Federal Health Update

JULY 8, 2016

Welcome to Federal Health Update. This newsletter is a compilation of the latest news in the federal health care sector.

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EXECUTIVE AND CONGRESSIONAL NEWS

- **On July 6, 2016, the House passed H.R. 1270 the Restoring Access to Medication Act of 2015.** This legislation repeals provisions of the Internal Revenue Code, added by the Patient Protection and Affordable Care Act that limit payments for medications from health savings accounts, medical savings accounts, and health flexible spending arrangements to only prescription drugs or insulin (thus allowing distributions from such accounts for over-the-counter drugs).

MILITARY HEALTH CARE NEWS

- **TRICARE and Military OneSource will host a webinar about TRICARE Eligibility after Divorce on Wednesday, July 13, 2016, 12:00 p.m. EDT.**

  The featured speaker for this event is Ms. Shane Pham. Ms. Pham is a member of the Defense Health Agency Policy and Operations Directorate. She has worked in multiple Military Health System positions to include a quality service manager, a referral management nurse, a medical coder, a TRICARE Europe representative and an Air Force medic.

Register at https://attendee.gotowebinar.com/register/963869651179988995. To access the webinar from a DoD network computer, please use the Defense Collaboration Services (DCS) link: https://conference.apps.mil/webconf/FormerSpouses. For audio, please dial 1-866-724-3083, access code 1085851.

Registration is on a first-come, first-serve basis and is limited due to system capacity. Participants must avoid sharing personal health information when asking a question. Questions will be taken at the end of the presentation.

To get custom information about TRICARE eligibility after a divorce, go to www.tricare.mil and answer a few questions to enter your profile.

- **The Defense Health Agency (DHA) has a director of Research, Development & Acquisition (RDA).**

  Rear Adm. Colin Chinn will oversee the agency's efforts to develop innovations to improve health outcomes for service members, retirees and their families.

  The former Director of TRICARE Region West/Pacific, has served several tours with the Marine Corps as a battalion surgeon. Chinn has staff physician tours at Naval Hospital Corpus Christi from 1990–1991 where he served as head, internal medicine and laboratory medical director; and staff gastroenterologist and Independent Duty Corpsman Program director at Naval Medical Center San Diego from 1993–1998.

  From 2000–2003 he was the director of Medical Services, Naval Hospital Okinawa. He served as the executive officer, Naval Hospital Lemoore from 2003–2006 and completed a two year tour as the 15th commanding officer of Naval Hospital, Oak Harbor from June 2006–June 2008.

  His most recent assignment was command surgeon, U.S. Pacific Command (USPACOM) from July 2013–April 2016, responsible for USPACOM global health engagement activities in the Indo-Asia-Pacific region.

  Chinn graduated from Johns Hopkins University in 1979 with a bachelor's degree in public health and received a master's degree in epidemiology from Johns Hopkins University School of Public Health in 1982. After his commissioning as an ensign in 1981, he attended the Medical College of Virginia through the Armed Forces Health Professions Scholarship Program and earned a Doctor of Medicine in 1985. He completed an internal medicine internship and residency at Naval Hospital Oakland, serving as chief medical resident in 1990. Chinn completed gastroenterology fellowship training at Naval Medical Center San Diego in 1993.

VETERANS AFFAIRS NEWS

- **The Commission on Care (CoC) released its final report on July 5, 2016.**

  The Commission was established by Congress under the Veterans Access, Choice, and Accountability Act of 2014, to examine veterans' access to Department of Veterans Affairs health care and to examine strategically how best to organize the Veterans Health Administration, locate health resources, and deliver health care to veterans during the next 20 years.

  Below are the Commission's final recommendations:

  1. Across the United States, with local input and knowledge, VHA should establish high-performing, integrated community health care networks, to be known as the VHA Care System, from which veterans will access high-quality health care services.
  2. Enhance clinical operations through more effective use of providers and other health

professionals, and improved data collection and management.

3. Develop a process for appealing clinical decisions that provides veterans protections at least comparable to those afforded patients under other federally supported programs.
4. Adopt a continuous improvement methodology to support VHA transformation, and consolidate best practices and continuous improvement efforts under the Veterans Engineering Resource Center.
5. Eliminate health care disparities among veterans treated in the VHA Care System by committing adequate personnel and monetary resources to address the causes of the problem and ensuring the VHA Health Equity Action Plan is fully implemented.
6. Develop and implement a robust strategy for meeting and managing VHA's facility and capital-asset needs.
7. Modernize VA's IT systems and infrastructure to improve veterans' health and well-being and provide the foundation needed to transform VHA's clinical and business processes.
8. Transform the management of the supply chain in VHA.
9. Establish a board of directors to provide overall VHA Care System governance, set long-term strategy, and direct and oversee the transformation process.
10. Require leaders at all levels of the organization to champion a focused, clear, benchmarked strategy to transform VHA culture and sustain staff engagement.
11. Rebuild a system for leadership succession based on a benchmarked health care competency model that is consistently applied to recruitment, development, and advancement within the leadership pipeline.
12. Transform organizational structures and management processes to ensure adherence to national VHA standards, while also promoting decision making at the lowest level of the organization, eliminating waste and redundancy, promoting innovation, and fostering the spread of best practices.
13. Streamline and focus organizational performance measurement in VHA using core metrics that are identical to those used in the private sector, and establish a personnel performance management system for health care leaders in VHA that is distinct from performance measurement, is based on the leadership competency model, assesses leadership ability, and measures the achievement of important organizational strategies.
14. Foster cultural and military competence among all VHA Care System leadership, providers, and staff to embrace diversity, promote cultural sensitivity, and improve veteran health outcomes.
15. Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.
16. Require top executives to lead the transformation of HR, commit funds, and assign expert resources to achieve an effective human capital management system.
17. Provide a streamlined path to eligibility for health care for those with an other-than-honorable discharge who have substantial honorable service.
18. Establish an expert body to develop recommendations for VA care eligibility and benefit design.

To read the final report of the Commission on Care and learn specific details of the recommendations, please visit please:
https://commissiononcare.sites.usa.gov/files/2016/07/Commission-on-Care_Final-Report_063016_FOR-WEB.pdf

- **The Department of Veterans Affairs (VA) announced the results from the most comprehensive analysis of veteran suicide rates in the U.S., examining over 55 million veteran records from 1979 to 2014 from every state in the nation.**

  This is a follow-up to a study conducted in 2010, which examined 3 million veteran records from 20 states. Based on the data from 2010, VA estimated the number of veteran deaths by suicide averaged 22 per day. The current analysis indicates that in 2014, an average of 20 veterans a day died from suicide.

  The final report will be publicly released later this month. Key findings of the analysis will include:

  - Sixty-five percent of all veterans who died from suicide in 2014 were 50 years of age or older.
  - Veterans accounted for 18 percent of all deaths from suicide among U.S. adults. This is a decrease from 22 percent in 2010.
  - Since 2001, U.S. adult civilian suicides increased 23 percent, while veteran suicides increased 32% in the same time period. After controlling for age and gender, this makes the risk of suicide 21% greater for Veterans.
  - Since 2001, the rate of suicide among US Veterans who use VA services increased by 8.8 percent, while the rate of suicide among Veterans who do not use VA services increased by 38.6 percent.
    - In the same time period, the rate of suicide among male veterans who use VA services increased 11 percent, while the rate of suicide increased 35 percent among male veterans who do not use VA services.
    - In the same time period, the rate of suicide among female veterans who use VA services increased 4.6 percent, while the rate of suicide increased 98 percent among female veterans who do not use VA services.

  Please also see our Suicide Prevention Fact Sheet at the following link: http://www.va.gov/opa/publications/factsheets/Suicide_Prevention_FactSheet_New_VA_Stats_070616_1400.pdf

GENERAL HEALTH CARE NEWS

- **The U.S. Health and Human Services (HHS) announced several new actions the department is taking to combat the nation's opioid epidemic.**

  The actions include

  - Expanding access to buprenorphine, a medication to treat opioid use disorder,
  - Proposing to eliminate any potential financial incentive for doctors to prescribe opioids based on patient experience survey questions, and a
  - Requiring Indian Health Service prescribers and pharmacists to check state Prescription Drug Monitoring Program (PDMP) databases before prescribing or dispensing opioids

for pain.

In addition, the department is launching more than a dozen new scientific studies on opioid misuse and pain treatment and soliciting feedback to improve and expand prescriber education and training programs.

The actions announced today build on the HHS Opioid Initiative, which was launched in March 2015 and is focused on three key priorities: 1) improving opioid prescribing practices; 2) expanding access to medication-assisted treatment (MAT) for opioid use disorder; and 3) increasing the use of naloxone to reverse opioid overdoses. They also build on the National Pain Strategy, the federal government's first coordinated plan to reduce the burden of chronic pain in the U.S.

For more details, please visit: http://www.hhs.gov/about/news/2016/07/06/hhs-announces-new-actions-combat-opioid-epidemic.html#

- **According to a new Centers for Disease Control and Prevention (CDC) report, about 90 people die each day from motor vehicle crashes in the United States, resulting in the highest death rate among 19 high-income comparison countries.**

  The U.S. has made progress in road safety, reducing crash deaths by 31 percent from 2000 to 2013. But other high-income countries reduced crash deaths even further—by an average of 56 percent during the same period.

  Lower death rates in comparison countries, as well as the high prevalence of risk factors in the U.S., suggest that we can make more progress in saving lives. Compared with other high-income countries, the US had the:

  - Most motor vehicle crash deaths per 100,000 population and per 10,000 registered vehicles;
  - Second highest percentage of deaths involving alcohol (31 percent); and
  - Third lowest front seat belt use (87 percent).

  If the U.S. had the same motor vehicle crash death rate as Belgium—the country with the second highest death rate after the U.S.—about 12,000 fewer lives would have been lost and an estimated $140 million in direct medical costs would have been averted in 2013. And if the U.S. had the same rate as Sweden—the country with the lowest crash death rate—about 24,000 fewer lives would have been lost and an estimated $281 million in direct medical costs would have been averted in 2013.

  CDC analyzed data compiled by the World Health Organization (WHO) and the Organization for Economic Co-operation and Development (OECD). CDC determined the number and rate of motor vehicle crash deaths in the U.S. and 19 other high-income countries and reported national seat belt use and percentage of deaths that involved alcohol-impaired driving or speeding, by country, when available. Countries included in the study were Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Ireland, Israel, Japan, Netherlands, New Zealand, Norway, Slovenia, Spain, Sweden, Switzerland, the United Kingdom, and the United States.

  Each country included in the study was a member of OECD, met the World Bank's definition for high income, had a population of more than 1 million people, and reported the annual number of motor vehicle deaths and vehicle miles traveled. In addition, the difference between the country-reported motor vehicle crash death rate and the WHO-estimated rate could not exceed 1 death per 100,000 population.

  The researchers recommend using seat belts in both front and rear seats, properly using car seats and booster seats for children through at least age 8, never drinking and driving, obeying speed limits, and eliminating distracted driving.

REPORTS/POLICIES

- **The GAO published *"Drug Shortages: Certain Factors Are Strongly Associated with This Persistent Public Health Challenge,"* (GAO-16-595) on July 7, 2016.** This report examines trends in drug shortages, FDA's efforts to prioritize reviews of drug submissions to address shortages, trends in FDA warning letters issued to sterile injectable manufacturing establishments for noncompliance with manufacturing standards, and the relationship between certain factors and shortages of sterile injectable drugs**.** http://gao.gov/assets/680/678281.pdf

HILL HEARINGS

- The Senate Appropriations Subcommittee on Military Construction and Veterans Affairs, and Related Agencies will hold a hearing on **July 13, 2016**, to examine a review of the Department of Veterans Affairs' electronic health record (VistA), progress toward interoperability with the Department of Defense's electronic health record, and plans for the future.

LEGISLATION

- **H.R.5648** (introduced July 6, 2016): To authorize an individual who is transitioning from receiving treatment furnished by the Secretary of Defense to treatment furnished by the Secretary of Veterans Affairs to continue receiving treatment from such individual's mental health care provider of the Department of Defense, and for other purposes was referred to House Veterans' Affairs.
  Sponsor: Representative Beto O'Rourke [D-TX-16]
- **H.R.5645** (introduced July 6, 2016): To authorize the Secretary of Health and Human Services to award grants for Alzheimer's disease research was referred to the House Committee on Energy and Commerce.
  Sponsor: Representative Steve Israel [D-NY-3]

MEETINGS

- The Disaster Health Education Symposium: Innovations for Tomorrow will be held on **Sept. 8, 2016**, at the Uniformed Services University in Bethesda, Md. https://ncdmph.usuhs.edu.
- The AUSA 2016 Annual Meeting & Exposition will be held **Oct. 3-5, 2015**, in Washington DC. http://ausameetings.org/2016annualmeeting/
- 2016 AMSUS Annual Continuing Education Meeting will be held on **Nov. 29- Dec. 2, 2016**, at the Gaylord National Harbor, Md. http://www.amsusmeetings.org/

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