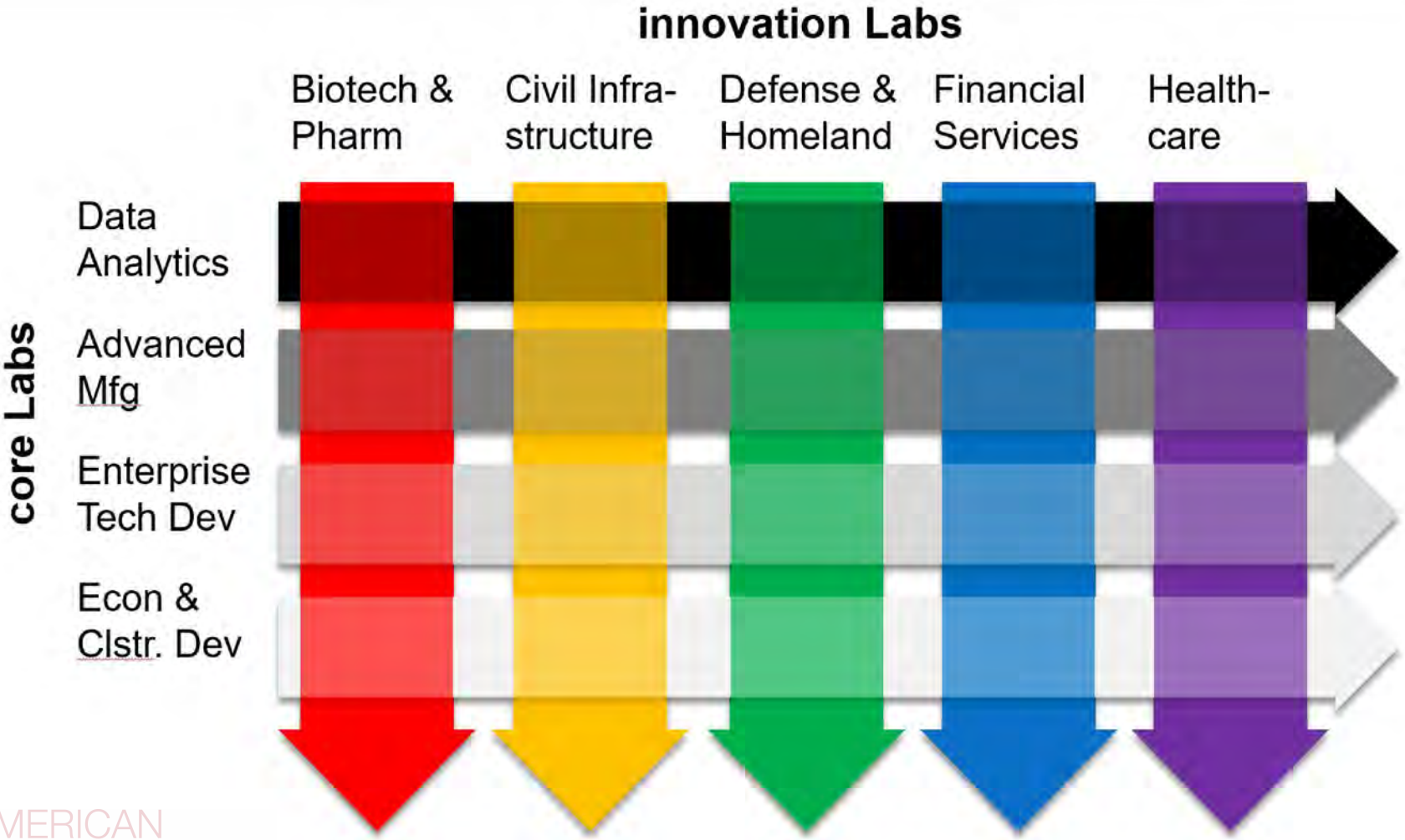
New Jersey Innovation Institute (NJII)



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NJII: Healthcare Delivery System Lab

Track Record of Success

2010 – 2015:	**$23 Million - Regional Extension Center, *formerly*** *NJ-HITEC* (9,000+ Physician and Specialist Network) #1 recognized in the country
2010 – Present:	**Health Information Exchange**, Highlander Health Data Network (5-hospital healthcare data exchange network)
2011 – Present:	**CMS Certified Data Registry** (300+ Measures covering over 40 specialties for over 4,500 providers)
2012 – Present:	**Population Health Service Provider** (Serving 17 DSRIP Hospitals, 5 ACOs, and 500,000 lives)
2015 – 2017:	**$5 Million - State-Designated Entity for Health IT** **State Portion (Infrastructure) –** NJ Master Person Index (MPI), Healthcare Provider Directory (HPD), Common Key Service (CKS), State Registry Gateway for Immunizations History **Federal Portion (Use Case) –** Statewide ADT Notification Service and Transitions of Care Use Cases
2015 – 2019:	**$50 Million - CMS Practice Transformation Network Awardee** (Transform 11,500 providers to achieve performance targets and MIPS / APM scoring and preparedness
2016 – 2018:	**$1.5 Million- Medicaid IAPD, Begins October 2016,** onboard and implement ToC for Medicaid Providers onto existing HIEs for the achievement of Meaningful Use

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VA-19-0799-J-001809

DS_00009444

NJII Core Services

- Meaningful Use
- Physician Quality Reporting System (PQRS) / GPRO Reporting
- Population Health: ACO / DSRIP / Commercial
- Practice Transformation Network
- Highlander HIE Community Support
- Transitional Care Management

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VA-19-0799-J-001810

DS_00009445

Meaningful Use

- Eligible Hospitals and Eligible Professionals
- ONC Regional Extension Center (NJ-HITEC since 2010)
- End-to-End Services Provided:
  - Core Measures Education and Guidance
  - Meaningful Use Reports Review and Remediation
  - Final Attestation Support
  - Audit Proofing / Documentation (NJII has ***never*** failed an audit)
- Remote Services available to ease burden on practice workflow and practice
- Free services if Eligible for Medicaid IAPD (Medicaid Provider Program – MPP)

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VA-19-0799-J-001811

DS_00009446

Physician Quality Reporting System

- NJII is a CMS Qualified Clinical Data Registry (required for submission to CMS)
- Link to Medicare Part B Reimbursements 
- Recognized for 5 years with CMS
- End-to-End Services Provided:
  - Measures Guidance and Optimization
  - Individual Measures, Measures Group, and Group Practice Reporting (GPRO)
  - Eligible to submit for ***every PQRS Measure***
  - Accepts electronic claims, EHR, and reports to populate measures for reporting
  - Provides manual data performance entry for those without a system
  - Benchmarking and Trending for Value-Based Modifier Calculation
- Remote services available
- Free for participants of the PTN Program

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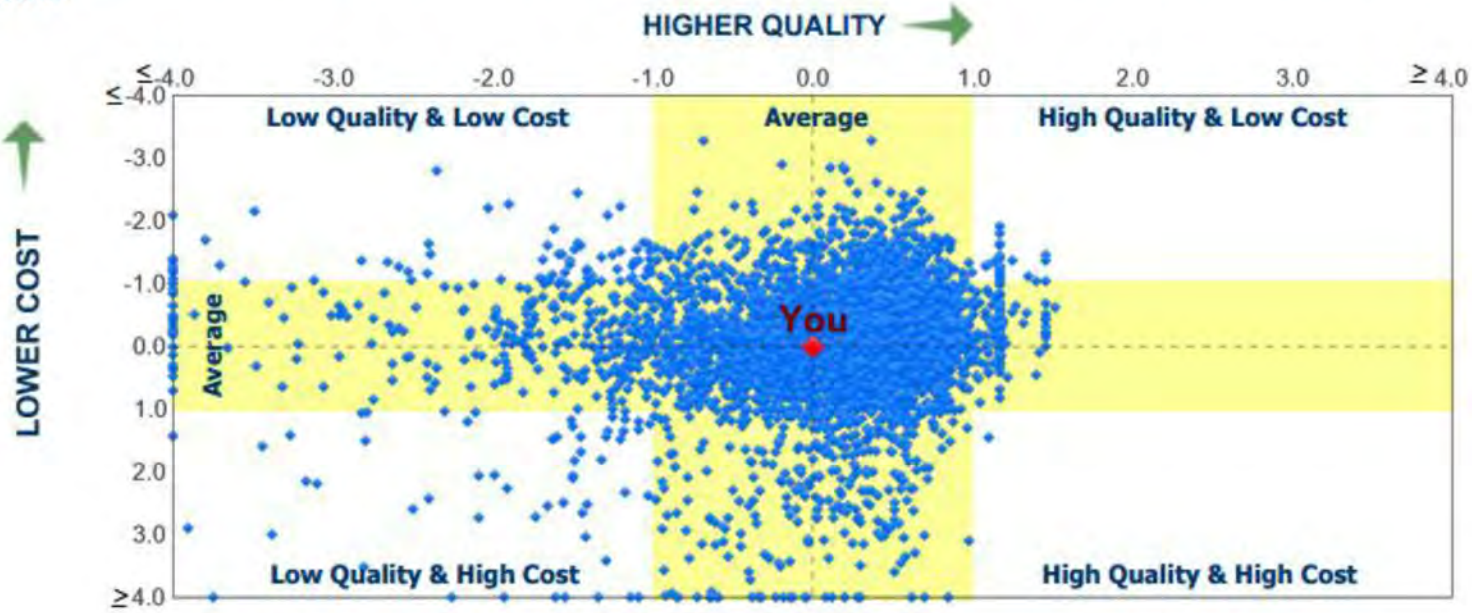
VA-19-0799-J-001812

DS_00009447

Quality and Cost Scoring

Your TIN's Performance: Average Quality, Average Cost

The scatter plot below displays your TIN's quality and cost performance ("You" diamond), relative to that of your peers.



Note: The scatter plot reflects the performance of a representative sample of your peers.

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VA-19-0799-J-001813

DS_00009448

Payment Affected by Scores

2014 Reporting with 2016 Adjustments

	Low Quality	Average Quality	High Quality
Low Cost	---	+1.0x*	+2.0x*
Average Cost	-1.0%	---	+1.0x*
High Cost	-2.0%	-1.0%	---

*x represents the payment adjustment factor, which is determined during CMS' analysis of the submitted PQRS data. ***In 2016 (based on 2014 reporting), x = 15.92%.***

300 Provider Medical Group earning $50 million in Medicare Part B scored High Quality and Average Cost = +$7,960,000 in 2016

VM payment adjustments are in addition to the -2% PQRS penalty. Non-reporters will be subject to an automatic PQRS and VM penalty, totalling **-6%**

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VA-19-0799-J-001814

DS_00009449

Population Health for Every Population

Medicare Shared Savings Program (MSSP):

- *Clinical Quality Data Measures Management for **5 MSSP ACOs***
- *Support Annual GPRO ACO measures reporting for 3 years*
- *GPRO Data extraction, gathering, aggregation, and reporting for all 25 clinical ACO measures*

Medicaid Delivery System Reform Incentive Payment Program (DSRIP):

- *Clinical Quality Data Measures Management for **17 DSRIP Hospitals***
- *Project-specific clinical data extraction, gathering, aggregation, and reporting for over **80 DSRIP measures***
- *Supported DSRIP Hospitals in earning **$47M** in incentives in 2015*

Commercial Horizon Health Innovation:

- *Clinical Quality Data Measures Management for **18,000 Horizon Health Lives***
- *Interoperability services for over **10+ EHR Systems in 12 different locations***
- *Support over **100 physicians***

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VA-19-0799-J-001815

DS_00009450

Supporting Delivery System Reform Incentive Payments (DSRIP)

Newark Beth Israel Medical Center
Children's Hospital of New Jersey
Barnabas Health
UNIVERSITY HOSPITAL
Newark, New Jersey

The Congestive Heart Failure Transition Program (CHF-TP)

- Left Ventricular Ejection Fraction (LVEF) Assessment
- Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction
- Controlling High Blood Pressure
- Post-Discharge Appointment for Heart Failure Patients
- Medication Reconciliation
- 30-Day All-Cause Readmission Following Heart Failure (HF) Hospitalization
- 30-Day All-Cause Readmission Following Acute Myocardial Infarction (AMI) Hospitalization
- Heart Failure Admission Rate

Saint Michael's
MEDICAL CENTER

Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension

- Lipid Management
- Foot Examination
- Eye Examination
- Comprehensive Diabetes Care (CDC): Hemoglobin A1C (HbA1C) testing
- Uncontrolled Diabetes Admission Rate (PQI 14)
- Diabetes Short-Term Complications Admission Rate (PQI 1)
- Hypertension Admission Rate
- Controlling High Blood Pressure
- Diabetes Long-Term Complications Admission Rate (PQI 3)

Jersey City Medical Center
Barnabas Health

Pediatric Asthma Case Management and Home Evaluations

- CAC-1: Relievers for Inpatient Asthma
- CAC-2 systemic corticosteroids for Inpatient Asthma
- Use of Appropriate Medications for People with Asthma
- Medication Management for People with Asthma – 75%
- Percent of patients who have had a visit to an Emergency Department for asthma in the past six months
- Percent of patients evaluated for environmental triggers other than environmental tobacco smoke (dust mites, cats, dogs, molds/fungi, cockroaches) either by history of exposure and/or by allergy testing
- Asthma admission rate

EAST ORANGE
GENERAL HOSPITAL

Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions

- Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction
- Controlling High Blood Pressure
- Post-Discharge Appointment for Heart Failure Patients
- Medication Reconciliation
- 30-Day All-Cause Readmission Following Heart Failure (HF) Hospitalization
- 30-Day All-Cause Readmission Following Acute Myocardial Infarction (AMI) Hospitalization
- Heart Failure Admission Rate
- Timely Transmission of Transition Record

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VA-19-0799-J-001816

DS_00009451

Reporting for Incentives

	2014 Performance Year			2015 Performance Year			Change
Measure Name	**Numerator**	**Denominator**	**Performance**	**Numerator**	**Denominator**	**Performance**	-
Left Ventricular Ejection Fraction (LVEF) Assessment	61	75	**81.33%**	74	85	**87.06%**	5.73%
Controlling High Blood Pressure	239	250	**95.60%**	171	250	**68.40%**	27.20%
Medication Reconciliation (18 – 64 years of age)	178	234	**76.07%**	230	240	**95.83%**	19.76%
Medication Reconciliation (65 and above years of age)	12	16	**75.00%**	5	10	**50.00%**	25.00%

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VA-19-0799-J-001817

DS_00009452

Applying the Quality Score

	2014 Comparison with CMS			
Measure Name	**NBI Performance**	**CMS Benchmark**	**CMS Standard Deviation**	**Standardized Score**
Left Ventricular Ejection Fraction (LVEF) Assessment	**81.33%**	**72.04%**	32.06%	**0.29**
Controlling High Blood Pressure	**95.60%**	**73.99%**	19.23%	**1.12**
Medication Reconciliation	**76.00%**	**81.63%**	22.59%	**-0.25**
			2014 Quality Score	Average

	2015 Comparison with CMS			
Measure Name	**NBI Performance**	**CMS Benchmark**	**CMS Standard Deviation**	**Standardized Score**
Left Ventricular Ejection Fraction (LVEF) Assessment	**87.06%**	**80.85%**	24.19%	**0.25**
Controlling High Blood Pressure	**68.40%**	**69.03%**	14.78%	**-0.04**
Medication Reconciliation	**81.63%**	**84.39%**	23.75%	**0.55**
			2015 Quality Score	Average

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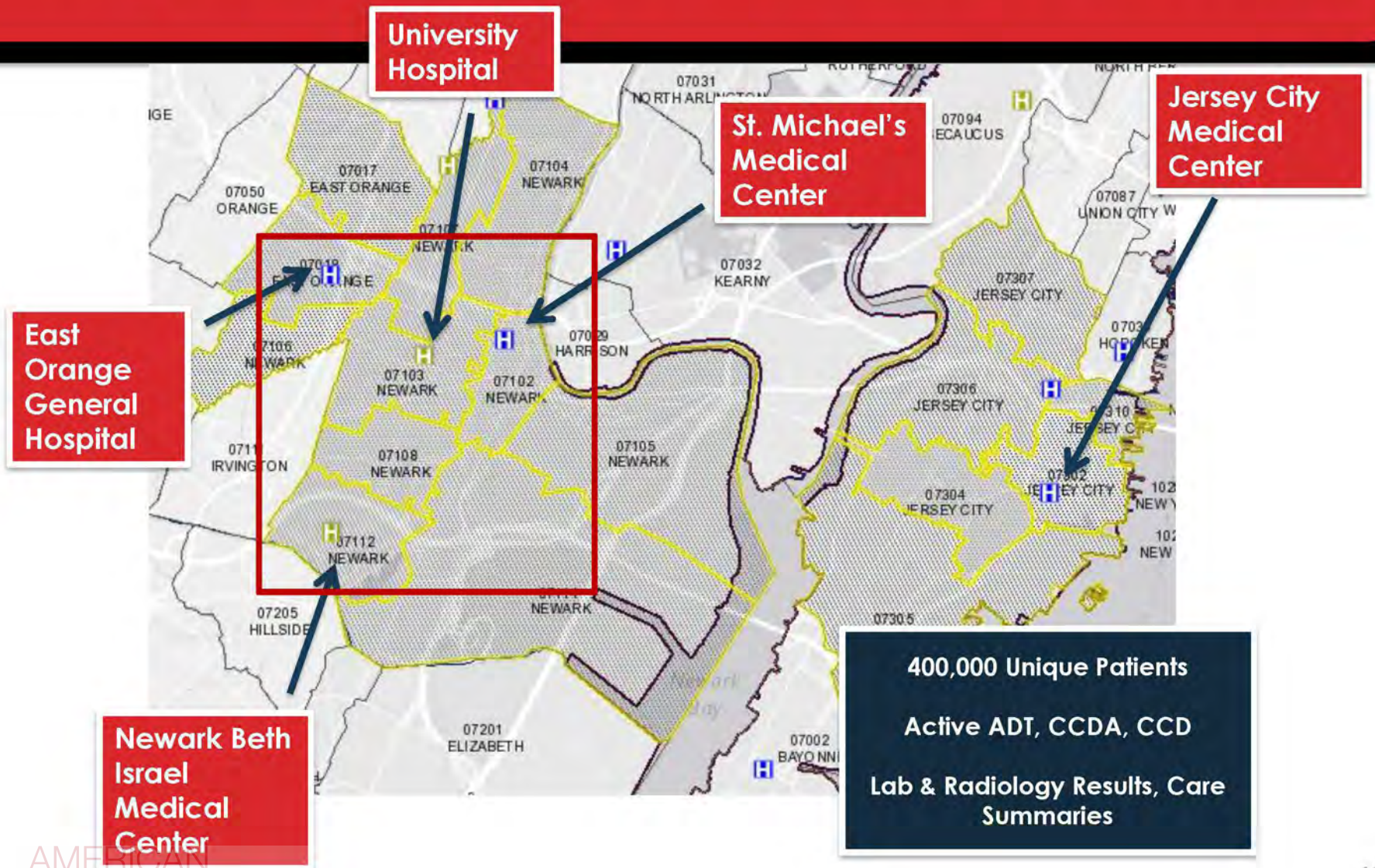
DS_00009453

Highlander Health Data Network



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VA-19-0799-J-001819

DS_00009454

Using Highlander to Support Clinical Use Cases

Newark Medicaid ACO – providing the quality measures reporting and analytics to the Newark Medicaid ACO

Description:

- Practice Transformation Network Participant – leveraging funds for on-site practice coaching and data gathering and reporting funds
- Management of attributed Medicaid ACO lives
- Quality Measures reporting to establish baseline measurements and thresholds for quality improvement
- PQRS Reporting Support
- MIPS Support
- On-site and Remote Support

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VA-19-0799-J-001820

DS_00009455

Using Highlander to Support Clinical Use Cases

Greater Newark Healthcare Coalition Member – supporting the mission of the Greater Newark Healthcare Coalition through state and federal grant programs

Highlights:

- Contracted to support the NJ DOH + Nicholson Foundation: Clinical Decision Support program (Completed August 2016 – parsed and have been able to execute and report CDS)
- Submission of Accountable Healthcare Communities federal grant to support the connection of social services related to clinical health
- NJ DOH Faith-Based Initiative Program which connects faith and wellness

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VA-19-0799-J-001821

DS_00009456

Using Highlander to Support Clinical Use Cases

Neonatal Use Case – Supporting the interoperable exchange of pre-delivery, delivery, and post-delivery medical information between Newark Community Health Center and Newark Beth Israel Medical Center

Interface Workflow:

- Newark Beth Israel electronically receives pregnancy record, ultrasound documents, and other specialty consult documents for all women at 24 weeks of gestation
- Upon an official admission and discharge from Newark Beth Israel, Highlander Health Data Network is notified and tracked
- Discharge summary and care delivery information is delivered to Highlander Health Data Network for secure exchange with Newark Community Health Center

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VA-19-0799-J-001822

DS_00009457

NJII Practice Transformation Network (Contributing factors)

TCPi Transforming Clinical Practices Initiative

- $50M Collaborative Agreement (grant)
- Transform 11,500 providers
- Better care to 500,000 chronic patients
  (includes attention to the underserved)
- Oct 2015 thru Sept 2019 (Dovetails into MIPS Reporting for 2019)

Goals

75% of all providers enrolled in value based
better care for patients, access, information…
Lower costs when coordinated
Prepare Providers for MIPS and Alternative Payment Models

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VA-19-0799-J-001823

DS_00009458

Practice Transformation Services

Reducing 30-Hospital Readmissions

Earn Upwards Adjustments and Avoid Penalties

Alternative Payment Model ***Graduation***

Weekly Quality Measures and Cost Reporting

On-site Transformation Coaching

Practice Transformation ***Network***

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VA-19-0799-J-001824

DS_00009459

Transitional Care Management

1. **Non-face to face** within two (2) business days
2. **Face to face office visit** within 7 – 14 days post qualified discharge
3. **Bill** Medicare at thirty (30) days post discharge date

Surveyed over 100 physicians, hospital executives, and other medical staff:

- *Average number of admissions per provider per week* ***~ 15***
- *15 patients per week X $200/TCM Claim X 52 weeks =* ***$156,000***

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VA-19-0799-J-001825

DS_00009460

TCM Model for Hospitals

Facts:
According to NJ DOH's *Healthcare Quality Assessment*, Hospital had the following **qualified** discharges in 2014:

Inpatient: **20,821**
Same Day Surgery: **5,141**
Inpatient Psych / Rehab: **1,426**

TOTAL: 27,388

Proposed Model:

If 20% converted to TCM = **5,477 X $150 = $821,550**

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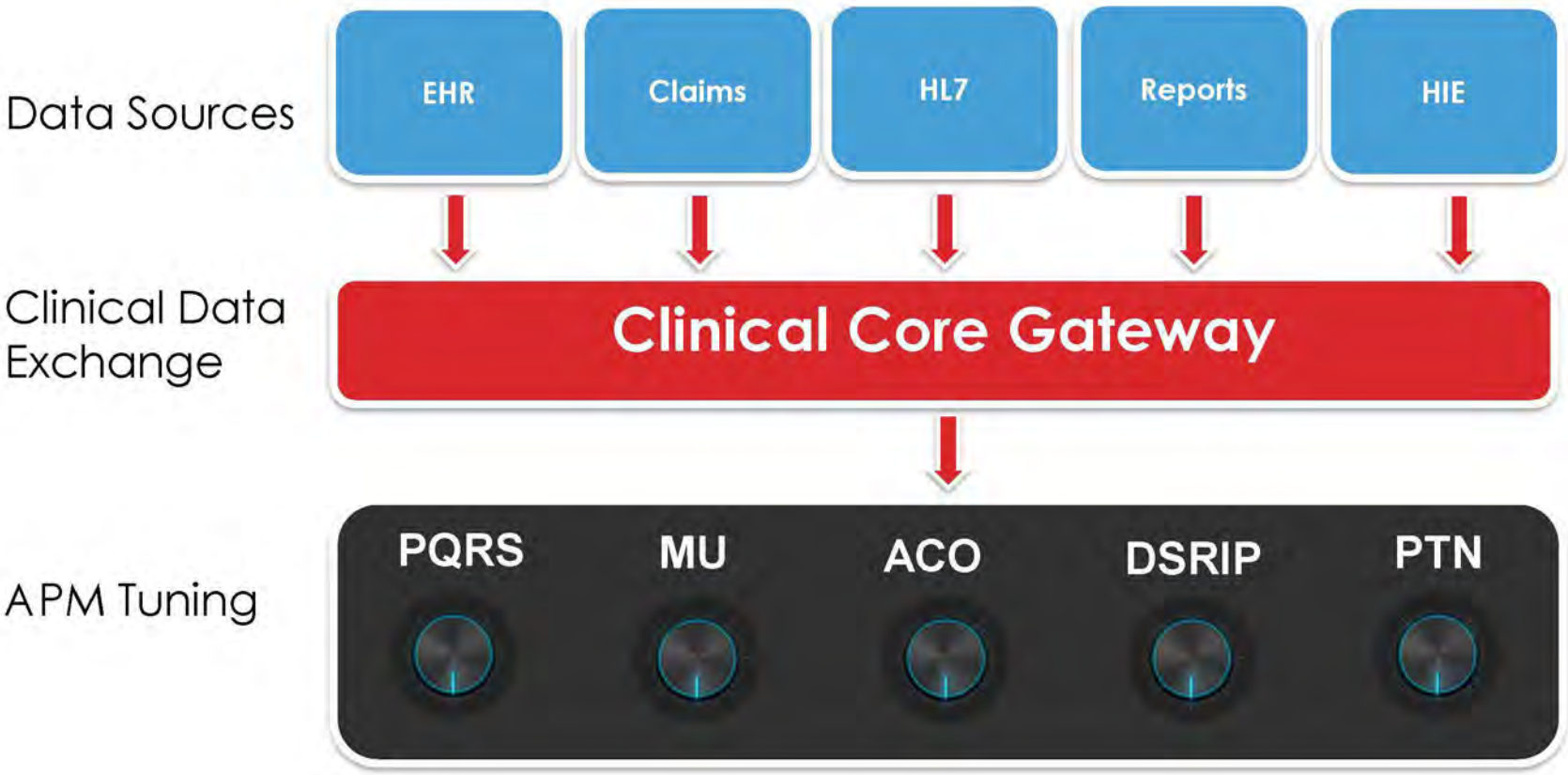
DS_00009461

Enabling Infrastructure



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VA-19-0799-J-001827

DS_00009462

NJHIN Overview

- NJHIN: Network of Networks in Statewide Coordination
  - Current Use Cases
    - ADT Notification Service (Transition of Care (TOC))
    - Active Care Relationship Service (ACRS™)
    - Statewide Health Provider Directory (HPD)
    - Common Key Service (CKS) and Master Person Index (MPI)
    - Immunization Registry Query
- First Use Case Next Steps
- Contact Information

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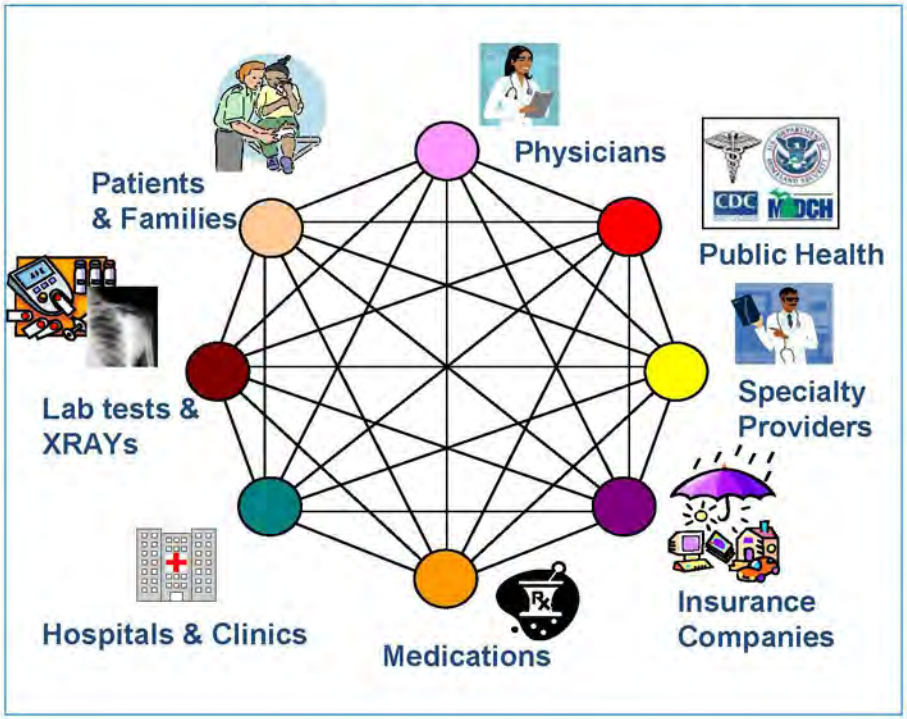
VA-19-0799-J-001828

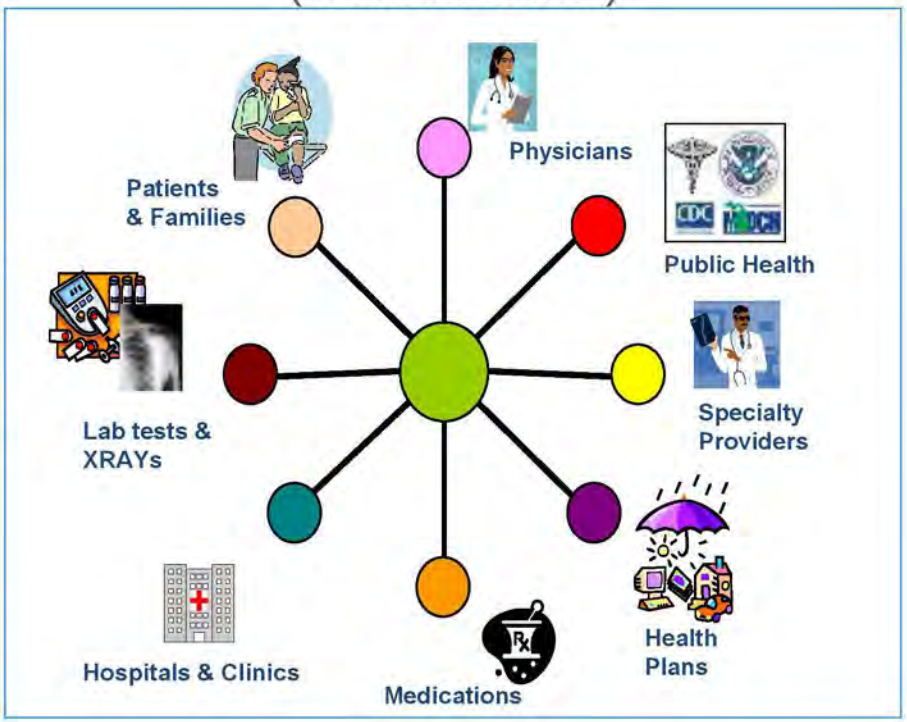
DS_00009463

Statewide Coordination

Duplication of effort, waste, & expense
(N*(N-1)/2 connections)



Shared Services
(N connections)



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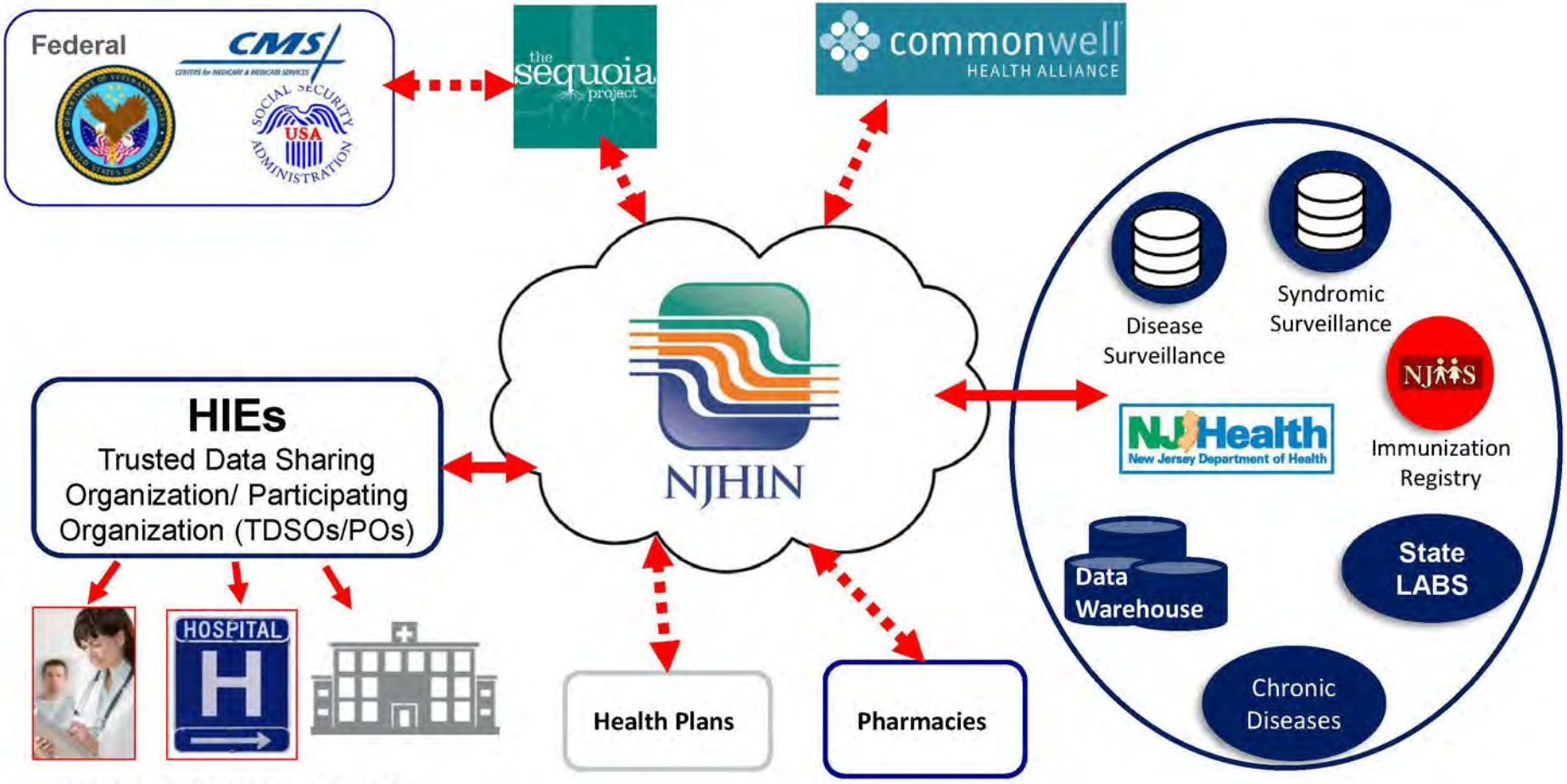
VA-19-0799-J-001829

DS_00009464

Network of Networks



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VA-19-0799-J-001830

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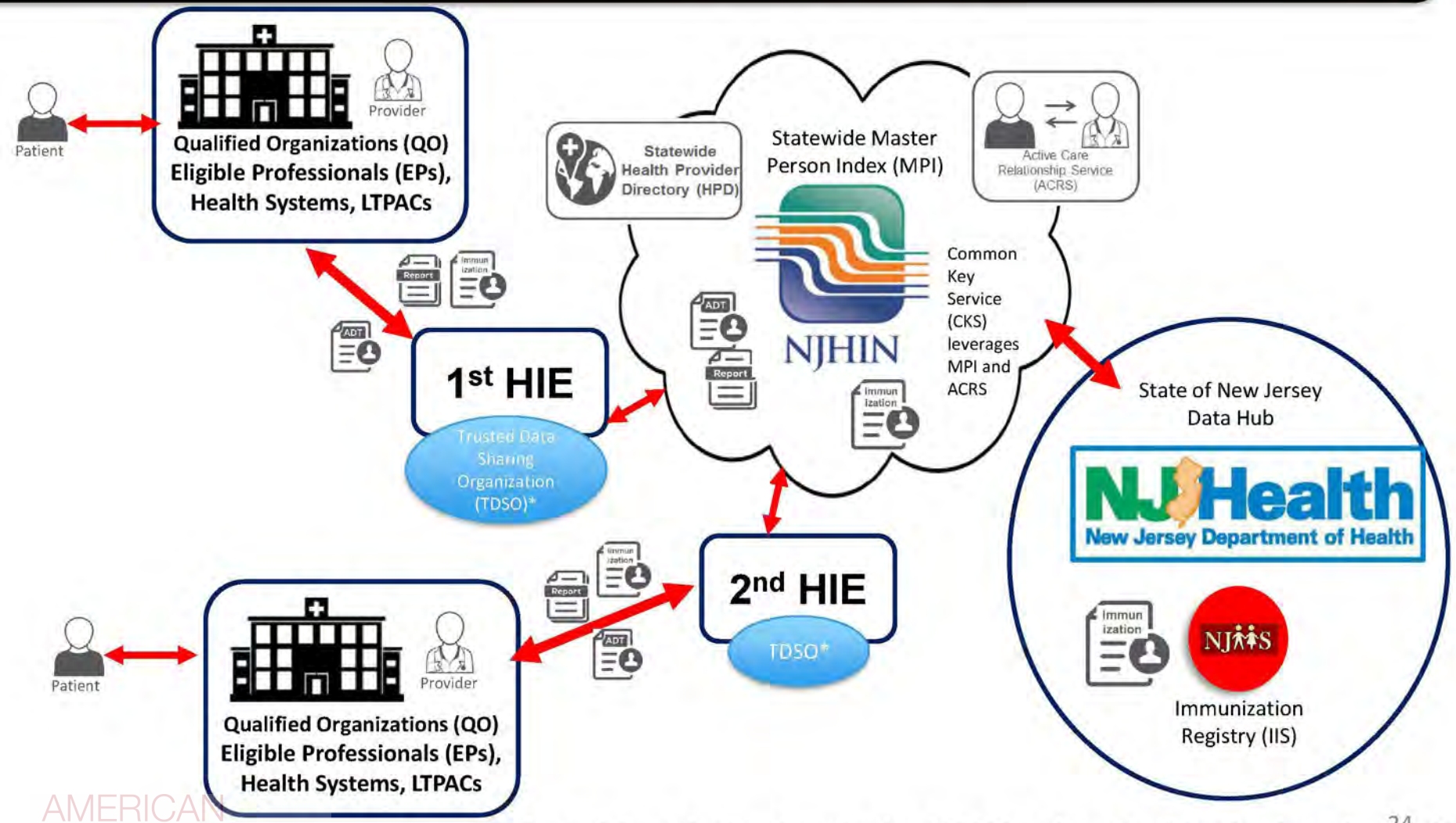
Current Use Cases



*Trusted Data Sharing Organization (TDSO) is also a Participating Organization (PO)

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DS_00009466

Statewide ADT Benefits

Benefits include:

- Transitional Care Management
- Reduce the risk of preventable 30-day readmissions
- Better outcomes
- Ensure access to care: coordinating care
- Opportunity for additional revenue

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VA-19-0799-J-001832

DS_00009467

ADT Example – Patient Matching Challenges



1) Tricia is admitted to hospital with MRN 19860122 and ADT initiated
2) Tricia has slightly different demographics in each provider EHR
3) Care Team challenged to coordinate care across organizations and systems

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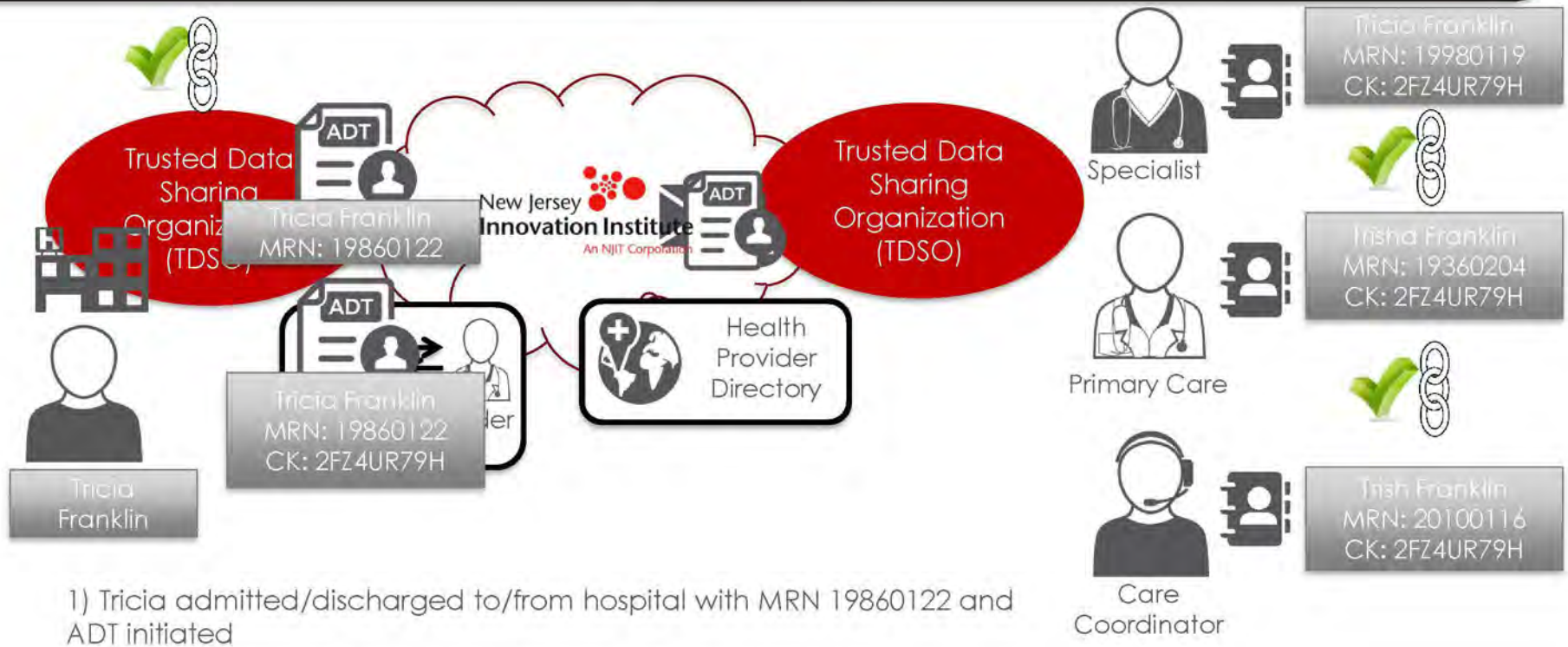
VA-19-0799-J-001833

DS_00009468

ADT Example – *With Common Key Service*



1) Tricia admitted/discharged to/from hospital with MRN 19860122 and ADT initiated

2) ACRS enriches ADT message with Tricia's Common Key

3) Tricia is accurately and reliably linked to her Care Team

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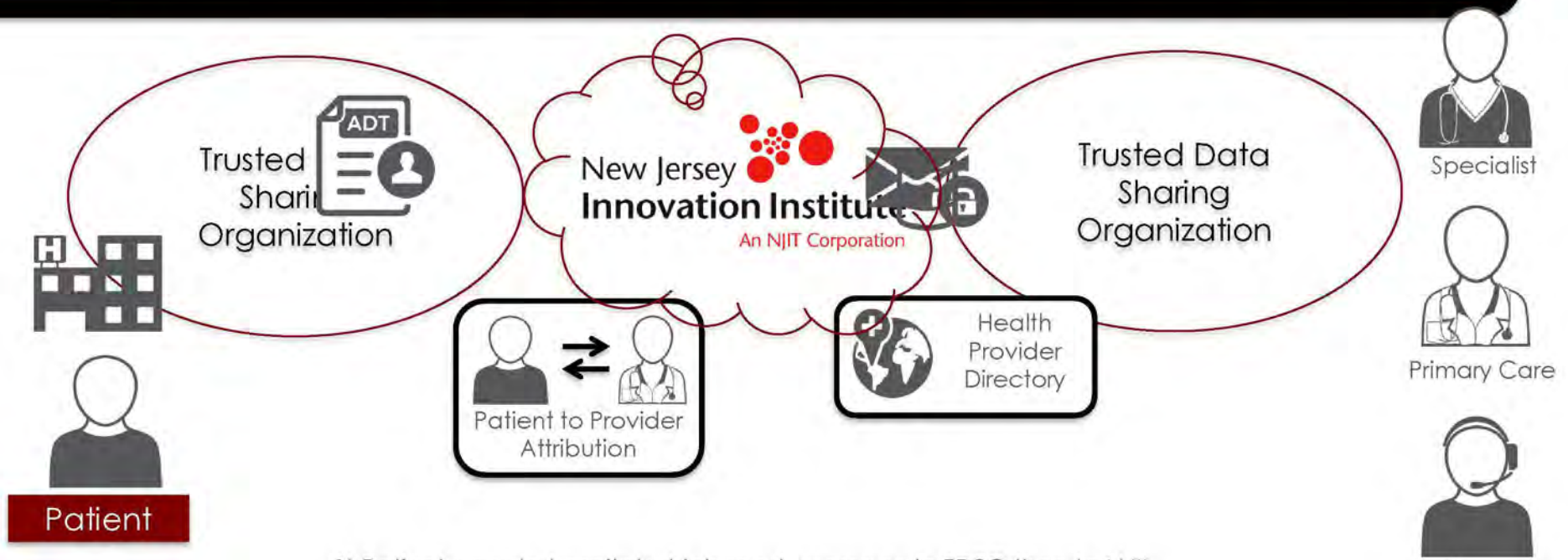
VA-19-0799-J-001834

DS_00009469

Trusted Statewide ADT Service



1) Patient goes to hospital which sends message to TDSO then to NJII

2) NJII checks patient-provider attribution and identifies providers

3) NJII retrieves contact and delivery preference for each provider

4) Notifications securely routed to providers based on electronic address and preferences

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VA-19-0799-J-001835

DS_00009470

Request Immunization History/Forecast Use Case

- Send an inquiry to NJIIS to determine:
  - Past immunizations (history)
  - Immunizations needed (forecast)
- Providers can maximize patient visits as an opportunity to verify if patient is current on immunizations
- Pharmacies can utilize this to upsell

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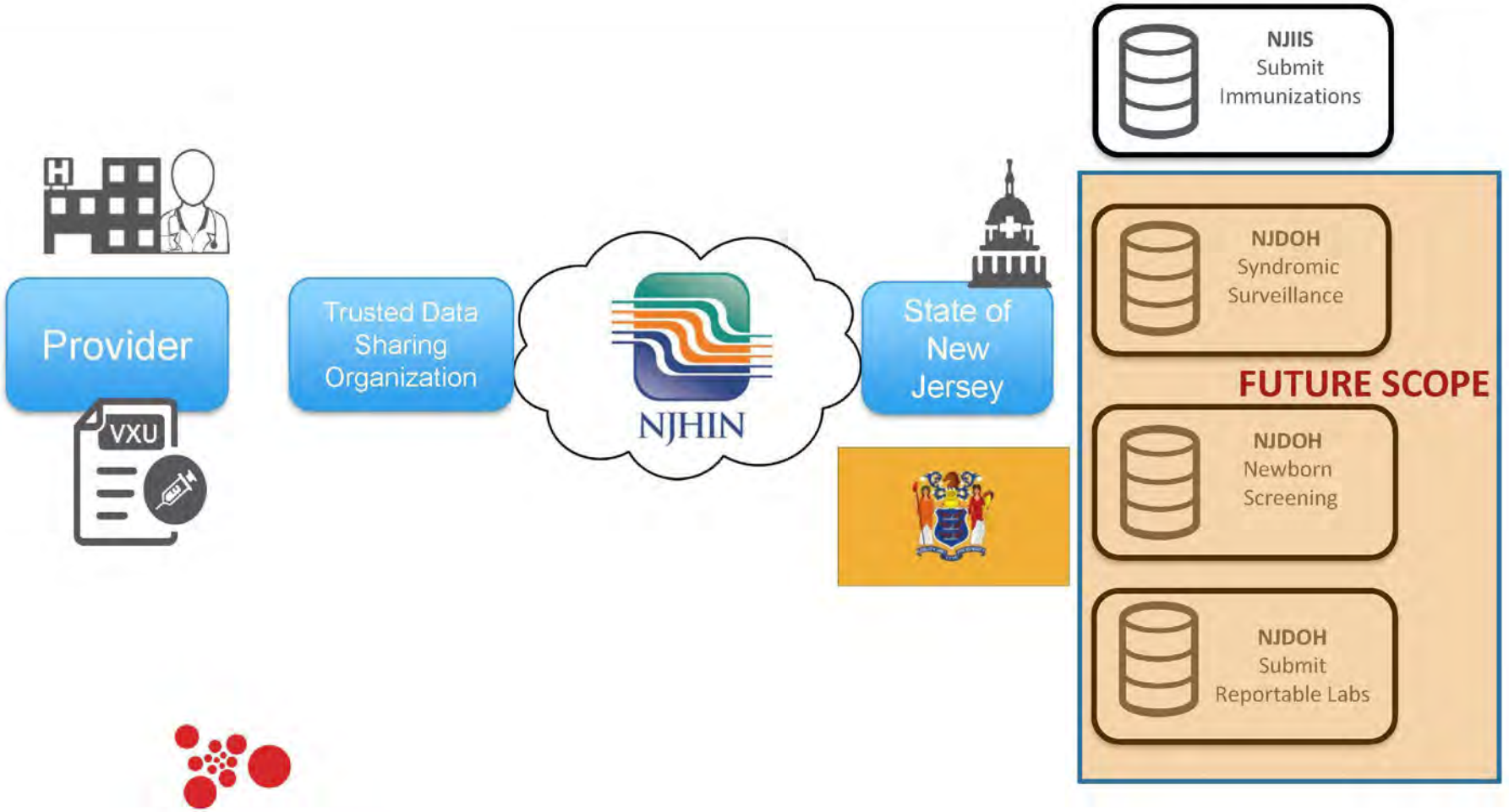
VA-19-0799-J-001836

DS_00009471

Submit Immunizations Use Case Possibility



VA-19-0799-J-001837

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Innovation Platform

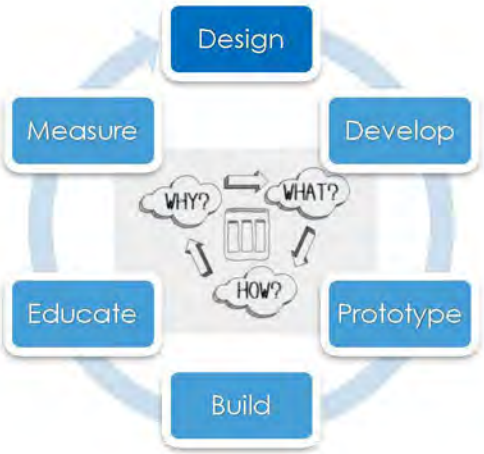
Design & Collaboration

Simulation & Prototyping

Education

EDC

Innovation Center Framework



- Your Apps
- Pop Health
- 3rd Party Apps
- API
- "SimPatient" Generator
- MPI / Permissions
- Storage
- Aggregation
- Intake
- Plugins

- Universities
- Resources
- Faculty
- Interns
- Sponsored Research

- 90+ Incubator Companies
- Tech-Transfer
- Pipeline
- Health IT Connections

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VA-19-0799-J-001838

DS_00009473

Central King Building Exterior



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Central King Building Interior



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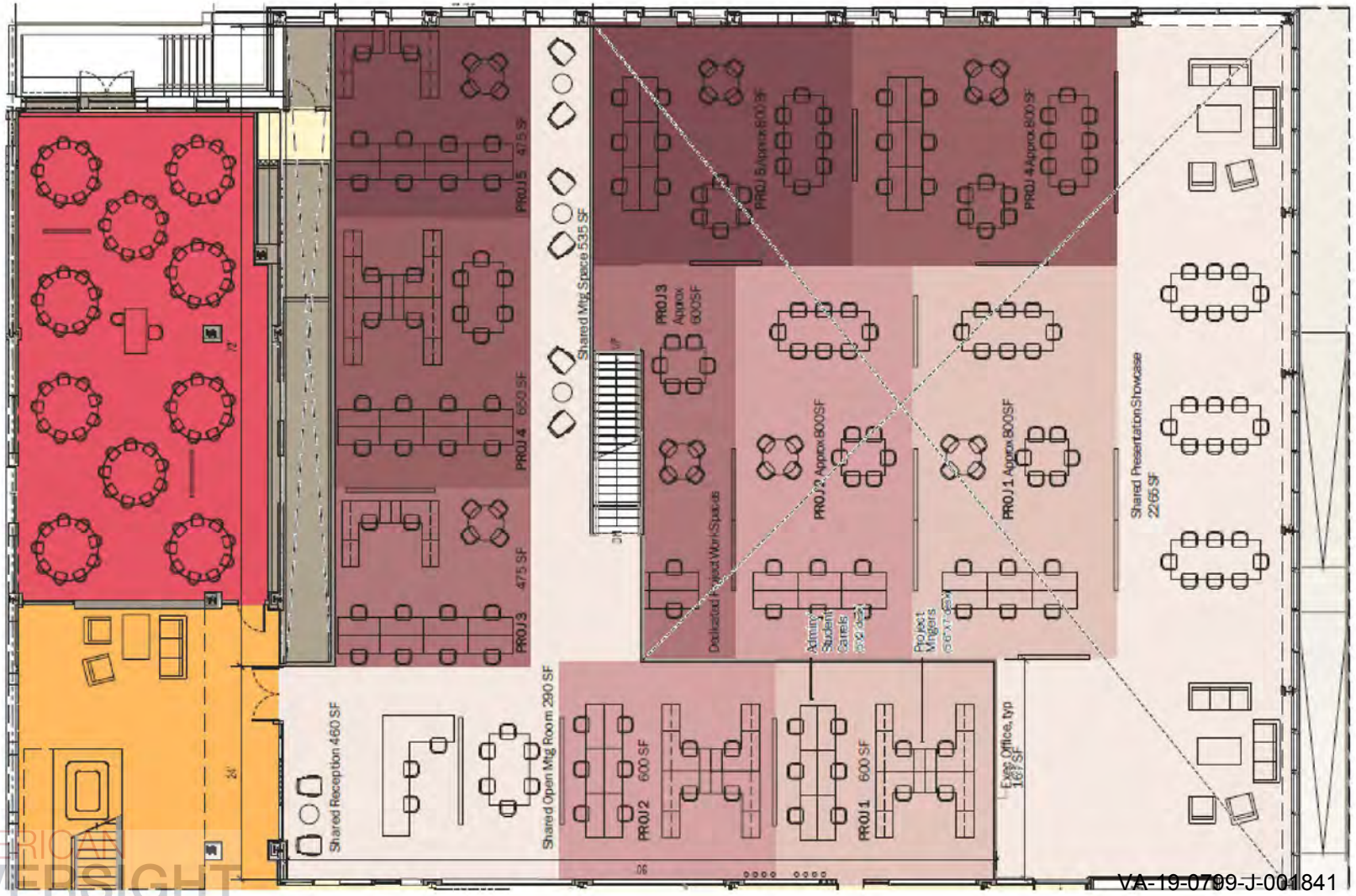
Central King Building Floor Plans



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VA-19-0799-J-001841

DS_00009476

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 11/27/2016 6:13:15 PM
To: (b) (6) ((b) (6) va.gov]
Subject: Re: [EXTERNAL] Fwd: Slides

Print materials I think is best

Sent from my iPad

On Nov 27, 2016, at 11:28 AM, (b) (6) ((b) (6) va.gov> wrote:

> Sure, anything else to go with it?
>
> How do you plan on showing the slides for your presentation, using the office laptop for 802, or having the staff print the materials?
>
> (b)
>
> -----Original Message-----
> **From:** David shulkin [Drshulkin@aol.com]
> **Sent:** Sunday, November 27, 2016 09:22 AM Eastern Standard Time
> **To:** (b) (6)
> **Subject:** [EXTERNAL] Fwd: Slides
>
> Can we print copies for the transition team on wednesday?
>
> Sent from my iPhone
>
> Begin forwarded message:
>
> > **From:** Poonam Alaigh <(b) (6) hotmail.com>
> > **Date:** November 27, 2016 at 8:20:33 AM EST
> > **To:** David shulkin <Drshulkin@aol.com>
> > **Subject: Re: Slides**
> >
> > please make sure you review this Fact Sheet too- this is a MUST USE!!
>
> ---
>
> **From:** David shulkin <Drshulkin@aol.com>
> **Sent:** Saturday, November 26, 2016 6:59 PM
> **To:** Poonam Alaigh
> **Subject:** Re: Slides
>
> Im good

AMERICAN OVERSIGHT

Sent from my iPhone

> On Nov 26, 2016, at 5:42 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>
> Are you ok with them and are you able to
>
> Sent from my iPhone

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Message

From: [redacted] va.gov]
Sent: 11/27/2016 4:28:09 PM
To: 'David shulkin' [Drshulkin@aol.com]
Subject: RE: [EXTERNAL] Fwd: Slides

Sure, anything else to go with it?

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 11/27/2016 2:22:04 PM
To: (b) (6) R. (b) (6) (b) (6) va.gov]
Subject: Fwd: Slides
Attachments: MyVA Access Fact Sheet_110716_v9.docx; Untitled attachment 20293.htm

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myVAaccess Fact Sheet

Focus Areas	2014	2016
Leadership Commitment		
Access as a Priority	• Inconsistent, fragmented and reactive approach towards improving access	• Access declared as the top strategic priority of VA • Proactivity using a three pronged approach that sets the vision and roadmap for access improvement: Prong #1- MyVA Access Declaration, Prong #2- Implementation Guidebook and Prong #3- Systems Engineering and Deployment
Identification of Veterans with Immediate Need for Timely Care	• Inability to identify Veterans with more immediate needs • Variability in the timeliness of care for Veterans with more immediate needs	• Scheduling was simplified to identify Veterans with the most immediate needs • In 2015 and 2016, two national stand down events were conducted to ensure Veterans with immediate needs received timely care • VA's nationwide commitment to achieving same day services for all Veterans with care needed right away in primary care and mental health by the end of 2016
Accountability for Access	• Lack of an integrated and accountable team to improve access in the organization	• ADUSH-level position created to lead newly created OVAC; solely focused on improving access to care in VHA
Care in the Community	• Veterans had limited options for care in the community	• In addition to existing community programs, the Choice Program expanded to serve Veterans: ○ The Choice provider network grew 85% over a year with over 350,000 providers and facilities ○ Choice authorizations have quadrupled from 380,000 in FY15 to nearly 2 million in FY16
Programs and Practices		
Access Best Practices	• Facilities had limited operational guidance regarding access improvement • Facilities were unaware of best practices in existence at other VAs	• MyVA Access Implementation Guidebook with 23 highly feasible/highly impactful solutions that help facilities achieve enhanced access • The VA Diffusion of Excellence Council also developed 11 access best practices for facility use
Seamless Care	• Veterans found it challenging to receive care from a VAMC different from their primary VA as their medical information was not readily available and staff at the receiving facility were unprepared for accepting such Veterans for care	• Veterans can seamlessly receive medical care and any information relevant to their care from any VA medical facility
Direct Scheduling without Primary Care Referral	• Referrals were required from primary care for Veterans to receive basic healthcare services	• Veterans can direct schedule appointments with audiology and optometry clinics with a plan for additional specialties to be added in 2017

VA | U.S. Department of Veterans Affairs

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myVAaccess Fact Sheet

Convenient Self Scheduling (VAR)	• Inability for Veterans to schedule their own medical appointments	• Completed successful pilots for VAR roll out • VAR will allow patients to self-schedule appointments using the application and is scheduled for general roll from Dec 2016 to Feb 2017
Expanding Telehealth Opportunity	• Telehealth options locally-oriented within healthcare systems or networks	• Establishing national, networked telehealth programs to maximize usage: o Over 1.5 million episodes of care reaching about 700K Veterans o Four telemental health hubs launched during 2016, five more telemental health hubs are presently being stood up
Tele-Video Care	• Lack of convenient, innovative video telehealth care for Veteran and provider to interact	• Clinical video telehealth program with a "secured Skype" like modality using smart phones/tablets has been developed and will be rolled out in local facilities in 2017
Communication and Training		
Field Focused Communication	• Incomplete field input on access initiatives • Disjointed access communication with conflicting messages to local facilities	• Established a bi-directional communication with field through working groups, educational sessions, standing meetings, leadership engagement, national meetings and forums like MyVA Access Community of Practice Calls • MyVA Access has an integrated communications plan guided by field-led IPT that developed a Veterans Awareness Campaign with templates and tools for same day services at VA
MSA Training	• Lack of standardized, coordinated training for MSAs	• Standardized MSA training established to include key topics such as customer service, Veteran experience and VSE, being rolled out by Dec 2016
Streamlined Consult Scheduling	• Thirty-one different ways to categorize a consult for scheduling	• Consult scheduling has been streamlined to two options: routine and urgent
HR and Capital Investments		
Group Practice Managers	• Disjointed clinical administrative operations to support access at VA Medical Centers • No GPM role or function	• GPMs are newly established roles that manage operations for all VA Medical facilities and conduct daily mini data-driven huddles for access improvement • 135 GPMs have been hired nationwide

VA | U.S. Department of Veterans Affairs

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myVAaccess Fact Sheet

Human Capital and Space	• Human capital and space for patient care activities were routinely cited as challenges to access.	• Hired approximately 95,000 employees, a 9.2% increase. Of these, over 7000 were physicians and over 17,000 nurses, increases of 11.2% and 11.9% respectively. • Activated 2.6 million square feet for patient care and supporting activities • Increased direct patient care by 11%, approximately 7.4 million additional patient care hours
Performance Measures and Outcomes		
Healthcare Dashboard	• Lack of standardized access metrics for use at local facilities	• Newly established healthcare dashboard that is used by national leadership and local facilities to manage access in real time including during daily mini-data driven huddles
Public Facing Data	• Public facing data did not provide meaningful signals of VA access improvements in Veteran satisfaction	• Early 2017, VA website will transparently report on meaningful signals that indicate VA progress in patient satisfaction with access and same day services capability
Veteran Satisfaction	• Lack of real-time data to assess Veteran satisfaction	• In FY16 89.4% of 2.6 M Veterans indicated they were completely satisfied or satisfied with access to care at VA through VetLink kiosks
Wait Times	• Wait times were 19.1 days from create date for all new patients	• Wait times were 17.2 days from create date for all new patients, which is a decrease of 1.9 days
Veterans with Immediate Needs	• 50.4% of referrals for new patients with urgent needs were completed within 7 days • There were around 57K stat consults in November 2015 waiting longer than 30 days for care	• In FY16, 61.0% of referrals for new patients with more immediate needs were completed within 7 days, an increase of 10.6% from FY14. • Around 500 stat consults are currently waiting longer than 30 days for care
Total Appointments and Users	• In FY14, there were 5.7M unique users and 70.8M total appointments within VA and in the community	• In FY16, there were 5.8M unique users and 74.2M total appointments, an increase of approximately 76,000 users and 3.4M appointments

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myVAaccess Fact Sheet

SUPPLEMENTAL MATERIAL

Acronyms

ADUSH	Assistant Deputy Under Secretary of Health
CoP	Community of Practice
GPM	Group Practice Manager
HR	Human Resources
IPT	Integrated Project Team
MSA	Medical Scheduling Assistant
OVAC	Office of Veterans' Access to Care
VA	Department of Veterans Affairs
VAR	Veterans Appointment Request
VSE	VistA Scheduling Enhancement

myVAaccess Declaration

1. Provide timely care, including same-day services in Primary Care, as needed
2. Provide timely Mental Health care, including same day services, as needed
3. Provide Veterans medically necessary care from another VA Medical Center, while away from their primary facility
4. Respond to routine clinical inquiries within 2 business days
5. Offer appointments and other follow-up options upon leaving clinic
6. Actively engage Veterans for timely follow-up if a clinic is canceled due to unforeseen circumstances
7. Integrate community providers as appropriate to enhance access
8. Offer Veterans extended clinic hours, and/or virtual care options, such as Telehealth, when appropriate
9. Transparently report access to care data to Veterans and to the public

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/18/2017 3:37:11 PM
To: (b) (6) (b) (6) @gmail.com]
Subject: Fwd: DEA renewal notice attached
Attachments: 4741_001.pdf; Untitled attachment 20328.htm

Pls prinr

Sent from my iPhone

Begin forwarded message:

From: "(b) (6) " (b) (6) @atlantichealth.org>
Date: January 18, 2017 at 10:16:28 AM EST
To: David shulkin <Drshulkin@aol.com>
Subject: DEA renewal notice attached

Hi David.

Hope all is going well.

From: (b) (6) @atlantichealth.org [mailto (b) (6) @atlantichealth.org]
Sent: Wednesday, January 18, 2017 10:08 AM
To: (b) (6) (b) (6) @atlantichealth.org>
Subject: Attached Image

****
****
****
******* Morristown Medical Center, located in Morristown, NJ, is a nationally-ranked regional medical center and a recognized leader in cardiovascular medicine, orthopedics and nursing. The hospital was ranked by U.S. News & World Report as a top hospital nationwide for cardiology & heart surgery and orthopedics. Morristown Medical Center also recognized as a "Best Regional Hospital," high performing in 16 types of care: abdominal aortic aneurysm repair, aortic valve surgery, colon cancer surgery, chronic obstructive pulmonary disease (COPD), gastroenterology & GI surgery, geriatrics, gynecology, heart bypass surgery, heart failure, hip replacement, knee replacement, lung cancer surgery, nephrology, neurology & neurosurgery, pulmonology, and urology. Morristown Medical Center's Gagnon Cardiovascular Institute performs more cardiac surgeries than any other hospital in New Jersey, placing its cardiac program in the top two percent in the country. The Atlantic Orthopedic Institute at Morristown Medical Center does the highest volume of joint and spine surgeries in New Jersey. In 2014, the hospital was re-designated a Magnet Hospital for Excellence in Nursing Service, the highest level of recognition by American Nurses Credentialing Center for facilities that provide acute care services, a distinction awarded to less than five percent of U.S. hospitals. Morristown Medical Center is certified as a Level I Regional Trauma Center by the American College of Surgeons, and designated a Level II Trauma Center by the state of New Jersey. Morristown Medical Center is part of Atlantic Health System (www.atlantichealth.org), one of the leading non-profit health

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care systems in New Jersey.
****
****
****
****

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U.S. Department of Justice
Drug Enforcement Administration
Diversion Control Division/ODR
Post Office Box 2639
Springfield, Virginia 22152-2639

www.dea.gov

December 25, 2016

2:85 141/212
SHULKIN, DAVID J MD
MORRISTOWN MEMORIAL HOSPITAL
100 MADISON AVE; BOX 1
MORRISTOWN NJ 07960-0000

10020192.3/015790

NOTICE OF REGISTRATION RENEWAL

SAVE TIME, RENEW YOUR REGISTRATION ONLINE!

In reference to registration: BS1054181

Expiration Date: February 28, 2017

Dear Registrant:

(b) (6) [redacted]

Thank you,

(b) (6) [redacted]

Erika Gehrmann, Chief
Registration and Program Support Section
Diversion Control Division

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Message

From: David Shulkin [drshulkin@aol.com]
Sent: 11/26/2016 1:43:04 PM
To: (b) (6) hotmail.com
Subject: Re: Can you open now

It looks really great. Thanks so much to everyone.

I did receive a note saying that the power points did not want a lot of powerpoints so I think I will create an executive summary version with some attachments as well in case we need to make it more like a discussion.

-----Original Message-----
From: Poonam Alaigh <(b) (6) hotmail.com>
To: David Shulkin <drshulkin@aol.com>
Sent: Sat, Nov 26, 2016 8:39 am
Subject: Can you open now

Let me know if you need anything else for the presentation- I have the team on standby. Also, can you have someone send me the transition documents/binder

I am working on the RFP all day today so will be on my computer and available in case you need to connect with me.

Sent from my iPhone

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Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 11/26/2016 1:39:15 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Can you open now

Let me know if you need anything else for the presentation- I have the team on standby. Also, can you have someone send me the transition documents/binder

I am working on the RFP all day today so will be on my computer and available in case you need to connect with me.

Sent from my iPhone

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Message

From: Jennifer Lee [(b) (6) @gmail.com]
Sent: 1/19/2017 9:12:16 PM
To: David Shulkin [drshulkin@aol.com]
Subject: concert

Hi David,
Thank you so very much for the invite to the concert today.
I was planning on going but we are still in the office working on prep materials for next week.
so sorry to miss...but wanted you to know it's for a good cause.
We're doing our very best to help with prep.
Hope to see you at DAV tonight. I missed you at the breakfast this morning.
Thanks!
Jen

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 11/27/2016 9:48:27 PM
To: (b) (6) [(b) (6) @gmail.com]
Subject: Fwd: transition slides
Attachments: transitionbrief.pptx; Untitled attachment 20403.htm

This is the correct set

Sent from my iPhone

Begin forwarded message:

> **From:** David Shulkin <drshulkin@aol.com>
> **Date:** November 26, 2016 at 9:53:03 PM EST
> **To:** DrShulkin@aol.com
> **Subject: transition slides**
>
> Changes
>
> HCAPHS remove clinically
> Trust 47-62
> SWAT remove choice program expiration under weakness
> Suicide prevention 163 should be 135
> 2018 budget add- Clay hunt act and gender alteration surgery

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VA | U.S. Department of Veterans Affairs

U.S. Department of Veterans Affairs Presidential Transition Briefing

Veterans Health Administration

Prepared for:
Agency Review Team

Briefed by:
David J. Shulkin, MD
Under Secretary of Health, Veterans Health Administration

November 2016

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Questions You May Find Relevant

- What has VHA been working on and has it made progress?
- What do veterans think of VHA care?
- How does VHA compare to the private sector?
- Are veterans waiting too long for care?
- What services should be provided in the community and what services within VHA?
- What are costs associated with moving more care out into the community?
- What are the critical issues facing VA in the next year?
- Are there sustainable fixes to funding future VHA care?

VA U.S. Department of Veterans Affairs

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VHA Overview



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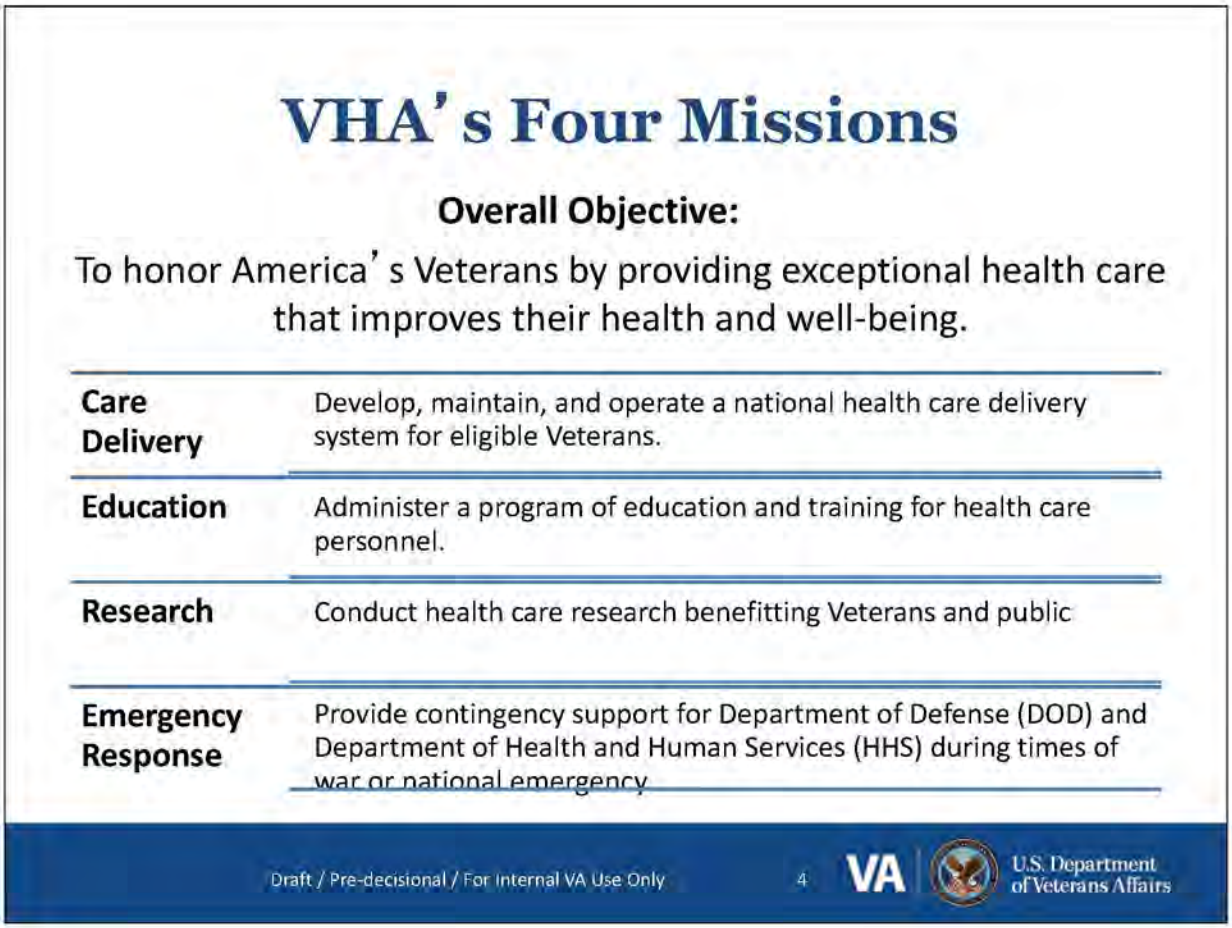

Our mission extends beyond healthcare for Veterans

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The Largest Healthcare System in the United States

- 1,234 health care facilities
  - 168 VA Medical Centers
  - 1,055 outpatient sites
- 25,000 physicians and
- 93,600 nurses (RN, LPN & NA)

- Over four times as many hospitals as Kaiser
- Over twice as many hospitals as DoD

Annual Workload Snapshot



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Annual Financial Report source file for graphic

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VA Healthcare Services Not Found in the Private Sector

- Caregivers
- Centers of Excellence(e.g., Blind Rehabilitation)
- Dental
- Homeless Programs
- Long Term Care
- Readjustment Counseling
- Rural Health Outreach
- Special Populations- Spina Bifida, Camp Lejeune
- Comprehensive Emergency Medical Program
- Health Professions Educational Assistance
- Income Verification Match
- Hepatitis C Treatments
- Prosthetics
- Comprehensive Behavioral Health Programs
- Blind Rehabilitation
- Veterans Crisis Line
- Beneficiary Travel

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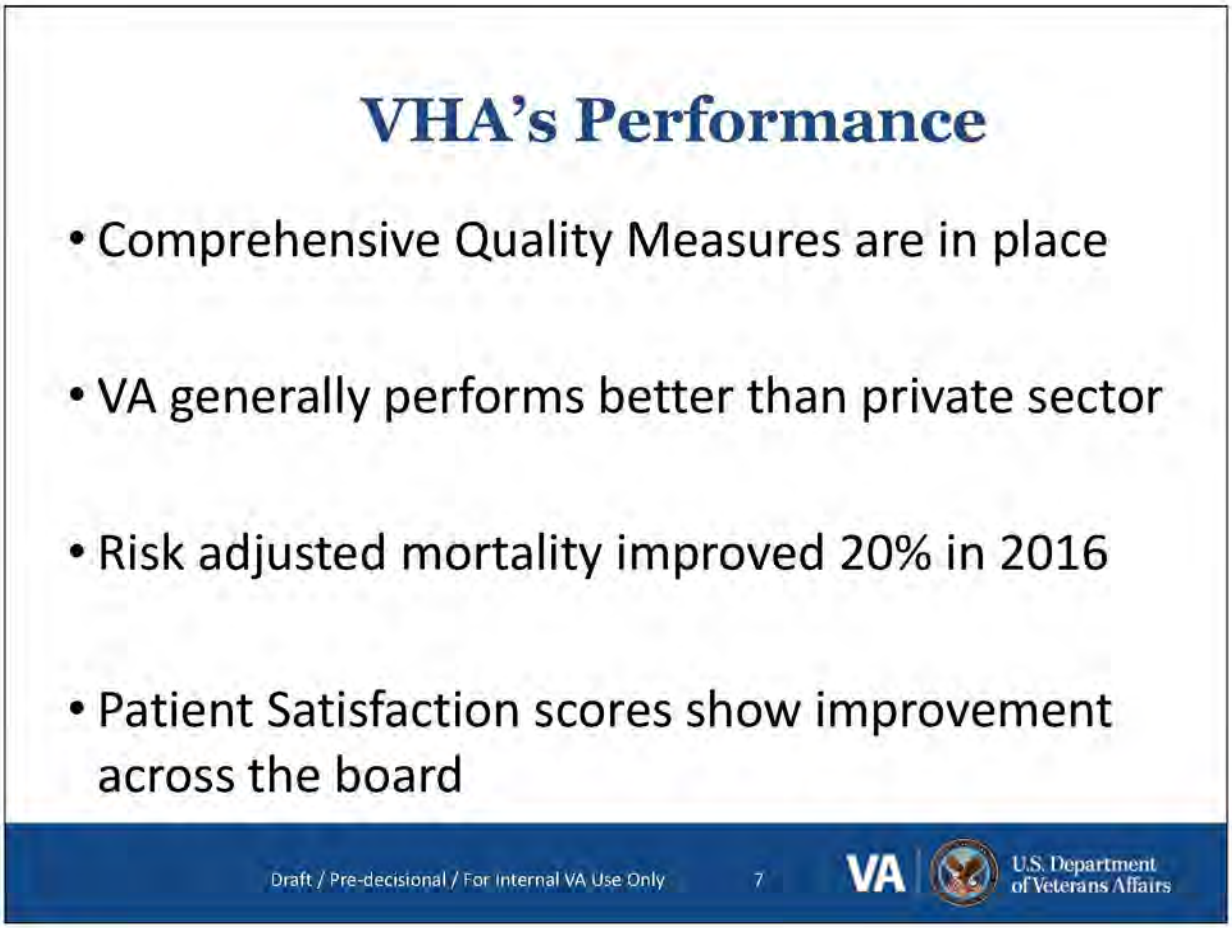

1st bullet:
Regarding Strategic Analytics for Improvement and Learning (SAIL) Model

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82% of VAMCs with Improvement
SAIL Quality Measures in Past Year

	FY16Q3 SAIL Quality Star Percentile Cut-Off					
Overall Quality FY15Q4-FY16Q3[1]	Top10% 5-Star	11-30th% 4-Star	31-70th% 3-Star	71-90th% 2-Star	Bottom10% 1-Star	Total
Large Improvement	8	18	35	20	9	90
Small Improvement	3	7	13	5	2	30
Trivial Improvement	1	3	3	3	1	11
Trivial Decline	3	1	0	0	1	5
Small Decline	1	1	2	0	1	5
Meaningful Decline	1	1	2	0	1	5
Total	17[2]	31[2]	55	28[3]	15[3]	146[4]

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Most Challenged Sites Making Improvements

Site	Indicator	FY14	FY16 (YTD)
Phoenix	CAPHS - Routine Care	66	74
	CAPHS - Urgent Care	51	56
Hines	CAPHS - Routine Care	83	88
	CAPHS - Urgent Care	74	78
Shreveport	CAPHS - Routine Care	79	82
	CAPHS - Urgent Care	65	70
Spokane	CAPHS - Routine Care	81	82
	CAPHS - Urgent Care	64	68
Greater LA	CAPHS - Routine Care	82	83

Note: a 4 to 5 point change is considered "[redacted] significant"

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USH 5 Priorities for Strategic Action

Access

We will provide timely access to Veterans as determined by their clinical needs.

PSA: We pledge that any Veteran with the requirement for urgent care will receive care at the right time appropriate to his or her clinical needs

Employee Engagement

We seek a work environment where employees are valued, supported, and encouraged to do their best for Veterans.

PSA: We will work to allow staff to have greater input into their work environment.



High Performance Network

We will ensure that Veterans receive the highest level of coordinated care within VA or from participating providers.

PSA: We will build a high performance network of care to best serve Veterans.

Best Practices

We will use best clinical practices. We also seek best practices in research, education, and management.

PSA: We seek to identify and disseminate best practices throughout VA.

Veterans First: Trust in VA Care

We will be there for our Veterans when they need us.

PSA: We will share our results on the quality and timeliness of how we care for Veterans.

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Priority 1: Access
Transformative Changes



MyVA Access Declaration

Prong 1

Prong 2

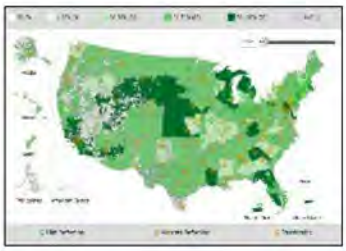
Access Improvement Solutions

National Deployment Strategy

Prong 3



Dr. David Shulkin signing the MyVA Declaration Statement on 4/7/2016



Transformative changes heading
Prong
Guidebook
Map

Same day Services for urgent needs
Path to SDA

Third slide is Results and impact that improve access

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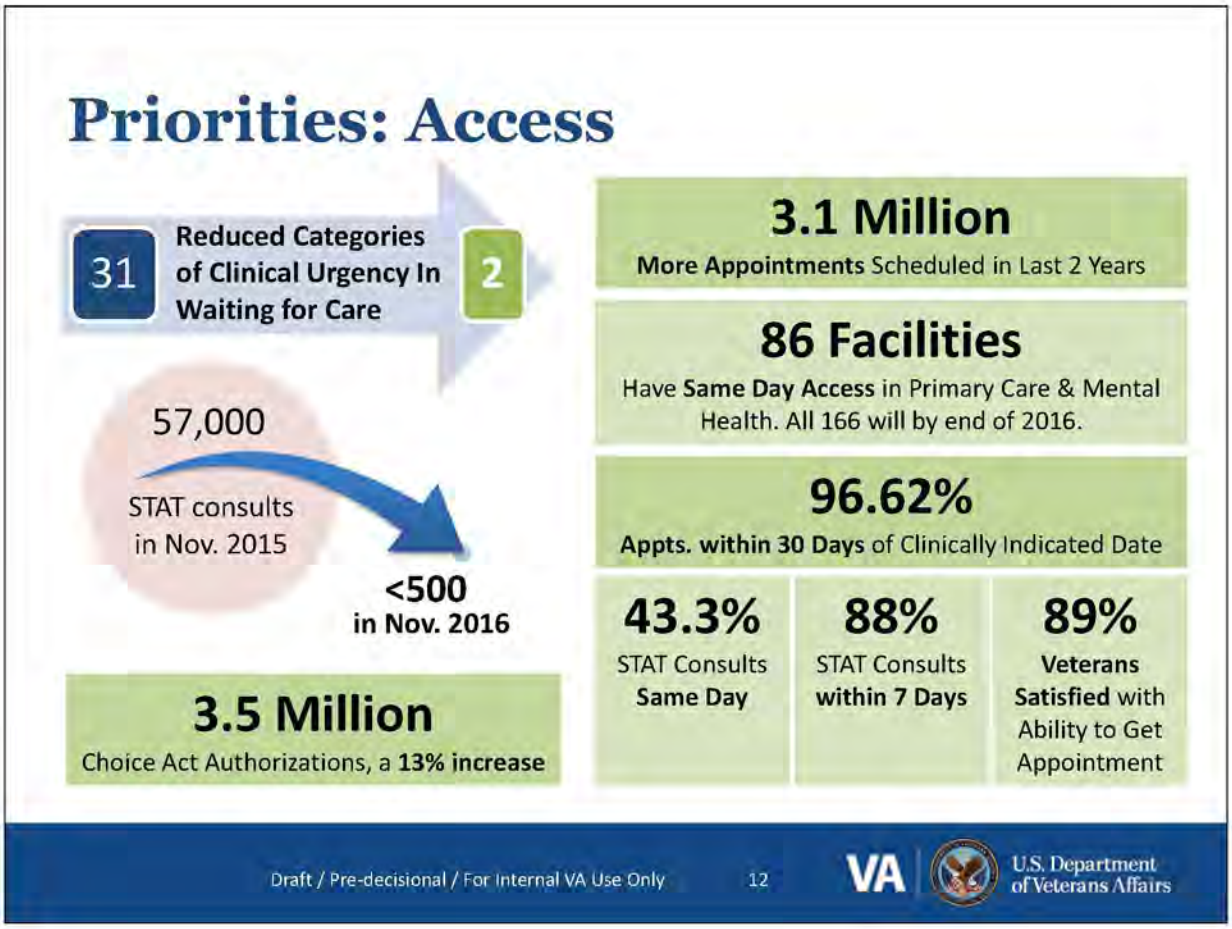

Second bullet is discussing STAT consults over 30 days

Categorized veterans waiting for care into clinical urgency (from 31 categories to 2)
57,000 stat consults in Nov 2015 to <600 in November 2016
3.1 Million more appointments scheduled in the last 2 years
86 facilities have Same Day Access in Primary Care and Mental Health. All 166 facilities will be able to offer these services by the end of 2016
89% of veterans satisfied with the ability to get an appointment (2.1 M veterans)
In October 2016, 96.62% of appointments were within 30 days of the clinically indicated or Veteran's preferred date
43.3% of stat consults were completed same day and 88% were seen within 7 days (a 22% increase from the start of the fiscal year)
Map of veterans evaluation of waiting times by site placed on internet on 11/11/16
Expanded scheduled hours on weekends and evenings, productivity, people, and space
More than 3.5 million authorizations through Choice from September 1, 2015 through August 31, 2016. This represents a 13% increase in authorizations when compared to the same period in 2014/2015

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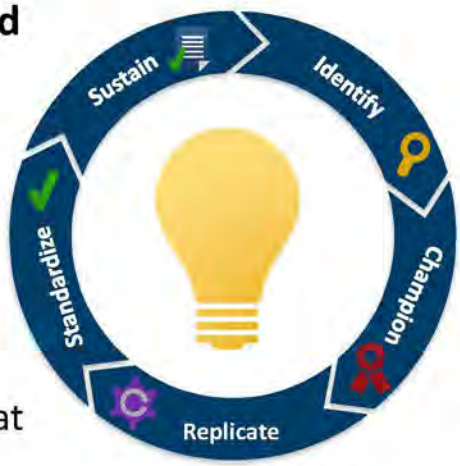
Priorities: Best Practices & Performing as an Integrated Enterprise

- Successfully replicating **13 USH Gold Status best practices 386 times** throughout the system:
  - ➢ **85** of those replications have been completed **within 9 months**
  - ➢ **301** of those replication projects are **ongoing and on track**
  - ➢ **Over 100 facilities** are replicating at least one of the best practices
- **Examples include Virtual Tumor Board and Pharmacist Clinics**



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Priorities – High Performance Network

- As of the end of FY 2016, the Veterans Choice provider network has grown by **85%** and includes more than **360,000** network providers.
- Clinical workload is up **12%** over the past two years—**9%** within VA and **31%** in the community. The **12%** increase translates into roughly **7.5 million** additional hours of care for Veterans.
- New Choice Plan submitted to Congress in October 2015
- RFP planned to be released at end of month for revisions to Community Care program



When Congress passed the Veterans Access, Choice and Accountability Act in 2014 (the Act), which established the Veterans Choice Program (VCP), the Act specified that the program may not furnish care or services after the expiration date of the program on August 7, 2017, or when the funding allocated ($10 billion) was exhausted.
Without further action by Congress before August 7, 2017, those Veterans that receive care through the current VCP (approximately one million unique Veterans have sought care through VCP since its implementation) will have to discontinue VCP care, and those Veterans newly authorized to receive VCP care will have to make alternative arrangements to receive care.
Other VA community care programs may not have the capacity to handle the entirety of patients who will come off of the current VCP. Wait times for appointments at VA facilities will likely rise if large numbers of Veterans return to VA to seek care.

Our goal for VA Community Care is to deliver a program that is easy to understand, simple to administer, and meets the needs of Veterans, community providers, and VA staff. How will we get there? Our approach consists of five components:
1. Eligibility: We want to provide easy to understand eligibility information to Veterans, community providers, and VA staff.
2. Referral and Authorizations: We want to streamline referral and authorizations, providing Veterans timely access to a community provider of their choice.
3. Care Coordination: We want to solidify care coordination through seamless health information exchanges.
4. Community Care Network: We plan to implement a Community Care Network that provides access to high-quality care inside and outside of VA.
5. Provider Payment (Claims): We want to become better partners to our community providers by paying them promptly and correctly.

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Second bullet references a comparison of FY 14 to FY 15 and was originally completed by Finance in March 2016

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Priority 4: Employee Engagement

- VA Pulse - **94,339 unique users**
- Holding **Quarterly Town Hall Meetings** and site based employee open forums
- **AES scores improved** from 3.45 (2014) to 3.58 (2016)



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Priority 5: Restoring Trust

		VE Measure	% Agree or Strongly Agree Jan-Mar 2016 (Q2) (n=24,415)	%Agree or Strongly Agree Apr-Jun 2016 (Q3) (n=29,873)	%Agree or Strongly Agree Jul-Sep 2016 (Q4) (n=27,758)
	BRAND	**"I trust VA to fulfill our country's commitment to Veterans"**	**55%**	**59%**	**60%**
VETERANS EXPERIENCE	EFFECTIVE	"I got the care or service I needed"	72%	74%	75%
	EASE	"It was easy to get the care or services I needed"	61%	65%	66%
	EMOTION	"I felt like a valued customer"	63%	67%	68%

This survey was conducted by an independent contractor and validated by survey subject matter experts from Research Triangle International.

Acknowledgements to National Center for Organizational Development Dr Scott Moore and VHA Operational Excellence Dr Steven Wright.

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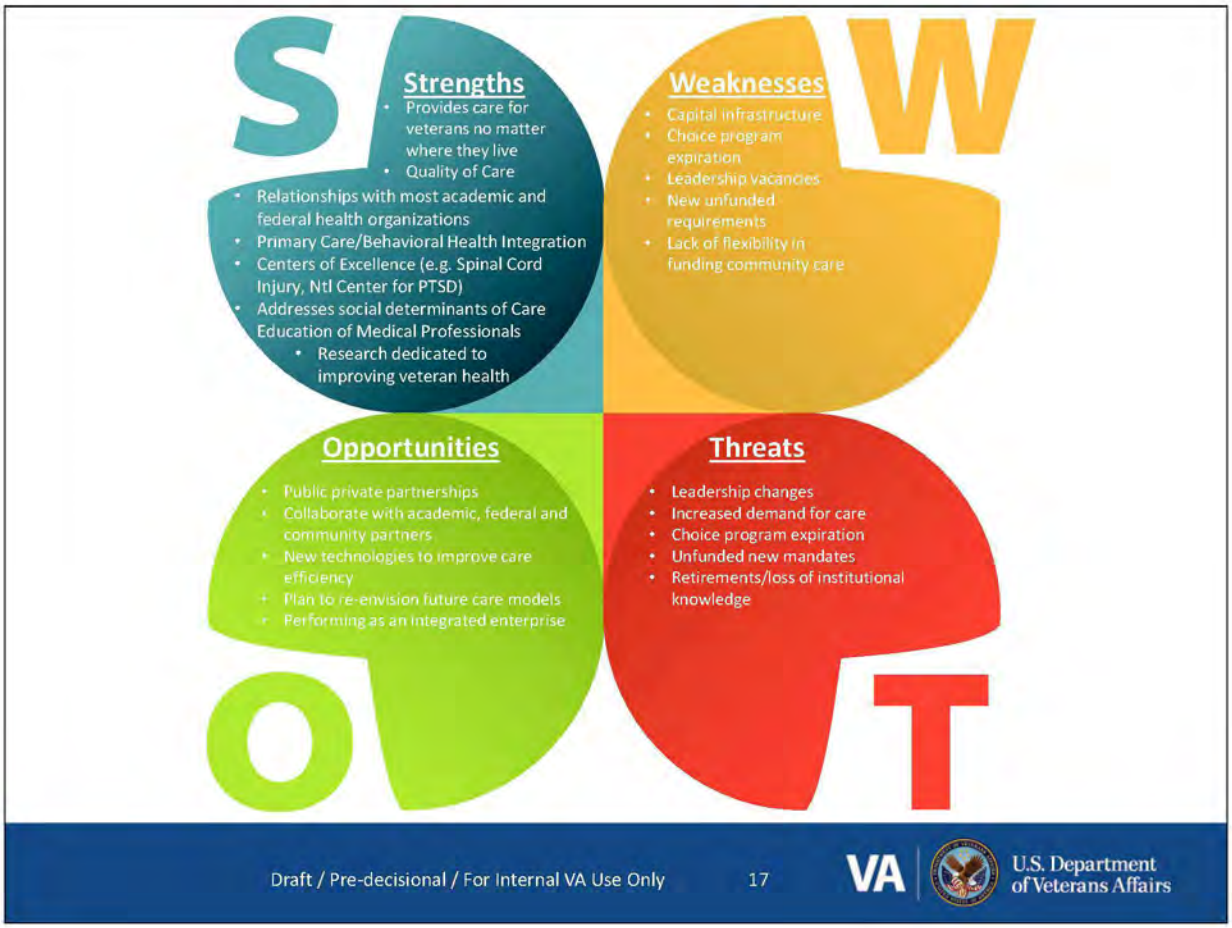

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Continuity of Leadership during a Crisis
Leadership vacancies and succession planning
Maintaining and Strengthening the Gains in Access (including Community Care), Quality, Engagement, and Trust
Direction of the Commission on Care Recommendations
Supporting VHA's Course for a Future Vision

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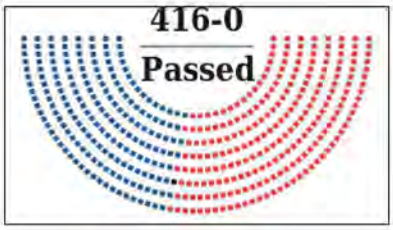
20 Years of Increasing Demand for Services

- 1996 "Veterans Eligibility Reform Act"
- Conflicts in Afghanistan and Iraq continued
  - –Congress provided eligibility for care for five years after discharge
- From 2002 to 2015, VHA outpatient volume increased from 46.5M to almost 97M visits
- 2014 "The Veterans Access, Choice and Accountability Act"



IRAQ AND AFGHANISTAN VETERANS OF AMERICA

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- Enactment of Public Law 104-262, "Veterans Eligibility Reform Act" in 1996 allowed VA to provide full continuum of care for all Veterans who chose to enroll for care

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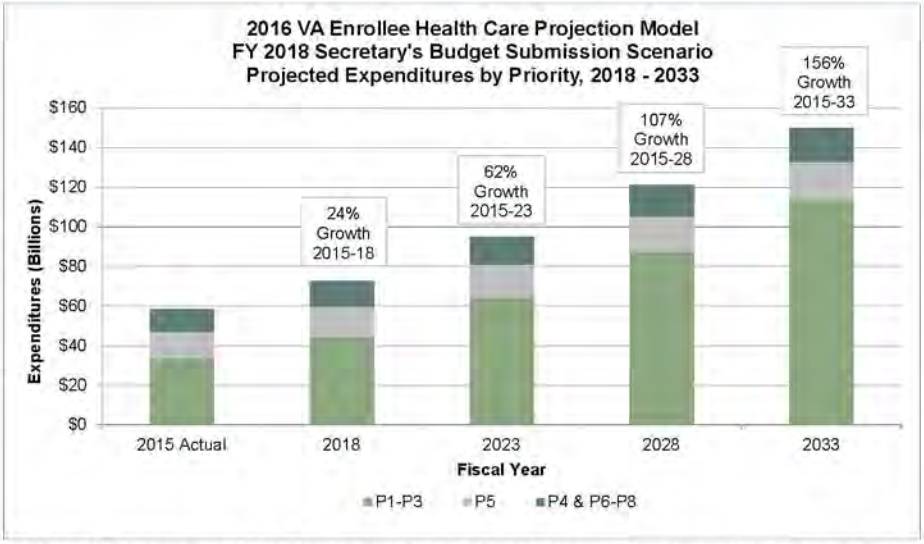
VA's Resource Requirements
Projected to Grow Significantly Over Time



2016 VA EHCPM, Budget Scenario (BAF) Note: The projections do not include requirements for several activities/ programs that are not projected by the VA EHCPM, including non-recurring maintenance, readjustment counseling, state-based long term services and supports programs, and some components of the CHAMPVA program.

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FY 18 Budget Gap

FY 17 Enacted Budget	FY 18 Enacted Budget	Change (% Change)
$72,835,537	$70,012, 287	-2,823,250 (-3.9%)

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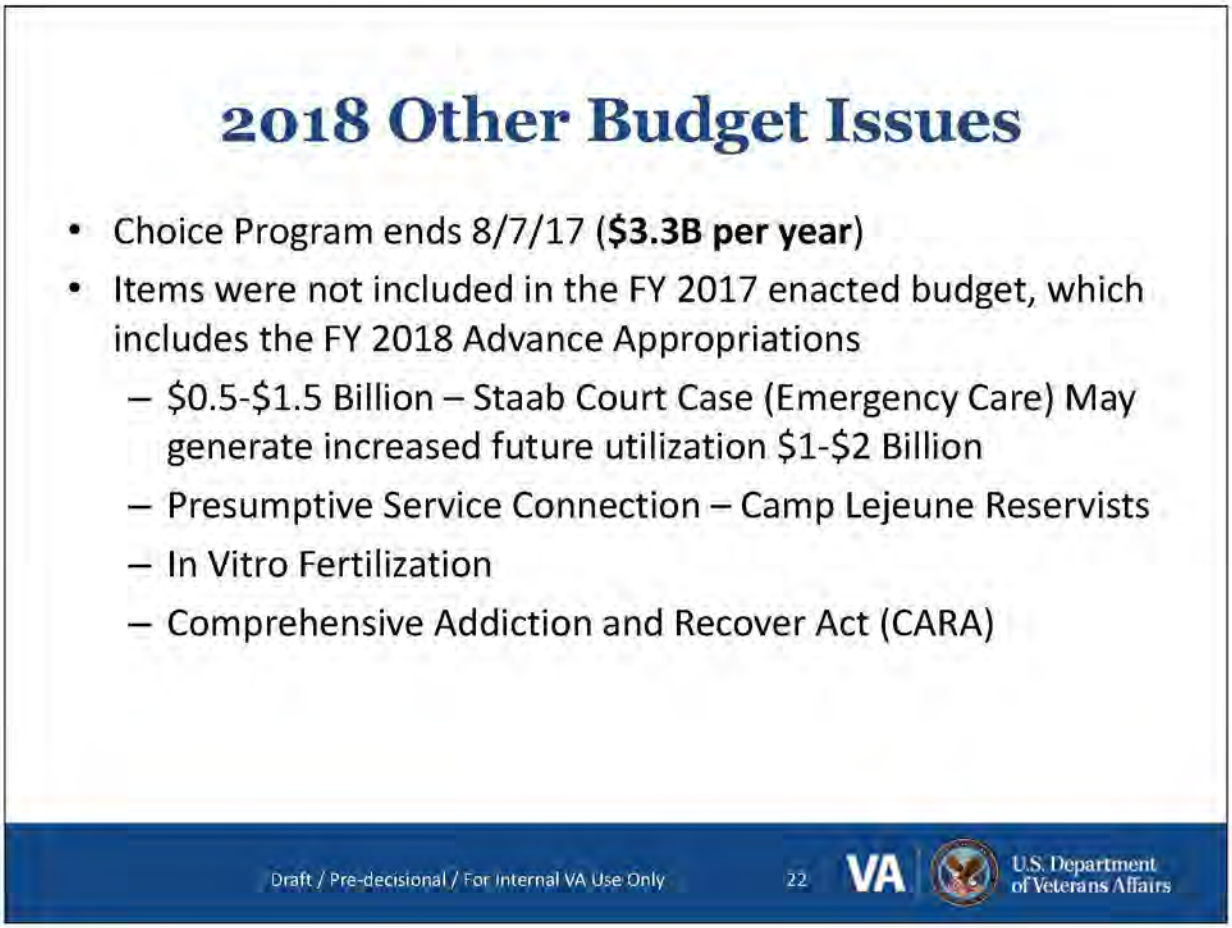

Bullet 3: Estimated budget numbers:
IVF6.5 Million FY 17, 13. million Fy18 --Maximum estimate Non VA Care funds
Adoption: 500K FY 17, 1.5 million FY 18—Maximum estimate
CARA = $153 million – crude estimate, some of which has already been incurred

Camp Lejeune.

Based on evidence there is sufficient scientific and medical evidence available to establish a presumption of connection between exposure to contaminants in the water supply at Camp Lejeune and the occurrence of eight health conditions

The proposed eight presumptive diseases are:
adult leukemia
aplastic anemia and other myelodysplastic syndromes
bladder cancer
kidney cancer
liver cancer
multiple myeloma
non-Hodgkin's lymphoma
Parkinson's disease

VA will not limit entitlement to active duty military personnel. Rather, VA proposes to presume exposure for all active duty, reserve and National Guard personnel who served at Camp Lejeune for no less than 30 cumulative days from August 1,

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1953, through December 31, 1987.

In addition, VA proposes to establish a presumption that individuals who served at Camp Lejeune during this period and later developed one of the presumptive diseases were disabled during the relevant period of service, thus establishing active military service for benefit purposes.

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VA Costs Not Found in Many Health Plans

$Millions	FY 2015	FY 2016	FY 2017
Beneficiary Travel	$853	$888	$924
Camp Lejeune	$10	$24	$21
Caregivers	$454	$623	$725
CHAMPVA, Spina Bifida, FMP, CWVV	$1,547	$1,817	$1,920
Comprehensive Emergency Medical Program	$147	$135	$139
Dental Care	$1,005	$1,035	$1,433
Health Professions Educational Assistance programs	$37	$56	$70
Homeless Programs	$1,507	$1,477	$1,591
Income Verification Match	$17	$19	$19
Long Term Care	$7,702	$8,223	$8,588
Readjustment Counseling	$221	$258	$244
Rural Health Outreach Initiatives	$219	$270	$250
Sharing Agreements - Services Provided by VA	$157	$157	$166
Subtotal	$13,875	$14,980	$16,090
Hepatitis C (assume 50% greater benefit)	$406.1	$500.0	$500.0
Mental Health (assume 50% greater benefit)	$2,283.9	$2,494.9	$2,610.6
Prosthetics (assume 50% greater benefit)	$909.0	$950.3	$1,215.2
Subtotal	$3,599.0	$3,945.2	$4,325.9
Total	$17,473.9	$18,924.9	$20,415.8

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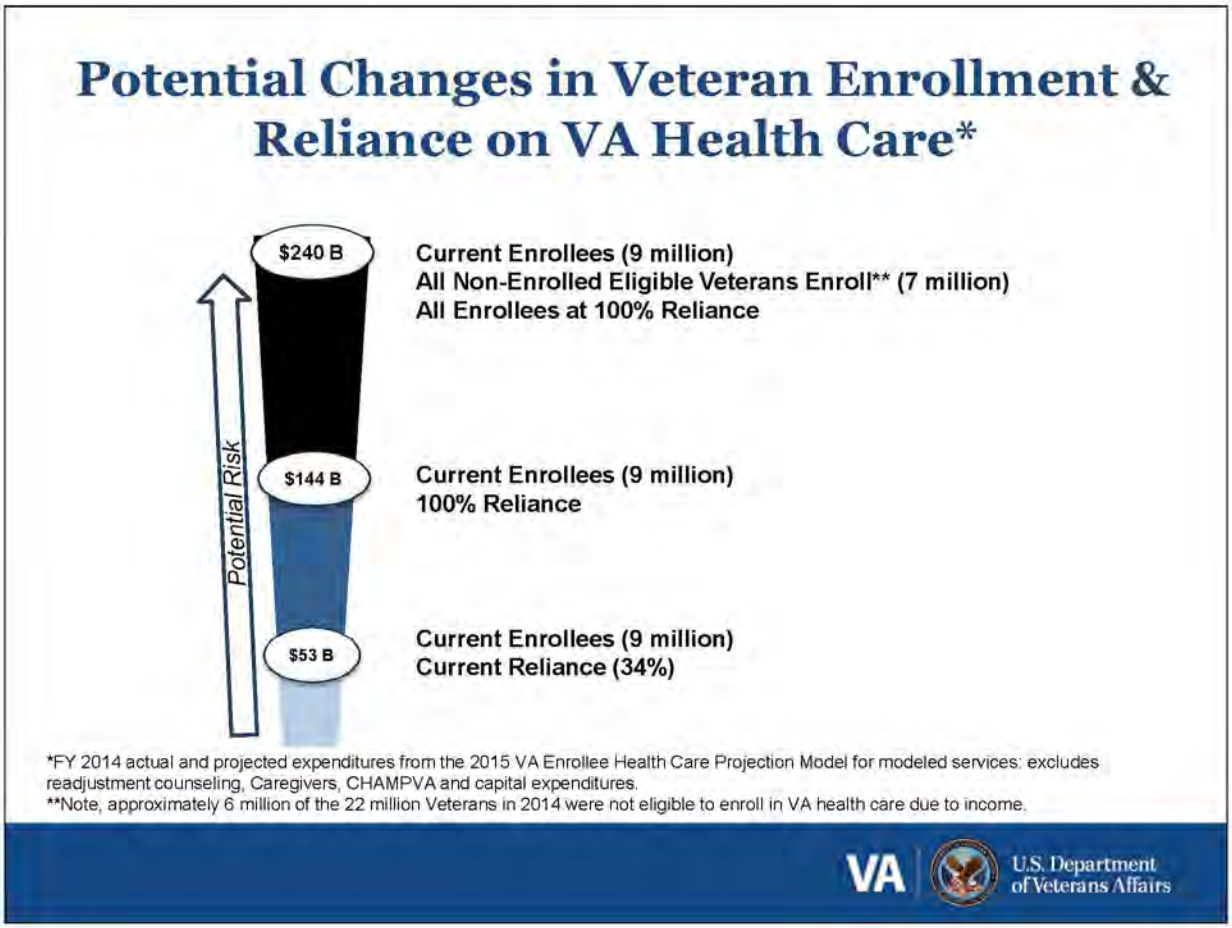

In 2014, costs for modeled services for 9 million enrollees at 34% reliance was $53 billion.

If all those 9 million enrollees used VA for all their health care, the cost in 2014 would have been $144 billion.

If all eligible but unenrolled veterans enrolled in VA and used VA for all their health care, the cost in 2014 would have been $240 billion.

All policy changes move this lever up and down as they impact either reliance on VA for health care, enrollment in VA, or both.

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Other Areas of Focus for FY 17

- Implement Full Practice Authority for Advance Practice Nurses
- Legislative fixes to "Care in the Community"
- Implement scheduling system for medical appointments
- Critical Pay for Medical Center Directors/other VA leaders
- 80-hour pay period
- Streamline Hiring/Onboarding Process
- Space – Leasing restrictions
- Facility Modernization – VHA aging Infrastructure
- Sustainable funding options for VA healthcare

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A Future Vision for VHA

- **Public Private Partnerships** to serve Veterans
- **Digital Health Platform**
- **Whole Health Medicine** (empowering veteran well-being)
- Develop the **High Performance Network** (role of VISNs)
- **Center of Excellence** and Foundational Care
- **Value Based Management** and Efficiency Strategies
- Strengthen VA as a **Learning Healthcare System**
- Accelerate **Precision Medicine** and foster innovation
- Provide access to **VA Research Data** for non VA researchers with appropriate safeguards
- **Train More** primary care and behavioral health students

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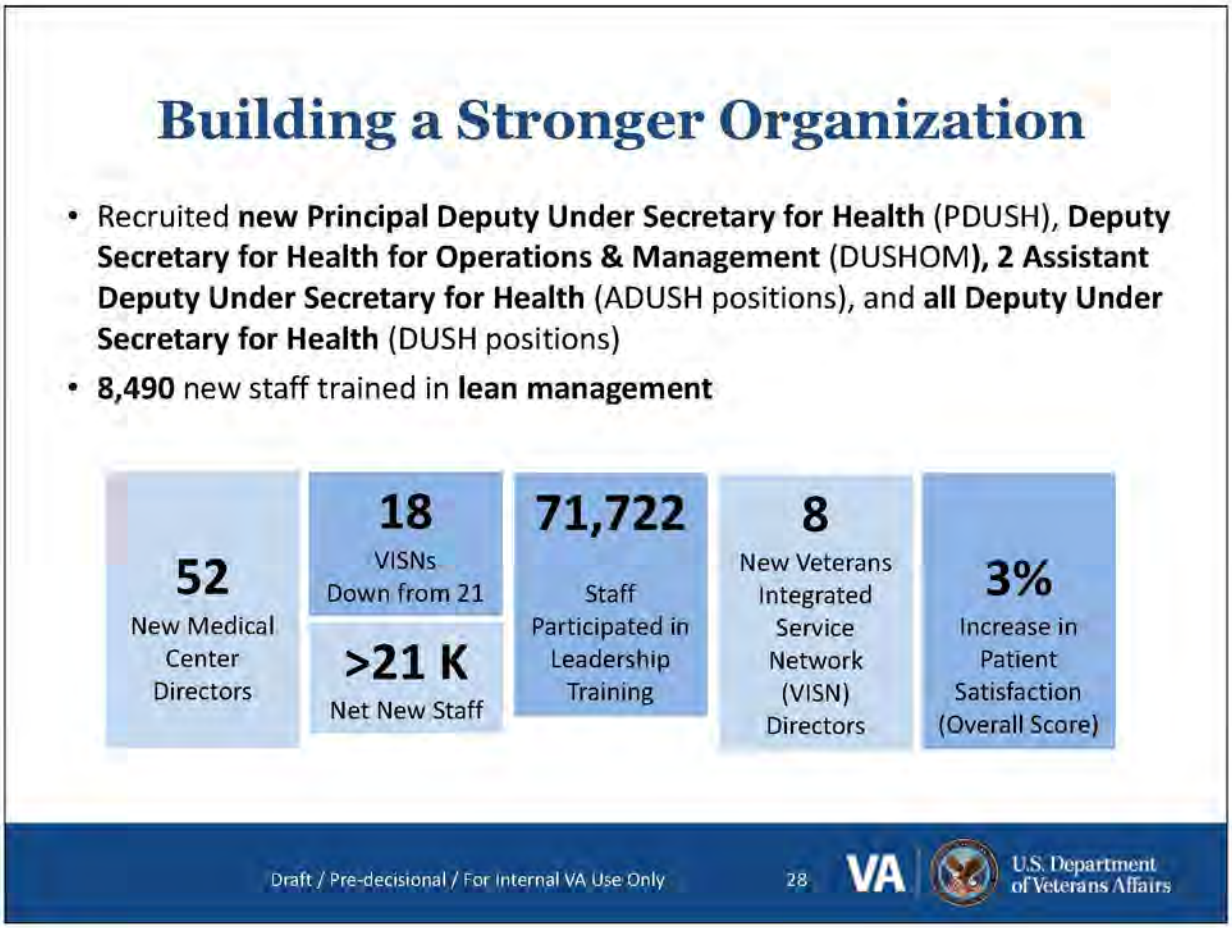
Our Commitment to Veterans

- ✓ Veterans should be at the center of what we do and how we deliver care at VHA
- ✓ No veteran with an urgent care need that may cause harm should wait for care
- ✓ VA must act like an integrated enterprise and a learning health system to benefit veterans most
- ✓ We will work closely with our academic, federal and community providers to deliver the highest outcomes to veterans
- ✓ VA leadership and staff must feel proud, fulfilled and empowered to deliver services to Veterans
- ✓ We must regain the trust and confidence of Veterans and the American public
- ✓ VA mission of research, education, and emergency preparedness must continue to contribute to improving the health of Veterans and all Americans

AMERICAN OVERSIGHT



5th bullet notes:

Precision Oncology is the targeting of cancer therapy to the molecular profile of the cancer. This is not new – for many years we have been tailoring cancer therapy for some cancers. An easy example is assessing breast cancer for the presence of estrogen receptors, then using medications that block the effect of estrogen, thus blunting the effect of hormones which drive breast cancer growth. However, in the last 10 years the ability to sequence many genes simultaneously has led to an understanding of the specific mutations that drive cancer growth in many tumor types. This has gone in parallel with the development of medications that target and inhibit the effect of these specific driver mutations. Use of these targeted therapies has resulted in dramatic responses in some cases that previously had very poor outcomes. Unfortunately, only a small minority of cancers have identifiable mutations and targeted therapy available. The VA is currently expanding a program of sequencing a large number of genes in solid cancers, with several aims: to identify mutations in cancers for which there is available targeted therapy and treat these Veterans with the best available therapy; to identify mutations in cancers that might make them susceptible to an approved drug as an off label use; and to identify Veterans with molecular profiles in their cancer that would allow them to consider enrolling in clinical trials. To address the analysis of the molecular data, the VHA has a partnership with IBM Watson Health. This partnership will enhance our ability to both ensure Veterans receive the best available care now, and that clinical and basic research will improve care in the future.

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Serving our Veterans and the Nation

Culture of Improvement

- 6th year – **VA's pharmacy benefits ranked among best in class**
- **24 million in cost avoidance** through our supply chain efforts
- An Integrated operations center to **proactively monitor and identify** issues in quality or access
- **23,000 pounds of used medications** returned and **destroyed** this year

Service to the Nation

- **9,860 research publications** in 2016
- Added **547.4 graduate medical education positions**
- Responded and deployed to **6 national emergencies**



AMERICAN OVERSIGHT

Public Health Issues

Hepatitis C Management

- In FY15 & 16, **VA treated a total of 69,294 Veterans with Hepatitis C** with an anticipated cure rate of over 90%.
- In CY2015, **69.9%** of the birth cohort (Veterans born between 1945-1965) were **screened for Hepatitis C**.



Reducing Opioid Abuse and Dependency

- 22% reduction in opioid use
- 42% reduction in use of opioids and benzodiazepines
- 32% reduction in dosages



Prevention Programs

- 42,000 Veteran Flu Shots at Walgreens
- MOVE! has helped over 600,000 patients lose weight, keep it off, and improve their health

Walgreens

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Suicide Prevention

- **Elevated Office** of Suicide Prevention
- Completed and released a **landmark, comprehensive data analyses of Veteran suicide rates**, examining over 50 million Veteran records from 1979 to 2014 from every state in the nation, providing critical insights to help inform and shape our policies and efforts
- Reach Vet Program initiated to **proactively reach out** to those at highest risk
- **Added 163 responders** to the Veterans crisis line and added direct connections from the phone system to VCL
- Hugely successful Suicide Prevention Month 2016 campaign **#BeThere** garnered **over 73 million social media impressions** across various platforms, over 420 million impressions from TV, radio, and out of home placements (earned and paid), and was supported via Twitter by Joe Mantegna and Senators McCain and Sanders



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Complex Care Needs

Homelessness

- There was a **17 percent decline in Veteran homelessness** between 2015 and 2016, quadruple the previous year's annual rate of decline
- Since 2010**, over 480,000 Veterans and their family members have been permanently housed**, rapidly rehoused, or prevented from falling into homelessness by HUD's targeted housing vouchers and VA's homelessness programs

We've cut Veteran homelessness nationwide by 47% since 2010

Providing Counseling Services where Veterans are Comfortable

- More than **1 million primary care/mental health integration visits**
- More than **1.5 million visits** to Vet Centers providing readjustment, Military Sexual Trauma and bereavement counseling services



Hep C Management Notes

VA follows CDC recommendations to screen everyone born between 1945-1965 as they are at the highest risk of having HCV. Screening is also recommended for those born outside of this cohort who have other risk factors.

Source: VA's National Center for Health Promotion and Disease Prevention (NCP) HCV Screening recommendations: http://vaww.prevention.va.gov/CPS/Screening_for_Hepatitis_C.asp

AMERICAN OVERSIGHT

Transformative Research

VA Research Importance

- Intramural research at **~100 VA medical centers** nationwide serving Veterans for nearly 100 years
- **2500** ongoing projects and **~3500** researchers
- Fiscal year 2016 realized **9820 published papers; 9 NJEM/11 JAMA**
- **Veteran centric** research studies are focused and relevant **to military service and healthcare needs**
- Embedding VA Research in a healthcare system generates **quicker, more economical scientifically based healthcare solutions**
- Veteran participants in Research contribute to **advancing healthcare for the population**, especially by participating in Veteran centric studies which are **not supported anywhere else**
- VA's intramural research program leverages the best clinician care providers to ask **Veteran relevant research** questions

Notable Recent Research Findings

- Finding that prolonged exposure therapy, psychotherapy technique, is an **effective treatment for PTSD**
- Showing that **deep brain stimulation** is helpful for patients with **Parkinson's disease**
- Established effectiveness of **PTSD treatments** and identified novel delivery pathways (e.g., **telehealth**) and additional **complementary and integrative health** approaches (e.g., meditation)
- Implemented **medical home models** and leveraged **predictive analytics** to improve access and quality of primary care for **Veterans who are homeless**
- Developed new **precision medicine** initiative to utilize **genomic information** to optimize care plan for **Veterans with depression**, a major factor associated with poor health outcomes and suicide
- Launched four randomized evaluations of national service programs on **suicide prevention, opioid prescribing, tele-dermatology, and home-based geriatric care**
- Conducted research on **virtual medical care** (e.g., e-consults) and specialty care access networks, resulting in enhanced access to care for prevalent medical conditions (e.g., chronic pain, Hepatitis C)

Innovative Research

Implanted prosthetic control (Isens)
Nerve cuff electrodes restore the sense of touch & muscle sensors restore dextrous control



Osseointegrated Prosthetic Attachment



DEKA/LUKE Arm
Highly functional robotic prosthetic arm system



Bimodal Foot/Ankle
Switches between stiff for stable standing and flexible for efficient walking



Manual Standing Wheelchair
Can be manually propelled in sitting or standing



Equifoot
Stores & returns energy more efficiently & instantly adapts to changes in slope



Recognition

- **3 Nobel Prizes in Physiology or Medicine**
  - Ferid Murad, M.D., Ph.D. Discoveries relating to nitric oxide.
  - Andrew W. Schally, Ph.D., M.D. (Multi), D.Sc.,h.c. Research on peptide hormone production in the brain.
  - Rosalyn Yalow, Ph.D. Development of radioimmunoassay.
- **Lasker Award Recipients (premier medical research award)**
  - 2012 - Thomas Starzl, M.D. Developed liver transplantation
  - Six Lasker winners between 1963-1975
- **2009 President's Baldrige Award for Performance Excellence** – Cooperative Studies Program Clinical Research Pharmacy Coordinating Center (only 2nd federal agency to receive the award)
- **2014-Drs. William Bauman and Ann Spungen of the Bronx VAMC receive Samuel J. Heyman Science and Environment Medal for research on spinal cord injury**
- **2016-Million Veteran Program** exceeds 500,000 enrollees and becomes the world's largest genomic research program

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Innovative Healthcare

Telehealth

- In FY 2016, 12% of all Veterans enrolled for VA care received telehealth-based care. This includes **2.17 million telehealth visits, touching 702,000 Veterans**.
- Upcoming expanded services through VAR and VA Video Connect in 2017.

Million Veterans Program

- Program to incorporate **precision medicine** to improve Veterans' health by establishing large database containing genetic, military exposure, lifestyle, and health information with over **520,000 enrollees** as of Oct. 2016

Office of Compassionate Innovation

- Launched **Mental Health Service Dog** pilot to assist Veterans with mental health conditions that impede their mobility
- Since Center for Compassionate Innovation announced in April 2016, 38 proposals received; **8 proposals have moved to field implementation or warm hand-off** and **3 have been closed**

New

VA / Watson Cancer Partnership for Precision Oncology

Connect Care

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FY2016 OIG and GAO Activities in VHA

- OIG published 388[1] reports on VHA this year
- GAO conducted 65[2] reviews this year
- Estimated time required from VHA staff to support OIG and GAO activities: 158,840 - 395,010 staff hours at a GS-13 to SES-level payscale.

- Calculations[3]
  - Conservative estimate (assumes 5 data calls during a 12 month period):
    - 209[4] reviews requiring 76 hours of staff time per review, minimum 10 GS-13 to SES level staff = 158,840 staff hours in 2016.
  - Realistically (assumes 10 data calls during a 12 month period):
    - 209[4] reviews requiring 126 hours of staff time per review, average 15 GS-13 to SES level staff = 395,010 staff hours in 2016.
  - Large reviews can pull 20 data calls, require full time staff or contractors to support and manage all of the data requests, and involvement from multiple VHA and department program offices. We have approximately 1-2 of these per year.

[1]*Source – OIG Semi-Annual Reports to Congress from Spring and Fall 2016*
[2]*Source – MRS hand count of GAO reviews underway during 2016*
[3]*Calculations do not include staff time during interviews or time spent orienting OIG or GAO to databases or facilities.*
[4]*Omitted 244 Criminal Investigations because these do not follow the same process as OIG and GAO reviews, health care inspections and audits.*

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Myths vs. Reality

Myth	Reality
Veterans cared for by VHA have similar issues to most other Americans	Users of VHA are older and have more complex medical issues than non-users (almost 50% of users have a mental health diagnosis)
Care in VHA is poor quality	Numerous independent studies have shown that quality or equal or better
VHA does not want to utilize private sector health providers	22% of all care currently is done in the community- Close to 4 million Choice Act Authorizations has been utilized
Veteran Suicides are only a VHA problem	Of the 20 Veterans who take their own life a day- 14 do not get care in VHA
The private sector offers the same services as in VHA	More than 20 billion dollars in care a year goes towards services not provided by private sector
Access to services is worse than the private sector	96.5% of veterans were seen within 30 days of their clinical indicated or preferred date. Similar data is not readily available from the private sector
Veterans want to use private sector providers and not VA services	Of the 1 million veterans that used Choice, less than 5000 veterans did not also receive their care in VHA

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Comparing VA Care to Private Sector

- 30-day risk-standardized **mortality rates are lower** in VA than those of non-VA hospitals for acute myocardial infarction and heart failure
- **MRSA infections declined** 69 percent in VA acute care facilities and 81 percent in spinal cord injury units over 5 years thanks to VA's aggressive MRSA prevention plan.
- VA performed the **same or significantly better** than non-VA providers on 12 of 14 **effectiveness measures in the inpatient setting**
- VA performed **significantly better** on 16 **outpatient HEDIS measures** compared with commercial HMOs and significantly better on 15 outpatient HEDIS measures compared with Medicare HMOs
- VA mental health care was **better than private-sector care by at least 30 percent on all seven performance measures**, with VA patients with depression more than twice as likely as private-sector patients to get effective long-term treatment
- **Outcomes for VA patients compared favorably** to patients with non-VA health insurance, with VA patients more likely to receive recommended evidence-based treatment

More data in press release: http://www.va.gov/opa/pressrel/includes/viewPDF.cfm?id=2778

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Who We Serve

- Veterans who rely most on the VA
  - Veterans with lower income
  - Veterans living in rural areas
  - Veterans without other access to health insurance coverage
  - Veterans with poorer self-reported health status
  - Veterans with higher rates of comorbidities
- The prevalence of many common conditions is projected to increase among Veterans over the next 10 years
- In the event of a potential future conflict, even moderate levels of deployment could substantially increase the size of the incoming cohort of VA patients

Findings from the independent assessment (section 201) Appendix A Demographics

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 11/27/2016 9:47:38 PM
To: (b) (6) [(b) (6) va.gov]
Subject: Re: [EXTERNAL] Fwd: transition slides

No sorry- this is the wrong set

Ill resend the correct set

Sent from my iPhone

On Nov 27, 2016, at 4:43 PM, (b) (6) (b) (6) R. [(b) (6) va.gov> wrote:

> Hi Sir,
>
> Sorry getting lost in version control, these look semi different than what David sent today at 2:43. (attached)
>
> Should we tell him to forgo updating his current deck and use the deck you sent to me ?
>
> (b)
>
> **From:** (b) (6) [mailto(b) (6) @gmail.com]
> **Sent:** Sunday, November 27, 2016 4:36 PM
> **To:** (b) (6)
> **Subject:** [EXTERNAL] Fwd: transition slides
> **Importance:** High
>
> ---------- Forwarded message ----------
> From: "David shulkin" <Drshulkin@aol.com>
> Date: Nov 27, 2016 4:22 PM
> Subject: Fwd: transition slides
> To: "(b) (6) <(b) (6) @gmail.com>
> Cc:
>
> This is the latest version and some corrections that still need to be made
>
> Sent from my iPhone
>
> Begin forwarded message:
>
> > **From:** David Shulkin <drshulkin@aol.com>
> > **Date:** November 26, 2016 at 9:53:03 PM EST
> > **To:** DrShulkin@aol.com
> > **Subject: transition slides**
> >
> > Changes
> >
> > HCAPHS remove clinically
> > Trust 47-62

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SWAT remove choice program expiration under weakness
Suicide prevention 163 should be 135
2018 budget add- Clay hunt act and gender alteration surgery

<VHAOrgBrief-PresidentialTransition-(b) (6)_v5.pptx>

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 11/27/2016 9:46:10 PM
To: (b) (6) [(b) (6) va.gov]
Subject: Re: [EXTERNAL] Fwd: transition slides

Yes

Sent from my iPhone

On Nov 27, 2016, at 4:43 PM, (b) (6) (b) (6) R. [(b) (6) va.gov> wrote:

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Cc:

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Sent from my iPhone

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Date: November 26, 2016 at 9:53:03 PM EST
To: DrShulkin@aol.com
Subject: transition slides

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<VHAOrgBrief-PresidentialTransition-(b) (6)_v5.pptx>

AMERICAN OVERSIGHT

Message

From: [(b) (6) [(b) (6) va.gov]
Sent: 11/27/2016 9:43:01 PM
To: 'David shulkin' [Drshulkin@aol.com]
Subject: RE: [EXTERNAL] Fwd: transition slides
Attachments: VHAOrgBrief-PresidentialTransition(b) (6) _v5.pptx

Hi Sir,

Sorry getting lost in version control, these look semi different than what David sent today at 2:43. (attached)

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VA | U.S. Department of Veterans Affairs

U.S. Department of Veterans Affairs Presidential Transition Briefing

Veterans Health Administration

Prepared for:
Agency Review Team

Briefed by:
David J. Shulkin, MD
Under Secretary of Health, Veterans Health Administration

November 2016

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Purpose and Agenda

- **Purpose:** To provide an overview of the Veterans Health Administration (VHA) and highlight major priorities and challenges
- **Overview:**
  - Organization Chart
  - Budget and FTEs
  - Assessment of VHA's Situation
    - Focus and Priorities
    - VHA's Performance
  - Accomplishments in FY 2016
  - Actions/Decisions for Next 100 Days
  - Future Directions and Opportunities for VHA

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Overview



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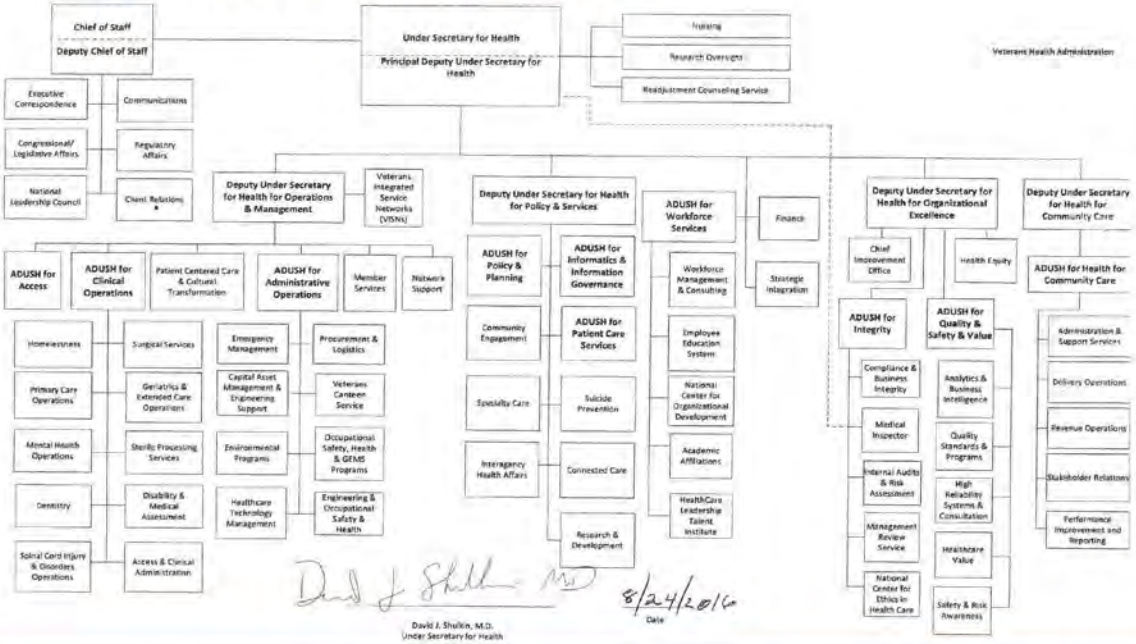
Organization Chart



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Budget and FTE

($ in 000)	2009 Actual	2010 Actual	2011 Actual	2012 Actual	2013 Actual	2014 Actual	2015 Actual	2016 Actual	2017 Enacted	Change 2016 v 2017 $/FTE	Change 2016 v 2017 %
Medical Services	30,761,000	34,755,000	37,061,727	39,705,335	41,323,000	43,418,000	45,195,886	52,442,183	45,371,812	-7,070,371	0.3%
Medical Community Care	0	0	0	0	0	0	0	0	7,246,181	7,246,181	
Medical Support & Compliance	4,405,500	4,882,000	5,262,454	5,479,650	5,738,000	5,983,000	5,874,091	6,060,984	6,498,000	437,016	7.2%
Medical Facilities (Includes NRM)	5,029,000	4,859,000	5,713,550	5,426,000	5,445,000	4,957,000	4,737,000	4,688,513	5,312,668	624,155	13.3%
Medical Care Appropriations	**40,195,500**	**44,496,000**	**48,037,731**	**50,610,985**	**52,506,000**	**54,358,000**	**55,806,977**	**63,191,680**	**64,428,661**	**1,236,981**	**2.0%**
Collections	2,766,908	2,847,565	2,775,213	2,830,302	2,903,000	3,087,990	3,422,806	3,503,146	3,558,307	55,161	1.6%
Total, Medical Care with Collections	**42,962,408**	**47,343,565**	**50,812,944**	**53,441,287**	**55,409,000**	**57,445,990**	**59,229,783**	**66,694,826**	**67,986,968**	**1,292,142**	**1.9%**
Medical Research	510,000	581,000	579,838	581,000	581,905	585,664	588,513	658,949	673,366	14,417	2.2%
Total Medical Programs Budget Authority	**43,472,408**	**47,924,565**	**51,392,782**	**54,022,287**	**55,990,905**	**58,031,654**	**59,818,296**	**67,353,775**	**68,660,334**	**1,306,559**	**1.9%**
Total FTE	**238,845**	**248,489**	**257,756**	**261,152**	**271,375**	**281,795**	**292,981**	**TBD**	**320,795**		

Note: Data excludes (DoD-VA Incentive Funds, DoD-VA Demostration Fund, Veterans Choice, & Canteen)

Medical Services

Funds direct health care costs (personnel, supplies, equipment, etc.).
Supplemented by the Medical Care Collections Fund.

Medical Support and Compliance

Funds supporting administrative services (VHACO, VHA Consolidated Activities (CMOPs, CPACs, etc.), medical center management teams (Director, Chief of Staff, Chief Medical Officer, and Chief Nurse), medical center support functions (quality of care oversight, security services, legal services, billing and coding activities, acquisition, procurement, and logistics activities), human resource management, logistics and supply chain management, financial management, and security and police.

Medical Facilities

Funds utilities, building and grounds maintenance and refurbishment, lease costs, engineering services, and other facilities management activities.

Community Care

Funds health care services for eligible Veterans and other beneficiaries purchased from community health care providers.

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Any others?

Medical and Prosthetic Research

Funds medical and prosthetic research and development programs.

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Overview—Four Missions

Overall Objective:

To honor America's Veterans by providing exceptional health care that improves their health and well-being.

Four Missions			
Care Delivery	**Education**	**Research**	**Emergency Response**
• Develop, maintain, and operate a national health care delivery system for eligible Veterans.	• Administer a program of education and training for health care personnel.	• Conduct health care research benefitting Veterans and public	• Provide contingency support for Department of Defense (DOD) and Department of Health and Human Services (HHS) during times of war or national emergency

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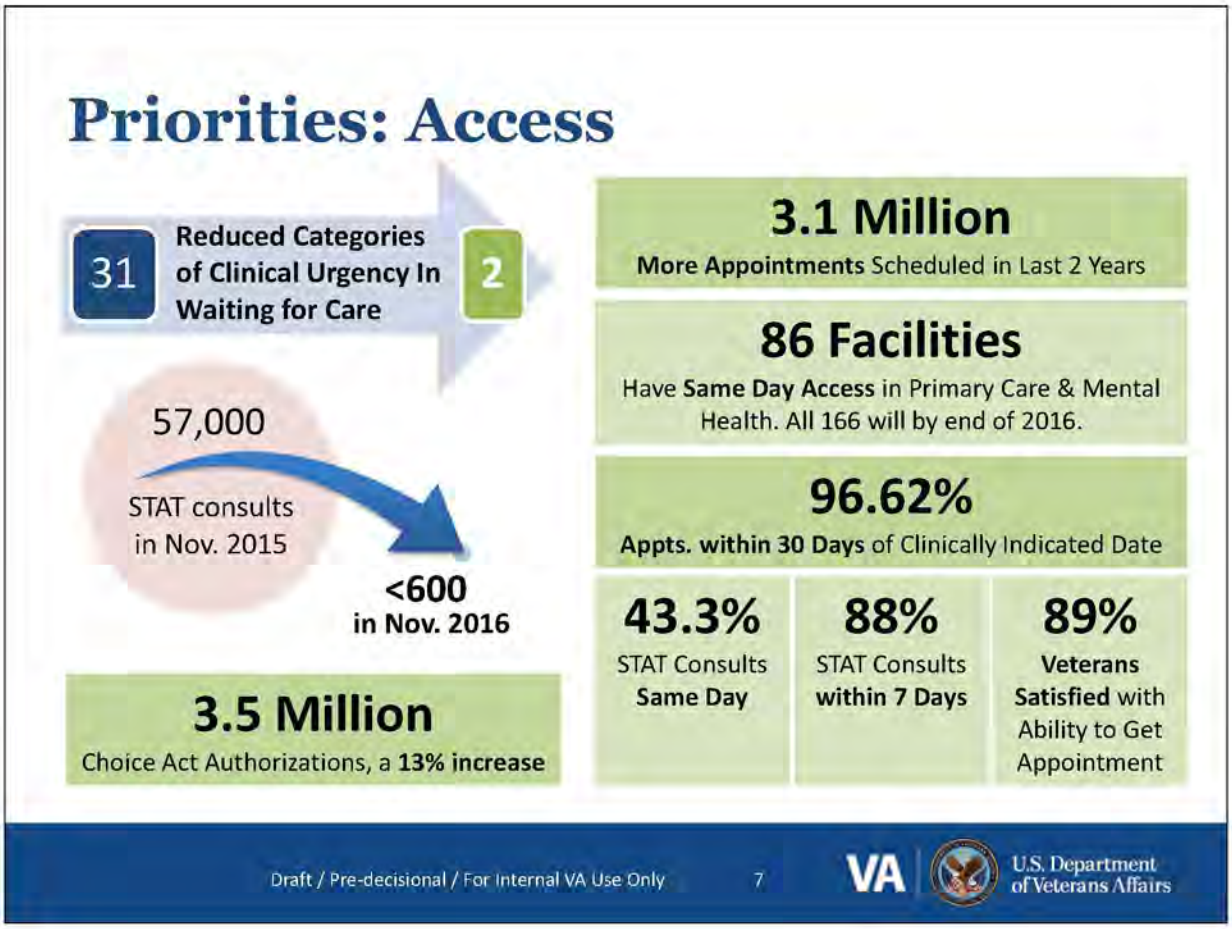

Second bullet is discussing STAT consults over 30 days

Categorized veterans waiting for care into clinical urgency (from 31 categories to 2)
57,000 stat consults in Nov 2015 to <600 in November 2016
3.1 Million more appointments scheduled in the last 2 years
86 facilities have Same Day Access in Primary Care and Mental Health. All 166 facilities will be able to offer these services by the end of 2016
89% of veterans satisfied with the ability to get an appointment (2.1 M veterans)
In October 2016, 96.62% of appointments were within 30 days of the clinically indicated or Veteran's preferred date
43.3% of stat consults were completed same day and 88% were seen within 7 days (a 22% increase from the start of the fiscal year)
Map of veterans evaluation of waiting times by site placed on internet on 11/11/16
Expanded scheduled hours on weekends and evenings, productivity, people, and space
More than 3.5 million authorizations through Choice from September 1, 2015 through August 31, 2016. This represents a 13% increase in authorizations when compared to the same period in 2014/2015

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Priorities: Best Practices & Performing as an Integrated Enterprise

- Successfully replicating **13 USH Gold Status best practices 386 times** throughout the system:
  - **85** of those replications have been completed **within 9 months**
  - **301** of those replication projects are **ongoing and on track**
  - **Over 100 facilities** are replicating at least one of the best practices
- Empowering employees with "Shark Tanks", granting Gold Status best practice status to at least **20 fellows per year**



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Priorities – High Performance Network

- As of the end of FY 2016, the Veterans Choice provider network has grown by **85%** and includes more than **350,000** network providers.
- Clinical workload is up **12%** over the past two years—**9%** within VA and **31%** in the community. The **12%** increase translates into roughly **7.5 million** additional hours of care for Veterans.
- New Choice Plan submitted to Congress in October 2015
- RFP planned to be released at end of month for revisions to Community Care program



When Congress passed the Veterans Access, Choice and Accountability Act in 2014 (the Act), which established the Veterans Choice Program (VCP), the Act specified that the program may not furnish care or services after the expiration date of the program on August 7, 2017, or when the funding allocated ($10 billion) was exhausted.
Without further action by Congress before August 7, 2017, those Veterans that receive care through the current VCP (approximately one million unique Veterans have sought care through VCP since its implementation) will have to discontinue VCP care, and those Veterans newly authorized to receive VCP care will have to make alternative arrangements to receive care.
Other VA community care programs may not have the capacity to handle the entirety of patients who will come off of the current VCP. Wait times for appointments at VA facilities will likely rise if large numbers of Veterans return to VA to seek care.

Our goal for VA Community Care is to deliver a program that is easy to understand, simple to administer, and meets the needs of Veterans, community providers, and VA staff. How will we get there? Our approach consists of five components:
1. Eligibility: We want to provide easy to understand eligibility information to Veterans, community providers, and VA staff.
2. Referral and Authorizations: We want to streamline referral and authorizations, providing Veterans timely access to a community provider of their choice.
3. Care Coordination: We want to solidify care coordination through seamless health information exchanges.
4. Community Care Network: We plan to implement a Community Care Network that provides access to high-quality care inside and outside of VA.
5. Provider Payment (Claims): We want to become better partners to our community providers by paying them promptly and correctly.

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When Congress passed the Veterans Access, Choice and Accountability Act in 2014 (the Act), which established the Veterans Choice Program (VCP), the Act specified that the program may not furnish care or services after the expiration date of the program on August 7, 2017, or when the funding allocated ($10 billion) was exhausted.

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Other VA community care programs may not have the capacity to handle the entirety of patients who will come off of the current VCP. Wait times for appointments at VA facilities will likely rise if large numbers of Veterans return to VA to seek care.

Second bullet references a comparison of FY 14 to FY 15 and was originally completed by Finance in March 2016

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Priorities

- **Employee Engagement**
  - ➢VA Pulse - **94,339 unique users**
  - ➢Holding **Quarterly Town Hall Meetings** and site based employee open forums
  - ➢AES scores improved from 3.45 (2014) to **3.58** (2016)



- **Restore Trust and Confidence**
  - ➢Trust in VA increased from 47% in 2015 to **61%** (November 2016)

2nd bullet:
The actual "Trust" question to Veterans is "I trust VA to fulfill our country's commitment to Veterans"

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1st bullet:
Regarding Strategic Analytics for Improvement and Learning (SAIL) Model

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VHA Accomplishments in 2016

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Suicide Prevention

- Elevated Office of Suicide Prevention
- Completed and released a landmark, comprehensive data analyses of Veteran suicide rates, examining over 50 million Veteran records from 1979 to 2014 from every state in the nation, providing critical insights to help inform and shape our policies and efforts
- Reach Vet Program initiated to proactively reach out to those at highest risk
- Added 163 responders to the Veterans crisis line and added direct connections from the phone system to VCL
- Hugely successful Suicide Prevention Month 2016 campaign #BeThere garnered over 73 million social media impressions across various platforms, over 420 million impressions from TV, radio, and out of home placements (earned and paid), and was supported via Twitter by Joe Mantegna and Senators McCain and Sanders



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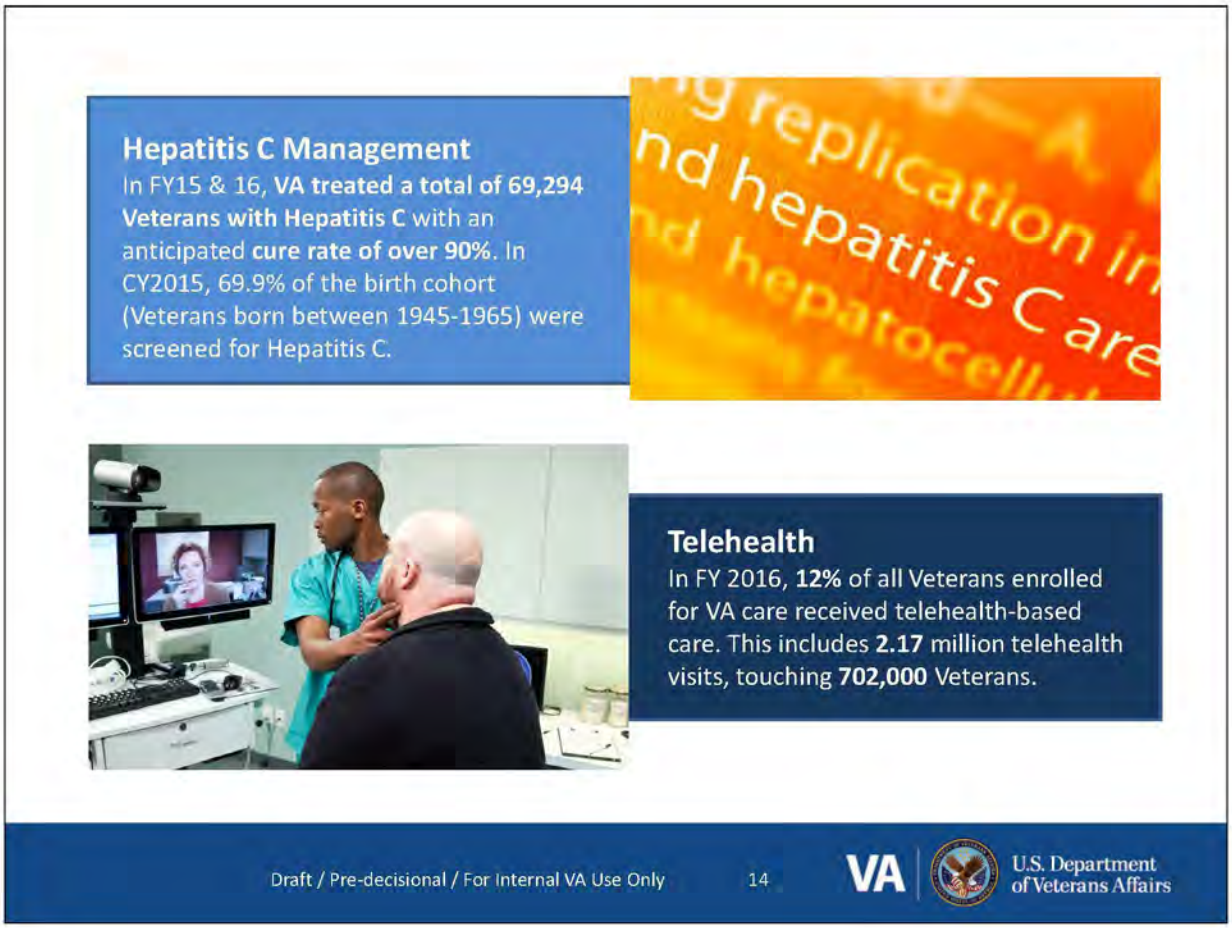

Hep C Management Notes

VA follows CDC recommendations to screen everyone born between 1945-1965 as they are at the highest risk of having HCV. Screening is also recommended for those born outside of this cohort who have other risk factors.

Source: VA's National Center for Health Promotion and Disease Prevention (NCP) HCV Screening recommendations: http://vaww.prevention.va.gov/CPS/Screening_for_Hepatitis_C.asp

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Accomplishments
(Continued)

Million Veterans Program

- Program to incorporate precision medicine to improve Veterans' health by establishing large database containing genetic, military exposure, lifestyle, and health information with over 520,000 enrollees as of Oct. 2016

Office of Compassionate Innovation

- Launched Mental Health Service Dog pilot to assist Veterans with mental health conditions that impede their mobility
- Since Center for Compassionate Innovation announced in April 2016, 38 proposals received; 8 proposals have moved to field implementation or warm hand-off and 3 have been closed

Homelessness

- There was a 17 percent decline in Veteran homelessness between 2015 and 2016, quadruple the previous year's annual rate of decline
- Since 2010, over 480,000 Veterans and their family members have been permanently housed, rapidly rehoused, or prevented from falling into homelessness by HUD's targeted housing vouchers and VA's homelessness programs

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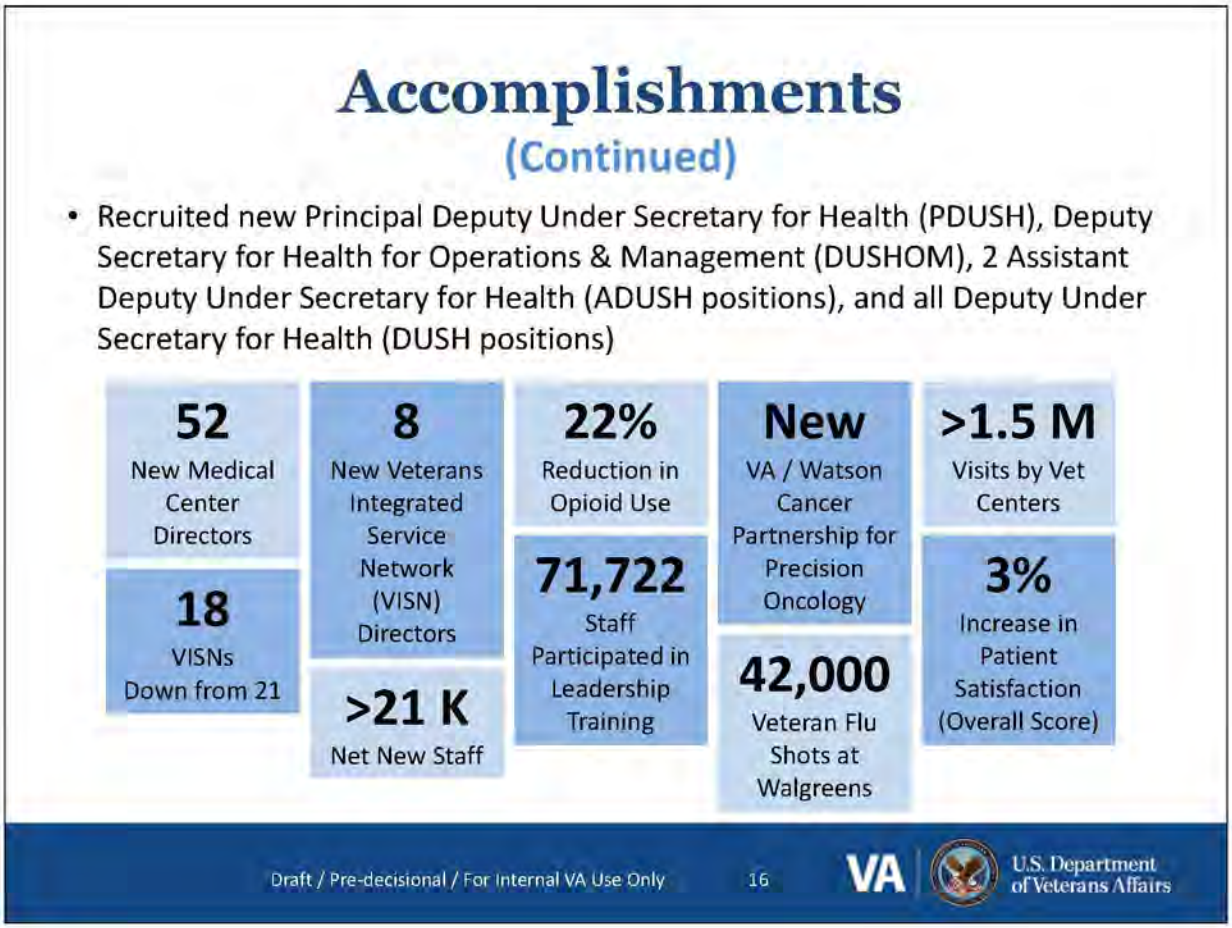

5th bullet notes:

Precision Oncology is the targeting of cancer therapy to the molecular profile of the cancer. This is not new – for many years we have been tailoring cancer therapy for some cancers. An easy example is assessing breast cancer for the presence of estrogen receptors, then using medications that block the effect of estrogen, thus blunting the effect of hormones which drive breast cancer growth. However, in the last 10 years the ability to sequence many genes simultaneously has led to an understanding of the specific mutations that drive cancer growth in many tumor types. This has gone in parallel with the development of medications that target and inhibit the effect of these specific driver mutations. Use of these targeted therapies has resulted in dramatic responses in some cases that previously had very poor outcomes. Unfortunately, only a small minority of cancers have identifiable mutations and targeted therapy available. The VA is currently expanding a program of sequencing a large number of genes in solid cancers, with several aims: to identify mutations in cancers for which there is available targeted therapy and treat these Veterans with the best available therapy; to identify mutations in cancers that might make them susceptible to an approved drug as an off label use; and to identify Veterans with molecular profiles in their cancer that would allow them to consider enrolling in clinical trials. To address the analysis of the molecular data, the VHA has a partnership with IBM Watson Health. This partnership will enhance our ability to both ensure Veterans receive the best available care now, and that clinical and basic research will improve care in the future.

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Accomplishments

- >21,000 net staff added since FY 2015
- 42,000 veterans receive flu shots with Walgreen's partnership
- Announced a partnership between VA and Stanford to bring particle beam therapy to veterans
- More than 1 Million primary care/mental health visits
- 6th year- VA's pharmacy benefits ranked among best in class
- 24 Million in cost avoidance through our supply chain efforts
- An Integrated operations center to proactively monitor and identify issues in quality or access

Notes:
there was actually a decrease in the number of PC VISITs from FY15 to FY16; however MH had a significant increase, 984,000 more VISITs, so it's close – I think with the right combination of clinic stops we could make the more than 1 Million PC and MH visits than last year statement work.

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Accomplishments
(Continued)

- More than 1 million primary care/mental health visits
- 6th year – VA's pharmacy benefits ranked among best in class
- 24 million in cost avoidance through our supply chain efforts
- An Integrated operations center to proactively monitor and identify issues in quality or access
- 23,000 pounds of used medications returned and destroyed this year
- 9,860 research publications in past year
- Added 547.4 graduate medical education positions
- 8,490 new staff trained in lean management
- Responded and deployed to 6 national emergencies

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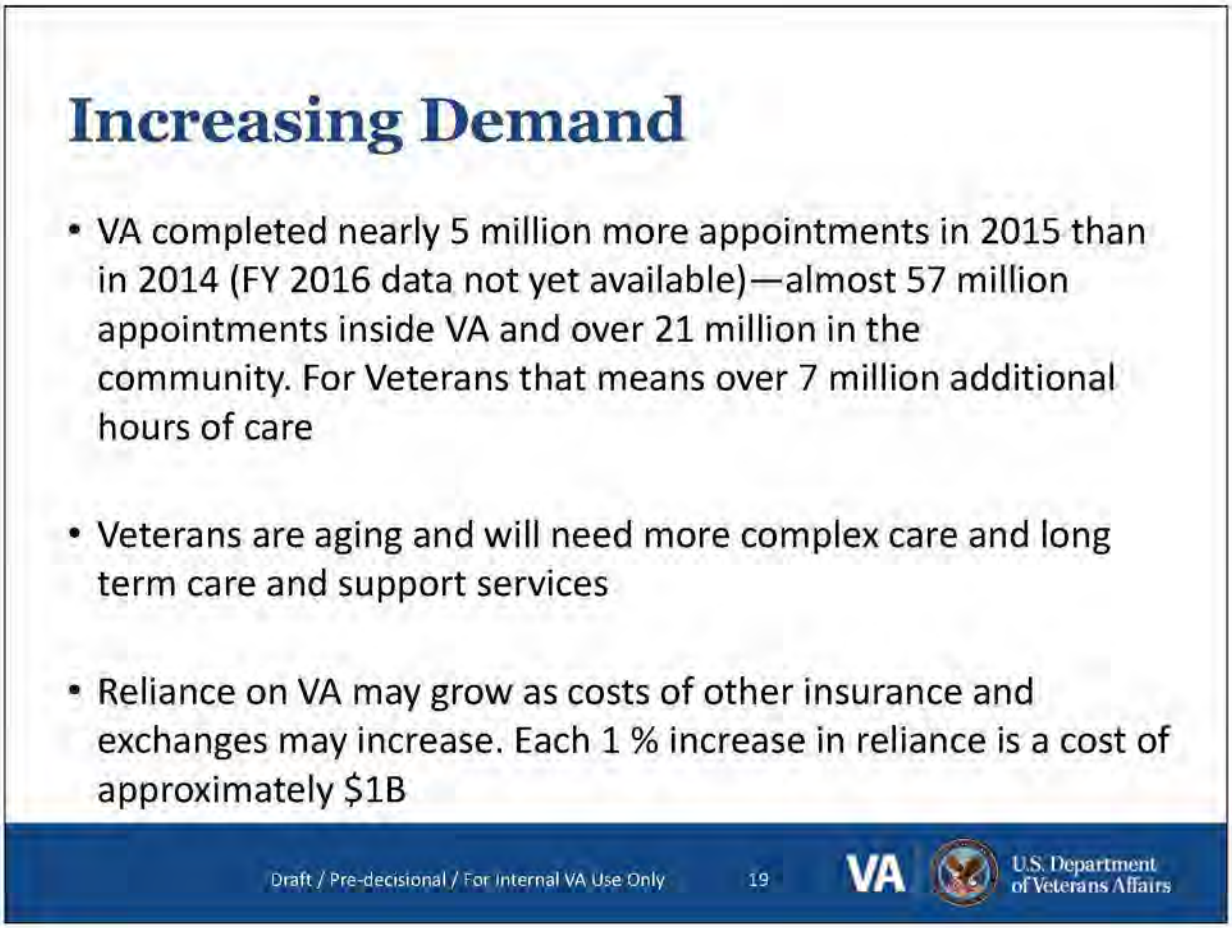

3rd bullet notes:
In 2014, enrollee reliance was estimated to be approximately 34%. We are currently updating reliance analysis with more recent Medicare data, but it is not available at this time. Reliance reflects the portion of health care services that an enrollee needs that we expect VA to provide or pay for. Some enrollees will get all of their health care from the VA and some will get none of their care, but most receive some portion of their care in the VA. For example, based on his/her morbidity, if an enrollee needs 10 office visits in a year and gets 4 of those office visits in VA. This enrollee is said to be 40 percent reliant on VA for office visits.

(b) (6) mentioned wanting to get graphs for this slide and the next from Mark Yow. As such, I haven't edited.

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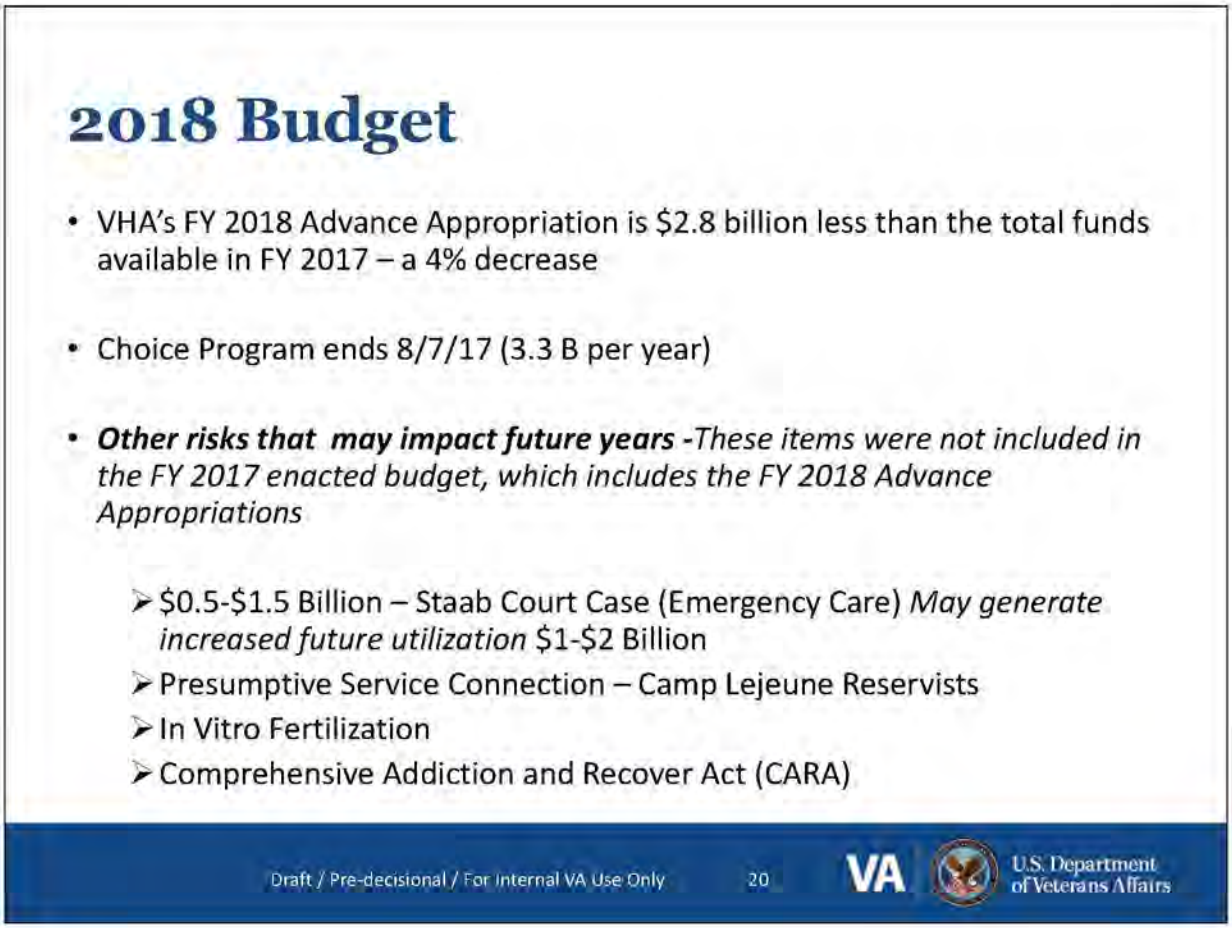

Bullet 3: Estimated budget numbers:
IVF6.5 Million FY 17, 13. million Fy18 --Maximum estimate Non VA Care funds
Adoption: 500K FY 17, 1.5 million FY 18—Maximum estimate
CARA = $153 million – crude estimate, some of which has already been incurred

Camp Lejeune.

Based on evidence there is sufficient scientific and medical evidence available to establish a presumption of connection between exposure to contaminants in the water supply at Camp Lejeune and the occurrence of eight health conditions

The proposed eight presumptive diseases are:
adult leukemia
aplastic anemia and other myelodysplastic syndromes
bladder cancer
kidney cancer
liver cancer
multiple myeloma
non-Hodgkin's lymphoma
Parkinson's disease

VA will not limit entitlement to active duty military personnel. Rather, VA proposes to presume exposure for all active duty, reserve and National Guard personnel who served at Camp Lejeune for no less than 30 cumulative days from August 1,

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1953, through December 31, 1987.

In addition, VA proposes to establish a presumption that individuals who served at Camp Lejeune during this period and later developed one of the presumptive diseases were disabled during the relevant period of service, thus establishing active military service for benefit purposes.

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VA Costs Not Found in Many Health Plans

$Millions	FY 2015	FY 2016	FY 2017
Beneficiary Travel	$853	$888	$924
Camp Lejeune	$10	$24	$21
Caregivers	$454	$623	$725
CHAMPVA, Spina Bifida, FMP, CWVV	$1,547	$1,817	$1,920
Comprehensive Emergency Medical Program	$147	$135	$139
Dental Care	$1,005	$1,035	$1,433
Health Professions Educational Assistance programs	$37	$56	$70
Homeless Programs	$1,507	$1,477	$1,591
Income Verification Match	$17	$19	$19
Long Term Care	$7,702	$8,223	$8,588
Readjustment Counseling	$221	$258	$244
Rural Health Outreach Initiatives	$219	$270	$250
Sharing Agreements - Services Provided by VA	$157	$157	$166
Subtotal	**$13,875**	**$14,980**	**$16,090**
Hepatitis C (assume 50% greater benefit)	$406.1	$500.0	$500.0
Mental Health (assume 50% greater benefit)	$2,283.9	$2,494.9	$2,610.6
Prosthetics (assume 50% greater benefit)	$909.0	$950.3	$1,215.2
Subtotal	**$3,599.0**	**$3,945.2**	**$4,325.9**
Total	**$17,473.9**	**$18,924.9**	**$20,415.8**

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Continuity of Leadership during a Crisis
Leadership vacancies and succession planning
Maintaining and Strengthening the Gains in Access (including Community Care), Quality, Engagement, and Trust
Direction of the Commission on Care Recommendations
Supporting VHA's Course for a Future Vision

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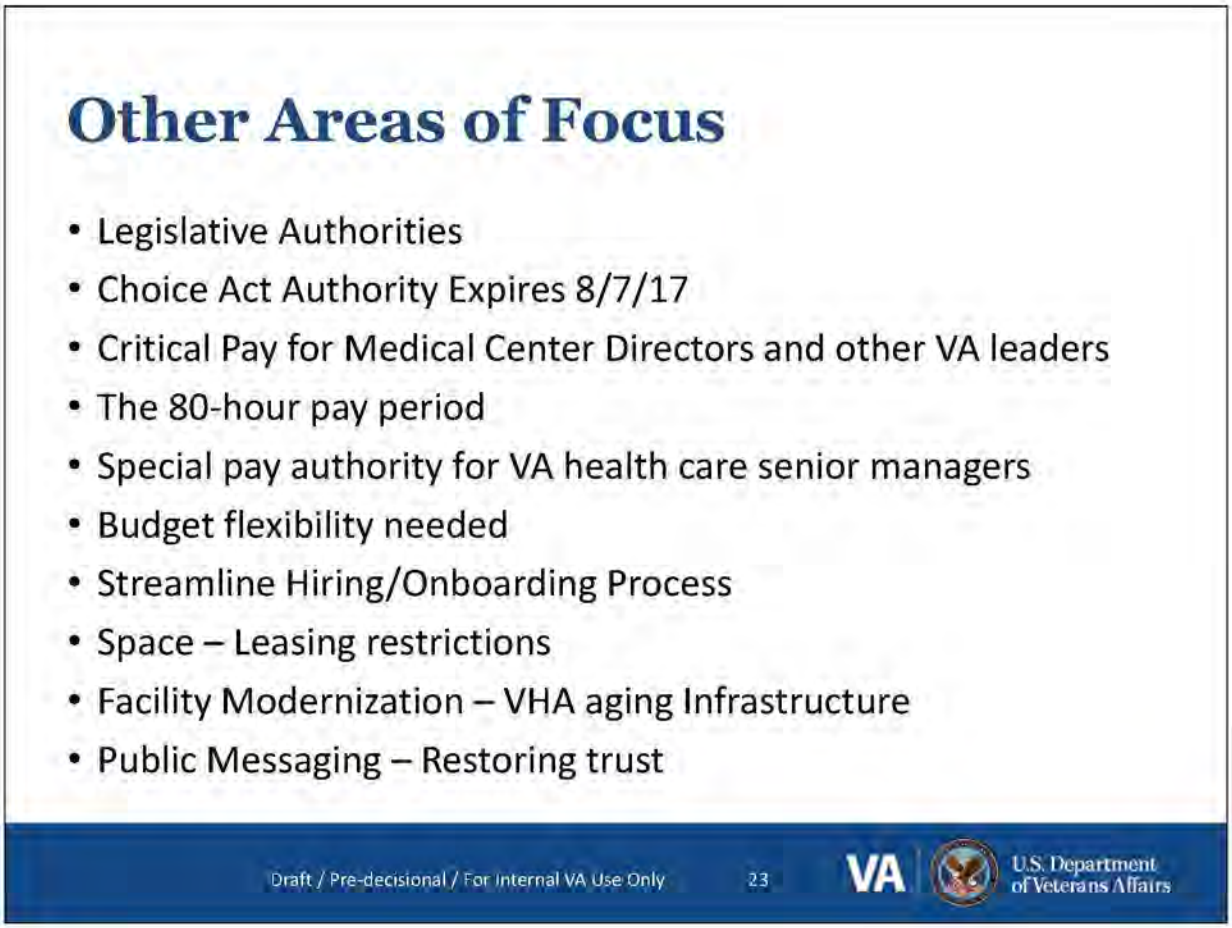

3RD BULLET:
The critical position pay authority (CPPA) allows the Secretary (or designee) to approve higher rates of pay for employees in positions that require expertise of an extremely high level in a scientific, technical, professional or administrative field critical to the Department's successful accomplishment of an important mission to the extent necessary to recruit or retain an individual exceptionally well-qualified for the critical position. Medical Center Directors and other Senior Executive Services (SES) VA health care senior managers would be eligible for CPPA.

Critical position pay requests must be submitted in writing only after it has been determined that the position in question cannot be filled with an exceptionally well-qualified individual through the use of other human resources flexibilities and pay authorities (e.g. recruitment, relocation and retention incentives, special salary rates, above minimum entrance rates).

The Secretary (or designee) must review and approve each critical position pay authority request before forwarding it to the Office of Personnel Management (OPM), who in consultation with the Office of Management and Budget (OMB) will issue final approval.

On September 22, 2016 OPM approved VA's request for CPPA for the Deputy Under Secretary for Health for Operations, 18 VISN Directors, 39 Level 1A Medical Center Directors, and 10 additional positions. 2 employees are in receipt of critical position pay and a plan is being developed for the additional positions.

Currently there is no special pay authority to compensate Medical Center Directors and other SES VA health care senior managers.

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Attached for reference is the signed/dated letter from OPM regarding critical pay.

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Other Areas of Focus Continued

- Implement Full Practice Authority for Advance Practice Nurses –*would increase VA ability to increase access*
- Expand telehealth capability
- Legislative fixes to "Care in the Community"
- Implement scheduling system for medical appointments
- Examining intermediate and long term funding options for VA healthcare

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Our Commitment to Veterans

- ✓ Veterans should be at the center of what we do and how we deliver care at VHA
- ✓ No veteran with an urgent care need that may cause harm should wait for care
- ✓ VA must act like an integrated enterprise and a learning health system to benefit veterans most
- ✓ We will work closely with our academic, federal and community providers to deliver the highest outcomes to veterans
- ✓ VA leadership and staff must feel proud, fulfilled and empowered to deliver services to Veterans
- ✓ We must regain the trust and confidence of Veterans and the American public
- ✓ VA mission of research, education, and emergency preparedness must continue to contribute to improving the health of Veterans and all Americans

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A Future Vision for VHA

- Public Private Partnerships to serve Veterans
- Digital Health Platform
- Whole Health Medicine (empowering veteran well-being)
- Develop the High Performance Network (role of VISNs)
- Center of Excellence and Foundational Care
- Value Based Management and Efficiency Strategies
- Strengthen VA as a Learning Healthcare System
- Accelerate Precision Medicine and foster innovation
- Provide access to VA research data for non VA researchers with appropriate safeguards
- Train more primary care and behavioral health students

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Myths vs. Reality

Myth	Reality
Veterans cared for by VHA have similar issues to most other Americans	Users of VHA are older and have more complex medical issues than non-users (almost 50% of users have a mental health diagnosis)
Care in VHA is poor quality	Numerous independent studies have shown that quality or equal or better
VHA does not want to utilize private sector health providers	22% of all care currently is done in the community- Close to 4 million Choice Act Authorizations has been utilized
Veteran Suicides are only a VHA problem	Of the 20 Veterans who take their own life a day- 14 do not get care in VHA
The private sector offers the same services as in VHA	More than 16 billion dollars in care a year goes towards services not provided by private sector
Access to services is worse than the private sector	96.5% of veterans were seen within 30 days of their clinical indicated or preferred date. Similar data is not readily available from the private sector
Veterans want to use private sector providers and not VA services	Of the 1 million veterans that used Choice, less than 5000 veterans did not also receive their care in VHA

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Is VA Healthcare Different than Private Sector Care?

- Caregivers
- Travel
- Dental
- Homeless Programs
- Long Term Care
- Readjustment Counseling
- Rural Health Outreach
- Special Populations- Spina Bifida, Camp Lejune
- Comprehensive Emergency Medical Program
- Health Professions Educational Assistance
- Income Verification Match
- Hepatitis C Treatments
- Prosthetics
- Comprehensive Behavioral Health Programs
- Blind Rehabilitation
- Veterans Crisis Line

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Budget and FTE's

FY 17 Enacted Budget	FY 18 Enacted Budget	Change (% Change)
$72,835,537	$70,012, 287	-2,823,250 (-3.9%)

Employees in VHA- 320,795 FTE's

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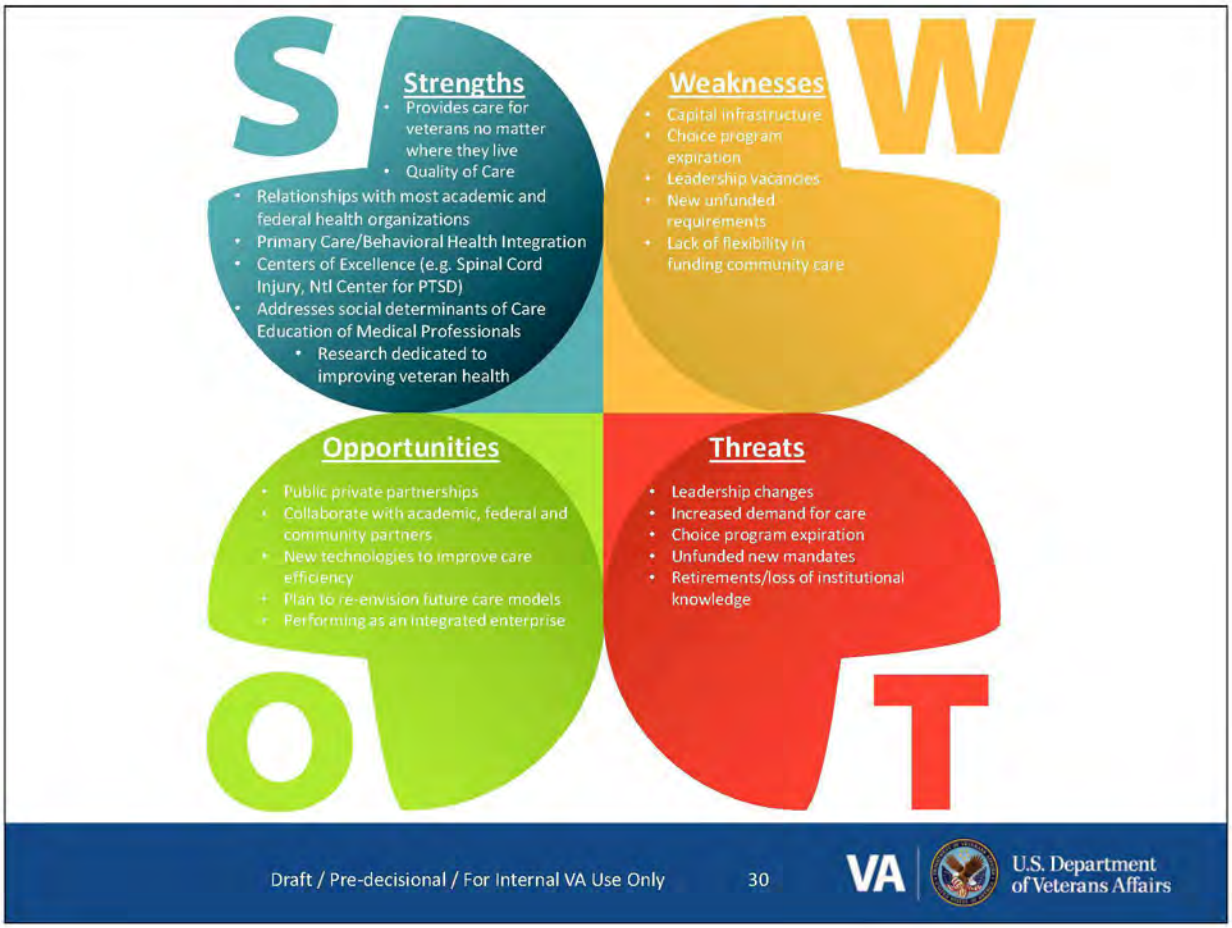

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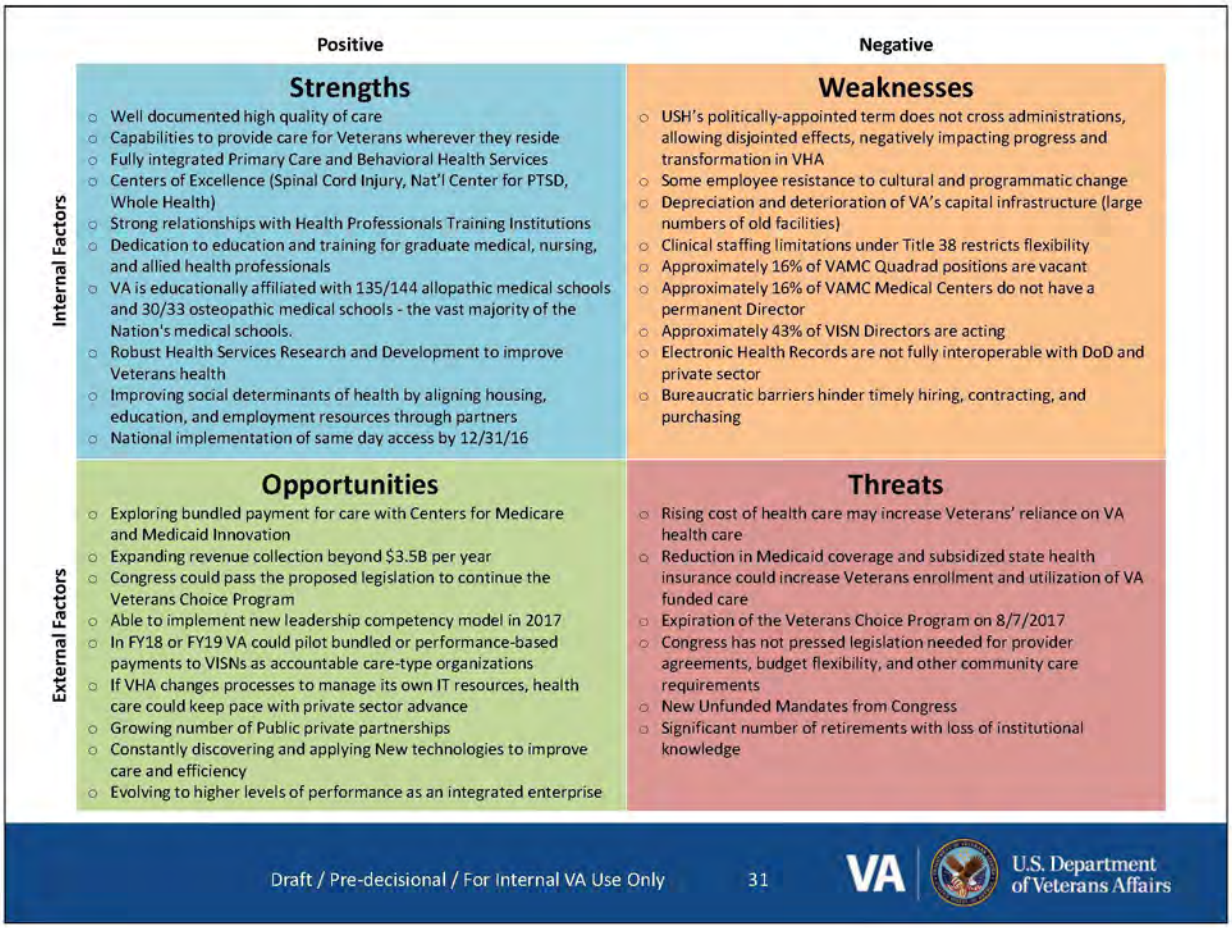

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Comparative Data

	VHA	Private Sector
Quality		
Satisfaction		
Access		
Employee Engagement		
HEDIS		

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Questions that may be Relevant

- Is VHA making progress?
- What do veterans think of VHA care?
- How does VHA compare to the private sector?
- What services should be provided in the community and what services within VHA?
- What are costs associated with moving more care out into the community?
- What is the impact of changes to ACA to VHA?
- Are there sustainable fixes to funding future VHA care?

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VA Research Importance

- Intramural research at ~100 VA medical centers nationwide serving Veterans for nearly 100 years
- 2500 ongoing projects and ~3500 researchers
- Fiscal year 2016 realized 9820 published papers; 9 NEJM/11 JAMA
- Veteran centric research studies are focused and relevant to military service and healthcare needs
- Embedding VA research in a healthcare system generates quicker, more economical scientifically based healthcare solutions
- Veteran participants in Research contribute to advancing healthcare for the population, especially by participating in Veteran centric studies which are not supported anywhere else
- VA's intramural research program leverages the best clinician care providers to ask Veteran relevant research questions

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Notable Recent Research Findings

- Finding that prolonged exposure therapy, psychotherapy technique, as an effective treatment for PTSD
- Showing that deep brain stimulation is helpful for patients with Parkinson's disease
- Established effectiveness of PTSD treatments and identified novel delivery pathways (e.g., telehealth) and additional complementary and integrative health approaches (e.g., meditation)
- Implemented medical home models and leveraged predictive analytics to improve access and quality of primary care for Veterans who are homeless
- Developed new precision medicine initiative to utilize genomic information to optimize care plan for Veterans with depression, a major factor associated with poor health outcomes and suicide
- Launched four randomized evaluations of national service programs on suicide prevention, opioid prescribing, tele-dermatology, and home-based geriatric care
- Conducted research on virtual medical care (e.g., e-consults) and specialty care access networks, resulting in enhanced access to care for prevalent medical conditions (e.g., chronic pain, Hepatitis C)

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Innovative VHA Research

Implanted prosthetic control (Isens)
Nerve cuff electrodes restore the sense of touch & muscle sensors restore dextrous control



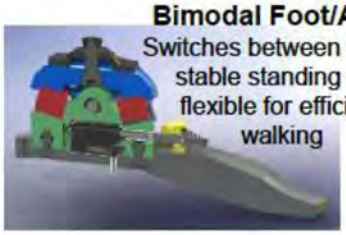
Osseointegrated Prosthetic Attachment



DEKA/LUKE Arm
Highly functional robotic prosthetic arm system



Bimodal Foot/Ankle
Switches between stiff for stable standing and flexible for efficient walking



Manual Standing Wheelchair
Can be manually propelled in sitting or standing



Equifoot
Stores & returns energy more efficiently & instantly adapts to changes in slope



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Recognition

- 3 Nobel Prizes in Physiology or Medicine
  - Ferid Murad, M.D., Ph.D. Discoveries related to nitric oxide.
  - Andrew W. Schally, Ph.D., M.D. (Multi), D.Sc.,h.c. Research on peptide hormone production in the brain.
  - Rosalyn Yalow, Ph.D. Development of radioimmunoassay.
- Lasker Award Recipients (premier medical research award)
  - 2012 – Thomas Starzl, M.D. Developed liver transplantation
  - Six Lasker winners between 1963-1975
- 2009 President's Baldrige Award for Performance Excellence – Cooperative Studies Program Clinical Research Pharmacy Coordinating Center (only 2nd federal agency to receive the award)
- 2014 – Drs. William Bauman and Ann Spungen of the Bronx VAMC receive Samuel J. Heyman Science and Environment Medal for research on spinal cord injury
- 2016 – Million Veteran Program exceeds 500,000 enrollees and becomes the world's largest genomic research program

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Spreading VA Best Practices with the Diffusion of Excellence Initiative

Best Practice Examples

eScreening
Mobile screening tool that captures answers to mental health screening questions while Veterans are in the waiting room, catching critical conditions like PTSD and suicidality more frequently and reliably.

Increasing Access to Primary Care with Pharmacists
Clinical pharmacy specialists (CPS) triage and manage medication issues for patients with chronic diseases, opening appointment slots for PCPs to address urgent patient needs.



Improving Same Day Access Using RNCM Chair Visits
Nurse Care Managers (RNCM) triage same-day requests for care, resolving certain issues themselves or transferring to a physician when necessary, serving as one solution that is allowing VA to meet the mission for same day services.

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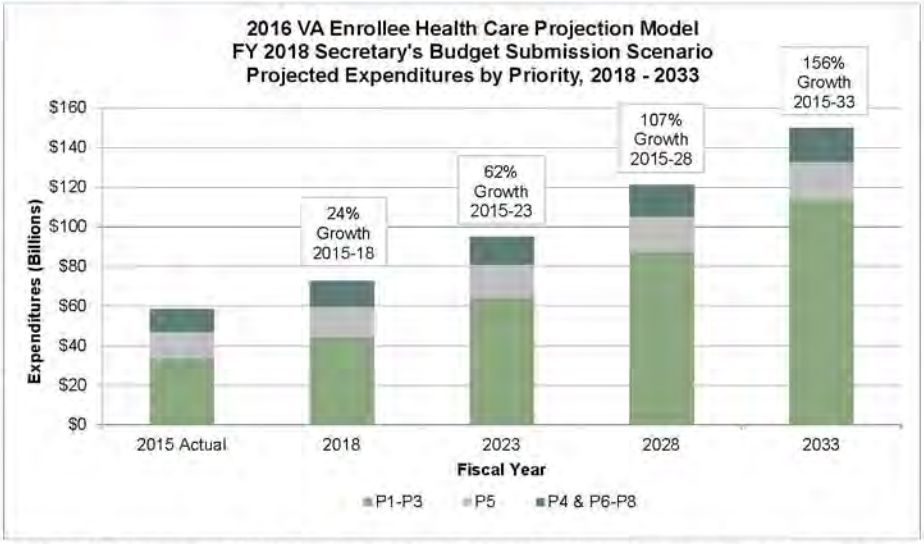
VA's Resource Requirements are Projected to Grow Significantly Over Time



2016 VA EHCPM, Budget Scenario (BAF) Note: The projections do not include requirements for several activities/ programs that are not projected by the VA EHCPM, including non-recurring maintenance, readjustment counseling, state-based long term services and supports programs, and some components of the CHAMPVA program.

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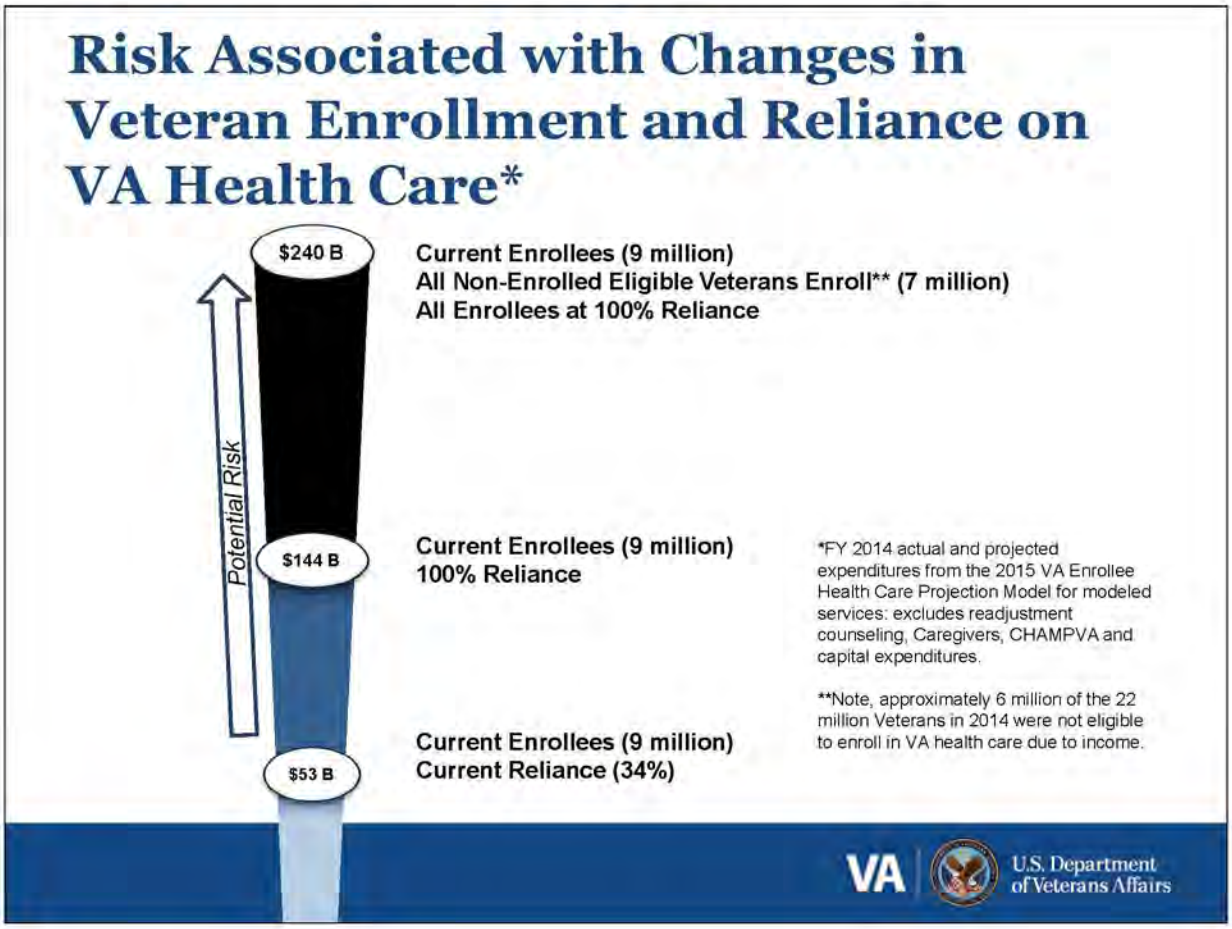

In 2014, costs for modeled services for 9 million enrollees at 34% reliance was $53 billion.

If all those 9 million enrollees used VA for all their health care, the cost in 2014 would have been $144 billion.

If all eligible but unenrolled veterans enrolled in VA and used VA for all their health care, the cost in 2014 would have been $240 billion.

All policy changes move this lever up and down as they impact either reliance on VA for health care, enrollment in VA, or both.

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 11/27/2016 9:21:09 PM
To: (b) (6) [(b) (6) @gmail.com]
Subject: Fwd: transition slides
Attachments: transitionbrief.pptx; Untitled attachment 20414.htm

This is the latest version and some corrections that still need to be made

Sent from my iPhone

Begin forwarded message:

> **From:** David Shulkin <drshulkin@aol.com>
> **Date:** November 26, 2016 at 9:53:03 PM EST
> **To:** DrShulkin@aol.com
> **Subject: transition slides**
>
> Changes
>
> HCAPHS remove clinically
> Trust 47-62
> SWAT remove choice program expiration under weakness
> Suicide prevention 163 should be 135
> 2018 budget add- Clay hunt act and gender alteration surgery

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Questions You May Find Relevant

- What has VHA been working on and has it made progress?
- What do veterans think of VHA care?
- How does VHA compare to the private sector?
- Are veterans waiting too long for care?
- What services should be provided in the community and what services within VHA?
- What are costs associated with moving more care out into the community?
- What are the critical issues facing VA in the next year?
- Are there sustainable fixes to funding future VHA care?

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VHA Overview



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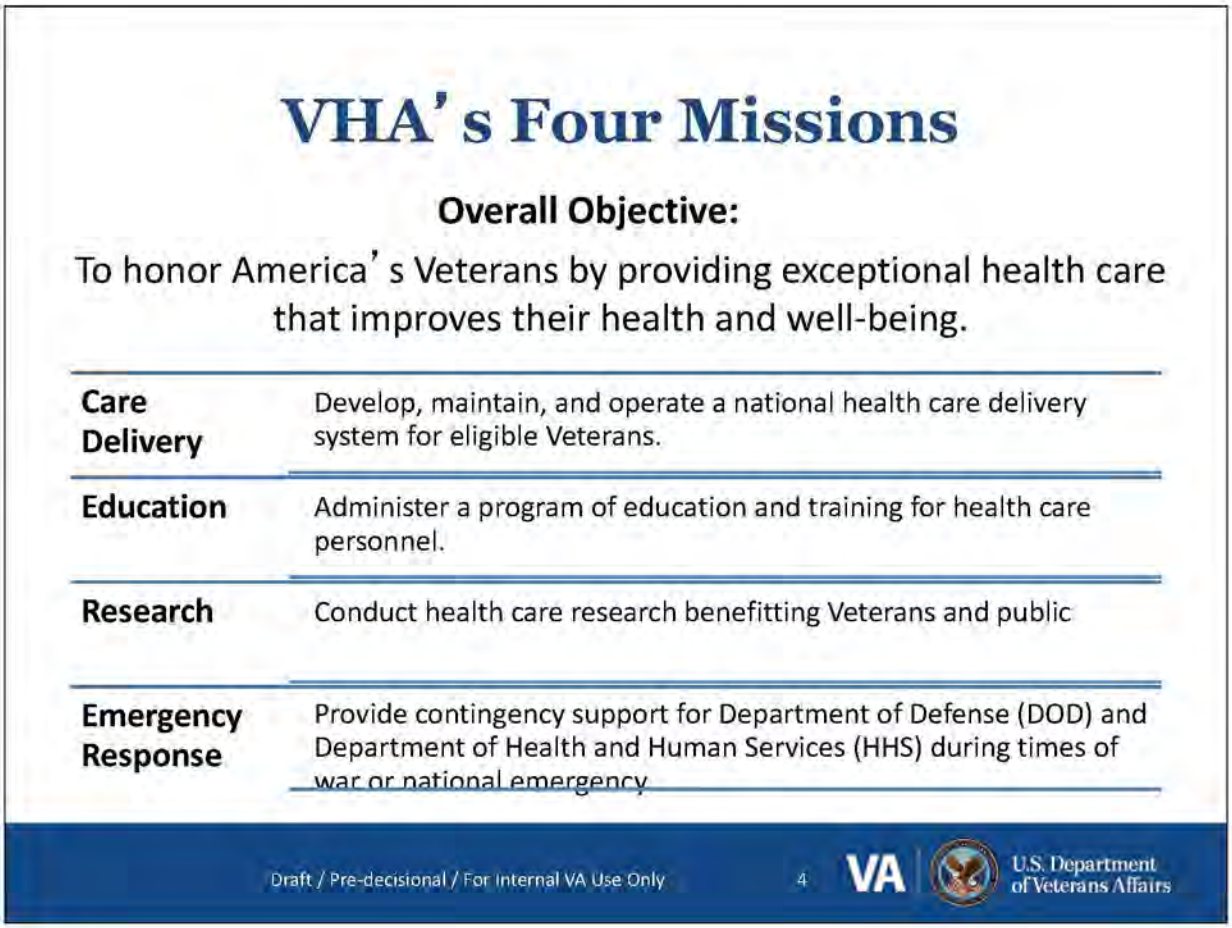

Our mission extends beyond healthcare for Veterans

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The Largest Healthcare System in the United States

- 1,234 health care facilities
  - 168 VA Medical Centers
  - 1,055 outpatient sites
- 25,000 physicians and
- 93,600 nurses (RN, LPN & NA)

- Over four times as many hospitals as Kaiser
- Over twice as many hospitals as DoD

Annual Workload Snapshot



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Annual Financial Report source file for graphic

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VA Healthcare Services Not Found in the Private Sector

- Caregivers
- Centers of Excellence(e.g., Blind Rehabilitation)
- Dental
- Homeless Programs
- Long Term Care
- Readjustment Counseling
- Rural Health Outreach
- Special Populations- Spina Bifida, Camp Lejeune
- Comprehensive Emergency Medical Program
- Health Professions Educational Assistance
- Income Verification Match
- Hepatitis C Treatments
- Prosthetics
- Comprehensive Behavioral Health Programs
- Blind Rehabilitation
- Veterans Crisis Line
- Beneficiary Travel

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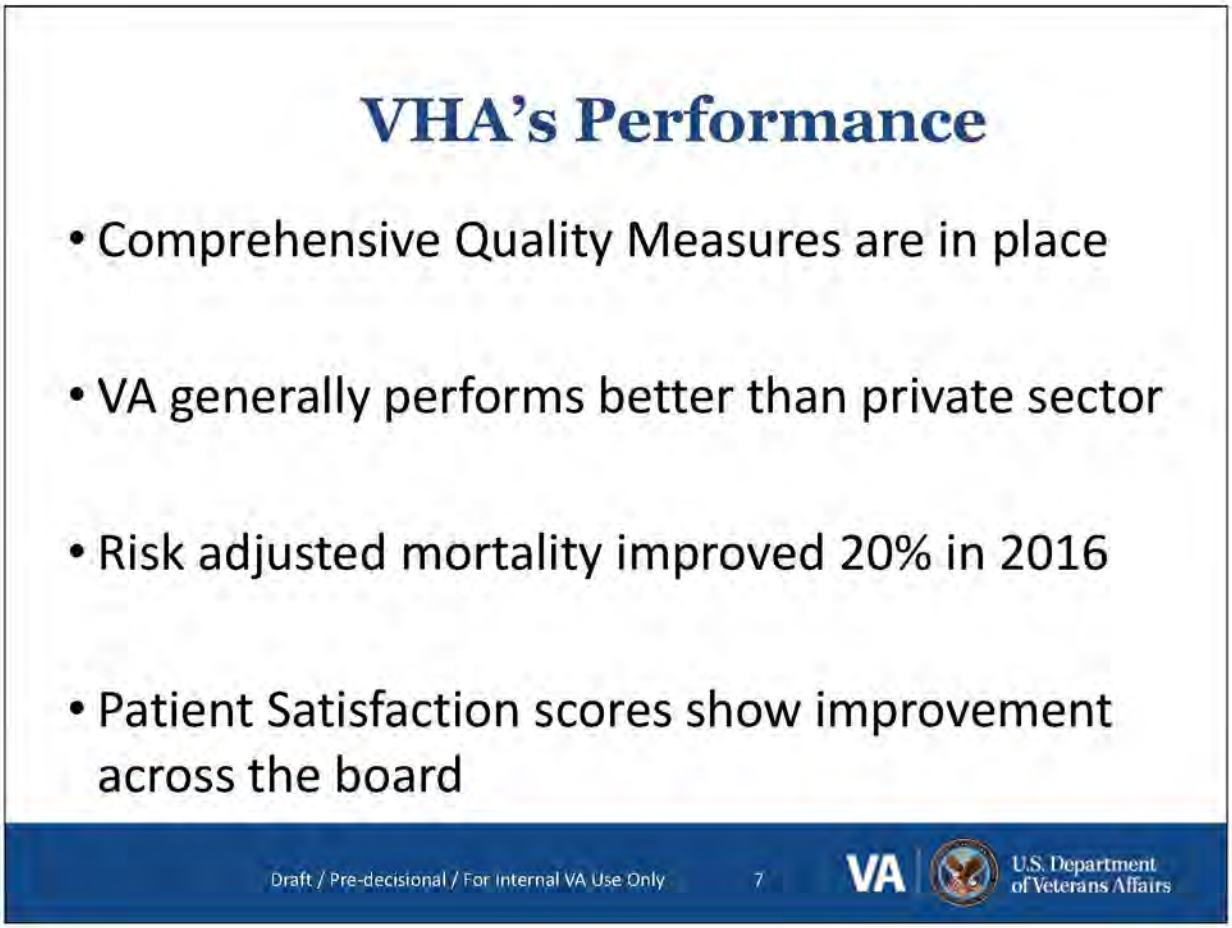

1st bullet:
Regarding Strategic Analytics for Improvement and Learning (SAIL) Model

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82% of VAMCs with Improvement
SAIL Quality Measures in Past Year

	FY16Q3 SAIL Quality Star Percentile Cut-Off					
Overall Quality FY15Q4-FY16Q3[1]	Top10% 5-Star	11-30th% 4-Star	31-70th% 3-Star	71-90th% 2-Star	Bottom10% 1-Star	Total
Large Improvement	8	18	35	20	9	90
Small Improvement	3	7	13	5	2	30
Trivial Improvement	1	3	3	3	1	11
Trivial Decline	3	1	0	0	1	5
Small Decline	1	1	2	0	1	5
Meaningful Decline	1	1	2	0	1	5
Total	17[2]	31[2]	55	28[3]	15[3]	146[4]

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Most Challenged Sites Making Improvements

Site	Indicator	FY14	FY16 (YTD)
Phoenix	CAPHS - Routine Care	66	74
	CAPHS - Urgent Care	51	56
Hines	CAPHS - Routine Care	83	88
	CAPHS - Urgent Care	74	78
Shreveport	CAPHS - Routine Care	79	82
	CAPHS - Urgent Care	65	70
Spokane	CAPHS - Routine Care	81	82
	CAPHS - Urgent Care	64	68
Greater LA	CAPHS - Routine Care	82	83

Note: a 4 to 5 point change is considered "[redacted] significant"

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USH 5 Priorities for Strategic Action

Access

We will provide timely access to Veterans as determined by their clinical needs.

PSA: We pledge that any Veteran with the requirement for urgent care will receive care at the right time appropriate to his or her clinical needs

Employee Engagement

We seek a work environment where employees are valued, supported, and encouraged to do their best for Veterans.

PSA: We will work to allow staff to have greater input into their work environment.



High Performance Network

We will ensure that Veterans receive the highest level of coordinated care within VA or from participating providers.

PSA: We will build a high performance network of care to best serve Veterans.

Best Practices

We will use best clinical practices. We also seek best practices in research, education, and management.

PSA: We seek to identify and disseminate best practices throughout VA.

Veterans First: Trust in VA Care

We will be there for our Veterans when they need us.

PSA: We will share our results on the quality and timeliness of how we care for Veterans.

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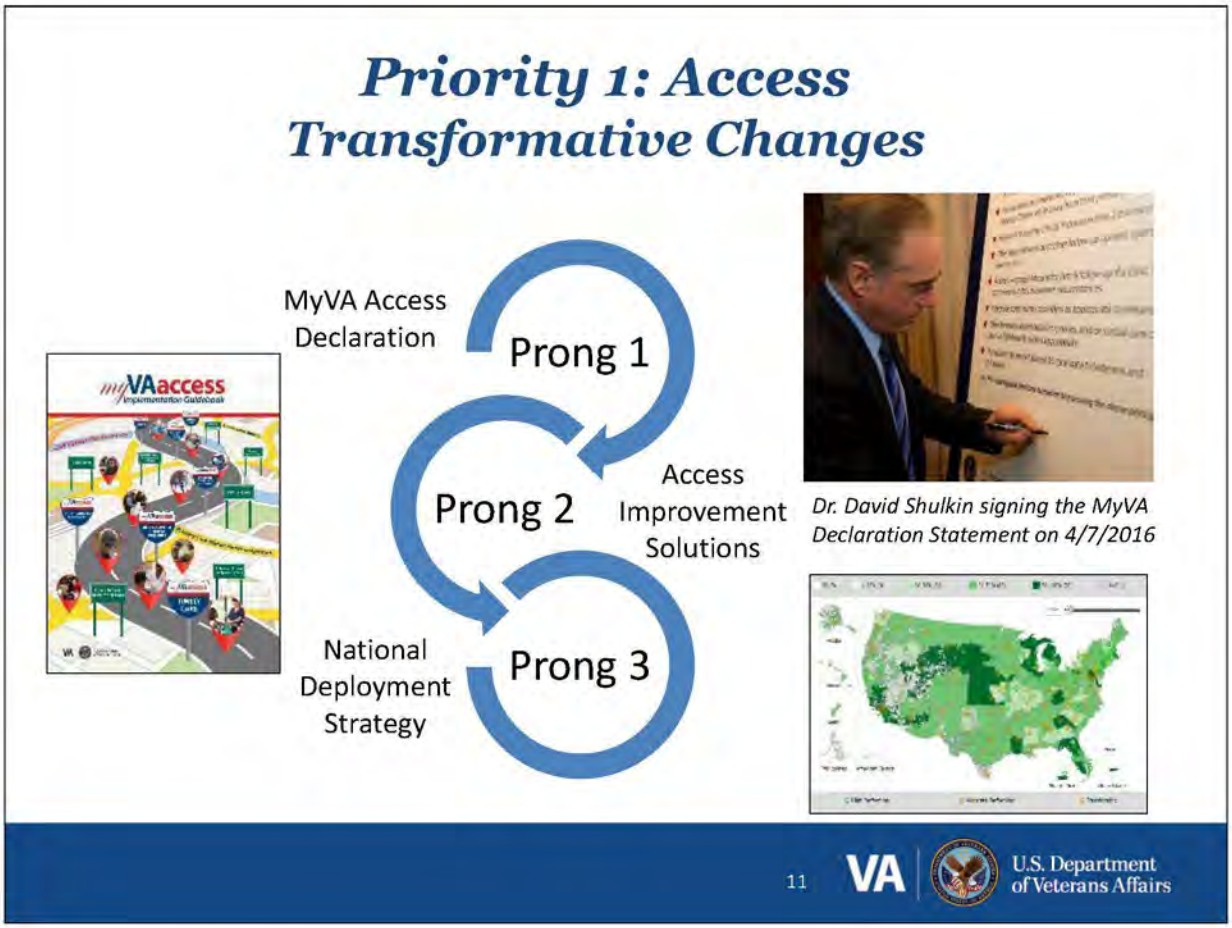

Transformative changes heading
Prong
Guidebook
Map

Same day Services for urgent needs
Path to SDA

Third slide is Results and impact that improve access

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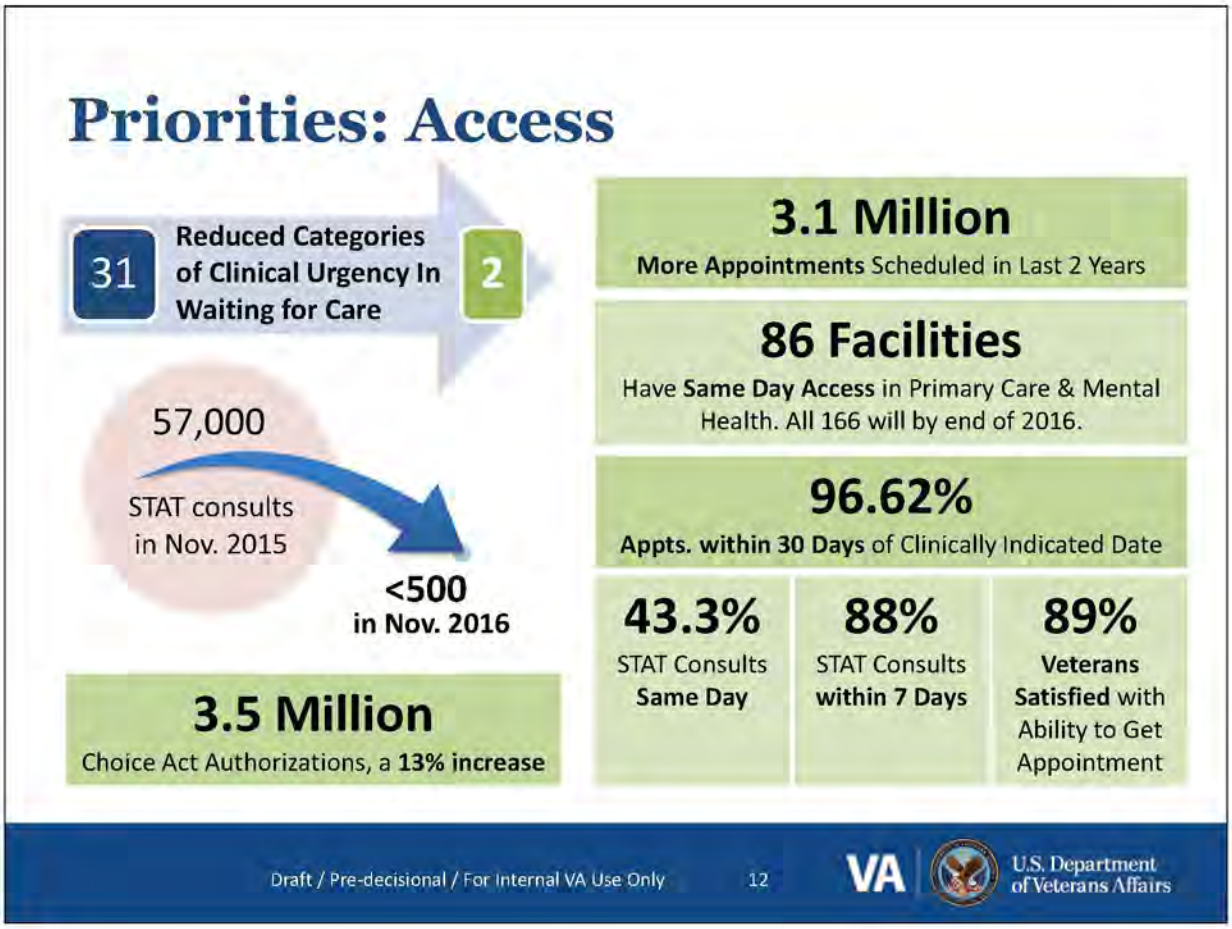

Second bullet is discussing STAT consults over 30 days

Categorized veterans waiting for care into clinical urgency (from 31 categories to 2)
57,000 stat consults in Nov 2015 to <600 in November 2016
3.1 Million more appointments scheduled in the last 2 years
86 facilities have Same Day Access in Primary Care and Mental Health. All 166 facilities will be able to offer these services by the end of 2016
89% of veterans satisfied with the ability to get an appointment (2.1 M veterans)
In October 2016, 96.62% of appointments were within 30 days of the clinically indicated or Veteran's preferred date
43.3% of stat consults were completed same day and 88% were seen within 7 days (a 22% increase from the start of the fiscal year)
Map of veterans evaluation of waiting times by site placed on internet on 11/11/16
Expanded scheduled hours on weekends and evenings, productivity, people, and space
More than 3.5 million authorizations through Choice from September 1, 2015 through August 31, 2016. This represents a 13% increase in authorizations when compared to the same period in 2014/2015

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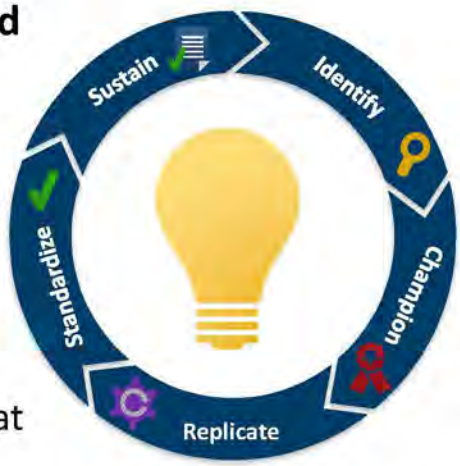
Priorities: Best Practices & Performing as an Integrated Enterprise

- Successfully replicating **13 USH Gold Status best practices 386 times** throughout the system:
  - ➢ **85** of those replications have been completed **within 9 months**
  - ➢ **301** of those replication projects are **ongoing and on track**
  - ➢ **Over 100 facilities** are replicating at least one of the best practices
- **Examples include Virtual Tumor Board and Pharmacist Clinics**



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Priorities – High Performance Network

- As of the end of FY 2016, the Veterans Choice provider network has grown by **85%** and includes more than **360,000** network providers.
- Clinical workload is up **12%** over the past two years—**9%** within VA and **31%** in the community. The **12%** increase translates into roughly **7.5 million** additional hours of care for Veterans.
- New Choice Plan submitted to Congress in October 2015
- RFP planned to be released at end of month for revisions to Community Care program



When Congress passed the Veterans Access, Choice and Accountability Act in 2014 (the Act), which established the Veterans Choice Program (VCP), the Act specified that the program may not furnish care or services after the expiration date of the program on August 7, 2017, or when the funding allocated ($10 billion) was exhausted.
Without further action by Congress before August 7, 2017, those Veterans that receive care through the current VCP (approximately one million unique Veterans have sought care through VCP since its implementation) will have to discontinue VCP care, and those Veterans newly authorized to receive VCP care will have to make alternative arrangements to receive care.
Other VA community care programs may not have the capacity to handle the entirety of patients who will come off of the current VCP. Wait times for appointments at VA facilities will likely rise if large numbers of Veterans return to VA to seek care.

Our goal for VA Community Care is to deliver a program that is easy to understand, simple to administer, and meets the needs of Veterans, community providers, and VA staff. How will we get there? Our approach consists of five components:
1. Eligibility: We want to provide easy to understand eligibility information to Veterans, community providers, and VA staff.
2. Referral and Authorizations: We want to streamline referral and authorizations, providing Veterans timely access to a community provider of their choice.
3. Care Coordination: We want to solidify care coordination through seamless health information exchanges.
4. Community Care Network: We plan to implement a Community Care Network that provides access to high-quality care inside and outside of VA.
5. Provider Payment (Claims): We want to become better partners to our community providers by paying them promptly and correctly.

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When Congress passed the Veterans Access, Choice and Accountability Act in 2014 (the Act), which established the Veterans Choice Program (VCP), the Act specified that the program may not furnish care or services after the expiration date of the program on August 7, 2017, or when the funding allocated ($10 billion) was exhausted.

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Second bullet references a comparison of FY 14 to FY 15 and was originally completed by Finance in March 2016

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Priority 4: Employee Engagement

- VA Pulse - **94,339 unique users**
- Holding **Quarterly Town Hall Meetings** and site based employee open forums
- **AES scores improved** from 3.45 (2014) to 3.58 (2016)



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Priority 5: Restoring Trust

		VE Measure	% Agree or Strongly Agree Jan-Mar 2016 (Q2) (n=24,415)	%Agree or Strongly Agree Apr-Jun 2016 (Q3) (n=29,873)	%Agree or Strongly Agree Jul-Sep 2016 (Q4) (n=27,758)
	BRAND	**"I trust VA to fulfill our country's commitment to Veterans"**	**55%**	**59%**	**60%**
VETERANS EXPERIENCE	EFFECTIVE	"I got the care or service I needed"	72%	74%	75%
	EASE	"It was easy to get the care or services I needed"	61%	65%	66%
	EMOTION	"I felt like a valued customer"	63%	67%	68%

This survey was conducted by an independent contractor and validated by survey subject matter experts from Research Triangle International.

Acknowledgements to National Center for Organizational Development Dr Scott Moore and VHA Operational Excellence Dr Steven Wright.

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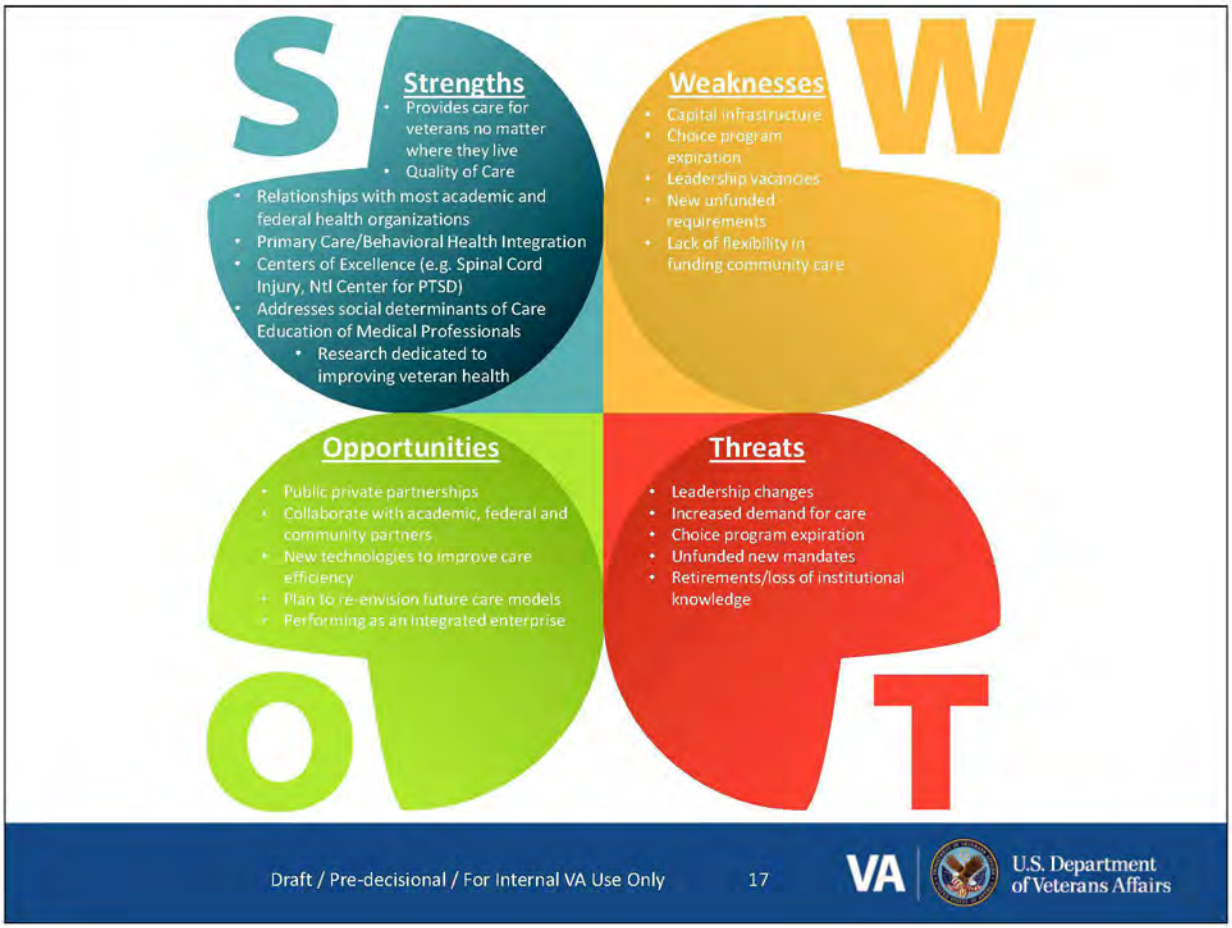

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Continuity of Leadership during a Crisis
Leadership vacancies and succession planning
Maintaining and Strengthening the Gains in Access (including Community Care), Quality, Engagement, and Trust
Direction of the Commission on Care Recommendations
Supporting VHA's Course for a Future Vision

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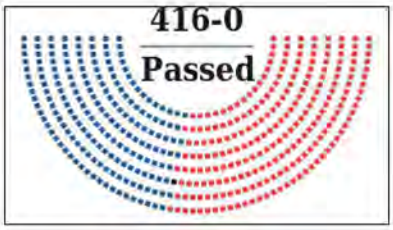
20 Years of Increasing Demand for Services

- 1996 "Veterans Eligibility Reform Act"
- Conflicts in Afghanistan and Iraq continued
  - –Congress provided eligibility for care for five years after discharge
- From 2002 to 2015, VHA outpatient volume increased from 46.5M to almost 97M visits
- 2014 "The Veterans Access, Choice and Accountability Act"



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- Enactment of Public Law 104-262, "Veterans Eligibility Reform Act" in 1996 allowed VA to provide full continuum of care for all Veterans who chose to enroll for care

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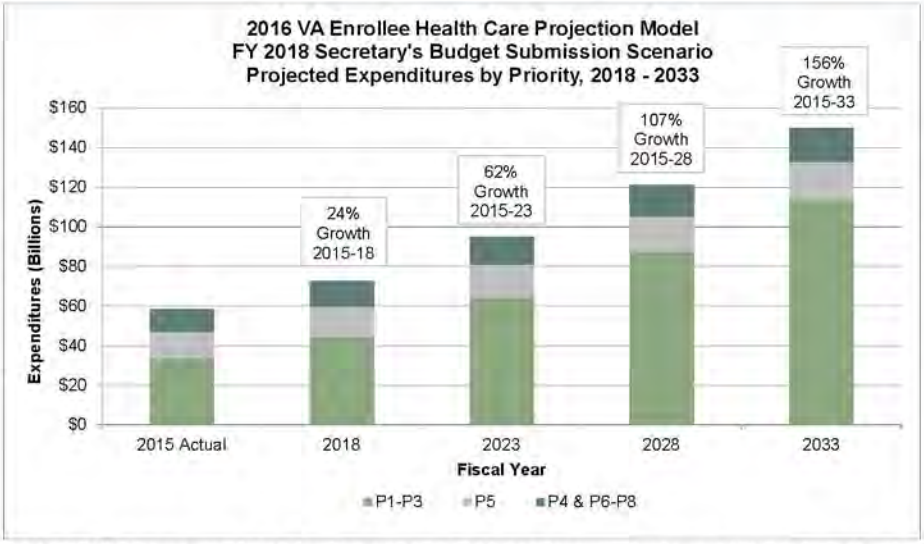
VA's Resource Requirements
Projected to Grow Significantly Over Time



2016 VA EHCPM, Budget Scenario (BAF) Note: The projections do not include requirements for several activities/ programs that are not projected by the VA EHCPM, including non-recurring maintenance, readjustment counseling, state-based long term services and supports programs, and some components of the CHAMPVA program.

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FY 18 Budget Gap

FY 17 Enacted Budget	FY 18 Enacted Budget	Change (% Change)
$72,835,537	$70,012, 287	-2,823,250 (-3.9%)

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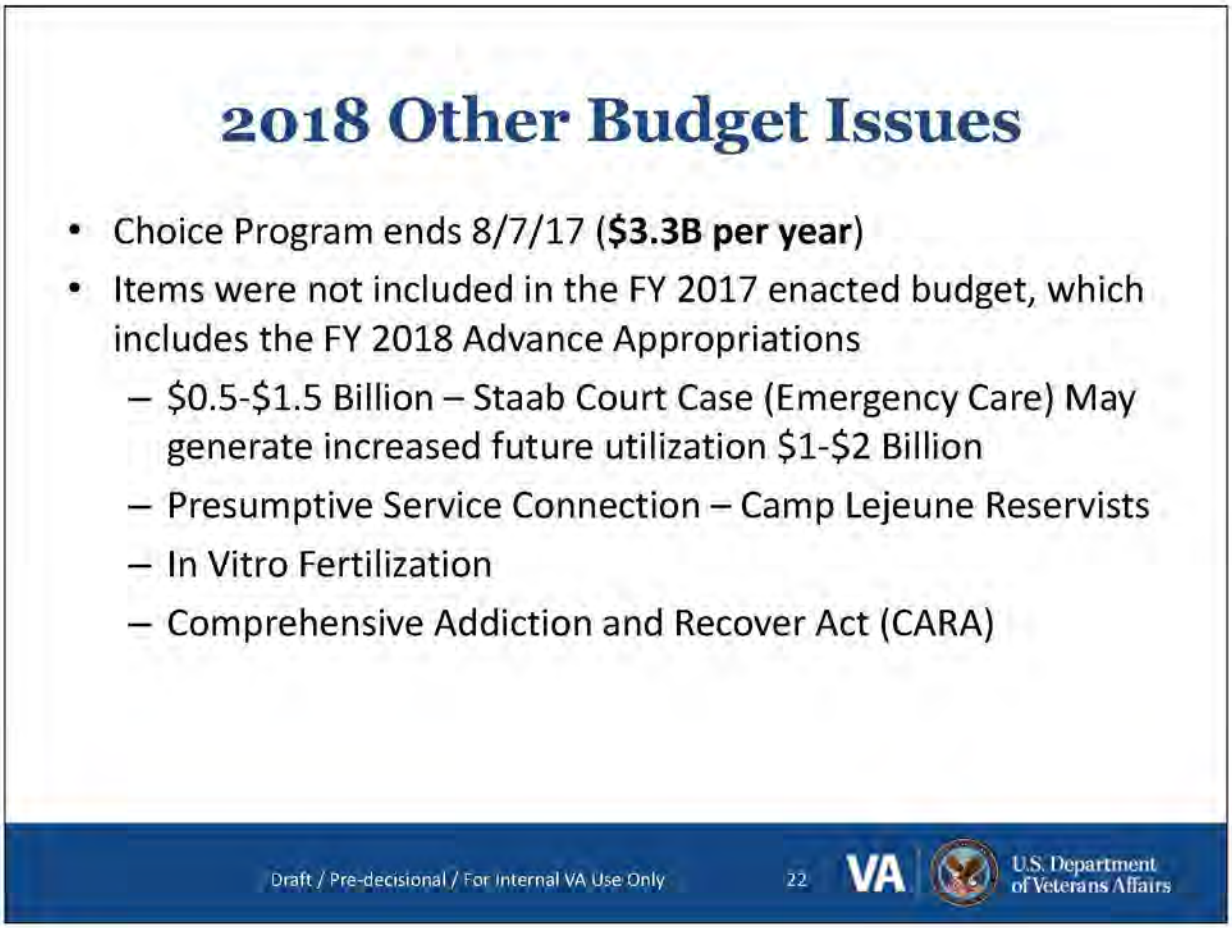

Bullet 3: Estimated budget numbers:
IVF6.5 Million FY 17, 13. million Fy18 --Maximum estimate Non VA Care funds
Adoption: 500K FY 17, 1.5 million FY 18—Maximum estimate
CARA = $153 million – crude estimate, some of which has already been incurred

Camp Lejeune.

Based on evidence there is sufficient scientific and medical evidence available to establish a presumption of connection between exposure to contaminants in the water supply at Camp Lejeune and the occurrence of eight health conditions

The proposed eight presumptive diseases are:
adult leukemia
aplastic anemia and other myelodysplastic syndromes
bladder cancer
kidney cancer
liver cancer
multiple myeloma
non-Hodgkin's lymphoma
Parkinson's disease

VA will not limit entitlement to active duty military personnel. Rather, VA proposes to presume exposure for all active duty, reserve and National Guard personnel who served at Camp Lejeune for no less than 30 cumulative days from August 1,

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1953, through December 31, 1987.

In addition, VA proposes to establish a presumption that individuals who served at Camp Lejeune during this period and later developed one of the presumptive diseases were disabled during the relevant period of service, thus establishing active military service for benefit purposes.

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VA Costs Not Found in Many Health Plans

$Millions	FY 2015	FY 2016	FY 2017
Beneficiary Travel	$853	$888	$924
Camp Lejeune	$10	$24	$21
Caregivers	$454	$623	$725
CHAMPVA, Spina Bifida, FMP, CWVV	$1,547	$1,817	$1,920
Comprehensive Emergency Medical Program	$147	$135	$139
Dental Care	$1,005	$1,035	$1,433
Health Professions Educational Assistance programs	$37	$56	$70
Homeless Programs	$1,507	$1,477	$1,591
Income Verification Match	$17	$19	$19
Long Term Care	$7,702	$8,223	$8,588
Readjustment Counseling	$221	$258	$244
Rural Health Outreach Initiatives	$219	$270	$250
Sharing Agreements - Services Provided by VA	$157	$157	$166
Subtotal	$13,875	$14,980	$16,090
Hepatitis C (assume 50% greater benefit)	$406.1	$500.0	$500.0
Mental Health (assume 50% greater benefit)	$2,283.9	$2,494.9	$2,610.6
Prosthetics (assume 50% greater benefit)	$909.0	$950.3	$1,215.2
Subtotal	$3,599.0	$3,945.2	$4,325.9
Total	$17,473.9	$18,924.9	$20,415.8

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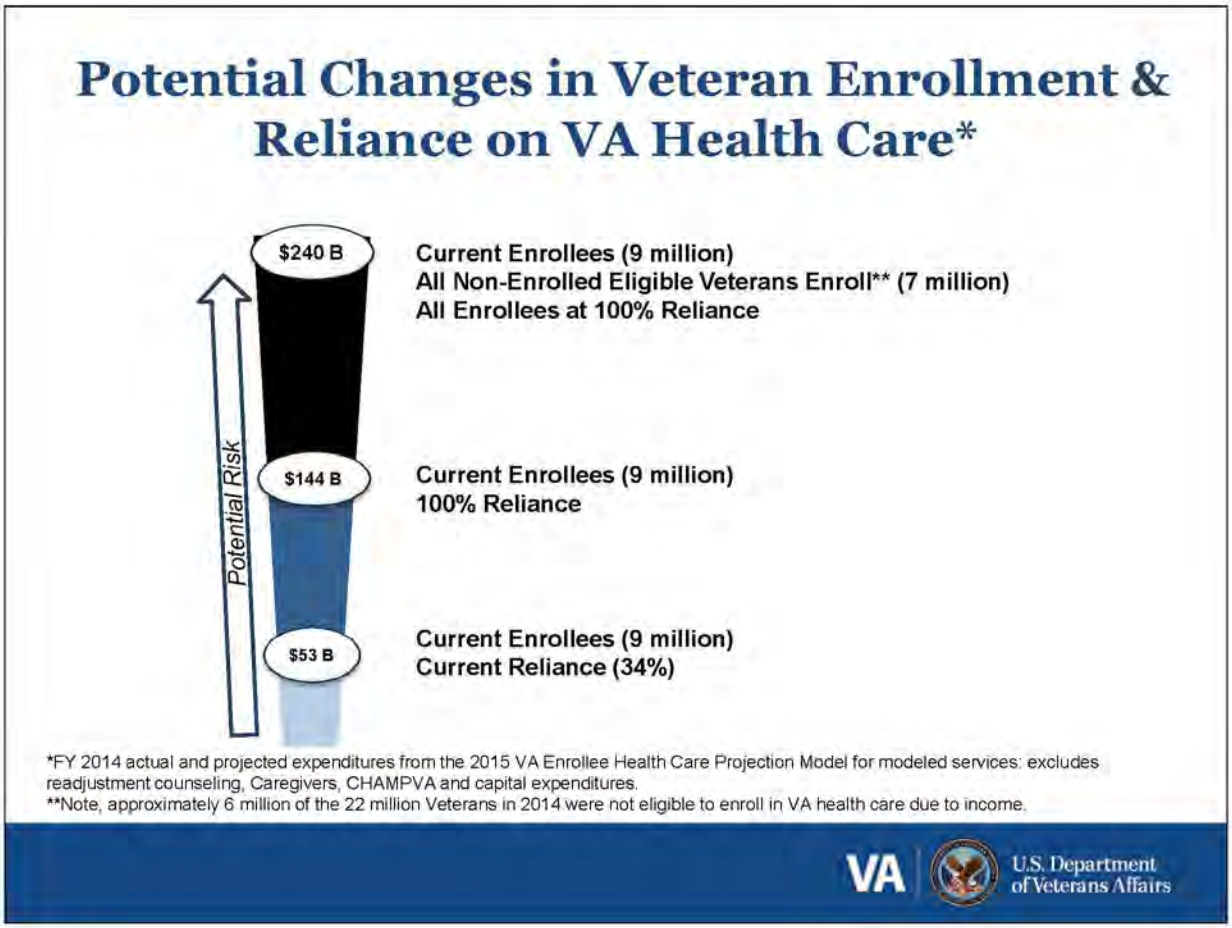

In 2014, costs for modeled services for 9 million enrollees at 34% reliance was $53 billion.

If all those 9 million enrollees used VA for all their health care, the cost in 2014 would have been $144 billion.

If all eligible but unenrolled veterans enrolled in VA and used VA for all their health care, the cost in 2014 would have been $240 billion.

All policy changes move this lever up and down as they impact either reliance on VA for health care, enrollment in VA, or both.

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Other Areas of Focus for FY 17

- Implement Full Practice Authority for Advance Practice Nurses
- Legislative fixes to "Care in the Community"
- Implement scheduling system for medical appointments
- Critical Pay for Medical Center Directors/other VA leaders
- 80-hour pay period
- Streamline Hiring/Onboarding Process
- Space – Leasing restrictions
- Facility Modernization – VHA aging Infrastructure
- Sustainable funding options for VA healthcare

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A Future Vision for VHA

- **Public Private Partnerships** to serve Veterans
- **Digital Health Platform**
- **Whole Health Medicine** (empowering veteran well-being)
- Develop the **High Performance Network** (role of VISNs)
- **Center of Excellence** and Foundational Care
- **Value Based Management** and Efficiency Strategies
- Strengthen VA as a **Learning Healthcare System**
- Accelerate **Precision Medicine** and foster innovation
- Provide access to **VA Research Data** for non VA researchers with appropriate safeguards
- **Train More** primary care and behavioral health students

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Our Commitment to Veterans

- ✓ Veterans should be at the center of what we do and how we deliver care at VHA
- ✓ No veteran with an urgent care need that may cause harm should wait for care
- ✓ VA must act like an integrated enterprise and a learning health system to benefit veterans most
- ✓ We will work closely with our academic, federal and community providers to deliver the highest outcomes to veterans
- ✓ VA leadership and staff must feel proud, fulfilled and empowered to deliver services to Veterans
- ✓ We must regain the trust and confidence of Veterans and the American public
- ✓ VA mission of research, education, and emergency preparedness must continue to contribute to improving the health of Veterans and all Americans

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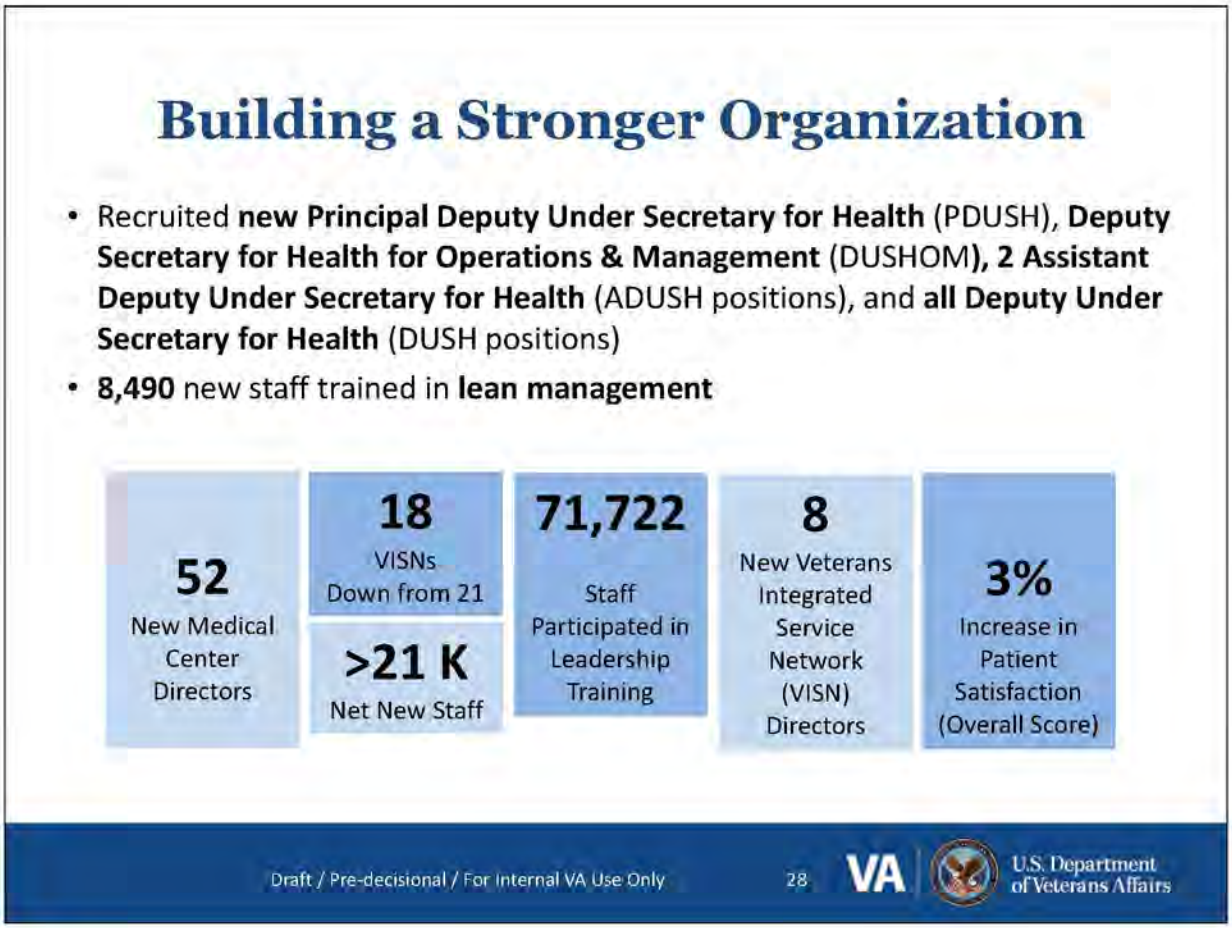

5th bullet notes:

Precision Oncology is the targeting of cancer therapy to the molecular profile of the cancer. This is not new – for many years we have been tailoring cancer therapy for some cancers. An easy example is assessing breast cancer for the presence of estrogen receptors, then using medications that block the effect of estrogen, thus blunting the effect of hormones which drive breast cancer growth. However, in the last 10 years the ability to sequence many genes simultaneously has led to an understanding of the specific mutations that drive cancer growth in many tumor types. This has gone in parallel with the development of medications that target and inhibit the effect of these specific driver mutations. Use of these targeted therapies has resulted in dramatic responses in some cases that previously had very poor outcomes. Unfortunately, only a small minority of cancers have identifiable mutations and targeted therapy available. The VA is currently expanding a program of sequencing a large number of genes in solid cancers, with several aims: to identify mutations in cancers for which there is available targeted therapy and treat these Veterans with the best available therapy; to identify mutations in cancers that might make them susceptible to an approved drug as an off label use; and to identify Veterans with molecular profiles in their cancer that would allow them to consider enrolling in clinical trials. To address the analysis of the molecular data, the VHA has a partnership with IBM Watson Health. This partnership will enhance our ability to both ensure Veterans receive the best available care now, and that clinical and basic research will improve care in the future.

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Serving our Veterans and the Nation

Culture of Improvement

- 6th year – **VA's pharmacy benefits ranked among best in class**
- **24 million in cost avoidance** through our supply chain efforts
- An Integrated operations center to **proactively monitor and identify** issues in quality or access
- **23,000 pounds of used medications** returned and **destroyed** this year

Service to the Nation

- **9,860 research publications** in 2016
- Added **547.4 graduate medical education positions**
- Responded and deployed to **6 national emergencies**



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Public Health Issues

Hepatitis C Management

- In FY15 & 16, **VA treated a total of 69,294 Veterans with Hepatitis C** with an anticipated cure rate of over 90%.
- In CY2015, **69.9%** of the birth cohort (Veterans born between 1945-1965) were **screened for Hepatitis C**.



Reducing Opioid Abuse and Dependency

- 22% reduction in opioid use
- 42% reduction in use of opioids and benzodiazepines
- 32% reduction in dosages



Prevention Programs

- 42,000 Veteran Flu Shots at Walgreens
- MOVE! has helped over 600,000 patients lose weight, keep it off, and improve their health

Walgreens

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Suicide Prevention

- **Elevated Office** of Suicide Prevention
- Completed and released a **landmark, comprehensive data analyses of Veteran suicide rates**, examining over 50 million Veteran records from 1979 to 2014 from every state in the nation, providing critical insights to help inform and shape our policies and efforts
- Reach Vet Program initiated to **proactively reach out** to those at highest risk
- **Added 163 responders** to the Veterans crisis line and added direct connections from the phone system to VCL
- Hugely successful Suicide Prevention Month 2016 campaign **#BeThere** garnered **over 73 million social media impressions** across various platforms, over 420 million impressions from TV, radio, and out of home placements (earned and paid), and was supported via Twitter by Joe Mantegna and Senators McCain and Sanders



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Complex Care Needs

Homelessness

- There was a **17 percent decline in Veteran homelessness** between 2015 and 2016, quadruple the previous year's annual rate of decline
- Since 2010**, over 480,000 Veterans and their family members have been permanently housed**, rapidly rehoused, or prevented from falling into homelessness by HUD's targeted housing vouchers and VA's homelessness programs

We've cut Veteran homelessness nationwide by 47% since 2010

Providing Counseling Services where Veterans are Comfortable

- More than **1 million primary care/mental health integration visits**
- More than **1.5 million visits** to Vet Centers providing readjustment, Military Sexual Trauma and bereavement counseling services



Hep C Management Notes

VA follows CDC recommendations to screen everyone born between 1945-1965 as they are at the highest risk of having HCV. Screening is also recommended for those born outside of this cohort who have other risk factors.

Source: VA's National Center for Health Promotion and Disease Prevention (NCP) HCV Screening recommendations: http://vaww.prevention.va.gov/CPS/Screening_for_Hepatitis_C.asp

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Transformative Research

VA Research Importance

- Intramural research at **~100 VA medical centers** nationwide serving Veterans for nearly 100 years
- **2500** ongoing projects and **~3500** researchers
- Fiscal year 2016 realized **9820 published papers; 9 NJEM/11 JAMA**
- **Veteran centric** research studies are focused and relevant **to military service and healthcare needs**
- Embedding VA Research in a healthcare system generates **quicker, more economical scientifically based healthcare solutions**
- Veteran participants in Research contribute to **advancing healthcare for the population**, especially by participating in Veteran centric studies which are **not supported anywhere else**
- VA's intramural research program leverages the best clinician care providers to ask **Veteran relevant research** questions

Notable Recent Research Findings

- Finding that prolonged exposure therapy, psychotherapy technique, is an **effective treatment for PTSD**
- Showing that **deep brain stimulation** is helpful for patients with **Parkinson's disease**
- Established effectiveness of **PTSD treatments** and identified novel delivery pathways (e.g., **telehealth**) and additional **complementary and integrative health** approaches (e.g., meditation)
- Implemented **medical home models** and leveraged **predictive analytics** to improve access and quality of primary care for **Veterans who are homeless**
- Developed new **precision medicine** initiative to utilize **genomic information** to optimize care plan for **Veterans with depression**, a major factor associated with poor health outcomes and suicide
- Launched four randomized evaluations of national service programs on **suicide prevention, opioid prescribing, tele-dermatology, and home-based geriatric care**
- Conducted research on **virtual medical care** (e.g., e-consults) and specialty care access networks, resulting in enhanced access to care for prevalent medical conditions (e.g., chronic pain, Hepatitis C)

Innovative Research

Implanted prosthetic control (Isens)
Nerve cuff electrodes restore the sense of touch & muscle sensors restore dextrous control



Osseointegrated Prosthetic Attachment



DEKA/LUKE Arm
Highly functional robotic prosthetic arm system



Bimodal Foot/Ankle
Switches between stiff for stable standing and flexible for efficient walking



Manual Standing Wheelchair
Can be manually propelled in sitting or standing



Equifoot
Stores & returns energy more efficiently & instantly adapts to changes in slope



Recognition

- **3 Nobel Prizes in Physiology or Medicine**
  - Ferid Murad, M.D., Ph.D. Discoveries relating to nitric oxide.
  - Andrew W. Schally, Ph.D., M.D. (Multi), D.Sc.,h.c. Research on peptide hormone production in the brain.
  - Rosalyn Yalow, Ph.D. Development of radioimmunoassay.
- **Lasker Award Recipients (premier medical research award)**
  - 2012 - Thomas Starzl, M.D. Developed liver transplantation
  - Six Lasker winners between 1963-1975
- **2009 President's Baldrige Award for Performance Excellence** – Cooperative Studies Program Clinical Research Pharmacy Coordinating Center (only 2nd federal agency to receive the award)
- **2014-Drs. William Bauman and Ann Spungen of the Bronx VAMC receive Samuel J. Heyman Science and Environment Medal for research on spinal cord injury**
- **2016-Million Veteran Program** exceeds 500,000 enrollees and becomes the world's largest genomic research program

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Innovative Healthcare

Telehealth

- In FY 2016, 12% of all Veterans enrolled for VA care received telehealth-based care. This includes **2.17 million telehealth visits, touching 702,000 Veterans**.
- Upcoming expanded services through VAR and VA Video Connect in 2017.

Million Veterans Program

- Program to incorporate **precision medicine** to improve Veterans' health by establishing large database containing genetic, military exposure, lifestyle, and health information with over **520,000 enrollees** as of Oct. 2016

Office of Compassionate Innovation

- Launched **Mental Health Service Dog** pilot to assist Veterans with mental health conditions that impede their mobility
- Since Center for Compassionate Innovation announced in April 2016, 38 proposals received; **8 proposals have moved to field implementation or warm hand-off** and **3 have been closed**

New

VA / Watson Cancer Partnership for Precision Oncology

Connect Care

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FY2016 OIG and GAO Activities in VHA

- OIG published 388[1] reports on VHA this year
- GAO conducted 65[2] reviews this year
- Estimated time required from VHA staff to support OIG and GAO activities: 158,840 - 395,010 staff hours at a GS-13 to SES-level payscale.

- Calculations[3]
  - Conservative estimate (assumes 5 data calls during a 12 month period):
    - 209[4] reviews requiring 76 hours of staff time per review, minimum 10 GS-13 to SES level staff = 158,840 staff hours in 2016.
  - Realistically (assumes 10 data calls during a 12 month period):
    - 209[4] reviews requiring 126 hours of staff time per review, average 15 GS-13 to SES level staff = 395,010 staff hours in 2016.
  - Large reviews can pull 20 data calls, require full time staff or contractors to support and manage all of the data requests, and involvement from multiple VHA and department program offices. We have approximately 1-2 of these per year.

[1]*Source – OIG Semi-Annual Reports to Congress from Spring and Fall 2016*
[2]*Source – MRS hand count of GAO reviews underway during 2016*
[3]*Calculations do not include staff time during interviews or time spent orienting OIG or GAO to databases or facilities.*
[4]*Omitted 244 Criminal Investigations because these do not follow the same process as OIG and GAO reviews, health care inspections and audits.*

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Myths vs. Reality

Myth	Reality
Veterans cared for by VHA have similar issues to most other Americans	Users of VHA are older and have more complex medical issues than non-users (almost 50% of users have a mental health diagnosis)
Care in VHA is poor quality	Numerous independent studies have shown that quality or equal or better
VHA does not want to utilize private sector health providers	22% of all care currently is done in the community- Close to 4 million Choice Act Authorizations has been utilized
Veteran Suicides are only a VHA problem	Of the 20 Veterans who take their own life a day- 14 do not get care in VHA
The private sector offers the same services as in VHA	More than 20 billion dollars in care a year goes towards services not provided by private sector
Access to services is worse than the private sector	96.5% of veterans were seen within 30 days of their clinical indicated or preferred date. Similar data is not readily available from the private sector
Veterans want to use private sector providers and not VA services	Of the 1 million veterans that used Choice, less than 5000 veterans did not also receive their care in VHA

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Comparing VA Care to Private Sector

- 30-day risk-standardized **mortality rates are lower** in VA than those of non-VA hospitals for acute myocardial infarction and heart failure
- **MRSA infections declined** 69 percent in VA acute care facilities and 81 percent in spinal cord injury units over 5 years thanks to VA's aggressive MRSA prevention plan.
- VA performed the **same or significantly better** than non-VA providers on 12 of 14 **effectiveness measures in the inpatient setting**
- VA performed **significantly better** on 16 **outpatient HEDIS measures** compared with commercial HMOs and significantly better on 15 outpatient HEDIS measures compared with Medicare HMOs
- VA mental health care was **better than private-sector care by at least 30 percent on all seven performance measures**, with VA patients with depression more than twice as likely as private-sector patients to get effective long-term treatment
- **Outcomes for VA patients compared favorably** to patients with non-VA health insurance, with VA patients more likely to receive recommended evidence-based treatment

More data in press release: http://www.va.gov/opa/pressrel/includes/viewPDF.cfm?id=2778

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Who We Serve

- Veterans who rely most on the VA
  - Veterans with lower income
  - Veterans living in rural areas
  - Veterans without other access to health insurance coverage
  - Veterans with poorer self-reported health status
  - Veterans with higher rates of comorbidities
- The prevalence of many common conditions is projected to increase among Veterans over the next 10 years
- In the event of a potential future conflict, even moderate levels of deployment could substantially increase the size of the incoming cohort of VA patients

Findings from the independent assessment (section 201) Appendix A Demographics

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Message

From: (b) (6) [(b) (6)@gmail.com]
Sent: 12/1/2016 7:55:42 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Change your seat at the airport

The airline would not allow us to change your seat, but said that you could change at the airport. Pay with your govt card and we will get reimbursed. We change your seat assignments often and pay with the corporate card.

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/1/2016 4:11:17 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Fwd: Acro Symposium - One Week From Today! Register Now!

Do we want to go?

Sent from my iPhone

Begin forwarded message:

From: Acro Pharmaceutical Services <marketing@acropharmacy.com>
Date: December 1, 2016 at 8:54:19 AM EST
To: drshulkin@aol.com
Subject: Acro Symposium - One Week From Today! Register Now!
Reply-To: marketing@acropharmacy.com



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We are pleased to invite you to our 10th Annual Symposium which will be held on **Wednesday, December 7th and Thursday, December 8th, 2016** at **The Hyatt at The Bellevue** in downtown Philadelphia.

This is our 10th year, so it is certain to be the best yet as we welcome back all the past attendees and those joining us for the first time. The event will kick off with an *evening reception* on **Wednesday, December 7th** followed by the *Symposium* on **Thursday, December 8th**. Registration will cover attendance to the opening networking reception, breakfast, Symposium and lunch.

Register Now!

The Hyatt is booked to capacity - If you are in need of hotel recommendations, please email marketing@acropharmacy.com

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The audience at this year's Symposium will include HealthPlan and PBM Executives, Specialty Pharmacy Industry Leaders and Biotech Pharmaceutical Executives. Topics will focus around the opportunities and challenges facing Specialty Pharmacy in the changing healthcare environment as addressed by speakers and our ever popular payer/pharmaceutical manufacturer panel discussion.

We have three speakers and a payer panel discussion planned for this year that will include key decision makers from several payers and managed care organizations. This is a great opportunity to network with senior pharmacy executives from regional health plans and pharmaceutical managed market executives.

Payer groups attending include:

Capital BlueCross - HealthPartners Plans - Independence BlueCross - PerformRx - Navitus Health Solutions - Horizon BCBS - Johns Hopkins Healthcare - BCBS of Tennessee - Independent Health and more to be announced. (Subject to Change)

Here is a snapshot view of the Symposium schedule:
(Subject to Change)

Wednesday, December 7, 2016:	Hyatt at The Bellevue, Philadelphia, PA
7:00 pm - 9:00 pm	Kick-Off Reception
Thursday, December 8, 2016:	Hyatt at The Bellevue, Philadelphia, PA
7:00 am - 8:00 am	Meeting Registration and Breakfast
8:00 am - 8:15 am	Welcome & Introductions
8:15 am - 9:15 am	**Speaker - "A Patient's Perspective"**
9:15 am - 10:15 am	**Speaker - "Election Implications for Healthcare"** ***Blair Childs - SVP Public Affairs, Premier Inc.***
10:15 am - 10:30 am	Break
10:30 am - 11:30 am	**Speaker - "IDNS, ACOs & Provider Groups - How to Navigate the Changing Channels in Specialty Pharmacy"** ***Suzette DiMascio - President & CEO, CSI Specialty Group***
11:30 am - 1:00 pm	Lunch/Networking
1:00 pm - 2:30 pm	**Specialty Medication Multidisciplinary Industry Panel Discussion** ***Moderated by Philip Gerbino, PharmD, President Emeritus - University of the Sciences***
2:30 pm	Conclusion

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We look forward to another stellar year and turnout! Questions regarding the Symposium can be directed to marketing@acropharmacy.com.

Regular Registration – $595

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 11/26/2016 3:56:21 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Fwd: [External] Please resend this final attached presentation
Attachments: image001.png; Untitled attachment 20443.htm; Untitled attachment 20446.ppt; Untitled attachment 20449.htm

Sent from my iPhone

Begin forwarded message:

From: Poonam Alaigh <(b) (6) hotmail.com>
Date: November 26, 2016 at 10:14:23 AM EST
To: David Shulkin <drshulkin@aol.com>
Subject: Fw: [External] Please resend this final attached presentation

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From: (b) (6) [USA] (b) (6) @bah.com>
Sent: Saturday, November 26, 2016 10:09 AM
To: Poonam Alaigh; (b) (6) (ERPi)
Subject: RE: [External] Please resend this final attached presentation

Good morning Poonam,

This is 1 of 3 e-mails. Saving the presentation a few different ways to hopefully make it easier to open.

Thank you,

(b) (6)

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(b) (6)

Lead Associate

Mobile (b) (6)

(b) (6) @bah.com

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From: Poonam Alaigh [mailto(b) (6) hotmail.com]
Sent: Saturday, November 26, 2016 10:00 AM
To: (b) (6) [USA] (b) (6) @bah.com>; (b) (6) (ERPi) (b) (6) @va.gov>
Subject: [External] Please resend this final attached presentation

(b) (6) I further edited the presentation yesterday and tried sending it to USH. For some reason, he cant open it. Can you see attached and then decompress it or change the format so that he can open it on his personal computer. Call me if you want to talk. Please see attached

Also please send as 2 separate emails- ppx and ppt

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U.S. Department of Veterans Affairs Presidential Transition Briefing

Veterans Health Administration

Prepared for:
Agency Review Team

Briefed by:
David J. Shulkin, MD
Under Secretary of Health, Veterans Health Administration

November 2016

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Purpose and Agenda

- **Purpose:** To provide an overview of the Veterans Health Administration (VHA) and highlight major priorities and challenges
- **Overview:**
  - Organization, Budget and FTEs
  - Our Mission and Who We Serve
  - Assessment of VHA's Situation
    - Priorities
    - Performance
  - Accomplishments in FY 2016
  - Future Direction, Priorities and Opportunities for VHA

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Relevant Questions

- Is VHA making progress?
- What do Veterans think of VHA care?
- How does VHA compare to the private sector?
- What services should be provided in the community and what services within VHA?
- What are costs associated with moving more care out into the community?
- What is the impact of changes to ACA to VHA?
- Are there sustainable fixes to funding future VHA care?

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Organization, Budget and FTEs

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Organizational Leadership



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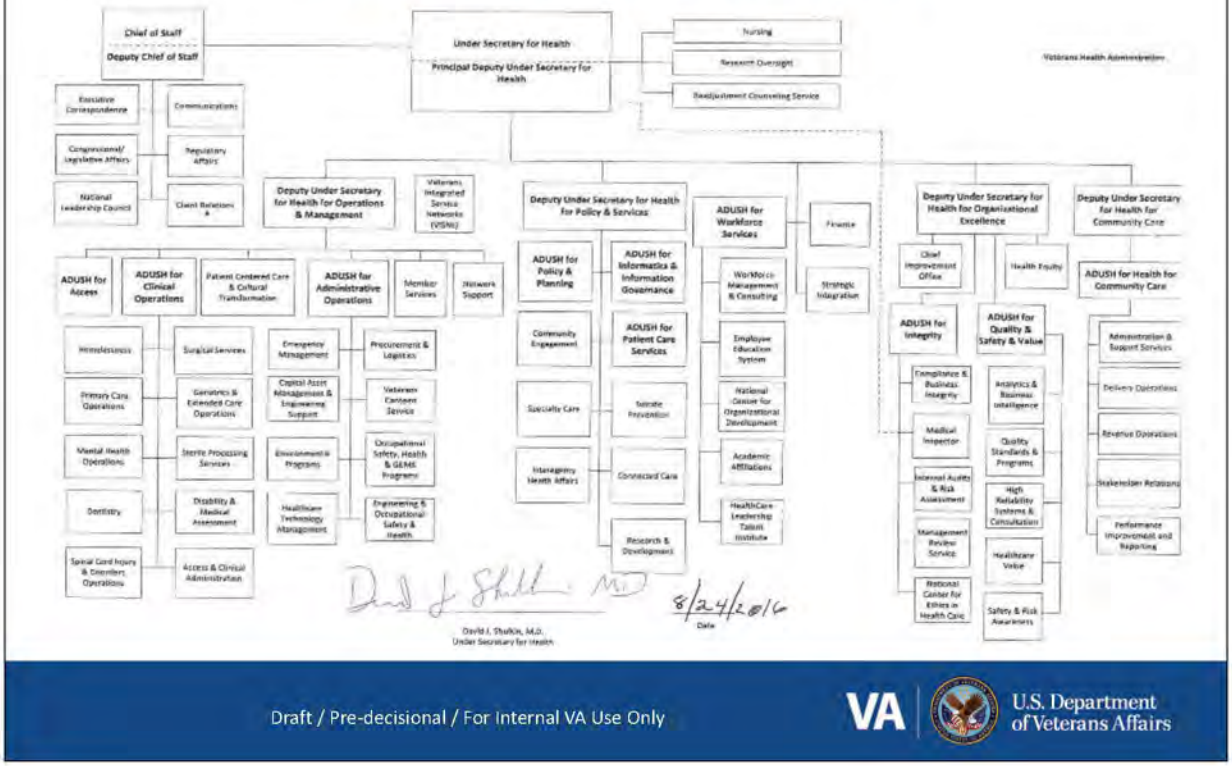
Organization Chart



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Budget and FTEs

FY 17 Enacted Budget	FY 18 Enacted Budget	Change (% Change)
$72,835,537	$70,012, 287	-2,823,250 (-3.9%)

Employees in VHA- 320,795 FTEs

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How We Are Different:
Our Mission and Who We Serve

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The Largest Healthcare System in the United States

- 1,234 health care facilities
  - 168 VA Medical Centers
  - 1,055 outpatient sites
- 25,000 physicians and
- 93,600 nurses (RN, LPN & NA)

- Over four times as many hospitals as Kaiser
- Over twice as many hospitals as DoD

Annual Workload Snapshot



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Annual Financial Report source file for graphic

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Who We Serve

- Veterans who rely most on the VA
  - Veterans with lower income
  - Veterans living in rural areas
  - Veterans without other access to health insurance coverage
  - Veterans with poorer self-reported health status
  - Veterans with higher rates of comorbidities
- The prevalence of many common conditions is projected to increase among Veterans over the next 10 years
- In the event of a potential future conflict, even moderate levels of deployment could substantially increase the size of the incoming cohort of VA patients

Findings from the independent assessment (section 201) Appendix A Demographics

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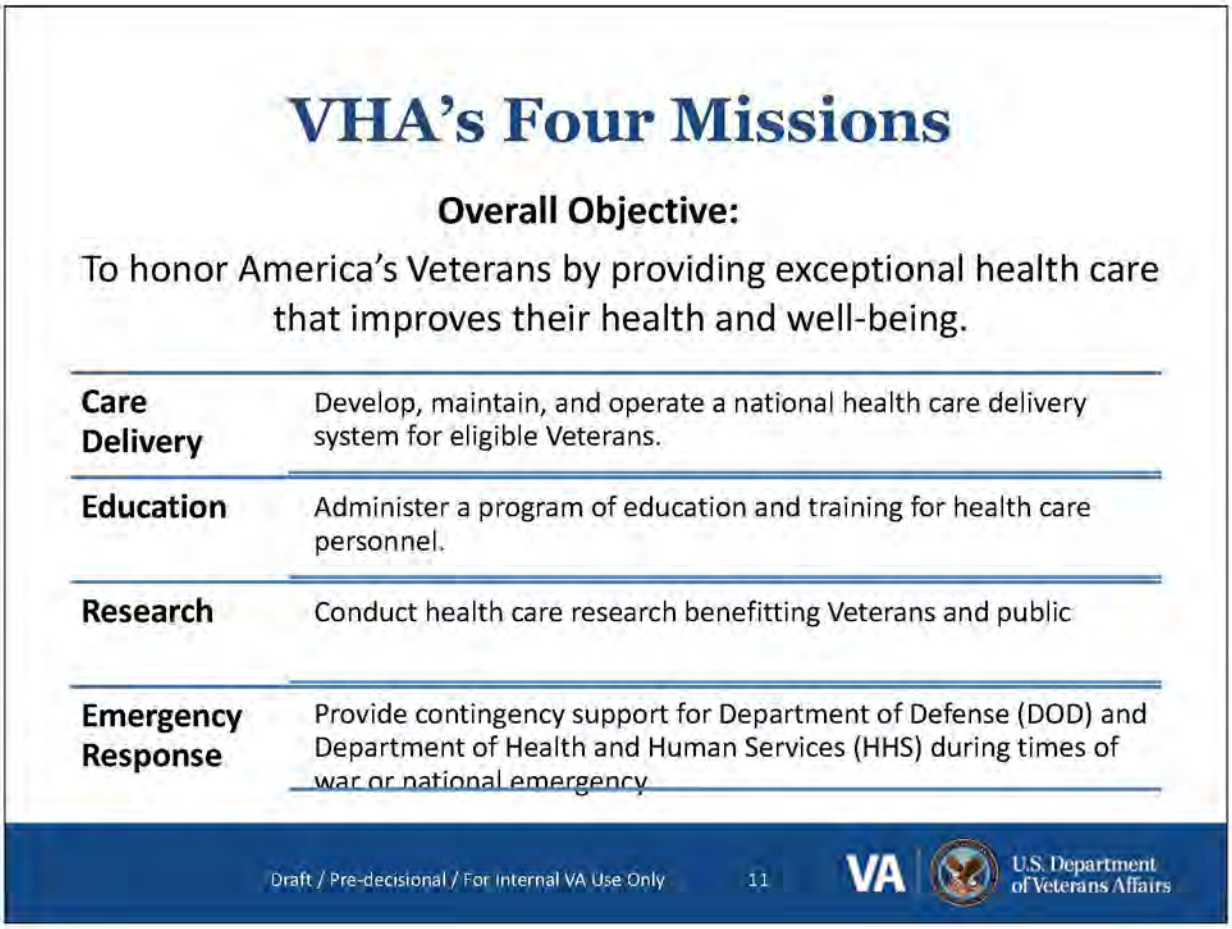

Our mission extends beyond healthcare for Veterans

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VA Healthcare Services Not Found in the Private Sector

- Caregivers
- Travel
- Dental
- Homeless Programs
- Long Term Care
- Readjustment Counseling
- Rural Health Outreach
- Special Populations- Spina Bifida, Camp Lejeune
- Comprehensive Emergency Medical Program
- Health Professions Educational Assistance
- Income Verification Match
- Hepatitis C Treatments
- Prosthetics
- Comprehensive Behavioral Health Programs
- Blind Rehabilitation
- Veterans Crisis Line
- Beneficiary Travel

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VA Healthcare Costs Not Found in the Private Sector

$Millions	FY 2015	FY 2016	FY 2017
Beneficiary Travel	$853	$888	$924
Camp Lejeune	$10	$24	$21
Caregivers	$454	$623	$725
CHAMPVA, Spina Bifida, FMP, CWVV	$1,547	$1,817	$1,920
Comprehensive Emergency Medical Program	$147	$135	$139
Dental Care	$1,005	$1,035	$1,433
Health Professions Educational Assistance programs	$37	$56	$70
Homeless Programs	$1,507	$1,477	$1,591
Income Verification Match	$17	$19	$19
Long Term Care	$7,702	$8,223	$8,588
Readjustment Counseling	$221	$258	$244
Rural Health Outreach Initiatives	$219	$270	$250
Sharing Agreements - Services Provided by VA	$157	$157	$166
Subtotal	$13,875	$14,980	$16,090
Hepatitis C (assume 50% greater benefit)	$406.1	$500.0	$500.0
Mental Health (assume 50% greater benefit)	$2,283.9	$2,494.9	$2,610.6
Prosthetics (assume 50% greater benefit)	$909.0	$950.3	$1,215.2
Subtotal	$3,599.0	$3,945.2	$4,325.9
Total	$17,473.9	$18,924.9	$20,415.8

Educational
Employment Services

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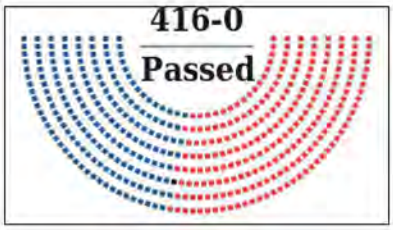
20 Years of Increasing Demand for Services

- 1996 "Veterans Eligibility Reform Act"
- Conflicts in Afghanistan and Iraq continued
  - Congress provided eligibility for care for five years after discharge
- From 2002 to 2015, VHA outpatient volume increased from 46.5M to almost 97M visits
- 2014 "The Veterans Access, Choice and Accountability Act"





- Enactment of Public Law 104-262, "Veterans Eligibility Reform Act" in 1996 allowed VA to provide full continuum of care for all Veterans who chose to enroll for care

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Myths vs. Reality

Myth	Reality
Veterans cared for by VHA have similar issues to most other Americans	Users of VHA are older and have more complex medical issues than non-users (almost 50% of users have a mental health diagnosis)
Care in VHA is poor quality	Numerous independent studies have shown that quality or equal or better
VHA does not want to utilize private sector health providers	22% of all care currently is done in the community- Close to 4 million Choice Act Authorizations has been utilized
Veteran Suicides are only a VHA problem	Of the 20 Veterans who take their own life a day- 14 do not get care in VHA
The private sector offers the same services as in VHA	More than 16 billion dollars in care a year goes towards services not provided by private sector
Access to services is worse than the private sector	96.5% of veterans were seen within 30 days of their clinical indicated or preferred date. Similar data is not readily available from the private sector
Veterans want to use private sector providers and not VA services	Of the 1 million veterans that used Choice, less than 5000 veterans did not also receive their care in VHA

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Impact of VHA Research

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VHA Priorities

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USH 5 Priorities for Strategic Action

Access

We will provide timely access to Veterans as determined by their clinical needs.

PSA: We pledge that any Veteran with the requirement for urgent care will receive care at the right time appropriate to his or her clinical needs

Employee Engagement

We seek a work environment where employees are valued, supported, and encouraged to do their best for Veterans.

PSA: We will work to allow staff to have greater input into their work environment.



High Performance Network

We will ensure that Veterans receive the highest level of coordinated care within VA or from participating providers.

PSA: We will build a high performance network of care to best serve Veterans.

Best Practices

We will use best clinical practices. We also seek best practices in research, education, and management.

PSA: We seek to identify and disseminate best practices throughout VA.

Veterans First: Trust in VA Care

We will be there for our Veterans when they need us.

PSA: We will share our results on the quality and timeliness of how we care for Veterans.

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Priority 1: Access
Transformative Changes



MyVA Access Declaration

Prong 1

Prong 2

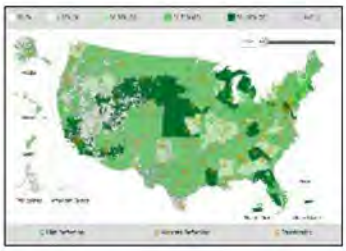
Access Improvement Solutions

National Deployment Strategy

Prong 3



Dr. David Shulkin signing the MyVA Declaration Statement on 4/7/2016



Transformative changes heading
Prong
Guidebook
Map

Same day Services for urgent needs
Path to SDA

Third slide is Results and impact that improve access

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Priority 1: Access

Same Day Access in Primary Care and Mental Health

By the end of this year, we may be the most accessible healthcare system in the United States

September
52 sites (31%)

October
85 Sites (51%)

November
123 Sites (74%)

December
166 Sites (100%)

Same Day Services:

If you need care right away during regular business hours, you are able to get services the same day, or if after hours, by the next day from a VA Medical Center or Health Care Center.

- Options for how that care might be provided include in person, via telephone, smart phone, through video care, secure messaging ,or other options.
- This care may be delivered by your provider or another appropriate clinical staff member based on availability and your care needs.
- *For a medical emergency always call 911 or report to the emergency room closest to where you are located.*

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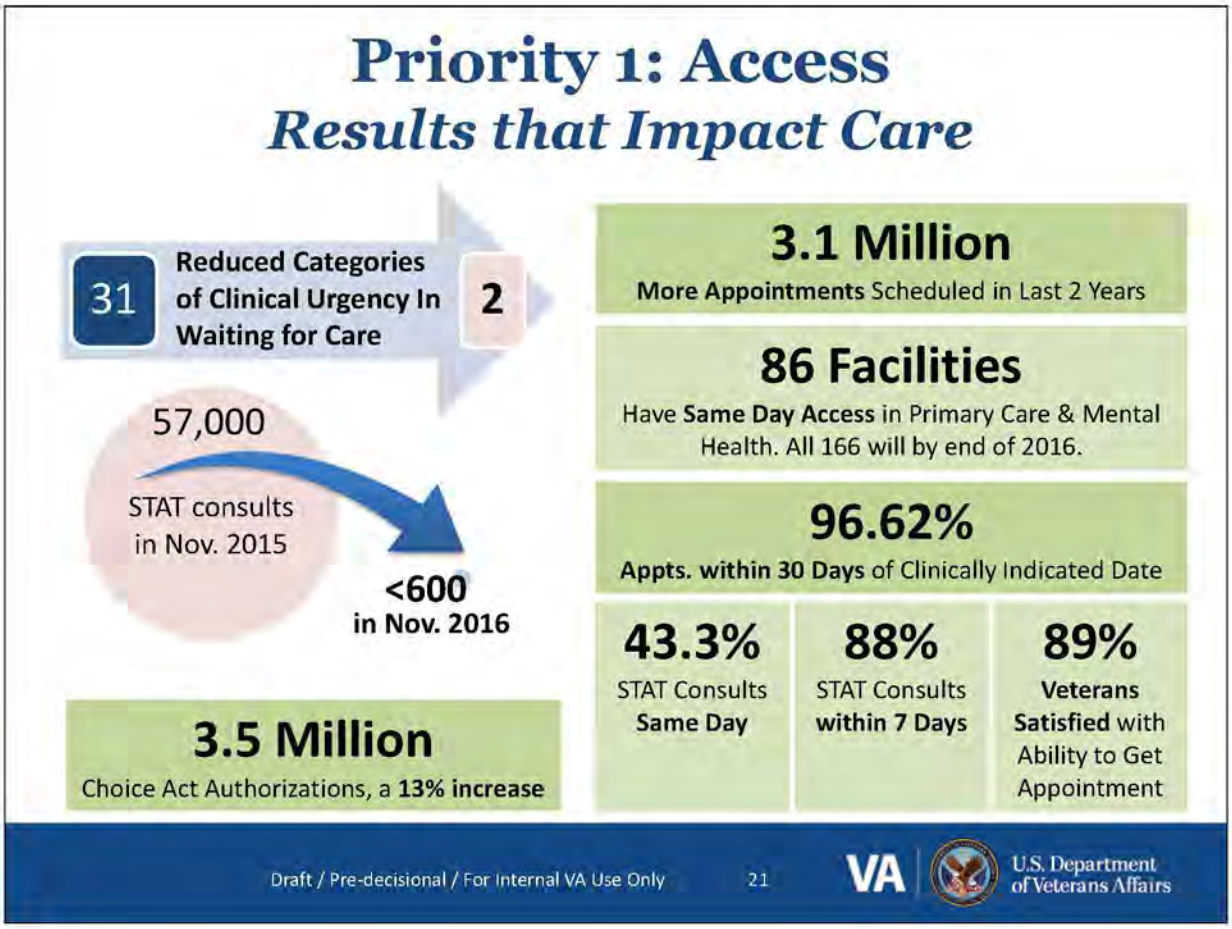

Second bullet is discussing STAT consults over 30 days

Categorized veterans waiting for care into clinical urgency (from 31 categories to 2)
57,000 stat consults in Nov 2015 to <600 in November 2016
3.1 Million more appointments scheduled in the last 2 years
86 facilities have Same Day Access in Primary Care and Mental Health. All 166 facilities will be able to offer these services by the end of 2016
89% of veterans satisfied with the ability to get an appointment (2.1 M veterans)
In October 2016, 96.62% of appointments were within 30 days of the clinically indicated or Veteran's preferred date
43.3% of stat consults were completed same day and 88% were seen within 7 days (a 22% increase from the start of the fiscal year)
Map of veterans evaluation of waiting times by site placed on internet on 11/11/16
Expanded scheduled hours on weekends and evenings, productivity, people, and space
More than 3.5 million authorizations through Choice from September 1, 2015 through August 31, 2016. This represents a 13% increase in authorizations when compared to the same period in 2014/2015

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Priority 2: Best Practices
& Performing as an Integrated Enterprise

- Successfully replicating **13 USH Gold Status best practices 386 times** throughout the system:
  - ➢**85** of those replications have been completed **within 9 months**
  - ➢**301** of those replication projects are **ongoing and on track**
  - ➢**Over 100 facilities** are replicating at least one of the best practices
- Examples would be using Pharmacists to manage medications and a Virtual Tumor Board



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Priority 3: High Performance Network

- As of the end of FY 2016, the Veterans Choice provider network has grown by **85%** and includes more than **350,000** network providers.
- Clinical workload is up **12%** over the past two years—**9%** within VA and **31%** in the community. The **12%** increase translates into roughly **7.5 million** additional hours of care for Veterans.
- New Choice Plan submitted to Congress in October 2015
- RFP planned to be released at end of month for revisions to Community Care program



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When Congress passed the Veterans Access, Choice and Accountability Act in 2014 (the Act), which established the Veterans Choice Program (VCP), the Act specified that the program may not furnish care or services after the expiration date of the program on August 7, 2017, or when the funding allocated ($10 billion) was exhausted.
Without further action by Congress before August 7, 2017, those Veterans that receive care through the current VCP (approximately one million unique Veterans have sought care through VCP since its implementation) will have to discontinue VCP care, and those Veterans newly authorized to receive VCP care will have to make alternative arrangements to receive care.
Other VA community care programs may not have the capacity to handle the entirety of patients who will come off of the current VCP. Wait times for appointments at VA facilities will likely rise if large numbers of Veterans return to VA to seek care.

Our goal for VA Community Care is to deliver a program that is easy to understand, simple to administer, and meets the needs of Veterans, community providers, and VA staff. How will we get there? Our approach consists of five components:
1. Eligibility: We want to provide easy to understand eligibility information to Veterans, community providers, and VA staff.
2. Referral and Authorizations: We want to streamline referral and authorizations, providing Veterans timely access to a community provider of their choice.
3. Care Coordination: We want to solidify care coordination through seamless health information exchanges.
4. Community Care Network: We plan to implement a Community Care Network that provides access to high-quality care inside and outside of VA.
5. Provider Payment (Claims): We want to become better partners to our community providers by paying them promptly and correctly.

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When Congress passed the Veterans Access, Choice and Accountability Act in 2014 (the Act), which established the Veterans Choice Program (VCP), the Act specified that the program may not furnish care or services after the expiration date of the program on August 7, 2017, or when the funding allocated ($10 billion) was exhausted.

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Other VA community care programs may not have the capacity to handle the entirety of patients who will come off of the current VCP. Wait times for appointments at VA facilities will likely rise if large numbers of Veterans return to VA to seek care.

Second bullet references a comparison of FY 14 to FY 15 and was originally completed by Finance in March 2016

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Priority 4: Employee Engagement

- VA Pulse - **94,339 unique users**
- Holding **Quarterly Town Hall Meetings** and site based employee open forums
- **AES scores improved** from 3.45 (2014) to 3.58 (2016)



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Priority 5: Restoring Trust

		VE Measure	% Agree or Strongly Agree Jan-Mar 2016 (Q2) (n=24,415)	%Agree or Strongly Agree Apr-Jun 2016 (Q3) (n=29,873)	%Agree or Strongly Agree Jul-Sep 2016 (Q4) (n=27,758)
	BRAND	**"I trust VA to fulfill our country's commitment to Veterans"**	**55%**	**59%**	**60%**
VETERANS EXPERIENCE	EFFECTIVE	"I got the care or service I needed"	72%	74%	75%
	EASE	"It was easy to get the care or services I needed"	61%	65%	66%
	EMOTION	"I felt like a valued customer"	63%	67%	68%

This survey was conducted by an independent contractor and validated by survey subject matter experts from Research Triangle International.

Acknowledgements to National Center for Organizational Development Dr Scott Moore and VHA Operational Excellence Dr Steven Wright.

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VHA Accomplishments in 2016

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Suicide Prevention

- **Elevated Office** of Suicide Prevention
- Completed and released a **landmark, comprehensive data analyses of Veteran suicide rates**, examining over 50 million Veteran records from 1979 to 2014 from every state in the nation, providing critical insights to help inform and shape our policies and efforts
- Reach Vet Program initiated to **proactively reach out** to those at highest risk
- **Added 163 responders** to the Veterans crisis line and added direct connections from the phone system to VCL
- Hugely successful Suicide Prevention Month 2016 campaign **#BeThere** garnered **over 73 million social media impressions** across various platforms, over 420 million impressions from TV, radio, and out of home placements (earned and paid), and was supported via Twitter by Joe Mantegna and Senators McCain and Sanders



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Innovative Healthcare

Telehealth

- In FY 2016, 12% of all Veterans enrolled for VA care received telehealth-based care. This includes **2.17 million telehealth visits, touching 702,000 Veterans**.
- Upcoming expanded services through VAR and VA Video Connect in 2017.

Million Veterans Program

- Program to incorporate **precision medicine** to improve Veterans' health by establishing large database containing genetic, military exposure, lifestyle, and health information with over **520,000 enrollees** as of Oct. 2016

Office of Compassionate Innovation

- Launched **Mental Health Service Dog** pilot to assist Veterans with mental health conditions that impede their mobility
- Since Center for Compassionate Innovation announced in April 2016, 38 proposals received; **8 proposals have moved to field implementation or warm hand-off** and **3 have been closed**

New

VA / Watson Cancer Partnership for Precision Oncology

Connect Care

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Complex Care Needs

Homelessness

- There was a **17 percent decline in Veteran homelessness** between 2015 and 2016, quadruple the previous year's annual rate of decline
- Since 2010**, over 480,000 Veterans and their family members have been permanently housed**, rapidly rehoused, or prevented from falling into homelessness by HUD's targeted housing vouchers and VA's homelessness programs

We've cut Veteran homelessness nationwide by 47% since 2010

Providing Counseling Services where Veterans are Comfortable

- More than **1 million primary care/mental health integration visits**
- More than **1.5 million visits** to Vet Centers providing readjustment, Military Sexual Trauma and bereavement counseling services



Hep C Management Notes

VA follows CDC recommendations to screen everyone born between 1945-1965 as they are at the highest risk of having HCV. Screening is also recommended for those born outside of this cohort who have other risk factors.

Source: VA's National Center for Health Promotion and Disease Prevention (NCP) HCV Screening recommendations: http://vaww.prevention.va.gov/CPS/Screening_for_Hepatitis_C.asp

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Public Health Issues

Hepatitis C Management

- In FY15 & 16, **VA treated a total of 69,294 Veterans with Hepatitis C** with an anticipated cure rate of over 90%.
- In CY2015, **69.9%** of the birth cohort (Veterans born between 1945-1965) were **screened for Hepatitis C**.



Reducing Opioid Abuse and Dependency

- 22% reduction in opioid use
- 42% reduction in use of opioids and benzodiazepines
- 32% reduction in dosages



Prevention Programs

- 42,000 Veteran Flu Shots at Walgreens
- MOVE! has helped over 600,000 patients lose weight, keep it off, and improve their health

Walgreens

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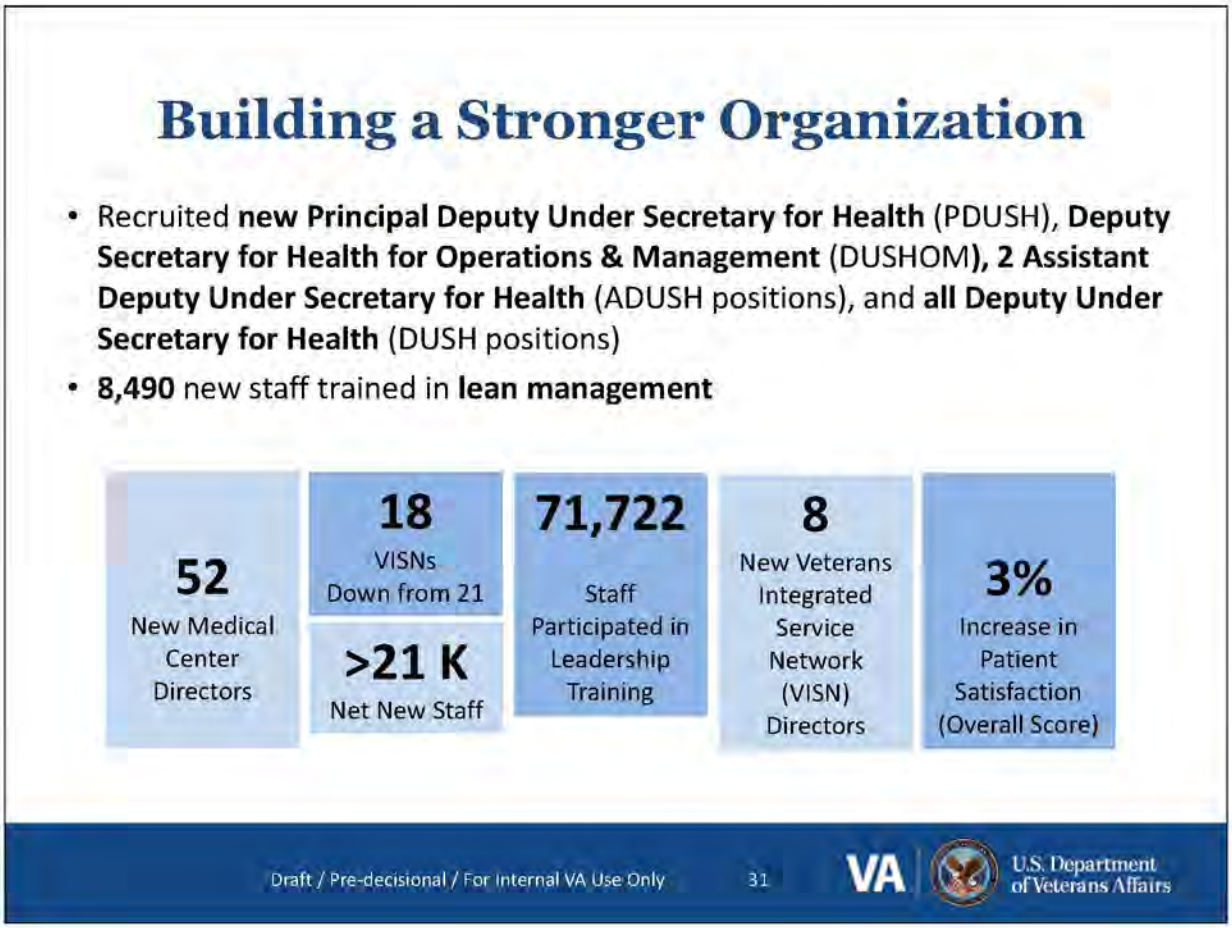

5th bullet notes:

Precision Oncology is the targeting of cancer therapy to the molecular profile of the cancer. This is not new – for many years we have been tailoring cancer therapy for some cancers. An easy example is assessing breast cancer for the presence of estrogen receptors, then using medications that block the effect of estrogen, thus blunting the effect of hormones which drive breast cancer growth. However, in the last 10 years the ability to sequence many genes simultaneously has led to an understanding of the specific mutations that drive cancer growth in many tumor types. This has gone in parallel with the development of medications that target and inhibit the effect of these specific driver mutations. Use of these targeted therapies has resulted in dramatic responses in some cases that previously had very poor outcomes. Unfortunately, only a small minority of cancers have identifiable mutations and targeted therapy available. The VA is currently expanding a program of sequencing a large number of genes in solid cancers, with several aims: to identify mutations in cancers for which there is available targeted therapy and treat these Veterans with the best available therapy; to identify mutations in cancers that might make them susceptible to an approved drug as an off label use; and to identify Veterans with molecular profiles in their cancer that would allow them to consider enrolling in clinical trials. To address the analysis of the molecular data, the VHA has a partnership with IBM Watson Health. This partnership will enhance our ability to both ensure Veterans receive the best available care now, and that clinical and basic research will improve care in the future.

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Serving our Veterans and the Nation

Culture of Improvement

- 6th year – **VA's pharmacy benefits ranked among best in class**
- **24 million in cost avoidance** through our supply chain efforts
- An Integrated operations center to **proactively monitor and identify** issues in quality or access
- **23,000 pounds of used medications** returned and **destroyed** this year

Service to the Nation

- **9,860 research publications** in 2016
- Added **547.4 graduate medical education positions**
- Responded and deployed to **6 national emergencies**



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VHA's Performance

- Comprehensive **Quality Measures** are in place
- VA generally performs **better than private sector**
- **82%** of medical centers showed **quantitative improvement** in quality last year
- Risk adjusted **mortality improved 20%** in 2016
- **Patient Satisfaction** scores show **improvement** across the board

1st bullet:
Regarding Strategic Analytics for Improvement and Learning (SAIL) Model

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82% of VAMCs with Improvement
SAIL Quality Measures in Past Year

	FY16Q3 SAIL Quality Star Percentile Cut-Off					
Overall Quality FY15Q4-FY16Q3[1]	Top10% 5-Star	11-30th% 4-Star	31-70th% 3-Star	71-90th% 2-Star	Bottom10% 1-Star	Total
Large Improvement	8	18	35	20	9	90
Small Improvement	3	7	13	5	2	30
Trivial Improvement	1	3	3	3	1	11
Trivial Decline	3	1	0	0	1	5
Small Decline	1	1	2	0	1	5
Meaningful Decline	1	1	2	0	1	5
Total	17[2]	31[2]	55	28[3]	15[3]	146[4]

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Most Challenged Sites Making Improvements

Site	Indicator	FY14	FY16 (YTD)
Phoenix	CAPHS - Routine Care	66	74
	CAPHS - Urgent Care	51	56
Hines	CAPHS - Routine Care	83	88
	CAPHS - Urgent Care	74	78
Shreveport	CAPHS - Routine Care	79	82
	CAPHS - Urgent Care	65	70
Spokane	CAPHS - Routine Care	81	82
	CAPHS - Urgent Care	64	68
Greater LA	CAPHS - Routine Care	82	83

Note: a 4 to 5 point change is considered "clinically significant"

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Comparative Data

	VHA	Private Sector
Quality		
Satisfaction		
Access		
Employee Engagement		
HEDIS		

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Studies showing better outcomes
JAMA

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Comparing VA Care to Private Sector

- 30-day risk-standardized **mortality rates are lower** in VA than those of non-VA hospitals for acute myocardial infarction and heart failure
- **MRSA infections declined** 69 percent in VA acute care facilities and 81 percent in spinal cord injury units over 5 years thanks to VA's aggressive MRSA prevention plan.
- VA performed the **same or significantly better** than non-VA providers on 12 of 14 **effectiveness measures in the inpatient setting**
- VA performed **significantly better** on 16 **outpatient HEDIS measures** compared with commercial HMOs and significantly better on 15 outpatient HEDIS measures compared with Medicare HMOs
- VA mental health care was **better than private-sector care by at least 30 percent on all seven performance measures**, with VA patients with depression more than twice as likely as private-sector patients to get effective long-term treatment
- **Outcomes for VA patients compared favorably** to patients with non-VA health insurance, with VA patients more likely to receive recommended evidence-based treatment

More data in press release: http://www.va.gov/opa/pressrel/includes/viewPDF.cfm?id=2778

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Future Direction, Priorities and Opportunities

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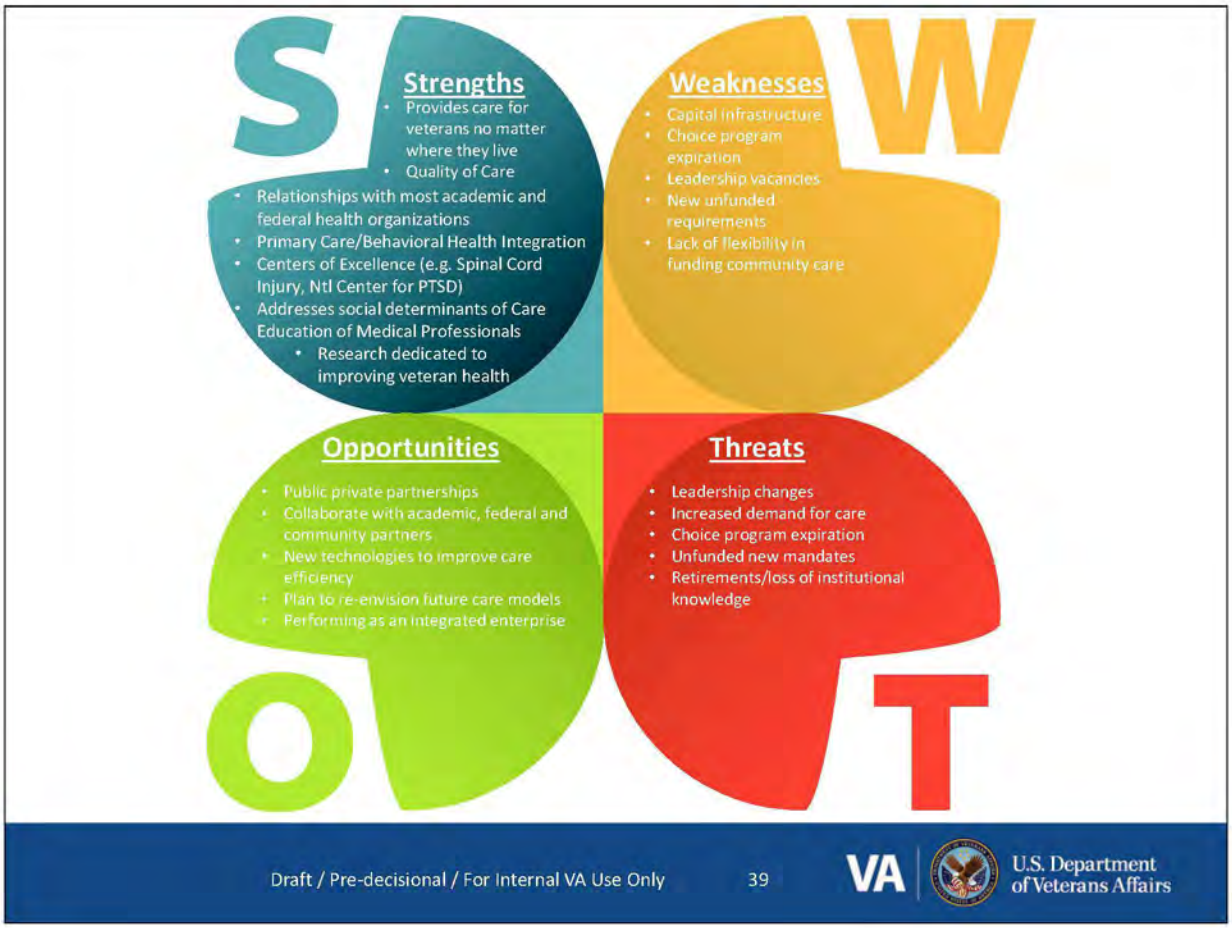

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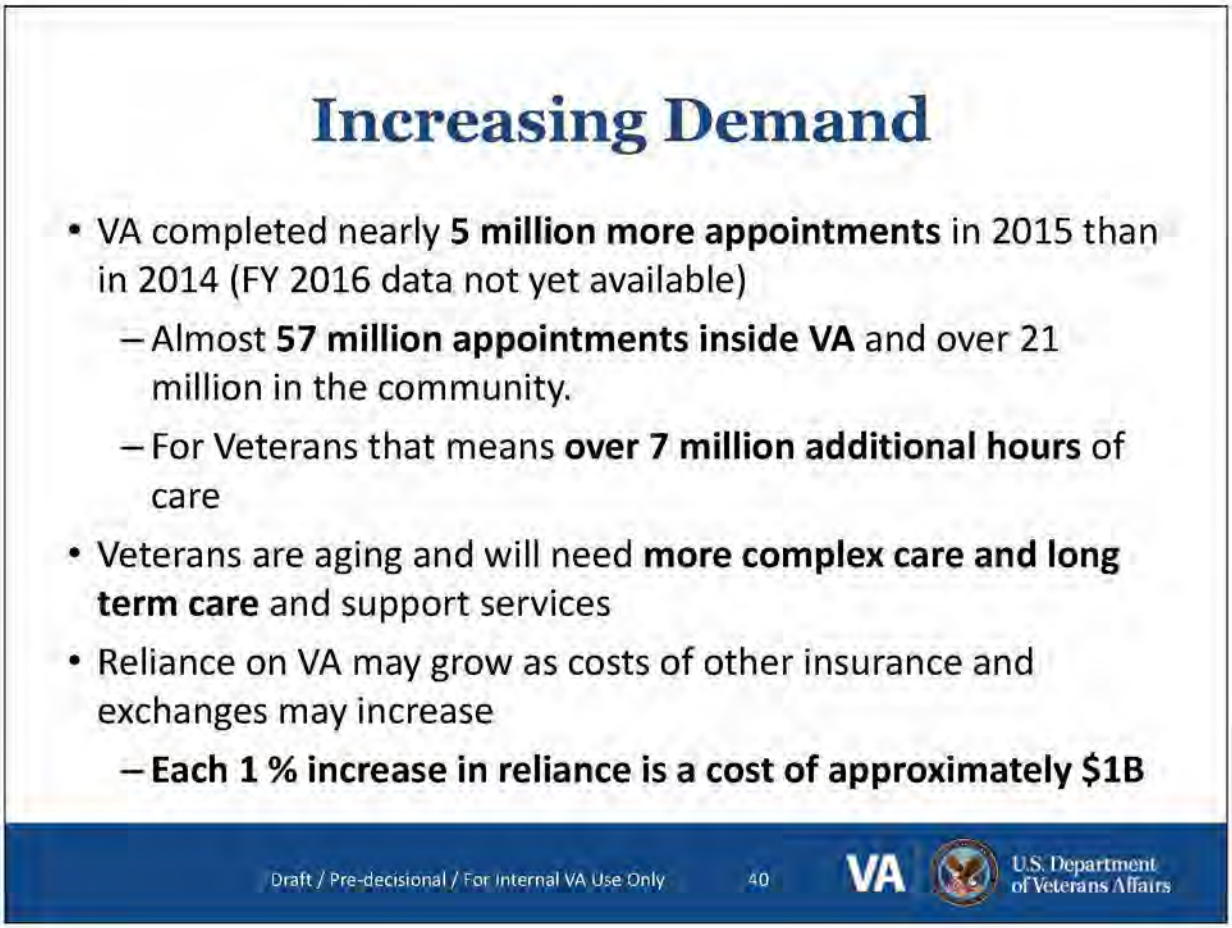

3rd bullet notes:
In 2014, enrollee reliance was estimated to be approximately 34%. We are currently updating reliance analysis with more recent Medicare data, but it is not available at this time. Reliance reflects the portion of health care services that an enrollee needs that we expect VA to provide or pay for. Some enrollees will get all of their health care from the VA and some will get none of their care, but most receive some portion of their care in the VA. For example, based on his/her morbidity, if an enrollee needs 10 office visits in a year and gets 4 of those office visits in VA. This enrollee is said to be 40 percent reliant on VA for office visits.

(b) (6) mentioned wanting to get graphs for this slide and the next from Mark Yow. As such, I haven't edited.

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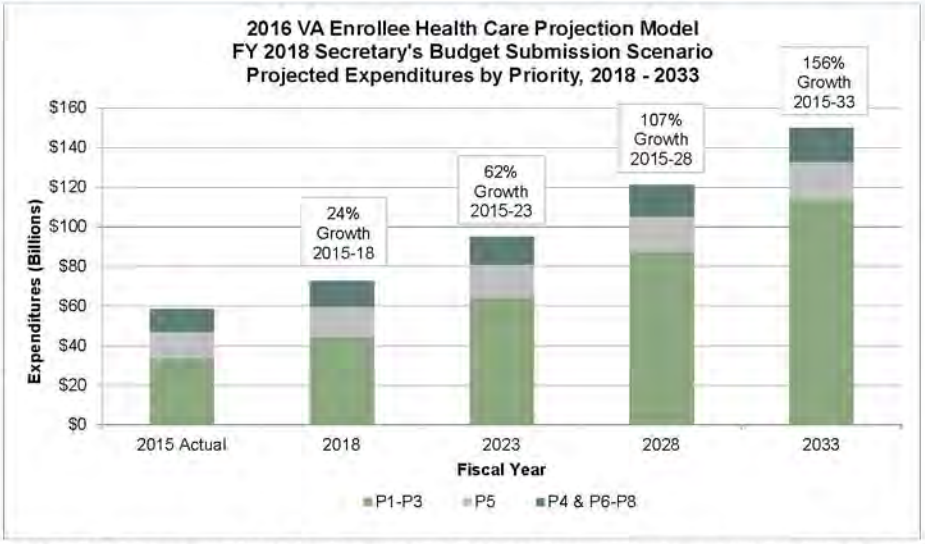
VA's Resource Requirements
Projected to Grow Significantly Over Time



2016 VA EHCPM, Budget Scenario (BAF) Note: The projections do not include requirements for several activities/ programs that are not projected by the VA EHCPM, including non-recurring maintenance, readjustment counseling, state-based long term services and supports programs, and some components of the CHAMPVA program.

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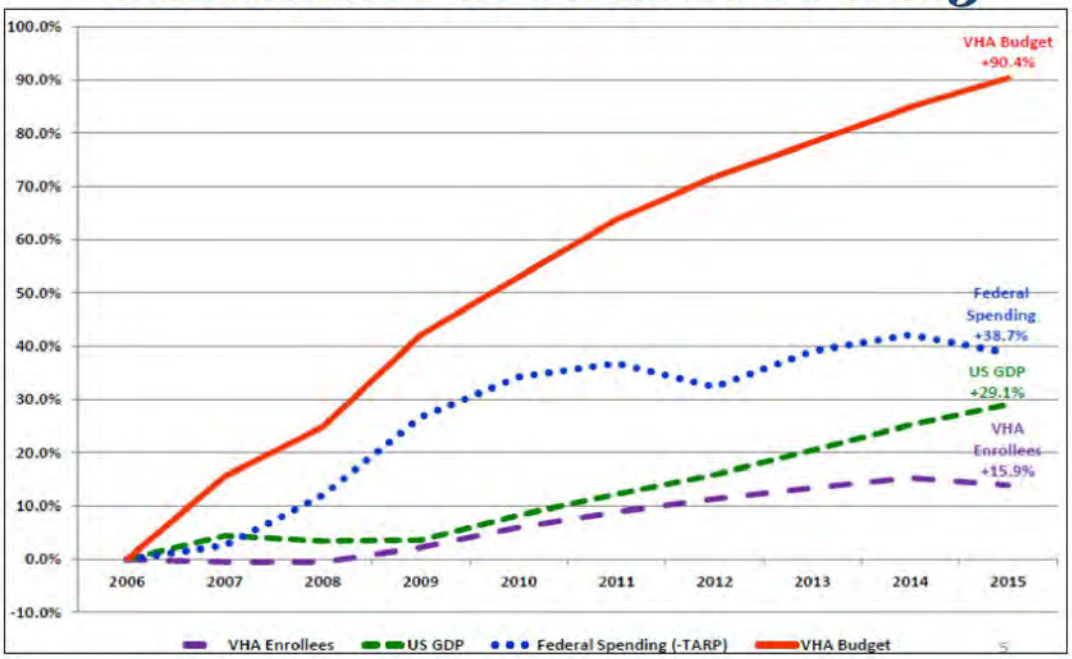
VA Medical Care Budget Challenge:
Cumulative Growth 2006-2015



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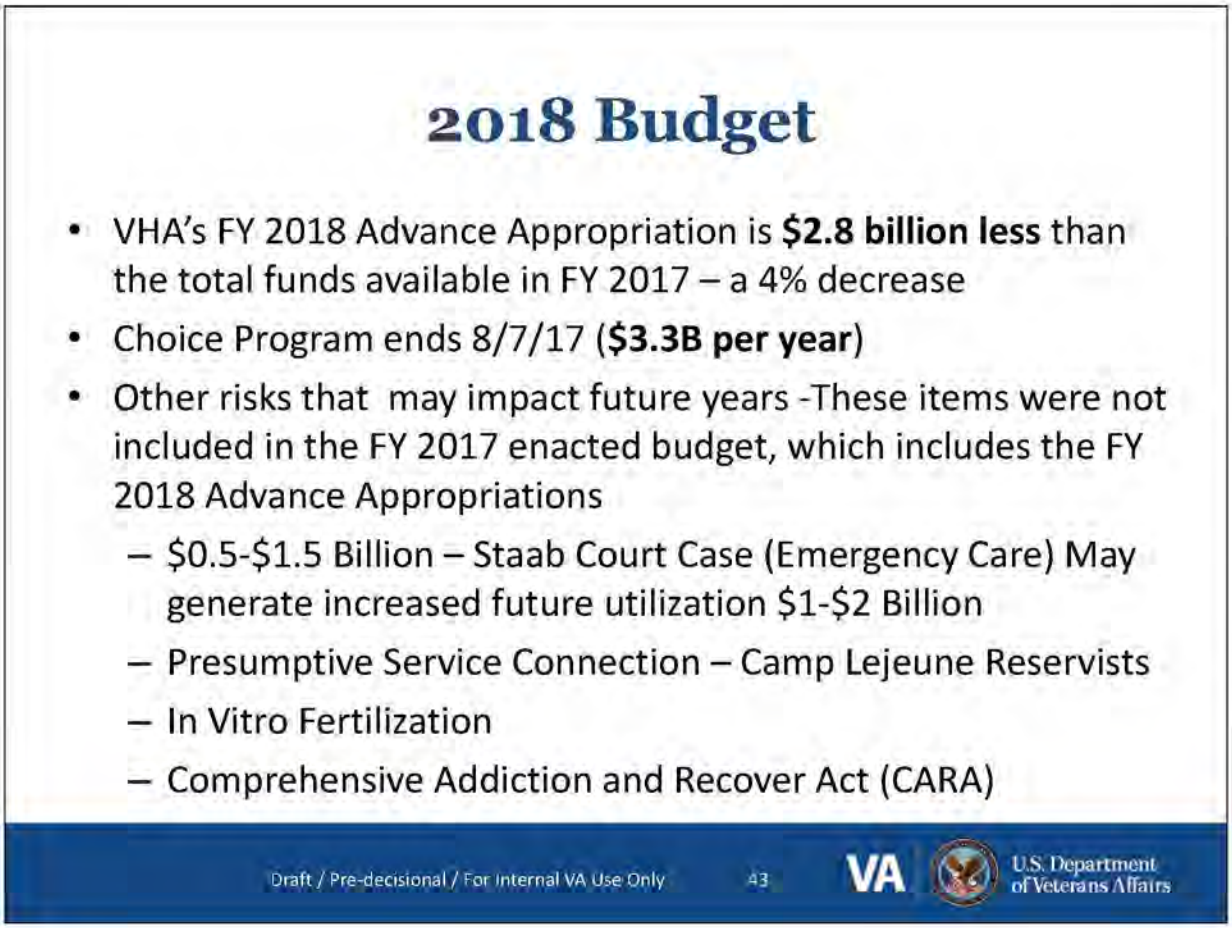

Bullet 3: Estimated budget numbers:
IVF6.5 Million FY 17, 13. million Fy18 --Maximum estimate Non VA Care funds
Adoption: 500K FY 17, 1.5 million FY 18—Maximum estimate
CARA = $153 million – crude estimate, some of which has already been incurred

Camp Lejeune.

Based on evidence there is sufficient scientific and medical evidence available to establish a presumption of connection between exposure to contaminants in the water supply at Camp Lejeune and the occurrence of eight health conditions

The proposed eight presumptive diseases are:
adult leukemia
aplastic anemia and other myelodysplastic syndromes
bladder cancer
kidney cancer
liver cancer
multiple myeloma
non-Hodgkin's lymphoma
Parkinson's disease

VA will not limit entitlement to active duty military personnel. Rather, VA proposes to presume exposure for all active duty, reserve and National Guard personnel who served at Camp Lejeune for no less than 30 cumulative days from August 1,

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1953, through December 31, 1987.

In addition, VA proposes to establish a presumption that individuals who served at Camp Lejeune during this period and later developed one of the presumptive diseases were disabled during the relevant period of service, thus establishing active military service for benefit purposes.

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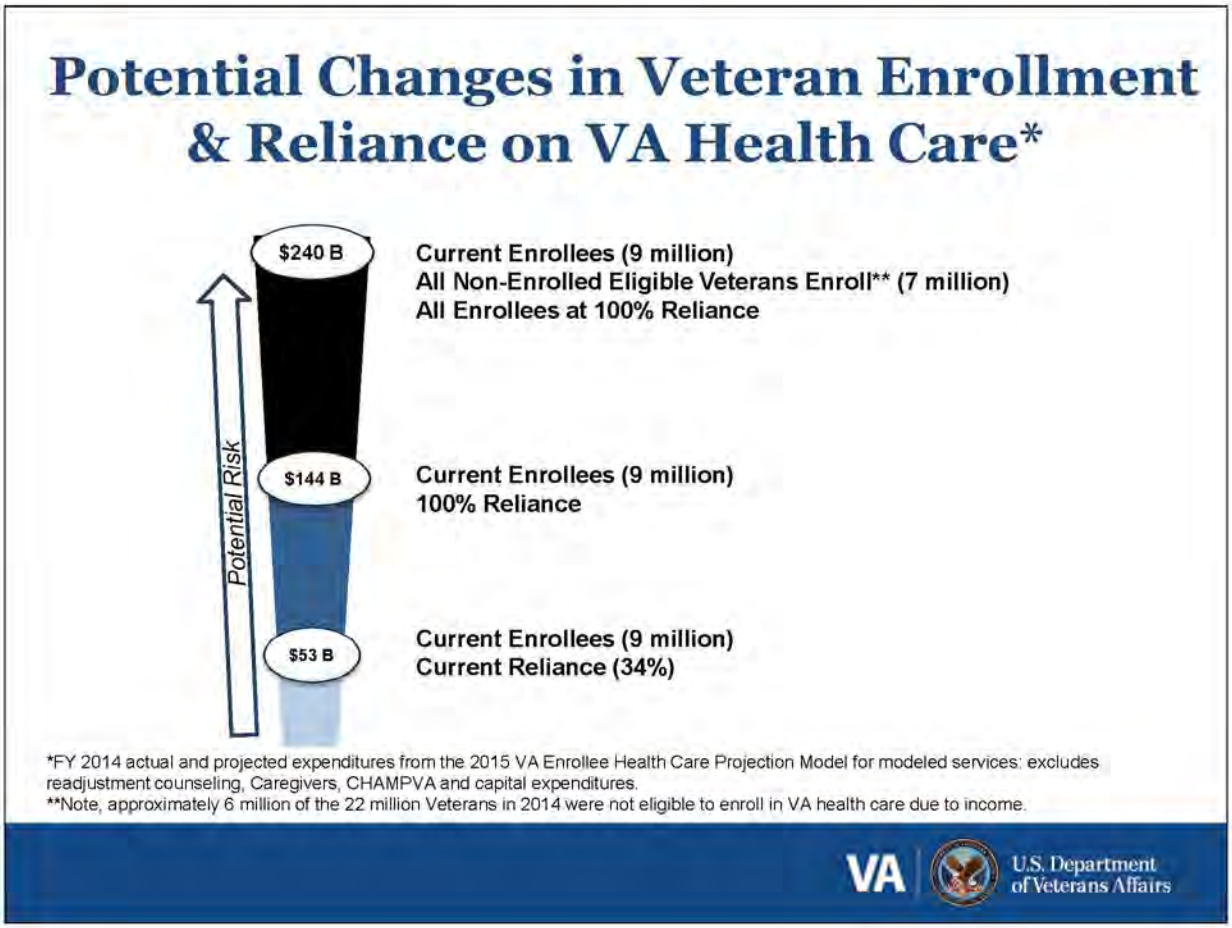

In 2014, costs for modeled services for 9 million enrollees at 34% reliance was $53 billion.

If all those 9 million enrollees used VA for all their health care, the cost in 2014 would have been $144 billion.

If all eligible but unenrolled veterans enrolled in VA and used VA for all their health care, the cost in 2014 would have been $240 billion.

All policy changes move this lever up and down as they impact either reliance on VA for health care, enrollment in VA, or both.

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Continuity of Leadership during a Crisis
Leadership vacancies and succession planning
Maintaining and Strengthening the Gains in Access (including Community Care), Quality, Engagement, and Trust
Direction of the Commission on Care Recommendations
Supporting VHA's Course for a Future Vision

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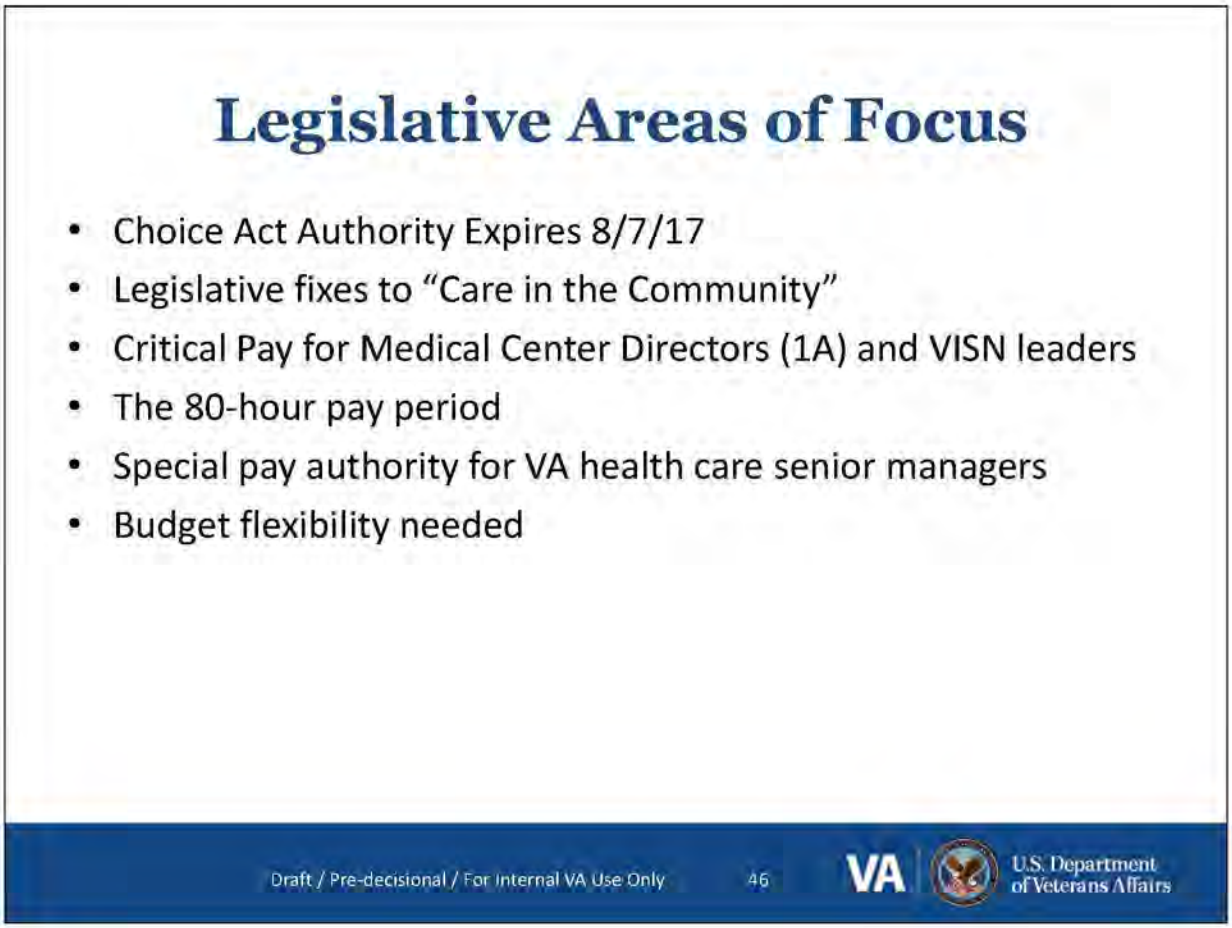

3RD BULLET:
The critical position pay authority (CPPA) allows the Secretary (or designee) to approve higher rates of pay for employees in positions that require expertise of an extremely high level in a scientific, technical, professional or administrative field critical to the Department's successful accomplishment of an important mission to the extent necessary to recruit or retain an individual exceptionally well-qualified for the critical position. Medical Center Directors and other Senior Executive Services (SES) VA health care senior managers would be eligible for CPPA.

Critical position pay requests must be submitted in writing only after it has been determined that the position in question cannot be filled with an exceptionally well-qualified individual through the use of other human resources flexibilities and pay authorities (e.g. recruitment, relocation and retention incentives, special salary rates, above minimum entrance rates).

The Secretary (or designee) must review and approve each critical position pay authority request before forwarding it to the Office of Personnel Management (OPM), who in consultation with the Office of Management and Budget (OMB) will issue final approval.

On September 22, 2016 OPM approved VA's request for CPPA for the Deputy Under Secretary for Health for Operations, 18 VISN Directors, 39 Level 1A Medical Center Directors, and 10 additional positions. 2 employees are in receipt of critical position pay and a plan is being developed for the additional positions.

Currently there is no special pay authority to compensate Medical Center Directors and other SES VA health care senior managers.

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Attached for reference is the signed/dated letter from OPM regarding critical pay.

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Organizational Areas of Focus

- Streamline Hiring/Onboarding Process
- Space: Leasing restrictions
- Facility Modernization: VHA aging Infrastructure
- Implement Full Practice Authority for Advance Practice Nurses: would increase VA ability to increase access
- Expand telehealth capability
- Implement scheduling system for medical appointments
- Examining intermediate and long term funding options for VA healthcare

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Our Commitment to Veterans

- ✓ Veterans should be at the center of what we do and how we deliver care at VHA
- ✓ No veteran with an urgent care need that may cause harm should wait for care
- ✓ VA must act like an integrated enterprise and a learning health system to benefit veterans most
- ✓ We will work closely with our academic, federal and community providers to deliver the highest outcomes to veterans
- ✓ VA leadership and staff must feel proud, fulfilled and empowered to deliver services to Veterans
- ✓ We must regain the trust and confidence of Veterans and the American public
- ✓ VA mission of research, education, and emergency preparedness must continue to contribute to improving the health of Veterans and all Americans

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A Future Vision for VHA

- **Public Private Partnerships** to serve Veterans
- **Digital Health Platform**
- **Whole Health Medicine** (empowering veteran well-being)
- Develop the **High Performance Network** (role of VISNs)
- **Center of Excellence** and Foundational Care
- **Value Based Management** and Efficiency Strategies
- Strengthen VA as a **Learning Healthcare System**
- Accelerate **Precision Medicine** and foster innovation
- Provide access to **VA Research Data** for non VA researchers with appropriate safeguards
- **Train More** primary care and behavioral health students

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Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 11/26/2016 3:14:23 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Fw: [External] Please resend this final attached presentation
Attachments: VHAOrgBrief-PresidentialTransition(b) (6) _v2 (002) REVISED Access Team v8.ppt

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From: (b) (6) [USA] (b) (6) @bah.com>
Sent: Saturday, November 26, 2016 10:09 AM
To: Poonam Alaigh; (b) (6) (ERPi)
Subject: RE: [External] Please resend this final attached presentation

Good morning Poonam,

This is 1 of 3 e-mails. Saving the presentation a few different ways to hopefully make it easier to open.

Thank you,

(b) (6)

Booz | Allen | Hamilton

(b) (6)

Lead Associate

Mobile: (b) (6)

(b) (6) @bah.com

www.boozallen.com

From: Poonam Alaigh [mailto:(b) (6) hotmail.com]
Sent: Saturday, November 26, 2016 10:00 AM

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To: (b) (6) [USA] (b) (6) @bah.com>; (b) (6) (ERPi) (b) (6) @va.gov>
Subject: [External] Please resend this final attached presentation

(b) (6) I further edited the presentation yesterday and tried sending it to USH. For some reason, he cant open it. Can you see attached and then decompress it or change the format so that he can open it on his personal computer. Call me if you want to talk. Please see attached

Also please send as 2 separate emails- ppx and ppt

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U.S. Department of Veterans Affairs Presidential Transition Briefing

Veterans Health Administration

Prepared for:
Agency Review Team

Briefed by:
David J. Shulkin, MD
Under Secretary of Health, Veterans Health Administration

November 2016

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Purpose and Agenda

- **Purpose:** To provide an overview of the Veterans Health Administration (VHA) and highlight major priorities and challenges
- **Overview:**
  - Organization, Budget and FTEs
  - Our Mission and Who We Serve
  - Assessment of VHA's Situation
    - Priorities
    - Performance
  - Accomplishments in FY 2016
  - Future Direction, Priorities and Opportunities for VHA

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Relevant Questions

- Is VHA making progress?
- What do Veterans think of VHA care?
- How does VHA compare to the private sector?
- What services should be provided in the community and what services within VHA?
- What are costs associated with moving more care out into the community?
- What is the impact of changes to ACA to VHA?
- Are there sustainable fixes to funding future VHA care?

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Organization, Budget and FTEs

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Organizational Leadership



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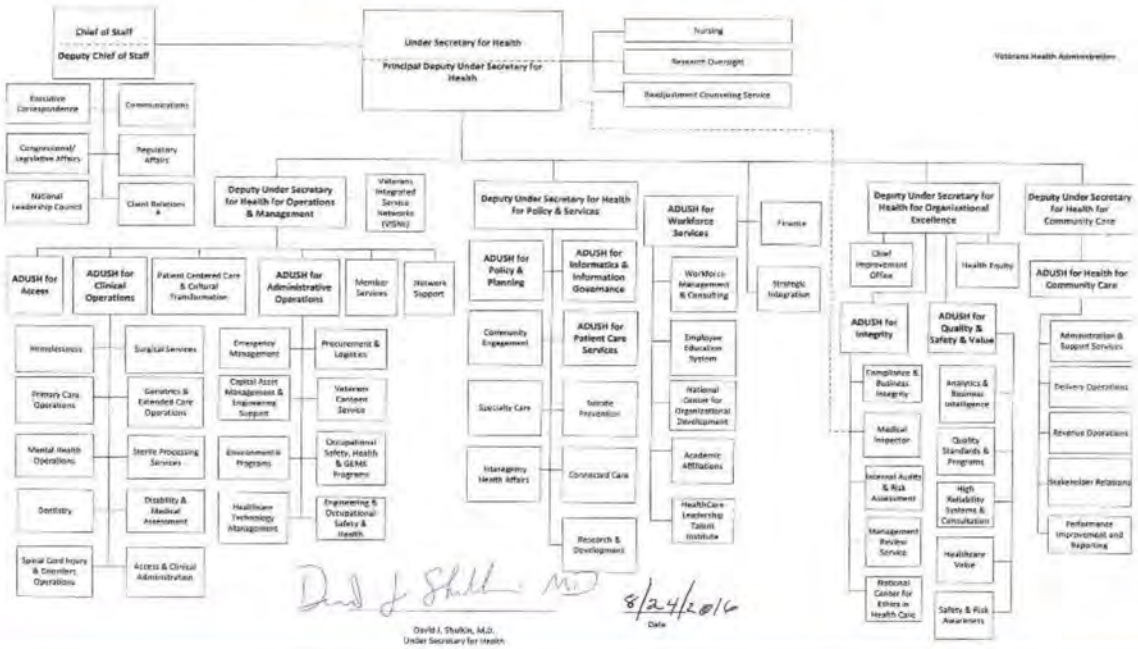
Organization Chart



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Budget and FTEs

FY 17 Enacted Budget	FY 18 Enacted Budget	Change (% Change)
$72,835,537	$70,012, 287	-2,823,250 (-3.9%)

Employees in VHA- 320,795 FTEs

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How We Are Different:
Our Mission and Who We Serve

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The Largest Healthcare System in the United States

- 1,234 health care facilities
  - 168 VA Medical Centers
  - 1,055 outpatient sites
- 25,000 physicians and
- 93,600 nurses (RN, LPN & NA)

- Over four times as many hospitals as Kaiser
- Over twice as many hospitals as DoD

Annual Workload Snapshot



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Annual Financial Report source file for graphic

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Who We Serve

- Veterans who rely most on the VA
  - Veterans with lower income
  - Veterans living in rural areas
  - Veterans without other access to health insurance coverage
  - Veterans with poorer self-reported health status
  - Veterans with higher rates of comorbidities
- The prevalence of many common conditions is projected to increase among Veterans over the next 10 years
- In the event of a potential future conflict, even moderate levels of deployment could substantially increase the size of the incoming cohort of VA patients

Findings from the independent assessment (section 201) Appendix A Demographics

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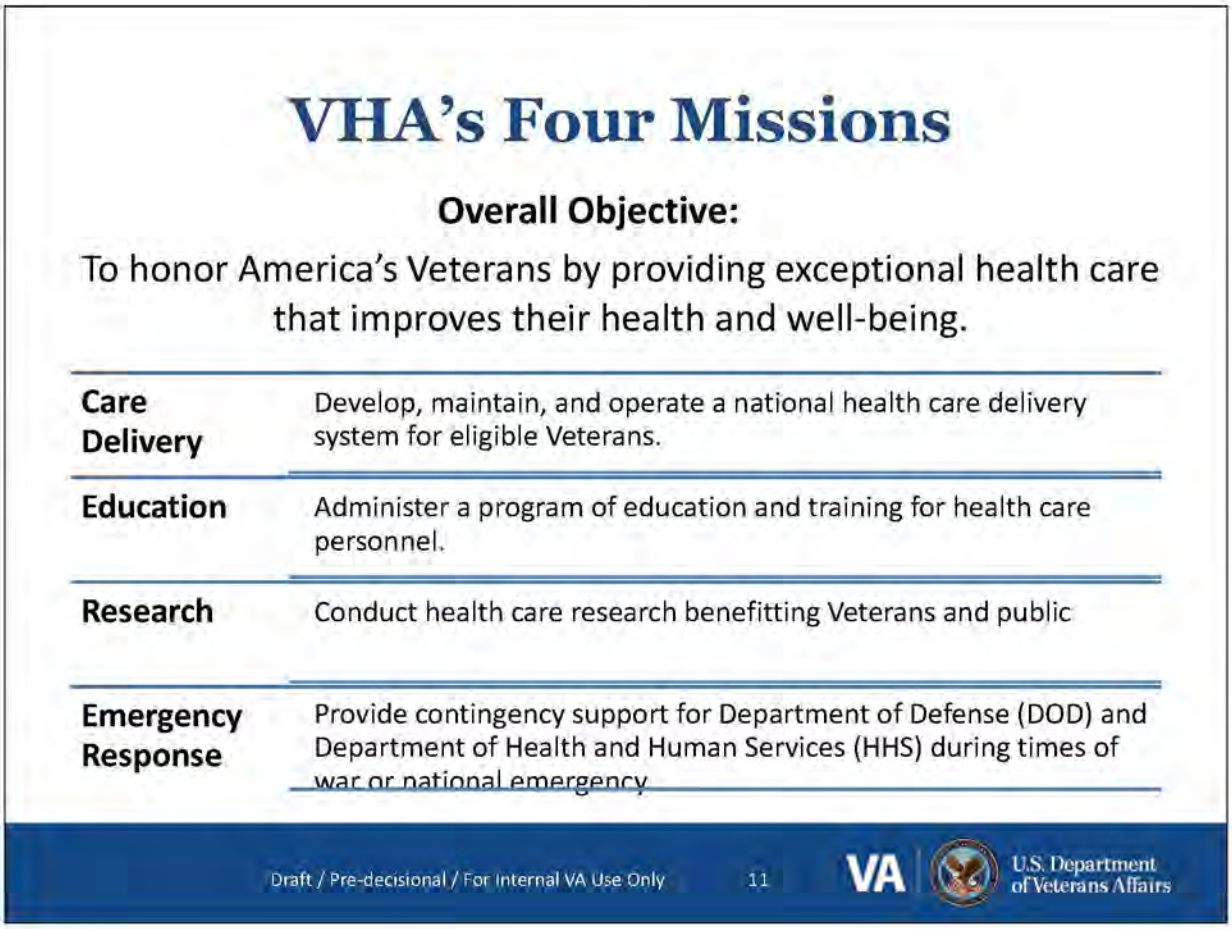

Our mission extends beyond healthcare for Veterans

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VA Healthcare Services Not Found in the Private Sector

- Caregivers
- Travel
- Dental
- Homeless Programs
- Long Term Care
- Readjustment Counseling
- Rural Health Outreach
- Special Populations- Spina Bifida, Camp Lejeune
- Comprehensive Emergency Medical Program
- Health Professions Educational Assistance
- Income Verification Match
- Hepatitis C Treatments
- Prosthetics
- Comprehensive Behavioral Health Programs
- Blind Rehabilitation
- Veterans Crisis Line
- Beneficiary Travel

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VA Healthcare Costs Not Found in the Private Sector

$Millions	FY 2015	FY 2016	FY 2017
Beneficiary Travel	$853	$888	$924
Camp Lejeune	$10	$24	$21
Caregivers	$454	$623	$725
CHAMPVA, Spina Bifida, FMP, CWVV	$1,547	$1,817	$1,920
Comprehensive Emergency Medical Program	$147	$135	$139
Dental Care	$1,005	$1,035	$1,433
Health Professions Educational Assistance programs	$37	$56	$70
Homeless Programs	$1,507	$1,477	$1,591
Income Verification Match	$17	$19	$19
Long Term Care	$7,702	$8,223	$8,588
Readjustment Counseling	$221	$258	$244
Rural Health Outreach Initiatives	$219	$270	$250
Sharing Agreements - Services Provided by VA	$157	$157	$166
Subtotal	$13,875	$14,980	$16,090
Hepatitis C (assume 50% greater benefit)	$406.1	$500.0	$500.0
Mental Health (assume 50% greater benefit)	$2,283.9	$2,494.9	$2,610.6
Prosthetics (assume 50% greater benefit)	$909.0	$950.3	$1,215.2
Subtotal	$3,599.0	$3,945.2	$4,325.9
Total	$17,473.9	$18,924.9	$20,415.8

Educational
Employment Services

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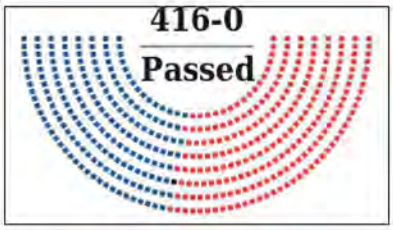
20 Years of Increasing Demand for Services

- 1996 "Veterans Eligibility Reform Act"
- Conflicts in Afghanistan and Iraq continued
  - Congress provided eligibility for care for five years after discharge
- From 2002 to 2015, VHA outpatient volume increased from 46.5M to almost 97M visits
- 2014 "The Veterans Access, Choice and Accountability Act"





- Enactment of Public Law 104-262, "Veterans Eligibility Reform Act" in 1996 allowed VA to provide full continuum of care for all Veterans who chose to enroll for care

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Myths vs. Reality

Myth	Reality
Veterans cared for by VHA have similar issues to most other Americans	Users of VHA are older and have more complex medical issues than non-users (almost 50% of users have a mental health diagnosis)
Care in VHA is poor quality	Numerous independent studies have shown that quality or equal or better
VHA does not want to utilize private sector health providers	22% of all care currently is done in the community- Close to 4 million Choice Act Authorizations has been utilized
Veteran Suicides are only a VHA problem	Of the 20 Veterans who take their own life a day- 14 do not get care in VHA
The private sector offers the same services as in VHA	More than 16 billion dollars in care a year goes towards services not provided by private sector
Access to services is worse than the private sector	96.5% of veterans were seen within 30 days of their clinical indicated or preferred date. Similar data is not readily available from the private sector
Veterans want to use private sector providers and not VA services	Of the 1 million veterans that used Choice, less than 5000 veterans did not also receive their care in VHA

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Impact of VHA Research

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VHA Priorities

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USH 5 Priorities for Strategic Action

Access

We will provide timely access to Veterans as determined by their clinical needs.

PSA: We pledge that any Veteran with the requirement for urgent care will receive care at the right time appropriate to his or her clinical needs

Employee Engagement

We seek a work environment where employees are valued, supported, and encouraged to do their best for Veterans.

PSA: We will work to allow staff to have greater input into their work environment.



High Performance Network

We will ensure that Veterans receive the highest level of coordinated care within VA or from participating providers.

PSA: We will build a high performance network of care to best serve Veterans.

Best Practices

We will use best clinical practices. We also seek best practices in research, education, and management.

PSA: We seek to identify and disseminate best practices throughout VA.

Veterans First: Trust in VA Care

We will be there for our Veterans when they need us.

PSA: We will share our results on the quality and timeliness of how we care for Veterans.

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Priority 1: Access
Transformative Changes



MyVA Access Declaration

Prong 1

Prong 2

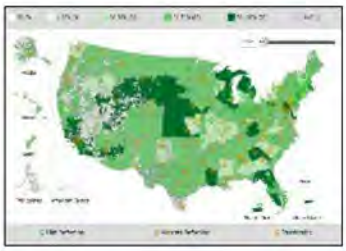
Access Improvement Solutions

National Deployment Strategy

Prong 3



Dr. David Shulkin signing the MyVA Declaration Statement on 4/7/2016



Transformative changes heading
Prong
Guidebook
Map

Same day Services for urgent needs
Path to SDA

Third slide is Results and impact that improve access

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Priority 1: Access

Same Day Access in Primary Care and Mental Health

By the end of this year, we may be the most accessible healthcare system in the United States

September
52 sites (31%)

October
85 Sites (51%)

November
123 Sites (74%)

December
166 Sites (100%)

Same Day Services:

If you need care right away during regular business hours, you are able to get services the same day, or if after hours, by the next day from a VA Medical Center or Health Care Center.

- Options for how that care might be provided include in person, via telephone, smart phone, through video care, secure messaging ,or other options.
- This care may be delivered by your provider or another appropriate clinical staff member based on availability and your care needs.
- *For a medical emergency always call 911 or report to the emergency room closest to where you are located.*

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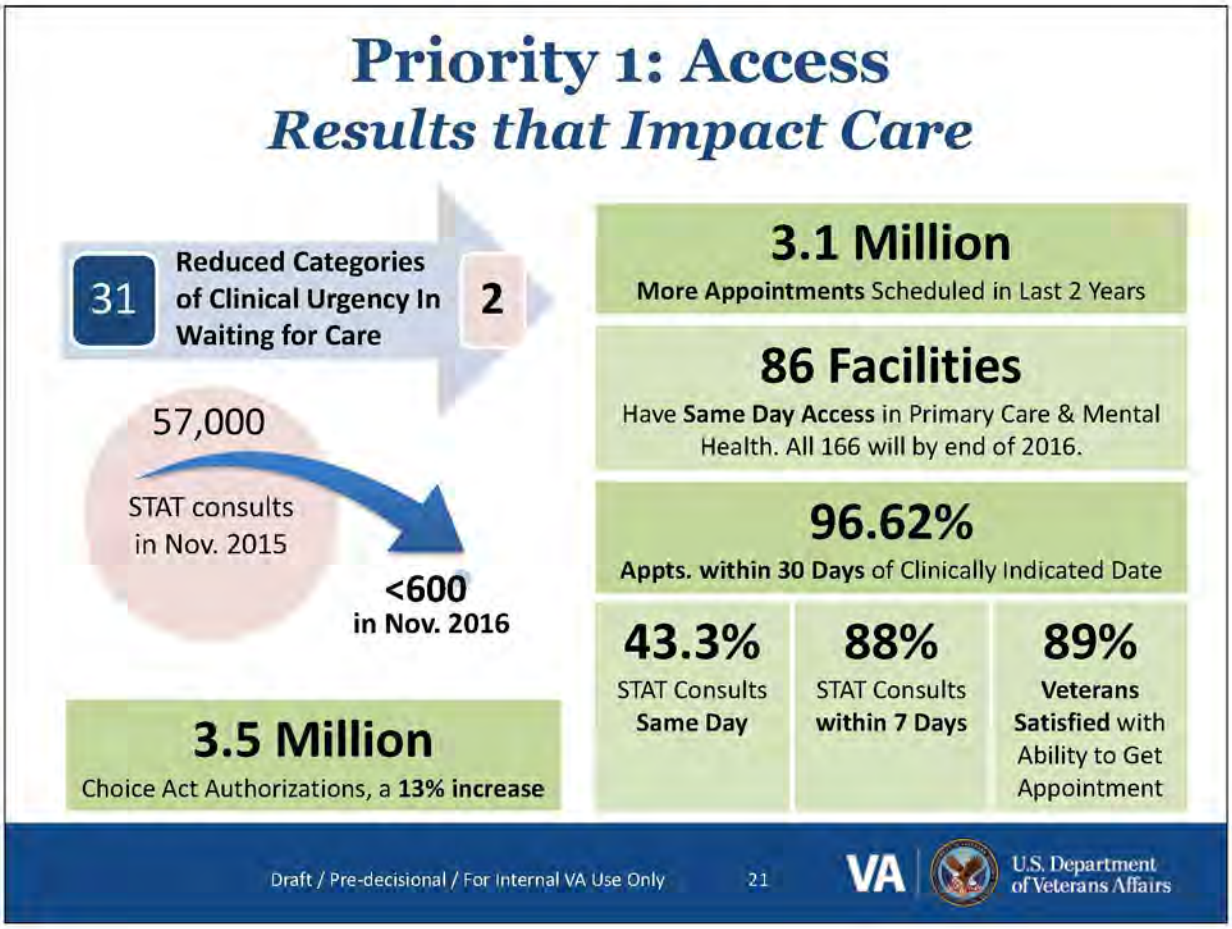

Second bullet is discussing STAT consults over 30 days

Categorized veterans waiting for care into clinical urgency (from 31 categories to 2)
57,000 stat consults in Nov 2015 to <600 in November 2016
3.1 Million more appointments scheduled in the last 2 years
86 facilities have Same Day Access in Primary Care and Mental Health. All 166 facilities will be able to offer these services by the end of 2016
89% of veterans satisfied with the ability to get an appointment (2.1 M veterans)
In October 2016, 96.62% of appointments were within 30 days of the clinically indicated or Veteran's preferred date
43.3% of stat consults were completed same day and 88% were seen within 7 days (a 22% increase from the start of the fiscal year)
Map of veterans evaluation of waiting times by site placed on internet on 11/11/16
Expanded scheduled hours on weekends and evenings, productivity, people, and space
More than 3.5 million authorizations through Choice from September 1, 2015 through August 31, 2016. This represents a 13% increase in authorizations when compared to the same period in 2014/2015

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Priority 2: Best Practices
& Performing as an Integrated Enterprise

- Successfully replicating **13 USH Gold Status best practices 386 times** throughout the system:
  - ➢**85** of those replications have been completed **within 9 months**
  - ➢**301** of those replication projects are **ongoing and on track**
  - ➢**Over 100 facilities** are replicating at least one of the best practices
- Examples would be using Pharmacists to manage medications and a Virtual Tumor Board



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Priority 3: High Performance Network

- As of the end of FY 2016, the Veterans Choice provider network has grown by **85%** and includes more than **350,000** network providers.
- Clinical workload is up **12%** over the past two years—**9%** within VA and **31%** in the community. The **12%** increase translates into roughly **7.5 million** additional hours of care for Veterans.
- New Choice Plan submitted to Congress in October 2015
- RFP planned to be released at end of month for revisions to Community Care program



Draft / Pre-decisional / For Internal VA Use Only 23 VA U.S. Department of Veterans Affairs

When Congress passed the Veterans Access, Choice and Accountability Act in 2014 (the Act), which established the Veterans Choice Program (VCP), the Act specified that the program may not furnish care or services after the expiration date of the program on August 7, 2017, or when the funding allocated ($10 billion) was exhausted.
Without further action by Congress before August 7, 2017, those Veterans that receive care through the current VCP (approximately one million unique Veterans have sought care through VCP since its implementation) will have to discontinue VCP care, and those Veterans newly authorized to receive VCP care will have to make alternative arrangements to receive care.
Other VA community care programs may not have the capacity to handle the entirety of patients who will come off of the current VCP. Wait times for appointments at VA facilities will likely rise if large numbers of Veterans return to VA to seek care.

Our goal for VA Community Care is to deliver a program that is easy to understand, simple to administer, and meets the needs of Veterans, community providers, and VA staff. How will we get there? Our approach consists of five components:
1. Eligibility: We want to provide easy to understand eligibility information to Veterans, community providers, and VA staff.
2. Referral and Authorizations: We want to streamline referral and authorizations, providing Veterans timely access to a community provider of their choice.
3. Care Coordination: We want to solidify care coordination through seamless health information exchanges.
4. Community Care Network: We plan to implement a Community Care Network that provides access to high-quality care inside and outside of VA.
5. Provider Payment (Claims): We want to become better partners to our community providers by paying them promptly and correctly.

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When Congress passed the Veterans Access, Choice and Accountability Act in 2014 (the Act), which established the Veterans Choice Program (VCP), the Act specified that the program may not furnish care or services after the expiration date of the program on August 7, 2017, or when the funding allocated ($10 billion) was exhausted.

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Other VA community care programs may not have the capacity to handle the entirety of patients who will come off of the current VCP. Wait times for appointments at VA facilities will likely rise if large numbers of Veterans return to VA to seek care.

Second bullet references a comparison of FY 14 to FY 15 and was originally completed by Finance in March 2016

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Priority 4: Employee Engagement

- VA Pulse - **94,339 unique users**
- Holding **Quarterly Town Hall Meetings** and site based employee open forums
- **AES scores improved** from 3.45 (2014) to 3.58 (2016)



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Priority 5: Restoring Trust

	VE Measure	% Agree or Strongly Agree Jan-Mar 2016 (Q2) (n=24,415)	%Agree or Strongly Agree Apr-Jun 2016 (Q3) (n=29,873)	%Agree or Strongly Agree Jul-Sep 2016 (Q4) (n=27,758)
BRAND	**"I trust VA to fulfill our country's commitment to Veterans"**	**55%**	**59%**	**60%**
VETERANS EXPERIENCE – EFFECTIVE	"I got the care or service I needed"	72%	74%	75%
VETERANS EXPERIENCE – EASE	"It was easy to get the care or services I needed"	61%	65%	66%
VETERANS EXPERIENCE – EMOTION	"I felt like a valued customer"	63%	67%	68%

This survey was conducted by an independent contractor and validated by survey subject matter experts from Research Triangle International.

Acknowledgements to National Center for Organizational Development Dr Scott Moore and VHA Operational Excellence Dr Steven Wright.

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VHA Accomplishments in 2016

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Suicide Prevention

- **Elevated Office** of Suicide Prevention
- Completed and released a **landmark, comprehensive data analyses of Veteran suicide rates**, examining over 50 million Veteran records from 1979 to 2014 from every state in the nation, providing critical insights to help inform and shape our policies and efforts
- Reach Vet Program initiated to **proactively reach out** to those at highest risk
- **Added 163 responders** to the Veterans crisis line and added direct connections from the phone system to VCL
- Hugely successful Suicide Prevention Month 2016 campaign **#BeThere** garnered **over 73 million social media impressions** across various platforms, over 420 million impressions from TV, radio, and out of home placements (earned and paid), and was supported via Twitter by Joe Mantegna and Senators McCain and Sanders



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Innovative Healthcare

Telehealth

- In FY 2016, 12% of all Veterans enrolled for VA care received telehealth-based care. This includes **2.17 million telehealth visits, touching 702,000 Veterans**.
- Upcoming expanded services through VAR and VA Video Connect in 2017.

Million Veterans Program

- Program to incorporate **precision medicine** to improve Veterans' health by establishing large database containing genetic, military exposure, lifestyle, and health information with over **520,000 enrollees** as of Oct. 2016

Office of Compassionate Innovation

- Launched **Mental Health Service Dog** pilot to assist Veterans with mental health conditions that impede their mobility
- Since Center for Compassionate Innovation announced in April 2016, 38 proposals received; **8 proposals have moved to field implementation or warm hand-off** and **3 have been closed**

New

VA / Watson Cancer Partnership for Precision Oncology

Connect Care

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Complex Care Needs

Homelessness

- There was a **17 percent decline in Veteran homelessness** between 2015 and 2016, quadruple the previous year's annual rate of decline
- Since 2010**, over 480,000 Veterans and their family members have been permanently housed**, rapidly rehoused, or prevented from falling into homelessness by HUD's targeted housing vouchers and VA's homelessness programs

We've cut Veteran homelessness nationwide by 47% since 2010

Providing Counseling Services where Veterans are Comfortable

- More than **1 million primary care/mental health integration visits**
- More than **1.5 million visits** to Vet Centers providing readjustment, Military Sexual Trauma and bereavement counseling services



Hep C Management Notes

VA follows CDC recommendations to screen everyone born between 1945-1965 as they are at the highest risk of having HCV. Screening is also recommended for those born outside of this cohort who have other risk factors.

Source: VA's National Center for Health Promotion and Disease Prevention (NCP) HCV Screening recommendations: http://vaww.prevention.va.gov/CPS/Screening_for_Hepatitis_C.asp

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Public Health Issues

Hepatitis C Management

- In FY15 & 16, **VA treated a total of 69,294 Veterans with Hepatitis C** with an anticipated cure rate of over 90%.
- In CY2015, **69.9%** of the birth cohort (Veterans born between 1945-1965) were **screened for Hepatitis C**.



Reducing Opioid Abuse and Dependency

- 22% reduction in opioid use
- 42% reduction in use of opioids and benzodiazepines
- 32% reduction in dosages



Prevention Programs

- 42,000 Veteran Flu Shots at Walgreens
- MOVE! has helped over 600,000 patients lose weight, keep it off, and improve their health

Walgreens

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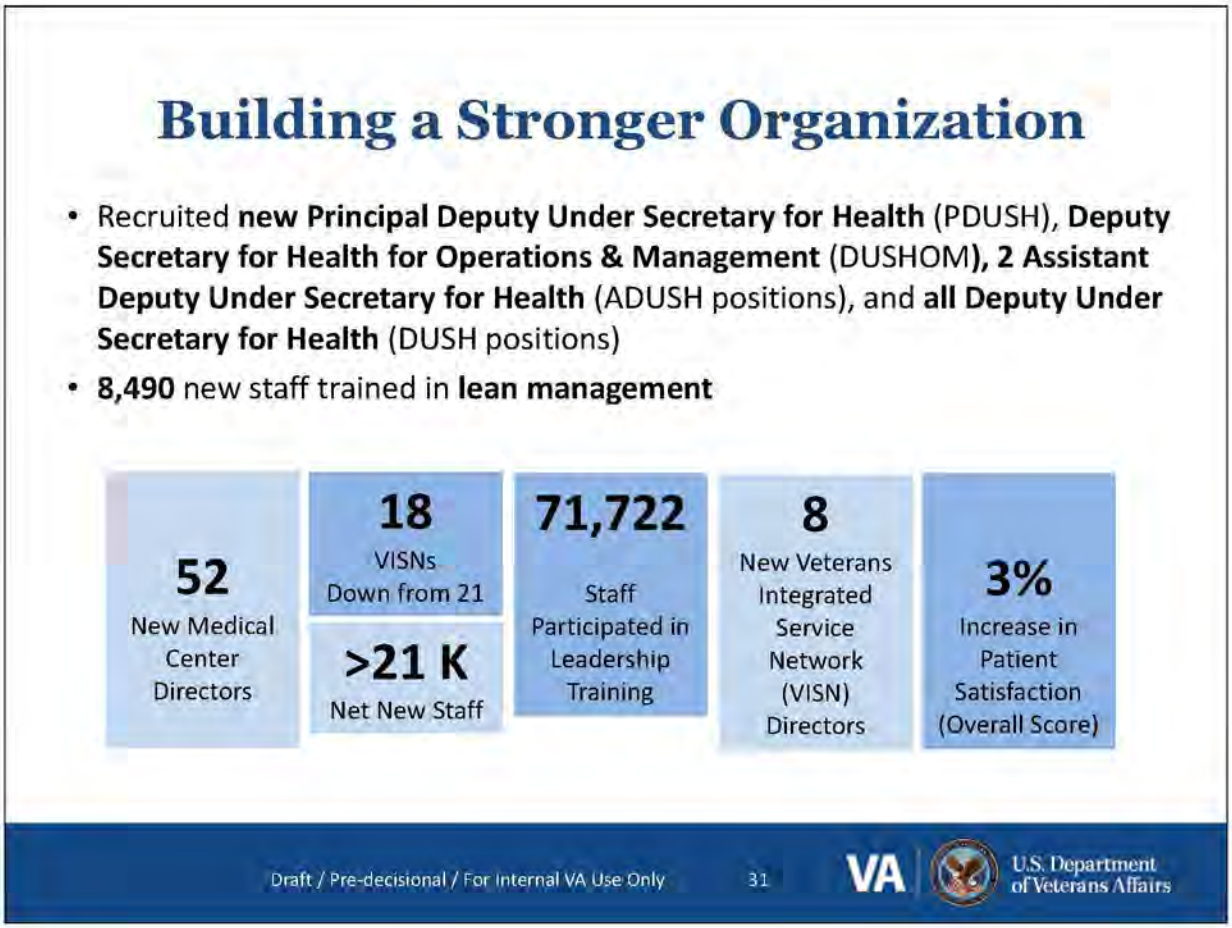

5th bullet notes:

Precision Oncology is the targeting of cancer therapy to the molecular profile of the cancer. This is not new – for many years we have been tailoring cancer therapy for some cancers. An easy example is assessing breast cancer for the presence of estrogen receptors, then using medications that block the effect of estrogen, thus blunting the effect of hormones which drive breast cancer growth. However, in the last 10 years the ability to sequence many genes simultaneously has led to an understanding of the specific mutations that drive cancer growth in many tumor types. This has gone in parallel with the development of medications that target and inhibit the effect of these specific driver mutations. Use of these targeted therapies has resulted in dramatic responses in some cases that previously had very poor outcomes. Unfortunately, only a small minority of cancers have identifiable mutations and targeted therapy available. The VA is currently expanding a program of sequencing a large number of genes in solid cancers, with several aims: to identify mutations in cancers for which there is available targeted therapy and treat these Veterans with the best available therapy; to identify mutations in cancers that might make them susceptible to an approved drug as an off label use; and to identify Veterans with molecular profiles in their cancer that would allow them to consider enrolling in clinical trials. To address the analysis of the molecular data, the VHA has a partnership with IBM Watson Health. This partnership will enhance our ability to both ensure Veterans receive the best available care now, and that clinical and basic research will improve care in the future.

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Serving our Veterans and the Nation

Culture of Improvement

- 6th year – **VA's pharmacy benefits ranked among best in class**
- **24 million in cost avoidance** through our supply chain efforts
- An Integrated operations center to **proactively monitor and identify** issues in quality or access
- **23,000 pounds of used medications** returned and **destroyed** this year

Service to the Nation

- **9,860 research publications** in 2016
- Added **547.4 graduate medical education positions**
- Responded and deployed to **6 national emergencies**



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VHA's Performance

- Comprehensive **Quality Measures** are in place
- VA generally performs **better than private sector**
- **82%** of medical centers showed **quantitative improvement** in quality last year
- Risk adjusted **mortality improved 20%** in 2016
- **Patient Satisfaction** scores show **improvement** across the board

1st bullet:
Regarding Strategic Analytics for Improvement and Learning (SAIL) Model

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82% of VAMCs with Improvement
SAIL Quality Measures in Past Year

	FY16Q3 SAIL Quality Star Percentile Cut-Off					
Overall Quality FY15Q4-FY16Q3[1]	Top10% 5-Star	11-30th% 4-Star	31-70th% 3-Star	71-90th% 2-Star	Bottom10% 1-Star	Total
Large Improvement	8	18	35	20	9	90
Small Improvement	3	7	13	5	2	30
Trivial Improvement	1	3	3	3	1	11
Trivial Decline	3	1	0	0	1	5
Small Decline	1	1	2	0	1	5
Meaningful Decline	1	1	2	0	1	5
Total	17[2]	31[2]	55	28[3]	15[3]	146[4]

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Most Challenged Sites Making Improvements

Site	Indicator	FY14	FY16 (YTD)
Phoenix	CAPHS - Routine Care	66	74
	CAPHS - Urgent Care	51	56
Hines	CAPHS - Routine Care	83	88
	CAPHS - Urgent Care	74	78
Shreveport	CAPHS - Routine Care	79	82
	CAPHS - Urgent Care	65	70
Spokane	CAPHS - Routine Care	81	82
	CAPHS - Urgent Care	64	68
Greater LA	CAPHS - Routine Care	82	83

Note: a 4 to 5 point change is considered "clinically significant"

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Comparative Data

	VHA	Private Sector
Quality		
Satisfaction		
Access		
Employee Engagement		
HEDIS		

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Studies showing better outcomes
JAMA

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Comparing VA Care to Private Sector

- 30-day risk-standardized **mortality rates are lower** in VA than those of non-VA hospitals for acute myocardial infarction and heart failure
- **MRSA infections declined** 69 percent in VA acute care facilities and 81 percent in spinal cord injury units over 5 years thanks to VA's aggressive MRSA prevention plan.
- VA performed the **same or significantly better** than non-VA providers on 12 of 14 **effectiveness measures in the inpatient setting**
- VA performed **significantly better** on 16 **outpatient HEDIS measures** compared with commercial HMOs and significantly better on 15 outpatient HEDIS measures compared with Medicare HMOs
- VA mental health care was **better than private-sector care by at least 30 percent on all seven performance measures**, with VA patients with depression more than twice as likely as private-sector patients to get effective long-term treatment
- **Outcomes for VA patients compared favorably** to patients with non-VA health insurance, with VA patients more likely to receive recommended evidence-based treatment

More data in press release: http://www.va.gov/opa/pressrel/includes/viewPDF.cfm?id=2778

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Future Direction, Priorities and Opportunities

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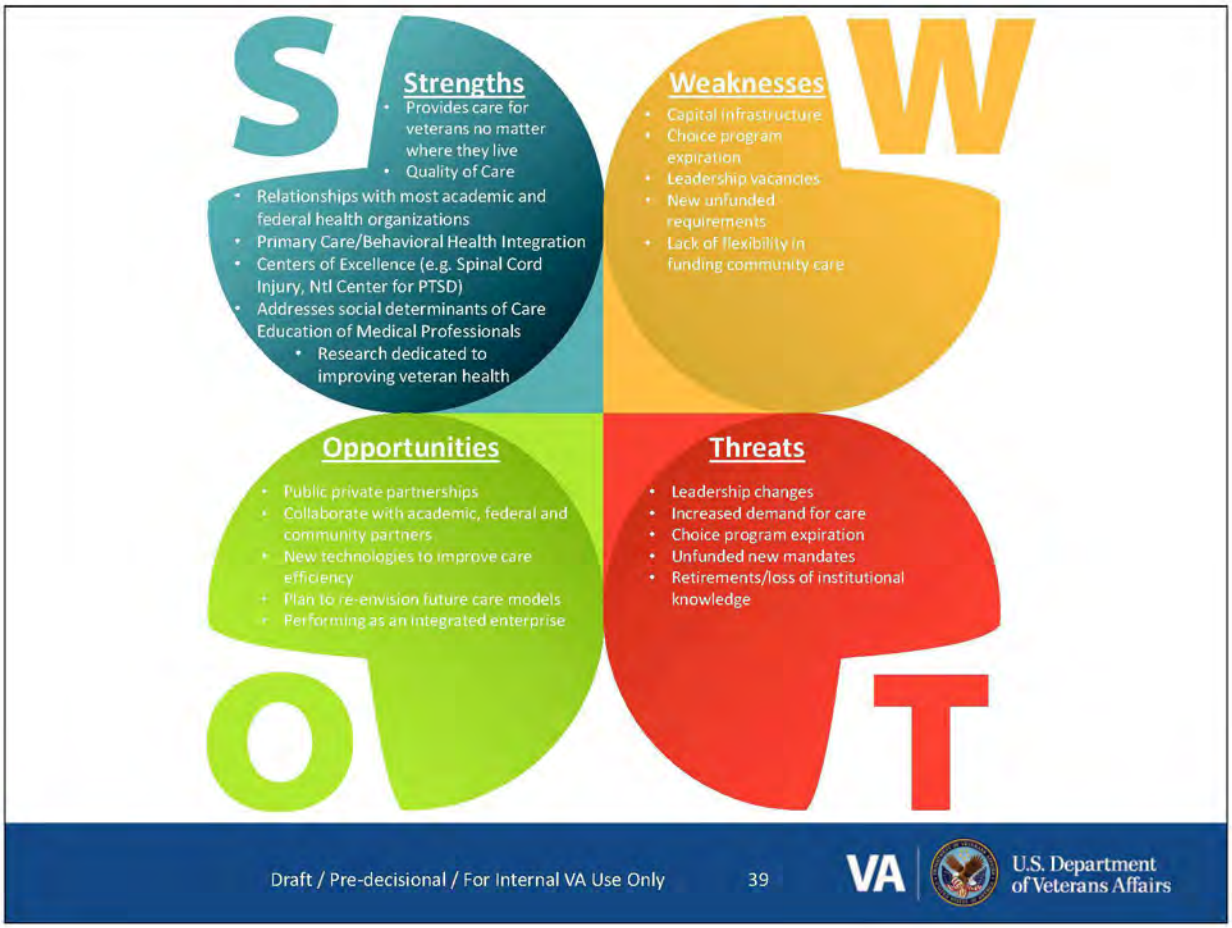

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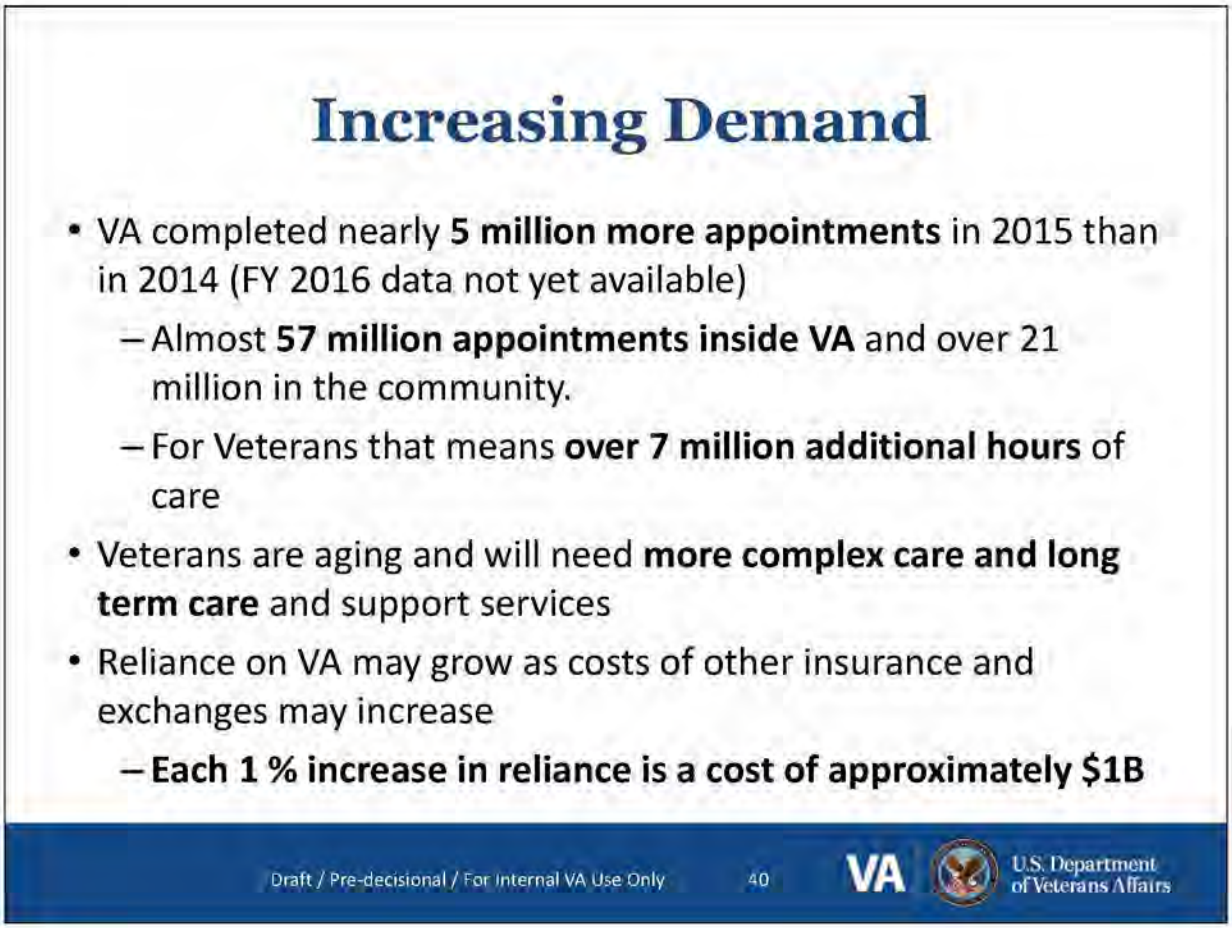

3rd bullet notes:
In 2014, enrollee reliance was estimated to be approximately 34%. We are currently updating reliance analysis with more recent Medicare data, but it is not available at this time. Reliance reflects the portion of health care services that an enrollee needs that we expect VA to provide or pay for. Some enrollees will get all of their health care from the VA and some will get none of their care, but most receive some portion of their care in the VA. For example, based on his/her morbidity, if an enrollee needs 10 office visits in a year and gets 4 of those office visits in VA. This enrollee is said to be 40 percent reliant on VA for office visits.

(b) (6) mentioned wanting to get graphs for this slide and the next from Mark Yow. As such, I haven't edited.

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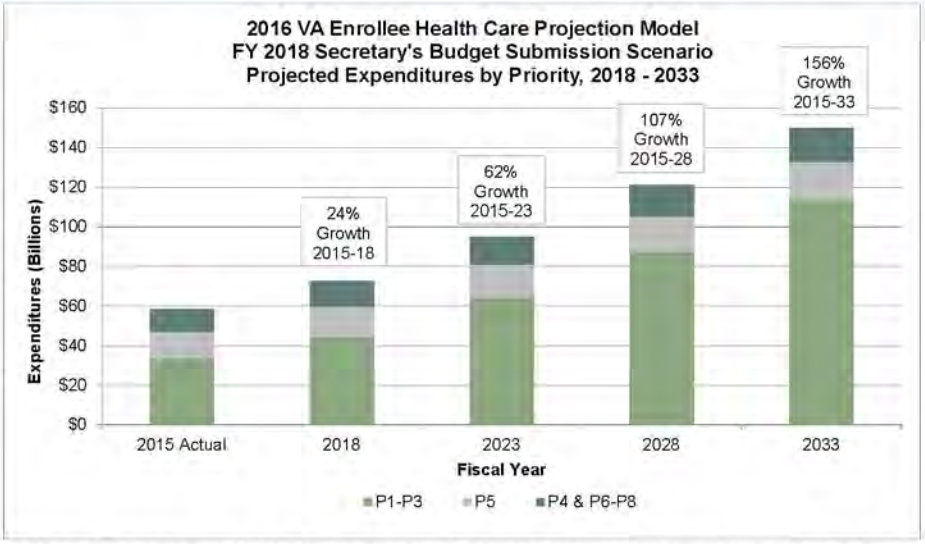
VA's Resource Requirements
Projected to Grow Significantly Over Time



2016 VA EHCPM, Budget Scenario (BAF) Note: The projections do not include requirements for several activities/ programs that are not projected by the VA EHCPM, including non-recurring maintenance, readjustment counseling, state-based long term services and supports programs, and some components of the CHAMPVA program.

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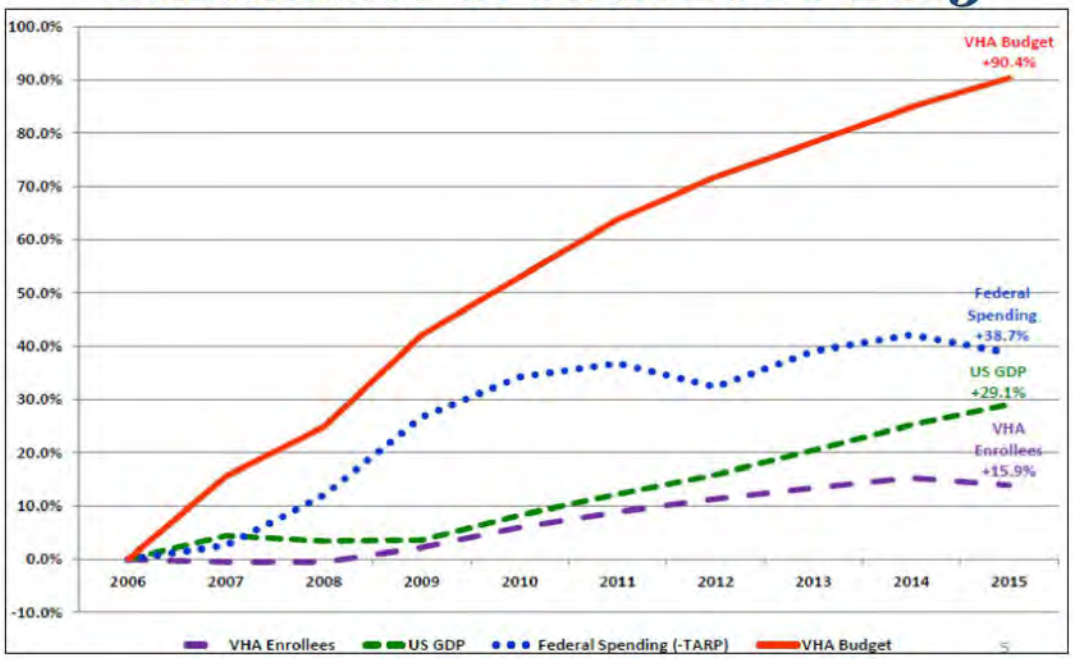
VA Medical Care Budget Challenge:
Cumulative Growth 2006-2015



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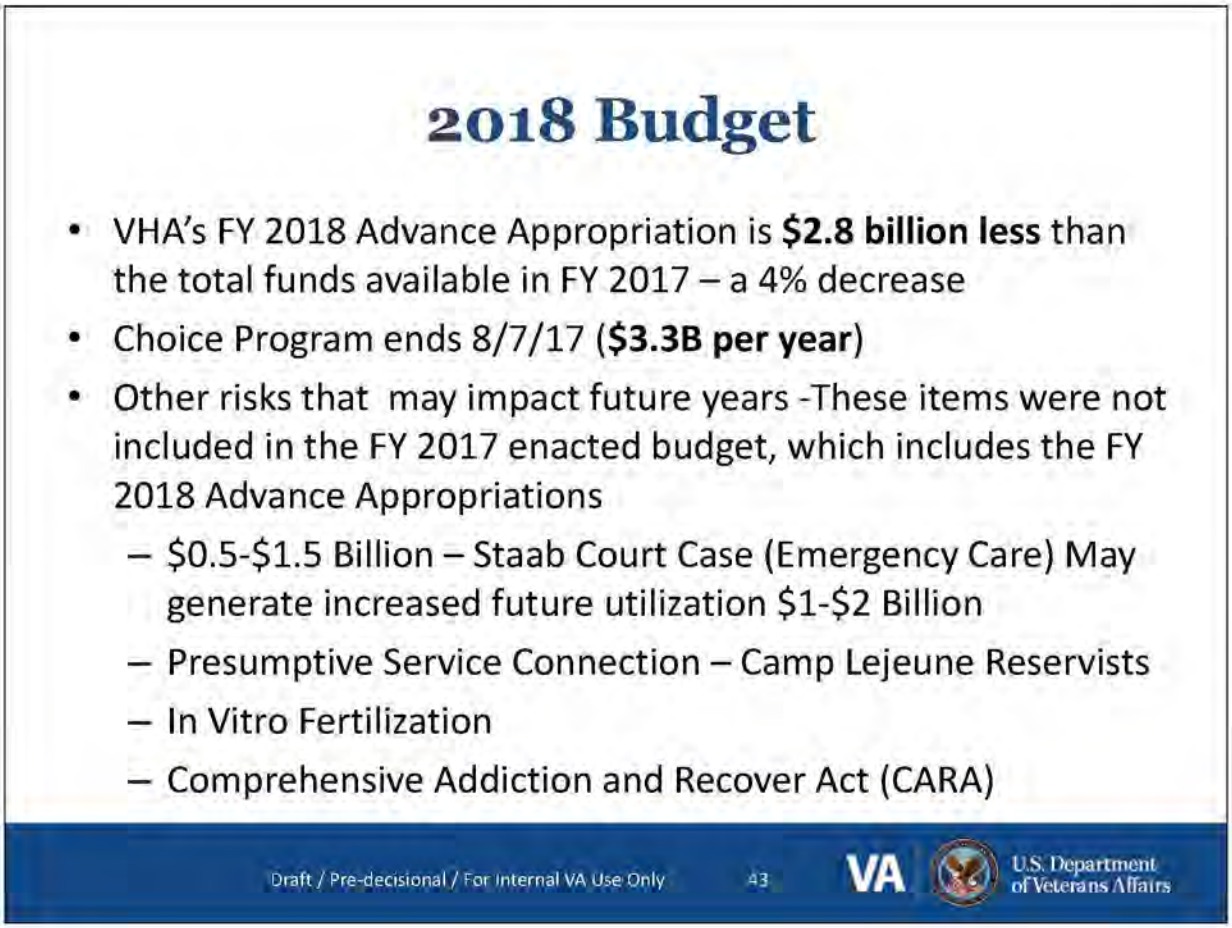

Bullet 3: Estimated budget numbers:
IVF6.5 Million FY 17, 13. million Fy18 --Maximum estimate Non VA Care funds
Adoption: 500K FY 17, 1.5 million FY 18—Maximum estimate
CARA = $153 million – crude estimate, some of which has already been incurred

Camp Lejeune.

Based on evidence there is sufficient scientific and medical evidence available to establish a presumption of connection between exposure to contaminants in the water supply at Camp Lejeune and the occurrence of eight health conditions

The proposed eight presumptive diseases are:
adult leukemia
aplastic anemia and other myelodysplastic syndromes
bladder cancer
kidney cancer
liver cancer
multiple myeloma
non-Hodgkin's lymphoma
Parkinson's disease

VA will not limit entitlement to active duty military personnel. Rather, VA proposes to presume exposure for all active duty, reserve and National Guard personnel who served at Camp Lejeune for no less than 30 cumulative days from August 1,

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1953, through December 31, 1987.

In addition, VA proposes to establish a presumption that individuals who served at Camp Lejeune during this period and later developed one of the presumptive diseases were disabled during the relevant period of service, thus establishing active military service for benefit purposes.

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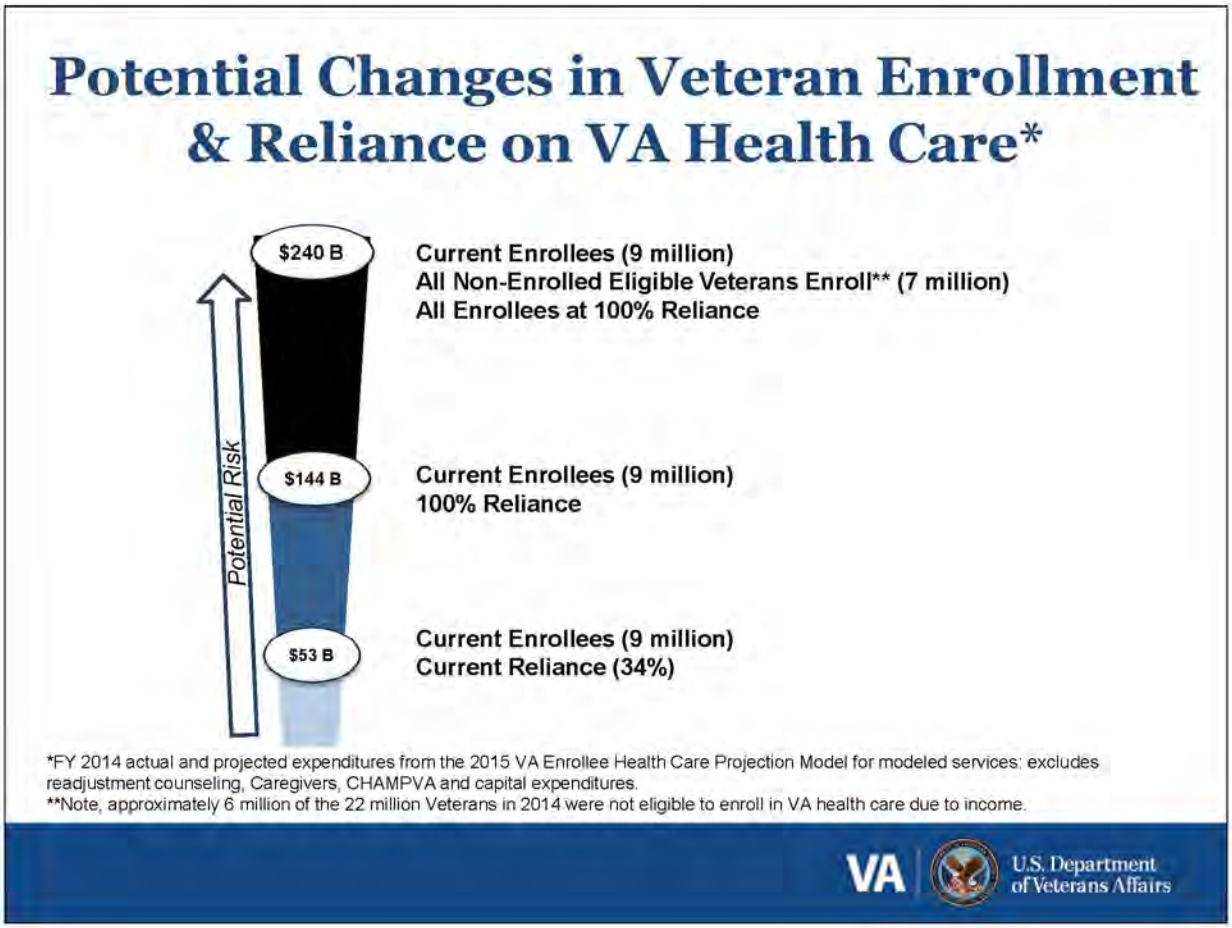

In 2014, costs for modeled services for 9 million enrollees at 34% reliance was $53 billion.

If all those 9 million enrollees used VA for all their health care, the cost in 2014 would have been $144 billion.

If all eligible but unenrolled veterans enrolled in VA and used VA for all their health care, the cost in 2014 would have been $240 billion.

All policy changes move this lever up and down as they impact either reliance on VA for health care, enrollment in VA, or both.

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Continuity of Leadership during a Crisis
Leadership vacancies and succession planning
Maintaining and Strengthening the Gains in Access (including Community Care), Quality, Engagement, and Trust
Direction of the Commission on Care Recommendations
Supporting VHA's Course for a Future Vision

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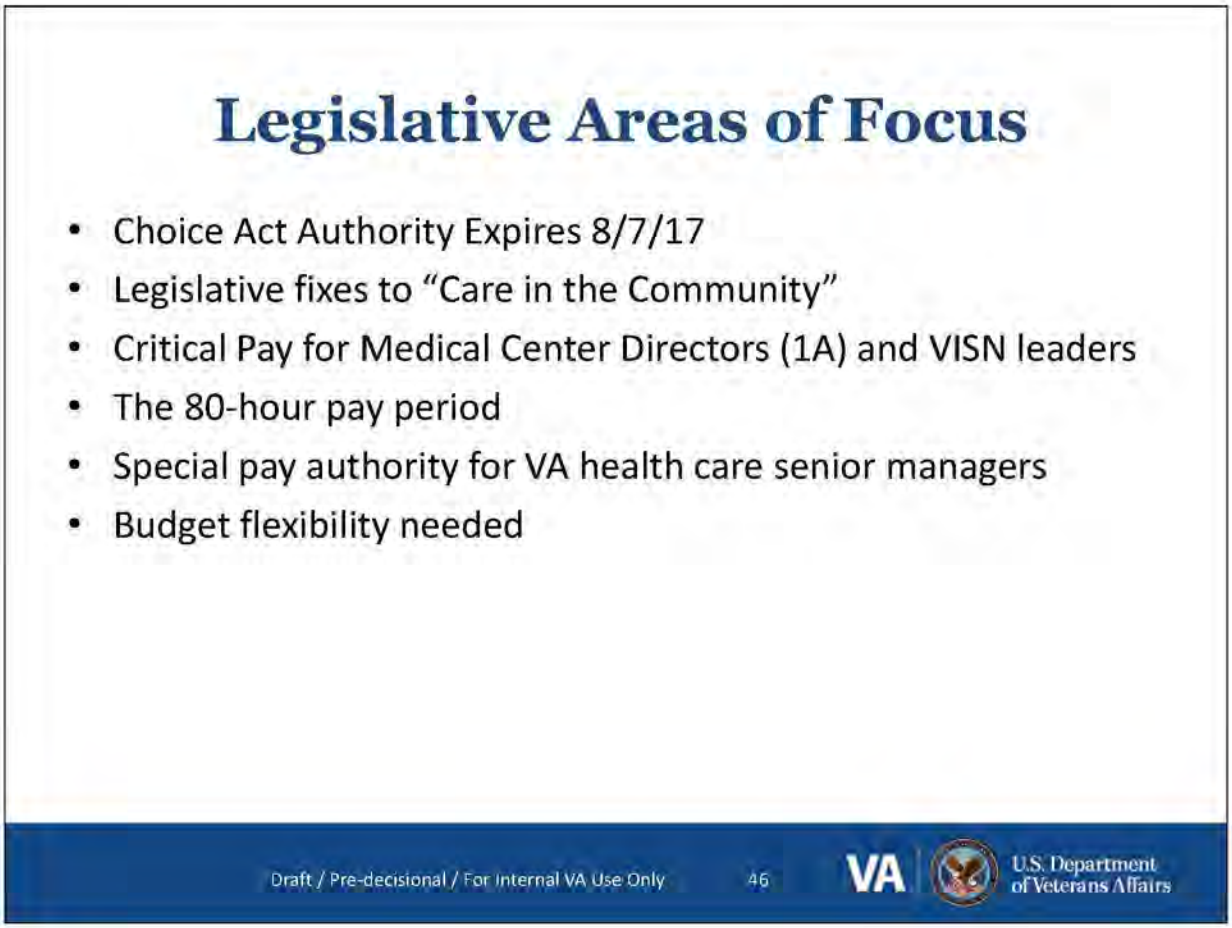

3RD BULLET:
The critical position pay authority (CPPA) allows the Secretary (or designee) to approve higher rates of pay for employees in positions that require expertise of an extremely high level in a scientific, technical, professional or administrative field critical to the Department's successful accomplishment of an important mission to the extent necessary to recruit or retain an individual exceptionally well-qualified for the critical position. Medical Center Directors and other Senior Executive Services (SES) VA health care senior managers would be eligible for CPPA.

Critical position pay requests must be submitted in writing only after it has been determined that the position in question cannot be filled with an exceptionally well-qualified individual through the use of other human resources flexibilities and pay authorities (e.g. recruitment, relocation and retention incentives, special salary rates, above minimum entrance rates).

The Secretary (or designee) must review and approve each critical position pay authority request before forwarding it to the Office of Personnel Management (OPM), who in consultation with the Office of Management and Budget (OMB) will issue final approval.

On September 22, 2016 OPM approved VA's request for CPPA for the Deputy Under Secretary for Health for Operations, 18 VISN Directors, 39 Level 1A Medical Center Directors, and 10 additional positions. 2 employees are in receipt of critical position pay and a plan is being developed for the additional positions.

Currently there is no special pay authority to compensate Medical Center Directors and other SES VA health care senior managers.

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Attached for reference is the signed/dated letter from OPM regarding critical pay.

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Organizational Areas of Focus

- Streamline Hiring/Onboarding Process
- Space: Leasing restrictions
- Facility Modernization: VHA aging Infrastructure
- Implement Full Practice Authority for Advance Practice Nurses: would increase VA ability to increase access
- Expand telehealth capability
- Implement scheduling system for medical appointments
- Examining intermediate and long term funding options for VA healthcare

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Our Commitment to Veterans

- ✓ Veterans should be at the center of what we do and how we deliver care at VHA
- ✓ No veteran with an urgent care need that may cause harm should wait for care
- ✓ VA must act like an integrated enterprise and a learning health system to benefit veterans most
- ✓ We will work closely with our academic, federal and community providers to deliver the highest outcomes to veterans
- ✓ VA leadership and staff must feel proud, fulfilled and empowered to deliver services to Veterans
- ✓ We must regain the trust and confidence of Veterans and the American public
- ✓ VA mission of research, education, and emergency preparedness must continue to contribute to improving the health of Veterans and all Americans

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A Future Vision for VHA

- **Public Private Partnerships** to serve Veterans
- **Digital Health Platform**
- **Whole Health Medicine** (empowering veteran well-being)
- Develop the **High Performance Network** (role of VISNs)
- **Center of Excellence** and Foundational Care
- **Value Based Management** and Efficiency Strategies
- Strengthen VA as a **Learning Healthcare System**
- Accelerate **Precision Medicine** and foster innovation
- Provide access to **VA Research Data** for non VA researchers with appropriate safeguards
- **Train More** primary care and behavioral health students

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Message

From: (b) (6) M.D. (b) (6) @mayo.edu]
Sent: 1/15/2017 9:45:21 PM
To: IP [@frenchangel59.com]
CC: Marc Sherman [mbs(b) (6) gmail.com]; Marisol Garcia [(b)@frenchangel59.com]; Bruce Moskowitz [brucem(b) (6) mac.com]; David shulkin [drshulkin@aol.com]; L Perl [(b) (6) @gmail.com]; (b) (6) [(b) (6) L@jhmi.edu]; (b) (6) [(b) @jhmi.edu]; (b) (6) [(b) (6) @ccf.org]; (b) (6) ccf.org; (b) (6) partners.org; (b) (6) [(b) @mayo.edu]; (b) (6) @partners.org
Subject: Re: Thank you

Ike, Bruce and Mark,
I am glad this was helpful.
(b)

(b) (6) M.D.
President and CEO
Mayo Clinic Administration
Mayo Building, East 11
Phone: (b) (6)
Fax: (b) (6)

On Jan 15, 2017, at 3:32 PM, IP <(b)@frenchangel59.com> wrote:

> Thank you again to everyone for taking time out of the weekend to join today's call. It was an excellent discussion and great progress.
>
> I also want to send a special thanks to (b) for preparing the materials so quickly.
>
> I look forward to our next call. Please have a nice rest of your weekend.
>
> All my Best,
>
> Ike

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/2/2016 3:06:18 AM
To: Poonam Alaigh [(b) (6) hotmail.com]

Do you have any pictures from the milken event?

Sent from my iPhone

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/20/2016 8:37:45 PM
To: (b) (6) [(b) (6) @gmail.com]
Subject: Re: Texts

Yes

Sent from my iPhone

> On Dec 20, 2016, at 4:24 PM, (b) (6) (b) (6) gmail.com> wrote:
>
> Hi, are you anywhere you can recieve texts? They want you to review the SAIL comments they put together. Vivieca is trying to reach you

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Message

From: (b) (6) [(b) (6)@gmail.com]
Sent: 12/20/2016 8:24:40 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Texts

Hi, are you anywhere you can recieve texts? They want you to review the SAIL comments they put together. Vivieca is trying to reach you

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Message

From: [redacted]@hotmail.com]
Sent: 12/2/2016 3:00:14 AM
To: [redacted] [redacted]@gmail.com]
CC: David Shulkin [drshulkin@aol.com]
Subject: Re: President of the United States Veterans Day 2016 Set B

Yes they are !

Sent from my iPhone

On Dec 1, 2016, at 9:58 PM, [redacted] <[redacted]@gmail.com> wrote:

> Was hoping to find you all in some of these photos. Nevertheless they are priceless
>
> ---------- Forwarded message ----------
> From: "[redacted] R." <[redacted]va.gov>
> Date: Dec 1, 2016 3:39 PM
> Subject: FW: President of the United States Veterans Day 2016 Set B
> To: [redacted]@gmail.com" [redacted]@gmail.com>
> Cc:
>
> **From:** [redacted] P.
> **Sent:** Thursday, December 01, 2016 3:31 PM
> **To:** [redacted]
> **Subject:** President of the United States Veterans Day 2016 Set B
> **Importance:** High
>
> [redacted] Photographer
>
> US Army Veteran
>
> Media Services (032B)
>
> Office of Administration
>
> Department of Veterans Affairs
>
> 810 Vermont Ave NW Room 175G
>
> Washington DC 20420

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Office: (b) (6)

Cell: (b) (6)

Request Media Services Support

VA Core Values: Integrity Commitment Advocacy Respect Excellence

VA Core Characteristics: Trustworthy | Accessible | Quality | Innovative | Agile | Integrated

<Veterans Day 2016 774A3561.jpg>
<Veterans Day 2016 774A3581.jpg>
<Veterans Day 2016 774A3593.jpg>
<Veterans Day 2016 774A3596.jpg>
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<Veterans Day 2016 IMG_3979.jpg>

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Message

From: David Shulkin [drshulkin@aol.com]
Sent: 11/16/2016 5:11:31 PM
To: (b) (6) [redacted]@gmail.com
Subject: milken foundation november 29- first draft
Attachments: milkenfoundationslides.pptx

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Prostate Foundation
November 29, 2016

David Shulkin MD
Under Secretary for Health
Veterans Health Administration

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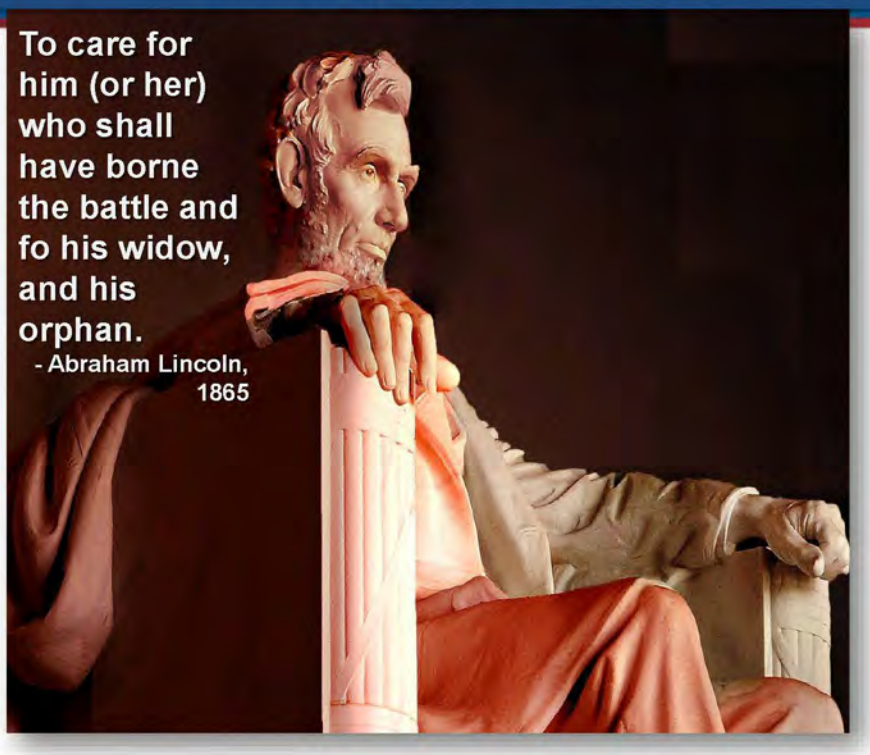
Fulfilling Our Mission



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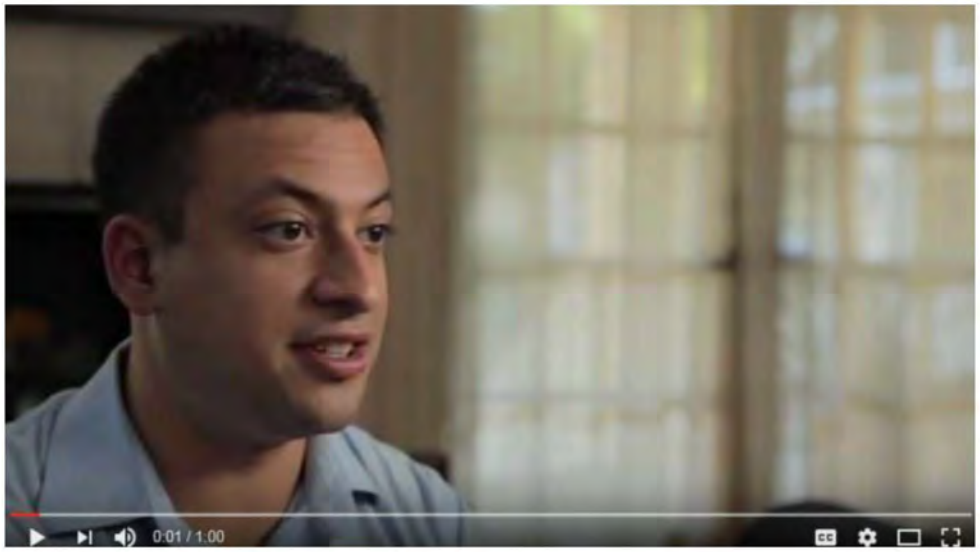
In Their Own Words



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Cancer Moonshot



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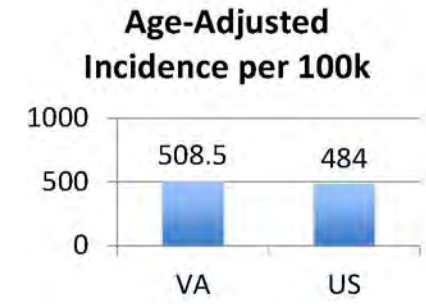
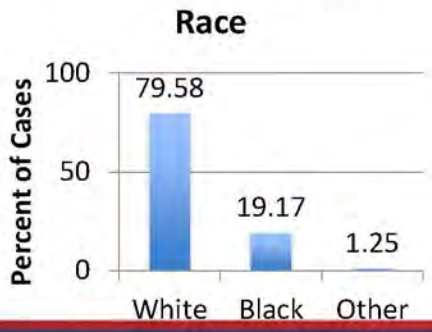
Cancer Incidence Among Patients of the VA Healthcare System

- Total cancers: 49,857
- Invasive cancers: 46,166 (3% of all US cancers)

US Region	n	%
Midwestern	9887	21.4
Northeastern	6851	14.8
Southern	19351	41.9
Western	10080	21.8





Zullig LL et al, 2016

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Most Common Cancers by Sex in Veterans Affairs' patients, 2010

	n	%	Males	Females		n	%
Prostate	13,438	30%			Breast	402	30%
Lung & bronchus	8,019	18%			Lung & bronchus	197	15%
Colon & rectum	3,705	8%			Colon & rectum	88	7%
Kidney & pelvis	1,733	4%			Uterine corpus	75	6%
Melanoma	1,674	4%			Melanoma	59	4%
Liver	1,553	3%			Thyroid	53	4%
All Sites	**44,836**	**97%**			**All Sites**	**1,330**	**3%**

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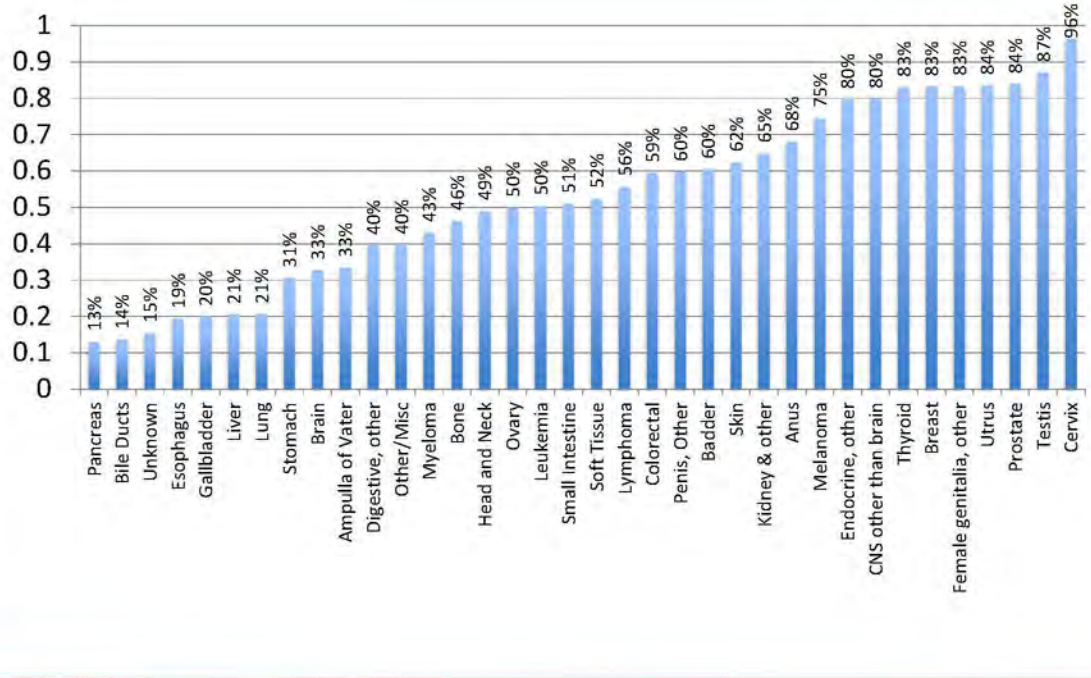
VA 5-year Cancer Survival Rate



VA-19-0799-J-002122

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MVP and PMI Summary Objectives

MVP participation available to all Veterans and DoD

State-of-the-art computational environment

Data access leading to scientific discoveries and publications



- Current enrollment **520,000** Veterans
- Enroll at least **1 Million** by 2020
- Expand secure computational capacity to serve more than **1,000** simultaneous VA and non-VA researchers by 2020
- Safe/secure, CLIA-compliant biorepository with back-up
- Establish mechanisms to return results responsibly to providers, EHR, and participants

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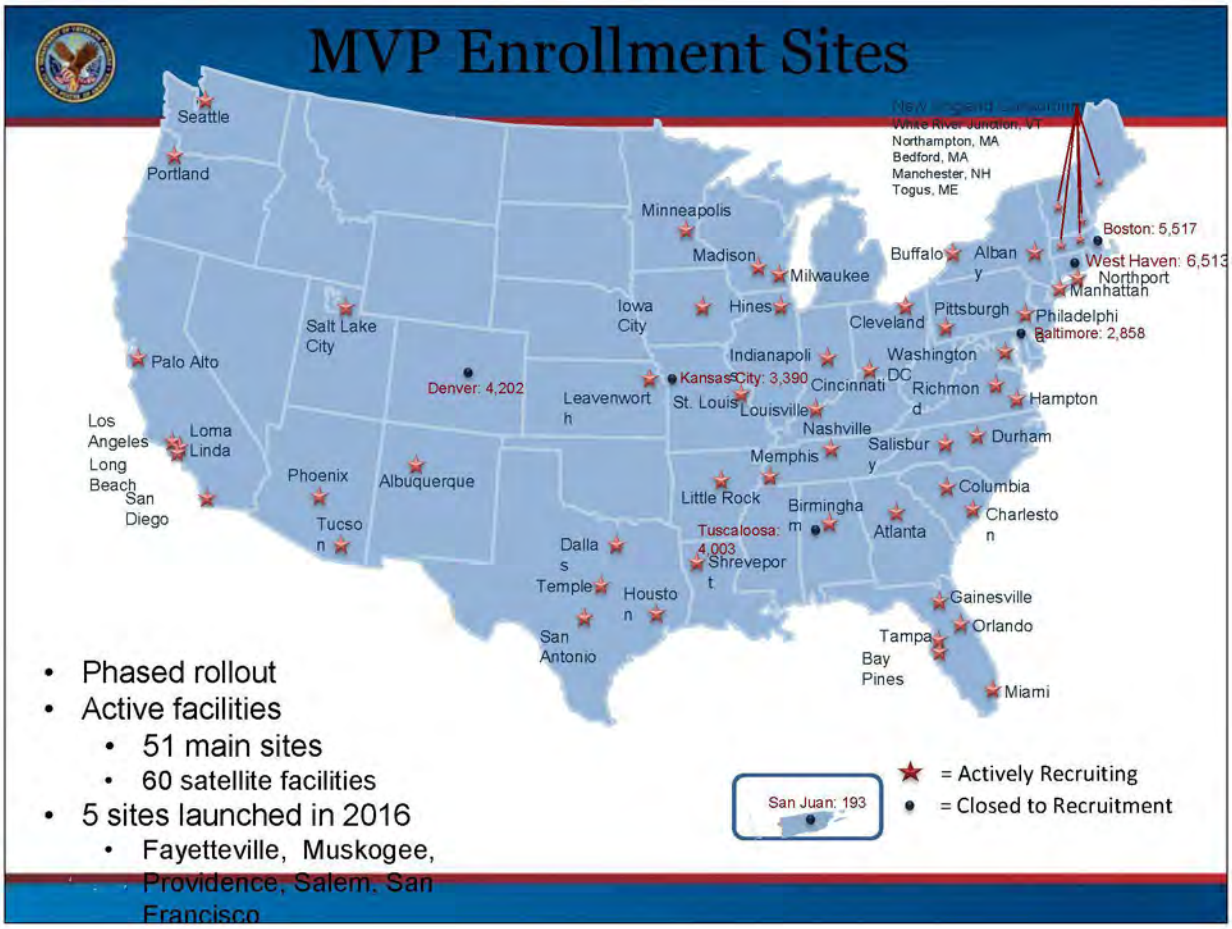

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- Full service biorepository
  - 4 million storage capacity
  - Fully automated with robotic sample retrieval
  - Processes 2000-2500 samples a week
    - DNA
    - Buffy
    - Plasma



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Ongoing Scientific Projects

Type of Project	Topic	VA & University Affiliations
Alpha test	Schizophrenia and Bipolar Disorder (CSP 572)	Miami, Bronx, West Haven and Boston VAs; University of Miami; Mt. Sinai School of Medicine; Yale; Harvard; Stanford
Alpha test	PTSD in Veterans (CSP 575B)	San Diego, West Haven and Boston VAs; UC San Diego; Yale
Alpha test	Gulf War Illness (CSP 2006)	Durham, West Haven and Boston VAs; Duke, Yale
Beta test	Cardiovascular Disease	Atlanta and Boston VAs; Emory; Harvard; Boston University
Beta test	Chronic Kidney Disease	Nashville and Memphis VAs; Vanderbilt; University of Tennessee Health Science Center
Beta test	Cardio-metabolic Disease	Palo Alto, Philadelphia, Albany, Boston and Phoenix VAs; University of Pennsylvania; Stanford; Albany Medical College; University of Massachusetts; Harvard; Arizona State University
Beta test	Multi-substance Abuse Disorders	West Haven & Philadelphia VAs; Yale; University of Pennsylvania
Beta test	Age-related Macular degeneration	Cleveland & Buffalo VAs; Case Western Reserve

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Partnership with DOE

- Leverage DOE's computing capabilities and VA's genomic expertise to unlock and develop better ways of preventing, detecting, treating, and curing disease
- VA and DOE sign interagency agreement to establish governance throughout the 5-year relationship
- Pilot to be launched on June 1, 2017
- Joint program named MVP Champion

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VA/MVP-DOE Prostate Cancer Project:

- Context and data sources for prostate cancer
  - 181,000 cases and 26,000 deaths projected in US for 2016
  - VA Cancer Registry: 12,500 cases in 2007 (*Zullig 2012*)
  - MVP data (Oct 3, 2016): among 508,820 participants with
  - genotyping data, 42,100 (8.3%) had prostate cancer per EMR
  - VA experience includes more than a decade of curating VA EMR data and retrieving tumor specimens for successful molecular characterization; DOE experience includes exascale computing, deep learning expertise, and NCI collaboration → "lessons learned" for proposed work

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VA and IBM's Watson



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Types of studies in prostate cancer

- Preclinical studies: *in vitro* and *in vivo* studies using tissue cultures, animal models, or human biological samples
- Clinical studies: interventional and effectiveness, clinical, epidemiological, and technological studies involving intact human subjects as the unit of examination
- Rehabilitation studies: research focusing on innovations and effective integration of preclinical, clinical, and applied rehabilitation studies to advance Veteran rehabilitation
- Implementation studies: research emphasizing models of patient care, care delivery, outcomes, cost, quality, and implementation into practice

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Prostate Cancer Portfolio

- Approximately 50 current awardees examining prostate cancer (a few holding more than one project)
- Prostate cancer awards represent 20% of the overall oncology portfolio
- Prostate cancer accounts for 20 % of the clinical trials in the oncology portfolio
- Support 8 highly productive non-clinician research scientists:
    - 3 Senior Research Career Scientists
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Examples of Preclinical Studies

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- Genetic biomarkers in clinical assessment of prostate cancer
- Highly specific targeting of the TMPRSS2/ERG fusion gene in prostate cancer
- Targeting the BMP pathway in metastatic cancer
- Targeting EZH2 in prostate cancer by Luteolin
- Targeted radiotherapy/chemotherapy treatment of prostate cancer
- Phage display for improved peptide-based tumor targeting and imaging agents
- CMV-based immunotherapy for prostate cancer
- Metabolic engineering of bacteria for cancer immunotherapy by gamma delta T cells

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Examples of Clinical Studies

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- CP19A1 gene and pharmacogentics of response*
- Heritable risk factors for familial prostate cancer*
- Adjuvant therapy for high risk prostate carcinoma: Docetazel and high dose calcitriol
- Onabotulinumtoxin(onaVoNT-A) vs Oral Tamsulosin for BPH and lower urinary tract symptoms
- Vitamin D3 supplementation for low-risk prostate cancer: A randomized trial

**Genomic studies*

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Examples of Rehabilitation Studies

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Opportunities to Leverage VA Data

Open access to de-identified data for non-VA researchers

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Mission: To enhance Veterans' health and well-being by offering emerging therapies that are safe and ethical, particularly after traditional treatments have been unsuccessful

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- Consider proposals where clinical benefits outweigh the risks
- Incorporate Veteran's voice in emerging therapies
- Leverage innovation to address the unique needs of the Veteran population
- Maintain fundamental principle to ***Do No Harm***

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end

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Incident Cancers by Site and Sex

Site	All	Male	Female
Prostate	13438 (29.11%)	13438 (29.97%)	NA[c]
Lung & bronchus	8216 (17.80%)	8019 (17.89%)	197 (14.81%)
Colorectal	3793(8.21%)	3705(8.26%)	88(6.62%)
Head & neck	2031 (4.40%)	2004 (4.47%)	27 (2.03%)
Kidney	1770 (3.83%)	1733 (3.87%)	37 (2.78%)
Melanoma	1733 (3.75%)	1674 (3.73%)	59 (4.44%)
Lymphoma	1655 (3.58%)	1602 (3.57%)	53 (3.98%)
Liver	1567 (3.39%)	1553 (3.46%)	14 (1.05%)
Urinary bladder	1546 (3.35%)	1536 (3.43%)	10 (0.75%)
Other	1410 (3.05%)	1378 (3.07%)	32 (2.41%)
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Anus	146 (0.32%)	136 (0.30%)	10 (0.75%)
Other GI organs	140 (0.30%)	135 (0.30%)	-
Ureter	110 (0.24%)	109 (0.24%)	-
Testis	90 (0.19%)	90 (0.20%)	NA[c]
Penis	84 (0.18%)	84 (0.19%)	NA[c]
Uterine corpus	75 (0.16%)	NA[c]	75 (5.64%)
Eye & Orbit	63 (0.14%)	62 (0.14%)	-
Gallbladder	50 (0.11%)	48 (0.11%)	-
Bones & joints	33 (0.07%)	30 (0.07%)	-
Ovary	32 (0.07%)	NA[c]	32 (2.41%)
Uterine cervix	29 (0.06%)	NA[c]	29 (2.18%)

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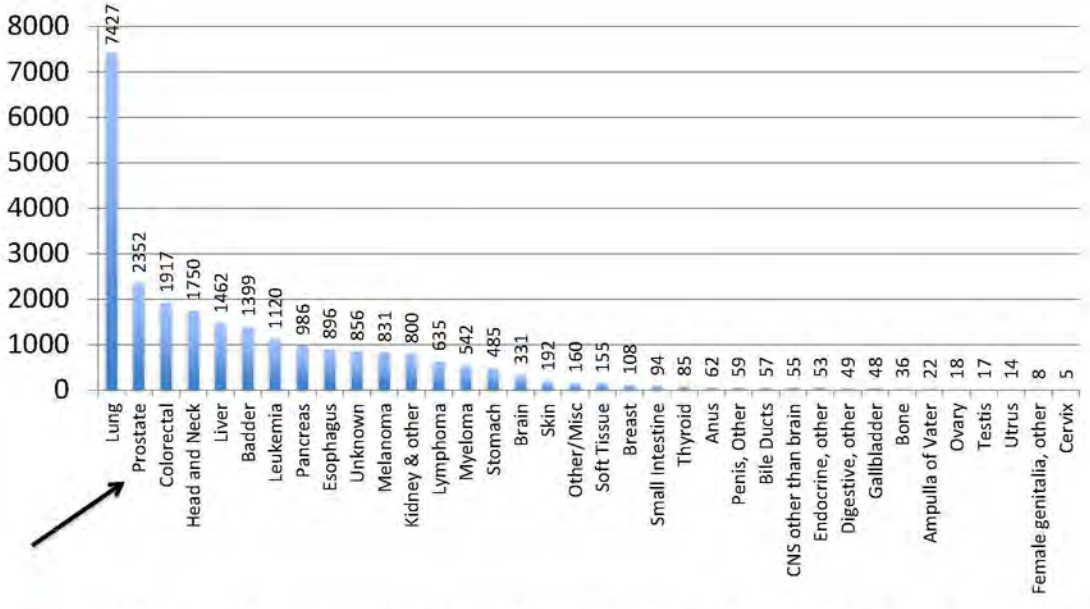
Deaths within 5 years of Diagnosis



Prostate Cancer associated with 2nd most deaths, in part due to high incidence

VA-19-0799-J-002143

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DS_00009783

	n	%	Males	Females		n	%
Prostate	13,438	30%			Breast	402	30%
Lung & bronchus	8,019	18%			Lung & bronchus	197	15%
Colon & rectum	3,705	8%			Colon & rectum	88	7%
Kidney & pelvis	1,733	4%			Uterine corpus	75	6%
Melanoma	1,674	4%			Melanoma	59	4%
Liver	1,553	3%			Thyroid	53	4%
All Sites	**44,836**	**97%**			**All Sites**	**1,330**	**3%**

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 1/6/2017 9:28:51 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: Status?!

Just getting oFf plane

But nothing at all to report

Not good

Ill call later

Sent from my iPhone

> On Jan 6, 2017, at 2:15 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>
> I have been texting you - you are MIA- that's a torture
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 1/6/2017 7:15:41 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Status?!

I have been texting you - you are MIA- that's a torture

Sent from my iPhone

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Message

From: David Shulkin [drshulkin@aol.com]
Sent: 11/16/2016 8:28:32 PM
To: (b) (6) [redacted]@gmail.com
Subject: final version launch pad talk
Attachments: milkenfoundationslides.pptx

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VA | U.S. Department of Veterans Affairs

Prostate Foundation
November 29, 2016

David Shulkin MD
Under Secretary for Health
Veterans Health Administration

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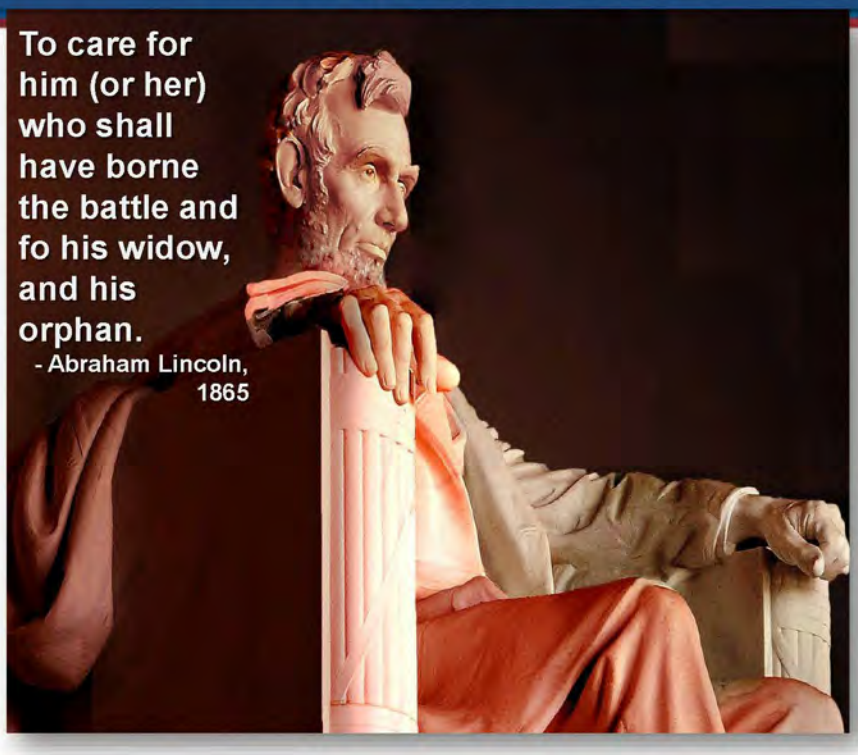
Fulfilling Our Mission



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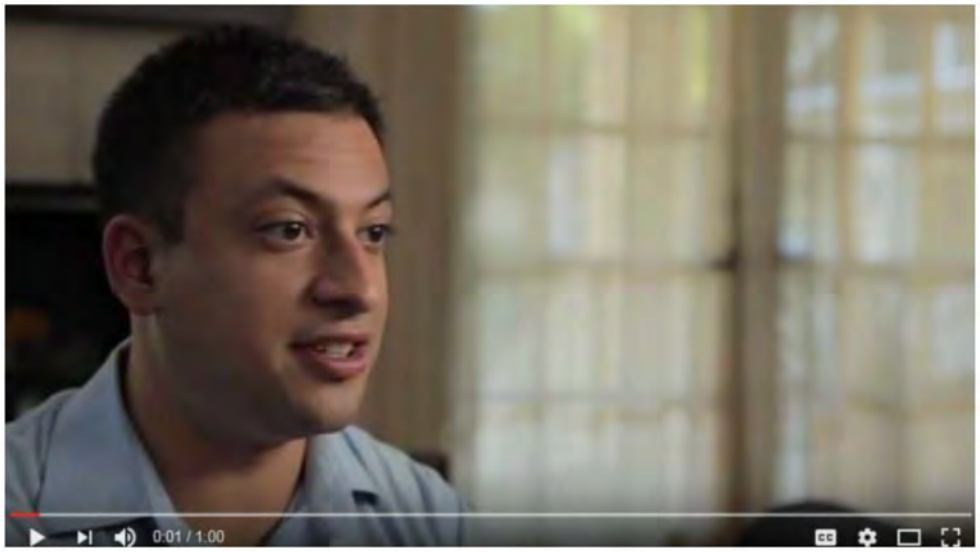
In Their Own Words



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Cancer Moonshot



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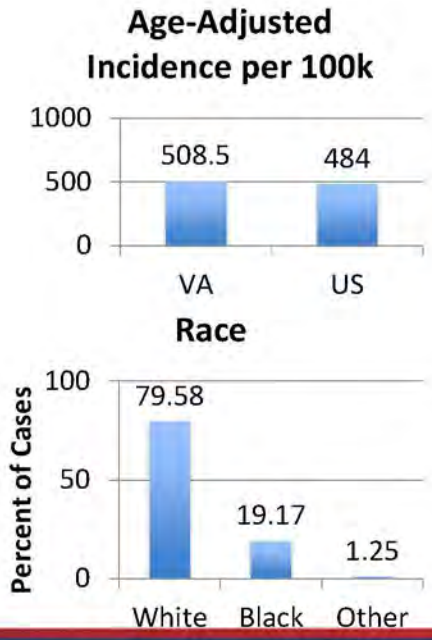
Cancer Incidence Among Patients of the VA Healthcare System

- Total cancers: 49,857
- Invasive cancers: 46,166 (3% of all US cancers)

US Region	n	%
Midwestern	9887	21.4
Northeastern	6851	14.8
Southern	19351	41.9
Western	10080	21.8



Zullig LL et al, 2016

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Most Common Cancers by Sex in Veterans Affairs' patients

	n	%	Males	Females		n	%
Prostate	13,438	30%			Breast	402	30%
Lung & bronchus	8,019	18%			Lung & bronchus	197	15%
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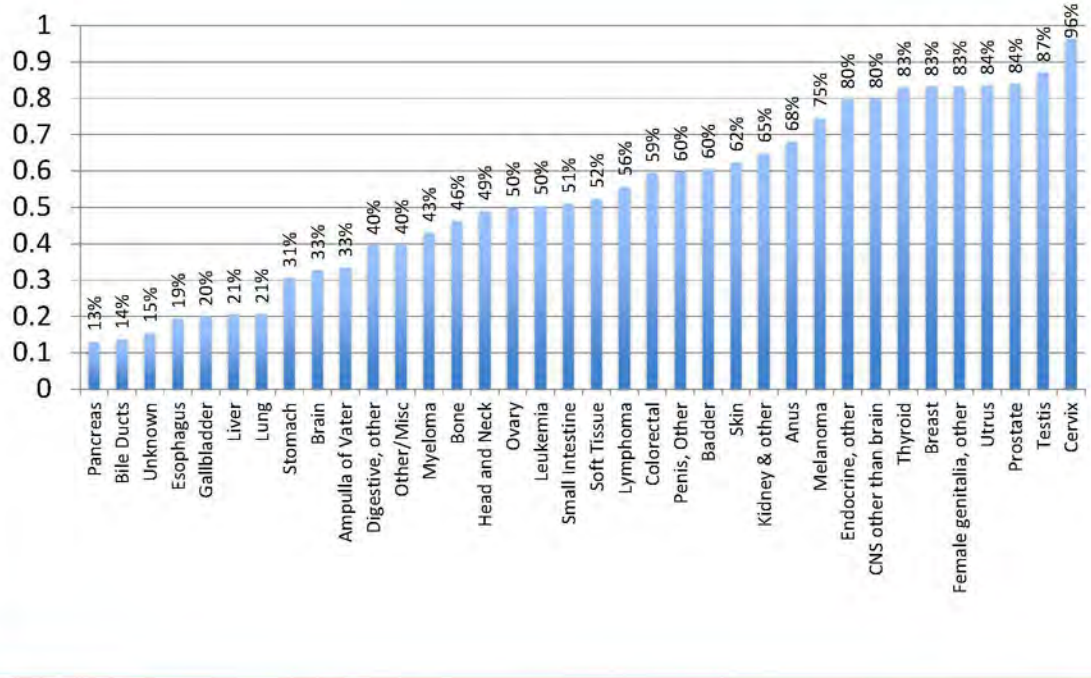
VA 5-year Cancer Survival Rate



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VA-19-0799-J-002154

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MVP and PMI Summary Objectives

MVP participation available to all Veterans and DoD

State-of-the-art computational environment

Data access leading to scientific discoveries and publications



- Current enrollment **520,000** Veterans
- Enroll at least **1 Million** by 2020
- Expand secure computational capacity to serve more than **1,000** simultaneous VA and non-VA researchers by 2020
- Safe/secure, CLIA-compliant biorepository with back-up
- Establish mechanisms to return results responsibly to providers, EHR, and participants

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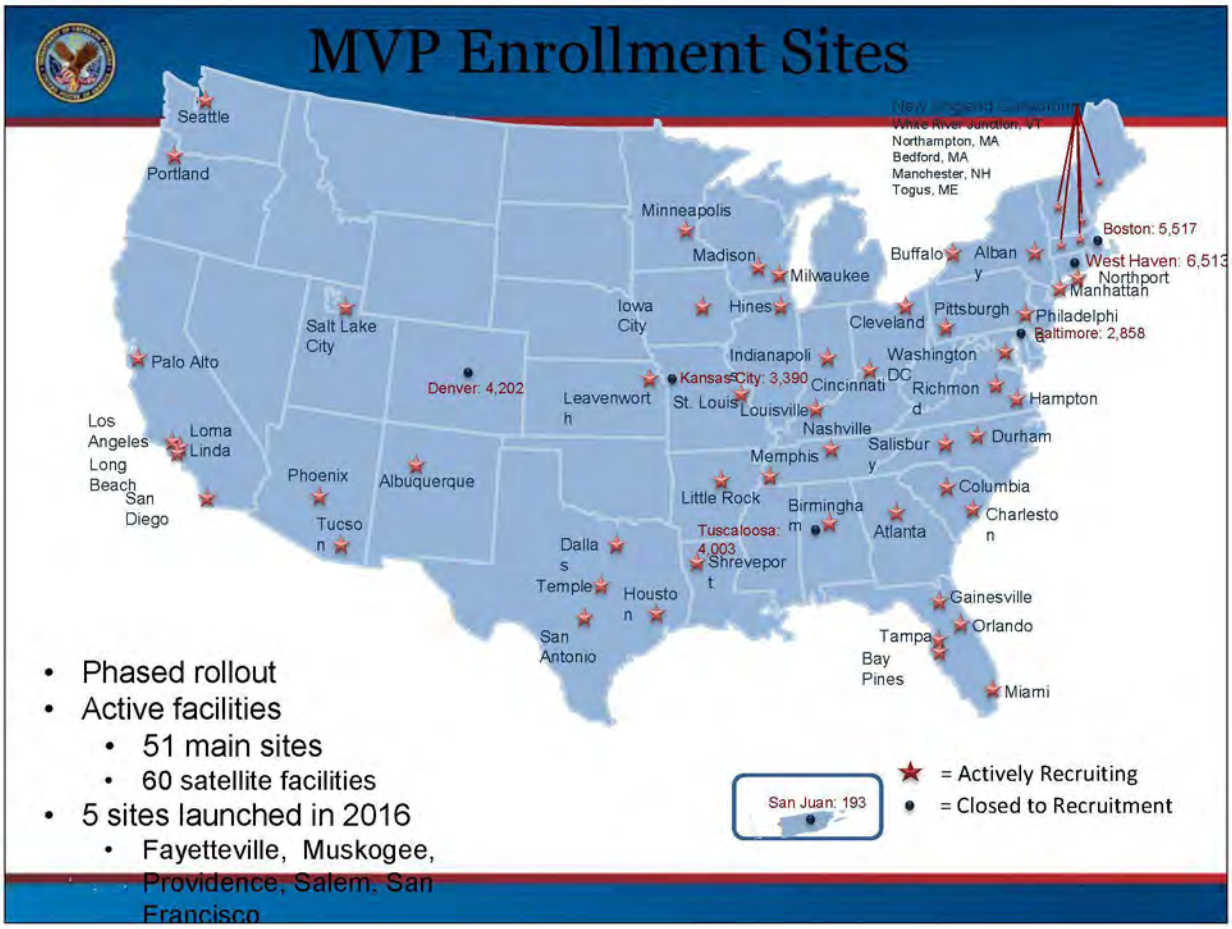

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- Full service biorepository
  - 4 million storage capacity
  - Fully automated with robotic sample retrieval
  - Processes 2000-2500 samples a week
    - DNA
    - Buffy
    - Plasma



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Ongoing Scientific Projects

Type of Project	Topic	VA & University Affiliations
Alpha test	Schizophrenia and Bipolar Disorder (CSP 572)	Miami, Bronx, West Haven and Boston VAs; University of Miami; Mt. Sinai School of Medicine; Yale; Harvard; Stanford
Alpha test	PTSD in Veterans (CSP 575B)	San Diego, West Haven and Boston VAs; UC San Diego; Yale
Alpha test	Gulf War Illness (CSP 2006)	Durham, West Haven and Boston VAs; Duke, Yale
Beta test	Cardiovascular Disease	Atlanta and Boston VAs; Emory; Harvard; Boston University
Beta test	Chronic Kidney Disease	Nashville and Memphis VAs; Vanderbilt; University of Tennessee Health Science Center
Beta test	Cardio-metabolic Disease	Palo Alto, Philadelphia, Albany, Boston and Phoenix VAs; University of Pennsylvania; Stanford; Albany Medical College; University of Massachusetts; Harvard; Arizona State University
Beta test	Multi-substance Abuse Disorders	West Haven & Philadelphia VAs; Yale; University of Pennsylvania
Beta test	Age-related Macular degeneration	Cleveland & Buffalo VAs; Case Western Reserve

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Partnership with DOE

- Leverage DOE's computing capabilities and VA's genomic expertise to unlock and develop better ways of preventing, detecting, treating, and curing disease
- VA and DOE sign interagency agreement to establish governance throughout the 5-year relationship
- Pilot to be launched on June 1, 2017
- Joint program named MVP Champion

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VA/MVP-DOE Prostate Cancer Project:

- Context and data sources for prostate cancer
  - 181,000 cases and 26,000 deaths projected in US for 2016
  - VA Cancer Registry: 12,500 cases in 2007 (*Zullig 2012*)
  - MVP data (Oct 3, 2016): among 508,820 participants with
  - genotyping data, 42,100 (8.3%) had prostate cancer per EMR
  - VA experience includes more than a decade of curating VA EMR data and retrieving tumor specimens for successful molecular characterization; DOE experience includes exascale computing, deep learning expertise, and NCI collaboration

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VA and IBM's Watson



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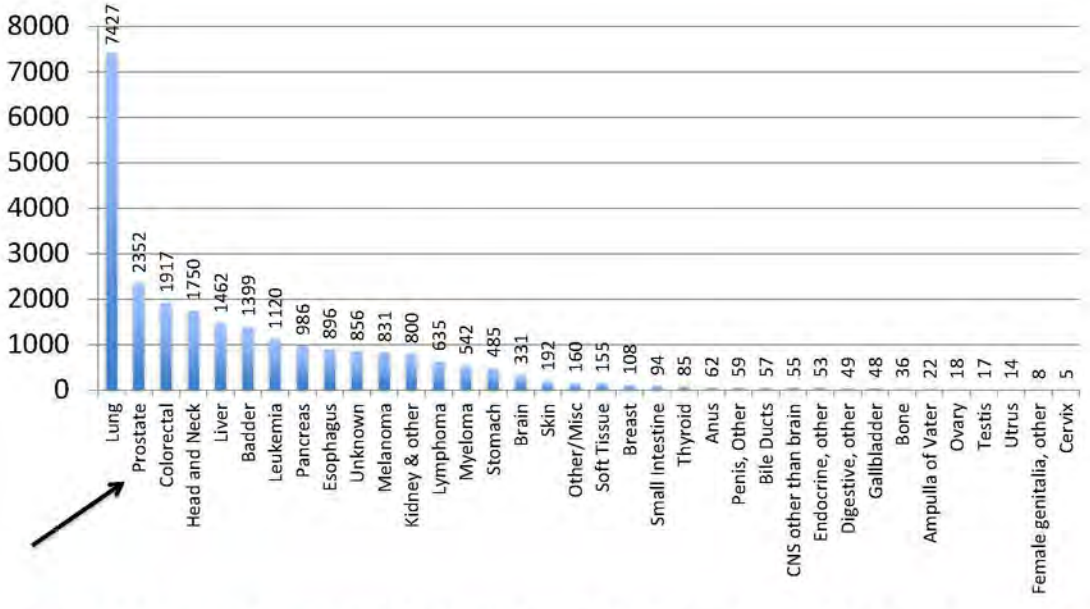
Deaths within 5 years of Diagnosis



Prostate Cancer associated with 2nd most deaths, in part due to high incidence

VA-19-0799-J-002175

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DS_00009819

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All Sites	**44,836**	**97%**			**All Sites**	**1,330**	**3%**

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/20/2016 2:51:17 PM
To: (b) (6) [(b) (6) @gmail.com]
Subject: Re:

Hope you are enjoying as well

Sent from my iPhone

On Dec 20, 2016, at 9:22 AM, (b) (6) <(b) (6) @gmail.com> wrote:

> Ok sounds good. I hope you have a nice time away from the office.
>
> Just between us, I always miss my boss :-).

> On Dec 20, 2016 9:14 AM, "David shulkin" <Drshulkin@aol.com> wrote:
> I did thanks
>
> Sent from my iPhone
>
> > On Dec 20, 2016, at 9:04 AM, (b) (6) <(b) (6) @gmail.com> wrote:
> >
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> >
> > (b)

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Sent: 12/20/2016 2:04:00 PM
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(b)

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Message

From: Jennifer Lee [(b) (6) @gmail.com]
Sent: 1/9/2017 8:42:01 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Important info

Please call when you can

Also this is (b) (6) cell:
(b) (6)

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 11/30/2016 8:59:08 PM
To: (b) (6) b) (6) @jefferson.edu]
Subject: Re: Secretary VA

If you wait a little bit you can find out what Russia looks like:

https://www.google.com/amp/www.breitbart.com/2016-presidential-race/2016/11/30/abc-news-sarah-palin-consideration-secretary-veterans-affairs/amp/?client=safari

😉

Sent from my iPhone

On Nov 30, 2016, at 3:51 PM, (b) (6) (b) (6) @jefferson.edu> wrote:

> David
>
> Got it. (b) is emailing him as to when we can chat. I will check in with (b) tomorrow. Thanks. (b)
> --
> (b) (6), M.D., M.B.A.
>
> President and CEO
> Thomas Jefferson University and Jefferson Health
> sklasko.com
> 12disruptors.com

On 11/30/16, 3:47 PM, "David shulkin" <Drshulkin@aol.com> wrote:

> (b) (6) just want to make sure you received this last email
>
> David
>
> Sent from my iPhone
>
> > On Nov 29, 2016, at 11:24 AM, David shulkin <Drshulkin@aol.com> wrote:

AMERICAN OVERSIGHT

(b) (6) i hope your thanksgiving was great. It was good to have our kids home with us.

I spoke to Secretary McDonald today and he would be pleased to speak with you at any point. He asked you use his personal email as our government emails are often made public . You can arrange a time to speak with him or however you want to handle.

His email is (b) (6) @gmail.com

Thanks

David

Sent from my iPhone

The information contained in this transmission contains privileged and confidential information. It is intended only for the use of the person named above. If you are not the intended recipient, you are hereby notified that any review, dissemination, distribution or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender by reply email and destroy all copies of the original message.

CAUTION: Intended recipients should NOT use email communication for emergent or urgent health care matters.

AMERICAN OVERSIGHT

Message

From: [(b) (6) b) (6) @jefferson.edu]
Sent: 11/30/2016 8:51:44 PM
To: David shulkin [Drshulkin@aol.com]
CC: [(b) (6) (b) (6) @jefferson.edu]
Subject: Re: Secretary VA

David

Got it. (b) is emailing him as to when we can chat. I will check in with (b) tomorrow. Thanks.
Steve
--
(b) (6), M.D., M.B.A.

President and CEO
Thomas Jefferson University and Jefferson Health
sklasko.com
12disruptors.com

On 11/30/16, 3:47 PM, "David shulkin" <Drshulkin@aol.com> wrote:

>(b) (6) just want to make sure you received this last email
>
>David
>
>Sent from my iPhone
>
>> On Nov 29, 2016, at 11:24 AM, David shulkin <Drshulkin@aol.com> wrote:
>>
>> (b) (6) i hope your thanksgiving was great. It was good to have our kids home with us.
>>
>> I spoke to Secretary McDonald today and he would be pleased to speak with you at any point. He asked you use his personal email as our government emails are often made public . You can arrange a time to speak with him or however you want to handle.
>>
>> His email is (b) (6) @gmail.com
>>
>> Thanks
>>
>> David
>>
>> Sent from my iPhone
>
The information contained in this transmission contains privileged and confidential information. It is intended only for the use of the person named above. If you are not the intended recipient, you are hereby notified that any review, dissemination, distribution or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender by reply email and destroy all copies of the original message.

CAUTION: Intended recipients should NOT use email communication for emergent or urgent health care matters.

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 11/30/2016 8:47:46 PM
To: (b) (6) (b) (6) @jefferson.edu]
Subject: Re: Secretary VA

(b) (6) just want to make sure you received this last email

David

Sent from my iPhone

> On Nov 29, 2016, at 11:24 AM, David shulkin <Drshulkin@aol.com> wrote:
>
> (b) (6) i hope your thanksgiving was great. It was good to have our kids home with us.
>
> I spoke to Secretary McDonald today and he would be pleased to speak with you at any point. He asked you use his personal email as our government emails are often made public . You can arrange a time to speak with him or however you want to handle.
>
> His email is (b) (6) @gmail.com
>
> Thanks
>
> David
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 11/29/2016 4:24:54 PM
To: (b) (6) (b) (6) @jefferson.edu]
Subject: Secretary VA

(b) (6) i hope your thanksgiving was great. It was good to have our kids home with us.

I spoke to Secretary McDonald today and he would be pleased to speak with you at any point. He asked you use his personal email as our government emails are often made public . You can arrange a time to speak with him or however you want to handle.

His email is (b) (6) @gmail.com

Thanks

David

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/9/2016 2:21:08 AM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re:(b)

No- i think its just old info-

Sent from my iPhone

> On Dec 8, 2016, at 9:18 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>
> He said 2 days ago and it was his counterpart at (b) I think chair of medicine - should I get the name?
>
> Sent from my iPad
>
>> On Dec 8, 2016, at 8:57 PM, David shulkin <Drshulkin@aol.com> wrote:
>>
>> Maybe it was a chair (there is a pulmonary guy who is the medicine chair that knows (b) who had not yet heard i pulled out
>>
>> Sent from my iPhone
>>
>>> On Dec 8, 2016, at 8:17 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>>>
>>> He just called to tell me that the (b) folks called to get a reference on you from him - he obviously gave a stellar one
>>>
>>> Sent from my iPhone
>>

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 12/9/2016 2:18:12 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re:(b)

He said 2 days ago and it was his counterpart at (b) I think chair of medicine - should I get the name?

Sent from my iPad

> On Dec 8, 2016, at 8:57 PM, David shulkin <Drshulkin@aol.com> wrote:
>
> Maybe it was a chair (there is a pulmonary guy who is the medicine chair that knows (b) who had not yet heard i pulled out
>
> Sent from my iPhone
>
>> On Dec 8, 2016, at 8:17 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>>
>> He just called to tell me that the (b) folks called to get a reference on you from him - he obviously gave a stellar one
>>
>> Sent from my iPhone
>

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/9/2016 1:57:03 AM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re:(b)

Maybe it was a chair (there is a pulmonary guy who is the medicine chair that knows (b) who had not yet heard i pulled out

Sent from my iPhone

> On Dec 8, 2016, at 8:17 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>
> He just called to tell me that the (b) folks called to get a reference on you from him - he obviously gave a stellar one
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/9/2016 1:55:58 AM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re:(b)

Strange was it recent? Can you find out for me when they called him and who? Because last week i told them it would not work out and we ended discussions (ill tell you why later but it was not a good fit)

Sent from my iPhone

> On Dec 8, 2016, at 8:17 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>
> He just called to tell me that the (b) folks called to get a reference on you from him - he obviously gave a stellar one
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 12/9/2016 1:17:16 AM
To: David Shulkin [drshulkin@aol.com]
Subject: (b)

He just called to tell me that the (b) folks called to get a reference on you from him - he obviously gave a stellar one

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 11/24/2016 7:14:26 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re:

Me too- have a great thanksgiving

Sent from my iPad

> On Nov 24, 2016, at 2:13 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>
> Truly thankful, grateful and feel blessed for our extraordinary friendship!!
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 11/24/2016 7:13:44 PM
To: David Shulkin [drshulkin@aol.com]

Truly thankful, grateful and feel blessed for our extraordinary friendship!!

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 11/16/2016 11:30:16 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: Can we meet this week?

Sounds good

Off now to new orleans

Sent from my iPhone

On Nov 16, 2016, at 5:19 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:

> One of my students who works for the BCBSA on policy
>
> Sent from my iPad
>
> Begin forwarded message:
>
> **From:** "(b) (6)" (b) (6) @bcbsa.com>
> **Date:** November 16, 2016 at 10:54:23 AM EST
> **To:** "(b) (6) hotmail.com" <(b) (6) hotmail.com>
> **Subject: Can we meet this week?**
>
> Dr. Alaigh,
> Are you available to meet sometime this week or weekend?
>
> -(b) (6)
>
> (b) (6)
> Managing Director, Federal Programs
> Office of Policy & Representation
> Blue Cross Blue Shield Association
> 1310 G St., NW, 12th Floor
> Washington, D.C. 20005
> (b) (6) direct
> (b) (6) cell

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 11/16/2016 10:19:41 PM
To: David shulkin [drshulkin@aol.com]
Subject: Fwd: Can we meet this week?

One of my students who works for the BCBSA on policy

Sent from my iPad

Begin forwarded message:

> **From:** (b) (6) " (b) (6) @bcbsa.com>
> **Date:** November 16, 2016 at 10:54:23 AM EST
> **To:** "(b) (6) hotmail.com" <(b) (6) hotmail.com>
> **Subject: Can we meet this week?**
>
> Dr. Alaigh,
> Are you available to meet sometime this week or weekend?
>
> -(b) (6)
>
> (b) (6)
> Managing Director, Federal Programs
> Office of Policy & Representation
> Blue Cross Blue Shield Association
> 1310 G St., NW, 12th Floor
> Washington, D.C. 20005
> (b) (6) direct
> (b) (6) cell

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) @gmail.com]
Sent: 12/2/2016 11:59:41 AM
To: David Shulkin [drshulkin@aol.com]; (b) [(b) (6) @hotmail.com]
Subject: Press Club With (b)
Attachments: 20161129_134359.jpg; 20161129_085639.jpg; 20161129_085630.jpg; 20161129_084008.jpg; 20161129_084006.jpg

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Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 12/6/2016 12:31:26 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Quick follow ups from yesterday

K- then don't worry, I will handle- all I thought was that having a few minutes with you on the phone and Pitt would legitimize what we are trying to create around creating your leadership legacy since it got buried in the HBS study. A few minutes from you for them to hear is so powerful. But do what you can.

Really hoping and praying that this works for jennie- focus on this, nothing in the entire universe is more important than her right now

Sent from my iPhone

> On Dec 6, 2016, at 7:25 AM, David shulkin <Drshulkin@aol.com> wrote:
>
> I am at the point i dont really worry about Rich- i think he is best when buried in the details of these projects- it keeps him busy
>
> Thanks about (b)
>
> Yes were good for Pitt but ive had a hard time getting to focus- for some reason im being hit with stuff all around and then jennie and merle in town now for 10 days to get this treament and its not going well so they need some attention- so the more you can drive it - i wouldd appreciate it
>
> Sent from my iPhone
>
>> On Dec 6, 2016, at 7:17 AM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>>
>> 1) was in a meeting with rich stone, Steve, (b) (6) - Rich is leaning towards Mass- I pushed hard against it with letting the process be what it is- he did acknowledge that you and he were on different pages on this, and I was representing your position on it.
>>
>> 2) spoke to (b) (6) and meeting him again on Thursday in D.C.- making progress and will let you know more later in the week
>>
>> 3) please confirm with (b) (6) the call with Pitt- she had a million questions about it from Rachel yesterday
>>
>> Sent from my iPhone
>

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/6/2016 12:25:04 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: Quick follow ups from yesterday

I am at the point i dont really worry about Rich- i think he is best when buried in the details of these projects- it keeps him busy

Thanks about (b)

Yes were good for Pitt but ive had a hard time getting to focus- for some reason im being hit with stuff all around and then jennie and merle in town now for 10 days to get this treament and its not going well so they need some attention- so the more you can drive it - i wouldd appreciate it

Sent from my iPhone

> On Dec 6, 2016, at 7:17 AM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>
> 1) was in a meeting with rich stone, Steve, (b) (6) - Rich is leaning towards Mass- I pushed hard against it with letting the process be what it is- he did acknowledge that you and he were on different pages on this, and I was representing your position on it.
>
> 2) spoke to (b) (6) and meeting him again on Thursday in D.C.- making progress and will let you know more later in the week
>
> 3) please confirm with (b) (6) the call with Pitt- she had a million questions about it from Rachel yesterday
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 12/6/2016 12:17:12 PM
To: David shulkin [drshulkin@aol.com]
Subject: Quick follow ups from yesterday

1) was in a meeting with rich stone, Steve, (b) (6) s- Rich is leaning towards Mass- I pushed hard against it with letting the process be what it is- he did acknowledge that you and he were on different pages on this, and I was representing your position on it.

2) spoke to (b) (6) and meeting him again on Thursday in D.C.- making progress and will let you know more later in the week

3) please confirm with (b) (6) the call with Pitt- she had a million questions about it from Rachel yesterday

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 11/29/2016 1:56:43 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Fwd: Re:

He r website- http://www.svcinc.org/

Sent from my iPad

On Nov 29, 2016, at 7:36 AM, David shulkin <Drshulkin@aol.com> wrote:

> Sent from my iPhone
>
> Begin forwarded message:
>
> > **From:** (b) (6) @gmail.com>
> > **Date:** November 29, 2016 at 6:54:56 AM EST
> > **To:** David shulkin <Drshulkin@aol.com>
> > **Subject: Re:**
> >
> > U.S. President-elect Donald Trump is set to name Indiana health policy consultant Seema Verma as his pick for administrator of the Centers for Medicare and Medicaid Services, a transition official told Reuters on Monday
> >
> > Sent from my iPhone
> >
> > On Nov 28, 2016, at 8:17 PM, David shulkin <Drshulkin@aol.com> wrote:
> >
> > > http://www.cbsnews.com/news/veterans-protest-hampshire-college-stopped-flying-us-flag/?ftag=CNM-00-10aab6j&linkId=31627065
> > >
> > > Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 11/29/2016 12:36:00 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Fwd: Re:

Sent from my iPhone

Begin forwarded message:

> **From:** (b) (6) @gmail.com>
> **Date:** November 29, 2016 at 6:54:56 AM EST
> **To:** David shulkin <Drshulkin@aol.com>
> **Subject: Re:**
>
> U.S. President-elect Donald Trump is set to name Indiana health policy consultant Seema Verma as his pick for administrator of the Centers for Medicare and Medicaid Services, a transition official told Reuters on Monday
>
> Sent from my iPhone
>
> On Nov 28, 2016, at 8:17 PM, David shulkin <Drshulkin@aol.com> wrote:
>
> > http://www.cbsnews.com/news/veterans-protest-hampshire-college-stopped-flying-us-flag/?ftag=CNM-00-10aab6j&linkId=31627065
> >
> > Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: [redacted] [redacted]@hotmail.com]
Sent: 1/17/2017 2:35:36 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Guest Services

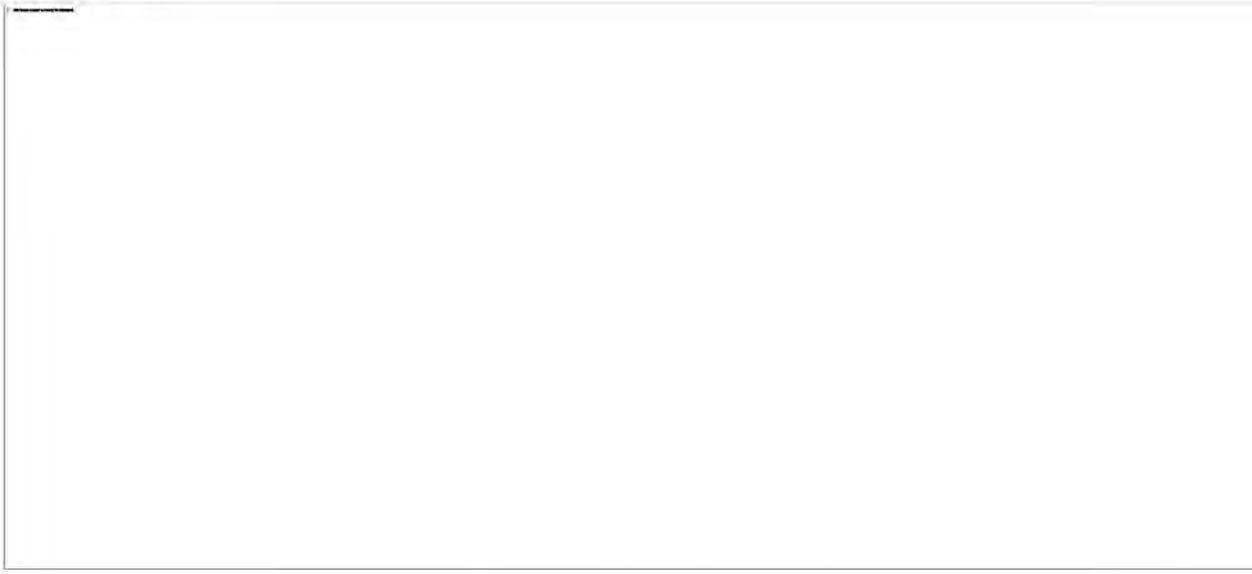
I asked [redacted] if she got hers. She said shed check in am or should i email marisol

Sent from my iPhone

On Jan 16, 2017, at 9:26 PM, David shulkin <Drshulkin@aol.com> wrote:

> Marisol
>
> Sent from my iPhone
>
> On Jan 16, 2017, at 8:18 PM, [redacted] <[redacted]@hotmail.com> wrote:
>
> > Idk but they got, [redacted] too. Do i ask marisol or [redacted]
> >
> > Sent from my iPhone
> >
> > Begin forwarded message:
> >
> > **From:** Poonam Alaigh <[redacted]hotmail.com>
> > **Date:** January 16, 2017 at 8:02:33 PM EST
> > **To:** "[redacted]@hotmail.com" <[redacted]@hotmail.com>
> > **Subject: Fw: Guest Services**
> >
> > [redacted] just got this- do I have to pick up the tickets from somewhere?
> >
> > ---
> >
> > **From:** Presidential Inaugural Committee 2017 <tickets@58pic2017.org>
> > **Sent:** Monday, January 16, 2017 7:16 PM
> > **To:** [redacted]hotmail.com
> > **Subject:** Guest Services

AMERICAN OVERSIGHT



The 58th Presidential Inauguration

We look forward to your attendance at the 58th Presidential Inauguration. Guest Services/Will Call w
week to resolve ticketing issues for Inaugural events. Please come to Guest Services at the Fairmont
experiencing problems with your tickets and need assistance. You may also pick up Swearing-In tick
receive your tickets by mail.

Only those tickets that were requested will be available at Will Call. No additional requests will be g
time.

Guest Services is located at the **Fairmont Hotel, 2401 M St NW, Washington, DC 20037, on the t**
hours of operation are Monday-Friday, 9am-6pm.

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Paid For By The 58th Presidential Inaugural Committee

AMERICAN OVERSIGHT

Message

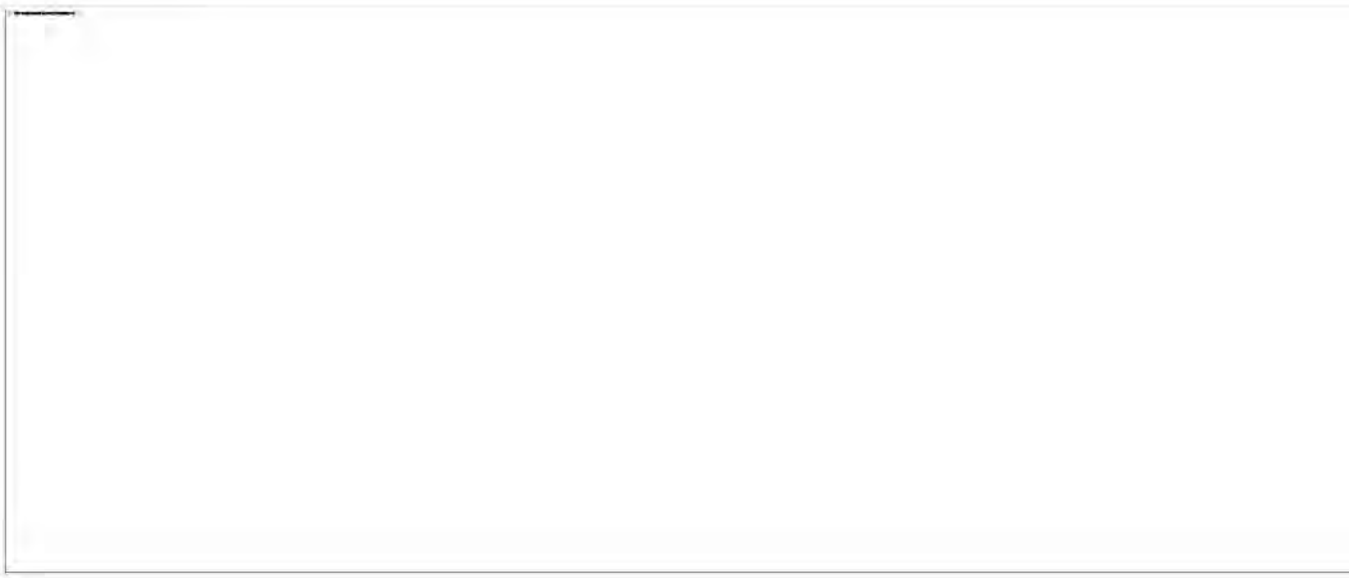
From: David shulkin [Drshulkin@aol.com]
Sent: 1/17/2017 2:26:52 AM
To: (b) [(b) (6) @hotmail.com]
Subject: Re: Guest Services

Marisol

Sent from my iPhone

On Jan 16, 2017, at 8:18 PM, (b) (6) <(b) (6) @hotmail.com> wrote:

> Idk but they got, (b) (6) too. Do i ask marisol or (b) (6)
>
> Sent from my iPhone
>
> Begin forwarded message:
>
> **From:** Poonam Alaigh <(b) (6) hotmail.com>
> **Date:** January 16, 2017 at 8:02:33 PM EST
> **To:** "(b) (6) @hotmail.com" <(b) (6) @hotmail.com>
> **Subject: Fw: Guest Services**
>
> (b) (6) just got this- do I have to pick up the tickets from somewhere?
>
> ---
>
> **From:** Presidential Inaugural Committee 2017 <tickets@58pic2017.org>
> **Sent:** Monday, January 16, 2017 7:16 PM
> **To:** (b) (6) hotmail.com
> **Subject:** Guest Services



AMERICAN OVERSIGHT

The 58th Presidential Inauguration

We look forward to your attendance at the 58th Presidential Inauguration. Guest Services/Will Call will be o week to resolve ticketing issues for Inaugural events. Please come to Guest Services at the Fairmont Hotel if experiencing problems with your tickets and need assistance. You may also pick up Swearing-In tickets if y receive your tickets by mail.

Only those tickets that were requested will be available at Will Call. No additional requests will be granted time.

Guest Services is located at the **Fairmont Hotel, 2401 M St NW, Washington, DC 20037, on the third flo hours of operation are Monday-Friday, 9am-6pm.**

© 2017. All Rights Reserved. [illegible]

Paid For By The 58th Presidential Inaugural Committee

AMERICAN OVERSIGHT

Message

From: [redacted] [redacted]@hotmail.com]
Sent: 1/17/2017 1:18:09 AM
To: David [drshulkin@aol.com]
Subject: Fwd: Guest Services

Idk but they got, [redacted] too. Do i ask marisol or [redacted]

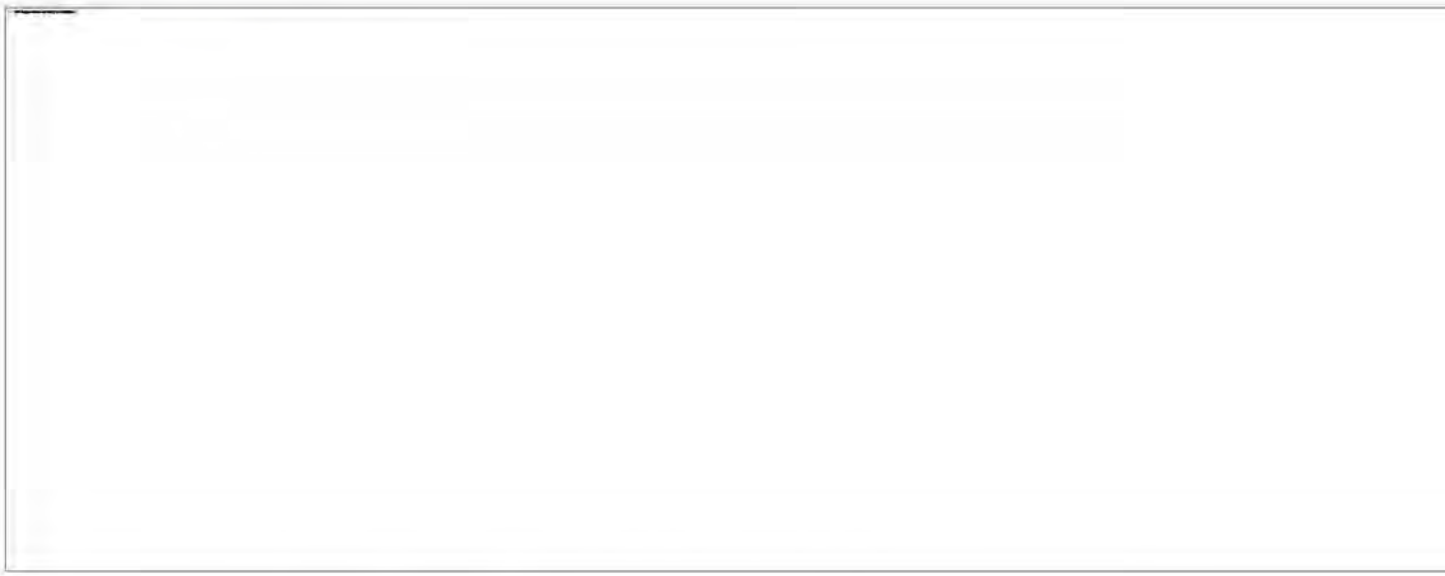
Sent from my iPhone

Begin forwarded message:

From: Poonam Alaigh <[redacted]hotmail.com>
Date: January 16, 2017 at 8:02:33 PM EST
To: "[redacted]@hotmail.com" <[redacted]@hotmail.com>
Subject: Fw: Guest Services

[redacted] just got this- do I have to pick up the tickets from somewhere?

From: Presidential Inaugural Committee 2017 <tickets@58pic2017.org>
Sent: Monday, January 16, 2017 7:16 PM
To: [redacted]hotmail.com
Subject: Guest Services



The 58th Presidential Inauguration

AMERICAN OVERSIGHT

We look forward to your attendance at the 58th Presidential Inauguration. Guest Services/Will Call will be open this week to resolve ticketing issues for Inaugural events. Please come to Guest Services at the Fairmont Hotel if you are experiencing problems with your tickets and need assistance. You may also pick up Swearing-In tickets if you did n receive your tickets by mail.

Only those tickets that were requested will be available at Will Call. No additional requests will be granted at this time.

Guest Services is located at the **Fairmont Hotel, 2401 M St NW, Washington, DC 20037, on the third floor. The hours of operation are Monday-Friday, 9am-6pm.**

© 2017 All Rights Reserved. | [illegible]

Paid For By The 58th Presidential Inaugural Committee

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 11/26/2016 11:59:29 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: Schedule Monday- Tuesday

Tuesday is the milken launchpad event all day- starts at the national press club at 8 with a ceo roundtable - i speak mid day

Monday -at 130 i have the prep for the bush institute which you should probably attend

Otherwise all routine stuff

Sent from my iPhone

> On Nov 26, 2016, at 6:21 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>
> Let me know if there is anything interesting you want me to join you in on Monday and Tuesday when I am in DC
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 11/26/2016 11:21:00 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Schedule Monday- Tuesday

Let me know if there is anything interesting you want me to join you in on Monday and Tuesday when I am in DC

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 11/14/2016 4:15:29 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Anytime this afternoon

For a 15min quick touching base and we can then have more time this evening? If not no worries- meeting Scott Blackburn for lunch and will try to get more scoop

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/10/2016 4:11:13 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: VHA Modernization

Ive seen but not participated

Its a consultant run journal club

Stuff ive done and reviewed years ago - not even worth my time but he had now used it as a political tool

Sent from my iPhone

On Dec 10, 2016, at 11:06 AM, Poonam Alaigh <(b) (6) hotmail.com> wrote:

> David you have been part of this group on "Modernization"- see below. This is the forum he has used to come up with the proposal with the help of OSI. He has been focused on structural and internal organizational transformation. He has been including the transition team and I have just heard (though don't know if it's true) that members of the transition team will attend his retreat in January.
>
> Sent from my iPad
>
> Begin forwarded message:
>
> **From:** "(b) (6) <(b) (6) @va.gov>
> **Date:** December 10, 2016 at 9:27:31 AM EST
> **To:** "(b) (6) hotmail.com" <(b) (6) hotmail.com>
> **Subject: FW: VHA Modernization**
>
> Hi Poonam,
> I thought you might find these documents to be of interest.
>
> ---
>
> **From:** (b) (6) (VHACO) **On Behalf Of** Stone, Richard A., MD
> **Sent:** Monday, November 21, 2016 11:42 AM
> **To:** Shulkin, David J., MD; Wright, Vivieca (Simpson); (b) (6) Yow, Mark W.; Yehia, Baligh R.; Clancy, Carolyn; Lee, Jennifer S. (VACO); Young, Steven W.; (b) (6) (b) (6) McConnell, Linda M.; Crump, Regan; (b) (6) ; Lynch, Thomas (VHA); (b) (6) ; Gaudet, Tracy, MD; (b) (6) ; (b) (6) ; Lapuz, Miguel H.; McDougall, Skye; Boyd, Teresa D (V20); (b) (6) FNCVAMC; (b) (6) Snyder, Robert
> **Subject:** VHA Modernization
> **Importance:** High
>
> Greetings Colleagues-
>
> It is hard to believe the year is coming to a close. The holiday season is upon us yet as always there is much to do to ensure Veterans receive the best care possible. Your role as dynamic leaders in this organization

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remains critical to the success of VHA. It is with change in mind that I reach out to you.
Numerous reports in the recent past indicate a need for "transformation" or "modernization" of the VHA at all levels of the agency. I would like to begin this journey with you. I will be reaching out to you individually to discuss your ideas for improving the organization and how we can partner together to improve the Veteran experience by simplifying/leaning our processes, examining possible alternative organizational models, and facilitating decision rights at the lowest level.

You should have received an invitation for the January leadership summit but if you didn't please reach out to me and copy (b) (6) (b) (6) @va.gov). We will meet Jan 17th to 18th in Washington DC to galvanize behind a common vision. In the meantime, I will regularly distribute both academic and experiential-based articles discussing organizational design on a bi-weekly basis. Please read these articles and attend our bi-weekly meeting. If you are in VACO for the meetings join me for snacks and refreshments. For those of you who are attending virtually I will make it up to you at the leadership summit in January but please dial in and engage.

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reforms have featured "successions of narrow 'solutions', yet none of the solutions tackle the underlying strategic and structural problems that work against value for patients." The article also provides a list of the reforms that have been undertaken; it's eye opening to see them listed all together. The fact that none of the reforms have worked to wholeheartedly change the healthcare system for the better leads one to believe there needs to be a broader approach such as the one Porter and Lee propose.

Important Background Readings

1. VA Health Care: Processes to Evaluate, Implement, and Monitor Organizational Structure Changes Needed, GAO, September 2016
2. Executive Summary, Choice Act Section 201: Independent Assessments - Leadership, September 2015.

Happy Holidays
Rich

<Executive Summary - Section 201 Independent Assessments - Part L.PDF>

<Fixing Health Care on the Front Lines - Redesign - Bohmer - HBR April 20....pdf>

<The Strategy That Will Fix Health Care - Porter and Lee - HBR Oct 2013.pdf>

<GAO-16-803 VHA Organizational Structure Monitoring.pdf>

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Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 12/10/2016 4:06:32 PM
To: David shulkin [drshulkin@aol.com]
Subject: Fwd: VHA Modernization
Attachments: Executive Summary - Section 201 Independent Assessments - Part L.PDF; Fixing Health Care on the Front Lines - Redesign - Bohmer - HBR April 20....pdf; The Strategy That Will Fix Health Care - Porter and Lee - HBR Oct 2013.pdf; GAO-16-803 VHA Organizational Structure Monitoring.pdf

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Prepared by:

McKinsey & Company, Inc.

A Product of the CMS Alliance to Modernize Healthcare
Federally Funded Research and Development Center
Centers for Medicare & Medicaid Services (CMS)

Prepared For:
U.S. Department of Veterans Affairs

At the Request of:
Veterans Access, Choice, and Accountability Act of 2014
Section 201: Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs

Assessment L (Leadership)

September 1, 2015

Prepared for CAMH under:
Prime Contract No. HHS-M500-2012-00008I
Prime Task Order No. VA118A14F0373

This document was prepared for authorized distribution only. It has not been approved for public release.

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Executive Summary

Scope

(b) (4), (b) (5)

[redacted]

Findings

(b) (4), (b) (5)

[redacted]

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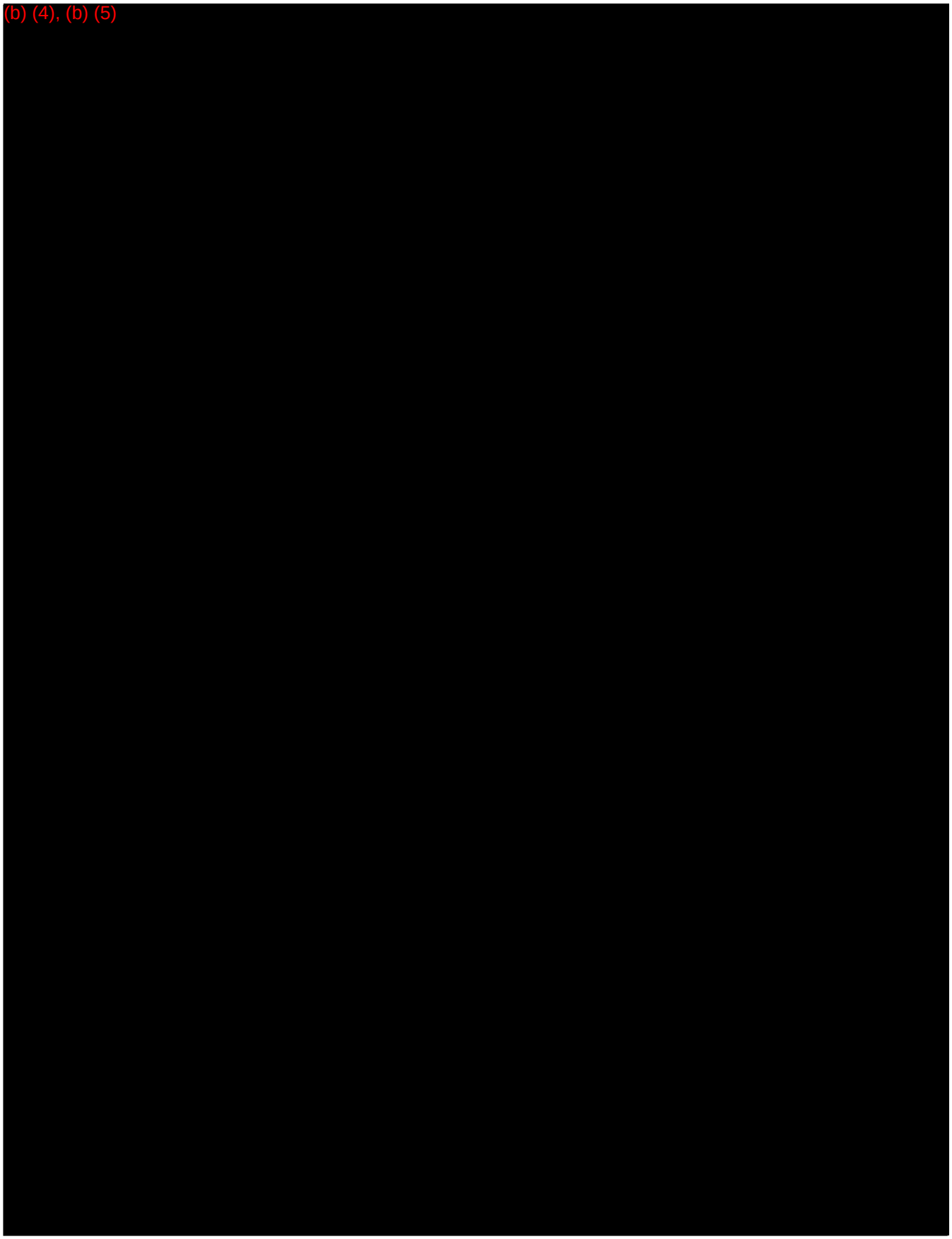
(b) (4), (b) (5)



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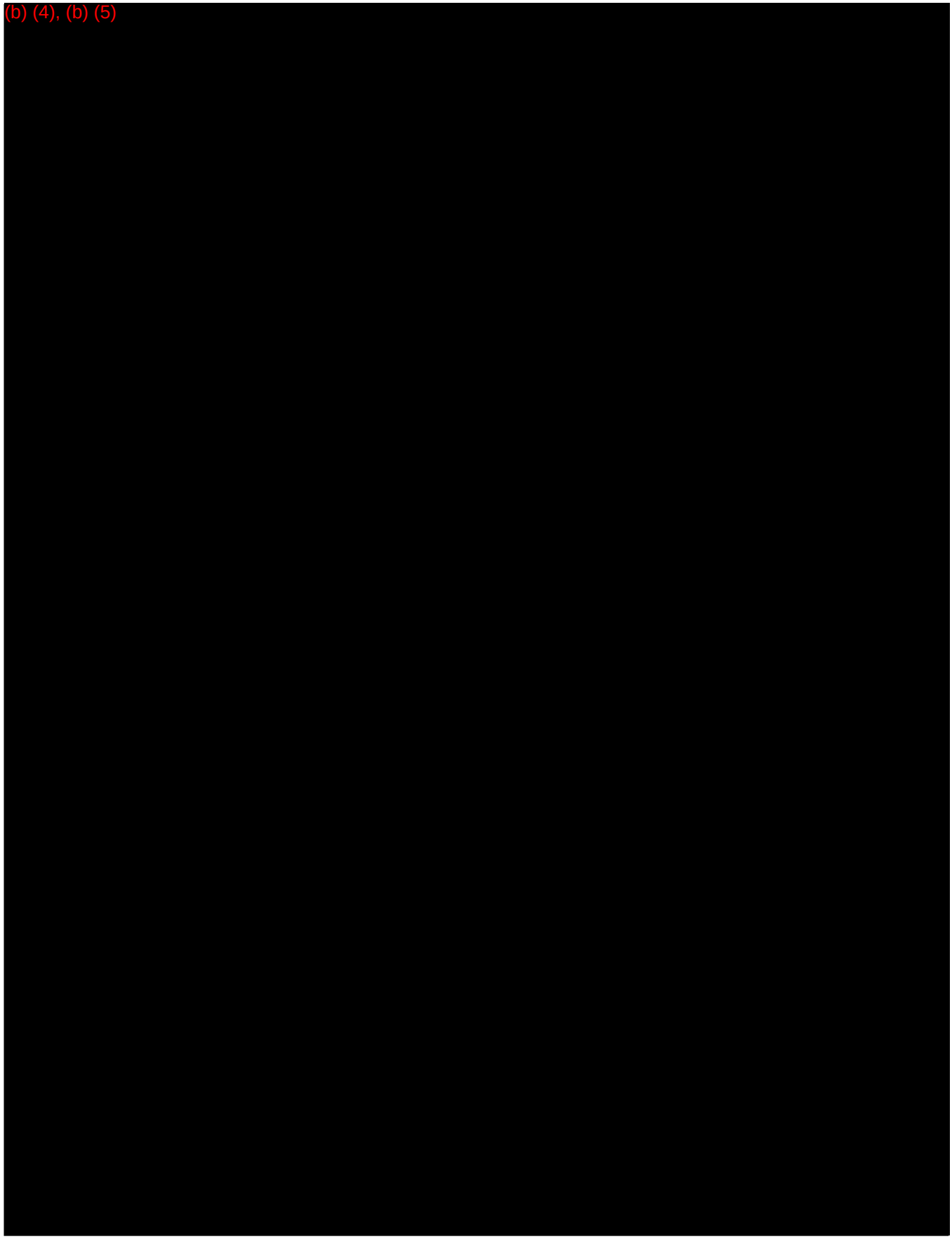

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(b) (4), (b) (5)

[redacted]

Recommendations

(b) (4), (b) (5)

[redacted]

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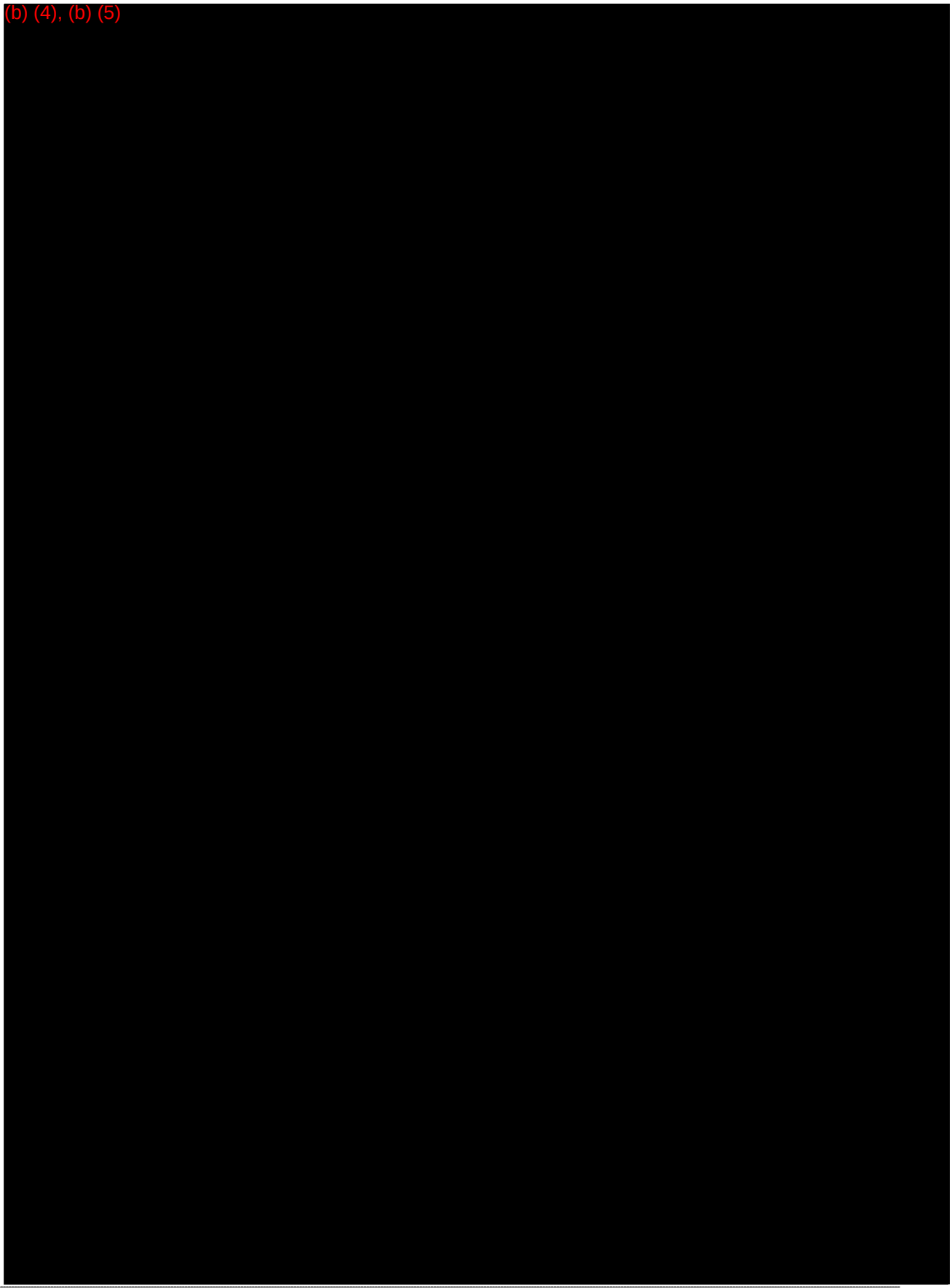

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Harvard Business Review

REORGANIZATION

Fixing Health Care on the Front Lines

by Richard M.J. Bohmer

FROM THE APRIL 2010 ISSUE



ARTWORK: DAVID MAISEL, **HISTORY'S SHADOW GM9**, 2010, ARCHIVAL PIGMENT PRINT, 40" X 30"

In the United States and around the world, there have been plenty of proposals for curing what ails health care. All of them—new organizational forms, alternative payment systems, and free-market competition—aim to tackle a universal challenge: improving the quality of health care and reducing, or at least curbing, its soaring cost. But the reality is that regardless of what happens to the many experiments and reform efforts, including the one in Washington, the basic structure of the health care system in the United States and most other countries will remain in place for the foreseeable future. General hospitals, independent practices, and (in the United States) fee-for-service payment are not going to disappear anytime soon. The only realistic hope for substantially improving care delivery is for the old guard to launch a revolution from within. Existing players must redesign themselves.

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- Capturing and applying the knowledge generated by day-to-day care.

The vast majority of health care organizations throughout the world are not designed to excel at all three. In fact, they are not really “designed” at all. The elements of most general hospitals—buildings, technologies, clinical services—have accreted over time. And most hospitals don’t determine how doctors work within their walls. Indeed, their role is to support physicians by assuring the quality and optimizing the availability of crucial resources for treating patients (nurses, beds, laboratories, X-ray facilities, and so on).

This is hardly surprising. The prevailing structures and processes reflect the nature of medical care before the explosion of medical knowledge over the past 30 years. They are legacies of the days when what was wrong with the patient and what to do about it were often opaque, disease incidence and progression were unpredictable, and each patient presented a unique set of challenges. Accordingly, diagnosis and treatment were left largely to the judgment of individual physicians, who achieved the best possible outcomes by providing customized care. Medicine was a cottage industry of autonomous artisans. Hospitals were considered “the doctor’s workshop.”

Times have changed. Diagnosing and treating many diseases—diabetes, hypertension, and coronary artery disease, to name a few—are no longer a matter of educated guesswork. Scientific advances have vastly increased the volume and specificity of medical knowledge, which can be translated into standardized processes and programmed into computerized decision-support systems. And in some instances, tasks traditionally performed by physicians can be delegated to other personnel or even to patients.

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Why Health Care Organizations Must Be Redesigned

The explosion of scientific knowledge over the past 30 years has profoundly changed how medical professionals care for patients, but the structures and processes of most health care organizations are legacies of an earlier era.

Before

The nature of medicine before scientific advances...

Disease cause was unexplainable

Disease occurrence and progression were unpredictable

Treatment outcome was uncertain

Patients were heterogeneous and manifested diseases in different ways

...and how that shaped health care delivery

Who Fragmented and independent providers widely distributed in the community; diversified hospitals with the resources to cope with complex health problems

When At the patient's request

Where In specifically configured health care settings, such as a physician's office, a hospital ward, or a clinic

What Customized diagnosis and treatment based on the individual physician's judgment

After

The nature of medicine after scientific advances...

The sad fact, though, is that science has far outstripped the ability of delivery organizations to apply it. Most are not configured to rapidly disseminate and use new knowledge. This helps explain why care known to be beneficial is not consistently administered, care of uncertain value is overprescribed, and avoidable harm abounds. By some estimates, it takes 10 to 20 years for a new practice to go from development to widespread adoption, and a recent RAND study found that in the United States the chance of receiving care that meets generally accepted standards is about 55%. Even though medical professionals since the middle of the nineteenth century have known that poor sanitation causes high rates of infection, simply getting care providers to routinely wash their hands remains a challenge.

By some estimates, it takes 10 to 20 years for a new practice to go from development to widespread adoption.

Nor are delivery organizations very good at systematically learning how to tackle the toughest cases, which account for the majority of health costs—patients who have either multiple interacting conditions or diseases that are difficult to diagnose or for which there is no obvious,

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Diagnoses are more accurate, treatment choices better specified, and treatments more reliable

Progression of disease and common complications and their precipitants are better characterized

Subgroups of patients with the same disease have been defined

...and the implications for how health care can be delivered

Who Professionals who are not necessarily doctors

When Before complications or exacerbations are manifest

Where Not necessarily during a face-to-face encounter between the patient and the care deliverer; in settings such as the patient's home, a fitness center, or a shopping mall

What Diagnosis and treatment based on highly specified protocols and decision rules; therapies targeting specific patient groups

definitive treatment. The care of these patients is often spread among an array of medical subspecialists, physical and occupational therapists, dieticians, nurse practitioners, and social workers—all of whom work at different sites. As a result, no single entity is responsible for overseeing and learning from their collective work by analyzing data to discern patterns that reveal what is and is not working.

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Modern health care organizations must be capable of simultaneously optimizing the execution of standardized processes for addressing the known and learning how to address the unknown—a tall order. A flaw in some of the proposals for fixing health care is the failure to address the complexity of patient care in which predictability and ambiguity exist side by side.

For example, some hospitals have applied principles of the Toyota Production System to perfect the technique for placing a central venous line. This has allowed them to reduce the associated infection rate to zero—a remarkable achievement—but it has not helped in the management of patients with multiple diseases whose condition is rapidly deteriorating. Similarly, retail clinics have increased access to and lowered the cost of care for patients with simple illnesses such as pinkeye and strep

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throat. But their response to people who come in with ambiguous problems is to refer them elsewhere. In short, no one approach is a panacea. Significant improvement in the overall quality and efficiency of health care will require redesigning delivery to integrate all such solutions.

Practically speaking, the main traditional players—established care-delivery networks, hospitals, and clinics—must lead the way in doing this. They are the only ones with the necessary size and scope. Some players have already begun reconfiguring themselves and making progress despite obstacles such as fee-for-service payment—a system that encourages the performance of procedures regardless of their impact on outcomes. Those that have attracted the most attention for their progress in eliminating waste and improving outcomes include Beth Israel Deaconess in Boston, Cincinnati Children's, Cleveland Clinic, Geisinger Health System in Pennsylvania, Intermountain Healthcare in Utah and Idaho, Istituto Clinico Humanitas near Milan, Kaiser Permanente in areas across the United States, and Virginia Mason in Seattle. These organizations understand that medical knowledge is now too voluminous to be stored in the heads of individual physicians and must instead be embedded in protocols and routines. In other words, they realize that curing disease has become an organizational responsibility. They consciously deploy their resources to achieve the best possible patient outcomes, collect and use data to relentlessly improve performance, and treat the daily practice of medicine as a source of insight and innovation.

But no single dominant design exists, which is not surprising given that each organization has its own environment, structure, and history. For example, Virginia Mason Medical Center is a single hospital whose physicians are salaried employees. Intermountain is a network of 25 hospitals with its own health plan whose doctors are a mix of salaried employees and independent practitioners. And the Mayo Clinic has a collaborative culture that dates back to the Mayo brothers' group practice in the late nineteenth century. An organizational design that is effective in one setting does not necessarily translate to another. More important than the specific designs are the four common principles on which they are based—the topic of the rest of this article.

Manage the Care

The first design principle is that the decisions, tasks, and workflows crucial to optimizing patient care must be the organization's primary focus. This represents a major change: Historically, delivery organizations have been structured to maximize the utilization of such resources as beds, tests, and

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procedure rooms. They have had little or no role in designing how specific illnesses were diagnosed and treated.

Although this model made sense when all care was judgment based and customized, it is a problem now that good outcomes depend on using well-developed evidence on the effectiveness of treatment to determine how care is provided and continuously learning from everyday practice. Applying evidence to practice requires standardization, not just of operational routines but also of the rules for making clinical decisions and executing tasks. Some hospitals have reduced infection rates by standardizing tasks such as the management of a patient on a ventilator. But others have gone further, specifying where possible the clinical decisions that precede tasks, such as whether the patient is a candidate for a test or therapy in the first place.

Intermountain provides an example of one approach to standardization. To the extent medical science allows, it specifies how a patient's health problems are diagnosed and treatments are selected and executed. In contrast to the loosely worded clinical guidelines that have been common in health care, Intermountain's clinical processes are defined by protocols: detailed descriptions of the sequence of tasks and decisions that lead to the resolution of a patient's health problem. For instance, its community-acquired-pneumonia protocol lays out how the patient's history and results of physical examinations and laboratory tests should be used to make a diagnosis. These same data are used to ascertain the severity of the pneumonia using a well-validated calculation. This, in turn, determines where patients should be treated (in an outpatient clinic, on the ward, or in the intensive care unit) and the oral or intravenous antibiotic that is most likely to be effective.

> **25%** The decrease in inpatient mortality from community-acquired pneumonia after the implementation of a standard protocol.

At Intermountain, each protocol is drafted by a small team of paid clinical experts who review the scientific literature and Intermountain's own experience. The team defines each variable—symptom, physical observation, or laboratory result—and the expected timeline for the patient's diagnosis, treatment, and recovery. This information is translated into a sequence of yes/no check boxes and specific test and treatment choices laid out to mirror the order in which a doctor usually does his or her work. A larger team of general practitioners, nurses, and information-systems and

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administrative personnel then ensures that the protocol is workable in practice. Both teams are permanent; they track the scientific literature and the organization's experience, and make minor adjustments monthly and major revisions every two years.

Intermountain limits the work involved by creating protocols only for the roughly 70 conditions that make up more than 90% of its caseload. These are predominantly common adult diseases—such as diabetes, hypertension, coronary artery disease, and some cancers—for which there are established treatments supported by robust scientific evidence.

Corral Variability

Intermountain's protocols do not help diagnose and treat conditions that are complicated and poorly understood, or for which the right course of action is more ambiguous. More than a quarter of Americans over 65 suffer from four or more interacting diseases, and many have conditions for which there is no definitive treatment. As a result, the overall care they require is highly variable and cannot be standardized. Organizations that deal effectively with this challenge apply a second broad principle: High- and low-variability care must be separated.

> The care many patients require is highly variable and cannot be standardized.

Intermountain achieves this by allowing doctors to override standardized clinical processes in ambiguous situations. In other words, even though it standardizes as many treatments as possible, it expects—even encourages—doctors to deviate from a protocol whenever they think doing so is in the patient's best interests. None of Intermountain's protocols is followed 100% of the time; the rate of deviation varies from one protocol to the next, depending in part on the inherent variation in the patient population with a given disease.

Another way to corral variability is to adopt the *hospital-within-a-hospital* (or *clinic-within-a-clinic*) model. This involves creating two units—one focused on uncomplicated cases and one on complicated cases. For example, at Duke University Medical System's clinic for treating congestive heart failure (CHF), one unit is staffed by nurse practitioners who apply standardized protocols to treat patients with uncomplicated CHF who are responding to treatment as expected. The other unit is staffed by cardiologists who use a wide array of tests and therapies and a customized process to

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address the needs of patients whose conditions are unstable, complex, or unusual in some way. This design allows the clinic to realize the benefits of operational focus—such as reliability, accuracy, and efficiency—while ensuring that no patient is turned away.

Istituto Clinico Humanitas uses a variant of this approach. Its campus comprises three distinct hospitals—elective, emergency, and rehabilitation—that are only a few hundred meters apart. Each has its own scope of work and focused operating system.

Organizations that employ the hospital-within-a-hospital model face three execution challenges. First, they need to ensure that all patients and caregivers have access to high-cost or scarce resources that must be shared, such as consultant senior doctors, nurses, and radiology services. Second, they must manage the interfaces between units so that patients can move quickly and smoothly between them as their needs demand. Finally, they must coordinate the flow of patients with complex or multiple illnesses among the specialized departments that contribute to their care.

Organizations can respond to these challenges in various ways. For example, Istituto Clinico Humanitas addresses the first by structuring its incentive system in a way that encourages doctors to consult in all three hospitals. Duke's CHF clinic relies on culture and process to address the second: It has embedded criteria in the protocols to initiate the transfer of a patient from one unit to another and has consciously created a collegial environment that fosters cooperation between nurse practitioners and cardiologists. To address the third, some organizations have created a coordinating function that shepherds patients through the various units providing their care.

In short, caring for patients with complex or poorly understood conditions demands sophisticated organizational designs. As specialized standalone services (such as clinics that treat simple illnesses or focus on a particular surgical procedure) proliferate, they need to be integrated into these designs. Yes, better information systems will help integrate them, but universal access to a patient's complete health record will not alone suffice. Without processes that coordinate care across organizational and professional boundaries, the fragmentation of care, already a headache for patients and their families and a source of waste, could worsen.

Reorganize Resources

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The third principle is that when delivery organizations redesign clinical processes, they must also reconfigure the supporting infrastructure and practices. Unfortunately, many organizations don't match the resources—the mix of staff, the management structure, the measurement and incentive systems, the IT system, the physical layout of the clinic or ward, the rules for sharing resources, the technology for diagnosing and treating diseases, educational programs, and so on—with their redesigned processes. The result: Highly trained specialists continue to perform work that could be handed off to nurse practitioners. Protocols are not translated into easy-to-follow steps in the IT system. Performance measures and budgets are still focused largely on costs and volume of services rather than patient outcomes. And professionals who should operate in teams instead work in silos.

That is why diagnosing and determining how to treat a woman with a suspicious abnormality in her breast can still take weeks and require a multitude of separate appointments with a surgeon, a radiologist, and an oncologist. Some clinics have managed to collapse this to four hours by reorganizing these specialists into a colocated team that reviews the test results, decides whether a biopsy is necessary and performs it if so, analyzes the results, and, if cancer is confirmed, determines the treatment options.

In other industries, organizational structures and business processes are configured to support the core production process. But most hospitals use the same set of resources to offer services ranging from prevention and screening to the treatment of acute and chronic conditions to palliative end-of-life care. Resources are structured as separate job shops, and patients wend a circuitous path among them, often suffering delays along the way because of insufficient capacity.

Intermountain is an exception. It has reconfigured its resources to support its protocols. Here are some examples:

- The steps in its protocols have been embedded in its electronic-medical-record system. As a result, when a doctor determines that a patient has a moderate case of community-acquired pneumonia, a drop-down menu in the EMR offers a choice of two drug regimens.

- To train medical staff members and keep them up to date, educational materials and activities have been developed for each protocol.

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- The teams responsible for developing protocols create measures that track compliance with and the impact of each one.

- Managers' compensation is determined in part by whether compliance with protocols meets predetermined goals established by Intermountain's board of directors. (Up to 25% of managers' compensation is tied to performance in six areas: clinical excellence, service excellence, physician engagement, operational effectiveness, employee engagement, and community stewardship.)

Health care organizations around the world are guided by the question "What care can we provide with the resources we have?" Whether the organization is a rural clinic in Rwanda treating AIDS and tuberculosis, a retail clinic at Wal-Mart handling minor ailments, or an academic medical center tackling the toughest, most complex cases, the question should be reversed: "What resources are required and how should they be configured for the care we need to provide?"

Some health care leaders will undoubtedly assume that their organizations cannot afford to adopt this mind-set, but it need not be expensive. Protocols and tracking measures are in the public domain. Data can be collected manually and analyzed inexpensively.

Learn from Everyday Care

The fourth principle is that the structure and processes of hospitals, clinics, and practices must be designed to help organizations systematically learn from their daily work. All too often, they are not. That's because of the traditional separation between the generation and application of medical knowledge: Basic scientists and clinical researchers create the knowledge, which is then taught to practicing doctors and nurses in the continuing education programs that they must take to maintain their licenses. And (in some countries) physicians' pay is tied to how well they incorporate this knowledge into their daily practice. In other words, knowledge flows one way—from research to practice.

In fact, valuable new knowledge about the nature of a disease, how to treat it, and how to organize the delivery of treatment is often generated by the daily practice of medicine. For example, two individuals—an obstetrician in Australia and a pediatrician in Germany—raised the alarm about thalidomide after observing in the late 1950s and early 1960s that patients in their practices who took the drug were giving birth to children with deformities. More recently, a group of cardiologists

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at the Mayo Clinic alerted the world that the diet drug combination Fen-Phen could cause pulmonary hypertension and heart-valve disease. And Kaiser Permanente's analysis of its own data helped show that Cox 2 inhibitors, a class of anti-inflammatory drugs, increase the risks of heart attack, thrombosis, and strokes. In all three cases, the drugs were withdrawn.

> Valuable knowledge about the treatment of disease is often generated by the daily practice of medicine.

Some organizations, recognizing that their staff generates large and small insights and innovations that could have a tremendous impact on performance, develop routines for creating, capturing, and disseminating such knowledge. For example, when a doctor at Intermountain overrides a protocol, it is taken as a sign of the protocol's failure to meet the needs of a particular patient. The teams developing the protocols collect the overrides, analyze them for patterns in patient outcomes, and incorporate what they learn in their revisions.

In addition, a support unit at Intermountain, whose responsibilities include evaluating clinicians' innovative ideas, has the resources to conduct small-scale internal studies. For example, a critical-care doctor went to the unit to seek help in testing his hunch that if ward patients whose conditions were rapidly deteriorating were transferred to intensive care earlier, the mortality rate would be reduced. The unit helped him conduct internal studies that ultimately resulted in the development of criteria for transferring ward patients to the intensive care unit. The criteria included a respiratory rate of greater than 35 breaths per minute for more than 30 minutes, systolic blood pressure of less than 85 for more than 30 minutes, and a heart rate of less than 40 or more than 140 for any amount of time. Subsequent studies found that patients transferred to the ICU within four hours of meeting one of those criteria had a mortality rate one-fourth the rate of those transferred after more than four hours.

The Hard Work of Redesign

While the debates over health care reform continue to rage, a quiet revolution in health care delivery is under way. Organizations are applying the four design principles described in this article to improve patient outcomes. The lesson they offer is that no one solution can be imposed from on

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high: One size will not fit all. Each organization must base its design on the needs of the population it serves, the local regulatory environment, and the available resources.

The revolution, though, is still in its early days and will take years to have a widespread impact. That's because redesign is not just a matter of launching a few high-profile pilot programs; it involves an enormous amount of detailed work at each clinic, ward, and practice.

Intermountain has been developing its system for clinical performance management for several decades. Virginia Mason has spent eight years revamping hundreds of clinical and supporting business processes and the places where this work is done. Beth Israel Deaconess began developing its nationally acclaimed IT system in the 1960s. And the never-ending breakthroughs in medical knowledge mean that the work at these institutions will never be completed. It is only through such hard work that we will be able to remove waste in health care—the unnecessary bureaucracy, the duplicative or unnecessary tests, the therapies of minimal value, the inappropriate use of expensive venues such as emergency rooms, and so on—which is estimated to account for as much as 50% of health care spending.

> **50%** The estimated amount of health care spending that goes toward unnecessary bureaucracy, duplicative tests, and other waste.

Admittedly, there are some formidable internal obstacles to progress. Redesign requires doctors to work across silos and as members of a team, and to appreciate the value of designing and implementing care processes while knowing when and how to deviate from them. This runs counter to the training and experience of many physicians, who have been rewarded for their individual skill and actions. Many administrators do not know enough about the details of medical care to work with physicians in developing protocols and learning systems. And people who were appointed to boards of directors because of their community standing or fund-raising abilities often don't have the capabilities needed to govern clinical operations.

Then there are the well-known external obstacles, such as ossified government bureaucracies and, in the United States, fee-for-service reimbursement, which reduces the revenue of institutions and individuals that make quality improvements. Intermountain, for example, estimates that the

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improved outcomes from its community-acquired-pneumonia protocol resulted in lost revenue of more than $1 million annually because patients ultimately needed fewer services or could be cared for in lower-margin settings.

But these obstacles do not mean that change is impossible. Confronted with the trade-off between improving patient outcomes and maximizing short-term revenues, many organizations routinely choose the former.

Often absent from the debate about how to increase access and contain costs is an appreciation of the root cause of the upheaval in health care: the explosion in medical knowledge and technology and the resulting dramatic improvement in the quality and quantity of life. In any industry in which tacit knowledge becomes explicit, new production systems, organizational forms, and roles must be developed. Health care is no different. Government policies can aid in the transition, but the clinicians and managers who labor in the organizations where patients receive their care must do the hard work of redesign. Health care reform is as much a management as a policy challenge.

A version of this article appeared in the April 2010 issue of *Harvard Business Review*.

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STRATEGY

The Strategy That Will Fix Health Care

by Michael E. Porter and Thomas H. Lee, MD

FROM THE OCTOBER 2013 ISSUE

In health care, the days of business as usual are over. Around the world, every health care system is struggling with rising costs and uneven quality despite the hard work of well-intentioned, well-trained clinicians. Health care leaders and policy makers have tried countless incremental fixes—attacking fraud, reducing errors, enforcing practice guidelines, making patients better "consumers," implementing electronic medical records—but none have had much impact.

It's time for a fundamentally new strategy.

At its core is maximizing value for patients: that is, achieving the best outcomes at the lowest cost. We must move away from a supply-driven health care system organized around what physicians do and toward a patient-centered system organized around what patients need. We must shift the focus from the volume and profitability of services provided—physician visits, hospitalizations, procedures, and tests—to the patient outcomes achieved. And we must replace today's fragmented system, in which every local provider offers a full range of services, with a system in which services for particular medical conditions are concentrated in health-delivery organizations and in the right locations to deliver high-value care.

Making this transformation is not a single step but an overarching strategy. We call it the "value agenda." It will require restructuring how health care delivery is organized, measured, and reimbursed. In 2006, Michael Porter and Elizabeth Teisberg introduced the value agenda in their

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book *Redefining Health Care*. Since then, through our research and the work of thousands of health care leaders and academic researchers around the world, the tools to implement the agenda have been developed, and their deployment by providers and other organizations is rapidly spreading.

The transformation to value-based health care is well under way. Some organizations are still at the stage of pilots and initiatives in individual practice areas. Other organizations, such as the Cleveland Clinic and Germany's Schön Klinik, have undertaken large-scale changes involving multiple components of the value agenda. The result has been striking improvements in outcomes and efficiency, and growth in market share.

There is no longer any doubt about how to increase the value of care. The question is, which organizations will lead the way and how quickly can others follow? The challenge of becoming a value-based organization should not be underestimated, given the entrenched interests and practices of many decades. This transformation must come from within. Only physicians and provider organizations can put in place the set of interdependent steps needed to improve value, because ultimately value is determined by how medicine is practiced. Yet every other stakeholder in the health care system has a role to play. Patients, health plans, employers, and suppliers can hasten the transformation—and all will benefit greatly from doing so.

Defining the Goal

The first step in solving any problem is to define the proper goal. Efforts to reform health care have been hobbled by lack of clarity about the goal, or even by the pursuit of the wrong goal. Narrow goals such as improving access to care, containing costs, and boosting profits have been a distraction. Access to poor care is not the objective, nor is reducing cost at the expense of quality. Increasing profits is today misaligned with the interests of patients, because profits depend on increasing the volume of services, not delivering good results.

In health care, the overarching goal for providers, as well as for every other stakeholder, must be improving value for patients, where value is defined as the health outcomes achieved that matter to patients relative to the cost of achieving those outcomes. Improving value requires either improving one or more outcomes without raising costs or lowering costs without compromising outcomes, or both. Failure to improve value means, well, failure.

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Embracing the goal of value at the senior management and board levels is essential, because the value agenda requires a fundamental departure from the past. While health care organizations have never been *against* improving outcomes, their central focus has been on growing volumes and maintaining margins. Despite noble mission statements, the real work of improving value is left undone. Legacy delivery approaches and payment structures, which have remained largely unchanged for decades, have reinforced the problem and produced a system with erratic quality and unsustainable costs.

All this is now changing. Facing severe pressure to contain costs, payors are aggressively reducing reimbursements and finally moving away from fee-for-service and toward performance-based reimbursement. In the U.S., an increasing percentage of patients are being covered by Medicare and Medicaid, which reimburse at a fraction of private-plan levels. These pressures are leading more independent hospitals to join health systems and more physicians to move out of private practice and become salaried employees of hospitals. (For more, see the sidebar "Why Change Now?") The transition will be neither linear nor swift, and we are entering a prolonged period during which providers will work under multiple payment models with varying exposure to risk.

Why Change Now?

Most hospitals and physician groups still have positive margins, but the pressure to consider a new strategic framework has increased dramatically.

Market forces are driving increasing numbers of hospital mergers and acquisitions, and the number of hospital beds has declined in the U.S. from 3 beds per 1,000 people in 1999 to 2.6 in 2010. Reimbursement rates are under pressure. Physician income has remained static over the past decade, and physicians know that simply working harder, faster, or longer can't compensate for their steadily increasing expenses. Meanwhile, national retailers like Walmart, CVS, and Walgreens are going after the primary care market on a large scale, by offering in-

In this environment, providers need a strategy that transcends traditional cost reduction and responds to new payment models. If providers can improve patient outcomes, they can sustain or grow their market share. If they can improve the efficiency of providing excellent care, they will enter any contracting discussion from a position of strength. Those providers that increase value will be the most competitive. Organizations that fail to improve value, no matter how prestigious and powerful they seem today, are likely to encounter growing pressure. Similarly, health insurers that are slow to embrace and support the value agenda—by failing, for example, to favor high-value providers—will lose subscribers to those that do.

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store clinics that provide basic services at prices as much as 40% below what physicians' offices charge.

These developments are not unique to the United States: A similar story is playing out in virtually every national health care system across the globe.

The economics of health care are changing, too. A provider's ability to increase fee-for-service revenue is threatened from every direction. U.S. government payors (Medicare and Medicaid) raise payment levels each year minimally, if at all. Yet most providers have been losing money on Medicare and Medicaid patients for a decade or more, and the magnitude of those losses only increases each year. Exacerbating the problem, the proportion of patients covered by government programs is growing: Medicaid will expand substantially in many states in 2014, as the Affordable Care Act is implemented, and the aging of the population will increase the percentage of Medicare patients for years beyond that. Reimbursement for these patients will continue to be pressured by tight federal and state government budgets. National Institutes of Health research cuts will make matters even worse for academic medical centers.

In the past, providers would cover losses from Medicare and Medicaid and from uninsured populations by demanding higher payment rates from commercial insurance plans—often winning increases of 8% to 10% per year. Those days are over. Employers are looking for decreases in their health care costs, and they're getting them by engaging in price negotiations, reducing benefits, raising deductibles, and expanding "narrowed

The Strategy for Value Transformation

The strategic agenda for moving to a high-value health care delivery system has six components. They are interdependent and mutually reinforcing; as we will see, progress will be easiest and fastest if they are advanced together. (See the exhibit "The Value Agenda.")

The Value Agenda

The strategic agenda for moving to a high-value health care delivery system has six components. They are interdependent and mutually reinforcing. Progress will be greatest if multiple components are advanced together.



The current structure of health care delivery has been sustained for decades because it has rested on its own set of mutually reinforcing elements: organization by specialty with independent

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network" products that direct patients to providers that accept lower rates or prove better outcomes. A program recently introduced by the California Public Employees' Retirement System (CalPERS) and Anthem Blue Cross, for example, requires many employees seeking a hip or knee replacement to use only hospitals that have agreed to a bundled fee for the procedure—or to pay the difference if they choose a higher-priced provider outside the network.

The intensifying pressure from employers and insurers for transparent pricing is already beginning to force providers to explain—or eliminate—hard-to-justify price variations. In our state, Massachusetts, the price for a brain MRI ranges from $625 to $1,650. And prices can vary by more than 50% for the same procedure in the same hospital, depending on the patient's insurer and the insurance product.

Patients will be asked to pay more and more. The percentage of the population in high-deductible health plans is now well into double digits, and it is rising. Many employees in these plans are increasingly unwilling or are simply unable to pay historical charges, and providers incur losses or bad publicity, or both, as they try to collect on the debts.

Provider organizations understand that, without a change in their model of doing business, they can only hope to be the last iceberg to melt. Facing lower payment rates and potential loss of market share if they charge higher prices, they have no choice but to improve value and be able to "prove it." As one senior executive recently told us, "We've been able to hide our prices for years inside insurance

private-practice physicians; measurement of "quality" defined as process compliance; cost accounting driven not by costs but by charges; fee-for-service payments by specialty with rampant cross-subsidies; delivery systems with duplicative service lines and little integration; fragmentation of patient populations such that most providers do not have critical masses of patients with a given medical condition; siloed IT systems around medical specialties; and others. This interlocking structure explains why the current system has been so resistant to change, why incremental steps have had little impact (see the sidebar "No Magic Bullets"), and why simultaneous progress on multiple components of the strategic agenda is so beneficial.

No Magic Bullets

The history of health care reform has featured a succession of narrow "solutions," many imposed on provider organizations by external stakeholders and introduced with great fanfare. For the most part, the solutions have focused on the levers that particular stakeholders can push and have been designed to preserve existing roles. None of them tackle the underlying strategic and structural problems that work against value for patients.

Individually and collectively, these "magic bullets" have inspired false hope and distracted attention from the real work at hand. Disappointment with their limited impact has created skepticism that value improvement in health care is possible

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products, but that's going to end as more and more people move into new, high-deductible products. We are going to have to be able to communicate exactly what we are giving patients, employers, and insurers for their money." He's right.

and has led many to conclude that the only solution to our financial challenges in health care is to ration services and shift costs to patients or taxpayers.

A realistic assessment of these piecemeal reforms reveals that none of them—or even all of them taken together—address the root causes of low value. While many of the steps are useful, there is no substitute for the strategic transformation the value agenda requires.

Regulation to combat physician fraud and self-dealing

Fraud and self-dealing occur, but enforcement here does not address the root causes of low-value health care. Regulations intended to reduce self-dealing can actually impede progress toward improving value, by inhibiting integrated care across specialties.

Consumer-driven health care

To date, incentives that encourage people to be better health care "consumers" have done little more than shift costs to patients. Also, consumer shopping can have only limited impact in a fragmented system where information about outcomes and price is lacking.

Evidence-based medicine (requiring providers to report compliance with guidelines)

Research-based practice guidelines are of course desirable, but compliance with them does not necessarily lead to improved outcomes or efficiency. Guidelines cover only a small slice of the overall care cycle and fail to reflect many individual patient circumstances. Rapid advances in medical knowledge constantly improve the state of the art, which means

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that providers are measured on compliance with guidelines that are often outdated.

New, more convenient models of primary care

New models of delivering routine primary care in lower-cost settings (such as retail clinics) have a role, but they will do little to address the bulk of health care costs, most of which are generated by care for more-complex diseases. Also, retail clinics and other adjuncts to primary care practices are not equipped to provide holistic and continuous care for healthy patients or acute and preventive care for patients with complex, chronic, or acute conditions.

Global capitation to control spending

Capitation—a payment model in which providers receive a flat fee for taking care of an individual enrolled in a health care plan, covering any and all needed services—provides a strong incentive to reduce spending but not necessarily to improve value. Patients and providers alike worry about the lack of alignment of a single global payment with patients' interests. This payment model also exposes providers to risks over which they have little control. Capitation motivates providers to offer every service line in an attempt to keep spending internal, instead of providing only services where they can offer excellent value.

Reduction of medical errors

Reducing errors is essential, but errors are just one of the outcomes that matter to patients. Reducing errors does not itself lead to a redesign of overall care that improves value.

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Care coordination, especially for expensive patients

If care coordinators are simply layered on top of a fragmented and dysfunctional delivery system, savings are modest (4% to 7% at best). When coordination takes place organically in IPUs, savings can reach 30% or more.

Electronic medical records (EMR)

Information technology is a powerful tool for enabling value-based care. But introducing EMR without restructuring care delivery, measurement, and payment yields limited benefits. And siloed IT systems make cost and outcomes measurement virtually impossible, greatly impeding value improvement efforts.

The components of the strategic agenda are not theoretical or radical. All are already being implemented to varying degrees in organizations ranging from leading academic medical centers to community safety-net hospitals. No organization, however, has yet put in place the full value agenda across its entire practice. Every organization has room for improvement in value for patients—and always will.

1: Organize into Integrated Practice Units (IPUs)

At the core of the value transformation is changing the way clinicians are organized to deliver care. The first principle in structuring any organization or business is to organize around the customer and the need. In health care, that requires a shift from today's siloed organization by specialty department and discrete service to organizing around the patient's medical condition. We call such a structure an integrated practice unit. In an IPU, a dedicated team made up of both clinical and nonclinical personnel provides the full care cycle for the patient's condition.

IPUs treat not only a disease but also the related conditions, complications, and circumstances that commonly occur along with it—such as kidney and eye disorders for patients with diabetes, or palliative care for those with metastatic cancer. IPUs not only provide treatment but also assume

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responsibility for engaging patients and their families in care—for instance, by providing education and counseling, encouraging adherence to treatment and prevention protocols, and supporting needed behavioral changes such as smoking cessation or weight loss.

In an IPU, personnel work together regularly as a team toward a common goal: maximizing the patient's overall outcomes as efficiently as possible. They are expert in the condition, know and trust one another, and coordinate easily to minimize wasted time and resources. They meet frequently, formally and informally, and review data on their own performance. Armed with those data, they work to improve care—by establishing new protocols and devising better or more efficient ways to engage patients, including group visits and virtual interactions. Ideally, IPU members are co-located, to facilitate communication, collaboration, and efficiency for patients, but they work as a team even if they're based at different locations. (See the sidebar "What Is an Integrated Practice Unit?")

What Is an Integrated Practice Unit?

1) An IPU is organized around a medical condition or a set of closely related conditions (or around defined patient segments for primary care).

2) Care is delivered by a dedicated, multidisciplinary team of clinicians who devote a significant portion of their time to the medical condition.

3) Providers see themselves as part of a common organizational unit.

4) The team takes responsibility for the full cycle of care for the condition, encompassing outpatient, inpatient, and rehabilitative care, and supporting services (such as nutrition, social work, and behavioral health).

5) Patient education, engagement, and follow-up are integrated into care.

Take, for example, care for patients with low back pain—one of the most common and expensive causes of disability. In the prevailing approach, patients receive portions of their care from a variety of types of clinicians, usually in several different locations, who function more like a spontaneously assembled "pickup team" than an integrated unit. One patient might begin care with a primary care physician, while others might start with an orthopedist, a neurologist, or a rheumatologist. What happens next is unpredictable. Patients might be referred to yet another physician or to a physical therapist. They might undergo radiology testing (this could happen at any point—even before seeing a physician). Each encounter is separate from the others, and no one coordinates the care. Duplication of effort, delays, and inefficiency is almost inevitable. Since no one measures patient

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6) The unit has a single administrative and scheduling structure.

7) To a large extent, care is co-located in dedicated facilities.

8) A physician team captain or a clinical care manager (or both) oversees each patient's care process.

9) The team measures outcomes, costs, and processes for each patient using a common measurement platform.

10) The providers on the team meet formally and informally on a regular basis to discuss patients, processes, and results.

11) Joint accountability is accepted for outcomes and costs.

outcomes, how long the process takes, or how much the care costs, the value of care never improves.

The impact on value of IPUs is striking. Compared with regional averages, patients at Virginia Mason's Spine Clinic miss fewer days of work (4.3 versus 9 per episode) and need fewer physical therapy visits (4.4 versus 8.8).

Contrast that with the approach taken by the IPU at Virginia Mason Medical Center, in Seattle. Patients with low back pain call one central phone number (206-41-SPINE), and most can be seen the same day. The "spine team" pairs a physical therapist with a physician who is board-certified in physical medicine and rehabilitation, and patients usually see both on their first visit. Those with serious causes of back pain (such as a malignancy or an infection) are quickly identified and enter a process designed to address the specific diagnosis. Other patients will require surgery and will enter a process for that. For most patients, however, physical therapy is the most effective next intervention, and their treatment often begins the same day.

Virginia Mason did not address the problem of chaotic care by hiring coordinators to help patients navigate the existing system—a "solution" that does not work. Rather, it eliminated the chaos by creating a new system in which caregivers work together in an integrated way. The impact on value has been striking. Compared with regional averages, patients at Virginia Mason's Spine Clinic miss fewer days of work (4.3 versus 9 per episode) and need fewer physical therapy visits (4.4 versus 8.8). In addition, the use of MRI scans to evaluate low back pain has decreased by 23% since the clinic's

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launch, in 2005, even as outcomes have improved. Better care has actually lowered costs, a point we will return to later. Virginia Mason has also increased revenue through increased productivity, rather than depending on more fee-for-service visits to drive revenue from unneeded or duplicative tests and care. The clinic sees about 2,300 new patients per year compared with 1,404 under the old system, and it does so in the same space and with the same number of staff members.

Wherever IPUs exist, we find similar results—faster treatment, better outcomes, lower costs, and, usually, improving market share in the condition. But those results can be achieved only through a restructuring of work. Simply co-locating staff in the same building, or putting up a sign announcing a Center of Excellence or an Institute, will have little impact.

IPUs emerged initially in the care for particular medical conditions, such as breast cancer and joint replacement. Today, condition-based IPUs are proliferating rapidly across many areas of acute and chronic care, from organ transplantation to shoulder care to mental health conditions such as eating disorders.

FURTHER READING

Turning Doctors into Leaders

LEADERSHIP FEATURE by Thomas H. Lee

Medicine is changing — and so must doctors. Here's how.

SAVE SHARE

Recently, we have applied the IPU model to primary care (see Michael E. Porter, Erika A. Pabo, and Thomas H. Lee, "Redesigning Primary Care," *Health Affairs,* March 2013). By its very nature, primary care is holistic, concerned with all the health circumstances and needs of a patient. Today's primary care practice applies a common organizational structure to the management of a very wide range of patients, from healthy adults to the frail elderly. The complexity of meeting their heterogeneous needs has made value improvement very difficult in primary care—for example, heterogeneous needs make outcomes measurement next to impossible.

In primary care, IPUs are multidisciplinary teams organized to serve groups of patients with similar primary and preventive care needs—for example, patients with complex chronic conditions such as diabetes, or disabled elderly patients. Different patient groups require different teams, different types of services, and even different locations of care. They also require services to address head-on the crucial role of lifestyle change and preventive care in outcomes and costs, and those services

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must be tailored to patients' overall circumstances. Within each patient group, the appropriate clinical team, preventive services, and education can be put in place to improve value, and results become measureable.

This approach is already starting to be applied to high-risk, high-cost patients through so-called Patient-Centered Medical Homes. But the opportunity to substantially enhance value in primary care is far broader. At Geisinger Health System, in Pennsylvania, for example, the care for patients with chronic conditions such as diabetes and heart disease involves not only physicians and other clinicians but also pharmacists, who have major responsibility for following and adjusting medications. The inclusion of pharmacists on teams has resulted in fewer strokes, amputations, emergency department visits, and hospitalizations, and in better performance on other outcomes that matter to patients.

2: Measure Outcomes and Costs for Every Patient

Rapid improvement in any field requires measuring results—a familiar principle in management. Teams improve and excel by tracking progress over time and comparing their performance to that of peers inside and outside their organization. Indeed, rigorous measurement of value (outcomes and costs) is perhaps the single most important step in improving health care. Wherever we see systematic measurement of results in health care—no matter what the country—we see those results improve.

Yet the reality is that the great majority of health care providers (and insurers) fail to track either outcomes or costs by medical condition for individual patients. For example, although many institutions have "back pain centers," few can tell you about their patients' outcomes (such as their time to return to work) or the actual resources used in treating those patients over the full care cycle. That surprising truth goes a long way toward explaining why decades of health care reform have not changed the trajectory of value in the system.

When outcomes measurement *is* done, it rarely goes beyond tracking a few areas, such as mortality and safety. Instead, "quality measurement" has gravitated to the most easily measured and least controversial indicators. Most "quality" metrics do not gauge quality; rather, they are process measures that capture compliance with practice guidelines. HEDIS (the Healthcare Effectiveness Data and Information Set) scores consist entirely of process measures as well as easy-to-measure

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clinical indicators that fall well short of actual outcomes. For diabetes, for example, providers measure the reliability of their LDL cholesterol checks and hemoglobin A1c levels, even though what really matters to patients is whether they are likely to lose their vision, need dialysis, have a heart attack or stroke, or undergo an amputation. Few health care organizations yet measure how their diabetic patients fare on all the outcomes that matter.

It is not surprising that the public remains indifferent to quality measures that may gauge a provider's reliability and reputation but say little about how its patients actually do. The only true measures of quality are the outcomes that matter to patients. And when those outcomes are collected and reported publicly, providers face tremendous pressure—and strong incentives—to improve and to adopt best practices, with resulting improvements in outcomes. Take, for example, the Fertility Clinic Success Rate and Certification Act of 1992, which mandated that all clinics performing assisted reproductive technology procedures, notably in vitro fertilization, provide their live birth rates and other metrics to the Centers for Disease Control. After the CDC began publicly reporting those data, in 1997, improvements in the field were rapidly adopted, and success rates for all clinics, large and small, have steadily improved. (See the exhibit "Outcomes Measurement and Reporting Drive Improvement.")

Outcomes Measurement and Reporting Drive Improvement

Since public reporting of clinic performance began, in 1997, in vitro fertilization success rates have climbed steadily across all clinics as process improvements have spread.



Measuring outcomes that matter to patients.

Outcomes should be measured by medical condition (such as diabetes), not by specialty (podiatry) or intervention (eye examination). Outcomes should cover the full cycle of care for the condition, and track the patient's health status after care is completed. The outcomes that matter to patients for a particular medical condition fall into three tiers. (For more, see Michael Porter's article "Measuring Health Outcomes: The Outcome Hierarchy," *New England Journal of Medicine,* December 2010.) Tier 1 involves the health status achieved. Patients care about mortality rates, of course, but they're also concerned about their functional status. In the case of prostate cancer treatment, for example, five-

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year survival rates are typically 90% or higher, so patients are more interested in their providers' performance on crucial functional outcomes, such as incontinence and sexual function, where variability among providers is much greater.

Outcomes That Matter to Patients: A Hierarchy

In measuring quality of care, providers tend to focus on only what they directly control or easily measured clinical indicators. However, measuring the full set of outcomes that matter to patients by condition is essential in meeting their needs. And when outcomes are measured comprehensively, results invariably improve.

Tier 1: Health status achieved or retained

Survival

Example: Hip Replacement

- Mortality rate (inpatient)

Degree of health or recovery

- Functional level achieved
- Pain level achieved
- Extent of return to physical activities
- Ability to return to work

Tier 2: Process of recovery

Time to recovery

- Time to begin treatment
- Time to return to physical activities

Tier 2 outcomes relate to the nature of the care cycle and recovery. For example, high readmission rates and frequent emergency-department "bounce backs" may not actually worsen long-term survival, but they are expensive and frustrating for both providers and patients. The level of discomfort during care and how long it takes to return to normal activities also matter greatly to patients. Significant delays before seeing a specialist for a potentially ominous complaint can cause unnecessary anxiety, while delays in commencing treatment prolong the return to normal life. Even when functional outcomes are equivalent, patients whose care process is timely and free of chaos, confusion, and unnecessary setbacks experience much better care than those who encounter delays and problems along the way.

Tier 3 outcomes relate to the sustainability of health. A hip replacement that lasts two years is inferior to one that lasts 15 years, from both the patient's perspective and the provider's.

Measuring the full set of outcomes that matter is indispensable to better meeting patients' needs. It is also one of the most powerful vehicles for lowering health care costs. If Tier 1 functional outcomes improve, costs invariably go down. If

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- Time to return to work

Disutility of care or treatment process (for instance, diagnostic errors, ineffective care, treatment-related discomfort, complications, adverse effects)

- Delays and anxiety
- Pain during treatment
- Length of hospital stay
- Infection
- Pulmonary embolism
- Deep-vein thrombosis
- Myocardial infarction
- Need for re-operation
- Delirium

Tier 3: Sustainability of health

Sustainability of health or recovery

Nature of recurrences

- Maintained functional level
- Ability to live independently
- Need for revision or replacement

Long-term consequences of therapy (for instance, care-induced illnesses)

any Tier 2 or 3 outcomes improve, costs invariably go down. A 2011 German study, for example, found that one-year follow-up costs after total hip replacement were 15% lower in hospitals with above-average outcomes than in hospitals with below-average outcomes, and 24% lower than in very-low-volume hospitals, where providers have relatively little experience with hip replacements. By failing to consistently measure the outcomes that matter, we lose perhaps our most powerful lever for cost reduction.

Over the past half dozen years, a growing array of providers have begun to embrace true outcome measurement. Many of the leaders have seen their reputations—and market share—improve as a result. A welcomed competition is emerging to be the most comprehensive and transparent provider in measuring outcomes.

FURTHER READING

How to Solve the Cost Crisis in Health Care

COSTS FEATURE by Robert S. Kaplan and Michael E. Porter

A new way to measure costs and compare them with outcomes.

SAVE SHARE

The Cleveland Clinic is one such pioneer, first publishing its mortality data on cardiac surgery and subsequently mandating outcomes measurement across the entire organization. Today, the Clinic publishes 14 different

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- Loss of mobility due to inadequate rehabilitation
- Risk of complex fracture
- Susceptibility to infection
- Stiff knee due to unrecognized complications
- Regional pain syndrome

SOURCE: "MEASURING HEALTH OUTCOMES," MICHAEL E. PORTER, NEW ENGLAND JOURNAL OF MEDICINE, DECEMBER 2010

"outcomes books" reporting performance in managing a growing number of conditions (cancer, neurological conditions, and cardiac diseases, for example). The range of outcomes measured remains limited, but the Clinic is expanding its efforts, and other organizations are following suit. At the individual IPU level, numerous providers are beginning efforts. At Dartmouth-Hitchcock's Spine Center, for instance, patient scores for pain, physical function, and disability for surgical and nonsurgical treatment at three, six, 12, and 24 months are now published for each type of low back disorder.

Providers are improving their understanding of what outcomes to measure and how to collect, analyze, and report outcomes data. For example, some of our colleagues at Partners HealthCare in Boston are testing innovative technologies such as tablet computers, web portals, and telephonic interactive systems for collecting outcomes data from patients after cardiac surgery or as they live with chronic conditions such as diabetes. Outcomes are also starting to be incorporated in real time into the process of care, allowing providers to track progress as they interact with patients.

To accelerate comprehensive and standardized outcome measurement on a global basis, we recently cofounded the International Consortium for Health Outcomes Measurement. ICHOM develops minimum outcome sets by medical condition, drawing on international registries and provider best practices. It brings together clinical leaders from around the world to develop standard outcome sets, while also gathering and disseminating best practices in outcomes data collection, verification, and reporting. Just as railroads converged on standard track widths and the telecommunications industry on standards to allow data exchange, health care providers globally should consistently measure outcomes by condition to enable universal comparison and stimulate rapid improvement.

Measuring the cost of care.

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For a field in which high cost is an overarching problem, the absence of accurate cost information in health care is nothing short of astounding. Few clinicians have any knowledge of what each component of care costs, much less how costs relate to the outcomes achieved. In most health care organizations there is virtually no accurate information on the cost of the full cycle of care for a patient with a particular medical condition. Instead, most hospital cost-accounting systems are department-based, not patient-based, and designed for billing of transactions reimbursed under fee-for-service contracts. In a world where fees just keep going up, that makes sense. Existing systems are also fine for overall department budgeting, but they provide only crude and misleading estimates of actual costs of service for individual patients and conditions. For example, cost allocations are often based on charges, not actual costs. As health care providers come under increasing pressure to lower costs and report outcomes, the existing systems are wholly inadequate.

Existing costing systems are fine for overall department budgeting, but they provide only crude and misleading estimates of actual costs of service for individual patients and conditions.

To determine value, providers must measure costs at the medical condition level, tracking the expenses involved in treating the condition over the full cycle of care. This requires understanding the resources used in a patient's care, including personnel, equipment, and facilities; the capacity cost of supplying each resource; and the support costs associated with care, such as IT and administration. Then the cost of caring for a condition can be compared with the outcomes achieved.

The best method for understanding these costs is time-driven activity-based costing, TDABC. While rarely used in health care to date, it is beginning to spread. Where TDABC is being applied, it is helping providers find numerous ways to substantially reduce costs without negatively affecting outcomes (and sometimes even improving them). Providers are achieving savings of 25% or more by tapping opportunities such as better capacity utilization, more-standardized processes, better matching of personnel skills to tasks, locating care in the most cost-effective type of facility, and many others.

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For example, Virginia Mason found that it costs $4 per minute for an orthopedic surgeon or other procedural specialist to perform a service, $2 for a general internist, and $1 or less for a nurse practitioner or physical therapist. In light of those cost differences, focusing the time of the most expensive staff members on work that utilizes their full skill set is hugely important. (For more, see Robert Kaplan and Michael Porter's article "How to Solve the Cost Crisis in Health Care," HBR September 2011.)

Without understanding the true costs of care for patient conditions, much less how costs are related to outcomes, health care organizations are flying blind in deciding how to improve processes and redesign care. Clinicians and administrators battle over arbitrary cuts, rather than working together to improve the value of care. Because proper cost data are so critical to overcoming the many barriers associated with legacy processes and systems, we often tell skeptical clinical leaders: "Cost accounting is your friend." Understanding true costs will finally allow clinicians to work with administrators to improve the value of care—the fundamental goal of health care organizations.

3: Move to Bundled Payments for Care Cycles

Neither of the dominant payment models in health care—global capitation and fee-for-service—directly rewards improving the value of care. Global capitation, a single payment to cover all of a patient's needs, rewards providers for spending less but not specifically for improving outcomes or value. It also decouples payment from what providers can directly control. Fee-for-service couples payment to something providers can control—how many of their services, such as MRI scans, they provide—but not to the overall cost or the outcomes. Providers are rewarded for increasing volume, but that does not necessarily increase value.

The payment approach best aligned with value is a bundled payment that covers the full care cycle for acute medical conditions, the overall care for chronic conditions for a defined period (usually a year), or primary and preventive care for a defined patient population (healthy children, for instance). Well-designed bundled payments directly encourage teamwork and high-value care. Payment is tied to overall care for a patient with a particular medical condition, aligning payment with what the team can control. Providers benefit from improving efficiency while maintaining or improving outcomes.

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Sound bundled payment models should include: severity adjustments or eligibility only for qualifying patients; care guarantees that hold the provider responsible for avoidable complications, such as infections after surgery; stop-loss provisions that mitigate the risk of unusually high-cost events; and mandatory outcomes reporting.

Governments, insurers, and health systems in multiple countries are moving to adopt bundled payment approaches. For example, the Stockholm County Council initiated such a program in 2009 for all total hip and knee replacements for relatively healthy patients. The result was lower costs, higher patient satisfaction, and improvement in some outcomes. In Germany, bundled payments for hospital inpatient care—combining all physician fees and other costs, unlike payment models in the U.S.—have helped keep the average payment for a hospitalization below $5,000 (compared with more than $19,000 in the U.S., even though hospital stays are, on average, 50% longer in Germany). Among the features of the German system are care guarantees under which the hospital bears responsibility for the cost of rehospitalization related to the original care.

In the U.S., bundled payments have become the norm for organ transplant care. Here, mandatory outcomes reporting has combined with bundles to reinforce team care, speed diffusion of innovation, and rapidly improve outcomes. Providers that adopted bundle approaches early benefitted. UCLA's kidney transplant program, for example, has grown dramatically since pioneering a bundled price arrangement with Kaiser Permanente, in 1986, and offering the payment approach to all its payors shortly thereafter. Its outcomes are among the best nationally, and UCLA's market share in organ transplantation has expanded substantially.

Employers are also embracing bundled payments. This year, Walmart introduced a program in which it encourages employees who need cardiac, spine, and selected other surgery to obtain care at one of just six providers nationally, all of which have high volume and track records of excellent outcomes: the Cleveland Clinic, Geisinger, the Mayo Clinic, Mercy Hospital (in Springfield, Missouri), Scott & White, and Virginia Mason. The hospitals are reimbursed for the care with a single bundled payment that includes all physician and hospital costs associated with both inpatient and outpatient pre- and post-operative care. Employees bear no out-of-pocket costs for their care—travel, lodging, and meals for the patient and a caregiver are provided—as long as the surgery is performed at one of the centers of excellence. The program is in its infancy, but expectations are that Walmart and other large employers will expand such programs to improve value for their

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employees, and will step up the incentives for employees to use them. Sophisticated employers have learned that they must move beyond cost containment and health promotion measures, such as co-pays and on-site health and wellness facilities, and become a greater force in rewarding high-value providers with more patients.

As bundled payment models proliferate, the way in which care is delivered will be transformed. Consider how providers participating in Walmart's program are changing the way they provide care. As clinical leaders map the processes involved in caring for patients who live outside their immediate area, they are learning how to better coordinate care with all of patients' local physicians. They're also questioning existing practices. For example, many hospitals routinely have patients return to see the cardiac surgeon six to eight weeks after surgery, but out-of-town visits seem difficult to justify for patients with no obvious complications. In deciding to drop those visits, clinicians realized that maybe local patients do not need routine postoperative visits either.

Providers remain nervous about bundled payments, citing concerns that patient heterogeneity might not be fully reflected in reimbursements, and that the lack of accurate cost data at the condition level could create financial exposure. Those concerns are legitimate, but they are present in any reimbursement model. We believe that concerns will fall away over time, as sophistication grows and the evidence mounts that embracing payments aligned with delivering value is in providers' economic interest. Providers will adopt bundles as a tool to grow volume and improve value.

4: Integrate Care Delivery Systems

A large and growing proportion of health care is provided by multisite health care delivery organizations. In 2011, 60% of all U.S. hospitals were part of such systems, up from 51% in 1999. Multisite health organizations accounted for 69% of total admissions in 2011. Those proportions are even higher today. Unfortunately, most multisite organizations are not true delivery systems, at least thus far, but loose confederations of largely stand-alone units that often duplicate services. There are huge opportunities for improving value as providers integrate systems to eliminate the fragmentation and duplication of care and to optimize the types of care delivered in each location.

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To achieve true system integration, organizations must grapple with four related sets of choices: defining the scope of services, concentrating volume in fewer locations, choosing the right location for each service line, and integrating care for patients across locations. The politics of redistributing care remain daunting, given most providers' instinct to preserve the status quo and protect their turf. Some acid-test questions to gauge board members' and health system leaders' appetite for transformation include: Are you ready to give up service lines to improve the value of care for patients? Is relocating service lines on the table?

Define the scope of services.

A starting point for system integration is determining the overall scope of services a provider can effectively deliver—and reducing or eliminating service lines where they cannot realistically achieve high value. For community providers, this may mean exiting or establishing partnerships in complex service lines, such as cardiac surgery or care for rare cancers. For academic medical centers, which have more heavily resourced facilities and staff, this may mean minimizing routine service lines and creating partnerships or affiliations with lower-cost community providers in those fields. Although limiting the range of service lines offered has traditionally been an unnatural act in health care—where organizations strive to do everything for everyone—the move to a value-based delivery system will require those kinds of choices.

Concentrate volume in fewer locations.

Second, providers should concentrate the care for each of the conditions they do treat in fewer locations. The stated promise of consumer-oriented health care—"We do everything you need close to your home or workplace"—has been a good marketing pitch but a poor strategy for creating value. Concentrating volume is essential if integrated practice units are to form and measurement is to improve.

Numerous studies confirm that volume in a particular medical condition matters for value. Providers with significant experience in treating a given condition have better outcomes, and costs improve as well. A recent study of the relationship between hospital volume and operative mortality for high-risk types of cancer surgery, for example, found that as hospital volumes rose, the chances of a patient's dying as a result of the surgery fell by as much as 67%. Patients, then, are often much better off traveling longer distance to obtain care at locations where there are teams with deep experience in their condition. That often means driving past the closest hospitals.

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Organizations that progress rapidly in adopting the value agenda will reap huge benefits, even if regulatory change is slow.

Concentrating volume is among the most difficult steps for many organizations, because it can threaten both prestige and physician turf. Yet the benefits of concentration can be game-changing. In 2009, the city of London set out to improve survival and prospects for stroke patients by ensuring that patients were cared for by true IPUs—dedicated, state-of-the-art teams and facilities including neurologists who were expert in the care of stroke. These were called hyper-acute stroke units, or HASUs. At the time, there were too many hospitals providing acute stroke care in London (32 of them) to allow any to amass a high volume. UCL Partners, a delivery system comprising six well-known teaching hospitals that serve North Central London, had two hospitals providing stroke care —University College London Hospital and the Royal Free Hospital—located less than three miles apart. University College was selected to house the new stroke unit. Neurologists at Royal Free began practicing at University College, and a Royal Free neurologist was appointed as the overall leader of the stroke program. UCL Partners later moved all emergency vascular surgery and complex aortic surgery to Royal Free.

These steps sent a strong message that UCL Partners was ready to concentrate volume to improve value. The number of stroke cases treated at University College climbed from about 200 in 2008 to more than 1,400 in 2011. All stroke patients can now undergo rapid evaluation by highly experienced neurologists and begin their recovery under the care of nurses who are expert in preventing stroke-related complications. Since the shift, mortality associated with strokes at University College has fallen by about 25% and costs per patient have dropped by 6%.

Choose the right location for each service.

The third component of system integration is delivering particular services at the locations at which value is highest. Less complex conditions and routine services should be moved out of teaching hospitals into lower-cost facilities, with charges set accordingly. There are huge value improvement opportunities in matching the complexity and skills needed with the resource intensity of the location, which will not only optimize cost but also increase staff utilization and productivity. Children's Hospital of Philadelphia, for instance, decided to stop performing routine tympanostomies (placing tubes into children's eardrums to reduce fluid collection and risk of

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infection) at its main facility and shifted those services to suburban ambulatory surgery facilities. More recently, the hospital applied the same approach to simple hypospadias repairs, a urological procedure. Relocating such services cut costs and freed up operating rooms and staff at the teaching hospital for more-complex procedures. Management estimated the total cost reduction resulting from the shift at 30% to 40%.

In many cases, current reimbursement schemes still reward providers for performing services in a hospital setting, offering even higher payments if the hospital is an academic medical center—another example of how existing reimbursement models have worked against value. But the days of charging higher fees for routine services in high-cost settings are quickly coming to an end. (See again the sidebar "Why Change Now?")

Integrate care across locations.

The final component of health system integration is to integrate care for individual patients across locations. As providers distribute services in the care cycle across locations, they must learn to tie together the patient's care across these sites. Care should be directed by IPUs, but recurring services need not take place in a single location. For example, patients with low back pain may receive an initial evaluation, and surgery if needed, from a centrally located spine IPU team but may continue physical therapy closer to home. Wherever the services are performed, however, the IPU manages the full care cycle. Integrating mechanisms, such as assigning a single physician team captain for each patient and adopting common scheduling and other protocols, help ensure that well-coordinated, multidisciplinary care is delivered in a cost-effective and convenient way.

5: Expand Geographic Reach

Health care delivery remains heavily local, and even academic medical centers primarily serve their immediate geographic areas. If value is to be substantially increased on a large scale, however, superior providers for particular medical conditions need to serve far more patients and extend their reach through the strategic expansion of excellent IPUs. Buying full-service hospitals or practices in new geographic areas is rarely the answer. Geographic expansion should focus on improving value, not just increasing volume.

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Targeted geographic expansion by leading providers is rapidly increasing, with dozens of organizations such as Vanderbilt, Texas Children's, Children's Hospital of Philadelphia, MD Anderson Cancer Center, and many others taking bold steps to serve patients over a wide geographic area.

Geographic expansion takes two principle forms. The first is a hub-and-spoke model. For each IPU, satellite facilities are established and staffed at least partly by clinicians and other personnel employed by the parent organization. In the most effective models, some clinicians rotate among locations, which helps staff members across all facilities feel they are part of the team. As expansion moves to an entirely new region, a new IPU hub is built or acquired.

Patients often get their initial evaluation and development of a treatment plan at the hub, but some or much care takes place at more-convenient (and cost-effective) locations. Satellites deliver less complicated care, with complex cases referred to the hub. If complications occur whose effective management is beyond the ability of the satellite facility, the patient's care is transferred to the hub. The net result is a substantial increase in the number of patients an excellent IPU can serve.

This model is becoming more common among leading cancer centers. MD Anderson, for example, has four satellite sites in the greater Houston region where patients receive chemotherapy, radiation therapy, and, more recently, low-complexity surgery, under the supervision of a hub IPU. The cost of care at the regional facilities is estimated to be about one-third less than comparable care at the main facility. By 2012, 22% of radiation treatment and 15% of all chemotherapy treatment were performed at regional sites, along with about 5% of surgery. Senior management estimates that 50% of comparable care currently still performed at the hub could move to satellite sites—a significant untapped value opportunity.

The second emerging geographic expansion model is clinical affiliation, in which an IPU partners with community providers or other local organizations, using their facilities rather than adding capacity. The IPU provides management oversight for clinical care, and some clinical staff members working at the affiliate may be employed by the parent IPU. MD Anderson uses this approach in its partnership with Banner Phoenix. Hybrid models include the approach taken by MD Anderson in its

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regional satellite program, which leases outpatient facilities located on community hospital campuses and utilizes those hospitals' operating rooms and other inpatient and ancillary services as needed.

Local affiliates benefit from the expertise, experience, and reputation of the parent IPU—benefits that often improve their market share locally. The IPU broadens its regional reach and brand, and benefits from management fees, shared revenue or joint venture income, and referrals of complex cases.

The Cleveland Clinic's Heart and Vascular Institute, a pioneering IPU in cardiac and vascular care, has 19 hospital affiliates spanning the Eastern seaboard. Successful clinical affiliations such as these are robust—not simply storefronts with new signage and marketing campaigns—and involve close oversight by physician and nurse leaders from the parent organization as well as strict adherence to its practice models and measurement systems. Over time, outcomes for standard cases at the Clinic's affiliates have risen to approach its own outcomes.

Vanderbilt's rapidly expanding affiliate network illustrates the numerous opportunities that arise from affiliations that recognize each partner's areas of strength. For example, Vanderbilt has encouraged affiliates to grow noncomplex obstetrics services that once might have taken place at the academic medical center, while affiliates have joint ventured with Vanderbilt in providing care for some complex conditions in their territories.

6: Build an Enabling Information Technology Platform

The preceding five components of the value agenda are powerfully enabled by a sixth: a supporting information technology platform. Historically, health care IT systems have been siloed by department, location, type of service, and type of data (for instance, images). Often IT systems complicate rather than support integrated, multidisciplinary care. That's because IT is just a tool; automating broken service-delivery processes only gets you more-efficient broken processes. But the right kind of IT system can help the parts of an IPU work with one another, enable measurement and new reimbursement approaches, and tie the parts of a well-structured delivery system together.

A value-enhancing IT platform has six essential elements:

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It is centered on patients.

The system follows patients across services, sites, and time for the full cycle of care, including hospitalization, outpatient visits, testing, physical therapy, and other interventions. Data are aggregated around patients, not departments, units, or locations.

It uses common data definitions.

Terminology and data fields related to diagnoses, lab values, treatments, and other aspects of care are standardized so that everyone is speaking the same language, enabling data to be understood, exchanged, and queried across the whole system.

It encompasses all types of patient data.

Physician notes, images, chemotherapy orders, lab tests, and other data are stored in a single place so that everyone participating in a patient's care has a comprehensive view.

The medical record is accessible to all parties involved in care.

That includes referring physicians and patients themselves. A simple "stress test" question to gauge the accessibility of the data in an IT system is: Can visiting nurses see physicians' notes, and vice versa? The answer today at almost all delivery systems is "no." As different types of clinicians become true team members—working together in IPUs, for example—sharing information needs to become routine. The right kind of medical record also should mean that patients have to provide only one set of patient information, and that they have a centralized way to schedule appointments, refill prescriptions, and communicate with clinicians. And it should make it easy to survey patients about certain types of information relevant to their care, such as their functional status and their pain levels.

The system includes templates and expert systems for each medical condition.

Templates make it easier and more efficient for the IPU teams to enter and find data, execute procedures, use standard order sets, and measure outcomes and costs. Expert systems help clinicians identify needed steps (for example, follow-up for an abnormal test) and possible risks (drug interactions that may be overlooked if data are simply recorded in free text, for example).

The system architecture makes it easy to extract information.

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In value-enhancing systems, the data needed to measure outcomes, track patient-centered costs, and control for patient risk factors can be readily extracted using natural language processing. Such systems also give patients the ability to report outcomes on their care, not only after their care is completed but also during care, to enable better clinical decisions. Even in today's most advanced systems, the critical capability to create and extract such data remains poorly developed. As a result, the cost of measuring outcomes and costs is unnecessarily increased.

The Cleveland Clinic is a provider that has made its electronic record an important enabler of its strategy to put "Patients First" by pursuing virtually all these aims. It is now moving toward giving patients full access to clinician notes—another way to improve care for patients.

Getting Started

The six components of the value agenda are distinct but mutually reinforcing. Organizing into IPUs makes proper measurement of outcomes and costs easier. Better measurement of outcomes and costs makes bundled payments easier to set and agree upon. A common IT platform enables effective collaboration and coordination within IPU teams, while also making the extraction, comparison, and reporting of outcomes and cost data easier. With bundled prices in place, IPUs have stronger incentives to work as teams and to improve the value of care. And so on.

Implementing the value agenda is not a one-shot effort; it is an open-ended commitment. It is a journey that providers embark on, starting with the adoption of the goal of value, a culture of patients first, and the expectation of constant, measurable improvement. The journey requires strong leadership as well as a commitment to roll out all six value agenda components. For most providers, creating IPUs and measuring outcomes and costs should take the lead.

As should by now be clear, organizations that progress rapidly in adopting the value agenda will reap huge benefits, even if regulatory change is slow. As IPUs' outcomes improve, so will their reputations and, therefore, their patient volumes. With the tools to manage and reduce costs, providers will be able to maintain economic viability even as reimbursements plateau and eventually decline. Providers that concentrate volume will drive a virtuous cycle, in which teams with more experience and better data improve value more rapidly—attracting still more volume. Superior IPUs will be sought out as partners of choice, enabling them to expand across their local regions and beyond.

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Maintaining market share will be difficult for providers with nonemployed physicians if their inability to work together impedes progress in improving value. Hospitals with private-practice physicians will have to learn to function as a team to remain viable. Measuring outcomes is likely to be the first step in focusing everyone's attention on what matters most.All stakeholders in health care have essential roles to play. (See the sidebar "Next Steps: Other Stakeholder Roles.") Yet providers must take center stage. Their boards and senior leadership teams must have the vision and the courage to commit to the value agenda, and the discipline to progress through the inevitable resistance and disruptions that will result. Clinicians must prioritize patients' needs and patient value over the desire to maintain their traditional autonomy and practice patterns.

Next Steps: Other Stakeholder Roles

The transformation to a high-value health care delivery system must come from within, with physicians and provider organizations taking the lead. But every stakeholder in the health care system has a role to play in improving the value of care. Patients, health plans, employers, and suppliers can hasten the transformation by taking the following steps—and all will benefit greatly from doing so.

Providers that cling to today's broken system will become dinosaurs. Reputations that are based on perception, not actual outcomes, will fade. Maintaining current cost structures and prices in the face of greater transparency and falling reimbursement levels will be untenable. Those organizations—large and small, community and academic—that can master the value agenda will be rewarded with financial viability and the only kind of reputation that should matter in health care—excellence in outcomes and pride in the value they deliver.

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STRATEGIC AGENDA	BOARD MEMBERS	PATIENTS	HEALTH PLANS AND EMPLOYERS
Organize into integrated practice units	Lead the reorganization of care away from departments and toward IPUs	Seek care only from experienced, multidisciplinary teams that provide integrated care for your condition	Offer strong incentives and information to enable patients to seek care from high-value IPUs for their condition
Measure outcomes and costs for every patient	• Commit to comprehensive measurement and reporting of outcomes as a basic strategy • Ensure that the organization adopts costing practices that accurately measure costs by patient condition	• Expect data on the full set of outcomes that matter • Seek care from organizations with demonstrated high-value care • Participate in patient-reported outcomes measurement	• Require measurement and reporting of outcomes as a condition of network membership • Make sure that understandable outcomes information by condition is easily accessible to patients and their families
Develop bundled prices for care cycles	Charge management with leading the development of bundled payments for common conditions and working proactively with payors to roll them out	Pursue care from providers that offer bundled payments and who offer good value compared with those of peers	• Accelerate the shift to bundled payments for medical conditions and primary care • Redesign billing systems to enable bundles
Integrate care delivery systems	Make an organizational commitment to full health system integration through consolidating service lines, siting care in the most cost-effective locations, and charging according to value	• Obtain care at the appropriate site within your health system • Expect care that is coordinated across sites with a clear leader	Reimburse for care on the basis of the type of facility that is appropriate for the condition and complexity of services, irrespective of where care is actually delivered
Grow excellent services across geography	Expand areas of excellence across geography through satellite facilities or affiliations	Seek care for complex conditions from the highest-value provider, even if the provider or care site is not local	• Focus networks on high-value providers for each condition regionally and nationally • Guide patients toward high-value providers and reward them for using those providers, reimbursing for travel where appropriate
Build an enabling information technology platform	Make a long-term investment in an IT platform that supports high-value, patient-centric care	Expect providers to have a single repository of your patient information and to offer you full access to your electronic medical record, tools for easy scheduling and prescription renewal, and the ability to communicate with clinicians	Offer incentives and support for providers to develop value- and patient-centric IT systems



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Gladys Raymond 15 days ago

Gladys Raymond, is my name an from Dallas Texas, United State of America. Herpes Virus an Diabetes is a terrible virus, Thanks to my Husband an Dr Ererdiawa. If not for my Husband and the help of the great Dr Erediawa my life would have been a mess! I was diagnose with Herpes virus an Diabetes in 2012, my husband encouraged me, and told me not to lose hope an Faith, I manage to give birth to a baby Boy Junior Raymond in 2014,who was free from this virus, and my Husband was always there for me! On 17th of March 2016, my Husband told me that he have found a man who can cure me. Base on scientist, they said there is no cure for Herpes an Diabetes virus; he told me that he has seen many testimonies about him (Dr Erediawa) on the internet. i thought of it an i told my Husband that i am not comfort with this ideal an beside there are many scam out there, but my Husband make me to understand that life is all about Risk, then we decided to contact him, we filled his Herbal home form, and he asked us to buy some local root and herbs items which we did! and he prepared for me a herbal medicine and sent it down to me an he gave me instruction on how to take the Herbal medicine which i did as he has instructed, he ask me to take it for 42 days, an said in the next one week, that is when i must have completed taken the Herbal medicine, i should go for test which i did, faithfully hopefully i went for the medical test, and Behold, I was cured, from this virus and its was not found in my Body system again... My Dear Husband and my Father Dr. Erediawa, God will surely bless the both of you, till the end of time Amen... i can really Believe today i am Herpes an Diabetes free, If you have any this problem kindly contact Dr Erediawa on is email: drerediawaherbs@gmail.com or call him on his mobile WhatsApp number +2348159412586

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Report to Congressional Requesters

September 2016

VA HEALTH CARE

Processes to Evaluate, Implement, and Monitor Organizational Structure Changes Needed

GAO-16-803

AMERICAN OVERSIGHT

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September 2016

VA HEALTH CARE

Processes to Evaluate, Implement, and Monitor Organizational Structure Changes Needed

GAO Highlights

Highlights of GAO-16-803, a report to congressional requesters

Why GAO Did This Study

GAO and others have expressed concerns about VHA's management of its health care system. In response, VA initiated a new regional framework to improve internal coordination and customer service, and VHA initiated an effort to realign its VISNs.

GAO was asked to review VHA's organizational structure—the operating units, processes, and other components used to achieve agency objectives. This report examines the extent to which (1) VHA has a process for evaluating recommended organizational structure changes to determine actions needed and implementing them as appropriate; and (2) VHA monitored and provided guidance for implementing the VISN realignment. GAO reviewed VHA documents, reviewed internal and external assessments of VHA, and interviewed officials from VHA central office and all VISNs. GAO evaluated VHA's actions against relevant federal standards for internal control.

What GAO Recommends

GAO recommends that VHA (1) develop a process to ensure that organizational structure recommendations are evaluated for implementation; and (2) evaluate the implementation of the VISN realignment to determine and correct deficiencies, and apply lessons learned to future organizational structure changes, such as possible changes to VISN staffing models. VA concurred with GAO's recommendations.

View GAO-16-803. For more information, contact Debra Draper at (202) 512-7114 or draperd@gao.gov.

What GAO Found

Recent internal and external reviews of Veterans Health Administration (VHA) operations have identified deficiencies in its organizational structure and recommended changes that would require significant restructuring to address, including eliminating and consolidating program offices and reducing VHA central office staff. However, VHA does not have a process that ensures recommended organizational structure changes are evaluated to determine appropriate actions and implemented. This is inconsistent with federal standards for internal control for monitoring, which state that management should remediate identified internal control deficiencies on a timely basis. GAO found instances where VHA actions in response to recent recommendations for organizational structure changes were incomplete, not documented, or not timely. For example, VHA chartered a task force to develop a detailed plan to implement selected recommendations from the independent assessment of VHA's operations required by the Veterans Access, Choice, and Accountability Act of 2014; according to VHA, the assessment cost $68 million. It found, among other things, that VHA central office programs and staff had increased dramatically in recent years, resulting in a fragmented and "silo-ed" organization without any discernible improvement in business or health outcomes. It recommended restructuring and downsizing VHA's central office. The task force of 18 senior Department of Veterans Affairs (VA) and VHA officials conducted work over about 6 months, but did not produce a documented implementation plan or initiate implementation of recommendations. Without a process that documents the assessment, approval, and implementation of organizational structure changes, VHA cannot ensure that it is making appropriate changes, using resources efficiently, holding officials accountable for taking action, and maintaining documentation of decisions made.

VHA central office's monitoring of the Veterans Integrated Service Networks (VISN) realignment—a recent and significant organizational structure change—has been limited, and the office has provided little implementation guidance. In October 2015, VHA began to implement a realignment of its VISN boundaries, which involves decreasing the number of VISNs from 21 to 18 and reassigning some VA medical centers (VAMC) to different VISNs. VHA officials anticipate this process will be completed by the end of fiscal year 2018. VHA officials on the task force implementing the realignment told GAO they thought VISNs could implement the realignment independently without the need for close monitoring. VHA also did not provide guidance to address VISN and VAMC challenges that could have been anticipated, including challenges with services and budgets, double-encumbered positions (two officials in the same position in merging VISNs), and information technology. Further, VHA officials said they do not have plans to evaluate the realignment. VHA's actions are inconsistent with federal internal control standards for monitoring (management should establish monitoring activities, evaluate results, and remediate identified deficiencies) and risk assessment (management should identify, analyze, and respond to changes that could affect the system). Without adequate monitoring, including a plan for evaluating the VISN realignment, VHA cannot be certain that the changes being made are effectively addressing deficiencies; nor can it ensure lessons learned can be applied to future organizational structure changes.

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Abbreviations

ADUSH	Assistant Deputy Under Secretary for Health
Choice Act	Veterans Access, Choice, and Accountability Act of 2014
DUSH	Deputy Under Secretary for Health
governance task force	Task Force on Improving Effectiveness of VHA Governance
Independent Assessment	*Independent Assessment of the Health Care Delivery Systems and Assessment Management Processes of the Department of Veterans Affairs*
VA	Department of Veterans Affairs
VAMC	VA medical center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

September 27, 2016

The Honorable Jeff Miller
Chairman
The Honorable Mark Takano
Acting Ranking Member
Committee on Veterans' Affairs
House of Representatives

The Honorable Corrine Brown
House of Representatives

The Honorable Derek Kilmer
House of Representatives

The Veterans Health Administration (VHA), within the Department of Veterans Affairs (VA), operates one of the nation's largest health care systems, with 168 VA medical centers (VAMC), more than 1,000 outpatient facilities, and a total health care budget of nearly $51 billion in fiscal year 2015.[1] VHA provided care to about 6.7 million veterans in fiscal year 2015 and the demand for its services is expected to grow in the coming years.

VHA's organizational structure—the operating units, processes, and other components used to achieve agency objectives—is governed by its senior leadership. This leadership team, which is led by the Under Secretary for Health, manages more than 40 clinical programs and administrative offices, including those that allow veterans to obtain care from a network of non-VA providers. It also oversees VHA's field operations, comprised of Veterans Integrated Service Networks (VISN) that manage networks of VAMCs and outpatient facilities.

[1]Outpatient facilities include community-based outpatient clinics and health care centers. Community-based outpatient clinics are located in areas surrounding VAMCs and provide primary care and some specialty care services that do not require a hospital stay. Health care centers are large multi-specialty outpatient clinics that provide surgical services in addition to other health care services.

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We and others have expressed significant concerns about VHA's management of its health care system, including VHA's ability to effectively provide and oversee timely access to health care for veterans.[2] In addition, in 2014, a series of events called into question the ability of veterans to gain timely access to care from VHA medical facilities.[3] As a result of these and other systemic problems, we concluded that VA health care is a high-risk area and added it to our High Risk List in 2015.[4]

In response to criticism that VHA was not succeeding in providing timely health care services to veterans, VA announced a major organizational initiative in September 2014 called MyVA. As part of this initiative, the department established a single regional framework for its three administrations—VHA, the Veterans Benefits Administration, and the National Cemetery Administration—dividing the United States into five regions based on state boundaries.[5] According to VA, this regional

[2]See, for example, GAO, *VA Health Care: Actions Needed to Improve Newly Enrolled Veterans' Access to Primary Care*, GAO-16-328 (Washington, D.C.: Mar. 18, 2016) and GAO, *VA Mental Health: Clearer Guidance on Access Policies and Wait-Time Data Needed*, GAO-16-24 (Washington, D.C.: Oct. 28, 2015). See also, for example, Department of Veterans Affairs, Office of Inspector General, *Veterans Health Administration, Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System*, Report No. 14-02603-267 (Washington, D.C.: Aug. 26, 2014) and VA, *Department of Veterans Affairs Access Audit, System-Wide Review of Access, Results of Access Audit Conducted May 12, 2014, through June 3, 2014*.

[3]Reviews by GAO, the VA Office of Inspector General, and others substantiated allegations of extended wait times for veteran appointments at VHA medical facilities. We found that VHA employees responsible for scheduling appointments at certain facilities engaged in inappropriate practices to make wait times appear more favorable.

[4]GAO, *High-Risk Series: An Update*, GAO-15-290 (Washington, D.C.: February 2015). GAO maintains a high-risk program to focus attention on government operations that it identifies as high risk due to their greater vulnerabilities to fraud, waste, abuse, and mismanagement or the need for transformation to address economy, efficiency, or effectiveness challenges.

[5]The Veterans Benefits Administration provides veterans, their families, and survivors with benefits and services such as compensation, pensions, fiduciary services, educational opportunities, vocational rehabilitation and employment services, and home ownership and insurance. The National Cemetery Administration inters eligible servicemembers, veterans, and family members in VA national cemeteries and maintains the graves and their environs as national shrines; it also provides other burial benefits to veterans and their families, such as medallions and markers for headstones that signify veterans' service.

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framework is intended to align the previously disparate organizational boundaries of VA's administrations in order to promote internal coordination and to support the rollout of a Veterans Experience office dedicated to enhancing customer service capabilities across the department. Following the MyVA initiative's implementation, VHA announced plans to realign and, in some cases, merge VISNs so that they are geographically aligned with MyVA's regional boundaries (hereafter referred to as the VISN realignment). In addition, Congress passed the Veterans Access, Choice, and Accountability Act of 2014 (Choice Act) to, among other things, improve veterans' timely access to care by expanding veterans' ability to obtain care from non-VA providers.[6]

Based on questions about VHA's ability to oversee its health care system and provide timely care, you asked us to conduct a management review of VHA that encompassed several key organizational components, including its organizational structure.[7] This report examines the extent to which

1. VHA has a process for evaluating recommended organizational structure changes to determine actions needed and implementing them as appropriate; and
2. VHA's central office monitored and provided guidance for its field operations implementing the VISN realignment.

To determine the extent to which VHA has a process for evaluating recommended organizational structure changes to determine actions needed and implementing them as appropriate, we reviewed relevant documentation from VHA, including organizational charts, directives, position descriptions, and memos to identify current policy and practice with regard to organizational structure changes. We also reviewed related internal and external assessments of VHA to determine deficiencies identified and recommendations made. Specifically, we reviewed two assessments that were required by the Choice Act—*the Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs* (Independent

[6]Pub. L. No. 113-146, tit. I, 128 Stat. 1754, 1755.

[7]We have additional forthcoming work related to VHA strategic planning, human capital, and information technology.

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Assessment) and the *Final Report of the Commission on Care*.[8] We also reviewed a report produced by an internal VHA task force chartered by the then Interim Under Secretary for Health to evaluate VHA's governance structure, the Task Force on Improving Effectiveness of VHA Governance (which we will refer to as the governance task force hereafter).[9] We interviewed VHA officials, including officials from VHA's National Leadership Council, other VHA senior leadership such as the Under Secretary for Health, and VISN and VAMC officials on their involvement in organizational structure changes.[10] We evaluated VHA's actions against federal internal control standards related to monitoring.[11]

To determine the extent to which VHA's central office provided monitoring and guidance to its field operations implementing the VISN realignment, we reviewed relevant documentation from VHA, VISN, and VAMC officials, including organizational charts, position descriptions, directives, and memos. We also reviewed related internal and external assessments of VHA's organizational structure. We interviewed VHA central office officials involved in the VISN realignment. We also interviewed directors from all 21 VISNs that existed prior to the VISN realignment, and directors from six selected VAMCs, about the extent to which their participation was solicited as part of recent organizational structure changes and to obtain their perspectives on organizational structure changes, such as the

[8]Centers for Medicare & Medicaid Services' Alliance to Modernize Healthcare Federally Funded Research and Development Center, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs*: Volume I: Integrated Report (Sept. 1, 2015). Commission on Care, *Final Report of the Commission on Care* (Washington, D.C.: June 30, 2016).

[9]VHA, *Task Force on Improving Effectiveness of VHA Governance: Report to the VHA Under Secretary for Health* (Feb. 28, 2015). The current Under Secretary for Health was confirmed by the Senate in June 2015. Prior to his confirmation, a VHA official served as the Under Secretary for Health in an interim capacity.

[10]The National Leadership Council is the Under Secretary for Health's governance structure for all policies, plans, and procedures across the entire VHA system. It is comprised of officials in leadership positions from VHA's central office and VISNs.

[11]GAO, *Standards for Internal Control in the Federal Government* GAO-14-704G (Washington, D.C.: September 2014).

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VISN realignment.[12] The six VAMCs were selected to provide variation in (1) whether the VAMC was affected by the realignment; (2) whether the associated VISN was affected by the realignment; (3) geographic location; (4) tenure of the VAMC director; (5) tenure of the VISN director; and (6) facility complexity level.[13] The six selected VAMCs were Huntington VAMC (Huntington, W.V.); Jerry L. Pettis Memorial Veterans' Hospital (Loma Linda, Calif.); John D. Dingell VAMC (Detroit, Mich.); Jonathan M. Wainwright Memorial VAMC (Walla Walla, Wash.); Nashville VAMC (Nashville, Tenn.); and Togus VAMC (Togus, Maine). The information from our VAMC interviews is not generalizable to all VAMCs. We evaluated the monitoring and guidance provided by VHA against federal internal control standards related to risk assessment and monitoring.[14]

We conducted this performance audit from September 2015 to September 2016 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[12]In some cases, officials had left their positions as VISN or VAMC directors at the time of our interviews (from January through April 2016), but were in a permanent or acting director role as of December 2015, when our interviewees were selected. For the purpose of this report, we refer to all acting or other temporarily assigned directors as directors.

[13]For the purpose of this review, we define (1) a VAMC as being affected by the realignment if the VAMC was changing VISNs and (2) a VISN as being affected by the realignment if the VISN gained or lost a VAMC in the realignment or merged with another VISN; 15 of the 21 VISNs were affected by the realignment. VHA categorizes medical centers according to complexity level, determined on the basis of the characteristics of the patient population, clinical services offered, educational and research missions, and administrative complexity.

[14]See GAO-14-704G.

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Background

VHA Organizational Structure

The Under Secretary for Health is the head of VHA and is supported by the Principal Deputy Under Secretary for Health, four Deputy Under Secretaries for Health (DUSH), and nine Assistant Deputy Under Secretaries for Health (ADUSH). Five of these senior leadership positions have been added since 2015. (See fig. 1.)

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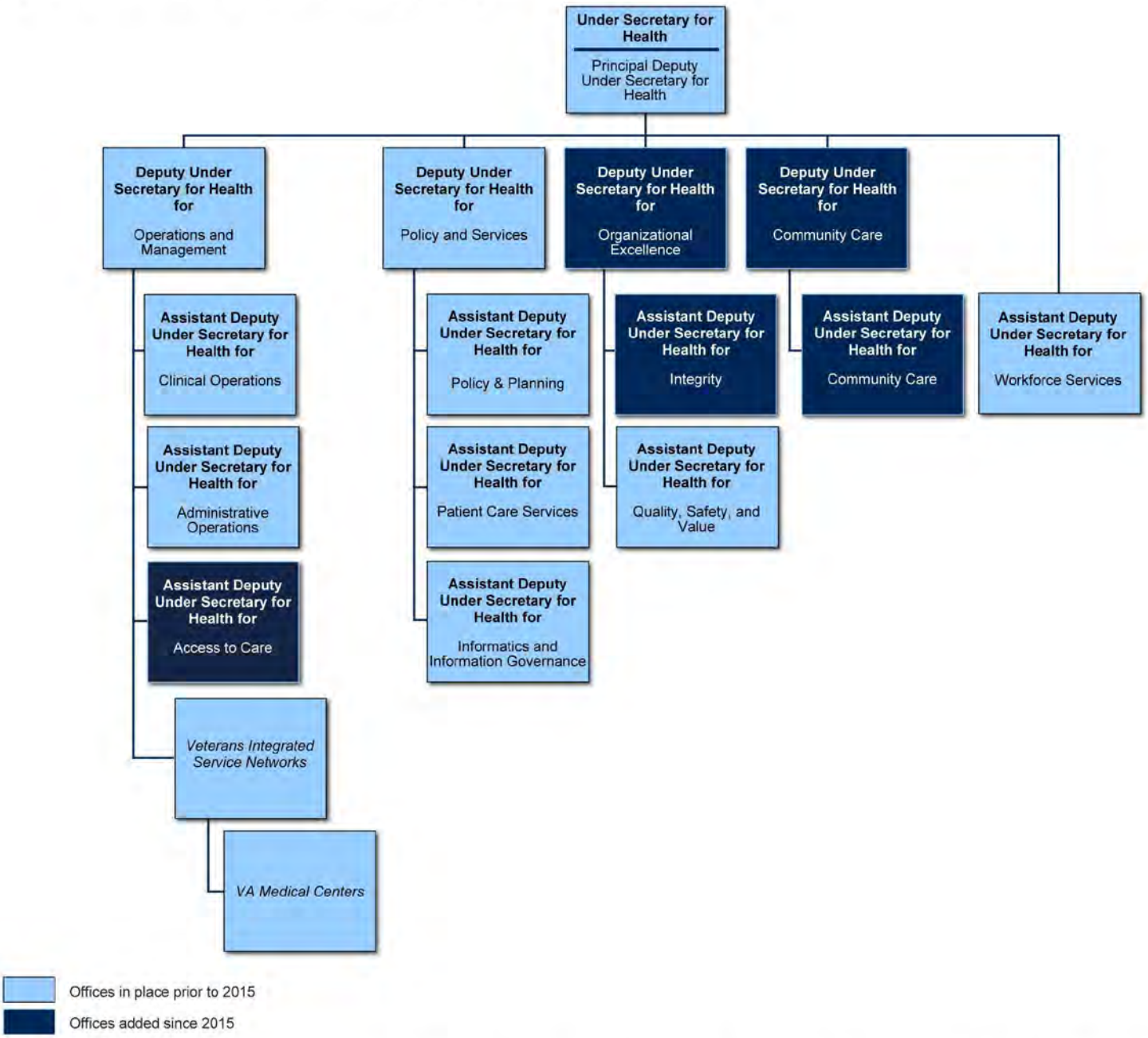
Figure 1: Veterans Health Administration's (VHA) Organizational Chart, May 2016



Source: VHA. | GAO-16-803

Note: In addition to the Deputy and Assistant Deputy Under Secretary positions shown in this figure, the following positions also report to the Under Secretary for Health: Chief of Staff, Chief Officer Readjustment Counseling Service, Executive Director of Research Oversight, and Chief Nursing

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Officer. Also, the Chief Financial Officer and Director of Strategic Integration report to the Principal Deputy Under Secretary for Health.

The four DUSH-level positions are

- **Operations and Management:** This official oversees VHA's field operations. All VISN directors report to the DUSH for Operations and Management; VISNs manage the day-to-day functions of VAMCs and outpatient facilities within their network. The Office of the DUSH for Operations and Management supports the VISNs by providing guidance and individual assistance to address operational challenges (such as personnel issues, adverse events at facilities, and implementation of legislation), and supporting the management of access to care (through the ADUSH for Access to Care position, added in 2016). The office also serves as the focal point for the flow of information and guidance between VHA central office and the VISNs and VAMCs.
- **Policy and Services:** This official oversees VHA offices focused on health care policy, information management, and research. The Office of the DUSH for Policy and Services is responsible for developing and promulgating VHA policies, employing information and informatics tools to improve patient outcomes, and measuring results to ensure continuous learning.
- **Organizational Excellence:** This official oversees program offices focused on assessing and improving quality and safety, providing VHA leadership with analytics to assess how VHA is performing as an organization, and addressing issues related to public trust and integrity. For example, the ADUSH for Integrity reports to the DUSH for Organizational Excellence and is responsible for the day-to-day management of offices focused on internal and external audits, compliance, and ethics. The Office of the DUSH for Organizational Excellence—created in 2015—serves as a hub to enable VHA to achieve the five priorities the Under Secretary of Health established in 2015, and to respond to our High Risk List designation.[15]

[15]In 2015, the Under Secretary for Health announced five priorities for VHA strategic action: (1) provide veterans timely access to health care; (2) create a work environment in which employees feel valued, supported, and encouraged to do their best; (3) ensure that veterans receive the highest level of care from VHA and non-VA providers; (4) use clinical best practices and best practices in research, education, and management; and (5) restore veterans' trust and confidence in VHA. For our High Risk List designation, see GAO-15-290.

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- **Community Care:** This official oversees all VHA community care programs and business processes, such as determining veterans' eligibility to receive health care benefits and purchasing care from non-VA providers. The Office of the DUSH for Community Care was created in 2015 to implement provisions in the Choice Act that expanded veterans' access to non-VA health care services and directed VHA to consolidate the administration of payment for care from non-VA providers.[16] Prior to the creation of this office, the administration of such care to veterans had been spread across VHA.

Internal and External Reviews of VHA Organizational Structure

Recent internal and external reviews of VHA operations have identified deficiencies in VHA's organizational structure and recommended changes that require significant restructuring to address, including eliminating and consolidating program offices and reducing VHA central office staff. For example, the Choice Act required VA to contract with a private entity to conduct an independent assessment of 12 areas of its health care delivery system and management processes, including VHA's leadership.[17] The Independent Assessment report, which VHA reported cost $68 million, was released in September 2015. It made recommendations across each of the 12 areas that support the report's four systemic findings of (1) a disconnect in the alignment of demand, resources, and authorities; (2) uneven bureaucratic operations and processes; (3) non-integrated variations in clinical and business data and tools; and (4) leaders not fully empowered due to a lack of clear authority, priorities, and goals.[18] For example, to address the finding of uneven bureaucratic business operations and processes, the report includes a recommendation for VHA to develop a patient-centered operations model that balances local autonomy with appropriate standardization and employs best practices for high-quality health care. To accomplish this,

[16]Pub. L. No. 113-146, §§ 101(a), 106(a), 128 Stat. 1755, 1768.

[17]Pub. L. No. 113-146, § 201(a)(1), 128 Stat. 1769. VHA contracted with the Centers for Medicare & Medicaid Services' Alliance to Modernize Healthcare (operated by MITRE Corporation, a private entity) and the Institute of Medicine to conduct the assessment. Parts of the evaluation were subcontracted to other organizations, including McKinsey & Company and the RAND Corporation.

[18] According to VA, the report contains a total of 188 recommendations. See *Independent Assessment,* Volume I.

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the report states that, among other things, VHA should reorient its central office to better support field operations in its delivery of care to veterans.

The Choice Act also established the Commission on Care, to be comprised of 15 members appointed by Congressional leaders or the President to examine, assess, and report on veterans' access to VA health care and to strategically examine how best to organize VHA, locate health resources, and deliver health care to veterans during the next 20 years.[19] The commission was also required to evaluate, assess, and report its findings on the Independent Assessment, including any findings, data, or recommendations, and to report any of its own recommendations for legislative or administrative action.[20] The commission's June 2016 report to the President included 18 recommendations to improve veterans' access to care and, more broadly, to improve the quality and comprehensiveness of that care, in part by making large-scale organizational changes.[21] For example, the commission recommended that VHA create local, networked systems of care that integrate traditional VHA and community care and remove restrictions to veterans seeking care from non-VA providers. It also recommended redesigning VHA's central office to better support field operations. The Choice Act required the President to submit a report to the Senate and House Committees on Veterans' Affairs and any other committees of Congress that the President considers appropriate within 60 days of the President's receipt of the commission report.[22, 23] The report was required to include an

[19]The act required that members of the commission meet certain qualifications. For example, at least one member must represent an organization that represents veterans and at least one other member must have experience as senior management for a private integrated health care system with an annual gross revenue of more than $50,000,000. Pub. L. No. 113-146, § 202(a)(b), 128 Stat 1773. Individuals selected to serve on the commission included decorated veterans, chief executive officers from major private health care systems, representatives from organizations that provide services to veterans, and health policy experts.

[20]Pub. L. No. 113-146, § 202(b), 128 Stat. 1774.

[21]On August 2, 2016, the Secretary of Veterans Affairs stated that VA found 15 of the commission's 18 recommendations feasible and advisable.

[22]Pub. L. No. 113-146, § 202(g), 128 Stat. 1776.

[23]On September 1, 2016, the President concurred with 15 of the 18 recommendations and directed VA to implement any of the 15 recommendations that the department was not already working to implement.

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assessment of the Commission on Care's recommendations and a description of the recommendations VHA is directed to implement.

In addition to the reviews required by the Choice Act, VHA initiated internal task forces to examine organizational structure changes and make recommendations. For example, VHA chartered its governance task force in December 2014, with the goal of making recommendations to improve operational effectiveness and efficiency, and to align the agency to strengthen business processes. According to the task force's charter, VHA needed to modify its governance structure to help address recent issues with substandard and inconsistent care delivery. The governance task force submitted a report in February 2015 with 21 recommendations.[24] For example, the task force recommended reorganizing VHA's central office around functional areas and establishing processes for regular review and revision of the VISN and VHA central office structures.

A governance task force recommendation to examine VISN staffing resulted in VHA chartering another task force, the VISN Staffing Task Force, in February 2015. In July 2015, this task force submitted a report to the DUSH for Operations and Management with recommendations for a new VISN staffing model. It included

- an option for reorganized VISN organizational structures;
- new positions focused on special populations (e.g., women's health, rural health), nursing, and communications; and
- staffing limits that would result in 95 fewer VISN full-time-equivalent staff nationally in fiscal year 2016 compared to fiscal year 2012.

In addition, VHA chartered a task force—the Integrated Project Team—in September 2015 to develop a detailed, time-limited, and organization-specific plan for, and initiate implementation of, selected recommendations from the Independent Assessment required by the Choice Act. According to the task force's charter, it was formed because, in a climate of intense public and congressional scrutiny, VHA needed to act quickly and could not afford to wait for the Commission on Care to

[24] *VHA Governance Task Force Report*.

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publish its recommendations, which were to incorporate the results of the Independent Assessment.

VHA Does Not Have a Process That Ensures Recommended Organizational Structure Changes Are Evaluated and Implemented

Despite several critical internal and external reviews, VHA does not have a process that ensures that recommendations resulting from these reviews are evaluated to determine appropriate actions and that any such appropriate actions are implemented. (See app. I for a table of recent internal and external reviews that examined VHA's organizational structure.) The lack of such processes is inconsistent with federal standards for internal control, which state that management should remediate identified internal control deficiencies on a timely basis.[25] This remediation may include evaluating the results of reviews to determine appropriate actions, and, once decisions are made, completing and documenting corrective actions on a timely basis.

We found instances where VHA task force actions in response to recent recommendations for organizational structure changes were incomplete, not documented, or not timely:

> **Governance task force.** A senior VHA official on the task force—one of 10 senior officials who worked on the February 2015 report—told us that the Under Secretary for Health did not approve 13 of the 21 recommendations, so they would not be implemented.[26] Additionally, VHA officials stated that there was no documentation of the Under Secretary for Health's decisions on the recommendations because they were communicated verbally. Some of these 13 unimplemented recommendations focused on organizational structure changes that were later repeated in the Independent Assessment's recommendations.[27] For example, the

[25]GAO-14-704G.

[26]The 10-member governance task force was comprised of senior leadership from VA, VHA central office (including two ADUSH-level officials), VISNs, and VAMCs. The task force and its support staff conducted their work over 9 weeks, including one 2-day work session for the full task force and additional multiple, day-long work sessions for task force subgroups. According to the governance task force report, it was necessary for some members to meet on a nearly daily basis to ensure the task force was able to produce recommendations within its timeframes. *VHA Governance Task Force Report.*

[27]*Independent Assessment*, Volume I.

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Independent Assessment and the VHA governance task force reports both noted that VHA central office programs and staff had increased dramatically in recent years, resulting in a fragmented and "silo-ed" organization without any discernible improvement in business or health outcomes, and recommended restructuring and downsizing VHA central office. The Under Secretary for Health told us that his immediate priorities were to focus on improving access to care and hiring officials for vacant senior-level positions, and as a result he did not want to make significant changes to VHA's organizational structure. Recommendations the Under Secretary for Health approved included those on improving the coordination and oversight of non-VA community care, restructuring the monthly meetings of VHA's National Leadership Council, and establishing processes to develop and improve health care performance measures.

VISN Staffing Task Force. VHA officials told us that the DUSH for Operations and Management verbally communicated approval of the task force's recommendations to change VISN staffing, which were developed over a week-long work session and incorporated input from all VISN directors.[28] VHA officials provided us a VISN organizational chart with revised VISN staffing limits as documentation of the DUSH's approval, but did not provide documentation of the decision made on each task force recommendation. For example, the documentation did not include the DUSH's decisions on the task force's recommendations on whether larger VISNs should be allowed to establish deputy network director positions, or if certain staff positions could be shared across VISNs. It also did not include information on why one staffing model was chosen over another. Officials stated that the DUSH was responsible for implementing the new VISN staffing model, but had not developed a timeline for its implementation. VHA officials were not able to provide us with any updates on implementation and told us in May 2016 that the task force had been disbanded.

[28]The eight-member task force included one ADUSH-level official and five VISN directors; their work session took place in April 2015. Other VISN directors not participating in the task force had the opportunity to provide input on the task force's recommendations during an in-person meeting of all VISN directors in May 2015.

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Integrated Project Team. The task force, made up of 18 senior VA and VHA officials, conducted its work over about 6 months but did not produce the detailed implementation plan of the Independent Assessment recommendations it was chartered to create, according to VHA officials.[29] A senior VHA official on the task force told us that the team planned to have a completed implementation plan in March 2016, and had identified senior-level VHA officials who would be responsible for ensuring implementation of the recommendations. The official also noted that the task force's work would be included in VHA's strategic planning summit in April 2016, at which point the task force would disband.[30] VHA officials later told us that although the Integrated Project Team developed eight topic areas that applied to the Independent Assessment's recommendations, and presented them at the strategic planning summit, they would not be moving forward with further work to develop and approve an implementation plan. In August 2016, VHA officials told us that since the strategic planning summit, they have been focused on addressing other priorities such as the Commission on Care report, proposed legislation that could affect VHA operations, and the Under Secretary for Health's five priorities for VHA.

VHA devoted significant time and effort to these different task forces, but then either did not act or acted slowly to implement recommendations. For example, all three task forces included senior officials from VHA's central office and VISNs, whose participation on the task forces created additional responsibilities beyond those related to their positions. In addition, all three sets of recommendations were available to VHA officials in 2015, but decisions on these recommendations were delayed by 6 months to 1 year after the report's completion, and in the case of the Integrated Project Team's work, decisions have not been made at all. One attribute of the federal internal control standard for timely remediation for identified deficiencies is assigning responsibility and

[29]The team included seven ADUSH-level officials, VHA's Chief Financial Officer, and representatives from VA's offices for Information and Technology; Acquisition, Logistics, and Construction; and Human Resource Administration.

[30]VHA held a strategic planning summit in April 2016. One of the objectives of the summit was to make decisions to guide the health care that VA provides or purchases over the following 3 years.

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authority for carrying out corrective actions. The three task force charters did not require senior leadership to make decisions on the results of reviews within a certain time frame, or ensure implementation of agreed-upon recommendations. As a result, when officials retired (as did the chairs for all three task forces) or resumed their regular duties, there were no other individuals or offices responsible for ensuring that recommendations were acted on, or any documentation available to track progress made. VHA officials expressed frustration and confusion at the lack of response from central office to the findings and recommendations resulting from task forces. Without a process for ensuring that the recommendations resulting from internal and external reviews are evaluated, decisions documented, and promptly acted on, VHA will not be able to ensure that officials are accountable for taking actions that will resolve deficiencies. VHA also cannot ensure that it is making efficient use of internal resources allocated to developing and implementing recommendations.

VHA Central Office Has Provided Little Monitoring and Did Not Anticipate Challenges for a Recent and Significant Organizational Structure Change, the VISN Realignment

The VISN realignment is a significant change to VHA's organizational structure; it is the first large-scale reorganization of VISN boundaries since the VISNs were created in 1995.[31] However, VISNs have been implementing this change with little monitoring from VHA's central office. In addition, VHA did not proactively identify and provide guidance to address challenges VISNs and VAMCs have encountered. These actions are inconsistent with federal standards for internal control concerning monitoring and risk assessment.[32] Specifically, these controls state that management should establish monitoring activities, evaluate the results, and remediate identified deficiencies in a timely manner. This monitoring may include ongoing activities that are built into operations, as well as evaluations that provide feedback on the effectiveness of the monitoring and identify possible deficiencies that require corrective actions. In addition, these controls state management should identify, analyze, and respond to changes that could affect the system.

[31]A smaller-scale reorganization of VISNs occurred in 2002 when VISNs 13 and 14 were merged to create VISN 23.

[32]GAO-14-704G.

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In October 2015, VHA began to implement a realignment of its VISN boundaries, with the goal of aligning them with MyVA regional boundaries. This involved decreasing the number of VISNs from 21 to 18 and reassigning some VAMCs to different VISNs. The governance task force evaluated several options for aligning VISN boundaries with MyVA regions and for aligning VISN boundaries better with state lines, and proposed an 18-VISN configuration. For example, the governance task force proposed reassigning West Virginia VAMCs so that they would all report to one VISN instead of four different VISNs. (See app. II for pre- and post-realignment VISN maps, and a table that shows the extent that each VISN is affected by the realignment.) VHA officials anticipate that the realignment will be completed, at the earliest, by the end of fiscal year 2018. Directors from the 15 VISNs affected by the realignment described a range of actions that needed to be completed as part of the realignment, including setting up new VISN governance structures; merging clinical and administrative functions; and assessing the operations in VAMCs that have been reassigned to a VISN to ensure they are in alignment with the VISN's practices, such as VAMCs' use of service contracts. According to VHA, the realignment is not expected to impact veterans' access to health care. For example, officials told us that the VISNs are expected to continue to honor historical geographical referral patterns for veterans—that is, to continue to refer veterans to the same VAMC or outpatient facility they were referred to prior to the realignment even if that VAMC or facility is part of a different VISN post-realignment.

VHA has provided little monitoring of VISNs' implementation efforts, and it has not provided adequate guidance in anticipation of implementation challenges. VHA chartered a task force—the VISN Realignment Workgroup—to implement the realignment across the VISNs. According to its charter, the task force is responsible for developing an implementation plan and timeline for the realignment, as well as identifying barriers and solutions to mitigate them. The task force is made up of VHA central office and VISN officials and led by the DUSH for Operations and Management and a VISN director. It meets monthly with VISNs affected by the realignment. Although these meetings provide a structure for VISN directors to share actions taken and challenges encountered in the realignment process, VHA has not taken an active role in implementing the realignment. VISN Realignment Workgroup officials told us that at the beginning of the realignment, the workgroup provided guidance in the form of a communication plan that answered frequently asked questions about the realignment's purpose, and made decisions about how the VISNs would be numbered. However, officials added that

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they wanted to be facilitators, rather than directors or implementers, for the realignment, and that VISN directors were capable of implementing the realignment independently without the need for a close level of monitoring.

Directors from several VISNs affected by the realignment told us that they have made decisions independently about how to implement the realignment in their VISNs, and many also noted that they continue to face challenges with implementation, including

- **services and budgets.** Directors from 12 of the 15 VISNs affected by the realignment told us they continue to face challenges in managing services and budgets. The director of a VISN that gained a VAMC with after-hours call center services on site told us he faced an unexpected task of consolidating his VISN's existing call center services with those being provided at the VAMC. In addition, a VAMC director expressed concern about potentially having to re-start a VISN strategic planning exercise that the VAMC had participated in for 18 months because the VISN to which it had been reassigned had not done similar planning work. Finally, several VISN directors expressed concerns about how the realignment would affect their budgets, including one director who was concerned about losing a large VAMC that supplemented budget losses for other, smaller VAMCs in the VISN.
- **"double-encumbered" positions.** Six of the 15 VISNs affected by the realignment are in the process of merging, which has resulted in double-encumbered positions—two officials serving in the same position, such as two Chief Financial Officers. For example, one VISN director told us at the time of our interview (February 2016) that there were about 30 double-encumbered positions between two merging VISNs, which represented about one-third of their total staff. According to VHA, 23 positions remained double-encumbered in the merged VISN as of August 2016. Several VISN directors described challenges in resolving double-encumbered positions. For example, without authorization to offer Voluntary Separation Incentive Payments—also known as buyout authority—or specific instructions from central office, directors told us they were concerned that any actions they took (such as having officials compete for the position) would be inconsistent with other VISNs. VHA officials told us that they have been involved in helping VISNs address double-encumbered positions, such as assisting in finding staff new positions within VHA, but not all such situations had been resolved. Further, according to VHA, one merged VISN received central office approval to pursue

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buyout authority, and two other merged VISNs were awaiting approval as of August 2016. VISN directors with double-encumbered staff expressed frustration at the lack of resolution of this issue and told us it has contributed to low staff morale. Double-encumbered positions were a VISN realignment challenge that VHA could have anticipated and made plans to address before the realignment started, but according to senior task force officials, the task force did not establish a subgroup on human resources until after the realignment began. As of August 2016, VHA reported there were 37 double-encumbered positions across the three merged VISNs.

- **information technology.** Six of the 15 directors from VISNs affected by the realignment told us that they continue to face information technology challenges, including having to manually reconstruct datasets to add or delete VAMCs that are still electronically associated with their former VISNs. One VISN director described difficulties in obtaining access rights to data from VAMCs that were reassigned to the VISN. Similarly, a VAMC director told us that the facility was no longer able to access its own data after changing VISNs because the data were located on their former VISN's server, requiring workarounds to gain access because there was no guidebook or plan for how to transfer VAMC data from one VISN to another.

VISN Realignment Workgroup officials told us they were aware of continued realignment challenges, but had no plans in place at the time of our review to expand their monitoring efforts to include an evaluation of the implementation of the realignment. Officials said that if they conducted an evaluation, the best time frame would be after the realignment is mostly complete because realignment actions are still in the process of being implemented. However, an evaluation may be useful to correct any identified implementation deficiencies. It can also help inform future organizational structure changes by offering VHA the opportunity to anticipate challenges and proactively provide guidance to address them. For example, the Under Secretary for Health told us he would be open to other VHA organizational structure changes in the future once he completes the process of filling vacant leadership positions within VHA.[33] In addition, the implementation of the Commission on Care

[33]According to VHA, as of May 2016, there were vacancies in 4 of the 14 VHA central office senior leadership positions; 3 of the 18 VISN director positions that will exist after the realignment is complete; and 36 of the 168 total VAMC director positions.

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report recommendations could result in large-scale organizational structure changes. VISN Realignment Workgroup officials told us they thought that an evaluation could also be useful for identifying any unintended consequences resulting from the realignment that bear examination.

Conclusions

VHA is aware that it is providing health care services to veterans in a time of significant scrutiny from us and others. This scrutiny comes in the wake of VHA's inability to provide timely health care services to veterans, which contributed to the placement of VA health care on our High Risk List. Although VHA has spent considerable resources—staff time and funds—on reviews and task forces that recommended improvements in its organizational structure, VHA lacks the processes needed to ensure that officials can evaluate those recommendations, document decisions, monitor and evaluate implementation, and hold staff accountable. In addition, without adequate monitoring, including a plan for evaluation, VHA cannot be certain it is effectively implementing the ongoing VISN realignment. VHA would also miss the opportunity to apply lessons learned from such an evaluation to future organizational structure changes, such as those it makes in response to the Commission on Care report's recommendations. Without processes for evaluating and implementing recommendations and actively monitoring major organizational structure changes, there is little assurance that VHA's delivery of health care to the nation's veterans will improve.

Recommendations for Executive Action

We recommend that the Secretary of Veterans Affairs direct the Under Secretary for Health to take the following two actions:

1. Develop a process to ensure that organizational structure recommendations resulting from internal and external reviews of VHA are evaluated for implementation. This process should include the documentation of decisions and assigning officials or offices responsibility for ensuring that approved recommendations are implemented.
2. Conduct an evaluation of the implementation of the VISN realignment to determine whether deficiencies exist that need corrective actions, and apply lessons learned from the evaluation to future organizational

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structure changes, such as possible changes to VISN staffing models or actions to implement Commission on Care recommendations.

Agency Comments

We provided a draft of this report to VA for comment. In its written comments, reproduced in appendix III, VA agreed with our conclusions and concurred with our recommendations. In its comments, VA stated that VHA plans to develop processes to ensure organizational structure changes are evaluated and implemented appropriately and to evaluate the implementation of the VISN realignment, with estimated completion dates for the development of these processes by March 2017 and September 2017, respectively. VA also stated that as the VISN realignment continues, VHA will strive to ensure a seamless flow of communication and execution of VHA's mission at all levels.

As agreed with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from its issue date. At that time, we will send copies of this report to the appropriate congressional committees, the Secretary of Veterans Affairs, the Under Secretary for Health, and other interested parties. In addition, the report will be available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or at draperd@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix IV.



Debra A. Draper
Director, Health Care

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Appendix I: Recent External and Internal Reviews That Include an Examination of Veterans Health Administration's (VHA) Organizational Structure

Table 1: External and Internal Reviews That Include an Examination of Veterans Health Administration's (VHA) Organizational Structure, 2014-2016

Reviewer	Reason for review	Work produced and actions taken
Reviews Conducted by External Entities		
Centers for Medicare & Medicaid Services' Alliance to Modernize Healthcare and the Institute of Medicine[a]	The Veterans Access, Choice, and Accountability Act of 2014 (Choice Act) required the Department of Veterans Affairs (VA) to contract with a private entity to assess 12 areas of its health care delivery system and management processes, including VHA's leadership.[b]	In September 2015, the reviewers produced a report, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs* (Independent Assessment).[c] It made recommendations across each of the 12 areas that support the report's four systemic findings of (1) a disconnect in the alignment of demand, resources, and authorities; (2) uneven bureaucratic operations and processes; (3) non-integrated variations in clinical and business data and tools; and (4) leaders not fully empowered due to a lack of clear authority, priorities, and goals.
Commission on Care	The Choice Act established a commission to be appointed by Congressional leaders or the President to • Evaluate, assess, and report on veterans' access to VA health care; • Strategically examine how best to organize VHA, locate health resources, and deliver health care to veterans during the next 20 years; and • Evaluate, assess, and report its findings on the Independent Assessment and to report any of its own recommendations for legislative or administrative action.[d]	In June 2016, the commission issued a report to the President with 18 recommendations to improve veterans' access to care and more broadly, to improve the quality and comprehensiveness of that care.[e] The Choice Act requires the President to produce, within 60 days of receiving the commission's report, a report that includes an assessment of the commission's recommendations and a description of the recommendations VHA is directed to implement.[f]
Reviews Conducted by VHA Internal Task Forces		
Task Force on Improving Effectiveness of VHA Governance	In December 2014, VHA chartered an internal task force to make recommendations to improve operational effectiveness and efficiency, and to align the agency to strengthen business processes.	In February 2015, the task force produced a report with 21 recommendations for improving VHA's governance structure.[g] For example, the task force recommended reorganizing VHA's central office around functional areas and establishing processes for regular review and revision of the Veterans Integrated Service Networks (VISN) and VHA central office structures. According to a VHA official, the Under Secretary for Health did not approve 13 of the 21 recommendations, but some actions were taken on other recommendations, including the task force's proposed structure for realigning the VISNs.
VISN Staffing Task Force	In February 2015, VHA chartered an internal task force to consider and recommend the appropriate mix and recommended staffing levels to effectively operate the 18 VISN structure, in response to a recommendation from the Task Force on Improving Effectiveness of VHA Governance to examine VISN staffing.	In July 2015, the task force produced a report with five recommendations for establishing a new VISN staffing model. VHA officials told us that the Deputy Under Secretary for Health for Operations and Management verbally communicated approval of the task force's recommendations, but as of May 2016, had not developed a timeline for implementation.[h]

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Reviewer	Reason for review	Work produced and actions taken
Integrated Project Team	In September 2015, VHA chartered an internal task force to develop a detailed, time-limited, and agency-specific plan for, and initiate implementation of, selected recommendations from the Independent Assessment.	According to VHA officials, the task force did not produce the detailed implementation plan of the Independent Assessment recommendations it was chartered to create. VHA officials told us that the task force developed eight topic areas that applied to the Independent Assessment's recommendations and presented them at VHA's 2016 strategic planning summit, but would not be moving forward with further work to develop and approve an implementation plan. As of August 2016, officials said they have been focused on addressing other priorities such as the Commission on Care report, proposed legislation that could affect VHA operations, and the Under Secretary for Health's five priorities for VHA.

Source: VHA. | GAO-16-803

[a]VHA contracted with the Centers for Medicare & Medicaid Services' Alliance to Modernize Healthcare (operated by MITRE Corporation, a private entity) and the Institute of Medicine to conduct the assessment. Parts of the evaluation were subcontracted to other organizations, including McKinsey & Company and the RAND Corporation.

[b]Pub. L. No. 113-146, § 201(a)(1), 128 Stat. 1754, 1769 (2014).

[c]Centers for Medicare & Medicaid Services' Alliance to Modernize Healthcare Federally Funded Research and Development Center, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs*: Volume I: Integrated Report (Sept. 1, 2015).

[d]Pub. L. No. 113-146, § 202(a)(b), 128 Stat 1773.

[e]Commission on Care, *Final Report of the Commission on Care* (Washington, D.C.: June 30, 2016).

[f]Pub. L. No. 113-146, § 202(g)(2), 128 Stat. 1776.

[g]VHA, *Task Force on Improving Effectiveness of VHA Governance: Report to the VHA Under Secretary for Health* (Feb. 28, 2015).

[h]The Deputy Under Secretary for Health for Operations and Management oversees VHA's field operations, comprised of VISNs that manage networks of VA medical centers and outpatient facilities.

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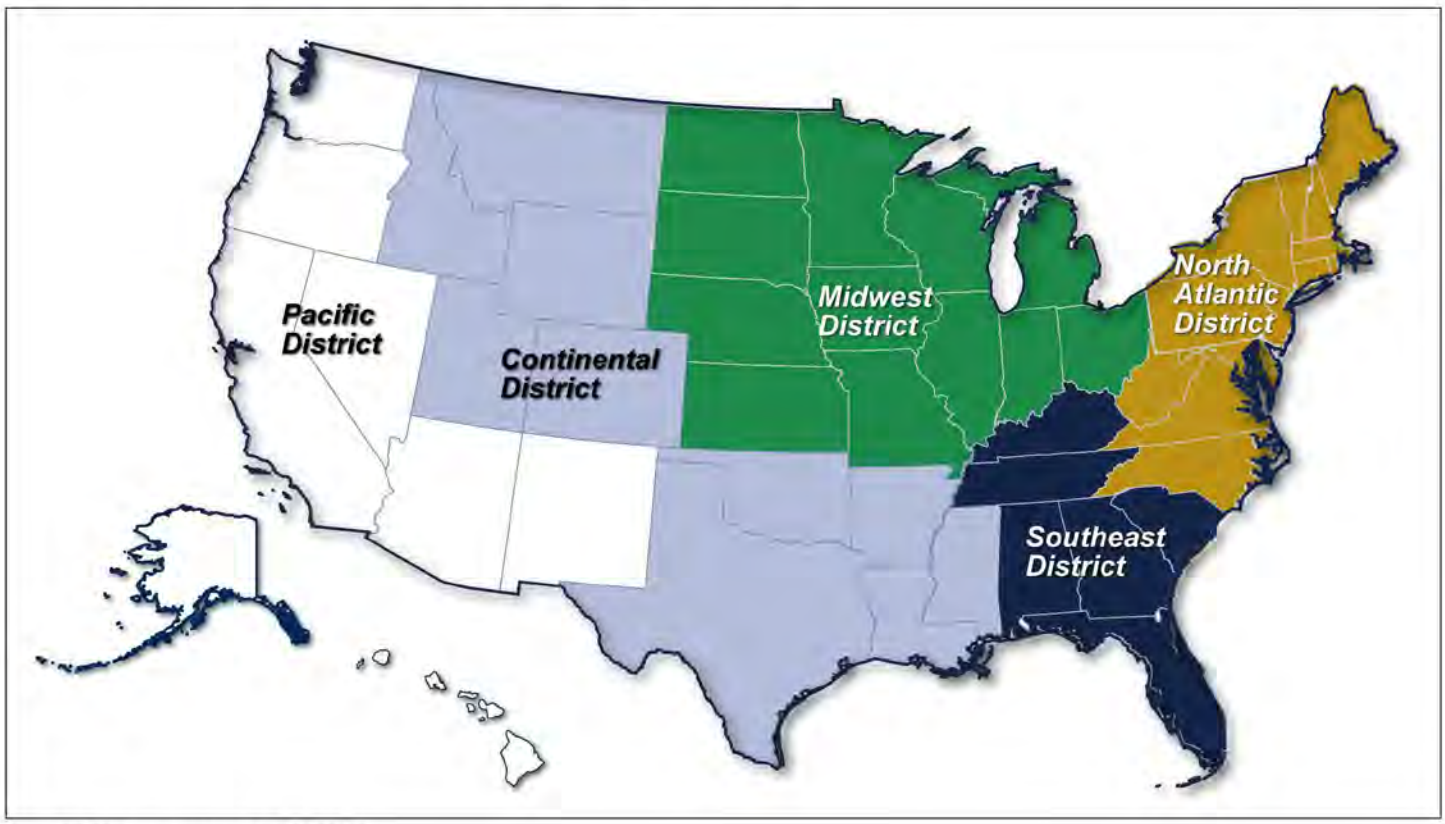
Appendix II: Department of Veterans Affairs' (VA) MyVA Regions and the Veterans Health Administration's (VHA) Veterans Integrated Service Network (VISN) Realignment

VA announced a major organizational initiative in September 2014 called MyVA. As part of this initiative, the department established a single regional framework for its three administrations—VHA, the Veterans Benefits Administration, and the National Cemetery Administration—dividing the United States into five regions based on state boundaries.[1] (See fig. 2.)

Figure 2: Department of Veterans Affairs' (VA) MyVA Regional Map, 2015



Source: VA, Map Resources (map). | GAO-16-803

[1]According to VA, the regional framework is intended to align the previously disparate organizational boundaries of VA's administrations in order to promote internal coordination and to support the rollout of a Veterans Experience office dedicated to enhancing customer service capabilities across the department.

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Following the MyVA initiative's implementation, VHA announced plans to realign, and in some cases, merge its VISNs—regional offices that oversee networks of VA medical centers (VAMC) and outpatient facilities—so that they geographically aligned with MyVA regional boundaries. (See figs. 3 and 4 for pre- and post-realignment VISN maps, respectively; and table 2 for information on the extent that each VISN is affected by the realignment.) The VISN realignment began in October 2015 and VHA officials anticipate it will be completed, at the earliest, by the end of fiscal year 2018.

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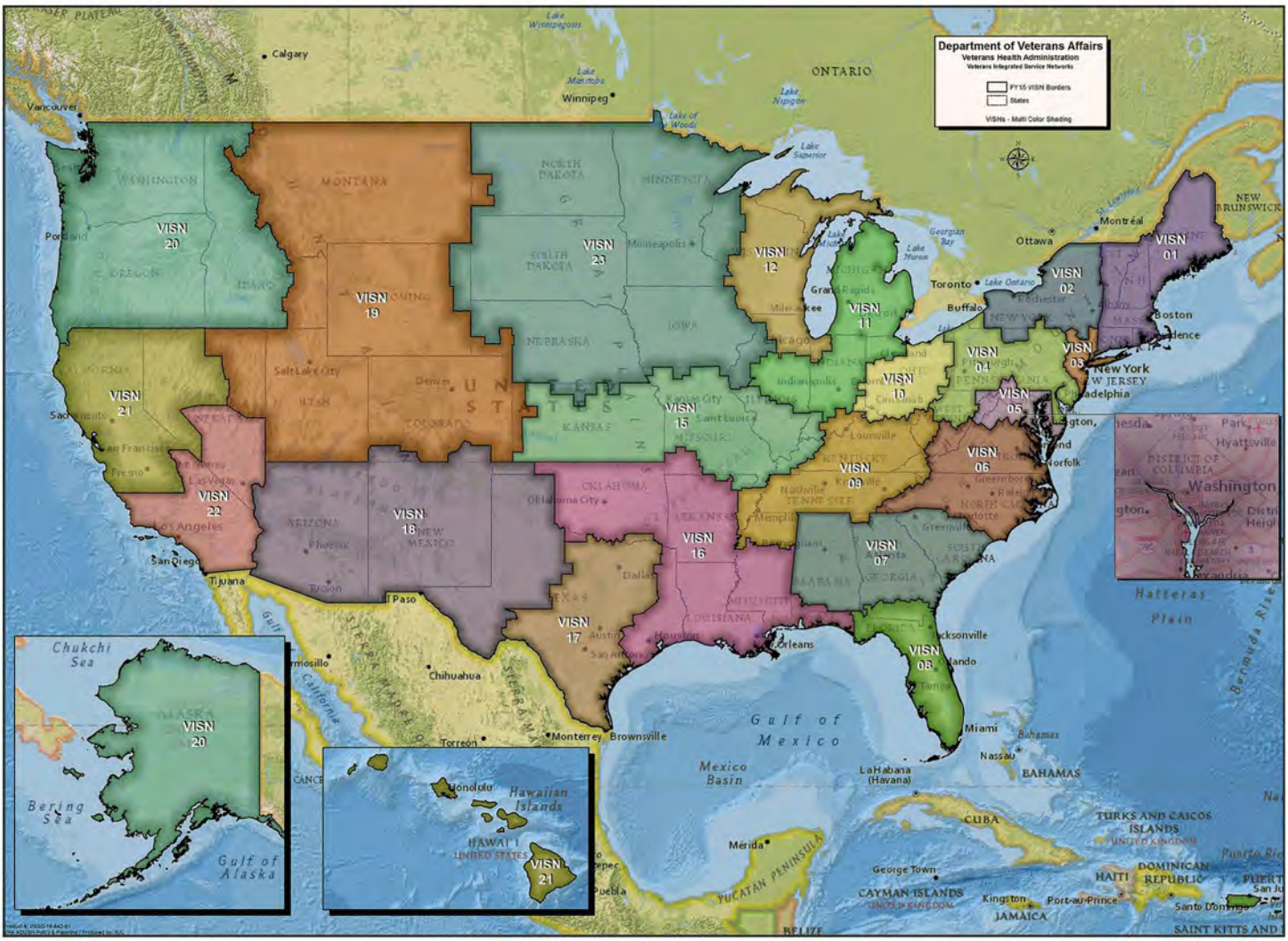
Figure 3: Department of Veterans Affairs' (VA) Veterans Health Administration's (VHA) Veterans Integrated Service Network (VISN) Pre-Realignment Map, September 2015



Source: VA. | GAO-16-803

Note: This map reflects the alignment of VISNs as of September 2015. In October 2015, VHA began a realignment of its VISNs—regional offices that oversee networks of VA medical centers and outpatient facilities—so that they are geographically aligned with the boundaries of five VA-established regions. VISNs are identified by numbers, which are not consecutive.

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Figure 4: Department of Veterans Affairs' (VA) Veterans Health Administration's (VHA) Veterans Integrated Service Network (VISN) Map after the VISN Realignment Is Complete, Expected at the End of Fiscal Year 2018



Source: VA. | GAO-16-803

Notes: In October 2015, VHA began a realignment of its VISNs—regional offices that oversee networks of VA medical centers and outpatient facilities—so that they are geographically aligned with the boundaries of five VA-established regions. VISNs are identified by numbers, which are not consecutive.

As part of the realignment, three sets of VISNs are in the process of merging: VISNs 2 and 3; 10 and 11; and 18 and 22 (VISNs 13 and 14 were merged to create VISN 23 in 2002).

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Table 2: Veterans Integrated Service Network (VISN) Changes under the VISN Realignment, Expected at the End of Fiscal Year 2018

Pre-realignment VISN	Changes under the VISN realignment
VISN 1	Not affected
VISN 2	Gains all VISN 3 Veterans Affairs medical centers (VAMC)
VISN 3	Merges into VISN 2
VISN 4	Loses Clarksburg, WV VAMC (VISN 5)
VISN 5	Gains Clarksburg, WV (VISN 4); Beckley, WV (VISN 6); and Huntington, WV (VISN 9) VAMCs
VISN 6	Loses Beckley, WV VAMC (VISN 5)
VISN 7	Not affected
VISN 8	Not affected
VISN 9	Loses Huntington, WV VAMC (VISN 5)
VISN 10	Gains all VISN 11 VAMCs except for Danville, IL VAMC (VISN 12)
VISN 11	Merges into VISN 10
VISN 12	Gains Danville, IL VAMC (VISN 11)
VISN 15	Not affected
VISN 16	Loses Oklahoma City, OK and Muskogee, OK VAMCs (VISN 19); and Houston, TX VAMC (VISN 17)
VISN 17	Gains Amarillo, TX and El Paso, TX VAMCs (VISN 18); and Houston, TX VAMC (VISN 16)
VISN 18	Merges into VISN 22
VISN 19	Gains Oklahoma City, OK and Muskogee, OK VAMCs (VISN 16)
VISN 20	Not affected
VISN 21	Gains Las Vegas, NV VAMC (VISN 22)
VISN 22	Gains all VISN 18 VAMCs except for Amarillo, TX and El Paso, TX VAMCs (VISN 17); Loses Las Vegas, NV VAMC (VISN 21)
VISN 23	Not affected

Source: Veterans Health Administration (VHA). | GAO-16-803

Note: The VISN realignment began in October 2015. VHA officials anticipate that the VISN realignment will be completed, at the earliest, by the end of fiscal year 2018.

Some VISN borders will cross state lines and MyVA regional boundaries once the realignment is complete. VHA officials told us this reflects geographical referral patterns and the locations of outpatient clinics, which can be across state lines from their associated VAMCs. VHA officials told us that the VISNs are expected to continue to honor historical geographical referral patterns for veterans—that is, to continue to refer veterans to the same VAMC or outpatient facility they were referred to prior to the realignment even if that VAMC or facility is part of a different VISN post-realignment.

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Appendix III: Comments from the Department of Veterans Affairs

DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

September 7, 2016

Ms. Debra Draper
Director, Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Draper:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, ***"VA HEALTH CARE: Processes to Evaluate, Implement, and Monitor Organizational Structure Changes Needed"*** (GAO-16-803). VA agrees with GAO's conclusions and concurs with GAO's recommendations to the Department.

The enclosure provides our general comments and sets forth the action to be taken to address the GAO draft report recommendations.

VA appreciates the opportunity to comment on your draft report.

Sincerely,

Gina S. Farrisee
Deputy Chief of Staff

Enclosure

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Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
"VA HEALTH CARE: Processes to Evaluate, Implement, and Monitor Organizational Structure Changes Needed"
(GAO-16-803)

GAO Recommendation: GAO recommends that the Secretary of Veterans Affairs direct the Under Secretary for Health to take the following two actions:

Recommendation 1: Develop a process to ensure that organizational structure recommendations resulting from internal and external reviews of VHA are evaluated for implementation. This process should include the documentation of decisions and assigning officials or offices responsibility for ensuring that approved recommendations are implemented.

VA Comments: Concur. This recommendation is related to High Risk Area 1 (ambiguous policies and inconsistent processes). The Veterans Health Administration (VHA) will develop a consistent process to ensure that organizational structure changes are evaluated and implemented appropriately.

VHA's Office of Workforce Management and Consulting (WMC) will develop a structured, methodical process to assess the implementation progress and outcomes of organizational structural recommendations. VHA has undertaken recent structural changes to improve system responsiveness and oversight, including the development of organizations and programs responsible for organizational excellence and care in the community and the realignment of the Veterans Integrated Service Networks (VISN) and VA medical centers.

WMC will review existing practices for optimal organization design, approval, implementation, and evaluation. This effort will build upon transformative activities already underway, including MyVA. WMC will ensure appropriate administrative functions are integrated into reorganization efforts, and that the organization evaluation process is fully documented and approved by VHA leadership. The status is in process and the target completion date is March 2017.

Recommendation 2: Conduct an evaluation of the implementation of the VISN realignment to determine whether defiencies exist that need corrective actions, and apply lessons learned from the evaluation to future organizational stucture changes, such as possible changes to VISN staffing models or actions to implement Commission on Care recommendations.

VA Comments: Concur. This recommendation is related to High Risk Area 2 (inadequate oversight and accountability). By evaluating the implementation of the VISN realignment, VHA will ensure proper oversight and make corrections where necessary.

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Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
"VA HEALTH CARE: Processes to Evaluate, Implement, and Monitor Organizational Structure Changes Needed"
(GAO-16-803)

VHA's WMC will evaluate the implementation of the VISN realignment to include the identification of deficiencies for correction, lessons learned, and potential changes to the VISN staffing models. The VISN Realignment Workgroup has been monitoring the implementation progress of various local realignment activities and will continue to make changes to the overall implementation plan based on conditions in the field. WMC will begin evaluation as the realignment activities near completion. At this point in time, several realignment processes and activities are in the beginning stages of implementation and too immature for evaluation. As the implementation activities near completion in fiscal year 2017, WMC will be better positioned to evaluate the effectiveness and efficiency of the VISN realignment processes. The status is in process and the target completion date is September 2017.

General Comments:

On January 26, 2015, VA announced that it was taking the first steps under the MyVA initiative to realign its many organizational maps into one map with five districts to better serve Veterans. As part of this Department-wide realignment, VHA began aligning existing VISN's with the five Department level districts. This realignment is resulting in the consolidation of certain VISNs and the redistribution of some facilities to new VISNs.

VA is working to reorganize the Department for success, guided by ideas and initiatives from Veterans, employees, and all of our shareholders. This reorganization is a part of the MyVA initiative and is designed to provide Veterans with a seamless, integrated, and responsive customer service experience.

VHA has been carefully executing the VISN realignment, and assessing the results for both best practices and for lessons learned in support of future efforts. VHA has made considerable progress in consolidating VISNs 2 and 3, and VISNs 10 and 11. VHA currently has 19 VISNs, and will have 18 by the end of fiscal year 2017.

As the ongoing VISN realignment continues, VHA will integrate the VISN process with the overall VHA processes for organizational analysis and redesign. VHA will strive for a seamless flow of organization analysis and change – connecting the field, VISN and Central Office organizational structures into a coherent model that enables the flow of communication and mission execution at all levels.

VHA is strongly committed to developing long-term solutions that mitigate risks to the timeliness, cost-effectiveness, quality and safety of VA's health care system. VHA is using the input from GAO and other advisory groups to identify root causes and to

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(GAO-16-803)

develop critical actions. VHA is dedicated to sustained improvement in the high risk areas.

The content in this report applies to high risk areas 1 (ambiguous policies and inconsistent processes) and 2 (inadequate oversight and accountability). VHA recognizes the value of a structured, methodical approach to optimal organization design. VHA is integrating existing activities and expertise to ensure a focused effort; leading to an enhanced process for organization design and approval in fiscal year 2017.

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Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

Debra A. Draper, (202) 512-7114 or draperd@gao.gov.

Staff Acknowledgments

In addition to the contact named above, Janina Austin, Assistant Director; Malissa G. Winograd, Analyst-in-Charge; Amanda Cherrin; and Amanda Pusey made key contributions to this report. Also contributing were Jennie F. Apter, George Bogart, Muriel Brown, and Jacquelyn Hamilton.

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/11/2016 8:14:15 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: proposal for nursing home project

I think thats right- if the commitment in total
Is less than 600 k - it will be harder to bring on real dedicated resources like (b) and (b) to build a company

Sent from my iPhone

On Dec 11, 2016, at 2:36 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:

> Yes- I think we make it a year and a minimum of 30 facilities - good point- I will incorporate - this should not be a surprise and I am sure she will get back to me to negotiate
>
> Sent from my iPhone
>
> On Dec 11, 2016, at 2:34 PM, David shulkin <Drshulkin@aol.com> wrote:
>
> > It looks good- should there be a minimum commitment to the performance phase- 3 months or 6 months? Would we do the assessment without the performance phase piece?
> >
> > Sent from my iPhone
> >
> > On Dec 11, 2016, at 1:31 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
> >
> > > Please review- if you think its OK- will send it along- I had committed to sending it to them by Monday
> > >
> > > <ACA- CAN S&S.docx>

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Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 12/11/2016 7:36:58 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: proposal for nursing home project

Yes- I think we make it a year and a minimum of 30 facilities - good point- I will incorporate - this should not be a surprise and I am sure she will get back to me to negotiate

Sent from my iPhone

On Dec 11, 2016, at 2:34 PM, David shulkin <Drshulkin@aol.com> wrote:

> It looks good- should there be a minimum commitment to the performance phase- 3 months or 6 months? Would we do the assessment without the performance phase piece?
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> Sent from my iPhone
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> On Dec 11, 2016, at 1:31 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>
> > Please review- if you think its OK- will send it along- I had committed to sending it to them by Monday
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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/11/2016 7:34:04 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: proposal for nursing home project

It looks good- should there be a minimum commitment to the performance phase- 3 months or 6 months? Would we do the assessment without the performance phase piece?

Sent from my iPhone

On Dec 11, 2016, at 1:31 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:

> Please review- if you think its OK- will send it along- I had committed to sending it to them by Monday
>
> <ACA- CAN S&S.docx>

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Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 12/11/2016 6:31:32 PM
To: David Shulkin [drshulkin@aol.com]
Subject: proposal for nursing home project
Attachments: ACA- CAN S&S.docx

Please review- if you think its OK- will send it along- I had committed to sending it to them by Monday

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Alaigh Care Associates
www.AlaighCare.com

Nursing Home Systems of Care Transformation

(b) (4)
[redacted]

Menu-Driven Services Provided by Alaigh Care Associates

Base Core Services

(b) (4)
[redacted]

Tailored Add-On Services- *pricing upon request*

- (b) (4)
  [redacted]

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Alaigh Care Associates
www.AlaighCare.com

- (b) (4)
- [redacted]

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Message

From: (b) (6) [(b) (6) @gmail.com]
Sent: 12/1/2016 1:30:51 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Fwd: American Airlines mobile boarding pass

We will work to change your seat in the morning

---------- Forwarded message ----------
From: <americanairlines@aa.com>
Date: Nov 30, 2016 8:29 PM
Subject: American Airlines mobile boarding pass
To: <(b) (6) @gmail.com>
Cc:

Retrieve your boarding pass:
https://www.aa.com/reservation/mbp.do?fN=DAVID&lN=SHULKIN&rL=RNFEDO&selectedIds=01.01

For iPhone, add your mobile boarding pass to Apple Wallet.

For Android, take a screenshot of your boarding pass to make it easy to retrieve.

We look forward to seeing you on board.

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Message

From: Bob McDonald [(b) (6) @gmail.com]
Sent: 12/3/2016 1:56:45 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re:

Great to hear David. I like the President and see many ways a partnership can help Veterans. Thanks. Bob

Sent from my iPhone

> On Dec 2, 2016, at 8:42 PM, David shulkin <Drshulkin@aol.com> wrote:
>
> Bob- i spoke today at the Bush Institute and president Bush gave a few remarks- he made it a particular point that VA is doing great work and that we dont get the recognition we deserve- clearly you did a great job with him and made a big impact
>
> David
>
> Sent from my iPhone

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 12/3/2016 1:42:38 AM
To: bob mcDonald [(b) (6) @gmail.com]

Bob- i spoke today at the Bush Institute and president Bush gave a few remarks- he made it a particular point that VA is doing great work and that we dont get the recognition we deserve- clearly you did a great job with him and made a big impact

David

Sent from my iPhone

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Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 11/26/2016 3:14:43 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Fw: [External] Please resend this final attached presentation
Attachments: VHAOrgBrief-PresidentialTransition-DJONES_v2 (002) REVISED Access Team v8.pptx

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From: (b) (6) [USA] (b) (6) @bah.com>
Sent: Saturday, November 26, 2016 10:10 AM
To: Poonam Alaigh; (b) (6) (ERPi)
Subject: RE: [External] Please resend this final attached presentation

Poonam,

Email 2 of 3.

Thank you,

(b) (6)

Booz | Allen | Hamilton

(b) (6)

Lead Associate

Mobile: (b) (6)

(b) (6) @bah.com

www.boozallen.com

From: Poonam Alaigh [mailto (b) (6) hotmail.com]
Sent: Saturday, November 26, 2016 10:00 AM

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To: (b) (6) [USA] (b) (6) @bah.com>; (b) (6) (ERPi) (b) (6) @va.gov>
Subject: [External] Please resend this final attached presentation

(b) (6) I further edited the presentation yesterday and tried sending it to USH. For some reason, he cant open it. Can you see attached and then decompress it or change the format so that he can open it on his personal computer. Call me if you want to talk. Please see attached

Also please send as 2 separate emails- ppx and ppt

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Purpose and Agenda

- **Purpose:** To provide an overview of the Veterans Health Administration (VHA) and highlight major priorities and challenges
- **Overview:**
  - Organization, Budget and FTEs
  - Our Mission and Who We Serve
  - Assessment of VHA's Situation
    - Priorities
    - Performance
  - Accomplishments in FY 2016
  - Future Direction, Priorities and Opportunities for VHA

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Relevant Questions

- Is VHA making progress?
- What do Veterans think of VHA care?
- How does VHA compare to the private sector?
- What services should be provided in the community and what services within VHA?
- What are costs associated with moving more care out into the community?
- What is the impact of changes to ACA to VHA?
- Are there sustainable fixes to funding future VHA care?

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Organization, Budget and FTEs

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Organizational Leadership



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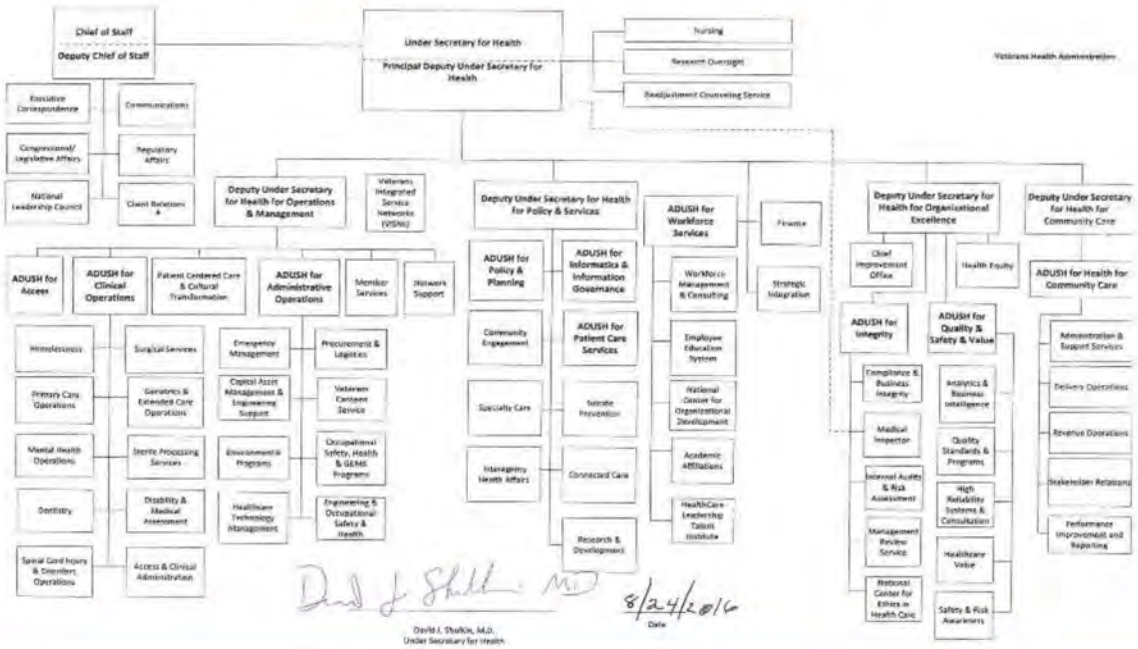
Organization Chart



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Budget and FTEs

FY 17 Enacted Budget	FY 18 Enacted Budget	Change (% Change)
$72,835,537	$70,012, 287	-2,823,250 (-3.9%)

Employees in VHA- 320,795 FTEs

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How We Are Different:
Our Mission and Who We Serve

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The Largest Healthcare System in the United States

- 1,234 health care facilities
  - 168 VA Medical Centers
  - 1,055 outpatient sites
- 25,000 physicians and
- 93,600 nurses (RN, LPN & NA)

- Over four times as many hospitals as Kaiser
- Over twice as many hospitals as DoD

Annual Workload Snapshot



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Annual Financial Report source file for graphic

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Who We Serve

- Veterans who rely most on the VA
  - Veterans with lower income
  - Veterans living in rural areas
  - Veterans without other access to health insurance coverage
  - Veterans with poorer self-reported health status
  - Veterans with higher rates of comorbidities
- The prevalence of many common conditions is projected to increase among Veterans over the next 10 years
- In the event of a potential future conflict, even moderate levels of deployment could substantially increase the size of the incoming cohort of VA patients

Findings from the independent assessment (section 201) Appendix A Demographics

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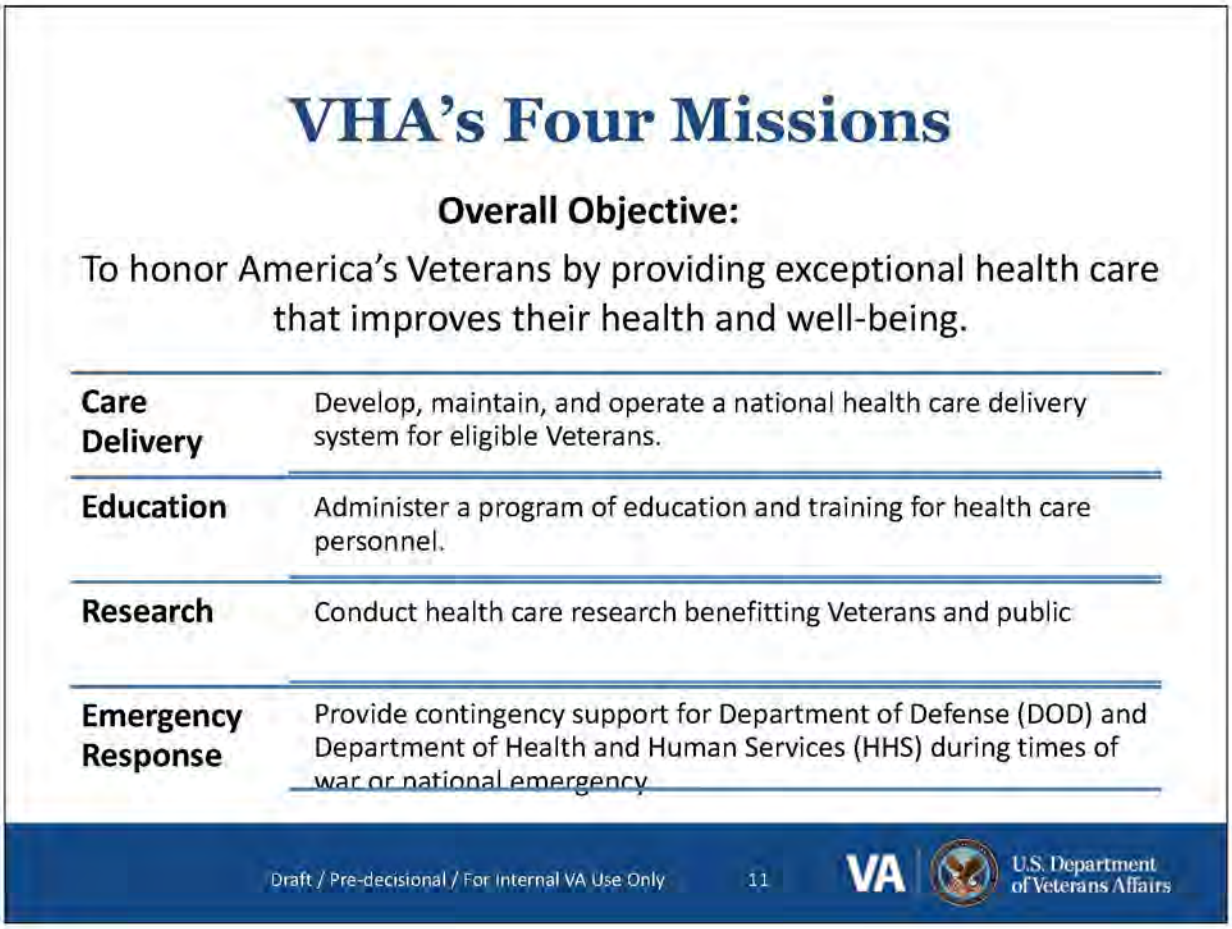

Our mission extends beyond healthcare for Veterans

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VA Healthcare Services Not Found in the Private Sector

- Caregivers
- Travel
- Dental
- Homeless Programs
- Long Term Care
- Readjustment Counseling
- Rural Health Outreach
- Special Populations- Spina Bifida, Camp Lejeune
- Comprehensive Emergency Medical Program
- Health Professions Educational Assistance
- Income Verification Match
- Hepatitis C Treatments
- Prosthetics
- Comprehensive Behavioral Health Programs
- Blind Rehabilitation
- Veterans Crisis Line
- Beneficiary Travel

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VA Healthcare Costs Not Found in the Private Sector

$Millions	FY 2015	FY 2016	FY 2017
Beneficiary Travel	$853	$888	$924
Camp Lejeune	$10	$24	$21
Caregivers	$454	$623	$725
CHAMPVA, Spina Bifida, FMP, CWVV	$1,547	$1,817	$1,920
Comprehensive Emergency Medical Program	$147	$135	$139
Dental Care	$1,005	$1,035	$1,433
Health Professions Educational Assistance programs	$37	$56	$70
Homeless Programs	$1,507	$1,477	$1,591
Income Verification Match	$17	$19	$19
Long Term Care	$7,702	$8,223	$8,588
Readjustment Counseling	$221	$258	$244
Rural Health Outreach Initiatives	$219	$270	$250
Sharing Agreements - Services Provided by VA	$157	$157	$166
Subtotal	$13,875	$14,980	$16,090
Hepatitis C (assume 50% greater benefit)	$406.1	$500.0	$500.0
Mental Health (assume 50% greater benefit)	$2,283.9	$2,494.9	$2,610.6
Prosthetics (assume 50% greater benefit)	$909.0	$950.3	$1,215.2
Subtotal	$3,599.0	$3,945.2	$4,325.9
Total	$17,473.9	$18,924.9	$20,415.8

Educational
Employment Services

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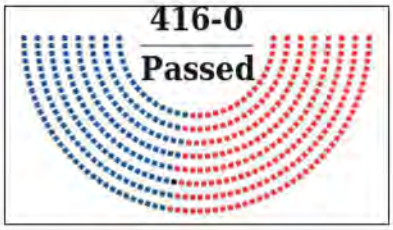
20 Years of Increasing Demand for Services

- 1996 "Veterans Eligibility Reform Act"
- Conflicts in Afghanistan and Iraq continued
  - Congress provided eligibility for care for five years after discharge
- From 2002 to 2015, VHA outpatient volume increased from 46.5M to almost 97M visits
- 2014 "The Veterans Access, Choice and Accountability Act"



IRAQ AND AFGHANISTAN VETERANS OF AMERICA

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- Enactment of Public Law 104-262, "Veterans Eligibility Reform Act" in 1996 allowed VA to provide full continuum of care for all Veterans who chose to enroll for care

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Myths vs. Reality

Myth	Reality
Veterans cared for by VHA have similar issues to most other Americans	Users of VHA are older and have more complex medical issues than non-users (almost 50% of users have a mental health diagnosis)
Care in VHA is poor quality	Numerous independent studies have shown that quality or equal or better
VHA does not want to utilize private sector health providers	22% of all care currently is done in the community- Close to 4 million Choice Act Authorizations has been utilized
Veteran Suicides are only a VHA problem	Of the 20 Veterans who take their own life a day- 14 do not get care in VHA
The private sector offers the same services as in VHA	More than 16 billion dollars in care a year goes towards services not provided by private sector
Access to services is worse than the private sector	96.5% of veterans were seen within 30 days of their clinical indicated or preferred date. Similar data is not readily available from the private sector
Veterans want to use private sector providers and not VA services	Of the 1 million veterans that used Choice, less than 5000 veterans did not also receive their care in VHA

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Impact of VHA Research

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VHA Priorities

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USH 5 Priorities for Strategic Action

Access

We will provide timely access to Veterans as determined by their clinical needs.

PSA: We pledge that any Veteran with the requirement for urgent care will receive care at the right time appropriate to his or her clinical needs

Employee Engagement

We seek a work environment where employees are valued, supported, and encouraged to do their best for Veterans.

PSA: We will work to allow staff to have greater input into their work environment.



High Performance Network

We will ensure that Veterans receive the highest level of coordinated care within VA or from participating providers.

PSA: We will build a high performance network of care to best serve Veterans.

Best Practices

We will use best clinical practices. We also seek best practices in research, education, and management.

PSA: We seek to identify and disseminate best practices throughout VA.

Veterans First: Trust in VA Care

We will be there for our Veterans when they need us.

PSA: We will share our results on the quality and timeliness of how we care for Veterans.

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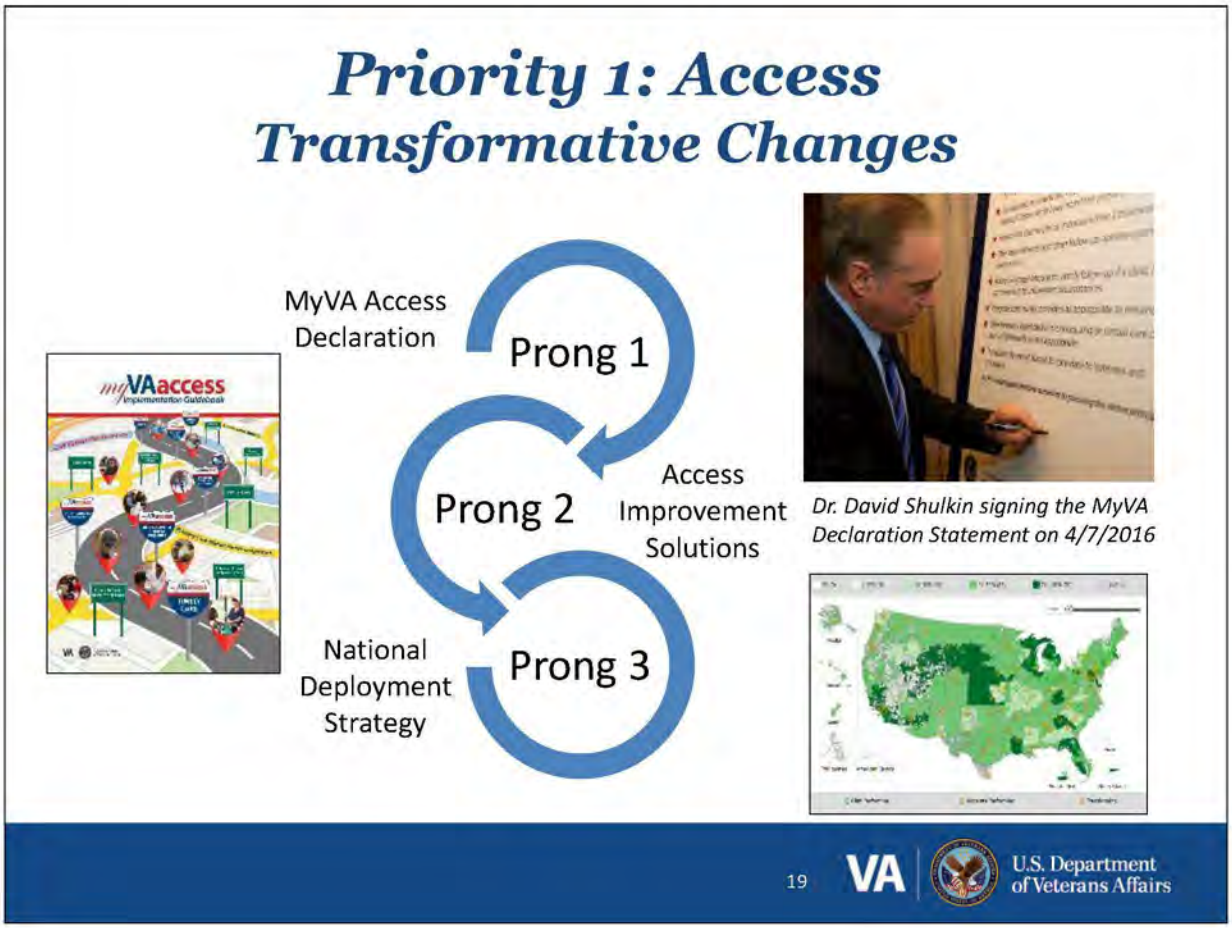

Transformative changes heading
Prong
Guidebook
Map

Same day Services for urgent needs
Path to SDA

Third slide is Results and impact that improve access

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Priority 1: Access

Same Day Access in Primary Care and Mental Health

By the end of this year, we may be the most accessible healthcare system in the United States

September
52 sites (31%)

October
85 Sites (51%)

November
123 Sites (74%)

December
166 Sites (100%)

Same Day Services:

If you need care right away during regular business hours, you are able to get services the same day, or if after hours, by the next day from a VA Medical Center or Health Care Center.

- Options for how that care might be provided include in person, via telephone, smart phone, through video care, secure messaging ,or other options.
- This care may be delivered by your provider or another appropriate clinical staff member based on availability and your care needs.
- *For a medical emergency always call 911 or report to the emergency room closest to where you are located.*

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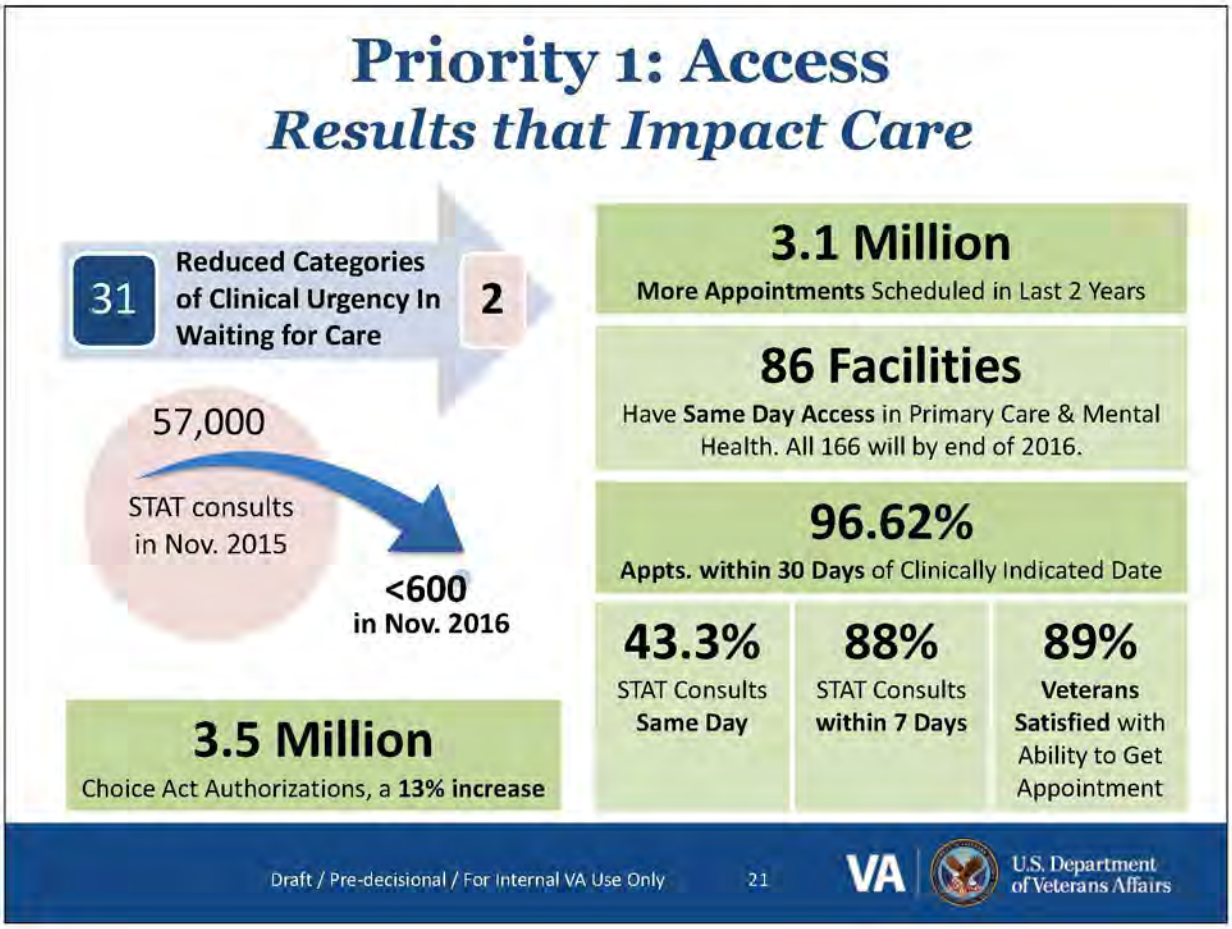

Second bullet is discussing STAT consults over 30 days

Categorized veterans waiting for care into clinical urgency (from 31 categories to 2)
57,000 stat consults in Nov 2015 to <600 in November 2016
3.1 Million more appointments scheduled in the last 2 years
86 facilities have Same Day Access in Primary Care and Mental Health. All 166 facilities will be able to offer these services by the end of 2016
89% of veterans satisfied with the ability to get an appointment (2.1 M veterans)
In October 2016, 96.62% of appointments were within 30 days of the clinically indicated or Veteran's preferred date
43.3% of stat consults were completed same day and 88% were seen within 7 days (a 22% increase from the start of the fiscal year)
Map of veterans evaluation of waiting times by site placed on internet on 11/11/16
Expanded scheduled hours on weekends and evenings, productivity, people, and space
More than 3.5 million authorizations through Choice from September 1, 2015 through August 31, 2016. This represents a 13% increase in authorizations when compared to the same period in 2014/2015

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Priority 2: Best Practices
& Performing as an Integrated Enterprise

- Successfully replicating **13 USH Gold Status best practices 386 times** throughout the system:
  - ➢**85** of those replications have been completed **within 9 months**
  - ➢**301** of those replication projects are **ongoing and on track**
  - ➢**Over 100 facilities** are replicating at least one of the best practices
- Examples would be using Pharmacists to manage medications and a Virtual Tumor Board



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Priority 3: High Performance Network

- As of the end of FY 2016, the Veterans Choice provider network has grown by **85%** and includes more than **350,000** network providers.
- Clinical workload is up **12%** over the past two years—**9%** within VA and **31%** in the community. The **12%** increase translates into roughly **7.5 million** additional hours of care for Veterans.
- New Choice Plan submitted to Congress in October 2015
- RFP planned to be released at end of month for revisions to Community Care program



Draft / Pre-decisional / For Internal VA Use Only 23 VA U.S. Department of Veterans Affairs

When Congress passed the Veterans Access, Choice and Accountability Act in 2014 (the Act), which established the Veterans Choice Program (VCP), the Act specified that the program may not furnish care or services after the expiration date of the program on August 7, 2017, or when the funding allocated ($10 billion) was exhausted.
Without further action by Congress before August 7, 2017, those Veterans that receive care through the current VCP (approximately one million unique Veterans have sought care through VCP since its implementation) will have to discontinue VCP care, and those Veterans newly authorized to receive VCP care will have to make alternative arrangements to receive care.
Other VA community care programs may not have the capacity to handle the entirety of patients who will come off of the current VCP. Wait times for appointments at VA facilities will likely rise if large numbers of Veterans return to VA to seek care.

Our goal for VA Community Care is to deliver a program that is easy to understand, simple to administer, and meets the needs of Veterans, community providers, and VA staff. How will we get there? Our approach consists of five components:
1. Eligibility: We want to provide easy to understand eligibility information to Veterans, community providers, and VA staff.
2. Referral and Authorizations: We want to streamline referral and authorizations, providing Veterans timely access to a community provider of their choice.
3. Care Coordination: We want to solidify care coordination through seamless health information exchanges.
4. Community Care Network: We plan to implement a Community Care Network that provides access to high-quality care inside and outside of VA.
5. Provider Payment (Claims): We want to become better partners to our community providers by paying them promptly and correctly.

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Second bullet references a comparison of FY 14 to FY 15 and was originally completed by Finance in March 2016

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Priority 4: Employee Engagement

- VA Pulse - **94,339 unique users**
- Holding **Quarterly Town Hall Meetings** and site based employee open forums
- **AES scores improved** from 3.45 (2014) to 3.58 (2016)



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Priority 5: Restoring Trust

	VE Measure	% Agree or Strongly Agree Jan-Mar 2016 (Q2) (n=24,415)	%Agree or Strongly Agree Apr-Jun 2016 (Q3) (n=29,873)	%Agree or Strongly Agree Jul-Sep 2016 (Q4) (n=27,758)
BRAND	**"I trust VA to fulfill our country's commitment to Veterans"**	**55%**	**59%**	**60%**
VETERANS EXPERIENCE – EFFECTIVE	"I got the care or service I needed"	72%	74%	75%
VETERANS EXPERIENCE – EASE	"It was easy to get the care or services I needed"	61%	65%	66%
VETERANS EXPERIENCE – EMOTION	"I felt like a valued customer"	63%	67%	68%

This survey was conducted by an independent contractor and validated by survey subject matter experts from Research Triangle International.

Acknowledgements to National Center for Organizational Development Dr Scott Moore and VHA Operational Excellence Dr Steven Wright.

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VHA Accomplishments in 2016

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Suicide Prevention

- **Elevated Office** of Suicide Prevention
- Completed and released a **landmark, comprehensive data analyses of Veteran suicide rates**, examining over 50 million Veteran records from 1979 to 2014 from every state in the nation, providing critical insights to help inform and shape our policies and efforts
- Reach Vet Program initiated to **proactively reach out** to those at highest risk
- **Added 163 responders** to the Veterans crisis line and added direct connections from the phone system to VCL
- Hugely successful Suicide Prevention Month 2016 campaign **#BeThere** garnered **over 73 million social media impressions** across various platforms, over 420 million impressions from TV, radio, and out of home placements (earned and paid), and was supported via Twitter by Joe Mantegna and Senators McCain and Sanders



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Innovative Healthcare

Telehealth

- In FY 2016, 12% of all Veterans enrolled for VA care received telehealth-based care. This includes **2.17 million telehealth visits, touching 702,000 Veterans**.
- Upcoming expanded services through VAR and VA Video Connect in 2017.

Million Veterans Program

- Program to incorporate **precision medicine** to improve Veterans' health by establishing large database containing genetic, military exposure, lifestyle, and health information with over **520,000 enrollees** as of Oct. 2016

Office of Compassionate Innovation

- Launched **Mental Health Service Dog** pilot to assist Veterans with mental health conditions that impede their mobility
- Since Center for Compassionate Innovation announced in April 2016, 38 proposals received; **8 proposals have moved to field implementation or warm hand-off** and **3 have been closed**

New

VA / Watson Cancer Partnership for Precision Oncology

Connect Care

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Complex Care Needs

Homelessness

- There was a **17 percent decline in Veteran homelessness** between 2015 and 2016, quadruple the previous year's annual rate of decline
- Since 2010**, over 480,000 Veterans and their family members have been permanently housed**, rapidly rehoused, or prevented from falling into homelessness by HUD's targeted housing vouchers and VA's homelessness programs

We've cut Veteran homelessness nationwide by 47% since 2010

Providing Counseling Services where Veterans are Comfortable

- More than **1 million primary care/mental health integration visits**
- More than **1.5 million visits** to Vet Centers providing readjustment, Military Sexual Trauma and bereavement counseling services



Hep C Management Notes

VA follows CDC recommendations to screen everyone born between 1945-1965 as they are at the highest risk of having HCV. Screening is also recommended for those born outside of this cohort who have other risk factors.

Source: VA's National Center for Health Promotion and Disease Prevention (NCP) HCV Screening recommendations: http://vaww.prevention.va.gov/CPS/Screening_for_Hepatitis_C.asp

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Public Health Issues

Hepatitis C Management

- In FY15 & 16, **VA treated a total of 69,294 Veterans with Hepatitis C** with an anticipated cure rate of over 90%.
- In CY2015, **69.9%** of the birth cohort (Veterans born between 1945-1965) were **screened for Hepatitis C**.



Reducing Opioid Abuse and Dependency

- 22% reduction in opioid use
- 42% reduction in use of opioids and benzodiazepines
- 32% reduction in dosages



Prevention Programs

- 42,000 Veteran Flu Shots at Walgreens
- MOVE! has helped over 600,000 patients lose weight, keep it off, and improve their health

Walgreens

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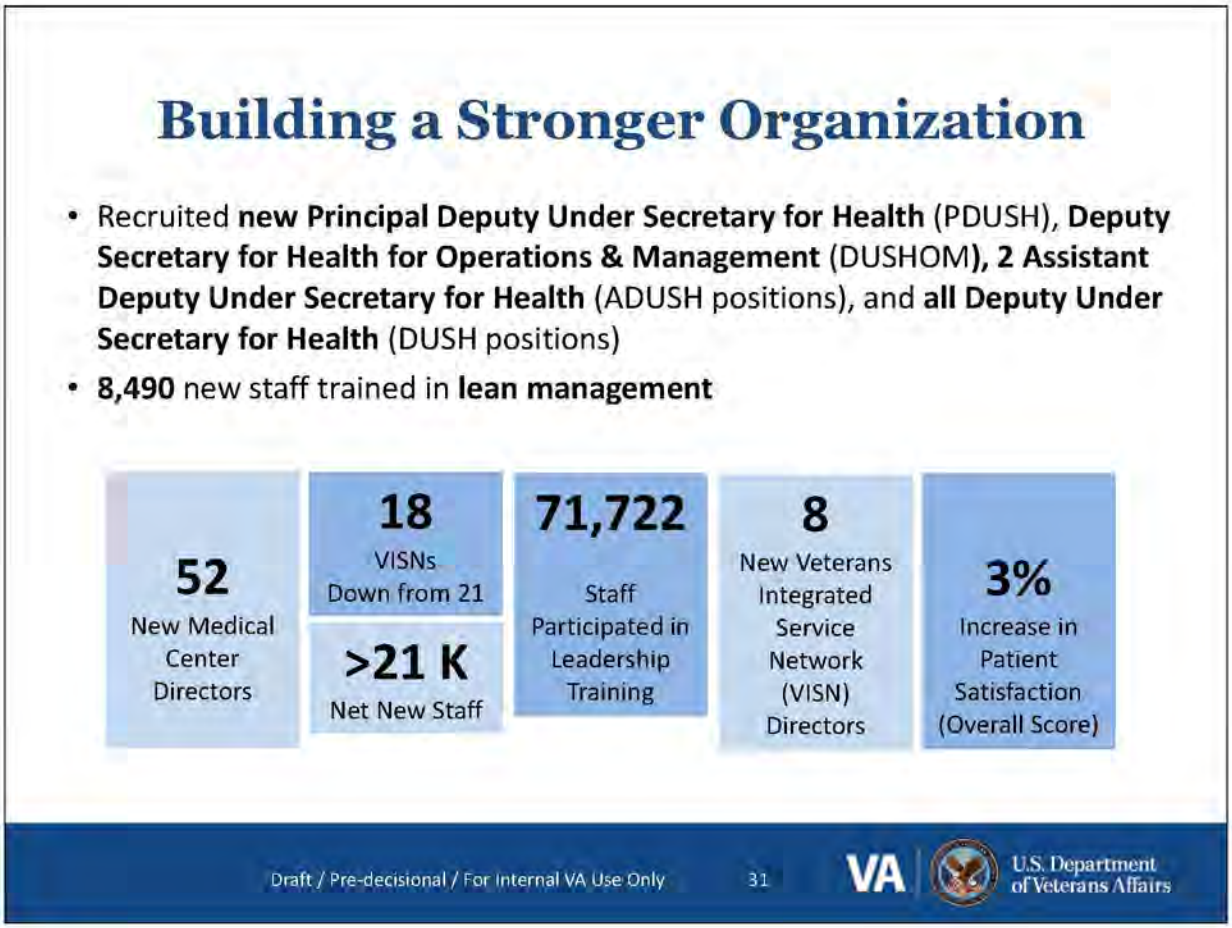

5th bullet notes:

Precision Oncology is the targeting of cancer therapy to the molecular profile of the cancer. This is not new – for many years we have been tailoring cancer therapy for some cancers. An easy example is assessing breast cancer for the presence of estrogen receptors, then using medications that block the effect of estrogen, thus blunting the effect of hormones which drive breast cancer growth. However, in the last 10 years the ability to sequence many genes simultaneously has led to an understanding of the specific mutations that drive cancer growth in many tumor types. This has gone in parallel with the development of medications that target and inhibit the effect of these specific driver mutations. Use of these targeted therapies has resulted in dramatic responses in some cases that previously had very poor outcomes. Unfortunately, only a small minority of cancers have identifiable mutations and targeted therapy available. The VA is currently expanding a program of sequencing a large number of genes in solid cancers, with several aims: to identify mutations in cancers for which there is available targeted therapy and treat these Veterans with the best available therapy; to identify mutations in cancers that might make them susceptible to an approved drug as an off label use; and to identify Veterans with molecular profiles in their cancer that would allow them to consider enrolling in clinical trials. To address the analysis of the molecular data, the VHA has a partnership with IBM Watson Health. This partnership will enhance our ability to both ensure Veterans receive the best available care now, and that clinical and basic research will improve care in the future.

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Serving our Veterans and the Nation

Culture of Improvement

- 6th year – **VA's pharmacy benefits ranked among best in class**
- **24 million in cost avoidance** through our supply chain efforts
- An Integrated operations center to **proactively monitor and identify** issues in quality or access
- **23,000 pounds of used medications** returned and **destroyed** this year

Service to the Nation

- **9,860 research publications** in 2016
- Added **547.4 graduate medical education positions**
- Responded and deployed to **6 national emergencies**



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VHA's Performance

- Comprehensive **Quality Measures** are in place
- VA generally performs **better than private sector**
- **82%** of medical centers showed **quantitative improvement** in quality last year
- Risk adjusted **mortality improved 20%** in 2016
- **Patient Satisfaction** scores show **improvement** across the board

1st bullet:
Regarding Strategic Analytics for Improvement and Learning (SAIL) Model

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82% of VAMCs with Improvement
SAIL Quality Measures in Past Year

	FY16Q3 SAIL Quality Star Percentile Cut-Off					
Overall Quality FY15Q4-FY16Q3[1]	Top10% 5-Star	11-30th% 4-Star	31-70th% 3-Star	71-90th% 2-Star	Bottom10% 1-Star	Total
Large Improvement	8	18	35	20	9	90
Small Improvement	3	7	13	5	2	30
Trivial Improvement	1	3	3	3	1	11
Trivial Decline	3	1	0	0	1	5
Small Decline	1	1	2	0	1	5
Meaningful Decline	1	1	2	0	1	5
Total	17[2]	31[2]	55	28[3]	15[3]	146[4]

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Most Challenged Sites Making Improvements

Site	Indicator	FY14	FY16 (YTD)
Phoenix	CAPHS - Routine Care	66	74
	CAPHS - Urgent Care	51	56
Hines	CAPHS - Routine Care	83	88
	CAPHS - Urgent Care	74	78
Shreveport	CAPHS - Routine Care	79	82
	CAPHS - Urgent Care	65	70
Spokane	CAPHS - Routine Care	81	82
	CAPHS - Urgent Care	64	68
Greater LA	CAPHS - Routine Care	82	83

Note: a 4 to 5 point change is considered "clinically significant"

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Comparative Data

	VHA	Private Sector
Quality		
Satisfaction		
Access		
Employee Engagement		
HEDIS		

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Studies showing better outcomes
JAMA

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Comparing VA Care to Private Sector

- 30-day risk-standardized **mortality rates are lower** in VA than those of non-VA hospitals for acute myocardial infarction and heart failure
- **MRSA infections declined** 69 percent in VA acute care facilities and 81 percent in spinal cord injury units over 5 years thanks to VA's aggressive MRSA prevention plan.
- VA performed the **same or significantly better** than non-VA providers on 12 of 14 **effectiveness measures in the inpatient setting**
- VA performed **significantly better** on 16 **outpatient HEDIS measures** compared with commercial HMOs and significantly better on 15 outpatient HEDIS measures compared with Medicare HMOs
- VA mental health care was **better than private-sector care by at least 30 percent on all seven performance measures**, with VA patients with depression more than twice as likely as private-sector patients to get effective long-term treatment
- **Outcomes for VA patients compared favorably** to patients with non-VA health insurance, with VA patients more likely to receive recommended evidence-based treatment

More data in press release: http://www.va.gov/opa/pressrel/includes/viewPDF.cfm?id=2778

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Future Direction, Priorities and Opportunities

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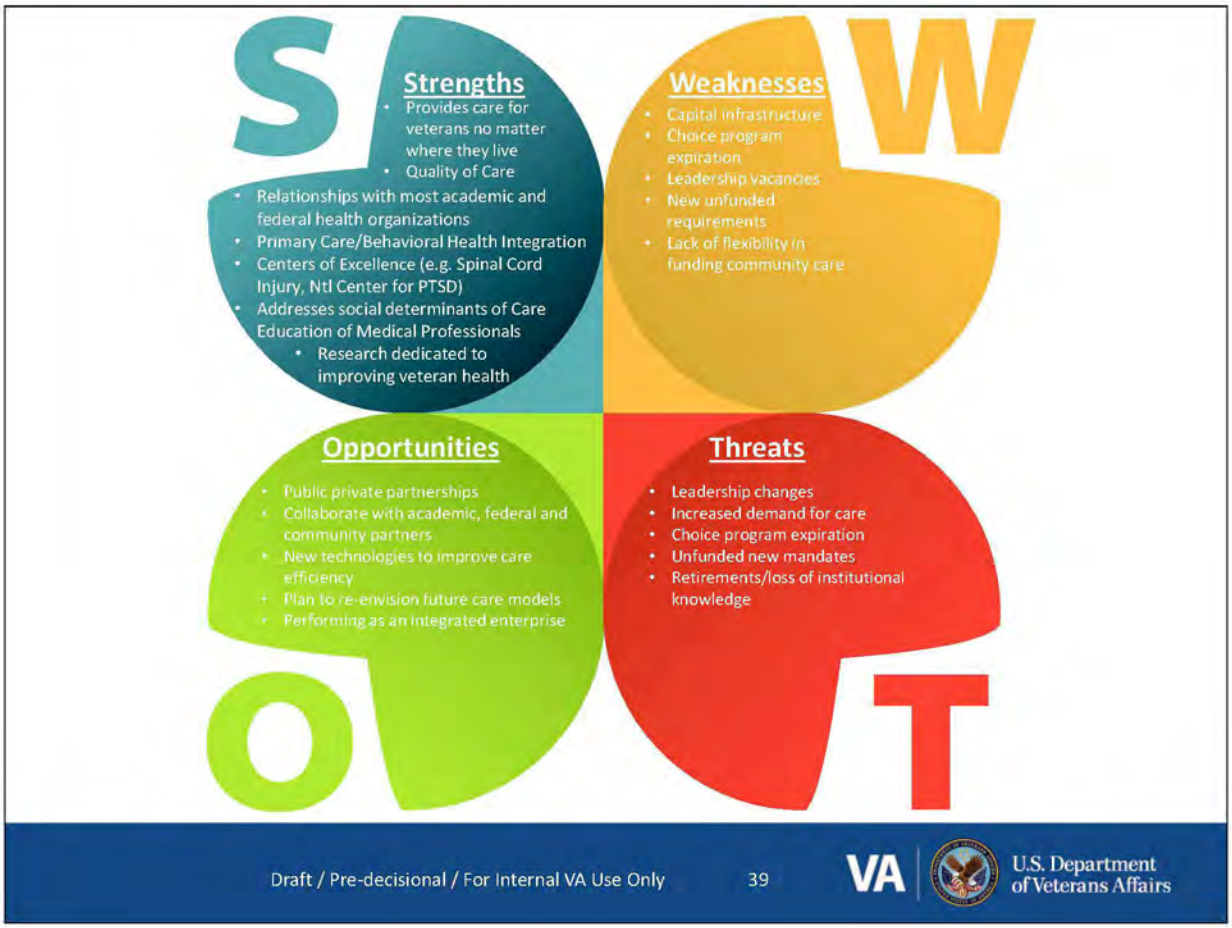

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Increasing Demand

- VA completed nearly **5 million more appointments** in 2015 than in 2014 (FY 2016 data not yet available)
  - Almost **57 million appointments inside VA** and over 21 million in the community.
  - For Veterans that means **over 7 million additional hours** of care
- Veterans are aging and will need **more complex care and long term care** and support services
- Reliance on VA may grow as costs of other insurance and exchanges may increase
  - **Each 1 % increase in reliance is a cost of approximately $1B**

3rd bullet notes:
In 2014, enrollee reliance was estimated to be approximately 34%. We are currently updating reliance analysis with more recent Medicare data, but it is not available at this time. Reliance reflects the portion of health care services that an enrollee needs that we expect VA to provide or pay for. Some enrollees will get all of their health care from the VA and some will get none of their care, but most receive some portion of their care in the VA. For example, based on his/her morbidity, if an enrollee needs 10 office visits in a year and gets 4 of those office visits in VA. This enrollee is said to be 40 percent reliant on VA for office visits.

(b) (6) mentioned wanting to get graphs for this slide and the next from Mark Yow. As such, I haven't edited.

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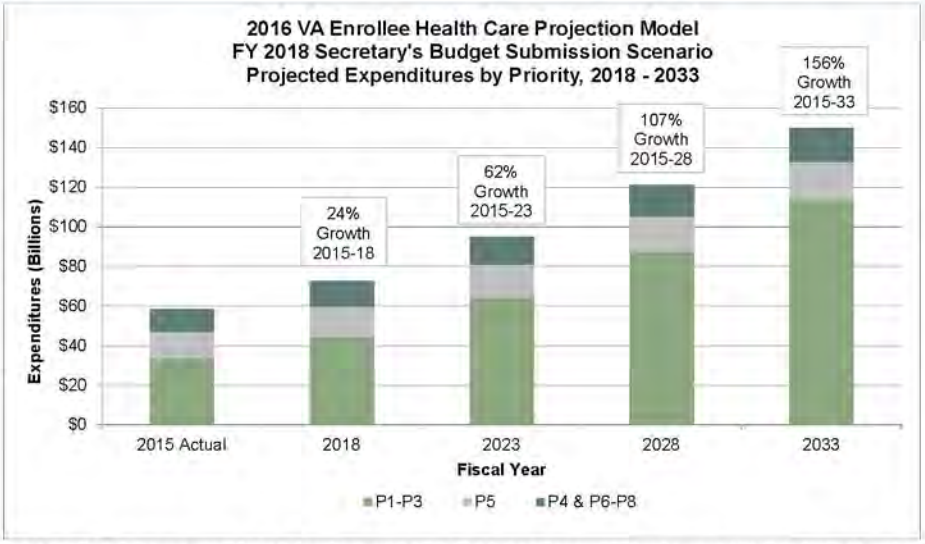
VA's Resource Requirements
Projected to Grow Significantly Over Time



2016 VA EHCPM, Budget Scenario (BAF) Note: The projections do not include requirements for several activities/ programs that are not projected by the VA EHCPM, including non-recurring maintenance, readjustment counseling, state-based long term services and supports programs, and some components of the CHAMPVA program.

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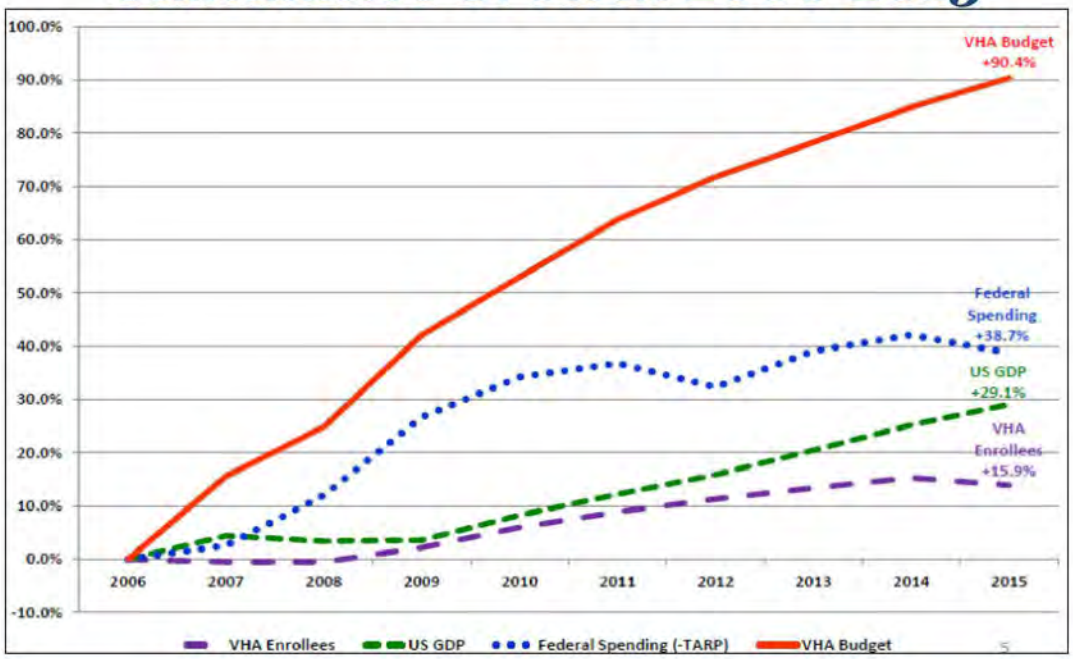
VA Medical Care Budget Challenge:
Cumulative Growth 2006-2015



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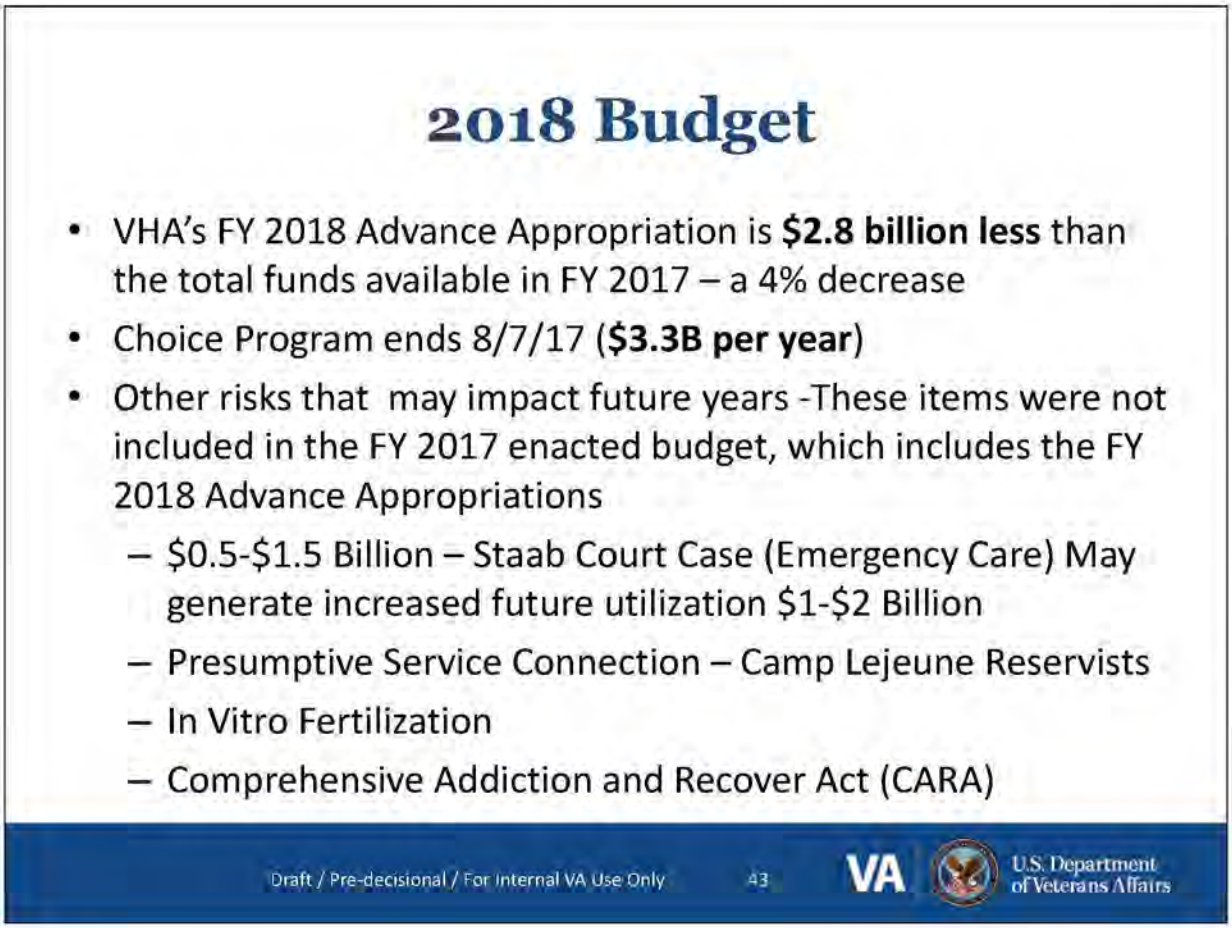

Bullet 3: Estimated budget numbers:
IVF6.5 Million FY 17, 13. million Fy18 --Maximum estimate Non VA Care funds
Adoption: 500K FY 17, 1.5 million FY 18—Maximum estimate
CARA = $153 million – crude estimate, some of which has already been incurred

Camp Lejeune.

Based on evidence there is sufficient scientific and medical evidence available to establish a presumption of connection between exposure to contaminants in the water supply at Camp Lejeune and the occurrence of eight health conditions

The proposed eight presumptive diseases are:
adult leukemia
aplastic anemia and other myelodysplastic syndromes
bladder cancer
kidney cancer
liver cancer
multiple myeloma
non-Hodgkin's lymphoma
Parkinson's disease

VA will not limit entitlement to active duty military personnel. Rather, VA proposes to presume exposure for all active duty, reserve and National Guard personnel who served at Camp Lejeune for no less than 30 cumulative days from August 1,

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1953, through December 31, 1987.

In addition, VA proposes to establish a presumption that individuals who served at Camp Lejeune during this period and later developed one of the presumptive diseases were disabled during the relevant period of service, thus establishing active military service for benefit purposes.

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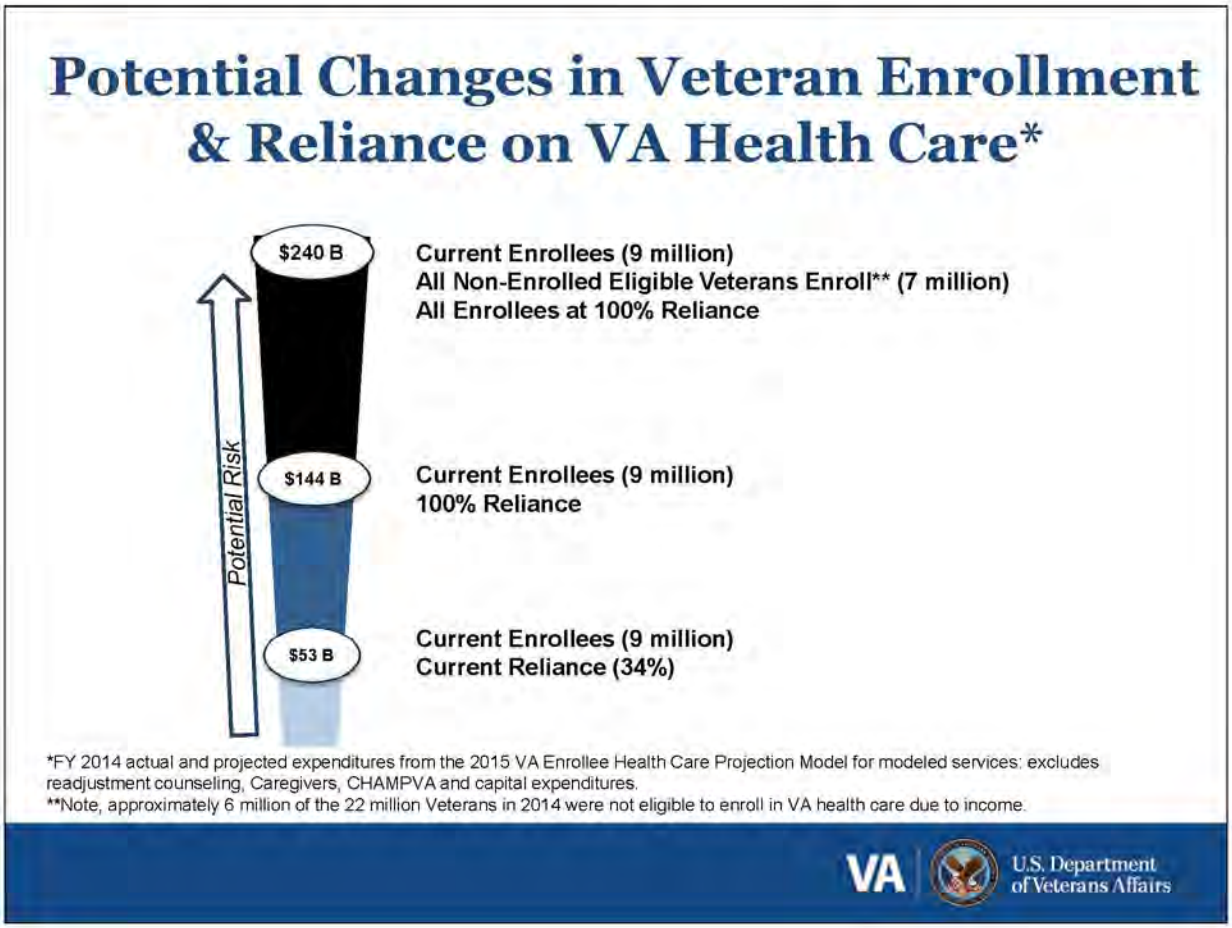

In 2014, costs for modeled services for 9 million enrollees at 34% reliance was $53 billion.

If all those 9 million enrollees used VA for all their health care, the cost in 2014 would have been $144 billion.

If all eligible but unenrolled veterans enrolled in VA and used VA for all their health care, the cost in 2014 would have been $240 billion.

All policy changes move this lever up and down as they impact either reliance on VA for health care, enrollment in VA, or both.

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Continuity of Leadership during a Crisis
Leadership vacancies and succession planning
Maintaining and Strengthening the Gains in Access (including Community Care), Quality, Engagement, and Trust
Direction of the Commission on Care Recommendations
Supporting VHA's Course for a Future Vision

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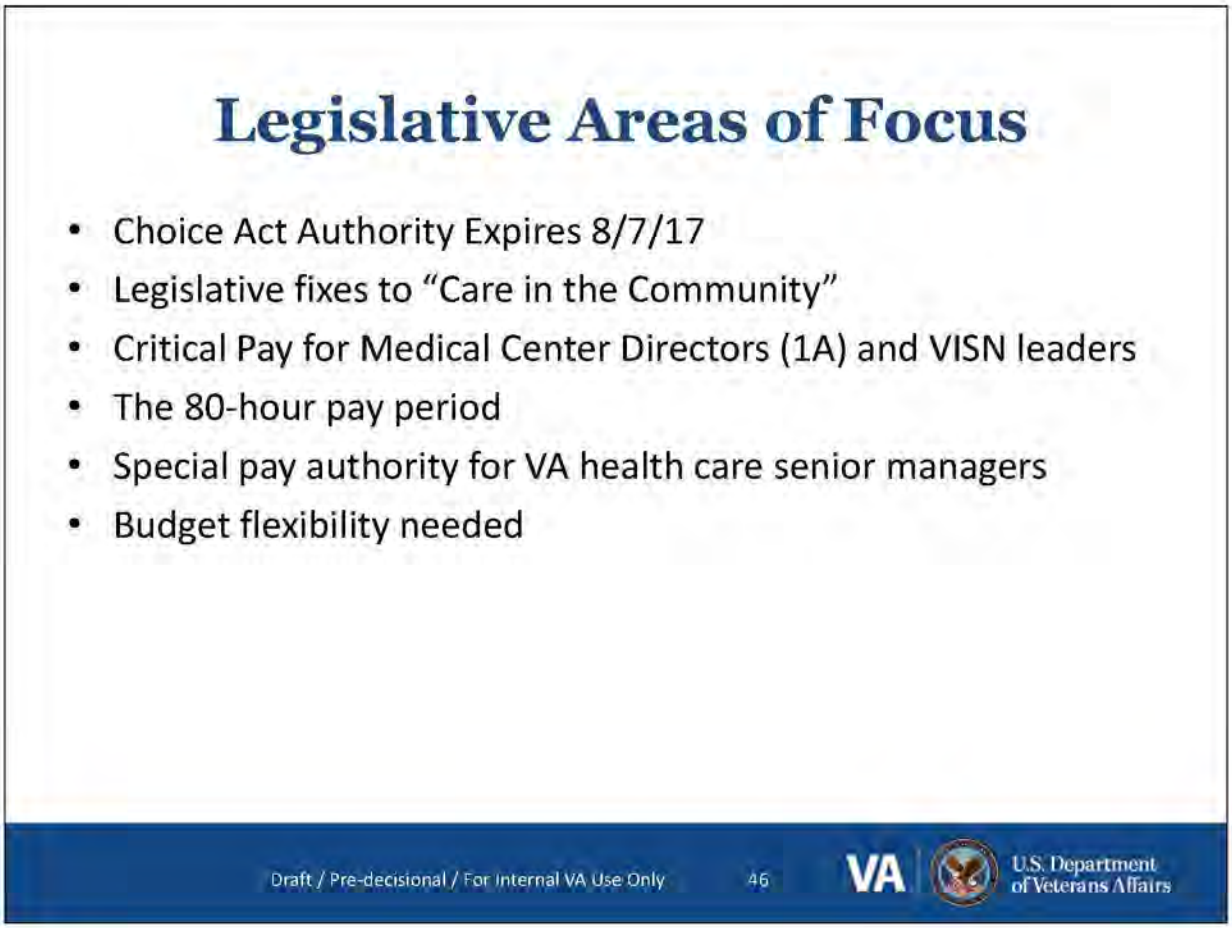

3RD BULLET:
The critical position pay authority (CPPA) allows the Secretary (or designee) to approve higher rates of pay for employees in positions that require expertise of an extremely high level in a scientific, technical, professional or administrative field critical to the Department's successful accomplishment of an important mission to the extent necessary to recruit or retain an individual exceptionally well-qualified for the critical position. Medical Center Directors and other Senior Executive Services (SES) VA health care senior managers would be eligible for CPPA.

Critical position pay requests must be submitted in writing only after it has been determined that the position in question cannot be filled with an exceptionally well-qualified individual through the use of other human resources flexibilities and pay authorities (e.g. recruitment, relocation and retention incentives, special salary rates, above minimum entrance rates).

The Secretary (or designee) must review and approve each critical position pay authority request before forwarding it to the Office of Personnel Management (OPM), who in consultation with the Office of Management and Budget (OMB) will issue final approval.

On September 22, 2016 OPM approved VA's request for CPPA for the Deputy Under Secretary for Health for Operations, 18 VISN Directors, 39 Level 1A Medical Center Directors, and 10 additional positions. 2 employees are in receipt of critical position pay and a plan is being developed for the additional positions.

Currently there is no special pay authority to compensate Medical Center Directors and other SES VA health care senior managers.

AMERICAN OVERSIGHT

Attached for reference is the signed/dated letter from OPM regarding critical pay.

AMERICAN OVERSIGHT

Organizational Areas of Focus

- Streamline Hiring/Onboarding Process
- Space: Leasing restrictions
- Facility Modernization: VHA aging Infrastructure
- Implement Full Practice Authority for Advance Practice Nurses: would increase VA ability to increase access
- Expand telehealth capability
- Implement scheduling system for medical appointments
- Examining intermediate and long term funding options for VA healthcare

AMERICAN OVERSIGHT

Our Commitment to Veterans

- ✓ Veterans should be at the center of what we do and how we deliver care at VHA
- ✓ No veteran with an urgent care need that may cause harm should wait for care
- ✓ VA must act like an integrated enterprise and a learning health system to benefit veterans most
- ✓ We will work closely with our academic, federal and community providers to deliver the highest outcomes to veterans
- ✓ VA leadership and staff must feel proud, fulfilled and empowered to deliver services to Veterans
- ✓ We must regain the trust and confidence of Veterans and the American public
- ✓ VA mission of research, education, and emergency preparedness must continue to contribute to improving the health of Veterans and all Americans

AMERICAN OVERSIGHT

A Future Vision for VHA

- **Public Private Partnerships** to serve Veterans
- **Digital Health Platform**
- **Whole Health Medicine** (empowering veteran well-being)
- Develop the **High Performance Network** (role of VISNs)
- **Center of Excellence** and Foundational Care
- **Value Based Management** and Efficiency Strategies
- Strengthen VA as a **Learning Healthcare System**
- Accelerate **Precision Medicine** and foster innovation
- Provide access to **VA Research Data** for non VA researchers with appropriate safeguards
- **Train More** primary care and behavioral health students

AMERICAN OVERSIGHT