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AN ASSESSMENT OF DEFICIENCIES AT THE NORTHPORT VA MEDICAL CENTER

FIELD HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTEENTH CONGRESS

SECOND SESSION

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AN ASSESSMENT OF DEFICIENCIES AT THE NORTHPORT VA MEDICAL CENTER

Tuesday, September 20, 2016

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

The Committee met, pursuant to notice, at 9:00 a.m., in the Auditorium, Northport VA Medical Center, 79 Middleville Road, Northport, NY, Hon. Jeff Miller [Chairman of the Committee] presiding.

Present: Representatives Miller, Zeldin, Takano, and Rice.

Also Present: Representative Israel.

OPENING STATEMENT OF JEFF MILLER, CHAIRMAN

The CHAIRMAN. This hearing will come to order.

I would like to welcome everybody today to our hearing entitled "An Assessment of Deficiencies at the Northport VA Medical Center."

Before we begin, I want to ask unanimous consent that Members of the New York delegation be allowed to join us on the dais to participate in today's hearing.

Without objection, so ordered.

Ladies and gentlemen, the purpose of the hearing today is to stress the number of problems that have arisen here at this facility. We as the oversight Committee would like to talk to some folks and get some answers today. We are going to focus primarily on quality of care as concerns the facility's state of repair or disrepair, leasing and contract leases and oversight lapses by management at the Veterans Health Administration.

I am sure you are all aware of the numerous issues that have been reported in the media regarding the Northport VA Medical Center. For instance, the operating room was shut down for months earlier this year due to rust and concrete particles being pumped out of the air conditioning ducts. The VA has told Committee Members that there were never any problems with the air quality and that reports to the contrary were overstated.

You are probably also aware of the air conditioning and cooling issues in the ultrasound suites. While VA will tell you that the air temperatures were never at unsafe levels, whistleblowers have informed this Committee of information to the contrary. At times, temperatures have reached higher than 80 degrees, rendering the ultrasound machines unusable.

Further, the facility has chosen to rent temporary air-cooled chillers. Internal VA documents obtained by investigators revealed

that the chillers have cost $1.9 million so far, and estimates that they will pay at least $2.8 million while they await the permanent system replacement.

We are also certainly aware of reports of dilapidated buildings, flooded walking tunnels, and other infrastructure problems that you have either read about or noticed upon entering this auditorium today.

All of these problems have been brought to the attention of this Committee by conscientious whistleblowers who, after seeing no action from their supervisors, made the correct decision to inform the public and the Congress of the unsafe conditions that exist here.

However, in addition to these obvious problems that have been reported in the press, as well as several suicides that have occurred on the campus, there are additional problems that VA has chosen to withhold from this Committee. For months, the Committee has investigated numerous additional problems at Northport related to funding malfeasance, the lack of control, and unreported suicides by veterans and employees. We have VA documentation showing that in the face of declining veteran populations and potential budget deficits related to fewer veteran-related funds at Northport, that Department leadership found a way to cold-call roughly 2,100 veterans who had not sought VA care in the past year. By improperly labeling these solicitation phone calls as an encounter, the facility was able to receive more than $4,200 per contact from VA system to allocate health care between medical facilities, the Veterans Equitable Resource Allocation or VERA system. Northport executive board meetings show that this effort, which is essentially VA leadership claiming money for providing health care to veterans that it did not provide, will result in an increase in VERA funding of approximately $843,129 as of the 2nd of this month, with a stated goal of nearly $10 million.

Facility staff raised concerns that this was wrong, but no apparent effort was made by leadership to put an end to it. This casts a long shadow over the validity of VA's claim that millions more veterans have been receiving appointments in the past two years, as the Secretary has repeatedly proclaimed. It also begs the question as to whether this practice takes place at other VA hospitals as a means of increasing their funding.

Unfortunately, this year has seen numerous suicides and near-death experiences by veterans and employees, some of which have not been reported to Congress or to the public. In January, a veteran overdosed on heroin while a resident of the Beacon House, a homeless veterans center run by a non-profit but is located here on the campus of Northport. In March, a second veteran died from an overdose of fentanyl on a Friday. His body was not discovered until Monday. In August, a veteran took his own life by a self-inflicted gunshot wound on VA premises. Allegedly, the veteran had sought care the day he took his life but was turned away. There is an additional case the Committee is aware of involving the death by suicide of a non-veteran employee who was committed to the Northport VA Hospital and confined for nine days under questionable circumstances. Additional questions remain as to how one of the veterans who overdosed obtained numerous vials of heroin and others obtained fentanyl, a Schedule II narcotic.

I guess it is not surprising that Committee investigators have documented poor control of the pharmaceuticals at Northport, which could contribute to diversion of drugs, as well as the potential for illicit drug trade on or near this campus. We are going to talk about these incidents and other issues today, and during this hearing, but for now, I will yield to the Ranking Member from California, Mr. Takano, for any opening statement he may have.

OPENING STATEMENT OF MARK TAKANO, ACTING RANKING MEMBER

Mr. TAKANO. Thank you, Mr. Chairman, for calling today's hearing. I would also like to thank my friend, Mr. Israel, for joining us, and all Members and witnesses here today who are participating in this hearing.

First I would like to extend my condolences to Mr. Kaisen's family on their loss. This is a tragedy. One veteran's suicide is one too many. We may never know why Mr. Peter Kaisen felt so helpless that he decided to take his own life here in the Northport VA Medical Center parking lot. However, we must get to the bottom of whether more could have been done to prevent this veteran from committing suicide.

This tragedy is a sobering reminder that with 20 veterans committing suicide every day, we must continue to provide vigilant oversight of VA's mental health and suicide prevention programs to ensure that veterans have access to high-quality and safe services offered at any VA medical center in the system.

I understand that Northport was recently recognized nationally for the development of a unified behavioral health center for military or veteran families, in cooperation with the Northwell Health System. I look forward to hearing more about this unique collaboration as we continue our work to reform the VA. This public-private partnership may serve as a model for the rest of the VA's health care system. Sharing best practices is critical to ensuring the best care is rendered to our veterans. Thank you, Dr. Bellehsen, for coming to speak about your program today.

Today we will also discuss infrastructure issues that have been plaguing the facility. I understand the facility is an older one and upkeep of the buildings can be costly, but the safety of veterans and employees who provide and receive services in the facility should be first and foremost. I understand that Members of Congress were not notified that the operating room was shut down due to safety concerns until a news article was published about veterans being sent to other facilities to get their surgeries completed. This is unacceptable. VA should be as transparent as possible when something as serious as an operating room is shut down due to safety. As lawmakers, we need to be made aware of these issues so we can ensure VA has the resources it needs to care for our veterans.

Mr. Chairman, thank you again for holding this hearing, and I look forward to the testimony from the witnesses, I yield back.

The CHAIRMAN. Thank you very much.

We have had a request from a veteran, and probably all of you would like to do this, and I think we will do it so that Mr. Colin

Kaepernick can hear the Pledge of Allegiance. So let's rise and salute our flag.

[Pledge of Allegiance.]

The CHAIRMAN. I would ask that all Members waive their opening statements as per the custom of this Committee.

I am now going to introduce our first and only panel of witnesses who are at the table. We will hear from Dr. Joan McInerney, Network Director for VISN 2. She is accompanied by Phillip Moschitta, Director of the Northport VA Medical Center; and Dr. Charlene Thomesen, Chief of Psychiatry at Northport VA Medical Center. We are also going to hear, as my colleague has already said, from Dr. Mayer Bellehsen, Director of the Mildred and Frank Feinberg Division Unified Behavioral Health Center for Military Veterans and their Families.

I would ask the witnesses if you would please stand so we can swear you in, and raise your right hand.

(Witnesses sworn.)

The CHAIRMAN. You may be seated.

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

Written statements of VA and Dr. Bellehsen will be made a part of the hearing record.

Dr. McInerney, you are now recognized for 5 minutes.

STATEMENT OF JOAN E. MCINERNEY, M.D.

Dr. MCINERNEY. Thank you. Thank you for the opportunity to discuss recent issues at the Northport VA Medical Center.

I was appointed as the Network Director of the Integrated VISN 2 VA New York/New Jersey health care system in May of 2016. I am a Board-certified Emergency Medicine physician with 24 years of experience prior to joining the VA in 2011 as the VISN 3 Chief Medical Officer. I am accompanied by Mr. Phillip Moschitta, Medical Center Director, and Dr. Charlene Thomesen, Associate Chief of Staff for Mental Health.

Regarding the recent tragedy involving one of our veterans, I wish to share some of the facts with the Committee. As reported in the press, a veteran took his life in the parking area at Northport on August 21st, 2016. Sadly, this is a true statement. However, allegations that he was turned away from our emergency department are false. A review of all available records reflects that the veteran did not reach out for help prior to taking his life.

In a recent—

Voice. What—

The CHAIRMAN. Ma'am, if I could ask you to please wait and allow us the opportunity to talk with the witnesses, I would appreciate it very much.

Dr. MCINERNEY. In a recent communication to Chairman Miller, it was alleged that two other veterans committed suicide at Northport this year. While I must respect the privacy details of their deaths, one of the individuals identified was a non-veteran employee who died in the community. The other veteran death was determined by the Suffolk County Medical Examiner not to be a suicide.

Northport has a long history of providing excellent clinical care and mental health at our main facility and our five community clinics. We are committed to providing excellent quality care to our veterans and have developed a comprehensive behavioral health continuum of care.

Northport's mental health walk-in clinic has been in existence for 25 years. An on-site psychiatrist is available 24/7 at the medical center should a patient present at any time requesting psychiatric help.

Northport has a strong reputation of caring for Long Island's 31,500 veterans who come to us for care. Outpatient visits increased 3.1 percent, and appointments for female veterans increased 8.4 percent over the past two years.

In Fiscal Year 2016, Northport completed over 318,000 outpatient appointments, with 99.2 percent of them within 30 days. Mental health access is at 99.95 percent. Specialty care access is at 98.4 percent. Our outpatient access surveys show that 93 percent of Northport's veterans receive a routine primary care appointment as soon as needed.

On February 17th, 2016, Northport OR staff detected sand-sized particles coming from the heating ventilation and air conditioning system in OR 4. Facility leaders rapidly assessed possible risks to patients and staff, and made the necessary decision to close all five of the ORs for veterans' safety. Patients who needed emergency surgery were transferred to affiliate and local hospitals for care. Patients scheduled for elective procedures were offered care through other VISN 2 facilities or in the community through the Veterans Choice program. Many patients opted to wait for the reopening of the Northport ORs. All decisions regarding surgeries were made with input from the patients and their physicians. Clinical review of surgical cases that were postponed has not identified any adverse effects or outcomes.

Through consultation with subject-matter experts within and outside of the VA, Northport developed a three-phase plan to resolve the issues to ensure that ORs could be reopened. The long-term plan for the ORs will be included in Northport's strategic capital investment plan.

Northport is an aging facility with many infrastructure requirements. The engineering staff estimates a complete OR replacement project could cost approximately $15 million to $18 million. To address critical infrastructure needs in Fiscal Year 2017 such as replacing electrical and HVAC systems, several roofing projects, and upgrading emergency generators, we estimate the facility will need approximately $45 million.

Finally, to address the deficiencies identified through the Facility Condition Assessment Plan, Northport would require approximately $290 million to correct deficiencies categorized as "past useful life" and/or projects needing immediate attention.

VA remains committed to ensuring America's veterans have access to the health care they have earned through service. We are committed to accountability and transparency, and providing any requested information to Members of Congress.

This concludes my testimony. We will be pleased to respond to any questions you may have.

[THE PREPARED STATEMENT OF DR. MCINERNEY APPEARS IN THE APPENDIX]

The CHAIRMAN. Dr. Bellehsen, you are recognized for 5 minutes.

STATEMENT OF MAYER BELLEHSEN, PH.D.

Dr. BELLEHSEN. Thank you. Good morning. I am Mayer Bellehsen, Director of Northwell Health's Mildred and Frank Feinberg Division of the Unified Behavioral Health Center for Military Veterans and their Families, also abbreviated as the UBHC, which is located 21 miles south of where we sit today in Bayshore, Long Island.

I want to thank Chairman Miller, Ranking Member Takano, and Members Zeldin, Rice and Israel for convening on Long Island this field hearing of the House Committee on Veterans Affairs.

Long Island is home to nearly 150,000 military veterans, so it is important that the Committee is here focusing on their health care needs and, as importantly, on the needs of their family members who are too often overlooked.

While I am not an employee of the Veterans Health Administration, I consider it an honor and privilege to serve alongside my Northport VA colleagues in an effort to assist our Nation's veterans and family members who have sacrificed for us. I am excited to present to the Committee a modest but effective veteran family health care model that Northwell Health and the Northport VA jointly established in 2012. I would like to thank the leadership from both Northwell Health and the Northport VA, including Michael Dowling, Dr. Blaine Greenwald, Director Phillip Moschitta, and Dr. Charlene Thomesen. I believe this joint enterprise reflects highly on the vision and boldness of leadership in both institutions, as well as their commitment to serving the veteran community.

We welcome the opportunity to give the Committee Members and/or its staff a tour at a future date. Based upon the success of our program, we urge the Committee Members to consider the possibility of replicating our successful model in your districts and, indeed, throughout the country.

The mission of the center is to operate a model public-private partnership between the Federal Veterans Administration Medical Center, the Northport VA, and a private-sector health system, Northwell Health, that successfully serves the behavioral health needs of military and veteran families. The novelty of this partnership included the proposals of co-location of services and crosstalk between staff from both institutions for the provision of coordinated care to the veteran family under one roof. I am pleased to share that in our nearly four years of operation, we have been largely successful in meeting our objectives. I would like to highlight two achievements in particular.

First is the establishment and maintenance of a unique public-private partnership. In 2012, the center was built and opened. This entailed construction of a 3,680-square-foot center for co-location and coordination of behavioral health services for the veteran and his or her family. The center was staffed by personnel from both institutions and began implementing its coordinated care model by December of 2012.

Within this center, the VA offers primary care and behavioral health services to the veteran in a community-based outpatient clinic called the VA Clinic at Bayshore. Meanwhile, Northwell Health offers behavioral health services to the family members at the Mildred and Frank Feinberg Division of the Unified Behavioral Health Center. These two centers are located side by side under one roof with shared spaces for collaboration.

Through a collaborative care model, the two institutions then meet weekly and as needed to coordinate care of shared cases. Co-location and collaboration has contributed to 61 percent of Northwell Health's clients being referred from the VA, which reflects on the success of the partnership in reaching this population. This was done for a modest investment of nearly $2.3 million over three-and-a-half years.

The second achievement is increased access to care. From inception through August of 2016, there have been 9,470 visits among 303 unique patients in the Northwell Health section of the UBHC. Meanwhile, there have been 10,017 visits among 1,040 unique patients at the VA section of the UBHC. Nearly half of the referrals to Northwell Health from the VA have resulted in collaborative care cases. Furthermore, 73 percent of the clients seen by Northwell Health clinicians are family members or have a close relationship to a veteran or military member, and 47 percent report no prior treatment. Additionally, due to co-location, clinicians from the Northwell Health side can regularly encourage veteran engagement with Northport VA when a family member reaches out independently or when a veteran finds their way to Northwell Health.

Although definitive conclusions are difficult to make without comparisons to other programs, the data suggest that the center is reaching individuals that may not regularly engage in treatment.

In summary, the Unified Behavioral Health Center is a novel public-private partnership that includes co-location of services and coordination of care between institutions that has resulted in increased benefits to the veteran community. The implementation of the public-private partnership such as these is a critical step for expanding family services to the veteran community. The model that has been piloted by Northwell Health and the Northport VA has demonstrated the viability of these partnerships to expand care to veteran families, and has had a significant impact on veteran family care on Long Island.

Further independent evaluation of the center is forthcoming, but I believe this model represents a promising avenue for supporting our Nation's veteran families.

I thank you again for the opportunity to discuss our center and welcome any questions you may have.

[THE PREPARED STATEMENT OF DR. MAYER BELLEHSEN APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much.

Mr. Moschitta, or Dr. McInerney, when a patient presents themselves to the emergency room, explain the process that the patient goes through. How do you track when somebody comes into the emergency room?

Dr. MCINERNEY. A patient would arrive at the emergency department, either walking or by ambulance, and they would register, and they would be—

The CHAIRMAN. And how do they register?

Dr. MCINERNEY. They tell the front desk clerk that they are there, and their name, and their last four, and then they would be referred to a triage desk where they would see a nurse. Their vital signs would be recorded, their chief complaint. Any unstable patients would be taken immediately to the physician, and the other patients would then be seen in order.

The CHAIRMAN. How many emergency room visits do you receive in a day?

If you would, just leave all the mics on.

Mr. MOSCHITTA. We see approximately 57 emergency room visits a day.

The CHAIRMAN. And is this how you register somebody, through triage, through this triage ticket?

Mr. MOSCHITTA. I am not sure myself about the triage ticket.

The CHAIRMAN. Doctor?

Dr. MCINERNEY. I am not sure either.

The CHAIRMAN. This is a triage ticket. It has the name and what the complaint is of the person that is coming in. You record their temperature, their pulse, their respiratory numbers, pain, oxygen saturation.

Dr. MCINERNEY. Yes, that is usual.

The CHAIRMAN. Then it says "Place ticket in time stamp machine, then place in blue container." You still use paper like this here?

Mr. MOSCHITTA. Yes, there are some paper documents.

The CHAIRMAN. Then what happens if this gets thrown away? Where is it registered?

Dr. MCINERNEY. You would still have the patient in front of you waiting to be seen.

The CHAIRMAN. Unless they went to the parking lot.

Mr. MOSCHITTA. Let me just speak on this a little bit. If the real question here is what happened to that individual on that Sunday, I think that is what we are alluding to.

The CHAIRMAN. I am not alluding to it.

Mr. MOSCHITTA. Okay, but we are going to talk about that a little bit, I guess.

The CHAIRMAN. Let's talk about it a lot.

Mr. MOSCHITTA. Okay. On that particular case, there is definitive video surveillance that shows this—

The CHAIRMAN. And where is that video?

Mr. MOSCHITTA. The police have it. It was also turned over to the FBI. On that Sunday—

The CHAIRMAN. Okay. How does this Committee get that video?

Mr. MOSCHITTA. I would assume, through protocol, you would request it and—

The CHAIRMAN. We are requesting the total video, unedited.

Mr. MOSCHITTA. Okay. Once again, I don't really know the protocol for this. I assume it is—

The CHAIRMAN. You just told me all I had to do was ask.

Mr. MOSCHITTA. No, I didn't say ask. I said you would have to request it. I know we have had some difficulties in the past where it has to be in writing. That is between you and our office in central office. But we have the document.

The CHAIRMAN. Mr. Moschitta, here is my promise to you.

Mr. MOSCHITTA. Yes.

The CHAIRMAN. Whatever it takes, even if we have to subpoena it. So get the video ready, because we are going to ask for it or request it.

Mr. MOSCHITTA. No, and we really want this to come out. You see, we are prohibited from really talking about any patient care issues.

The CHAIRMAN. Even when the deceased's wife is here and she would allow you to speak very openly about it?

Mr. MOSCHITTA. We just do not—it is not our policy to talk about patient care issues in a forum like this.

The CHAIRMAN. You just said you were prevented. You are not prevented. You have a policy that won't allow you to do it. There is not a law because HIPAA—the patient is deceased—

Mr. MOSCHITTA. I don't believe that ends with the patient deceased, and there is a certain amount of respect we give to our veterans. We will gladly talk to you in private about his care, but in a public forum like this, I will not discuss his care. I will talk in generalities on this—

The CHAIRMAN. Okay, then let me do this, let me do this.

Ma'am, would you allow them to talk publicly about what occurred?

Mrs. KAISEN. Definitely, definitely. I do not want this to go in vain.

The CHAIRMAN. It will not go in vain, I can promise you that, ma'am.

Mrs. KAISEN. Thank you.

Mr. MOSCHITTA. Okay. Once again, I will not talk in specifics of this patient.

The CHAIRMAN. Because?

Mr. MOSCHITTA. Because, once again, it is not our policy to discuss patient care and patient care issues in public like this. I will talk to you privately. I will gladly have any family member there—

The CHAIRMAN. But you are very quick to talk to the fact that he did not present, so you are talking about his care.

Mr. MOSCHITTA. What I am trying to explain—I am not talking about his care. I am talking about the events that occurred that day, okay? And on that particular day, there is, once again, definitive video evidence—because when you came on board this premise, there was a checkpoint. Well, that checkpoint now records you were here. So we know exactly when people come aboard, and we also know when the person was reported—the incident occurred. That was a total of 12 minutes.

We also have video surveillance in the ED area which shows the individual did not present. Now, I don't really want to go beyond that because then I would be discussing his care. But the FBI was called immediately, along with the Suffolk County Police and the Inspector General. They came on board that Sunday. There is also forensic evidence that they mentioned that shows how long he

stayed in a certain area. So it was physically impossible to go from the incident to the ED.

Now, I want to thank Congressmen King and Israel for asking for an FBI investigation because they did come in, and we are awaiting their report, because that report will, I am positive, show that the accusation that our staff turned away a veteran—which is repulsive to me, okay? Our staff would never do something like that. That is not our history, and that is just very insulting to think that. I think it will vindicate or at least set the record straight that it did not occur.

The CHAIRMAN. All right. Thank you.

Mr. Takano?

Mr. TAKANO. Mr. Moschitta or Dr. McInerney, can you just explain the privacy constraints that you have even if a family member in a public setting like this might give her assent to talk about a family member's health history? What are the constraints that you are under as far as privacy under the HIPAA laws?

Dr. MCINERNEY. We don't typically talk about patient issues in a public forum. We have offered to meet with you privately. We can do it today, and we can give you further information. We would be happy to meet with Mr. Kaisen's wife.

Mr. TAKANO. That's fine.

Mr. MOSCHITTA. To go even further, not only did our staff, but other staff individuals looked through the medical record. All his care was appropriate. Now, once again, not all patients—and I am not talking particularly here—come to us for every single issue that they might have. Some people choose not to get care for certain issues. You have the copy of the medical records. If you look through the records, you will see the care he got was excellent.

Mr. TAKANO. I understand that. But I am just saying that we can't, as a matter of policy for any veteran in a public forum, discuss their case.

Mr. MOSCHITTA. Just out of respect, similar to the articles in the papers where they are mentioning people's conditions. We find it, in VA, repulsive.

Mr. TAKANO. I want to yield—to Kathleen, Miss Rice. Kathleen, may I yield to you? You seem to know this point of law as a lawyer.

Miss RICE. Yes, sure. What you are saying is that is your policy. It is not the policy; it is the law, okay? And with all due respect to the family, whether you are a veteran or not, there are certain protections in the law that preclude anyone, certainly sitting on this panel, from going into the medical care or condition of any patient, whether they were served at the Northport VA or any other hospital anywhere.

With all due respect to his widow—and my condolences to you—you are not legally able to waive the protections that the law gives your husband. They actually outlive him for the next 15 years. So I think we should just move on from that. I think it is an appropriate area of inquiry to go into the video, which I appreciate you responding to the Chairman's request that you hand that over, because I think it can be enlightening. But I think we should just stay away from any medical issues, and it is not a choice you are making, sir. It is the law, and everyone should understand that, be-

cause everyone in this room would want that protection for themselves.

Mr. MOSCHITTA. I appreciate that. Thank you.

[Applause.]

Mr. TAKANO. I think my colleague from New York—and I respect tremendously her background as a lawyer, as a prosecutor who understands the HIPAA statute.

Dr. McInerney, regarding the suicides and reports of deaths of those affiliated with the Northport VAMC, what are you doing to ensure that veterans and families are aware of the available services offered here at Northport?

Dr. MCINERNEY. We have a very robust behavioral health continuum at Northport, and that includes access to a psychiatrist 24/7, an open access clinic daily, substance abuse services on a regular basis. Dr. Thomesen could talk a little bit more, but you directed it to me.

One of the other things that we have in VA which is wonderful, and Northport excels at, is the primary care mental health integration, where a mental health provider is at the primary care clinics and they can have a conversation with a veteran about life stresses—they lost a job, they lost a spouse, they can't pay the rent—before they really need to see a psychiatrist. You can determine that a patient is really in need of more services from the VA.

Mr. TAKANO. Dr. Thomesen, would you like to elaborate?

Dr. THOMESEN. Yes. Thank you for the opportunity.

I think one of our biggest struggles is getting the word out to every veteran, because any loss of a veteran we take personally, and we take deeply, and my condolences to the family.

We constantly strive to improve access, to add to services. We have provided a psychiatrist available 24/7 on site. They are not being called. They are here in the building. They will receive phone calls, as well as see people in person because we know that even though there is a veterans crisis line nationally, our veterans of Long Island really feel Northport is their home, and they call us.

We are available to them. We have run a walk-in clinic, as Dr. McInerney said, for over 25 years so that veterans without appointments, because we know our mental health patients may not make their appointments, they can come in when it is convenient for them at any time and see a physician. You are not going to find that in the community.

We have a mental health presence, including psychiatrists and other staff, at every one of our CBOC locations, from East Meadow to Riverhead. We track those appointment times, we monitor them, and when we need to, we add days because we never want to make a veteran wait for mental health care because when they are ready, they are ready.

What we did at Bayshore was another way to try to reach our veteran patients who are often reluctant, our Vietnam veterans who don't trust the government. It is hard for us to get them to trust us. So we have the Bayshore clinic so if a family member wants to self-identify and know how they can help their veteran, they can come first, the idea being that with time, we can coax and get that veteran in, because that is our goal, is to get every veteran help and never have a suicide.

Dr. MCINERNEY. I would add that the VA is incredibly committed to trying to assist veterans before they are so stressed that they consider suicide. One of the pilots that the VA is working on nationally is called Reach Vet, and it is expected to be rolled out over the next two months to all the facilities, including Northport.

What it is, is a statistical model that they built with the National Institute of Mental Health. This actually takes 100 or so demographic findings on any patient, and they can predict more accurately than just clinical modeling which patients are at higher risk so that the facilities are able to reach out to them and offer them more services before it becomes a crisis.

Mr. TAKANO. Thank you, Dr. McInerney.

Mr. MOSCHITTA. Can I just add one thing to this? Because Dr. Thomesen has been the chief of psychiatry for many years and has done a lot of great work.

But when I got here eight years ago, we really fast-forwarded to move around our CBOCs so we do have access throughout all of Long Island. Four of the five CBOCs were relocated, so we now have coverage from the Cross Island Parkway, which is as far west as we go, to basically Montauk Point. We also added and assured that all CBOCs had mental health coverage so that there is availability of getting into the system regardless of where you live on Long Island. That is also why we never had issues with access. We were very proactive, thanks to the leadership here and the advice of really good people.

Mr. TAKANO. Thank you for that response.

The CHAIRMAN. Mr. Zeldin, you are recognized for 5 minutes.

Mr. ZELDIN. Thank you, Chairman. Thank you to the Veterans' Affairs Committee for being here for this field hearing. I thank all of our witnesses, as well as all of our veterans in the audience.

First off, I would just like to say that through the years, up until very recently, I continued to hear from the veterans in my district who have nothing but the best to say about the quality of care that they have received here at Northport VA. It is over the course of the last few months that we started to receive an increase in feedback from individuals that resulted in some pretty serious allegations, which is why we are here, to get answers.

First off, just to pick up where the questions were leaving off regarding the recent suicide, is this video a continuous feed for the entire 12 minutes?

Mr. MOSCHITTA. Yes. The video I think goes back about maybe two weeks. So we actually retrospectively looked to see if the person was on campus weeks prior. We looked through the scheduling package to see if maybe we missed something prior.

Mr. ZELDIN. I am just asking about the 12 minutes—

Mr. MOSCHITTA. No, it is a continuous feed.

Mr. ZELDIN. Okay. So there are no breaks in the video.

Mr. MOSCHITTA. No. Actually, what happens is you see it from the checkpoint. The vehicle was picked up on another camera as it moved along the campus, to where he finally parked the car. So that is a continuous feed.

Mr. ZELDIN. How many camera shots? Two?

Mr. MOSCHITTA. No, no. It is a film.

Mr. ZELDIN. I understand, but there are multiple cameras.

Mr. MOSCHITTA. I would say two. We don't have a camera in that parking lot.

Mr. ZELDIN. Is there any period of time while the veteran was here on site that is not accounted for on video?

Mr. MOSCHITTA. What I am trying to say, is we know when he entered the campus, we know via video where he went, and we know the time the individual was seen, and that is a 12-minute period.

Mr. ZELDIN. Is there any period of time where the veteran is not on video that is not accounted for?

Mr. MOSCHITTA. Well, in the parking lot.

Mr. ZELDIN. How much of the 12 minutes is the veteran not accounted for?

Mr. MOSCHITTA. I am not sure. It is about a quarter of a mile from the ED to where the parking lot is. So, you know, when you start to whittle down the time, if you come in on the campus, you have 12 minutes to work with, because we know definitely when someone saw the individual. It takes about 2 minutes to go across the campus. There is some forensic evidence. And that is why I say I would really rather defer to the FBI report. This way it is not my impression, my interpretation. They are going to, I am positive, give all the facts to show that it was physically impossible to move around the campus in less than 9 minutes.

Mr. ZELDIN. I am just asking how much of the 12 minutes was the veteran not accounted for.

Mr. MOSCHITTA. I really can't answer that. I am not sure.

Mr. ZELDIN. Whistleblowers allege that the veteran did report to the ER, as you are aware of, and signed his name on a paper ER log, which was allegedly destroyed to cover up the veteran's visit to the emergency room. Did the veteran report to the emergency room?

Mr. MOSCHITTA. He never reported to the emergency room. Once again, you have staff that checked him in. You have doctors, you have nurses, and we have a camera in that area that showed there was nobody there.

Now, also, if you are familiar with the facility, we call it the red canopy area. That is how he would have entered the building there to go to the ED. There is a camera there, and in that 12-minute period he never entered the building.

Mr. ZELDIN. The paper logs are deposited into the blue box?

Mr. MOSCHITTA. I am not aware of that actual process, so I don't want to comment on it.

Mr. ZELDIN. Is anyone able to—if someone wants to go to the emergency room—

Mr. MOSCHITTA. I can get you the exact process relatively quickly.

Mr. ZELDIN. Are you aware of the blue box in the emergency room?

Mr. MOSCHITTA. No.

Mr. ZELDIN. Is anyone, any of the witnesses, aware of a blue box?

Dr. MCINERNEY. I am not.

Mr. ZELDIN. Was any employee here at Northport instructed not to speak with media or to Congress at any time once you became aware this hearing was going to take place?

Mr. MOSCHITTA. No, no, absolutely not.

Mr. ZELDIN. We have heard from employees claiming that there was a considerable effort made by facility leadership to threaten employees not to speak to media or the Committee.

Mr. MOSCHITTA. Can I respond to that?

Mr. ZELDIN. Sure.

Mr. MOSCHITTA. That absolutely did not occur. I think what is interesting here as we go along, there will be a pattern of things that are said that I believe we can show did not occur. You know, your opening comments, Chairman Miller, were excellent. Based on what you said, I would be here too as a Committee Member. It does merit being here, and we welcome you here because we can show that we do everything for the best interest of the patients. Some of these accusations are just beyond belief, that we would have an emergency department—because it is not just one person—conspire not to treat somebody. Think of that, how repugnant that is.

So all I am saying, is we welcome you here, and we hope all of these types of issues come up. As you indicated, you received a letter that said we had two other suicides here, and they weren't suicides here. They weren't two veterans. One was a staff employee. The other one, by the coroner's exam, indicated that he died of other issues.

So you are going to see a continuous array of falsehoods because people have other issues here.

Mr. ZELDIN. And I appreciate you bringing that point up because I did want to—I actually have a lot of questions and a limited amount of time.

I will yield back and wait for the next round.

The CHAIRMAN. Miss Rice, you are recognized.

Miss RICE. Thank you so much, Mr. Chairman. I want to thank you for coming all the way here to New York to a facility that I think everyone will agree serves the veterans really at the top notch, one of the top-notch facilities across the country.

So, I just want to start by—and, Mr. Moschitta, I think you can probably correct me if I am wrong. It was my understanding that Members of the Committee staff were here a couple of weeks ago, spent two or three days here?

Mr. MOSCHITTA. Yes.

Miss RICE. The VA staff, right?

Mr. MOSCHITTA. The Chairman's staff.

Miss RICE. The Chairman's staff. And they were given access to the facility, the areas that they requested to see?

Mr. MOSCHITTA. Absolutely.

Miss RICE. And they were able to speak to employees here unfettered, without any—

Mr. MOSCHITTA. Yes. They requested not to be escorted. They requested just to be brought from Point A to Point B, and we complied with that.

Miss RICE. Okay. And they were given access to the various facilities, or areas of the facility that they wanted to see?

Mr. MOSCHITTA. Wherever they wanted to go.

Miss RICE. Okay. So I would assume that because there is an FBI and law enforcement investigation into the incident that we were talking about, that if the videotape were to be procured by

this Committee, that would actually have to be facilitated through law enforcement, which confiscated the videos. Is that correct?

Mr. MOSCHITTA. Once again, you are the lawyer—

Miss RICE. Did you give the videos to law enforcement?

Mr. MOSCHITTA. I am not sure if we gave the original or a copy. I am not sure. I can find that out for you.

Miss RICE. Well, to the best of your knowledge, it is part of the criminal—potential law enforcement investigations going on.

Mr. MOSCHITTA. Yes, and we are told that the investigation is over. We are just waiting for the report. We had hoped we would have the report prior to this so we could share with everybody.

Miss RICE. Okay. So maybe what we could do as the Committee, is request that tape, because from your explanation of it, it seems to be pretty dispositive of the issue. I am sure that no one on this Committee is insinuating by anyone's questioning that this facility or anyone employed here would intentionally turn away a person in need. I am sure that is not where any of this questioning is going. We would just like to get answers, and I am sure that that video will answer some of those questions, so thank you very much.

Mr. MOSCHITTA. And I respect that very much because this is how we are going to get the truth out.

Miss RICE. Right.

Mr. MOSCHITTA. These kinds of falsehoods hurt the facility and hurt patient care, because when you start putting this stuff in the papers without the proper follow-up, people take it as fact. You are going to have veterans out in the community who are going to say, I am not going to come to Northport if they are turning away people for care.

Now, all of you know our reputation. We are patient-centered, focused on our patients, and that would never happen under my watch or, believe me, anybody else's watch here, because our staff and our volunteers—we have the most committed volunteers in the country. They would never allow it.

So all I can say is that we want to clear the air here.

Miss RICE. Okay. Thank you.

Now, Dr. Bellehsen, I really would love for you to talk more about the public-private partnership that you initiated, because I believe that this is going to be—should be a role model of a pilot program of a public-private partnership that we can hopefully export throughout the country. To me, the unique nature of it is that it doesn't just address the needs of the individual veteran, but the needs of their family as well, because we all know that when the brave men and women in this country wear the uniform of this country and they go to theaters of war all over the world, their family who is left behind is serving just as much as they are. When their loved one comes back and is trying to go into the reintegration process, that must include the family unit so that we can do everything that we can to allow this reintegration to be successful.

So if you could just, using the remainder of my time, in your best way just explain why this is such a success and how it works.

Dr. BELLEHSEN. Thank you. I appreciate the opportunity to talk about our program. I do believe it is really cutting edge. The conversations regarding the collaboration began way back in 2010, which was ahead of the curve in terms of the recognition of the

need to be advancing care really through partnerships and through family members.

Dr. Thomesen was involved at that early level, in fact, in establishing the program and the grant to catalyze our efforts. Thankfully, I believe we have been very successful in reaching out to this community, and I would highlight that we have been, through our partnership, able to reach veterans from across eras. Oftentimes, our focus may be on recent returning veterans, and rightly so, but we have also reached out to family members that have been impacted from Vietnam back through World War II.

Miss RICE. If I could just stop you there, because one of the issues that we find very often about the services at the VA, and facilities in the private sector encounter is getting the word out about what services there are, and how to connect to the servicemember in an effective way. So maybe you could just talk about how it is, and keep your voice up so everyone in the room can hear.

Dr. BELLEHSEN. Sure. Well, that is another area where we have been able to partner closely with the VA to publicize information about our program. We have undertaken also a media strategy at Northwell to engage press and other events to make it known to the family members because, as Dr. Thomesen indicated earlier in her testimony, sometimes we will be able to help the veteran and the veteran family by a family member self-identifying. It is difficult sometimes to engage the veteran directly, and this offered us another path to engage the entire family unit.

Miss RICE. Okay. I think we are going to have another round. So, Mr. Chairman, I want to thank you again for coming here and for being interested in the kind of care that veterans get at Northport, and I appreciate you coming here. Thank you.

The CHAIRMAN. Thank you very much.

Mr. Israel, you are recognized.

Mr. ISRAEL. Thank you, Mr. Chairman. And to my colleagues, welcome to the finest congressional district in America. I am glad you are here. I am sorry you are not here under more appropriate circumstances.

Mr. Chairman, I have represented this hospital for 16 years in Congress. I will be leaving Congress at the end of this year. I must tell you for the record, we have had our ups and our downs with Mr. Moschitta and his predecessors. There are times when my constituents and I have been satisfied. There have been times when my constituents and I have been dissatisfied. But I do not doubt for a moment that the vast majority of doctors and nurses, and personnel at this facility strive to give the best care that they can, the vast majority, and where there are deficiencies we need to cure those deficiencies, investigate them, and stop them.

[Applause.]

Mr. ISRAEL. And I would also say—and then I have some questions—while I believe that this hearing is entirely appropriate and necessary, I know that my colleagues, and I understand that a hearing in a facility is not enough. Ultimately, we need to make sure that we are putting our money where our questions are, and providing long-term and sustainable investments in veterans' care in this country. That is the ultimate answer.

[Applause.]

Mr. ISRAEL. Now, Mr. Moschitta, I have two questions for you. One, is you stated that the FBI has told you that their investigation is complete?

Mr. MOSCHITTA. Yes.

Mr. ISRAEL. And how long was that investigation?

Mr. MOSCHITTA. It took about three days, because I believe that I wasn't here on that Sunday, but the person who came back to investigate was the officer agent on-site when it happened, because when it occurred, we followed the policy, and we called the FBI and all law enforcement agencies. They took over the scene.

Mr. ISRAEL. So what triggered your decision? You said we followed the policy. Tell us what triggered that policy, your decision to call the IG, you said, the Inspector General.

Mr. MOSCHITTA. Yes. In other words, we notify our police, and they have their protocols on who to get in to assist us in an investigation. So they called the FBI, the IG, the Suffolk County Police. Everybody was on-site immediately.

Mr. ISRAEL. Okay. Mr. Moschitta, I want to ask you a final question about how you track patient satisfaction. According to some of what I have read, Mr. Kaisen was frustrated with the care that he may have received here in the past. He was frustrated, according to some reports. You can dispute those reports. He had some deep concerns about past care.

This is a big enterprise. You have 37 emergency room visits every day.

Mr. MOSCHITTA. Fifty-seven.

Mr. ISRAEL. Fifty-seven. Forgive me. Fifty-seven every day. This is a big enterprise, and sometimes big enterprises fail to adequately track customer satisfaction. I don't call my constituents constituents. I call them customers. Your patients are consumers of a service.

What do you do to receive feedback from your customers? What kind of evaluations do you receive so that if somebody is frustrated with the amount of care that they are getting, or the quality of care, you know about it early?

Mr. MOSCHITTA. There are formal programs. SHEP, we get certain statistics from that. We also have Truthpoint, which is real-time data. Now, once again, the individual has to want to participate, okay? I also have an open-door policy. I am in my office from 6:00 to 8:00 every morning, and anybody can come in and see me personally. That is patients, families, volunteers, employees.

Mr. ISRAEL. Do you have a customer service person? Is there somebody that someone can go to when they feel that their care is not being provided adequately?

Mr. MOSCHITTA. Plus we have customer service reps. And truthfully, what else occurs here is we have our volunteers. They are our eyes and ears. The people you see in the back here are like employees. They are here seven days a week, and they are very vocal when they see something not going on, and they know how to get the—gravitate it and get it. So we have many mechanisms to look at patient satisfaction.

Mr. ISRAEL. How many customer service personnel, as you represent them, do you have?

Mr. MOSCHITTA. We have two.

Mr. ISRAEL. Two for a patient population of—

Mr. MOSCHITTA. Well, we have roughly 31,500 that come throughout the course of a year, obviously not every day. So we have two full-time people. But we consider, truthfully, all of our staff customer service reps. They bring forward issues from our patients.

Mr. ISRAEL. I have just a final question because my time is running out. Are those two people who are customer service representatives for a total population of 31,000 specifically trained in their field as customer service representatives?

Mr. MOSCHITTA. Yes.

Mr. ISRAEL. And that is all they do?

Mr. MOSCHITTA. And they are clinicians. That is all they are, 100 percent of the time.

Mr. ISRAEL. Thank you, Mr. Chairman.

Mr. MOSCHITTA. Also, we can provide you data, if you like, on our national numbers, because we are probably in the top 10 percent in customer satisfaction. So we are willing to share that data with you.

Mr. ISRAEL. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Mr. Israel.

I will also associate myself with your remarks as it relates to the employees and volunteers at this facility. I have been on the ground here for less than 24 hours, and I have heard wonderful, glowing things about this facility, and that is not necessarily what we are here to talk about today. We are here to look into a couple of issues that beg questions from this Committee.

But I, too, want to assure those that work here, serve the veterans of this country, that it is my belief that there are a few folks within the system as a whole, not being specific to this facility, that in fact are not doing what they are supposed to do, and our job is to provide oversight and see if we can find out who those are and hold them accountable.

I would like to talk just for a moment, move from the suicide here on this campus. Dr. McInerney, I am very interested in knowing about the patient engagement initiative—Mr. Moschitta, you can answer that question—whereby people were directed to call veterans. I want to know, was that initiated here? Where did that come from? I understand that you received $4,500—not you, but the budget got $4,500 per veteran that went back into your budget. Can you give us—

Mr. MOSCHITTA. Now, do you mind if I read a statement? Because, actually, I figured this would come up. It will explain the program. What this basically is is an outreach program. There is a program that you run to see how many of your patients, your existing patients, are not returning. We break that into two categories, those that are registered in primary care, and have not returned in the last year to see their doctor. So you outreach them to schedule an appointment. That is good care. That is what we should be doing.

Then we have roughly another 2,000 patients who come here for, say, audiology, dental, and have never enrolled in primary care. So

we are trying to get them into the system so that we can provide the care.

These are non-billable events. The only time that it counts really into our numbers is when they come for the visit. So what you are trying to do is encourage them to come for help. If I am the physician and I am following up with one of my patients that hasn't been there in a year, hopefully I engage in a conversation, see how he is, see if I can help him. There is such a thing called a telephone. But that is not a clinic. It is not a visit, per se. I am not a physician, so I am just trying to give you the gist of the program. This is to get patients back into our system to utilize us.

The CHAIRMAN. And I think that is a good idea if you are talking about bringing people back into the system. But according to VA documents from this month, in September at least, 445 veterans have been contacted, 247 encounters were completed, and that amounted to over $800,000 in revenue. Where did the revenue come from?

Mr. MOSCHITTA. There is no revenue here at this point. When they come back into the system and we see them, then you start operating under the VERA model. Once again, our budget is predicated on seeing veterans. So we have a huge initiative in outreaching. We want to get as many veterans on Long Island into the system.

I have mentioned to Dr. McInerney prior that I would welcome her to have some people come into the facility and look at what we do, and I can guarantee you that we are not doing anything wrong. As a matter of fact, this is the proper way to do it. You should try to engage as many veterans as possible in the fine health care we provide here.

Dr. MCINERNEY. And, Mr. Chairman, I would like to add that it really is important to reach out to veterans you haven't seen in a while. They are not getting their flu shot, they may be drinking, they may be deteriorating. It is important to know that. But it is also important from an access perspective, because if someone hasn't come for two years and we don't know why, to Mr. Israel's point, it is a good way to follow-up on patient satisfaction, but it is also important to know did they move out of state, did they get admitted to a nursing home, are they never coming back to us, in which case those positions need to be opened up to improve access.

There is an initiative across the VA called the Group Practice Manager. Every facility has hired one. And really, that person—and Northport has a really strong one—really they look at the panels to see that they are all active patients, that there aren't patients who have left the system who are blocking appointments for other veterans. So this is really an aggressive thing that has happened since Phoenix, and Northport is aggressive about it.

The CHAIRMAN. Can you tell me, what is vesting? I am reading through—

Mr. MOSCHITTA. Well, they have to come in and be seen by a doctor, and certain services have to be performed. That means, then, they are eligible for VERA reimbursement. Now, as Dr. McInerney mentioned, the Group Practice Manager, which she is currently working on because she oversees this program, it is developing a process so we don't get into the situation where we lose track of

4,000 or 3,000 patients. It should be part of the everyday work of every team, that they monitor their patients and they do what is best for the patients.

The CHAIRMAN. And who makes the calls? Is it doctors who make the call, nurses who make the call? Who actually makes—

Mr. MOSCHITTA. It could be a combination, because they are responsible for their patients.

The CHAIRMAN. Could it be non-medical personnel doing it?

Mr. MOSCHITTA. I think for those who are in our system, but not being seen in PACT, it might be possible for a non-clinician just to explain the services. But I think we do it mainly with clinical staff.

The CHAIRMAN. And I appreciate the opportunity. It is very, very important. So it is your understanding and your testimony to this Committee that if a physician calls somebody to follow-up and get them to come back to the VA, that is not a billable—

Mr. MOSCHITTA. Correct. There is a telephone encounter.

The CHAIRMAN. Okay, but it is not billable.

Mr. MOSCHITTA. My understanding is, it is not billable.

Dr. MCINERNEY. And my understanding as well.

Mr. MOSCHITTA. I am asking Dr. McInerney to have somebody come in from the outside, in other words, and actually oversee it to prove this. But this is, once again, another issue where there is misinformation that is leading us down a road, and that is why we are having this meeting.

The CHAIRMAN. Thank you.

Mr. Takano?

Mr. TAKANO. So, Mr. Moschitta, you would welcome an audit to just verify that things that are not billable are not being billed?

Mr. MOSCHITTA. The only way you improve is by having people come in and take a look, okay? No matter how bad things are, you always learn from it, and you improve from it. So we try to have that philosophy of continuous process improvement. If we find something wrong, we fix it. But I can tell you there has been no effort whatsoever to do something knowingly wrong, and I am confident on this one here because the person I get the information from is our best data person. He knows his stuff.

Mr. TAKANO. Thank you.

I would like to turn to Dr. Bellehsen. I come from the Inland Empire in Southern California. I have a fine VA medical center, Loma Linda, but my area is—I hear from VA, I hear from community providers about the inadequate levels of mental health care. It is a problem that is community-wide, and I have to say that I am quite impressed with the experiment that you started in 2012, this public-private partnership. I agree with my colleague, Miss Rice, that this could be a model for the country.

I found your testimony very helpful. Your role as the private provider is to serve the family, while the VA serves the veteran, and it is a health eco-system.

What challenges did you encounter bringing this public-private partnership about? Can you comment on the challenges that you had, briefly?

Dr. BELLEHSEN. Thank you. Yes. And I would also add that one of the novel proposals in our program is serving them together through a coordinated model. So it is not simply that we are sitting

side by side and the VA is serving veterans and we are serving families, but we are also integrating and coordinating our treatment the best that we can when permission is given by family members and the veteran.

I think I would highlight the principal challenge that we face is that of financial sustainability. We were seeded by grants and local funding donors, and we did so with the expectation that this would be costly, but it was a commitment on the part of our institution, Northwell Health, to serve this population. Going forward, we are looking towards achieving models of sustainability that would allow these kinds of programs to be replicable, in fact, throughout the country.

Mr. TAKANO. I understand that some of the revenue that you are trying to tap into is actually private health care insurance or other health care insurance that the family might have, in addition to the veteran having his or her benefits.

Dr. BELLEHSEN. Correct, yes. In early 2016 we began implementing a process of billing for our services, along with offering sliding scales as needed to patients that had any challenges to help augment some of the fundraising that our foundation and our system has been continuously engaged in.

Mr. TAKANO. Of course, under the Affordable Care Act, there has been a mandate that mental health services are part of every policy.

Dr. BELLEHSEN. Correct, and that may have had a role. We weren't billing prior to 2016 and the Affordable Care Act, but it has made it possible for many of our clients to engage in services.

Mr. TAKANO. The VA sometimes encounters difficulty in recruiting physicians and other providers to work at the VA. I don't know if you can answer this question, or maybe it is more properly addressed to Dr. McInerney. How do you recruit those physicians to your facility, Doctor or Mr. Moschitta?

Dr. MCINERNEY. Well, many people have the mission of the veterans at heart, and they want to work with the veterans. But also we have affiliates with various medical schools throughout the country, and that encourages physicians and providers, nurse practitioners and others, to join along with the VA.

Mr. TAKANO. Do you have a problem getting providers to work at the facility?

Dr. MCINERNEY. In Northport, we have very limited problems. New York is really a hub of physicians. Occasionally, we will struggle with a dermatologist or a urologist or a thoracic surgeon. They are a little bit harder to find. But primary care, we are fine with that.

Mr. TAKANO. Psychiatry? Mental health?

Dr. MCINERNEY. Psychiatry, we have a wealth of folks.

Mr. TAKANO. Thank you.

The CHAIRMAN. Mr. Zeldin?

Mr. ZELDIN. Thank you, Mr. Chairman.

Picking up where we left off, Mr. Moschitta, the two individuals who died here at Northport prior to the most recent suicide, is it true that one of these people died and wasn't discovered for days?

Mr. MOSCHITTA. Yes. The person was involved in a vocational rehab program, so he was in a work site. It is a clothing room that

he would man. It was on a Friday. Then he was found on Monday. He did not live on the premises here, although it was mentioned that he lived in Beacon House. We have a Beacon House here on the grounds, but Beacon House runs housing all throughout Long Island. He lived off the premises. And I do believe—we would have to check, but I do believe it is not even a case where we fund his housing. So he was fairly independent.

Mr. ZELDIN. Where was he found?

Mr. MOSCHITTA. If I remember, a storeroom inside that area he worked.

Mr. ZELDIN. And was he working at that time?

Mr. MOSCHITTA. Well, he was working up until, yes, that time.

Mr. ZELDIN. But he was here for work?

Mr. MOSCHITTA. Right.

Mr. ZELDIN. And what did he die from?

Mr. MOSCHITTA. Well, the medical examiner indicated other than suicide. Beyond that, I personally won't comment. So clearly, it was not a suicide by the Suffolk County Medical Examiner.

Mr. ZELDIN. Okay. But it is possible—I mean, we were informed that he had overdosed.

Mr. MOSCHITTA. All I am saying is that according to the Medical Examiner, he did not die from suicide.

Mr. ZELDIN. Okay, but you wouldn't comment whether or not he overdosed from fentanyl?

Mr. MOSCHITTA. I wouldn't. Maybe Dr. McInerney. Because your follow-up questions I wouldn't be able to answer.

Dr. MCINERNEY. I have not seen the Medical Examiner's report.

Mr. ZELDIN. One of the things I would really love to be able to improve following this hearing, and we have had some dialogue on this recently in the past few months, is improving communication between the Northport VA and the Long Island congressional delegation, especially on topics that we are going to be fielding questions for. When we get asked why the operating rooms were closed for three months, and we didn't even know the operating rooms were closed at all, and as it relates to the most recent suicide that took place here, again fielding questions that we didn't have the answer to, and now we are finding out that there was this death that took place and we have to ask about it now—

Mr. MOSCHITTA. Could I just comment on that?

Mr. ZELDIN. Go ahead.

Mr. MOSCHITTA. Because I think that is a very good point. What I will do is, I will have our PR staff host a summit for all congressional delegation's aides, because I think we communicate pretty well with the delegation. However, I think what we really have to fine-tune is every item you really expect to be communicated about. The issue of the OR, I publicly apologize for that. I own that. I did not inform you. We were laser focused on making sure the patients got care and that we got the ORs up and running again. So I do take ownership for that. But some of these other things, we normally wouldn't.

So I think we have a summit here and we just ensure that we are on the same page.

Mr. ZELDIN. That is great. And beyond that, just moving forward, continuous communication when we should be updated on some-

thing that we should know. In order for us to be able to best fight for Northport VA and the veterans, we need to know what all the issues are.

Can you speak about what you know of your most pressing air quality issues here at Northport VA?

Mr. MOSCHITTA. Okay. Once again, I am not an air quality expert, but let's talk about the OR, for example. At no time, even when we had a discharge, was the air quality below standard. What you had was a discharge of rust. Rust was heavier than—how do I describe it? It is not airborne, okay? When we measure the air quality, we have an outside company come in, they set up a machine, it sucks in the air, and then it analyzes it. So our air quality in all these areas has never fallen below standard.

This was a case of granules that came out that fell more or less straight down, and our concern was, as small of a chance as it was, it might go onto a person's shoulder, it might go onto a nurse's arm or something, and fall into a wound.

We took the highest level of care to make sure our patients were safe. Immediately, all the patients were looked at, and they have all been communicated with. They have been rescheduled. It is interesting that it took three months to find out, and in a sense that was because there weren't patient complaints because they got handled right away, with the majority of patients wanting to wait for the ORs to reopen because they trust us here.

So that is why I think I messed up in not informing you because we were more focused on the patients and getting them taken care of.

Mr. ZELDIN. And I appreciate you saying that. We did get some feedback after the news came out which we have been working through, and for the sake of time I am going to have to yield back and wait for the next round, but I am going to want to pick up on this air quality issue again.

Mr. MOSCHITTA. Okay.

The CHAIRMAN. Miss Rice?

Miss RICE. Thank you, Mr. Chairman.

Mr. Moschitta, what I would like to talk about is an issue that is affecting a lot of VAs across the country, and that is infrastructure. We have facilities that were built 100 years ago. So what I would like to do is, because what I think this is going to require is a major commitment on the part of the VA and the Federal Government, obviously Congress, where the funding comes from—and it is not just—we have infrastructure problems. Everyone here on Long Island knows the infrastructure issues that we have.

So if you could just talk about what the issues, specific infrastructure needs are here, and how it is affecting your ability to effectively serve the veteran population.

Mr. MOSCHITTA. Well, the campus is 88 years old. We have 57 buildings. Most of them are 88 years old, so you would expect there are going to be a lot of infrastructure issues. We had a facility assessment three years ago—I think we have another one coming up in October—which at that point in time identified $290 million worth of renovations required.

Now, when you roll that up nationally, and this number, I am not sure how accurate it is, I think they are looking at close to $17

billion is needed nationally in order to bring all of the VAs up to snuff. This is a huge task for the congressional people. I really applaud you for trying to work on that. But unless the pot of money in central office is adequate enough, what we have to do here is we prioritize, we submit our request, and that competes nationally against other types of submissions across the country.

We have a very aggressive, I think, maintenance program. Can it improve? Absolutely. But when you consider some of these areas we are talking about, 15 and 20 years beyond their life expectancy and we still keep them up and running, there is some effectiveness with our maintenance program.

We have made some changes locally to try to get out ahead of the curve. For example, when our associate director retired, I recognized that this is really our number-one priority here. We recruited, and I was looking to get someone who really had that kind of expertise to oversee and personally take charge of these issues, and we recruited a Navy veteran—excuse me—an Air Force veteran who is a retired colonel, but his primary responsibility was facility operations. So he is working very closely now to ensure that our project management is better and our oversight is better.

Two things that he has already brought forward which I think are fairly innovative. One is his self-help philosophy where he identifies staff that can do some of these major jobs. So when we talk about roofs, some of the roofs here can cost $600,000 to $800,000 to replace. We are now on our third roof replacement done with internal staff, okay? And basically what you are doing, is you are paying for the labor, which is a staff person who we are paying anyway, and supplies. So we are seeing significant savings in that, which will also justify adding additional staff, probably, to that department.

The other thing is the innovation in this training program. He used to run this program. It is where you partner with the military reservists, and these are individuals who get deployed into areas where they do construction. But part of their readiness training is they spend two-week intervals—they need to practice this. So we are going to try to get an MOU—we are very close to it—where we would have reservists come on-site with units. We provide the materials, and they will be able to do our sidewalks, do our stoops, do projects. This here is very innovative for us, and although there might not be enough money nationally, we are trying to move ahead aggressively to self-help.

Miss RICE. Thank you, Mr. Chairman.

Mr. ZELDIN. Mr. Israel?

Mr. ISRAEL. Thank you, Mr. Chairman.

Mr. Moschitta, I want to return to the issue of the operating room closures. You said that you own that, you take responsibility for it, for the lack of communication with the congressional delegation. But in my view, more important than communication with the congressional delegation is did you solve the problem.

In May Mr. Zeldin, Miss Rice, Mr. King and I sent a letter to Secretary McDonald asking him for a full report on the operating room closures and the failed HVAC system. On June 24th we received a response from David Shulkin, Under Secretary of Health for the VA, who stated, "Northport's next step is fully resolving its

HVAC systems and has engaged an outside consultant to complete a full evaluation of the system."

What steps have been taken to fully evaluate the system? If there was a full evaluation, what were the results? And what is your plan moving forward to ensure that we never again have to learn that operating rooms have been closed because of a faulty HVAC system?

Mr. MOSCHITTA. Okay. The operating rooms were closed, I think it was on February 17th, when the particles came out of the vent. They were analyzed. They were shown to be all three forms of rust which composed the inside of the ductwork. I know there are some reports that say it was asbestos, but there is no asbestos component in this. So this was purely rust, not airborne, so that it wasn't an air quality issue.

We then cleaned the ducts twice, and then we reopened three of the five ORs, because three of the five never had any particulate matter come out, only to find a month later that those three had a discharge. That is when we re-closed them all. So we weren't continuously closed from February to June.

Very innovatively, they came up with a resolution to the media problem with these fan-assisted HEPA filters. It is very complicated because what you do is you mount a HEPA filter, which is like a very tight screen, so the particles can't fall out. Each vent had to have one mounted, fan assisted, because there is air flow, which means you have to have so many exchanges of air in the OR. So you couldn't just put a filter up there; it would block the air flow. So you needed the fan assisted so it can draw it out at the same rate, which meant you had to bring electricity to every vent. It was a huge undertaking.

That was installed, and since then we have had no issues. We check the screens regularly, and we have had very, very minimal discharge.

When we talk about the original issue, the discharge was minor. It wasn't like a puff of black smoke. I know people have all kinds of visions of what this is. It is basically rust particles that fell straight down. You could see them on the floor right underneath the unit.

We did bring in a consultant. He felt that the air handler and system could get some refurbishment right now which would allow us to continue the OR for five, six, seven years.

Mr. ISRAEL. And that is underway, that refurbishment?

Mr. MOSCHITTA. We are waiting for the contract to be awarded, which is momentarily. We are hoping it can be awarded very quickly, and it is not a very long duration of a contract. So that will be fixed.

In the meantime, we are working up the plans to make sure it is in our SCIP program for an assessment on whether we are going to do a total OR replacement or partial. We would like, obviously, a total replacement. But until it is assessed—

Mr. ISRAEL. When will that determination be made? Final question. As to whether you need to—

Mr. MOSCHITTA. Well, it goes through the final process. I can't tell you when the final determination is. I know we have now some breathing room given that we will refurbish. So I can't really tell

you when that will happen. I know it has gotten a lot of attention in central office, even from the Secretary himself. He is committed to getting us stabilized and rolling. So we are all working on this.

Mr. ISRAEL. Well, I hope that my colleagues will join in the letter to Secretary McDonald asking him when the final determination will be made.

The CHAIRMAN. Thank you, Mr. Israel.

I want to talk a little bit about the maintenance and funding that goes on here. I know there were three projects that were funded, but unfortunately there was a cascading effect of something that our Committee knows all too well, the Aurora billion-dollar budget overrun. There was $115 million of facility maintenance funds that were moved in order to try to fill that gap. Obviously, it didn't fill the gap because we had to take almost a billion dollars out of the Choice fund. There were two projects here, elevator modernization and a generator project, I think, that were affected by that. Is that true, Mr. Moschitta? Do you recall?

Mr. MOSCHITTA. Well, we have had projects that have stalled. Not all our projects run smoothly. So if you want to talk about a specific project, I would have to take it for the record and get back to you on that specific project. But we do have issues at times getting the projects complete.

The CHAIRMAN. And what usually are the reasons that they stall? Is it always funding, or is it not being able to get a competitive bid?

Mr. MOSCHITTA. In some cases—well, I am not a contracting officer, so I don't really want to speculate. I think a lot of people own why sometimes things don't happen. What I am pleased to say is that with our integration, there is new leadership in contracting, and we have found this individual to be a breath of fresh air.

There is a big education component. So when we write our Statement of Work, we are starting to really communicate with contracting to make sure our Statement of Work is correct. So I think under this new leadership you are going to see a lot more positive results. Long Island is a very difficult place in respect to contracts. We don't in some cases get a lot of bids, and that is very difficult. We will project that a contract will cost XYZ, and then you will get one bid and it is three times the amount. So it is a tough market.

But I think—I feel confident that our project oversight, our maintenance, the facilities, with the new switch in leadership, we are committed to process improvement here.

The CHAIRMAN. Can you talk a little bit—I spoke in my opening statement about the cooling tower situation as it related to the ultrasound rooms. Can you tell me what is going on there and why the need for the portable cooling system or cooling towers?

Mr. MOSCHITTA. Yes. The cooling tower itself, there was no real issues with the cooling tower. A pipe, a high-pressure pipe burst. As a result of the water, it damaged beyond repair the rest of the cooling tower. The cooling tower is what cools Building 200. It cools two of the nursing home units and some other areas.

Now, we were fortunate. It was in March, so it wasn't—if it was in August, it might have been a little more difficult. We immediately went out and through emergency procurement got two portable chillers here, and that then takes the place of our cooling

tower, and that fluctuates. So during certain months of the year we use two. When we get into the heavy air conditioning season, we rent two more, for four. So when you hear numbers like $110,000, that is for the four per month. However, you have to offset that with not running the cooling tower. There are expenses with running the cooling tower and the maintenance and things of that nature. So we figure on an average that $110,000 offset by the savings is roughly around a $55,000, $60,000-per-month bill. It is not $110,000, because we gave you the cost that we are paying, but we didn't give you the cost of offset.

The CHAIRMAN. And the pipe you said just burst?

Mr. MOSCHITTA. Yes.

The CHAIRMAN. And the reason for the bursting of the pipe?

Mr. MOSCHITTA. Well, it is like at home, my pipe burst and it had the flood—

The CHAIRMAN. Well, was it—

Mr. MOSCHITTA [continued]. from the exterior, my understanding is you couldn't tell there was an issue. But these are high-pressure pipes, and it burst. Once again—

The CHAIRMAN. There wasn't a problem with improper use of funds within the system?

Mr. MOSCHITTA. No. I can ask our engineers, but—

The CHAIRMAN. I am going to send you a follow-up question about that as well.

Mr. MOSCHITTA. Yes.

The CHAIRMAN. Because again, pipes do burst, I understand that, but pipes also burst for maintenance issues, and I would like to get a little more information.

Mr. Zeldin?

Mr. ZELDIN. I wanted to get back to air quality. But before I do, with regards to the veteran who died on a Friday, found on a Monday, was there an FBI investigation for that?

Mr. MOSCHITTA. Yes. We called—similar to any death like that, the police have their protocol. They called the FBI, they called the IG.

Mr. ZELDIN. Okay. Are you sure the FBI completed an investigation in that case? Have you seen a report?

Mr. MOSCHITTA. I have not seen the report. I am only going through our police department.

Mr. ZELDIN. Suffolk County Police, were they involved in that?

Mr. MOSCHITTA. I would have to get back to you because I don't know exactly if Suffolk County was here.

Mr. ZELDIN. Regarding the other gentleman who died here on campus who we spoke about as well—there were three that have been mentioned here—was there an FBI investigation report on that?

Mr. MOSCHITTA. Two died on campus. One was not on campus. One was a non-vet.

Mr. ZELDIN. I am sorry. So the non-vet, this was the individual who worked here and became a patient here, and then he died off campus.

Mr. MOSCHITTA. Yes. What occurred was there was a humanitarian mission, and then he was discharged, and I think it was four to five weeks later.

Mr. ZELDIN. Did you say that he didn't commit suicide? I don't want to put anything—

Mr. MOSCHITTA. No, I never said anything on that. Once again, it is in the private sector. I think—

Mr. ZELDIN. So there wouldn't be an FBI investigation?

Mr. MOSCHITTA. No, no, no.

Mr. ZELDIN. Because that one took place off campus?

Mr. MOSCHITTA. Correct.

Mr. ZELDIN. Okay. Getting back to air quality, I asked what your most pressing concerns were, and you were speaking specifically about the operating rooms. What about the rest of the campus? What kind of air quality concerns do you have right now?

Mr. MOSCHITTA. Once again, the quality of air, to the best of my knowledge, has never come back other than meets all the standards.

Mr. ZELDIN. Is there—

Mr. MOSCHITTA. And that is by an outside company. We don't do that testing ourselves. We contract somebody to come in. They test the air, they give you all of the—whatever is in the air, and they let you know that it is safe.

Mr. ZELDIN. So you are not aware of any air quality concerns outside of the operating rooms?

Mr. MOSCHITTA. Correct. Once again, in the operating rooms, I don't want to belabor this.

Mr. ZELDIN. I understand.

Mr. MOSCHITTA. It is not air quality in the operating rooms. It was particulate matter that came out.

Mr. ZELDIN. I know. In my last round of questions I asked what your most pressing air quality concerns were, and you were speaking about the issues that forced the OR to be closed. I can't help myself that, while I am sitting here—and I am not an expert. I mean, I am looking literally at the ceilings right here, and is that bad duct work that has all the black material around—

[Applause.]

Mr. ZELDIN. I am not an expert. I just want to understand why that—

Mr. MOSCHITTA. I am not an expert on that, but clearly we have to clean them. I mean, you know, it is a matter of dusting them. This doesn't necessarily mean—it is just like at home. When you go into your own house, if you have your air conditioning running, there is a certain residual of dust that accumulates.

Mr. ZELDIN. Is it true that there was a person who was in surgery when the power went out during surgery?

Mr. MOSCHITTA. I don't know.

Mr. ZELDIN. You are not aware of anyone having been in surgery and there was at least a power surge that took place?

Mr. MOSCHITTA. No, we have had a power surge. I am just not aware of it. I can tell you I would have been aware if there was an adverse impact to that patient. No adverse impact occurred.

Mr. ZELDIN. Okay, but you are not aware of any power issues during surgeries?

Mr. MOSCHITTA. We had a power—

Mr. ZELDIN. What is the power surge that you are aware of?

Mr. MOSCHITTA. The one I am aware of is PSE&G at their substation had a power surge, which meant that our electricity got impacted. Our back-up generator, that is where it failed, our back-up generator, okay? We notified PSE&G. We were out of power for about 45 minutes because PSE&G had to clear the line because they had people working on it, and what we do is, the switch is thrown, so we go to another feed. But you can't do that while someone is working on the line, obviously.

Mr. ZELDIN. Okay. During those 45 minutes, is it true that someone was on a table in an operating room?

Mr. MOSCHITTA. I am not sure. I can find that out for you.

Mr. ZELDIN. It is possible, though, that someone was on a table in the operating room during—

Mr. MOSCHITTA. Well, anything is possible. But I am saying I know for a fact I would have remembered if there was an adverse impact to a patient.

Mr. ZELDIN. The reason I ask is just because one of the people who came forward said that there was someone on a table in an operating room when there was a power surge that took place. The back-up generators failed. The power was out for about 44 minutes. So it is very consistent with what you said.

Mr. MOSCHITTA. Right.

Mr. ZELDIN. The only thing is that one part of the complaint that was shared with our office specifically as it relates to someone actually being on the table in surgery at that time.

Mr. MOSCHITTA. Yes. But I think, from my perspective, I am more patient focused. So knowing that no patient had any adverse impact is more important to me at this point in time. That is why I can say safely there was no negative impact to the patient. Whether a patient was on a table, I don't recollect that.

Mr. ZELDIN. I am out of time, but my understanding is that the back-up generator and the PSE&G issue were two separate issues.

Mr. MOSCHITTA. Yes. As a result of PSE&G having an issue with their substation, our back-up generator didn't kick in, and within the day we fixed it.

Mr. ZELDIN. Okay. Thank you.

The CHAIRMAN. Mr. Takano, I apologize, I skipped you.

Mr. TAKANO. Thank you, Mr. Chairman.

Mr. Moschitta, can you tell me, during that time when the ORs were shut down and many of the customers here were encouraged to go into the community, and you said a number of patients elected to wait until your OR was reopened, can you roughly give me an idea of how many veterans chose to wait versus those that went into the community?

Mr. MOSCHITTA. Do you have the exact amount?

Dr. MCINERNEY. Well, there were 154 patients who were postponed due to the OR being closed. At this point in time there are still 22 pending, but that is because of patient choice. They chose to wait until after the summer for their surgery.

Mr. TAKANO. They had procedures that weren't so time sensitive?

Dr. MCINERNEY. Exactly.

Mr. TAKANO. And they preferred to wait to get their care from the VA?

Mr. MOSCHITTA. Yes.

Dr. MCINERNEY. Yes. And what we did is every one of them conferred with their physician to make sure that the decision was a safe decision. At the network level, we have actually looked back with the facility at all the cases that were postponed to make sure that there was no adverse events for any of those patients who were postponed.

Mr. TAKANO. And the Choice Act did provide them with that opportunity to make a choice, actually. Right?

Dr. MCINERNEY. Yes.

Mr. TAKANO. So those that needed more pressing procedures, whose procedures were more pressing, they were able to go to the private providers and get the care.

Dr. MCINERNEY. Yes.

Mr. TAKANO. And you can assure us that everybody who needed immediate care was taken care of, and everybody was informed in a timely manner of the options before them?

Dr. MCINERNEY. Yes. To the best of our knowledge, yes.

Mr. MOSCHITTA. And there was full disclosure to the patients.

Mr. TAKANO. So VISN 2 and VISN 3 were integrated together, and it is now known as VISN 2. Is that correct?

Dr. MCINERNEY. Yes.

Mr. TAKANO. How was this integration of the VISNs managed? You alluded to the difficulty with planning and construction functions of the previous arrangement, and I am getting some sense that the planning of facilities and construction maintenance is a challenge. Having been the trustee of a major community college district in California, maintenance facilities planning construction requires a certain expertise which the CEO of the organization doesn't have, and they really need somebody good in that place. Otherwise, things begin to deteriorate, maintenance isn't done, ORs in this case have the problems they have.

Can you tell me about whether or not this new integration—you alluded that it was better. What was it like before? I am just trying to get a sense of the stability of the leadership, the continuity of the leadership in this area, the management.

Dr. MCINERNEY. So, prior to October 2015, there was a VISN 2 and a VISN 3. VISN 2 was upstate New York State, and VISN 3 was downstate New York State, as well as New Jersey, and both of the VISNs were fairly small, and a decision was made as part of the restructuring out of Secretary McDonald's office to develop the districts, the VA experienced districts, to merge the two VISNs. So that was accomplished October 15th. Because of that, then there was realignment of our relationship with contracting. There was a contracting group in 2, and there was a contracting group in 3, and now there is just one contracting group.

So there have been some efficiencies. There has been some new partnerships, some new alignment, some new learning, different ways to do things. It has been very interesting.

Mr. MOSCHITTA. The part that I was referring to is that with this new leadership, the approach is much different. It is much more collaborative. I think it is really stripping it down to the bare essentials and building it up again by training and getting people to talk together, and that is why I feel very confident that both in contracting and in projects and stuff, we are making headway.

Mr. TAKANO. Part of the cost overrun at Aurora was just the astounding number of change orders, which indicated to me very poor planning and lack of collaboration with the people that use the facilities, all these changes. When cost overruns happen, I am looking to the change order issues.

Mr. MOSCHITTA. And you are right, and that is why I think the collaboration and knowledge is going to help us quite a bit; and also, as I indicated, my associate director, that is his background. So these weekly calls, I have my senior leader on those calls. So this is not being delegated to a lower level. At the very top, he is there facilitating to make sure that we are working together.

Mr. TAKANO. All right. Well, thank you.

The CHAIRMAN. Miss Rice?

Miss RICE. Dr. Bellehsen, what I would like you to do, if you could, can you speak specifically about the benefits for family members who receive health care or access support services at the Northwell side of the facility, while the veteran receives care on the Northport side?

Dr. BELLEHSEN. Sure. And I would note that we also have a pending Rand Corporation evaluation that has been conducted of our center which is forthcoming in the next month or so. So while I can't speak specifically to the results in that document until it is released, a lot of our findings hopefully are also going to be backed up with that evaluation.

Specifically, we have been able to assist families in various means. Some family members, as they struggle with the challenges of reintegration, can suffer themselves with mental health difficulties such as depression, secondary traumatization. They can also experience caregiver burden. And all of those areas have been areas of focus for our providers.

Additionally, we are able to give the family members education and even just a place to come together to find support and validation for their experiences, which they have explained to us has been just monumental for them. One family in particular, I recall when they were doing focus groups around our patients, had shared that in her experience, when she was going out into the general community divorced from the VA providers, and just finding ad hoc providers out in the community, she felt no sense of understanding of her challenges and found providers were encouraging her, for example, to dissolve the family and divorce; whereas by coming to centers like ours, she felt that she had a place that understood her challenges and was able to help sustain the family unit.

Miss RICE. Have you had any conversations with any higher-ups within the VA about your success? Are you waiting for this report? Are you trying to serve as a best practice for this kind of public-private partnership?

Dr. BELLEHSEN. We did have one general conversation a while back, nothing definitive in terms of plans towards replication, but our hope is that this report coming out will document the best practices, the processes that need to be put in place, and demonstrate the viability of doing these kinds of partnerships that will hopefully support interest by others in other parts of the country to replicate.

Miss RICE. Thank you.

Dr. BELLEHSEN. Thank you.

The CHAIRMAN. Mr. Israel?

Mr. ISRAEL. Thank you, Mr. Chairman.

Mr. Moschitta, I have an obligation to ask about some language in a New York Times story. I would like to read it to you and then get your response for the record.

In the New York Times it says, "Hospital officials, including the facility's director, have been called to testify at this hearing. According to a person familiar with the investigation who was not authorized to speak and requested anonymity, they will also be asked about allegations of widespread fraud, including the collection of thousands of dollars in fees to care for veterans who were never actually treated. According to internal emails and current and former employees familiar with the alleged scheme, who spoke on the condition of anonymity because they feared retaliation, nurses were directed to make cold calls to veterans and then code those calls to look as though they had been solicited by the patient, not the practitioner, in order to enhance revenue. One former hospital employee likened the practice to your private physician calling you out of the blue to check on you, then billing your insurance company for the call. The former employee, who asked to speak anonymously to avoid reprisal, said the practice was a means of padding the numbers."

And then finally, "The goal of the calls, according to the internal emails," says the New York Times, "was to contact around 2,000 veterans and thus raise enough money by the end of the current fiscal year to patch a large hole in the hospital's growing deficit of more than $11 million."

How do you respond to that, Mr. Moschitta?

Mr. MOSCHITTA. I think that was some of the questioning from Congressman Zeldin. It was 4,000 patients we were reaching out. Once again, this is a veteran engagement project. We are trying to get those veterans who are not utilizing our system into the system. This does not close our budget. We don't get this money. And as I said previously, these encounters are not billable, so there is no money generated on this.

We are a VISN, and we work very close with our VISN leadership. So when we talk about an $11 or $12 million deficit, as a VISN we work that out. So right now we will be able to close this year, thanks to the help of our VISN director and our leadership. But clearly, there is no fraud here. And I mentioned earlier that we welcome someone coming in and taking a look.

Mr. ISRAEL. Well, I did want to follow-up on Mr. Zeldin's inquiry. So the former hospital employee who was the source of this would you characterize as just uninformed, didn't understand that this was part of your patient engagement process?

Mr. MOSCHITTA. Well, if it is a former employee, they are former for different reasons. We hold people accountable. I can't speculate on who this is, but if I was to speculate, there are a certain number of employees both on the staff currently and off the staff that have a motive why they perpetuate these kinds of rumors, lies, and falsehoods, even though they don't realize necessarily it is to the detriment of our patients, because when you put stuff like that in

the paper, our patients feel they are coming to a place they can't feel safe in.

This is why I am very happy you are here, and I keep saying it, because we have to clear the air. I don't want any employee at this medical center, or any volunteer, or any patient to think anything less than we are the best there is for them, okay? We will try to always improve. That is our goal. But when you spread this kind of stuff that we are not caring for people in the ED, it is a terrible thing and it hurts patient care.

Mr. ISRAEL. So there were no internal emails that suggest that employees or nurses should contact veterans and raise money to cover a budget gap?

Mr. MOSCHITTA. There is no intent to raise money like a raffle or something like that—

Mr. ISRAEL. That wasn't my question. So you are saying there are no internal emails that suggest otherwise?

Mr. MOSCHITTA. No, not at all. Now, once again, we did mention that if the person belongs to a panel, then that panel, that doctor and nurse are responsible for reengaging their patient. So that is how they are involved. They are doing what they should be doing as clinicians.

Mr. ISRAEL. Okay. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Moschitta, can we talk a little bit about the non-veteran who was an employee? We won't talk specifics. As I understand it, he was a full-time employee, and he voluntarily committed himself into your facility?

It is important, because my next question is going to be I understand that he did write a letter asking to be discharged from the facility, a 72-hour letter, and my question is, were the proper procedures followed at that point? Because as I understand it, in New York—and I don't know if the New York laws apply as it relates to the 72-hour letter, whether you have to go to the judicial—

Voice. But—

The CHAIRMAN [CONTINUED]. I apologize, but I am asking the question of the gentleman here.

Mr. MOSCHITTA. That part of the question—and I can turn it over to Dr. Thomesen, the Chief of Psychiatry. I can say yes, we followed all the regulations and all that was done appropriately.

The CHAIRMAN. Doctor, can you talk about it?

Dr. THOMESEN. Without speaking, Chairman, to this particular case, but I can tell you, in general, we do follow New York State law. We have a mental hygiene legal services attorney—

The CHAIRMAN. So if somebody submits a letter to you asking to be released—

Dr. THOMESEN. Yes.

The CHAIRMAN [CONTINUED].—it is my understanding that you have to do one of two things: either you release him, or you have to get a court order to keep them in. And that was done, either one or the other was done.

Dr. THOMESEN. I can't speak to this particular case, but our processes follow New York State law. We have a New York State mental hygiene legal services attorney—

The CHAIRMAN. Well, you are answering the question, then.

Dr. THOMESEN. Yes.

The CHAIRMAN. You followed the law to the letter. That is all I need to know.

Dr. THOMESEN. Yes, sir.

The CHAIRMAN. Okay. Thank you.

Go ahead. Take your time, Mr. Takano.

Mr. TAKANO. Dr. Bellehsen, I would like to shine a little more light on the program. So your responsibility is for the families, and you work very much in tandem with the VA.

Dr. BELLEHSEN. Yes.

Mr. TAKANO. And my understanding, is you get the permission of the veteran and the permission of the family so that the therapy or the mental health services can be done very much holistically. They are not siloed. Is that correct?

Dr. BELLEHSEN. Yes. The beauty of our partnership is that we can be flexible. So there are instances where perhaps a family member will come to us independently of the veteran, who may or may not be engaged in treatment. But on the other hand, there will be instances where we can see a family that has come to us through the veteran as well. And when a veteran and their family both agree to us being able to coordinate the treatment, we can do that.

Mr. TAKANO. Has this been a challenge in mental health services pertaining to veterans across our country because of our private—Miss Rice, I think so eloquently pointed out what is at stake, and it is for a good purpose. We want to protect people's privacy. But in terms of really doing mental health care that makes a difference, that will prevent suicides, that will lead to healing, it also can't be siloed. So where we can break down, get past the privacy issues by getting consent by all the parties, can you tell me how beneficial this is?

Dr. BELLEHSEN. Yes. I believe it is extremely beneficial in many respects. In general, I find that to be able to coordinate and communicate care—and I am a clinician first, and I often find it very challenging whenever I need to communicate and coordinate care with providers from other organizations. So having a platform where we can regularly meet, both at scheduled and unscheduled times, to be able to communicate important information has been immensely helpful. At times, it has enabled us to work with certain family units even if one of the members has been somewhat disengaged from treatment.

So a family member can report this is still happening for the veteran, and we can then promote engagement of that veteran.

Mr. TAKANO. Dr. Thomesen—and, Mr. Moschitta, please feel free to jump in—from your point of view in terms of serving the veteran and knowing other veteran administrators in the VA, this sort of partnership and being able to engage the family, can you comment on how important this is?

Mr. MOSCHITTA. Yes. I think this is a blessing for Northport and Long Island veterans. I have to commend Dr. Thomesen for taking a leadership role. When we first discussed this, this was a very difficult process to go down because it was uncharted. It took probably close to a year to figure out how to even have this linkage come together. But I get a fair number of patients that come forward,

and I think there was even one on CNN that talked about how this saved their lives.

We are not typically allowed to treat the children or the spouses, so having the ability to collaborate as two clinicians on the total health care of a family unit is extraordinary. So we want to thank Northwell. It is really an outstanding thing.

Mr. TAKANO. I am interested in this Rand study. I am interested in hearing back from Northwell, your company.

Dr. BELLEHSEN. Yes.

Mr. TAKANO. Your thoughts on how we can make this sustainable financially, and whether it involves expanding the scope of what we do at the VA or working with the private insurers. Do you have thoughts on this?

Dr. BELLEHSEN. I do have some thoughts. I think that is, again, why we began the process of billing insurance. But I do know that even with current billing of insurance, the cost of sustaining centers like these is quite expensive. So I do believe exactly that point, working potentially with insurers and with the Federal Government perhaps to get additional augmenting payments for these families in particular, I believe would be extremely beneficial.

Mr. TAKANO. Mr. Chairman, I hope that the Health Subcommittee might look into this partnership. It is a public-private partnership, and I know that both sides of the aisle are very much interested in making sure the VA retains its traditional coordinating role, the role as coordinator of care. But, of course, we are talking about not a competitive relationship, but one of cooperation, where there is a partnership not competitive in nature but cooperative in nature.

Dr. BELLEHSEN. Exactly, one in which the expertise of both institutions can be leveraged so that, as Director Moschitta was saying, we can work with the spouses, but also the children, which is not an area that is historically under the scope of VA care, and the VA can continue to work with the veteran.

Mr. TAKANO. Thank you. Thank you very much.

The CHAIRMAN. Before I recognize Mr. Zeldin, I want to ask a question, and this is pretty dangerous. But how many of you are veterans in this room who have used the services here at this facility? Raise your hands.

[Applause.]

The CHAIRMAN. All right. So that is the employees who are applauding for you, and we applaud you as well.

Now, how many of you are satisfied with your care?

Hands down.

How many of you are not satisfied with your care?

That is what I needed to know.

Mr. Zeldin?

Thank you very much.

Mr. MOSCHITTA. Can I make a comment, please?

The CHAIRMAN. You can't make a comment. You already have made—go ahead.

Mr. MOSCHITTA. Those who raised their hands who are not satisfied, I would appreciate if my staff could take their name and we could find out why, because we will try to rectify that. Thank you.

[Applause.]

The CHAIRMAN. Good. Thank you. And I will say this, based on the information that was provided, it is much more lopsided to the pro side than the con side. I think if folks truly want to find a way to solve some of the issues that may affect your personal health care, I think it is very important that you do engage, and let's see if we can get it resolved. If not, I am going to tell you who you call next. You call your Member of Congress who has people on their staff that deal with veteran issues every single day. Don't wait until you are so frustrated that you want to leave the system.

Mr. Zeldin?

Voice. Mr. Chairman, respectfully—

The CHAIRMAN. Sir, if you don't mind, I apologize. Mr. Zeldin has time to ask—I apologize, but we just can't take comments from everybody today in the audience. I appreciate it very much.

Voice. I request permission to speak.

The CHAIRMAN. I will be glad to speak to you afterwards.

Mr. ZELDIN. Mr. Chairman, I would echo that, too. The comments that we received, they are more on the pro side than the con side. It has always been that historically as far as my interactions.

Flooding. Can you tell us what kind of flooding issues you have here at Northport VA? Because one of the other areas where we received a lot of feedback in recent months is that you guys have some flooding issues.

Mr. MOSCHITTA. Well, during the heavy, heavy rainstorms, we do have walkways that connect buildings. Some of those have water seepage. We have roadways that are not perfectly level anymore, so we have flooding and puddles of that nature. We have leaks in some of our roofs. Once again, I am happy to say my associate director has really initiated that self-help, so we are starting to replace the roofs ourselves at significant savings to the taxpayer.

So, yes, there are water seepage issues.

Mr. ZELDIN. Is there more than, say, 5 or 10 years ago?

Mr. MOSCHITTA. I would assume. The building hasn't gotten younger. It keeps getting older, so we are going to have issues. And that is part of our plan, to rectify this. Some of these are not easily rectified.

Mr. ZELDIN. And I really appreciate that point. There are 1,258 capital requests Department-wide, 1,258. Every year, they reprioritize this list. There are 1,258. How many of those requests are Northport VA's?

Mr. MOSCHITTA. If you are referring to the SCIP plan, I think we have 73 items on there, but they compete against everything else.

Mr. ZELDIN. I know. This is what I want to talk about. What is your highest ranked request on that list?

Mr. MOSCHITTA. At this point, I couldn't tell you the number one—

Mr. ZELDIN. Is it possible that your top ranked request is 542 out of 1,258?

Mr. MOSCHITTA. It could be, because there is also criteria that are established. So, for example, I know that nationally right now they are looking for projects that will improve access and things of that nature.

Mr. ZELDIN. And it is possible that your lowest ranked is 1,257 out of 1,258?

Mr. MOSCHITTA. Could be.

Mr. ZELDIN. I don't think that Northport is alone with the answer to that last question you gave me, that system-wide we are seeing the system falling into a state of disrepair. The Veterans' Affairs Committee has held hearings on, for example, the project in Aurora that is $1 billion over budget, and when they were in front of our Committee, the Department said they were operating off of what they referred to as an artificial budget. One of my colleagues on the other side of the aisle asked when she was going to get a timeline of when there was going to be an actual budget, and the Department wasn't able to answer that. So the follow-up question is, well, can you give us an idea of when you will have a timeline? She was asking if there was a timeline to have a timeline to have a real budget.

What happens when your capital—this is just one project; there are others as well. What happens is—and this is not so much specific to Northport VA, but it directly impacts every veteran in this room, and it impacts this entire facility here. If your highest request is 542 out of 1,258, you are never going to get any of your requests satisfied. So next year, if they do another rank order, and you have dozens of requests, and next year your highest ranked request is 512, and then the following year after that it is 515, the way that the money is currently being spent—and look no further than Aurora—is resulting in none of your requests, none of your requests, and that is something that greatly concerns me.

I don't want to speak for my colleagues here from the rest of the congressional delegation, but knowing where their hearts are in our conversations about the Northport VA and delivering high-quality care for our veterans, there is something seriously wrong with the fact that none of the requests here are ever getting satisfied because of the way money is being mismanaged at the Departmental level.

[Applause.]

The CHAIRMAN. Miss Rice?

Miss RICE. No questions.

The CHAIRMAN. Mr. Israel?

Mr. ISRAEL. Thank you, Mr. Chairman. This will be my final round.

Mr. Moschitta, I want to go back to the notion of customer care and the process for evaluations. The Chairman—I am going to extend the danger the Chairman created. The Chairman asked for a show of hands of how many people were satisfied with the services and the care that they receive, the vast majority of the people here. Then he asked how many were dissatisfied; hands went up.

I am going to ask, of the people who have been dissatisfied with the care, how many of you have had contact or interaction with one of the two customer service personnel that Director Moschitta referenced earlier?

One, two, three, four. Four.

Mr. Moschitta, is it possible that with a total customer base of 32,000 and 57 emergency room visits a day, that you should be ramping up the number of personnel that are available to have daily contact with your customers to ensure that they are satisfied?

And if they are dissatisfied, to resolve the difficulties that they are encountering?

Mr. MOSCHITTA. Well, we will take that part of it under consideration. That is only one small aspect of our customer service program. Many people come to my office, and not just me, but my entire front office staff, and those don't get recorded.

Mr. ISRAEL. But you are busy fixing HVAC systems. You are busy trying to reopen emergency operating rooms.

Mr. MOSCHITTA. No, no. What I am trying to say is, it is a multifaceted approach on how we try to accommodate the patients. First of all, we do try to have in each department a customer service rep. They are trained, and discussed, and rolled out by these two individuals. So it is a pyramid. You have the two at the top, and then each department has a rep. So they are supposed to be referred to see how that service can resolve the issue within the service at the lowest level. Because remember, when you are a customer service rep, you don't know the ins and outs of every single department, so it is best to have the department resolve it.

Then you have the customer service reps, and then many of them filter up to the front office, and I have a staff assistant, my secretarial staff. They also know, never turn away a vet. When there is an issue, you have to try to resolve the issue. All those things count as far as how we are trying to resolve issues, and they don't really get into a statistical database.

So there are many avenues for this. Whether or not we need another official customer service rep, I promise you I will look at that.

Mr. ISRAEL. If you would, I would appreciate that. You have to do two things. You have to fix this problem at the top, which is in Washington, D.C. with the management of the VA. I have had some long-running battles with them, so it has to be fixed at the top. But it also has to be improved here on the ground, and it seems to me that one of the deficiencies is there just aren't enough people communicating with your customers to understand where there is a problem, and to solve it before it grows into a crisis that requires a congressional hearing.

Thank you, Mr. Chairman.

[Applause.]

The CHAIRMAN. Mr. Zeldin?

Mr. ZELDIN. Thank you, Mr. Chairman.

Mr. Moschitta, can you speak further about the inability that you are finding to use local labor for these capital projects?

Mr. MOSCHITTA. Well, it is two-fold. One, when we talk labor, we are talking about hiring plumbers and carpenters and things of that nature. Some of those it is hard to hire even for our own staff. Competitively, they make a lot more money on the outside and going into Manhattan. So locally to fill slots, that is a challenge.

The second thing is it is a little difficult when contracts are put out on the street for bids to get a lot of different contractors. It is that competition that really drives the cost down. It seems to be the same group. We have some very good contractors. We have some marginal ones. So we would love somehow to have more competition. I don't know if that is within our ability to achieve that.

Mr. ZELDIN. I would love to talk to you more about that aspect to see if there is a way to utilize more local labor for a lot of needs that exist moving forward.

Mr. MOSCHITTA. Yes.

Mr. ZELDIN. Can you speak about the golf course and how that is owned or leased?

Mr. MOSCHITTA. Yes. It is leased with the American Legion. It is a 20-year lease. I think it is up in 2020, at which time then it will be competitively bid. There is not going to be an automatic renewal. It has to be competitively bid.

It is a very nice relationship. They pay for all their expenses, so it is no cost to us. They mow, they maintain, they make a lot of improvements to the golf course. They recently had their parking lot re-done. There is brick work.

Mr. ZELDIN. When you say "they"—

Mr. MOSCHITTA. The American Legion.

Mr. ZELDIN. Oh, the American Legion.

Mr. MOSCHITTA. As long as I have been here. So it is a 20-year contract, so I guess it is—

Mr. ZELDIN. And do you have any idea, if you want to go play 18 holes, how much does it cost?

Mr. MOSCHITTA. I am not a golfer, but I think it is around $14 or so a round. Now, any of our patients that are in-house can play for free.

Mr. ZELDIN. Is the VA subsidizing the golf course at all? Does it pay for itself?

Mr. MOSCHITTA. It pays for itself. Now, we get approximately $35,000 to $40,000 income from them. There is a formula. The first $300,000 that they make in revenue, we get $30,000, and then every $5,000 after that we get $500. So we are getting an income from that, and we are shedding the expense of maintaining it. So it is a big advantage to us.

Mr. ZELDIN. There are a lot of questions, and we have a limited amount of time here. I really appreciate you being here, but we are leaving here with further questions. So your responses to what is ahead is very important.

Mr. MOSCHITTA. Always available.

Mr. ZELDIN. I will say that the Chairman did send a letter to the Secretary of the Department of Veterans Affairs at the end of July with many very specific questions asking for a response by the end of August, which he didn't receive. So in order for us to be able to get to the bottom of everything else that we need to, we need more forthcoming responses right up to the Secretary level.

Additionally, I would like to know more about the use of paper, paper logs, that process that you were unable to answer some of those questions earlier, just to know what is true and not true about a lot of the stuff that has been shared with us. So if you could answer for us afterwards as to where there is a sensitivity on the part of the Committee, knowing how the use of paper in other parts of the system has caused some pretty large scandals. So to be able to clear the air as it relates to Northport VA, if you can let us know exactly what your use of paper is, your system, and most specifically the emergency room, that would be very helpful.

And one last word. I really appreciate Dr. Bellehsen being here, and I just want to say that the importance of peer support for our veterans with post-traumatic stress disorder, traumatic brain injury, the Northport VA working with Suffolk County Department of Veterans Affairs—I see Tom from the office here in Suffolk. Suffolk and Nassau County take peer support incredibly seriously. The peer support model is one that I believe should be replicated nationally, and it is saving lives.

So your ability to continue to network with the people who are here, I am very interested in delivering better peer support. We will save further lives moving forward, and it is something that I would hope that you could talk to your peers about all across the Department of Veterans Affairs, because we do need to replicate that everywhere. I appreciate Northwell taking that leadership role and participating.

Chairman, thank you for visiting from the 1st Congressional District of Florida.

Chairman Miller and his Committee have been absolutely amazing and diligent through the years. So much that we know of the need to improve the standard of care, delivering a higher standard of care for veterans, so much that we know is a product of Chairman Miller's time with the gavel, and I really do appreciate everything the Veterans' Affairs Committee has done.

This is my own personal observation, and I know that there are many people out there who might take exception with it if they have been on the wrong end of it. But out of 535 Members of Congress, my personal opinion, and I will leave that there, is that there is no other Member of Congress who has done more to shed light on really important issues impacting our veterans than Chairman Jeff Miller, who is retiring at the end of the year, maybe for the benefit of some of the people who have been on the wrong end of some of what we read about in the papers and in the news over the course of the last few years. But who knows, maybe he won't go too far.

Chairman Miller, good luck in your retirement. Thank you for being here and taking this investigation so seriously.

The CHAIRMAN. Thank you very much, Mr. Zeldin.

[Applause.]

The CHAIRMAN. Any closing remarks?

Mr. Takano?

Mr. TAKANO. Let me echo the last sentiment of my colleague from New York, Mr. Zeldin. I have worked alongside Chairman Miller for the past almost four years now, and he is a wily as well as charming individual, and he can be very enticing to make you think that his point of view is correct even when it is wrong.

But I want to also say that we have done a number of things as Republicans and Democrats between us personally and Members of the Committee to do a lot of things that I think have been in the Nation's interest and foremost in the interest of our veterans.

So, Chairman Miller, I said this on the floor of the House and I will say it here, we wish you well in your retirement, and thank you for your service.

One veteran suicide is one suicide too many, and my heart goes out to the Kaisen family again, and I am very sorry for your loss.

If that tragic event has allowed us to come together and take a look at the service here and to in the process actually validate the things that you are doing right, and also to call into question things that maybe we can improve upon, then that is something that has been a good that has come out of it. So we can redeem a tragedy, and we thank you for—so we can give thanks to that. So, Ms. Kaisen, thank you. It brings me great joy to see—this is the satisfying part of this work.

Mr. Moschitta, I see that you welcome an audit of the outreach program, and if we can clear the air—and I agree with you, it is so important to make sure that our veterans here and everywhere know that we can clear the air, and if there is any cloud about the operations here, that we can clear it up.

Dr. Bellehsen, I hope that the Health Subcommittee will review the work that you are doing. I await with great anticipation the Rand study. And as I said, Congress is very much interested in fostering these sorts of partnerships between the VA and the private health care system.

And as the Congress should take a closer look at what the Federal Government role can be in addressing not only veterans, but their families in the context of mental health care. It is kind of common sense that you can't really separate the veteran out from the family and the effects of post-traumatic stress, or traumatic brain injury, or a whole host of other challenges that the veteran is facing health-wise without also addressing the family.

So the question is to me, to what extent should the Federal Government be involved in expanding our scope of care to family members when it comes to addressing mental health care? To what extent should your organization have to rely on private health care insurance to make it possible for you to address family members? So that is a big question, something that we will have to wrestle with, and that is why the Rand report will be very helpful to us.

Mr. Chairman, I am very thankful for the Committee meetings that you have called, and this Committee meeting has been very enlightening, and I have learned a lot about a very promising pilot program. Thank you, and I yield back.

The CHAIRMAN. Thank you very much, Mr. Takano.

I would say that we are here at the request of the Long Island delegation. Certainly, Mr. Zeldin and Miss Rice are Members of the VA Committee. I appreciate their diligence in what we are about as a Committee.

The first thing I want to do from a bookkeeping standpoint is all Members will have 5 legislative days in which to revise or extend their remarks or add extraneous materials.

Without objection, so ordered.

I know everybody in the audience that may have wanted to speak today did not have an opportunity to speak.

Voice. None did.

The CHAIRMAN. We are—this is a congressional hearing.

Voice. Some people—

The CHAIRMAN. We will speak to anybody that wishes to speak afterwards. But for the official record, we invited these witnesses because we had specific issues that had been brought to us that we wanted to have answered. Now, whether the testimony today was

truthful or not—I assume it was—that is why we swore the witnesses in.

This is not the end of the investigation that is taking place from this standpoint. This Committee will continue its investigation even long after I am gone as the Chairman of this particular Committee. We have an oversight responsibility not just to this facility but to every facility across the Department of Veterans Affairs.

I know the vast majority of people that work at the VA want to do the right thing and are employed by the VA for the right reason, and that is to serve the veterans. That is obvious by the show of hands that I saw today. That is obvious by the casual conversations that I have had with individuals in the 24 hours that I have been here who were not solicited but are veterans who came here for their health care and had good experiences.

Everybody is not going to have a good experience everywhere they go. Our job is to try to find out why. Those of you who have not had good experiences have a great opportunity now, and we are not talking about—this is particularly within the Veterans Health Administration, the VHA side of the ledger. We know there is a whole lot more when it comes to disability claims and the processing, and how that process works. Mr. Moschitta, if you would like to take that on, you are welcome to take that too.

We just passed out of Congress last week a piece of reform legislation that was, I think, the number-one issue for the Secretary and this Administration, and if we can get it moved over in the Senate, I think it will make a difference.

Again, I want to thank you all for being here. Those of you who served in Vietnam, 50 years, we say welcome home, to those of you who served this country so ably, and when you came home you were not treated well. Never again in the United States of America.

[Applause.]

The CHAIRMAN. With that, everybody who has worn the uniform of this Nation and your family members have our utmost thanks.

This hearing is adjourned.

[Whereupon, at 11:30 a.m., the Committee was adjourned.]

A P P E N D I X

Prepared Statement of Joan E. McInerney, M.D., M.B.A., M.A., F.A.C.E.P.

Good Morning, Chairman Miller, Acting Ranking Member Takano, and Members of the Committee. Thank you for the opportunity to discuss quality of care, infrastructure, leasing, and contract issues at the Northport VA Medical Center (VAMC). I am accompanied today by Mr. Philip Moschitta, Medical Center Director at Northport VAMC.

I was appointed as the Network Director of the Veterans Integrated Service Network (VISN) 2 VA New York/New Jersey Network in May 2016. I am a Board certified Emergency Medicine/Internal Medicine physician with 24 years of experience at major Level I Emergency Departments (EDs) in the public sector in New York. I joined VA in 2011, as Chief Medical Officer of VISN 3. As the proud daughter of a World War II Veteran, I am honored to bring my experience and skills to our Veteran patients. Mr. Moschitta, the brother of a Vietnam Era Veteran and nephew of a World War II Veteran, began his VA career 44 years ago as a kinesiotherapist treating disabled Veterans. Since being appointed Director nearly eight years ago, he has witnessed the unmatched passion and dedication with which Northport's employees deliver care. The Northport VAMC has long had a strong reputation for caring for 31,500 Veterans within its Long Island catchment area, who come to us each year for care.

Access

Nationally, between August 2015 and July 2016, VA completed approximately 57.46 million appointments in VA facilities. This is 830,000 more appointments than the 56.63 million that VA completed in the same period the year prior, and almost 2.9 million more appointments than the same timeframe two years prior. Eighty-five percent of Veterans are seen within seven days of their clinically indicated date, 96 percent within 30 days, and 22 percent are actually completed on the same day.

Since April 2014, VA has hired 7,366 more physicians, 25,849 more nurses, and 57,870 additional staff nationwide. This means we have hired a net total of 26,392 employees—a 9 percent increase. This includes a net increase of 2,332 physicians or 10.3 percent, and a net increase of 6,818 nurses, or 11.6 percent. We also activated approximately 2.2 million square feet of clinical and support space, including long-term care facilities. Physician productivity is up 11.3 percent, which translates to an additional 7.4 million hours of care. Between October and June, we increased authorizations for community care by 458,386, or 20 percent, from the same period the prior year. We have established four new regional tele-mental health hubs, and are expanding tele-primary care hubs to further expand access.

Even as VA's efficiency rises, Veterans need more services from VA than ever before. At the Northport VAMC, outpatient visits have increased 3.1 percent and appointments for female Veterans have increased 8.4 percent over the past two years. In fiscal year (FY) 2016 to date, Northport VAMC completed over 318,000 outpatient appointments with 99.2 percent of them within 30 days of the Veteran's preferred date. In fact, the average wait time for a mental health appointment is less than 2 days and Northport outperforms the 90th percentile in providing outpatient urgent Mental Health Care. Specialty Care access is at 98.4 percent within 30 days. New Primary Care, Specialty Care, and Mental Health Care appointments are completed within 30 days and exceed the 90th percentile.

VA's FY 2016, quarter 2 outpatient access surveys show that 93 percent of Northport's Veterans always or usually got a routine primary care appointment as soon as they needed. For routine specialty care, this number is 89 percent. Northport's outpatient satisfaction scores are in the top 25 percent of VA facilities for 5 out of 7 satisfaction composite areas.

To expand access of services to our Veterans, Northport VAMC has introduced mobile health units, which allow our patients closer-to-home access to VA audiology and podiatry services. These mobile units also provide rural health care, community

enrollment outreach events, and are prepared for deployment under the emergency management program. We have also been working to provide extended hours that accommodate our working Veterans. We have hired approximately 38 new staff to optimize Veteran access.

Mental Health

Before reviewing our comprehensive mental health programs at Northport, I would first like to take a moment to address the August 21, 2016 death by suicide of a Veteran on medical center campus. The health and well-being of the courageous men and women who have served in uniform is the highest priority for VA and the Northport VAMC. We are committed to providing timely access to high quality, recovery-oriented mental health care that anticipates and responds to Veterans' needs and supports their reintegration into their communities.

Sadly, a Veteran took his life in a parking area at Northport VAMC on August 21, 2016. Review of campus videos, emergency department (ED) records, phone records, and the Veterans Crisis Line records reflect that the Veteran did not reach out for help prior to taking his life. It has been reported that two other Veterans committed suicide at Northport VAMC this year. While I must respect the families' privacy in the details of their loved ones' deaths, I can share that one of the individuals was a non-Veteran employee who died in the community. The other circumstance involved a Veteran where the Suffolk County Medical Examiner determined the death was not due to suicide.

The Northport VAMC has a long history of providing excellent clinical care in Mental Health, both at our main facility and our five community clinics. The leadership and clinicians are committed to providing quality care to Veterans, and have developed a comprehensive Behavioral Health Continuum of Care. Our goal and intent is to continue working as hard as we can to provide the care and services needed to hopefully eliminate Veteran suicides in our service area.

Access to mental health services can be obtained the same day for any person identifying an urgent need. Northport's mental health walk-in clinic has been in existence for over 25 years. It is available to Veterans without an appointment so they are able to see a dedicated psychiatrist when needed. An on-site psychiatrist is available in our Medical Center 24/7, should a patient present to the ED at any time requesting psychiatric help. This has been cited as a Best Practice by the Office of Mental Health Operations. Our intent is to continue providing this important aspect of care to our Veterans.

Our mental health specialty services include 42 acute care hospital beds, as well as substance abuse services, including outpatient detoxification, a day treatment program, a dual-diagnosis program, a psycho-social rehabilitation program, case management for Veterans, a mental health clinic, and residential programs for both substance abuse and posttraumatic stress disorder.

Our Substance Abuse Access Care Center provides walk-in availability for Veterans to see a substance abuse specialist, without an appointment. We also developed a unique written agreement with the Suffolk County Police. The goal of the arrangement is to ensure that any Veteran they engage who has a mental health crisis is brought directly to Northport, rather than a community hospital.

Northport recently received national recognition for the development of a Unified Behavioral Health Center for military or Veteran families. It was accomplished in cooperation with the Northwell Health system (formerly known as North Shore Long Island Jewish system). Through this synergy, Northport serves Veterans at our community clinic in Bayshore, while Northwell cares for the family members in a model of co-located collaborative care. The model acknowledges the stress that all family members experience as Veterans receive care, and evidences the value of family support to deal with the wounds of war.

Northport has embraced the national VA initiative to incorporate Mental Health into Primary Care. This has increased the opportunity for Veterans to identify personal challenges with pain, anxiety, sleep, depression, readjustment issues, life changes, and substance abuse during Primary Care visits—without having to commit to visiting a psychiatrist—as that may, from the Veteran's perspective, carry an undesired stigma.

Cognizant of the substance abuse challenges facing many Veterans and the prevalence of harmful drug use on Long Island, Northport clinicians have made a concerted effort to address substance abuse in the Veteran population through the national Opioid Safety Program. This initiative has reduced the number of patients on high dose oral opioids by 47 percent from January 2015, through June 2016, while expanding complementary medicine alternatives such as acupuncture, meditation, and interventional pain management. We also are working to increase the use of newer, more sensitive urine toxicology methods. This will ideally further inform

VA clinicians in each instance of care, ideally foster more honest conversations between clinicians and Veteran patients, and enable VA to provide proactive treatments including the opioid antagonists when appropriate. In this regard, we appreciate Congress' recent enactment of new authorities to support expanded access to opioid antagonists.

Infrastructure Issues

Northport VA Medical Center is a tertiary care level 1 Joint Commission accredited facility serving Veterans in Nassau and Suffolk County, NY. The VA Medical Center is located in Northport, NY with outpatient clinics in: East Meadow, Patchogue, Riverhead, Bay Shore and Valley Stream, NY.

Northport VAMC's Building 200 cooling towers unfortunately failed on March 10, 2015. Immediate actions to help alleviate the situation included the rental of four portable chillers on March 12, 2015. The units provide cooling for the main hospital, outpatient clinics, and a portion of the Community Living Centers, and Administrative areas at an approximate net cost of $50,000 per month.

Immediately after the failure, VA decided to pursue a Utility Energy Services Contract with a local utility company named National Grid for replacement of this critical infrastructure. Using this contract vehicle, VA would replace the failed equipment with energy efficient components and could pay back the utility through energy and operational savings over a number of years. Contract performance began in August 2016, and is currently set for completion in Fall 2017.

On February 17, 2016, Northport VAMC's operating room (OR) staff detected sand-sized particles (later analyzed and identified as rust) coming from the heating, ventilation, and air condition (HVAC) system in OR 4. Facility leaders determined that the condition posed a potential risk to the health of patients and staff, and made the necessary decision to close all five ORs for Veteran safety.

Northport's attention then quickly turned to ensuring that Veterans would continue to receive proper and timely care in a safe environment. Patients who needed emergent surgical procedures were transferred to affiliate and local hospitals. Patients scheduled for elective procedures were offered care through other VISN 2 facilities in New York City, and in the community through the Veterans Choice Program. All decisions regarding surgeries were made with input and feedback from the patients and their physicians. Clinical reviews of those Veterans whose surgeries were relocated or postponed have not revealed any adverse effects or outcomes.

For three consecutive weeks after the initial OR closure, activities to remediate the problem included duct cleaning, continued surveillance for particles, installation of temporary filters, and consultative meetings with pertinent experts. Air and surface testing samples were taken in the ORs, to determine and confirm the efficacy of our remediation efforts. Analysis of the samples through an independent environmental reference laboratory revealed insignificant levels of an airborne fungus cladosporium, which Infection Control experts concluded would not pose a health risk. Accordingly, three of the five ORs were reopened on March 14, 2016.

On April 13, 2016, particulates were observed again in one of the three open ORs. To ensure patient safety, VA leadership closed all three ORs for open surgical cases. Through consultation with subject matter experts within and outside of VA, Northport developed the following three-phase plan to resolve the issue so the ORs could then be reopened:

1.Fan-assisted high-efficiency particulate air (HEPA) filters were chosen as the immediate action to control the particulate discharge. On June 1, 2016, VA received the fan-assisted HEPA filters, which were custom designed and created to fit into the ORs. Through the use of these filters, and upon confirming that the situation had sufficiently improved, the first 3 of the 5 ORs opened for patient care on June 7, 2016. All the ORs were open by June 16, 2016. Subsequent sampling and testing revealed no particulate discharge.

2.Following the reopening of Northport VAMC's ORs, an independent consultant conducted a forensic inspection of the OR air handler. It determined that the air handler could be refurbished to a safe condition. Based on VA's assessment, coupled with the observations and recommendations of this independent consultant, the Northport VAMC is pursuing a contract to refurbish the OR HVAC system. This is the intermediate plan for the OR.

3.The ultimate long-term plan is to evaluate the potential to ultimately replace the ORs by submitting a proposal through VA's Strategic Capital Investment Plan.

Lastly, we sincerely apologize for not alerting our Congressional partners sooner during this event. Please know that going forward our goal will be to ensure we pro-

vide more timely notice to you if and when similar events transpire. We truly appreciate the unwavering interest and support that you provide to our VA personnel and local Veterans.

Moving Forward

The October 2015 integration of VISN 3 into VISN 2 has created new and improved synergies, transparency and alignments. Constructive interactions among the medical centers and contracting have increased dramatically in the past year and have created improved cooperation and efficiencies. This has included enhanced procurement package development, as well as contract awarding, implementation, and administration. This has helped us work to achieve our related goal to ensure quality and timely construction and maintenance of our facilities, respect for underlying budget constraints, and stewardship of our Nation's tax dollars.

During this process, leadership will continue to assess our current and future needs and project planning to better understand the underlying factors and develop enhanced planning processes to include risk assessment and cost based analyses. This will enable us to develop improved long range capital investment plans based on lessons learned and consideration of best practices.

We are also committed to strengthening our incident command team so that we are better prepared should similar crises arise in the future. This team will include administrative and clinical leadership, as well as personnel in the areas of engineering, patient and environmental safety, infection control, contracting, and appropriate VA subject matter experts. We believe this is crucial to ensuring safety, access, quality, and financial stewardship. Northport VAMC is committed to the Secretary's MyVA Initiative of putting Veterans first and at the center of what we do. In that regard, we are excited and look forward to continuing our efforts to improving the Veteran experience, improving the employee experience so we can better serve Veterans, improving internal support services, establishing a culture of continuous improvement, and enhancing strategic partnerships.

Conclusion

The leadership of VA, VISN 2, and the Northport VAMC are committed to ensuring excellent, high quality patient-centered care at all times and in all venues. We strive for prompt access, excellence in patient care, and superior clinical outcomes. Our clinical care teams value the importance of the Veteran experience. VA remains committed to ensuring America's Veterans have access to the health care they have earned through service. We are committed to accountability and transparency in providing any requested information to our Congressional stakeholders.

Mr. Chairman, this concludes my testimony. Thank you for the opportunity to testify before the Committee today. We appreciate your support of Veterans. We would be pleased to respond to any questions that you and Members of the Committee may have.

Prepared Statement of Mayer Bellehsen, PhD.

Good morning. I am Mayer Bellehsen Ph.D., Director of Northwell Health's Mildred and Frank Feinberg Division of the Unified Behavioral Health Center for Military Veterans and their Families.

I want to thank Chairman Miller, Ranking Member Takano and Members Zeldin, Rice and Israel for convening on Long Island this field hearing of the House Committee on Veterans' Affairs.

Long Island's Nassau and Suffolk Counties are home to nearly 150,000 military veterans so it is important that the Committee is here focusing upon their health care needs and, as importantly, on the needs of their family members who are too often overlooked.

While I am not an employee of the Veterans Health Administration, I consider it an honor and privilege to serve alongside my Northport Veterans Administration Medical Center (VAMC) colleagues in an effort to assist our Nation's veterans and family members who have sacrificed for us. As the Director of the Northwell Health Feinberg Division of the Unified Behavioral Health Center, I have been directly involved with the operations of this Center from its opening in late October, 2012, until today. As such, I am able to speak to the successes of this unique, first-of-its-kind public-private partnership in which co-location of services and coordination of care is collaborated on between Northwell Health and the Northport VAMC to serve veterans and their families.

I am excited to present to the Committee a modest but effective veteran family health care model that Northwell Health established in 2012 in cooperation with the Northport Veterans Administration Medical Center. In particular, I would like to thank the leadership from both Northwell Health and the Northport VAMC, including Michael Dowling, Blaine Greenwald, MD, Phillip Moschitta, and Charlene Thomesen, MD. I believe this joint enterprise reflects highly on the vision and boldness of leadership in both institutions, as well as their commitment to serving the veteran community. The data I will present demonstrates that with a modest investment, public-private partners like our not-for-profit Northwell Health and the Northport VAMC can generate significant clinical successes for our deserving veteran families.

People will often ask about the scale of the necessary investment. I shall provide budgetary details later in my testimony. The essential point, however, is that an effective health care program does not require a multi-story expensively equipped building. Instead, I have attached to my testimony the actual floor plan for our 3,680 square foot store front facility in downtown Bay Shore. We would welcome the opportunity to give the Committee and/or its staff a tour at a future date.

Based upon the success of our program, we urge the Committee members to consider the possibility of replicating our successful model in your districts and, indeed, throughout the country.

I would like to first share with you the history of this partnership and then our achievements. The Center was first conceived of in the context of conversations that started in 2010 regarding possibilities for collaboration between Northwell Health (formerly known as North Shore-Long Island Jewish Health System) and the Northport Veteran Administration Medical Center. Building off of Northwell Health's prior efforts to serve military members and their families, along with Northport VAMC's expertise in serving veterans, leadership from both institutions agreed that it would be advantageous to pursue a novel, public-private partnership to expand care to veteran families.

The impact of military service on veterans has been well documented (Tanielian et al. 2008) and the desire for families to be further integrated into services has been highlighted (Shell & Tanielian, 2011). Furthermore, we know that there is an impact on the family members of those who have served when re-integration challenges and mental health difficulties such as Post Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), Depression and Substance Abuse are present (Amadzadeh & Malekian, 2004; Chandra et al. 2010; Dekel & Goldblatt, 2008; Tanielian et al. 2013). However, due to Veterans Health Administration guidelines, there were limitations on the ability for the VAMC to assist the family system. Historically, the mandate of the Veterans Health Administration is to care for the individual veteran. There are instances in which it can assist family members, but there are limitations as well, including: 1) situations where a family member would like to engage in treatment, but the veteran is not engaged, 2) cases where individual services are needed for an adult family member independent from the veteran, and 3) when children are involved and require child focused treatments.

As a result, it is often the case that the family members look to ad hoc providers in the private sector for care. There is no structured clinical path for the VA and private providers to collaborate on a treatment plan for the veteran's family as a unit.

Gaps in coverage and the need for partnerships to address them have been recognized as an important area to focus on within the veteran space. To this end, in 2012, President Obama signed an executive order calling for collaboration between the VHA and local community-level partners in order to improve the services provided to servicemembers and their families (Department of Defense, 2013). However, Northwell Health and the Northport VAMC were ahead of the curve in pioneering a model for addressing these needs.

As a consequence of the conversations in 2010 and in response to a request for proposals by The Robert Wood Johnson Foundation, the Unified Behavioral Health Center for Military Veterans and their Families (UBHC) was proposed and then established. The mission of the Center is to operate a model public-private partnership (between a Federal Veterans Administration (VA) Medical Center (Northport VAMC) and a private sector Health System (Northwell Health)) that successfully serves the behavioral health needs of military and veteran families.

The novelty of this partnership included the development and maintenance of a Center that promotes co-location of services and cross-talk between staff from both institutions for the provision of coordinated care to the veteran family. The VA offers primary care and behavioral health services to the veteran in a Community Based Outpatient Center (CBOC) called the VA Clinic at Bay Shore, while Northwell Health offers behavioral health services to the family members at the

Mildred and Frank Feinberg Division of the Unified Behavioral Health Center. These two centers are located side by side under one roof, with shared spaces for collaboration. Through a collaborative care model, the two institutions meet regularly to coordinate care of shared cases.

The Center was established with five principal goals in mind: These included:

1.Model a new form of public-private partnership to meet the needs of military and veteran families.

2.Increase access to behavioral health services for veterans and their families.

3.Offer evidence-based, quality treatment to ameliorate mental health distress born by veterans and their families and improve quality of life.

4.Conduct outreach to the community to de-stigmatize mental health service, and

5.Document and disseminate this model for others to consider in replication.

Achievements

I am pleased to share that in our nearly four years of operation, we have been largely successful in meeting our objectives. These accomplishments are a testament to the positive working relationship between our institutions' administrative and clinical staff along with our shared commitment to serving our military and veteran community. Supporting documentation of these accomplishments can be found in the attached Exhibits A–F. Achievements include:

Establishment of a unique public-private partnership- In 2012, the Unified Behavioral Health Center was built and opened in Bay Shore, NY. This entailed construction of a 3,680 square foot center for co-location and coordination of behavioral health services for the veteran and his or her family. The Center was staffed by personnel from both institutions and began implementing its coordinated care model by December, 2012. The model has included weekly coordinated treatment team meetings with staff from both institutions along with occasional integration of staff located at other Northport VAMC facilities via teleconferencing. Co-location and collaboration has contributed to 61% of Northwell Health clients being referred from the VA, which reflects on the success of partnerships in reaching this population. Additionally, this arrangement has led to monthly opportunities for cross education to share knowledge regarding family and veteran related challenges across institutions.

Increased Access to Care- The partnership has also lead to increased access to care for veterans and their families. From inception through August 31st, 2016 there have been 9,470 visits among 303 unique patients in the Northwell Health section of the UBHC (the Feinberg Division). Meanwhile, there have been 10,017 visits among 1,040 unique patients at the VA section of the UBHC. Prior to opening the CBOC in Bay Shore, the Northport VAMC operated two mobile CBOCs in Islip and Lindenhurst. Notably, when the Northport VAMC contrasts the visits in its Bay Shore CBOC to the year prior to opening this facility, they find an increase of 4% in unique patients encountered in the region.

As a result of the partnership, nearly half of the referrals to Northwell Health from the VA have resulted in collaborative care cases (i.e. cases wherein the VA sees the veteran, Northwell Health sees at least one family member, and permission is given to coordinate treatment). Furthermore, 73% of the clients seen by Northwell Health clinicians are family members or have a close relationship to a veteran/military member and 47% report no prior treatment. Although definitive conclusions are difficult to make without comparisons to other programs, this data suggests that the Center is reaching individuals that may not regularly engage in treatment. Additionally, over half of the clients seen by Northwell Health connect their difficulties to the invisible wounds of war such as PTSD. Lastly, 20% of our active clients at present are children who would otherwise not likely receive treatment in a veteran informed space.

Satisfaction with Services- As a result of our collaborative efforts, clinicians largely report that they are satisfied with the model and clients report that they are satisfied with services and outcomes. An independent evaluation of the Center is being conducted by the RAND Corporation and I have been informed that they will be releasing their evaluation in October, 2016. This evaluation will also include some analysis of satisfaction and outcomes. However, in the Northwell Health section, our staff's clinical observations that incorporate the use of standard psychometric tools and patient report already suggest that patients are achieving desirable improvements.

Beyond the successes captured in these numbers, the stories of those we serve are most compelling. As highlighted in the stories of our clients such as an interview

conducted by CNN with one couple treated at the Center (Exhibit C), it is our belief that our partnership has not only resulted in greater care for a veteran's family, but it has benefitted the veteran as well. Furthermore, due to co-location, clinicians from the Northwell Health side can regularly encourage veteran engagement with the Northport VAMC when a family member reaches out independently or when a veteran finds their way to Northwell Health. While there are no statistics to capture this, I can anecdotally report on numerous instances when I have been able to walk a veteran over to the VA to engage them in VA care. I was always met with receptivity and a quick response to engage the veteran in treatment.

Promotion of the Model- The Unified Behavioral Health Center has been highlighted by the White House as an example of community partnership. Additionally, reports by CNN and the Agency for Healthcare Research and Quality have featured this Center as a model (Exhibit C). More recently, the RAND Corporation released a paper that reviews the landscape of public-private partnerships in delivering care to veterans (Pedersen et al., 2015). It noted that there are very few such partnerships in delivering behavioral health care and it highlighted the UBHC as one of a kind in delivering co-located, coordinated care for the veteran and their family. As noted above, the RAND Corporation has been conducting an independent evaluation of the r Center and will produce a report that comments on the program in the month of October. Ultimately, it is the hope of UBHC staff that the report will add legitimacy to the argument for the Federal Government to do more in supporting the replication and sustainability of other centers similar to the UBHC on a national level.

Cost of Operations- The Northwell Health section of our Center is currently staffed by 4.5 full time employees that range in professional background. For the 3.5 years from inception through June, 2016 we have been able to operate our program at a cost of $2,319,661 (Exhibit D). This amount has been secured through various channels, including a Robert Wood Johnson Foundation and Local Funding Partners grant, and through ongoing subsidization and fundraising efforts by Northwell Health. Additionally, our Center began billing processes in 2016 to help offset costs of sustaining the Center.

In summation, the model of the Unified Behavioral Health Center for Military Veterans and their Families is a novel public-private partnership that includes co-location of services and coordination of care between institutions that has resulted in increased benefits to the veteran community, including: expansion of services to the family (including children), greater dialogue between institutions to coordinate care, efficient referrals of services for veterans and family members, greater education on family related challenges for VAMC staff, greater education on veterans' culture and challenges for private sector staff, and easier access to the networks of support that both partner institutions can offer. Staff report that they believe the model is effective and clients at the UBHC report feeling satisfied with their treatment.

It is my belief that the center has had an important impact on the landscape of veteran care and veteran family care on Long Island, and should continue to have an impact. The key elements of success have been co-location and coordination of care. The creation of a new site tailored to this task was undertaken, but this may not always be necessary as future partnership may want to utilize existing space on VA grounds or on the grounds of a private sector institution. As long as there is adequate engagement of staff from both institutions through regular coordination of care and some degree of co-location, it is likely that these centers can achieve the goals of enhanced care for the veteran and the family.

The implementation of a public-private partnership between a private sector health system and the VHA is a critical step for expanding family services to the veteran community. The model that has been piloted by Northwell Health and the Northport VAMC at The Unified Behavioral Health Center for Military Veterans and their Families has demonstrated the viability of partnerships. Further independent evaluation of the Center is forthcoming, but I believe this model represents a promising avenue for supporting our Nation's veteran families.

I thank you again for the opportunity to discuss our Center and welcome any questions you may have.