Without objection, it is so ordered.

The amendment (No. 1271), in the nature of a substitute, was agreed to as follows:

(Purpose: In the nature of a substitute)

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Department of Veterans Affairs Provider Accountability Act''.

SEC. 2. ACCOUNTABILITY WITHIN VETERANS HEALTH ADMINISTRATION.

(a) REPORTING MAJOR ADVERSE ACTIONS TO NATIONAL PRACTITIONER DATA BANK AND STATE LICENSING BOARDS.—Section 7461 of title 38, United States Code, is amended by adding at the end the following new subsection:

''(f)(1) Whenever the Under Secretary for Health (or an official designated by the Under Secretary) brings charges based on conduct or performance against a section 7401(1) employee and as a result of those charges a covered major adverse action is taken against the employee, the Under Secretary shall, not later than 30 days after the date on which such covered major adverse action is carried out—

''(A) transmit to the National Practitioner Data Bank of the Department of Health and Human Services and the applicable State licensing board the name of the employee, a description of the covered major adverse action, and a description of the reason for the covered major adverse action; and

''(B) update the VetPro System, or successor system, with a record of the covered major adverse action taken and an indication that information was transmitted under subparagraph (A).

''(2) The Under Secretary for Health—

''(A) shall enroll all 7401(1) employees in a continuous query of their record within the National Practitioner Data Bank; and

''(B) shall develop and implement a mechanism for maintaining and updating the information collected through such continuous query within the VetPro System, or successor system, to facilitate the sharing of such information between Veterans Integrated Service Networks.

''(3) In this subsection, the term 'covered major adverse action' means a major adverse action with respect to a section 7401(1) employee that originated from circumstances in which the behavior of the employee so substantially failed to meet generally-accepted standards of clinical practice as to raise reasonable concern for safety of patients.''.

(b) PROHIBITION ON SIGNING SETTLEMENTS WITH CERTAIN CLAUSES.—

(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary of Veterans Affairs may not enter into a settlement agreement relating to an adverse action against a section 7401(1) employee under which the Department of Veterans Affairs would be required to conceal a serious medical error or a lapse in generally-accepted standards of clinical practice.

(2) EXCEPTION.—Paragraph (1) shall not apply to a negative record if the head of the Office of Accountability and Whistleblower Protection of the Department and the Special Counsel (established by section 1211 of title 5, United States Code) jointly certify that the negative record is not legitimate.

(c) TRAINING ON CREDENTIALING AND PRIVILEGING.—The Under Secretary for Health of the Department of Veterans Affairs shall provide to all staff of the Veterans Health Administration who handle hiring, privileging, and credentialing mandatory training on—

(1) all policies of the Veterans Health Administration for credentialing and privileging; and

(2) when and how to report adverse actions to the National Practitioner Data Bank of the Department of Health and Human Services, State licensing boards, and other relevant entities.

(d) SENSE OF CONGRESS ON UPDATES TO THE VHA HANDBOOK.—It is the sense of Congress that—

(1) Congress recognizes that the confusion regarding practices in the Veterans Health Administration for reporting to State licensing boards stems from a lack of guidance in the Veterans Health Administration handbook 1100.18;

(2) Congress strongly recommends that the Secretary of Veterans Affairs update such handbook to ensure that employees of the Veterans Health Administration, officials of the Veterans Integrated Services Networks, and officials of the Department of Veterans Affairs understand and are able to utilize the role of State licensing boards to effectively prevent instances of failed reporting and future patient safety concerns;

(3) Congress recognizes the broad authority of the Veterans Health Administration to report to State licensing boards those employed or separated health care professionals whose behavior and clinical practice so substantially failed to meet generally-accepted standards of clinical practice as to raise reasonable concern for safety of patients and requests that such handbook is updated to reflect appropriate reporting channels to ensure employee understanding of those procedures and authorities; and

(4) in developing the new handbook, the Secretary of Veterans Affairs should consult with—

(A) State licensing boards;

(B) the Centers for Medicare & Medicaid Services;

(C) the National Practitioner Data Bank of the Department of Health and Human Services; and

(D) the exclusive representative of section 7401(1) employees.

(e) SECTION 7401(1) EMPLOYEE DEFINED.—In this section, the term ''section 7401(1) employee'' has the meaning given that term in section 7461(c)(1) of title 38, United States Code.

The bill (S. 221), as amended, was ordered to be engrossed for a third reading, was read the third time, and passed.

IMPROVING SAFETY AND SECURITY FOR VETERANS ACT OF 2019

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of S. 3147, introduced earlier today.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (S. 3147) to require the Secretary of Veterans Affairs to submit to Congress reports on patient safety and quality of care at medical centers of the Department of Veterans Affairs, and for other purposes.

There being no objection, the Senate proceeded to consider the bill.

Mr. MCCONNELL. I ask unanimous consent that the bill be considered read a third time and passed and that the motion to reconsider be considered made and laid upon the table.

The PRESIDING OFFICER. Without objection, it is so ordered.

The bill (S. 3147) was ordered to be engrossed for a third reading, was read the third time, and passed as follows:

S. 3147

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Improving Safety and Security for Veterans Act of 2019''.

SEC. 2. DEPARTMENT OF VETERANS AFFAIRS REPORTS ON PATIENT SAFETY AND QUALITY OF CARE.

(a) REPORT ON PATIENT SAFETY AND QUALITY OF CARE.—

(1) IN GENERAL.—Not later than 30 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report regarding the policies and procedures of the Department relating to patient safety and quality of care and the steps that the Department has taken to make improvements in patient safety and quality of care at medical centers of the Department.

(2) ELEMENTS.—The report required by paragraph (1) shall include the following:

(A) A description of the policies and procedures of the Department and improvements made by the Department with respect to the following:

(i) How often the Department reviews or inspects patient safety at medical centers of the Department.

(ii) What triggers the aggregated review process at medical centers of the Department.

(iii) What controls the Department has in place for controlled and other high-risk substances, including the following:

(I) Access to such substances by staff.

(II) What medications are dispensed via automation.

(III) What systems are in place to ensure proper matching of the correct medication to the correct patient.

(IV) Controls of items such as medication carts and pill bottles and vials.

(V) Monitoring of the dispensing of medication within medical centers of the Department, including monitoring of unauthorized dispensing.

(iv) How the Department monitors contact between patients and employees of the Department, including how employees are monitored and tracked at medical centers of the Department when entering and exiting the room of a patient.

(v) How comprehensively the Department uses video monitoring systems in medical centers of the Department to enhance patient safety, security, and quality of care.

(vi) How the Department tracks and reports deaths at medical centers of the Department at the local level, Veterans Integrated Service Network level, and national level.

(vii) The procedures of the Department to alert local, regional, and Department-wide leadership when there is a statistically abnormal number of deaths at a medical center of the Department, including—

(I) the manner and frequency in which such alerts are made; and

(II) what is included in such an alert, such as the nature of death and where within the medical center the death occurred.

(viii) The use of root cause analyses with respect to patient deaths in medical centers of the Department, including—

(I) what threshold triggers a root cause analysis for a patient death;

(II) who conducts the root cause analysis; and

(III) how root cause analyses determine whether a patient death is suspicious or not.

(ix) What triggers a patient safety alert, including how many suspicious deaths cause a patient safety alert to be triggered.

(x) The situations in which an autopsy report is ordered for deaths at hospitals of the Department, including an identification of—

(I) when the medical examiner is called to review a patient death; and

(II) the official or officials that decide such a review is necessary.

(xi) The method for family members of a patient who died at a medical center of the Department to request an investigation into that death.

(xii) The opportunities that exist for family members of a patient who died at a medical center of the Department to request an autopsy for that death.

(xiii) The methods in place for employees of the Department to report suspicious deaths at medical centers of the Department.

(xiv) The steps taken by the Department if an employee of the Department is suspected to be implicated in a suspicious death at a medical center of the Department, including—

(I) actions to remove or suspend that individual from patient care or temporarily reassign that individual and the speed at which that action occurs; and

(II) steps taken to ensure that other medical centers of the Department and other non-Department medical centers are aware of the suspected role of the individual in a suspicious death.

(xv) In the case of the suspicious death of an individual while under care at a medical center of the Department, the methods used by the Department to inform the family members of that individual.

(xvi) The policy of the Department for communicating to the public when a suspicious death occurs at a medical center of the Department.

(B) A description of any additional authorities or resources needed from Congress to implement any of the actions, changes to policy, or other matters included in the report required under paragraph (1)

(b) REPORT ON DEATHS AT LOUIS A. JOHNSON MEDICAL CENTER.—

(1) IN GENERAL.—Not later than 60 days after the date on which the Attorney General indicates that any investigation or trial related to the suspicious deaths of veterans at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia, (in this subsection referred to as the ''Facility'') that occurred during 2017 and 2018 has sufficiently concluded, the Secretary of Veterans Affairs shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report describing—

(A) the events that occurred during that period related to those suspicious deaths; and

(B) actions taken at the Facility and throughout the Department of Veterans Affairs to prevent any similar reoccurrence of the issues that contributed to those suspicious deaths.

(2) ELEMENTS.—The report required by paragraph (1) shall include the following:

(A) A timeline of events that occurred at the Facility relating to the suspicious deaths described in paragraph (1) beginning the moment those deaths were first determined to be suspicious, including any notifications to—

(i) leadership of the Facility;

(ii) leadership of the Veterans Integrated Service Network in which the Facility is located;

(iii) leadership at the central office of the Department; and

(iv) the Office of the Inspector General of the Department of Veterans Affairs.

(B) A description of the actions taken by leadership of the Facility, the Veterans Integrated Service Network in which the Facility is located, and the central office of the Department in response to the suspicious deaths, including responses to notifications under subparagraph (A).

(C) A description of the actions, including root cause analyses, autopsies, or other activities that were conducted after each of the suspicious deaths.

(D) A description of the changes made by the Department since the suspicious deaths to procedures to control access within medical centers of the Department to controlled and non-controlled substances to prevent harm to patients.

(E) A description of the changes made by the Department to its nationwide controlled substance and non-controlled substance policies as a result of the suspicious deaths.

(F) A description of the changes planned or made by the Department to its video surveillance at medical centers of the Department to improve patient safety and quality of care in response to the suspicious deaths.

(G) An analysis of the review of sentinel events conducted at the Facility in response to the suspicious deaths and whether that review was conducted consistent with policies and procedures of the Department.

(H) A description of the steps the Department has taken or will take to improve the monitoring of the credentials of employees of the Department to ensure the validity of those credentials, including all employees that interact with patients in the provision of medical care.

(I) A description of the steps the Department has taken or will take to monitor and mitigate the behavior of employee bad actors, including those who attempt to conceal their mistreatment of veteran patients.

(J) A description of the steps the Department has taken or will take to enhance or create new monitoring systems that—

(i) automatically collect and analyze data from medical centers of the Department and monitor for warnings signs or unusual health patterns that may indicate a health safety or quality problem at a particular medical center; and

(ii) automatically share those warnings with other medical centers of the Department, relevant Veterans Integrated Service Networks, and officials of the central office of the Department.

(K) A description of the accountability actions that have been taken at the Facility to remove or discipline employees who significantly participated in the actions that contributed to the suspicious deaths.

(L) A description of the system-wide reporting process that the Department will or has implemented to ensure that relevant employees are properly reported, when applicable, to the National Practitioner Data Bank of the Department of Health and Human Services, the applicable State licensing boards, the Drug Enforcement Administration, and other relevant entities.

(M) A description of any additional authorities or resources needed from Congress to implement any of the recommendations or findings included in the report required under paragraph (1).

(N) Such other matters as the Secretary considers necessary.

PERMITTING THE SECRETARY OF VETERANS AFFAIRS TO ESTABLISH A GRANT PROGRAM

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Committee on Veterans' Affairs be discharged from further consideration of H.R. 2385 and the Senate proceed to its immediate consideration.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (H.R. 2385) to permit the Secretary of Veterans Affairs to establish a grant program to conduct cemetery research and produce educational materials for the Veterans Legacy Program.

The PRESIDING OFFICER. Is there objection to proceeding to the measure?

There being no objection, the committee was discharged, and the Senate proceeded to consider the bill.

Mr. MCCONNELL. I further ask unanimous consent that the bill be considered read a third time.

The PRESIDING OFFICER. Without objection, it is so ordered.

The bill was ordered to a third reading and was read the third time.

Mr. MCCONNELL. I know of no further debate on the bill.

The PRESIDING OFFICER. Is there further debate?

Hearing no further debate, the bill having been read the third time, the question is, Shall the bill pass?

The bill (H.R. 2385) was passed.

Mr. MCCONNELL. I ask unanimous consent that the motion to reconsider be considered made and laid upon the table with no intervening action or debate.

The PRESIDING OFFICER. Without objection, it is so ordered.

AUTHORIZING STATES AND TRIBAL ORGANIZATIONS THAT RECEIVE GRANTS FROM THE NATIONAL CEMETERY ADMINISTRATION FOR ESTABLISHMENT, EXPANSION, OR IMPROVEMENT OF A VETERANS' CEMETERIES TO USE AMOUNTS OF SUCH GRANTS FOR STATE AND TRIBAL ORGANIZATION CEMETERY PERSONNEL TO TRAIN AT THE TRAINING CENTER OF THE NATIONAL CEMETERY ADMINISTRATION

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Committee on Veterans' Affairs be discharged from further consideration of S. 2096 and the Senate proceed to its immediate consideration.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (S. 2096) to amend title 38, United States Code, to authorize States and tribal organizations that receive grants from the National Cemetery Administration for establishment, expansion, or improvement of a veterans' cemeteries to use amounts of such grants for State and tribal organization cemetery personnel to train at the training center of the National Cemetery Administration, and for other purposes.