LEGISLATIVE HEARING ON H.R. 3843, H.R. 4041, H.R. 5428, H.R. 5516, H.R. 5543, H.R. 5641, H.R. 5996, H.R. 6123, H.R. 6127, H.R. 6220, AND DRAFT LEGISLATION

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

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

ONE HUNDRED ELEVENTH CONGRESS

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WEDNESDAY, SEPTEMBER 29, 2010

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:00 a.m., in Room 334, Cannon House Office Building, Hon. Michael Michaud [Chairman of the Subcommittee] presiding.

Present: Representatives Michaud, Perriello, Brown of South Carolina, and Stearns.

OPENING STATEMENT OF CHAIRMAN MICHAUD

Mr. MICHAUD. I would like to call the hearing to order, and thank everyone for coming today.

Today's legislative hearing is an opportunity for Members of Congress, veterans, the U.S. Department of Veterans Affairs (VA), and other interested parties to provide their views and discussion on legislation that has been introduced within the Subcommittee's jurisdiction.

This is an important part of the legislative process that will encourage a frank discussion of ideas. We have 12 important bills before us today.

We have been hearing that votes might be called between 11:00 and 12:00, so I would ask unanimous consent that my full remarks be submitted for the record so we can try to speed up the hearing process. Hearing no objection, so ordered.

Mr. MICHAUD. So I now would recognize Mr. Brown, our distinguished Ranking Member, for any opening statement that he may have.

[The prepared statement of Chairman Michaud appears on p. 25.]

OPENING STATEMENT OF HON. HENRY E. BROWN, JR.

Mr. BROWN OF SOUTH CAROLINA. Thank you, Mr. Chairman.

I, too, would like to submit my opening statement for the record. And I would like unanimous consent to also offer Ranking Member of the full Committee, Steve Buyer's statement for the record.

Mr. MICHAUD. Without objection, so ordered.

[The prepared statement of Congressman Brown appears on p. 25.]

[The prepared statement of Congressman Buyer appears on p. 82.]

Mr. MICHAUD. We will now go to our first panel. And I would recognize Mr. Sestak, to introduce his bill to the Committee.

And I want to thank you very much, first of all for your service to our great Nation and also for your willingness to come today.

STATEMENTS OF HON. JOE SESTAK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA; HON. TIMOTHY J. WALZ, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MINNESOTA; HON. JOHN BARROW, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA; AND HON. CLIFF STEARNS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

STATEMENT OF HON. JOE SESTAK

Mr. SESTAK. Thank you, Mr. Chairman and Ranking Member Brown.

First I would like to acknowledge the great work that this Subcommittee has done in the recent Congress. It is providing unprecedented ways and means to care for our veterans, those who have gone into harm's way on our behalf.

However, with these additional resources, the VA has a responsibility to Congress, the American public, and most especially our veterans to see that it operates the highest possible standards of care.

In support of that goal, I am here to discuss my bill, H.R. 3843, the "Transparency for America's Heroes Act."

This legislation directs the Secretary of Veterans Affairs to make available on the VA Web site redacted records and documents, but not personal identifying information, created by the VA as part of a medical quality assurance program.

It would also require the Secretary to ensure that such records created during the 2-year period prior to the enactment of this Act are also made available in a similar manner.

I authored this bill because I have grown increasingly troubled by reports that give rise to concern of a lingering lack of consistent care and accountability within the VA.

I must be very clear that I hold in highest regard the thousands of dedicated professionals of the VA, many who have spent their entire careers in the service of our veterans. However, for the past 24 months, there have been too many revelations of substandard care for our vets.

Congress, and the American public, have been belatedly informed of prostate cancer victims who received insufficient treatment, the possible exposure of more than 1,800 veterans to serious diseases including hepatitis and human immunodeficiency virus (HIV) while undergoing routine dental procedures, deficiency in thoracic care.

And last September, we learned only after a Freedom of Information Act (FOIA) request was filed that some elderly veterans were being subjected to substandard, potentially neglectful care in the

Philadelphia Community Living Center at Philadelphia VA Medical Center.

The nursing home, according to the Long-Term Care Institute's report, "Failed to provide a sanitary and safe environment for the residents. And there was a significant failure to promote and protect the residents' rights to autonomy and to be treated with respect and dignity."

Some of the examples cited shock the conscious. For example, one patient with an open foot wound was left unattended for so long that live maggots were found falling out of the wound. Additionally, the floor was found to be covered with dried blood and feeding tubes.

Another diabetic patient complained of chronic failure on the staff's part to administer his insulin shots on schedule.

After hearing these reports, it came to my attention that there were two other recent inspections, one by the Office of Inspector General (OIG) of the VA and one by the Joint Commission on Accreditation of Healthcare Organizations, both of which concluded the facility met quality standards based on the metrics used.

However, it took this separate external investigation of the Long-Term Care Institute, using a different set of inspection criteria to find the maggots, to identify the serious problems at the facility under its older leadership.

What concerns me is the two VA conducted reviews failed to discover these deficiencies and that a Freedom of Information Act request was required to bring this latest revelation, this known latest revelation of poor care to light.

In fact, the report should not have even been released after the FOIA petition was filed under the current law because the third-party inspection was conducted on the VA's quality assurance authority. And in this case, the report was inadvertently leaked by a VA official who did not follow the normal protocol.

This leads me to believe that there may be numerous of other cases of deficient care, which will never see the light of day because of the inspections in question like the one conducted by the Long-Term Care Institute that were conducted under the VA quality assurance authority.

Under current law, records and documents created by the VA as part of a designated quality assurance program are confidential and privileged and as a result cannot be disclosed to any person or entity except when specifically authorized by statute.

And, yet, in Pennsylvania, similar facilities' reports for citizens of America that are not veterans are placed on Web sites.

The standard rationale for this practice is according to the VA to, "Create a proactive culture of quality improvement allowing for early identification and resolution of quality issues." Obviously that was not done.

The VA also states that, "Elimination of protected document status for quality management activity documents would possibly have a chilling effect on the level of objectivity reflected within these improvement activities."

As a former Admiral who led men and women into battle, I disagree with this assessment. I am convinced there is a need for a cultural and procedural sea change in the way the VA medical sys-

tem operates and that the best way to ensure quality care in the VA is through a stringent, transparent oversight.

I certainly learned in the Navy to expect what you inspect and to know what you have found. This entails vigilance on the part of both Congress and the general public. If there are other instances of inadequate VA care, they should be revealed immediately along with a confirmation that appropriate corrective actions have been taken like they were not in this case.

My bill, as I conclude, would accomplish this without releasing sensitive information, which could be used to identify patients and health care professionals. After all, even my personal service record can be given out in public, redacted obviously.

If we fail to ensure this kind of accountability, the goals of the current Administration, the hard work of the recent Congress to finally provide our veterans the care and resources they have been denied for so long will be compromised. At issue is the very credibility and accountability of one of our Nation's most important health care providers and that of the government itself.

I am reminded of the long-term consequences for us, the Executive Branch, to treat veterans and their families in responsible kind of ways we have tried to do after a failure for too long, particularly after Vietnam.

As our troops continue to return from Iraq and Afghanistan, we can and must do better. Thank you, Mr. Chairman.

[The prepared statement of Congressman Sestak appears on p. 26.]

Mr. MICHAUD. Thank you very much, Mr. Sestak, for that description of your piece of legislation.

Are there any questions of the Subcommittee for Mr. Sestak?

Hearing none, thank you very much.

Mr. SESTAK. Thank you, Mr. Chairman.

Thank you, Mr. Brown.

Mr. MICHAUD. I would like to recognize Mr. Walz, who is also a Member of the Veterans' Affairs Committee who serves his country with distinction, to introduce his legislation.

Mr. Walz.

STATEMENT OF HON. TIMOTHY J. WALZ

Mr. WALZ. Well, thank you, Chairman Michaud and Ranking Member Brown, for this opportunity to be here.

I also want to thank you and tell you what a privilege it is to serve with you on the full Committee. The two of you put veterans first and foremost in everything you do. And for that, I am incredibly grateful.

I am here today to testify on a bipartisan bill introduced by myself, Mr. Bilirakis, Mr. Miller, and Mr. Pascrell, H.R. 6123, the "Veterans Traumatic Brain Injury and Rehabilitative Services Improvement Act."

First and foremost, the care that our soldiers are getting at our VA hospitals is top quality. I think all of us in this room have recognized the incredible efforts that have been made, especially dealing with traumatic brain injury (TBI). But one of the things that I think we see missing is a cohesive, holistic approach to this care.

And this bill does a couple of things that are critically important for these veterans to achieve the quality of life we want to have them achieve.

We are doing a great job of the VA doing on the health professional side of things, but it would cover other VA support services that contribute to the maximum quality of life, things like helping with reemployment, helping with other things as far as adaptive types of things, and then doing a second thing that is not clarified in the current provisions, and this makes it a little broader. We are asking them to not simply improve lost functioning but to maintain that improvement once it is gained.

Some of the brain-based research and the things we are seeing show that we can continue to get improvement or at least hold those achievements that we have gotten for these veterans. And I want to make sure that that gets there.

The ambiguities in the law make the TBI treatment very narrow. It is incredibly good quality of care on the physical side of things. We are not encompassing the whole range of things that we could do. So we need to make sure that there is a comprehensive approach. That is what this bill ensures. It provides comprehensive care instead of just physical care.

And I want to be very clear with our VA folks who are here, and we get great input from them on this. This is not creating any new programs. It is integrating existing programs for the quality of life improvement of the veterans. It is just a better way of defining how we care for these TBI patients. It is a better way of making sure that it is veteran and family centered in how that care goes across the spectrum of things.

This bill has the full support of the Wounded Warrior Project, the Disabled American Veterans, the Blinded Veterans, and the Enlisted Association of the National Guard.

And I want to take special time to thank Ralph Ibson and Christine Hill at the Wounded Warrior Project for bringing this. These are folks that are out there every day with our heroes. They are out there trying to understand what it is going to take to bring them back to a quality of life that get as close to approximation as we can to a normal existence for these folks. And that is what we want to try and do.

So I am appreciative of the work that has been done on this. I want to be very clear. I am appreciative of the incredible care that is given to these wounded warriors through the VA. I think we can define with this bill a little broader on what the VA can go ahead and deliver in terms of comprehensive, holistic care to these veterans.

And I think at the end of the day, the American people want to see us do everything possible to take these wounded warriors back home, to give them all the care possible, and to improve their quality of life to allow them to function both in the workplace, in social settings, and beyond just physical functioning.

So with that, I would be happy to take any question and, again, thank both of you for the work you are doing.

[The prepared statement of Congressman Walz appears on p. 28.]

Mr. MICHAUD. Thank you very much, Mr. Walz, and also thank you very much for your hard work and dedication on the Veterans'

Affairs Committee. We value your opinion and appreciate all the hard work that you have been doing. So, thank you.

Mr. WALZ. Thank you, Mr. Chairman.

Mr. MICHAUD. Are there any questions?

Seeing none, thank you very much.

Mr. WALZ. Thank you.

Mr. MICHAUD. Mr. Barrow, I also want to thank you for coming today to bring forward H.R. 4041 and I look forward to hearing your testimony. Mr. Barrow.

STATEMENT OF HON. JOHN BARROW

Mr. BARROW. Well, thank you, Mr. Chairman. It is an honor to be with you and thank you for allowing me to testify today.

I want to thank you and my South Carolina neighbor, Mr. Brown, for the tremendous leadership you all are showing in closing the gap that has existed for too long now between the promises that have been made to our veterans and the resources we have committed toward meeting those needs and fulfilling those promises.

The most consistent and frustrating feedback that I get from people I represent is from veterans having problems with the VA. I suspect it is the same for some of you in your districts as well.

The initial disability determination can take too long. Communication with the VA can be weak. Once they are in the system, it is hard to navigate. Facilities can be too far away.

Well, I can see how major programs in the VA could benefit from a major overhaul and I realize that is not going to happen any time soon. For better or for worse, the system works well enough for enough folks that the demand for a major overhaul will be a long time coming. But I do not think any of us really believes that the current system works as well as it could or should.

The problem with today's VA is its complexity. The medical needs of returning veterans are more complex than they have ever been. We design very intricate treatments and benefits and services to meet those needs. Unfortunately, it has become so complex that you need specialized training just to wade through the bureaucracy of it all.

My purpose in coming today is to promote a bill I have introduced, H.R. 4041, which will give veterans the tools they need to navigate this maze.

We all agree that every wounded warrior should have an individualized plan for recovery coordinated by a professional who is trained to successfully navigate the VA system of services and benefits.

The Dole-Shalala Commission calls these professionals Federal Recovery Coordinators (FRCs) and made them a major component of their comprehensive recommendations to improve the VA. The Federal Recovery Coordinator Program has been authorized by Congress since 2008, but today there are only 20 Federal Recovery Coordinators spread across the entire country coordinating the care of only around 500 wounded veterans.

My bill will increase the number of Federal Recovery Coordinators, formalize their training, and establish guidelines and best practices for successful care coordination.

As envisioned and designed by the Dole-Shalala Commission, a Federal Recovery Coordinator would be a nurse or a social worker with a Master's Degree who has excellent communication, leadership, and resource navigation skills. Today's wounded warrior might have a unique combination of traumatic physical injury, post-traumatic stress disorder (PTSD), substance abuse, or marital problems, trouble finding a job, or trouble reintegrating back into the community. A recovery coordinator acts as an air traffic controller to guide veterans to the proper treatment and benefit options.

I have submitted for the record personal testimonies from a few returnees that I represent whose Federal Recovery Coordinators have been a Godsend. I commend them to you.

Despite its obvious benefits and successes, the program is in its infancy and needs some help in order to be all that it can be. My bill will help in three specific ways.

First and foremost, the bill authorizes formal training for 45 new Federal Recovery Coordinators in the next 3 years. It is obvious that we have too many veterans who desperately need these services and we do not have nearly enough coordinators to meet the demand.

Second, my bill authorizes the development of specialized case management software to complement the work of trained care coordinators.

Third, my bill authorizes the development of uniform best practices for recovery coordination. The coordinators out there today are blazing valuable new trails, but they work out of sight of each other. We need to develop and promote what works best so that all of our wounded veterans will get the best chance at getting what they need.

Our goal here has to be helping the veterans who need it and to do it as fast and effectively as we possibly can. I have seen the Federal Recovery Coordinator Program in action and I am convinced this really is the best way forward.

I appreciate the opportunity to testify before you. I appreciate the Committee's willingness to take a deeper look at this legislation. And I will be happy to answer any questions.

[The prepared statement of Congressman Barrow appears on p. 28.]

Mr. MICHAUD. Thank you very much, Mr. Barrow, for your description of the legislation you presented today. I really appreciate your advocacy on behalf of our veterans as well.

Are there any questions for Mr. Barrow?

Thank you very much, Mr. Barrow. I appreciate your coming.

Mr. BARROW. Thank you, Mr. Chairman.

Mr. MICHAUD. I would like to recognize Mr. Stearns who also sits on the Veterans' Affairs Committee. I really appreciate your efforts in helping us deal with veterans' issues. And Mr. Stearns has two bills before us today, H.R. 5516 and H.R. 5996.

So, Mr. Stearns.

STATEMENT OF HON. CLIFF STEARNS

Mr. STEARNS. Good morning and thank you, Mr. Chairman.

And thank you, Ranking Member, Mr. Brown of South Carolina.

As you mentioned, I have two bills before the Committee today, H.R. 5516, the "Access to Appropriate Immunization for Veterans," and H.R. 5996, a bill to help veterans with chronic obstructive pulmonary disease, COPD.

The first bill is a bipartisan bill that I am proud to have introduced as a co-founder of the COPD Caucus. COPD is the fourth leading cause, of death in the United States. It is predicted to be the third leading cause of death by the year 2020 beating both diabetes and stroke. And 126,000 Americans die each year from this disease. That is about one death every 4 minutes.

My bill, Mr. Chairman, would increase the VA's ability to diagnose, treat, and manage COPD. COPD is a chronic condition that does not have a cure. Early detection and treatment is important to slow or arrest the progression of the disease.

It is estimated that more than 12 million people are diagnosed with COPD and, yet, this number is believed to be small as COPD is often under-diagnosed. The Centers for Disease Control and Prevention, CDC, estimates that over 24 million Americans have symptoms of COPD.

Despite all this, there is a lack of awareness by patients and doctors about this disease. It is a progressive disease. Early detection is extremely important. Because there is no cure, early treatment is vital. Because the COPD rate is three times higher in the veterans' population, Mr. Chairman, than the civilian population, how can the VA not be providing this type of specialized care? COPD is the fourth most common diagnoses among hospitalized veterans ages 65 to 74.

H.R. 5996 would have the VA develop treatment protocols and related tools for the diagnosis, treatment, and management of chronic obstructive pulmonary disease. It would also have the VA establish a pilot smoking cessation program targeted towards individuals who have COPD.

While there are many ways that someone can develop this type of disease, the most common is from smoking. However, it should be noted that COPD has underlying genetic risk factors and healthy nonsmokers can also develop COPD.

I think it is important to note that this is not giving VA any new authority. VA already has the authority to do what I am asking for. But for whatever reason, they have not aggressively moved to develop these treatment protocols for the fourth leading cause of death in the United States. My bill would have the VA begin to develop these treatments for our veterans.

This bill has the support of the U.S. COPD Coalition, the COPD Foundation, the American Thoracic Society, the American Association for Respiratory Care, and the Alpha-1 Foundation and the Alpha-1 Association.

And I would like to submit, Mr. Chairman, by unanimous consent the letters of support for the record.

Mr. MICHAUD. Is there any objection? Hearing none, so ordered.

Mr. STEARNS. The other bill is the "Access to Appropriate Immunizations for Veterans Act of 2010," H.R. 5516. The VA already has the authority to provide vaccines to veterans to immunize them against preventable diseases.

However, the VA has only established performance measures for two vaccines. For these two vaccines against the flu and pneumonia, the vaccination rate increased from 27 percent to almost 80 percent and hospitalization rates dropped in half.

My bill would extend all the Centers for Disease Control and Prevention's recommended vaccines to the performance measures.

It is important to note that the vaccines are not just for children. In fact, just last week, the *New York Times* ran an article on how important it is for adults to receive vaccines and booster shots.

I would like to read a part of this article quickly. "Adult immunizations are not just an important way to prevent the spread of the disease, immunizations are also a phenomenally cost-effective way to preserve health. When you compare the cost of getting sick with these diseases to the cost of a simple vaccine, it is a modest investment, said Dr. Robert Hopkins, a professor of internal medicine and pediatrics at the University of Arkansas for Medical Centers."

According to the CDC, each year, approximately 70,000 adult Americans die from vaccine preventable diseases. Influenza alone is responsible for over one million ambulatory care visits, 200,000 hospitalizations, and 30,000 deaths.

Only 7 percent of Americans over the age of 60 have received the vaccine to protect them from shingles, a painful nerve infection.

Just 11 percent of young women have received the vaccine against HPV (human papillomavirus), the virus that causes 70 percent of cervical cancers.

Many of our veterans who are in a high-risk category of contracting vaccine preventable diseases, including those with HIV, hepatitis C, and substance abuse disorder, are enrolled in the VA health care system and could simply benefit from receiving these vaccines.

I want the VA to provide superior quality care to our veterans. Adding vaccinations to the performance measure is a simple common-sense idea that will increase the level of care available and save money by stopping preventable diseases.

The bill would also require the VA to report back to Congress on their progress of supporting vaccinations within the veterans' populations.

And I would like in conclusion to enter the *New York Times* article into the record and the CDC's recommended vaccination schedule for adults by unanimous consent.

Mr. MICHAUD. Is there any objection?

Hearing none, so ordered.

Mr. STEARNS. And thank you, Mr. Chairman, for allowing me to testify.

[The prepared statement and attachments of Congressman Stearns appears on p. 34.]

Mr. MICHAUD. Thank you very much, Mr. Stearns, for your testimony on both bills.

Are there any questions from the Committee?

Hearing none, thank you very much.

I would like to call up the second panel. And while they are coming up, I will introduce them. We have Jacob Gadd from the American Legion; Carl Blake from the Paralyzed Veterans of America

(PVA); Adrian Atizado from the Disabled American Veterans (DAV); and Ralph Ibson from the Wounded Warrior Project (WWP).

We also heard from Mr. Filner and Ms. Pingree. They will be here a little bit later to present their testimony on the bills that they have introduced.

We will start with Mr. Gadd from the American Legion.

STATEMENTS OF JACOB B. GADD, DEPUTY DIRECTOR, VETERANS AFFAIRS AND REHABILITATION COMMISSION, AMERICAN LEGION; CARL BLAKE, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; ADRIAN M. ATIZADO, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; AND RALPH IBSON, SENIOR FELLOW FOR POLICY, WOUNDED WARRIOR PROJECT

STATEMENT OF JACOB B. GADD

Mr. GADD. Mr. Chairman and Members of the Subcommittee, thank you for this opportunity today for the American Legion to present our views on today's pending legislation.

As this legislation covers many different pieces of legislation, I will highlight a few of the bills and draft legislation beginning with H.R. 4041, to authorize certain improvements in the Federal Recovery Coordinator Program.

In 2007, the American Legion approved Resolution 29, Improvements to Implement a Seamless Transition, where we recommended a single recovery coordinator to ensure efficient rehabilitation and transition from military to civilian life and eliminate the delays and gaps in treatment and services.

The program was designed and created an individualized care coordination plan for severely injured servicemembers in order to ensure a warm handoff for severely wounded servicemembers transitioning between the U.S. Department of Defense and VA.

With close to two million servicemembers having deployed in Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF), and now New Dawn, VA has only reported to date that less than 1,000 servicemembers have been assisted through this program.

The American Legion, therefore, recommends expanding the program areas of the FRC Program to include program eligibility, increasing the FRC staff to one individual coordinator per State, and improving communication at the national, State, and local levels.

First, the American Legion believes that coordination of care, especially those who are severely wounded, is essential to ensure they receive the education and benefits that they need and have earned.

However, the American Legion believes efforts to improve care coordination must be directed at not only the severely wounded but any veteran transitioning and to ensure they do not fall through the cracks.

Second, VA reported in 2010 that five new FRCs are in the process of being hired, which brings the total number to 25 across the country.

The American Legion recommends having an FRC within each State to ensure all active-duty Reserve and Guard units receive the same education, outreach, and benefits assistance.

Third, in some cases, the American Legion has had difficulty contacting the FRCs through phone, e-mail, or mailing address. In addition, the program should increase its outreach through use of a dedicated Web page to update current contact information.

Finally, in regards to development of a computerized tracking program, the American Legion applauds VA's new application, the care management and tracking and reporting application, CMTRA. This tracking tool allows VA to coordinate care amongst a wide variety of providers such as the OEF/OIF care management team.

However, the American Legion recommends that consolidation of a new software tool be compatible with the CMTRA tool to prevent redundancy or to have any veterans that may fall through the cracks.

Next, H.R. 5641, VA's authorized under title 38, Code of Federal Regulations to provide a comprehensive array of medically necessary in-home services. VA defines a medical foster home as a noninstitutional long-term care setting for veterans.

The Medical Foster (MF) Program is owned or rented by the medical foster home caregiver. Each VA medical center facility appoints an MF coordinator and ensures quality assurance, inspections, maintaining of files and patients.

The American Legion would like to take additional time to contact some veterans within this program to see their safety and get feedback from them on this program.

Draft legislation to amend title 38 to ensure that the Secretary provides veterans with information concerning service-connected disabilities, several Department service officers for the American Legion have identified that the Veterans Health Administration (VHA) providers are not assisting veterans with questions a provider interprets as claims related.

The American Legion is working with Central Office to understand the reasons for this disconnect between VHA and the Veterans Benefits Administration (VBA) and we intend to recommend a Fast Letter or new VHA directive be sent to the field to clarify this policy on VA treating physicians in the case where medical evidence on the veteran's behalf is there and the provider from VHA is not helping with the VBA side on the claims process.

As always, the American Legion thanks this Committee for the opportunity to testify and represent the positions of over 2.4 million veteran members. Thank you.

[The prepared statement of Mr. Gadd appears on p. 47.]

Mr. MICHAUD. Thank you very much.

Mr. Blake.

STATEMENT OF CARL BLAKE

Mr. BLAKE. Chairman Michaud, Members of the Subcommittee, on behalf of Paralyzed Veterans of America, I would like to thank you for the opportunity to be here to testify today.

Since you have my full written statement for the record, I will limit my comments to just a select few bills.

PVA cautiously supports H.R. 3843, the "Transparency for America's Heroes Act." Transparency is critical for the public to be able to see and understand what its government is doing.

Requiring VA to publish redacted medical quality assurance records on the VA's Web site will provide users of the VA a better understanding of the successes or failures of the VA and the quality of care delivered to veterans.

This may encourage greater efforts on the part of VA employee staff and leadership to ensure that the best care is provided to veterans while ensuring openness.

However, PVA's concern stems from the need for privacy with these health care records. And the comments of Congressman Sestak notwithstanding, it is important that sufficient safeguards be put in place to prevent the unintended release of personal health information that may be detrimental to a VA patient.

PVA supports H.R. 5428, to better educate injured and amputee veterans on their rights and the requirement that VA staff who work at prosthetics and orthotics clinics or who work as patient advocates for veterans understand these rights as well.

This bill would ensure that VA prosthetics clinics around the country prominently display the Injured and Amputee Veterans' Bill of Rights and that VA employees fully understand it.

This reaffirms the idea that a veteran in need of an assistive device or prosthetic gets the highest quality item available and in a timely manner.

As expressed in previous testimony on this topic, PVA is concerned, however, that this legislation's language seems to ignore veterans who may be in need of special equipment who suffer from a specific disease and not just a physical injury.

PVA supports H.R. 5543, to repeal the prohibition on collective bargaining with respect to compensation for VA employees which may improve the collective bargaining rights and procedures for certain health care professionals in the VA.

AS PVA testified in March of this year, these changes would be a positive step in addressing the recruitment and retention challenges the VA faces to hire key health care professionals, particularly registered nurses, physicians, physician assistants, and other selected specialists.

PVA generally supports H.R. 5641, the "Heroes at Home Act." However, it is essential that proper protections are put in place to ensure that it is the desire of the veteran to be transferred to a non-VA nursing home and only in the case that the foster home meets VA standards at the time of transfer.

PVA generally supports H.R. 6127. However, we do have some concerns with the issues surrounding this bill. While we see no real argument with granting these men and women who experienced the exposures outlined by this bill, Access to the VA health care system, we question why this is the only group singled out for enrollment.

Given the long-standing discussions about Operation Iraqi Freedom, veterans being exposed to burn pits or servicemembers exposed to other hazardous materials in any number of settings, we believe proper consideration needs to be given to a broader spectrum of veterans and servicemembers.

PVA generally supports the provisions of the discussion draft on improvements to VA homeless programs. Too many veterans con-

tinue to live on the streets due to drug, mental health, financial, and employment challenges.

Expansion of grant programs for improvements to facilities and increased outreach to more homeless veterans may help them receive services and rehabilitation and achieve the Secretary's goal to end veterans' homelessness.

But as PVA testified last October, we do have some concerns about the long-term effects of the legislation. By adjusting the payments for geographic areas, we believe it is aimed at providing greater funding to higher cost localities. This may actually reduce the total number of homeless veterans that can be served if future increases in overall program funding are insufficient.

While the argument could be made that reductions in funding for low cost areas may offset increases to high cost areas, the funding levels provided for homeless programs are seldom sufficient anyway to provide for all the veterans who may need to take advantage of these critical services.

PVA would recommend a very cautious approach on this legislation to ensure that the most vulnerable veterans are not inadvertently hurt in efforts to provide greater funds for some of them.

PVA would like to thank the Subcommittee once again for the opportunity to testify and I would be happy to answer any questions that you might have. Thank you.

[The prepared statement of Mr. Blake appears on p. 52.]

Mr. MICHAUD. Thank you very much, Mr. Blake.

Mr. Atizado.

STATEMENT OF ADRIAN M. ATIZADO

Mr. ATIZADO. Mr. Chairman, Members of the Subcommittee, thank you for inviting DAV to testify at this important hearing of the Subcommittee on Health.

DAV is an organization of 1.2 million service-disabled veterans and devote our energies to rebuilding the lives of disabled veterans and their families.

For the sake of brevity, I will only present a number of bills and would refer the Subcommittee to our written testimony.

DAV is pleased to support H.R. 5516 based on our National Resolution No. 36. Our Resolution calls for VA to maintain a comprehensive high-quality health care system specifically including preventative health services. Preventative health services are an important component of the maintenance of general health, especially in elderly and disabled populations.

This bill could contribute to significant cost avoidance by reducing the spread of infectious diseases and by obviating the need for health interventions in acute illnesses.

DAV applauds the intent of H.R. 5641, the "Heroes at Home Act," which would allow VA to contract with certified medical foster homes and pay for care of veterans already eligible for VA paid nursing home care.

DAV is pleased with VA's innovation by offering medical foster homes as part of its long-term care program. Notably patient participation while voluntary into this program reports and yields exceedingly high veteran satisfaction.

Under this program, the cost to VA is less than $60 a day. Understandably, VA perceives this program as a cost-effective alternative to nursing home placement and it is gaining popularity in the VA based on its expansion of this program.

However, because this program operates under VA's community residential care authority, veterans in medical foster home programs have to pay for their care from about $50 to as much as $130 a day even veterans who are otherwise entitled to nursing home care fully paid for by VA whether it is under the law or by VA's policy.

As part of *The Independent Budget,* DAV is greatly concerned that veterans living in medical foster homes are required to use personal funds as payment. These would include VA disability compensation. In addition, veterans who do not have the resources to pay a medical foster home caregiver may not avail themselves of such a critical benefit.

DAV urges the Subcommittee to favorably consider this bill and that it be moved expeditiously.

H.R. 6123 would sharpen rehabilitative requirements within the VA to ensure that veterans with TBI under VA care are afforded the opportunity for maximal rehabilitation, which will hopefully lead to independence and a higher quality of life.

DAV appreciates the bill's intent to fix an existing gap in current law affecting the treatment of brain injured veterans. And this legislation is fully consistent with our National Resolution and, therefore, endorse this bill and urge enactment by Congress.

DAV also supports H.R. 6127, which would provide access for certain veterans to VA health care under the Department's special treatment authority under Priority Group 6.

Much like my colleague, Mr. Blake, from PVA, we do ask for the Subcommittee's consideration to afford the same eligibility of other veterans who were exposed to toxic and environmental hazards, specifically those veterans who were exposed to open air burn pits in Iraq and Afghanistan.

You know, tests on these burn pits, Mr. Chairman, in the war zones have revealed that the fires have released dioxins, benzene, volatile organic compounds including substances which cause cancer.

Finally, DAV supports the draft legislation to make improvements to VA's programs for homeless veterans. As the Subcommittee is aware, there is a great need for specific emphasis on the needs of homeless women veterans, women veterans, and homeless veterans with children. Homeless veterans suffering from serious mental illness is also a vulnerable population.

Section 2 would provide comprehensive services to the vulnerable population of homeless veterans with special needs. And we note that Section 3 of this bill is identical to Section 3 of H.R. 4810, which the House has unanimously passed in March of this year.

DAV believes this section would provide organizations serving homeless veterans the flexibility to look at their program design to provide the full range of supportive services in the most economical manner.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or other Members of the Subcommittee may have. Thank you.

[The prepared statement of Mr. Atizado appears on p. 56.]

Mr. MICHAUD. Thank you very much, Mr. Atizado.

Mr. Ibson.

STATEMENT OF RALPH IBSON

Mr. IBSON. Mr. Chairman, Mr. Brown, thank you for inviting Wounded Warrior Project to testify this morning.

And let me preface my remarks by explaining that Wounded Warrior Project's public policy is informed fully by our daily contacts and work with wounded warriors and their family members across the country.

Several of the bills under consideration today address issues of profound concern to those warriors and their families. And of those, H.R. 6123, Mr. Walz's bill, is of exceptional importance and addresses deep concerns that we have heard from many, many families.

As Mr. Walz indicated, VA facilities have many, many dedicated, committed rehabilitation staff, yet the services provided are often limited in duration and in scope.

Just yesterday as part of a several day workshop, an empowerment summit focused on and serving combat veterans with PTSD, I had the occasion to speak to a veteran from Maine, a combat veteran who explained that he also had TBI, and had not really made much use of his eligibility for VA care. He went to the Togas VA Medical Center and was advised that they would provide him therapy for residuals of his TBI, but limited to 12 sessions. And the explanation was, "we do not provide maintenance therapy."

Well, as this gentleman pointed out to me and as research clearly indicates, there is profound cause for concern with that approach where gains that have been made, cognitive and otherwise, can be lost and that veteran's conditions simply regresses.

For young veterans with severe TBI, and there are many, many of them, reintegration into their communities and pursuing goals such as meaningful work and independent living may be as important as their medical recovery. But many have difficulty with community integration, and social isolation can be a persistent issue. Yet, individuals with severe TBI who receive individualized services to foster independence and social interaction are able to participate meaningfully in community settings.

These patients often need more than medical rehab to achieve maximum independence and they encounter difficulties at many VA facilities, which either perceive they lack the authority, or simply are unwilling to provide, nonmedical supports that are provided in other VA programs. These include supported employment or life skills coaching.

As Mr. Walz indicated, his bill is a simple one. It would eliminate and close gaps, eliminate barriers in the system, and we think lead to enhanced recovery and fuller rehabilitation for veterans with many levels of TBI. And we strongly support it.

Let me touch on a few other bills that raise issues for wounded warriors.

H.R. 5428 would direct VA to disseminate, display, and educate Department employees on an Injured and Amputee Veterans' Bill of Rights relating to VA prosthetics and orthotics.

While there have been substantial improvements in VA prosthetics care over the years, the bill does address important concerns that warriors have voiced with us.

We are not confident, however, that enacting this measure would solve the problems that it highlights. To direct VA to disseminate the list of so-called rights does not make those expectations enforceable, nor does the bill require VA to take actions that would convert those expectations into reality.

Nevertheless we would be pleased to work with the Subcommittee and Committee to explore ways to bolster the bill.

H.R. 4041 would direct VA to fund training of recovery coordinators through a school of nursing and medicine. We concur with earlier expressed views that there is a need to enlarge the program to make greater numbers of FRCs available, particularly to warriors who did not get an FRC because the program was created in 2007. Many of those with severe injuries predating that date have not had that kind of help and still need it.

We are not persuaded, though, that VA needs the authority that H.R. 4041 would establish nor that its methodology is necessarily an optimal one in terms of avenues for training future FRCs.

We concur with earlier expressed views that H.R. 6127 is consistent with earlier legislation that established health care eligibility related to toxic exposures. But we do question the incident-specific focus of the bill and believe that there would be merit in taking a more systematic approach given the range of toxic exposures that OIF/OEF veterans have experienced.

And, lastly, we would comment on H.R. 3843 discussed earlier. We certainly share a concern for ensuring the quality of care afforded veterans in VA health care facilities. At the same time, a vibrant medical quality assurance program is an important element in fostering a culture of quality improvement.

And while transparency is certainly important in sustaining confidence in the quality of VA health care, confidentiality has long been deemed a critical element in ensuring the integrity of an effective medical quality assurance program.

While we take no position in terms of how best to balance those competing tensions, transparency against confidentiality and a strong quality assurance program, this is an area where we would caution the Committee to proceed in a very carefully and in a measured way.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Ibson appears on p. 67.]

Mr. MICHAUD. Thank you very much, Mr. Ibson.

And I want to thank the other three panelists as well for your testimony on all the bills we have before us today.

Any questions, Mr. Brown?

Mr. BROWN OF SOUTH CAROLINA. No questions.

Mr. MICHAUD. Thank you.

As we move forward looking at these bills, later we will probably submit additional questions in writing to each of you. So, if you could respond in a timely manner, I would appreciate it.

If there are no questions, I would like to thank the second panel.

I would like to now recognize Congresswoman Pingree who has H.R. 6220. She is my colleague from Maine. I appreciate her willingness to come today and her advocacy on veterans' issues. She definitely has been a true advocate for veterans.

I know you have been tied up in the Rules Committee, so I want to thank you for taking the time to come over to present testimony to the Subcommittee on H.R. 6220.

STATEMENT OF HON. CHELLIE PINGREE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MAINE

Ms. PINGREE. Thank you very much, Chairman Michaud.

I apologize for being late this morning, but it is a busy morning. I guess we are trying to cram everything into as little time as possible.

And I want to thank you on your great work on behalf of veterans in the State of Maine. It is a pleasure to serve as your junior member in the State of Maine.

Chairman Michaud and Ranking Member Brown, thank you for having me here today. I am happy to be here in front of the Veterans' Affairs Subcommittee on Health to talk about the bill I recently introduced, the "Inform All Veterans Act," H.R. 6220.

This bill will ensure that veterans are given complete information about service-connected benefits at all VA medical centers. All too often a veteran will visit a VA medical center, ask how to file a claim for service-connection, and are either not given correct information on how to pursue their claim or, worse, they leave the medical center thinking their claim is underway when it is not.

This is a symptom of the Veterans Health Administration, Veterans Benefits Administration not communicating well with each other, operating effectively, or operating in silos. Interagency communication is a necessity, especially when we are talking about basic earned services.

Under this bill, the VHA would be required to ask during the check-in process if a veteran would like information about the disability claims process. If the answer is yes, then straightforward, easy to understand literature is shared, which will outline how to contact VBA to start the disability claims process.

I believe Congress has a responsibility to take care of our veterans and I know you all do as well. We cannot do that if we do not inform them about health care and compensation their service has earned them.

This common-sense approach will help veterans avoid the bureaucratic red tape that often prohibits many veterans from even filing a claim.

Again, thank you, Chairman Michaud and Ranking Member Brown, for allowing me to be here today and for all both of you do on behalf of our Nation's veterans. I am happy to answer any questions that you have about this bill.

[The prepared statement of Congresswoman Pingree appears on p. 71.]

Mr. MICHAUD. Thank you very much, Ms. Pingree, for bringing forth the legislation.

Mr. Brown, do you have any questions?

Mr. BROWN OF SOUTH CAROLINA. I appreciate very much you coming. Certainly it has been a pleasure to serve with your Ranking Member from the great State of Maine.

Ms. PINGREE. I will bring that news back home. Thank you very much.

Mr. MICHAUD. Thank you very much.

I know Mr. Filner is on his way, but why don't we go with panel three who is Dr. Bob Jesse, from VHA. He is accompanied by Walter Hall, who is the Assistant General Counsel.

STATEMENT OF ROBERT L. JESSE, M.D., PH.D., PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY WALTER A. HALL, ASSISTANT GENERAL COUNSEL, OFFICE OF GENERAL COUNSEL, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. JESSE. Well, good morning, Mr. Chairman and Members of the Subcommittee. Thank you for inviting me here today to present the Administration's views on several bills that would affect the VA's programs of benefits and services.

Joining me today is Mr. Walter Hall, the Assistant General Counsel.

Before I begin my remarks, I would like to thank Ranking Member Brown for his service on the Committee and in Congress as he retires at the end of this term. America's veterans and VA have benefitted from your efforts. Thank you.

Turning to the legislation under consideration, VA agrees with the intent of many of the items on today's docket and looks forward to working together to understand how we can best support and improve care for veterans.

First, H.R. 3843, the "Transparency for America's Heroes Act," would dramatically limit the scope of confidentiality of VA benefits in assessing the quality of its programs. While VA strongly supports transparency in its programs and has done more to enable veterans to make informed decisions with regard to patient care than almost any other health care system in the country, we do oppose this legislation.

Confidentiality of records that contain discussion of quality of health care, even if they do not identify an individual, is instrumental to ensuring that employees are willing to be forthcoming about quality issues that arise at their facilities.

Current law protects a limited category of records, specifically quality assurance records. In order to qualify for these protections, these records must meet the criteria outlined in VA's implementing regulations.

VA welcomes the opportunity to meet with the Committee to discuss current protections in the law as well as additional approaches to increasing the transparency in VA's quality assurance programs.

Similarly, VA agrees with the intent of H.R. 5428, the Injured and Amputee Veterans' Bill of Rights, and we recognize the unique needs of injured and amputee veterans. We understand that injured and amputee veterans have clinical needs that are distinct from those of other patients, but we cannot support rights that

would limit VA's ability to monitor and control quality of care and provider performance.

What we cannot provide to our own clinics in prosthetics and orthotic services, we readily purchase through contractual arrangements with more than 600 vendors and providers who are approved by the Department.

VA also supports the intent of H.R. 5516, the "Access to Appropriate Immunizations for Veterans Act of 2010," and H.R. 5996, which would support the prevention, diagnosis, treatment, and management of chronic obstructive pulmonary disease.

VA is already doing a great deal on each of these areas to address the goals of this legislation. For example, our medical benefits package offers veterans immunizations against infectious diseases. And VA has long maintained smoking cessation is a major focus for health promotion and disease prevention.

The delivery of preventive care, which includes vaccinations and tobacco intervention has been well established in VA's performance measurement system for over 10 years.

VA strongly supports a draft bill under consideration that reflects the Secretary's proposed legislation and we deeply appreciate the Committee's consideration of these initiatives. This bill will improve VA's ability to serve veterans and strengthen VA's recruitment and retention efforts in several important ways.

We deeply value the contributions of our employees and enjoy a collaborative and positive working relationship with the unions across the country. We hold retention of employees as a critically important goal and encourage the management teams of VA facilities to offer professional development opportunities and to encourage personal growth.

However, VA does not support H.R. 5543, a bill affecting collective bargaining regarding compensation other than rates of basic pay. VA has testified previously about other proposals that were very similar and VA believes that this bill suffers in the same ways as the earlier measures did.

H.R. 5543 would subject many discretionary aspects of the title 38 compensation to collective bargaining. H.R. 5543 would result in unprecedented changes that would be disruptive to the VA health care system. It would permit unions to bargain over, grieve, and arbitrate a subject—employee compensation—that is generally exempted from collective bargaining.

This bill would allow independent, third-party arbitrators and other non-VA, nonclinical, labor third parties who lack clinical training and expertise to make compensation determinations.

Over the past year, VA has worked closely with all of our union partners to address concerns they have raised regarding the subjects that are excluded from collective bargaining by law.

All these union leaders recently met with Secretary Shinseki to discuss recommendations of a joint union/VA work group. The Secretary has accepted several of the work group's recommendations and will make a final decision on all of them shortly.

We would be glad to brief the Committee on our continuing efforts in this area.

Mr. Chairman, this concludes my prepared statement. I would be pleased to answer any questions.

[The prepared statement of Dr. Jesse appears on p. 71.]

Mr. MICHAUD. Thank you very much, Doctor.

In reference to H.R. 3843, in light of the recent safety lapse in certain medical centers involving dirty reusable medical equipment, I do not know why the VA would oppose this legislation.

What steps has the VA taken to bring transparency to patient safety?

Dr. JESSE. Well, I think the transparency comes at the end of a process in many respects so that when issues like the Reusable Medical Equipment issues arise, it does take some amount of time to work through the process of understanding what happened and who is responsible. And we have several mechanisms with which we can do that.

Initially you can use the quality assurance protections to go and do interviews, but, in fact, what we have done in almost all these cases is to use administrative investigation boards, which actually are public. This Committee gets copies of their reports.

Mr. MICHAUD. When you look at quality assurance, it is my understanding that the OIG has cited VA several times for not complying with their recommendations.

I guess my only concern is, what is it going to take to get VA to do what it should be doing?

Dr. JESSE. My understanding of this is that every OIG recommendation be closed out at some point. So they cannot be ignored or, you know, just be swept aside.

And so there actually is a process for us to go through and to acknowledge each of the recommendations and come to an agreement with the OIG that, in fact, we have met what they requested.

I will admit that sometimes that process is a lot longer than both the OIG or VA would like, but often the issues are very complex.

Mr. MICHAUD. Yes. I have seen the OIG reports. In some cases, after 10 years, VA has still not acted on these recommendations.

I guess the concern that I have is, veterans lives are at stake, so when is management going to wake up and deal with these serious problems? I am just concerned about VA not moving forward to address some of these serious concerns.

Dr. JESSE. Yes sir, and as are we. And we actually have, I think, new processes at least at the administrative level to ensure that we are tracking and from our perspective, we have been ensuring that at facility levels, Veterans Integrated Service Network levels, attention is being paid to these issues.

Sometimes it requires national solutions including, for instance, implementation of IT fixes that will take considerably more time. In the interim, we can often put in stop-gap measures that do not fully meet what the OIG's require, but at least we are moving in the correct direction.

Mr. MICHAUD. On the collective bargaining issue, I have heard stories of VA nurses who have no recourse if they are denied overtime pay, which negatively affects retention.

Does VA have administrative solutions to help address these problems? If not through the bill that is before us, are there other solutions, and how quickly would these solutions be available?

Dr. JESSE. I will defer to Mr. Hall for that one.

Mr. HALL. Yes, sir. As Dr. Jesse said in his testimony, the Secretary recently met with all the union leaders to discuss the results, the outcomes of a work group that has been together for the last 9 months looking at all the section 7422 issues and coming up with recommendations as to how best address their concerns with the way section 7422 has been interpreted by the Department and to develop methods to make the outcomes more coherent, more understandable to them, and more reasonable as far as how they are interpreted to provide them some mechanism or some recourse when situations, which are not bargainable present issues, for example, the pay issues that technically cannot be addressed under the law for good reasons in certain situations, but they have overlap into situations where it does not seem to make much sense.

We are going to continue to work with them and develop mechanisms and procedures and policies and provide training to both management and the unions on how those mechanisms will apply. And that is ongoing. It is going on now.

Mr. MICHAUD. Mr. Brown.

Mr. BROWN OF SOUTH CAROLINA. Thank you very much. I appreciate both of you coming today and I thank you for helping take care of all of our veterans coming back from these and previous wars.

In previous testimony, we heard that you have somewhere around 300,000 employees and you treat over six million veterans a year. It is a massive undertaking.

But we certainly do not want to make light of any issues that might come up in our Districts. We recognize that there is a massive task and a lot of effort going forward to serve our veterans. We recognize that you have an intense commitment to veterans just like we do and we are grateful for that.

My question is about immunization. I know that that is a big thing trying to get people to be vaccinated. The flu shots might be available at this time.

How do you actually go about trying to reach your base population?

Dr. JESSE. Well, for influenza immunization, whether it is the seasonal or H1N1, this is an event that has to occur annually. The vaccines change, although, in fact, I think H1N1 will be incorporated into the seasonal vaccine this year, which is different than say Pneumovax which only has to be done essentially once.

Mr. BROWN OF SOUTH CAROLINA. Or tetanus or some other.

Dr. JESSE. Tetanus is every 10 years. So we will start with the annuals. When those vaccines become available, first of all, that is a very strict performance measure. We look at the rates of immunization with expectations that everyone including the staff are immunized. And facilities have taken many different approaches to this. In the end, it is not the approach but the outcome that is the most important.

But just for example, to make it easy, rather than having to have a clinic appointment to get your vaccine, they will often just set up vaccination clinics in the main lobby. So where I am from, even the staff, would just walk down the lobby and go in and get my vaccine.

So we do that in a very concentrated period to try and get as many veterans as possible, but every patient presenting for clinic will be checked on whether they had the vaccine or not. And the nurses are then essentially empowered to give the vaccine without requiring a physician.

My personal anecdote to this is in one of my clinics a year or so ago, all four of the patients, the first four patients I had seen had been instructed by the nurse to ask me if I had gotten my vaccine because they were looking out for me. So it is——

Mr. BROWN OF SOUTH CAROLINA. Let me interrupt you if I might. I know that in the general population, the drugstores advertise, "come here and get your vaccination." If you are a Medicare patient, all you need to do is sign some kind of document.

Do we have any kind of a contract arrangement with these folks so it would make it a little easier for the veterans? I represent the Charleston area. We do have some clinics out in the north Charleston region, but the main hospital is downtown. And somebody, say, living in St. Stephen, or some rural parts of Berkeley County, the commute certainly might be a couple hours of time.

Do you have working arrangements with any of the local providers?

Dr. JESSE. We have arrangements through our broad outreach networks, but obviously you cannot do a flu vaccine through telehealth. So that is one area where we actually have to have personal contact.

I am not aware that we do, but I will certainly take that back as a notion and see if we can move that forward. I do not know if there is any legal reason we can or cannot do it, but certainly we want to get them all vaccinated. And understanding there is a relatively narrow window of time when we have to get the seasonal flu shot in, it would make sense.

Mr. BROWN OF SOUTH CAROLINA. I think the general population has become very concerned about getting the flu. I think there is a lot of national media that draws them to receive that vaccination.

I was just thinking that we could make it a little bit more convenient for them to be able to get it. I think that would be so important. I appreciate your interest on that.

Thank you.

[The VA subsequently provided the following information:]

Question 1: Does VA currently have any arrangements with private health care providers or retailers to provide influenza vaccinations to its enrollees?

Response: No. All vaccinations are administered by VA staff or through arrangements with VA affiliates. Veterans Health Administration (VHA) facilities offer seasonal influenza vaccine to all enrolled Veterans who meet criteria for vaccination at no cost. Veterans may choose to receive their flu vaccine through retail establishments or through other places within their communities at their own or third party payers' expense. Local Public Health Departments often have flu vaccination programs that offer vaccine to anyone in the community including Veterans and their families, sometimes at no cost or on sliding scales.

Question 2: Furthermore, does VA have the authority to enter into such arrangements?

Response: Yes, VA is able to contract for these services under existing Federal Acquisition Regulations.

Enrolled Veterans who require these services as part of a continuation of care, will be eligible for payment for these services, if VA facilities are unavailable, or geographically inaccessible under the Fee authorities. This requires a pre-author-

ization from VA. We do not have the authority to authorize services provided without pre-authorization.

There is also no authority to pay for these services where VA facilities are available or when Veterans are not actively receiving health care services from VA. These limitations may impact the number of Veterans who could be covered either under the Fee authorities or via a contract.

Although VA does have the authority to preauthorize this service for eligible Veterans on a Fee basis, the procedural requirements prior to receiving such preauthorization are likely to deter most Veterans from utilizing such non-VA medical care. In addition, many Veterans would be required to receive the service at a VA facility due to the geographic inaccessibility criteria and the fact that Veterans receiving care from VA can readily be immunized during their regular visits to VA. If VA were to pursue such a strategy, a national contract is the most appropriate vehicle for providing these services.

The challenge facing VHA (as well as in the private sector) is the resistance among some individuals to recognize the benefit of receiving flu vaccine. Reasons for not receiving flu vaccine include fear of needles, concerns that the vaccine isn't safe, or that the vaccine will actually make the recipient sick with flu, and some simply don't want foreign drugs in their bodies.

We continue to educate the VA community about the safety and effectiveness of influenza vaccine. Availability of influenza vaccine is not anticipated to be an issue during the 2010–11 flu season. For the upcoming flu season, VA has ordered a total of 3.3 million doses of flu vaccine compared to 2.6 million doses ordered for the 2009–2010 flu season.

In summary, public health experts recognize influenza vaccination as a powerful tool to prevent the spread of influenza. Currently flu vaccine is available through all VA medical facilities at no cost to eligible Veterans and staff. VA believes that our community approach to influenza vaccination ultimately has a positive impact on the health of our Veteran population, VA staff, and others within our facilities.

Question 3: Would such arrangements be feasible?

Response: It may be feasible to award a national contract for this purpose but it would not be cost-effective, nor is there evidence of a need for this service. VA vaccinates large numbers of Veterans through its medical centers and Community Based Outpatient Clinics (CBOCs) and Veterans also have access to low cost or no cost vaccine through their local health departments. VA procures its vaccines at extremely competitive prices and offers them to Veterans at all VA Medical Centers and CBOCs; therefore accessibility is not an issue. The current VA cost for each dose of influenza vaccine is $9.48 when administered by VA personnel. Current costs in community pharmacies average $30 per vaccination. If VA used a reimbursement model, it would cost an additional $7 to process a patient's claim, for a cost differential of $27.52 per patient, If 25 percent of VA's patients used this service, it would cost an additional $77 million dollars per year.

New Federal recommendations from the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP) are that all eligible persons age 6 months and older should receive seasonal influenza vaccination (CDC MMWR, August 6, 2010 (59)). To reduce the threat of influenza-related illnesses and deaths within the U.S. and individual communities, VHA continues to have an aggressive campaign to promote influenza vaccination. Of Veterans enrolled in VA, flu vaccination rates for those Veterans aged 50 or older have continually been higher than the national average. During the 2008/2009 influenza season, VHA vaccinated 69 percent of those age 50 to 64 compared to the national rate of 40 percent. For those 65 and older, the VHA vaccination rate was 83 percent compared to the national rate of 66 percent. That same year, VHA vaccinated 64 percent of health care workers. (VHA Office of Quality and Performance; Occupational Health, Safety and Prevention Strategic Health Care Group; and CDC MMWR August 6, 2010 (59); RR8, page 30).

In 2009 VHA's Public Health Strategic Health Care Group (PHSHG) conducted national Veteran patient focus groups on influenza. From these focus groups, Veterans indicated a robust awareness of influenza vaccination campaigns and accessibility to flu vaccine. This awareness can be linked to facilities' implementation of best practices for flu vaccination and strong public health messaging to target Veteran populations. VHA has made flu vaccination convenient to Veterans by providing flexible hours for flu vaccination clinics, "drive-thru" flu vaccination programs and walk-in vaccine clinics not requiring an appointment.

Mr. MICHAUD. Well, once again, I would like to thank you, Dr. Jesse and Mr. Hall, for coming today. And there probably will be

more questions submitted for the record as we move forward with the bills that were included today. And I want to thank you for your testimony.

And, likewise, I would like to thank the two previous panels as well.

If there are no other questions, I would adjourn the hearing. Thank you all for coming. I appreciate it.

Dr. JESSE. Thank you, Mr. Chairman.

[Whereupon, at 11:05 a.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Michael H. Michaud, Chairman, Subcommittee on Health

I would like to thank everyone for coming today.

Today's legislative hearing is an opportunity for Members of Congress, veterans, the VA and other interested parties to provide their views on and discuss introduced legislation within the Subcommittee's jurisdiction in a clear and orderly process. This is an important part of the legislative process that will encourage frank discussions and new ideas.

We have twelve bills before us today which address a number of important issues for our veterans and provide the staff of the Department of Veterans Affairs with the necessary tools to provide the best care for our veterans. First, we have a bill that would bring more transparency to the VA's medical quality assurance program, through which the Department aims to provide a systematic review of their health care activities. Specifically, VA would be required to make medical quality assurance records available to the public so that veterans and the general public will have access to important information about the care that is provided at VA health care facilities. Next, we have legislation providing for a bill of rights for our injured and amputee veterans given the large numbers of our servicemembers who are returning home with injuries to or loss of their limbs. We also have several bills that would improve the health care that our veterans receive such as a pilot program for chronic obstructive pulmonary disease; provision of immunizations to address vaccine-preventable diseases; adult medical foster homes for veterans; improved TBI care; help for homeless veterans with special needs; and the extension of health care eligibility for veterans who served in the Qarmat Ali region of Iraq. Finally, we have bills before us today that would help the staff of the Department of Veterans Affairs provide better care for our veterans. This includes a bill to better train Federal Recovery Coordinators; a bill to train VA health care facilities staff to provide important information about VBA benefits; and a bill to authorize collective bargaining over certain compensation related labor-management disputes.

I look forward to hearing the views of our witnesses on the bills before us today.

Prepared Statement of Hon. Henry E. Brown, Jr., Ranking Republican Member, Subcommittee on Health

Thank you, Mr. Chairman, and good morning.

We have a number of important veterans' bills before us today and I look forward to hearing from several of my colleagues, our friends from various veterans' service organizations, and representatives from the Department of Veterans Affairs (VA) to address their potential merits and/or unintended consequences.

Our Ranking Member, Steve Buyer, is the sponsor of two of the bills on the agenda—H.R. 5641, the Heroes at Home Act and H.R. 6127, the Extension of Health Care Eligibility for Veterans who Served at Qarmat (Car-mot) Ali Act. Unfortunately, Steve is unable to be here this morning and I ask unanimous consent that his statement be included in the record.

In his absence, I would like to take a few minutes to explain these important legislative initiatives.

H.R. 5641, the Heroes at Home Act, would increase the long-term care options for veterans by allowing VA to enter into a contract with a certified adult foster home to pay for the long-term care of veterans already eligible for VA-paid nursing home care.

Medical foster homes are non-institutional settings that provide a personalized approach to long-term care. Veterans who choose medical foster home care reside

in the home of their chosen foster home caregiver who in turn provides that veteran with around-the-clock care and company.

Each prospective caregiver is required to pass a VA screening, Federal background check, and home inspection and must agree to undergo annual caregiver training and regular announced and unannounced home visits by VA's adult foster home coordinators and professionals from VA's Home Care Team. In addition, each veteran must agree to enroll in VA's Home Health Services to provide added support.

As the need for long-term care grows, it will become increasingly important to provide our honored veterans with options that allow them to make the care choice that best fits their needs. VA has been assisting veterans in obtaining medical foster home care since 2002 and many of the veterans who benefitted from this unique service have service-connected disability ratings that entitle them to VA-paid long-term care.

H.R. 5641 would authorize VA to contract with medical foster homes to cover the costs of care for those veterans already eligible for VA provided nursing home care.

H.R. 6127, the Extension of Health Care Eligibility for Veterans who Served at Qarmat Ali Act, is legislation that is particularly dear to the veterans in my home State. It would extend the VA health care enrollment period by 5 years for veterans who served at Qarmat (Car-mot) Ali, Iraq and were notified of possible exposure to a toxic chemical known as sodium dichromate.

Not long after the conflict in Iraq began, Army National Guard units from South Carolina—my home State—as well as units from Indiana, Oregon, West Virginia, and individual augmentees from 17 other States across the Nation were called to serve at the Qarmat (Car-mot) Ali water treatment facility.

Unfortunately, these veterans recently received notification by VA that during their service they may have been exposed to a toxic chemical which could result in a number of serious respiratory issues, skin lesions, burns, and other ear, nose, throat, and skin disorders.

While these veterans were eligible to enroll in VA health care for 5 years after separation from service, those who reentered civilian life following their 2003 deployment would have been required to enroll by 2008—a full 2 years before initial notification of the potential exposure and subsequent health risk.

It is essential that these veterans have immediate access to VA's high quality health care system in order to receive preventative care and services to improve health outcomes and quality of life.

Further, my good friend and colleague from Florida, Mr. Stearns, also has two bills before us today concerning important preventative care methods to improve the health and well-being of American veterans. I thank him for his leadership on this Subcommittee and anticipate hearing his comments and further discussion of these initiatives.

I want to thank my many colleagues who have sponsored the bills on our agenda this morning and all of the witnesses who have taken the time to participate today. I yield back the balance of my time.

Prepared Statement of Hon. Joe Sestak, a Representative in Congress from the State of Pennsylvania

Chairman Michaud, Ranking Member Brown, and distinguished Members of the Subcommittee, to begin, I would like to acknowledge the very hard work of this Committee and our colleagues of both parties in the 110th and 111th Congresses who have provided the Department of Veterans Affairs unprecedented ways and means to care for our Veterans and their families. Though the VA had been severely underfunded for too long, congressional efforts since 2007 now afford our Veterans of three generations access to the best care ever afforded those who go into harm's way on our behalf.

However, with those additional resources the VA has the responsibility to Congress, the American public, and most especially our Veterans to see that it operates to the highest possible standards of care. In support of that goal it is an honor to appear before you today to discuss my bill, H.R. 3843, the Transparency for America's Heroes Act. This legislation directs the Secretary of Veterans Affairs to make available on the Department of Veterans Affairs (VA) Web site redacted records and documents—but not personal identifying information—created by the VA as part of a medical quality-assurance program. It would also require the Secretary to ensure that any such records created during the 2-year period before the enactment of this Act are also made available in the same manner.

I authored this bill because I have grown increasingly troubled by reports that give rise to concern of a lingering lack of consistent care and accountability within the VA. I must be very clear that I have the highest regard for the thousands of dedicated professionals of the VA—many of whom have spent their entire careers in service to our Veterans. However, for the past 24 months there have been too many revelations of substandard care for Veterans. Congress and the American public have been belatedly informed of prostate cancer victims who received insufficient treatment, the possible exposure of more than 1,800 Veterans to serious diseases, including Hepatitis and HIV, while undergoing routine dental procedures, deficiencies in thoracic care and last September we learned—only after a Freedom of Information Act request was filed—that some elderly Veterans were being subjected to substandard, potentially neglectful care in the Philadelphia Community Living Center at the Philadelphia VA Medical Center.

The nursing home, according to the Long Term Care Institute's report, "failed to provide a sanitary and safe environment for their residents . . . (and) there was a significant failure to promote and protect their residents' rights to autonomy and to be treated with respect and dignity." Some of the examples cited shock the conscience. For example, one patient with an open foot wound was left unattended for so long that maggots were found falling out of the wound. Additionally, the floor was found to be covered with dried blood and feeding tubes. Another diabetic patient complained of chronic failure on the staff's part to administer his insulin shots on schedule.

After hearing these reports, it came to my attention that there were two other recent inspections, one by the Inspector General of the VA and one by the Joint Commission on Accreditation of Health Care Organizations, both of which concluded that the facility met quality standards based on the metrics used. However, it took this separate, external investigation by the Long Term Care Institute—using a different set of inspection criteria—to identify the serious problems at the facility under its old leadership.

What concerns me is the two VA-conducted reviews failed to discover these deficiencies, and that a Freedom of Information Act (FOIA) request was required to bring this latest revelation of poor care to light. In fact, the report should not have even been released after the FOIA petition was filed under current law because the third-party inspection was conducted under the VA's quality-assurance authority. In this case, the report was inadvertently leaked by a VA official who did not follow the normal protocol. This leads me to believe that there may be numerous other cases of deficient care which will never see the light of day because the inspections in question, like the one conducted by the Long Term Care Institute, were conducted under the VA quality-assurance authority.

Under current law, records and documents created by the VA as part of a designated quality-assurance program are confidential and privileged, and as a result cannot be disclosed to any person or entity except when specifically authorized by statute. The stated rationale for this practice is, according to the VA, to "create a proactive culture of quality improvement allowing for early identification and resolution of quality issues." The VA also states that "elimination of protected document status for quality management activity documents would possibly have a chilling effect on the level of objectivity reflected within these improvement activities."

As a former Admiral who led men and women into battle, I disagree with this assessment. I am convinced there is a need for a cultural and procedural sea-change in the way the VA medical system operates—and that the best way to ensure quality care in the VA is through stringent oversight. This entails vigilance on the part of both Congress and the general public. If there are any other instances of inadequate VA care, they should be revealed immediately along with confirmation that appropriate corrective actions have been taken. My bill would accomplish this, without releasing sensitive information which could be used to identify patients and health care professionals.

If we fail to ensure this kind of accountability, the goals of the current administration and the hard work of the 110th and 111th Congress, to finally provide our Veterans the care and resources they have been denied for so long, will be compromised.

At issue is the very credibility of one of our Nation's most important and visible health care providers and that of our government itself. I am reminded of the long-term consequences of government's failure for over two decades—both in the Executive Branch and Congress—to treat Veterans and their families in a responsible and accountable way. As our troops continue to return from Iraq and Afghanistan, we can, and must, do better.

Thank you, Mr. Chairman.

Prepared Statement of Hon. Timothy J. Walz, a Representative in Congress from the State of Minnesota

Chairman Michaud, Ranking Member Brown, thank you for holding this legislative hearing.

I'm here today to talk about H.R. 6123, the Veterans' Traumatic Brain Injury Rehabilitative Services Improvements Act.

In short, this bi-partisan bill does two things:

- First, it would clarify that VA rehab services are not limited to those provided by a health professional **but would cover other VA services or supports that contribute to maximizing independence and quality of life.**
- Second, it would clarify that current provisions for TBI care are to be read more broadly, not simply to improve lost functioning **but to prevent losing the gains that have been achieved.**

Because of ambiguities in current law, TBI treatment at the VA narrowly focuses TBI care on physical restoration only.

When a veteran suffering from TBI comes to the VA for treatment, **they need to be presented with a comprehensive approach to rehabilitation that will allow them to recover function, achieve independence and fully integrate back into their communities.**

This bill ensures we provide comprehensive care instead of just physical rehabilitation, which is what is presently available to our injured veterans, **without creating any new programs within the VA.** It simply uses the programs that are already present at the VA to build a more complete rehab program.

Our wounded warriors deserve the best care and support we can give them, and this bill ensures that the VA uses all the tools at its disposal to care for those heroes that have "borne the battle."

That's why this bill has the full support of the Wounded Warrior Project, the Disabled American Veterans, Blinded Veterans Association, and the Enlisted Association of the National Guard of the United States.

I'd like to take this opportunity to thank Ralph Ibson and Christine Hill of the Wounded Warrior Project for their work on this bill. Without their dedication and the dedication of countless veterans' advocates around the country, we wouldn't be where we are today.

I'd also like to thank Representatives Bilirakis, Miller, and Pascrell for your support and leadership on this issue.

Thank you again, and I yield the remainder of my time.

Prepared Statement of Hon. John Barrow, a Representative in Congress from the State of Georgia

Thank you for the chance to testify before you today.

The most consistent and frustrating feedback I get from the people I represent is from veterans having problems with the VA. I suspect that it's the same for you in your districts. The initial disability determination takes too long. Communication with the VA can be weak. Once they're in, the system can be hard to navigate. Facilities can be remote.

While I can see how major programs in the VA need a major overhaul, I realize that's not likely to happen any time soon. For better or worse, the system works well enough for enough folks that the demand for a major overhaul will be a long time coming. But I don't think any of us really believes that the current system works as well as it could or should.

The problem with today's VA is its complexity. The medical needs of returning veterans are more complex than they've ever been. And we've designed very intricate treatments and benefits and services to meet those needs. Unfortunately, it's become so complex that you need specialized training to wade through the bureaucracy of it all. My purpose in coming here today is to introduce you to a bill I've introduced which will give veterans the tools to navigate the maze.

We all agree that every wounded warrior should have an individualized plan for recovery, coordinated by a professional, who is trained to successfully navigate the VA system of services and benefits.

The Dole/Shalala Commission calls these professionals Federal Recovery Coordinators, and made them a major component of their comprehensive recommendations to improve the VA.

A Federal Recovery Coordinator Program has been authorized by Congress since 2008, but today there are only 20 Federal Recovery Coordinators spread across the entire country, coordinating the care of only around 500 wounded veterans. My bill will increase the number of Federal Recovery Coordinators, formalize their training, and establish guidelines and best practices for successful care coordination.

As envisioned and designed by the Dole/Shalala Commission, a Federal Recovery Coordinator would be a nurse or social worker with master's degree, who has excellent communication, leadership, and resource navigation skills. Today's wounded warrior might have a unique combination of traumatic physical injury, PTSD, substance abuse, or marital problems, trouble finding a job, or trouble reintegrating back into the community. A Recovery Coordinator acts as an "air traffic controller" to guide veterans to the proper treatment and benefit options.

I've submitted for the record personal testimonies from a few returnees I represent, whose Federal Recovery Coordinators have been a godsend. I commend them to you.

Despite its obvious benefits and successes, the program is in its infancy and needs some help in order to be all that it can be. My bill will help in these specific ways:

First and foremost, the bill authorizes formal training for 45 new FRCS in the next 3 years. It's obvious that we have too many veterans who desperately need these services, but we don't have nearly enough coordinators to meet the demand.

Second, my bill authorizes the development of specialized case management software to complement the work of trained care coordinators.

Third, my bill authorizes the development of uniform best practices for recovery coordination. The coordinators out there today are blazing valuable new trails, but they work out of sight of each other. We need to develop and promote what works best, so that all of our wounded warriors will have the best chance of getting what they need.

Our goal here has to be helping the veterans who need it, and to do it as fast and effectively as we possibly can. I've seen the Federal Recovery Coordinator Program in action, and I'm convinced that this really is the best way forward. I appreciate the opportunity to testify before you, I appreciate the Committee's willingness to take a deeper look at this legislation, and I'll be happy to answer any questions.

ADDITIONAL MATERIALS

September 27, 2010

Dear Members of the Committee:

My husband is SGT (ret.) Darryl Wallace, an OEF veteran who was wounded June 9th, 2007 when an IED went off under the seat of his Humvee. He lost both legs in the explosion, and was sent to Walter Reed Army Medical Center, and eventually to the Active Duty Rehab Unit at the Charlie Norwood VA Medical Center in Augusta, Georgia.

I am writing to you to let you know the most helpful thing to us in my husband's recovery has been the Federal Recovery Coordinator we have been assigned, Ms. Erin Jolly. She helps when the VA doesn't want to help or they are giving you the runaround. We can call our FRC and Erin can get stuff done.

For example, when Darryl was overdosing all the time and he was being put on the psych ward, he just needed help. Our FRC was able to get in touch with a treatment center, get all the information together, and Erin was the one who got everyone in the whole process to get it done so Darryl could go into treatment. He is doing very well now because of it.

If I ever have any questions about anything, I call our FRC and she can tell me the information or can find out if she doesn't know.

FRCs do not give you the runaround.

Once, my husband's VA physician told us she couldn't see him for a week, and our FRC got him in to see the doctor the same day. If it wouldn't have been for our FRC a lot of stuff would have been overlooked: pain management, his well being, and his welfare.

Every wounded warrior needs a Federal Recovery Coordinator because if they don't like what a doctor or case worker is doing, the FRC will get it done. It's a big bureaucracy, a lot of stuff gets swept under the rug, and not dealt with, but the FRC makes sure it all gets handled.

Our FRC prioritizes what we need, and gets us where we need to go, when we need to go. I have never had a problem that the FRC has not been able to solve.

She answers calls after hours and when we need her. When I need her, she's there for me and my husband. She works from home on her laptop to help us.

I love my FRC and I've told them that when they've called to do surveys.

Every soldier that comes back needs one. Doctors are excellent but FRCs play a big part in the recovery too—had it not been for our FRC a lot of stuff would not have been dealt with.

Tiffany Wallace
Harlem, GA

September 25, 2010

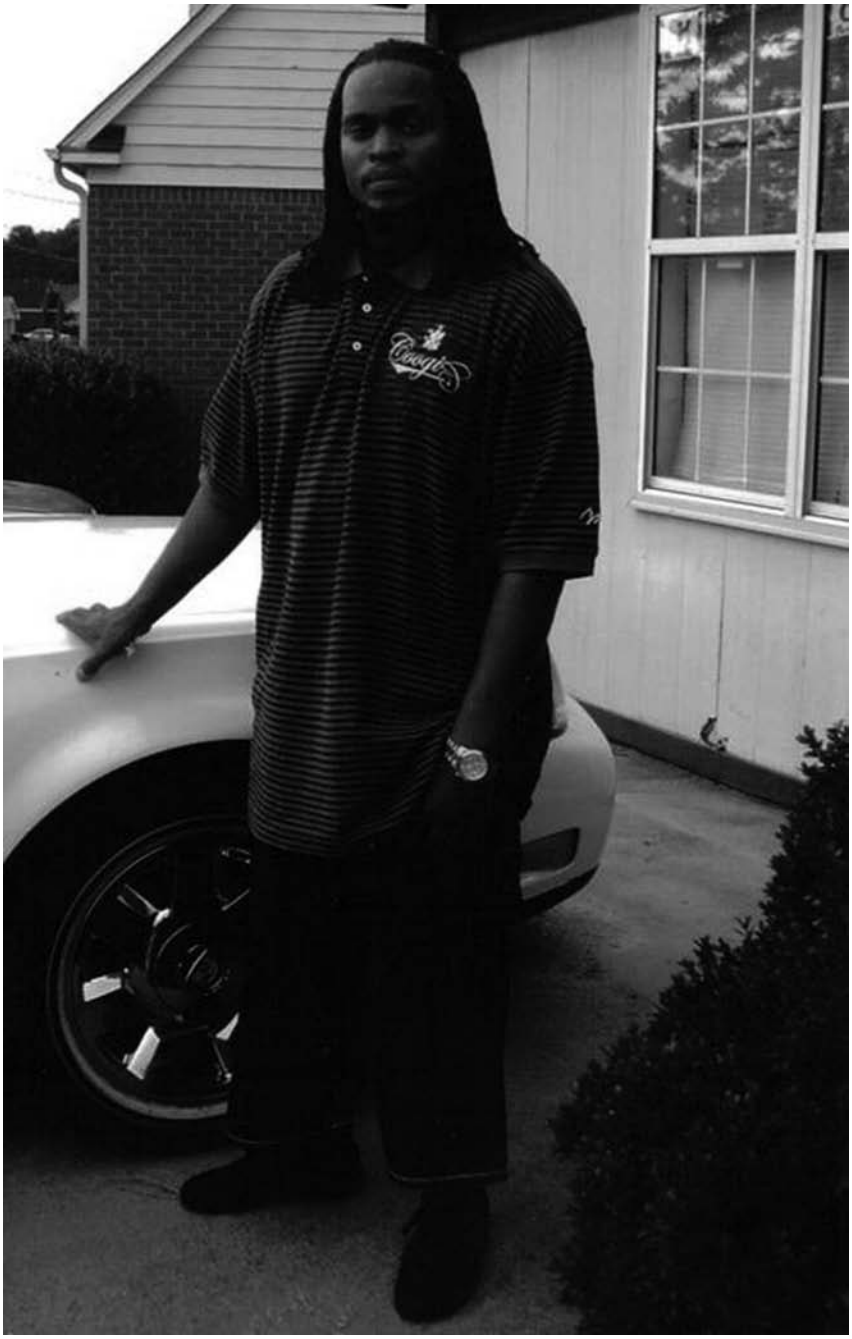
Dear Congressman Barrow:

I believe that the Federal Recovery Coordinator program is a great program, especially for veterans like myself that do not know how to navigate through the VA system that well.

I had received inaccurate information about and was not told about VA services I was entitled to. For instance, I was told I could not get a benefit while I was an inpatient in the PTSD program at the VA until after I completed the program. However, my Federal Recovery Coordinator told me that I could receive benefits while attending the program. This information was very helpful to me because I was able to get the help that I needed without worrying about how my family was going to maintain while I received treatment for PTSD.

My Federal Recovery Coordinator also helped me complete paperwork to start my benefits. The Federal Recovery Coordinator also keeps me informed on any updates in VA benefits and services the VA has to offer. I greatly appreciate all the help of my Federal Recovery Coordinator has provided me with, without her I would have been lost.

Karl Mitchell
OIF Veteran
Purple Heart recipient



Prepared Statement of Hon. Cliff Stearns, a Representative in Congress from the State of Florida

Thank you Chairman Michaud and Ranking Member Brown.

I have two bills before the Committee today. H.R. 5516—Access to Appropriate Immunizations for Veterans and H.R. 5996—a bill to help veterans with chronic obstructive pulmonary disease (COPD).

H.R. 5996 is a bipartisan bill that I'm proud to have introduced as the co-founder of the COPD caucus. COPD is the 4th leading cause of death in the U.S., and is predicated to be the 3rd leading cause of death by 2020, beating both diabetes and stroke. 126,000 Americans die each year from this disease—that's about 1 death every 4 minutes.

My bill would increase the VA's ability to diagnose, treat and manage COPD. COPD is a chronic condition that does not have a cure. Early detection and treatment is important to slow or arrest the progression of the disease. It is estimated that more than 12 million people are diagnosed with COPD and yet this number is believed to be too small as COPD is often under-diagnosed. The Centers for Disease Control and Prevention (CDC) estimates that over 24 million Americans have symptoms of COPD.

Despite all this, there is a lack of COPD awareness by patients and doctors.

Because this is a progressive disease, early detection is important.

Because there is no cure, early treatment is vital.

Because the COPD rate is three times higher in the veteran population than the civilian population, how can the VA not be providing this type of specialized care? COPD is the fourth most common diagnosis amongst hospitalized veterans aged 65–74.

H.R. 5996 would have the VA develop treatment protocols and related tools for the diagnosis, treatment and management of chronic obstructive pulmonary disease. It would also have the VA establish a pilot smoking cessation program targeted towards individuals who have COPD. While there are many ways that someone can develop COPD, the most common is from smoking. However, it should also be noted that COPD has underlying genetic risk factors and healthy non-smokers can develop COPD.

I think it's important to note that this is not giving VA any new authority. VA already has the authority to do what I'm asking for, but for whatever reason, they have not aggressively moved to develop these treatment protocols for the 4th leading cause of death in the United States. My bill would have the VA begin to develop these treatments for our veterans.

H.R. 5996 has the support of the U.S. COPD Coalition, the COPD Foundation, the American Thoracic Society, the American Association for Respiratory Care, the Alpha-1 Foundation and the Alpha-1 Association. I'd like to submit their letters of support for the record.

My other bill is the Access to Appropriate Immunizations for Veterans, H.R. 5516. The VA already has the authority to provide vaccines to veterans to immunize them against preventable diseases. However, the VA has only established performance measures for two vaccines. For these two vaccines against the flu and pneumonia, the vaccination rate increased from about 27 percent to almost 80 percent and hospitalization rates dropped in half.

My bill would extend all the Centers for Disease Control & Prevention's recommended vaccines to the performance measures. It is important to note that vaccines are not just for children. In fact, just last week the NY Times ran an article on how important it is for adults to receive vaccines and booster shots.

I'd like to read a part of this article:

> "Adult immunizations are not just an important way to prevent the spread of disease. Immunizations are also a phenomenally cost-effective way to preserve health.
>
> "'When you compare the cost of getting sick with these diseases to the cost of a vaccine, it's a modest investment,' said Dr. Robert H. Hopkins, a professor of internal medicine and pediatrics at the University of Arkansas for Medical Sciences."

According to the CDC, each year approximately 70,000 adult Americans die from vaccine-preventable diseases. Influenza alone is responsible for over one million ambulatory care visits . . . 200,000 hospitalizations . . . and 30,000 deaths. Only 7 percent of Americans over the age of 60 have received the vaccine to protect them from shingles, a painful nerve infection. Just 11 percent of young women have received the vaccine against HPV that cause 70 percent of all cervical cancers.

Many of our veterans who are in the "high-risk" category of contracting vaccine-preventable diseases—include those with HIV, Hepatitis C and substance abuse disorder—are enrolled in the VA health care system and could benefit from receiving vaccinations.

I want the VA to provide superior quality health care to our veterans. Adding vaccination to the performance measure is a simple common-sense idea that will increase the level of care available and save money by stopping preventable diseases. The bill would also require the VA to report back to Congress on their progress of supporting vaccinations within the veteran population.

And I'd like to enter this NY Times article into the record and the CDC's recommended vaccination schedule for adults.

Alpha-1 Association
Miami, FL.
September 28, 2010

The Honorable Cliff Stearns
2370 Rayburn House Office Building
Washington, DC 20515

Dear Representative Stearns,

On behalf of the Alpha-1 Association's Board of Directors, I wish to express our heartfelt appreciation for your leadership in Chronic Obstructive Pulmonary Disease (COPD) in the veterans' community and to express our support for the passage of H.R. 5996.

The Alpha-1 Association is a patient-focused and patient-driven organization dedicated to identifying individuals affected by Alpha-1 and improving the quality of their lives through support, education, advocacy and to encourage participation in research. As a 501(c) (3) not-for-profit membership organization, the Association has been providing services to Alphas and their families since 1991.

This bill affects our patient community. According to the National Heart, Lung & Blood Institute, 3 percent of the 12 million people that have been diagnosed with COPD in the United States have Alpha-1.

Alpha-1 is a genetic condition that may result in serious, chronic lung and/or liver disease at various ages in life (children and adults). It is often misdiagnosed as asthma or smoking-related Chronic Obstructive Pulmonary Disease (COPD).

Individuals with Alpha-1 may develop emphysema even if they have never smoked. Despite treatments, including protein replacement, adults may require a lung transplant due to severe emphysema.

As the foremost provider of health care services to over 8 million veterans, the Department of Veterans Affairs has a unique opportunity to become a leader in the fight against Alpha-1 (Genetic COPD). H.R. 5996 will allow the VA to take a comprehensive approach in reducing the burden of Alpha-1 through innovative prevention, education and treatment strategies. It will also provide for the critically needed research into best practices that will help to simultaneously reduce costs and improve quality of life.

Our Association and the COPD community care deeply about the need to address COPD in America's veteran population. The VA system has been a leader in health systems research and H.R. 5996 will build on a record of using innovative methods to improve the health of the veterans it serves. We encourage your colleagues to join you in support of H.R. 5996. Congress' actions will mark a great step towards addressing the burden that COPD places on veterans, their families and the health care delivery system.

We are happy to support your efforts in any way that will aid you in obtaining passage of H.R. 5996.

Sincerely,

Marlene Erven
Executive Director

American Association for Respiratory Care
Irving, TX.
August 15, 2010

The Honorable Cliff Stearns
2370 Rayburn House Office Building
Washington, DC 20515

Dear Representative Stearns:

The American Association for Respiratory Care (AARC) a 50,000 member professional association for respiratory therapists endorses and fully supports H.R. 5996. This legislation will direct the Secretary of Veterans Affairs to improve the prevention, diagnosis, and treatment of veterans with chronic obstructive pulmonary disease (COPD).

Respiratory therapists provide clinical care and services to pulmonary patients across the continuum of care ranging from the hospital settings, to rehabilitation centers, to skilled nursing facilities, to home care and in physician offices.

Among the important provisions of H.R. 5996 is a special emphasis on assisting our Nation's veterans with smoking cessation efforts—a leading contributor to COPD. Respiratory therapists are on the front lines as health care professionals who assist the public with smoking prevention and cessation efforts.

There are over 1,700 respiratory therapists currently employed in the Veterans health care system. With the enactment of H.R. 5996, there will be a cadre of respiratory therapists already in place to help implement the directives mandated by this important legislation.

Thank you again for your foresight and commitment to our Nation's veterans and their health care.

Sincerely,

Tim Myers, BS, RRT-NPS
President

American Lung Association
Washington, DC.
October 4, 2010

The Honorable Cliff Stearns
U.S. House of Representatives
Washington, DC 20515

Dear Representative Stearns:

The American Lung Association is pleased to support H.R. 5596, legislation to improve the prevention, diagnosis, and treatment of veterans with chronic obstructive pulmonary disease (COPD). Chronic obstructive pulmonary disease takes a tremendous human and financial toll on the Department of Veterans Affairs. An estimated 8 percent of veterans in the Department of Veterans Affairs (VA) health care system have been diagnosed with COPD. COPD ranks as the fourth most common reason for hospitalization in the VA patient population. It is the fourth most common cause of death in the United States, and it is projected to become the third leading cause of mortality by 2020.

H.R. 5996 will require the development of treatment protocols and related tools for the prevention, diagnosis, treatment, and management of chronic obstructive pulmonary disease. The legislation also will bolster biomedical and prosthetic research programs regarding this disease. These steps are urgently needed to help improve patient outcomes.

Between 80 and 90 percent of all COPD cases are caused by smoking. The best way to prevent COPD and many diseases the VA health care system manages is to quit smoking or not to smoke in the first place. H.R. 5996 will help address this by directing the VA, in conjunction with Centers for Disease Control and Prevention, to develop improved techniques and best practices for assisting veterans with chronic obstructive pulmonary disease in successfully quitting smoking.

According to the *2008 Study of Veteran Enrollees' Health and Reliance Upon VA,* over 70 percent of VA enrollees report that they have smoked at one time in their lives. Currently 19.7 percent smoke. This is down from 22.2 percent in 2005 and

21.5 percent in 2007 and shows some important momentum in the right direction. Among the 70 percent of the VA population who has ever smoked, over twenty 5 percent (25.5) say they've recently quit smoking, again, a step in the right direction.

Sadly, the VA will continue to battle this problem for some time to come. The current smoking rate for active duty military is 30.4 percent, with smoking rates highest among personnel ages 18 to 25—especially among soldiers and Marines. The Department of Veterans Affairs estimates that more than 50 percent of all active duty personnel stationed in Iraq smoke.

H.R. 5596 is an important step to address COPD and the toll of tobacco on our Nation's veterans. We look forward to working with you to pass this lifesaving legislation.

Sincerely,

Charles D. Connor
President and Chief Executive Officer

cc: The Honorable John Lewis

COPD Foundation
Washington, DC.
August 10, 2010

The Honorable Cliff Stearns
2370 Rayburn House Office Building
Washington, DC 20515

Dear Representative Stearns,

On behalf of the COPD Foundation's Board of Directors, I wish to express our heartfelt appreciation for your leadership in Chronic Obstructive Pulmonary Disease (COPD) in the veterans' community and to express our support for the passage of H.R. 5996.

The COPD Foundation is the national not-for-profit organization solely dedicated to representing individuals with COPD in the United States. As you know, COPD, or Chronic Obstructive Pulmonary Disease, is an umbrella term used to describe progressive lung diseases, encompassing emphysema, chronic bronchitis, refractory asthma, and severe bronchiectasis.

The NIH estimates that 12 million adults have COPD and another 12 million are undiagnosed or developing COPD. COPD is currently the fourth leading cause of death in the U.S. and it is estimated to become the third leading cause of death by 2020. The impacts on the economy are severe, with national costs projected to be $49.9 billion in 2010, in part due to COPD's status as the second leading cause of disability.

As the foremost provider of health care services to over 8 million veterans, the Department of Veterans Affairs has a unique opportunity to become a leader in the fight against COPD. H.R. 5996 will allow the VA to take a comprehensive approach to reducing the burden of COPD through innovative prevention, education and treatment strategies. It also provides for critically needed research into best practices that will help to simultaneously reduce costs and improve quality of life.

Our organization and the COPD community care deeply about the need to address COPD in America's veteran population. A 2003 study revealed that COPD was the fourth most common diagnosis amongst hospitalized veterans and a strong predictor for patient readmission following a hospital stay. The VA system has been a leader in health systems research and H.R. 5996 will build on a record of using innovative methods to improve the health of the veterans it serves. We encourage your colleagues to join you in support of H.R. 5996. Congress' actions will mark a great step towards addressing the burden that COPD places on veterans, their families and the health care delivery system.

We were excited to learn that the House Committee on Veterans' Affairs will hold a hearing on September 29, 2010 that will include a discussion of H.R. 5996. If there is an opportunity to provide a witness at this hearing we would be pleased to identify a patient, physician or researcher who could lend substance to the discus-

sion of COPD in the Veterans' population. We are happy to support your efforts in any way that will aid you in obtaining passage of H.R. 5996.

Sincerely,

John W. Walsh
President

EFFORTS
Kansas City, MO.
October 1, 2010

Dear Representative Stearns,

On behalf of EFFORTS, www.emphysema.net, an online COPD, support, advocacy organization we wish to thank you for your leadership with regard to COPD and our Veterans and to offer our full support for the passage of H.R. 5996.

Currently, COPD ranks as the fourth leading cause of death in the U.S. behind heart disease, cancer, and cardiovascular disease, and it is the only major disease that continues to show increased mortality rates each year. In contrast, seven of the other ten leading causes of death actually showed decreases in mortality.

In Healthy People 2010, a publication of The Centers for Disease Control (CDC) and the National Institutes of Health (NIH), one central recommendation was that developing better methods for early detection of COPD is of utmost importance. It is often stated that COPD is diagnosed after age 65. However, in a recent survey of 338 members of our EFFORTS organization, we found that the age of diagnosis averaged 47 years for females and 56 years for males. It was also noted that many were experiencing symptoms of their disease long before they were actually diagnosed. Unfortunately, it is not at all uncommon for someone to have lost 50 percent or more of his/her lung function before they are diagnosed.

COPD is an enormous economic burden to society. It strikes during the height of the productive years, significantly interferes with the ability to earn a living, forces many to go on Medicare disability or take early retirement at an early age, and often disrupts the lives of the individual and family for many years before death occurs. According to data from the NHLBI, the direct costs of health care services and indirect costs related to loss of productivity for COPD were $26 billion in 1998 and $30.4 billion in 2000. Medical expenses for COPD patients are extremely high because of frequent visits to the emergency room, extended hospital stays, and expensive medications. In 1997, there were an estimated 13.4 million physician office visits and more than 600,000 hospitalizations for COPD (NHLBI, 2001). Data from the Centers for Disease Control indicate that diseases of the respiratory system rank #3 in the number of emergency room visits. It is expected that all of the costs associated with COPD will continue to spiral upward because the prevalence of COPD is continuing to rise each year.

There are only a few treatment options available to the millions of patients who suffer from this killer disease. None provides a cure and only treat the symptoms. Physicians can experiment with medications developed for asthma, consider surgery, prescribe oxygen, and/or refer the patient for pulmonary rehabilitation. Unfortunately, Lung Volume Reduction Surgery (LVRS), a procedure shown to be helpful to some but not all patients, is not covered by Medicare and many insurance companies because it is considered to be an experimental procedure. Lung transplantation is a viable option, but the strict medical requirements and critical shortage of organ donors make it available to a relatively small number of patients. Pulmonary rehabilitation, universally recognized as extremely important for optimizing patients' overall physical conditioning, is not universally available to everyone in need because it is not covered by Medicare in most States.

One medicine was developed specifically for COPD a few years ago. Another "blockbuster" drug with great promise has been tested and approved in several countries outside the U.S., but has not yet been approved by the FDA. At a recent hearing at the FDA (9/02), it was determined that although this important drug was safe and shown to bring significant improvement in measures of lung function, the FDA still wanted additional testing. This ruling will cause a significant delay in the availability of this important drug to people with COPD.

We believe that the continuing rise in death and disability due to COPD in this country is distinct public health emergency. Millions of children under the age of

18 begin smoking every day. Approximately 15 percent to 20 percent of those who smoke will eventually develop severely disabling COPD, and there are growing concerns about the harmful effects of our environment on lung function.

Many patients with COPD are totally reliant on the Veterans Administration for their medical care. As an organization, EFFORTS is excited to learn that the House Committee on Veterans Affairs will be holding a hearing that will include a discussion of COPD and will support your efforts in any way that will aid the passage of H.R. 5996.

Sincerely,

EFFORTS Executive Board
Joan Esposito V.P. N.J.
Ann Lornie V.P. UK
Maggie Borger IL
Edna Fiore CO.
Jean Rommes IA.
Michael MacDonald MA. &
Linda Watson N.Y.
President

NTM Info and Research, Inc.
Coral Gables, FL.
October 1, 2010

The Honorable Cliff Stearns
2370 House Office Building
Washington, DC 20515

Dear Representative Stearns,

On behalf of NTM Info & Research (NTMir), I wish to express our appreciation for your leadership in Chronic Obstructive Pulmonary Disease (COPD) in the veterans' community and to express our support for the passage of H.R. 5996.

NTMir is the national not-for-profit organization dedicated to pulmonary nontuberculous mycobacterial (NTM) disease. COPD, or Chronic Obstructive Pulmonary Disease, is an umbrella term used to describe progressive lung diseases, encompassing emphysema, chronic bronchitis, refractory asthma, severe bronchiectasis, and NTM lung disease.

The NIH estimates that 12 million adults have COPD and another 12 million are undiagnosed or developing COPD. COPD is currently the fourth leading cause of death in the U.S. and is estimated to become the third leading cause of death by 2020. The impacts on the economy are severe, with national costs projected to be $49.9 billion in 2010, in part due to COPD's status as the second leading cause of disability.

As the foremost provider of health care services to over 8 million veterans, the Department of Veterans Affairs has a unique opportunity to become a leader in the fight against COPD. H.R. 5996 will allow the VA to take a comprehensive approach to reducing the burden of COPD through innovative prevention, education and treatment strategies. It also provides for critically needed research into best practices that will help to simultaneously reduce costs and improve quality of life.

NTMir and the COPD community care deeply about the need to address COPD in America's veteran population. A 2003 study revealed that COPD was the fourth most common diagnosis among hospitalized veterans and a strong predictor for patient readmission following a hospital stay. The VA system has been a leader in health systems research and H.R. 5996 will build on a record of using innovative methods to improve the health of the veterans it serves. We encourage your colleagues to join you in support of H.R. 5996. Congress' actions will mark a great step

toward addressing the burden that COPD places on veterans, their families and the health care delivery system.

Sincerely,

Philip Leitman
President

Respiratory Health Association of Metropolitan Chicago
Chicago, IL.
October 4, 2010

Honorable Cliff Stearns
U.S. Representative
2370 Rayburn House Office Bldg.
Washington, DC 20515

Dear Congressman Stearns,

Respiratory Health Association of Metropolitan Chicago (RHAMC) urges support of H.R. 5996 which seeks to improve the prevention, diagnosis, and treatment of veterans with COPD. The legislation directs the Veterans Administration Secretary to focus attention and resources toward addressing COPD within the population they serve.

RHAMC has been dedicated to community lung health since 1906. Our mission is to promote healthy lungs and fight lung disease through research, advocacy and education. RHAMC launched the COPD Initiative in response to the growing impact of COPD upon our communities. The goals are to increase COPD awareness, educate the public and health care community, advance COPD policies, advocate for people living with COPD.

There is a growing, active and engaged COPD patient community that is advocating for improved programming and coverage addressing COPD. The patients and caregivers in our communities seek more resources dedicated to addressing COPD.

COPD is the fourth leading cause of death in Illinois. An estimated 500,000 adults in Illinois alone suffer from COPD. Smoking is the primary cause, but exposure to lung irritants like vapors and dusts in occupational settings as well as secondhand smoke contribute to COPD. In the past 5 years, more women died of COPD than men in the United States. In Illinois, more women than men are hospitalized every year for COPD.

Veterans Administration needs to take a comprehensive approach to reducing the burden of COPD through innovative prevention, education and treatment strategies. This legislation also provides for critically needed research into best practices that will help to simultaneously reduce costs and improve quality of life.

We applaud the House Committee on Veterans' Affairs for addressing this issue and we support passage of H.R. 5996.

Sincerely,

Joel J. Africk
President and Chief Executive Officer

New York Times
September 24, 2010
Cost and Lack of Awareness Hamper Adult Vaccination Efforts
By Lesley Alderman

VACCINES are not just for children.

About 11,500 cases of whooping cough, or pertussis, have been reported nationwide so far this year. In California, where the infections are nearing a record high, nine infants have died.

It is likely that some of those children had not received all their shots, experts say. But some of those deaths might have been prevented if more adults, too, had been immunized.

Though public health authorities have long recommended that adults get a pertussis booster shot, just half have done so. Without it, they risk passing this illness to vulnerable children.

"Almost everyone understands how important it is for children to be immunized," said Dr. Melinda Wharton, deputy director of the National Center for Immunization and Respiratory Diseases at the Centers for Disease Control and Prevention, "but adults need vaccines too."

Far too few get them. The C.D.C. recommends that people 19 and older receive immunizations against as many as 14 infectious diseases. (Not all adults require every vaccine.) Yet most adults rarely think about getting the shots—until they step on a rusty nail or begin planning travel to a developing country.

Only 7 percent of Americans over age 60, for instance, have received the herpes zoster vaccine, which prevents shingles, a painful nerve infection. Just 11 percent of young women have received the vaccine against the two types of human papilloma virus that cause 70 percent of all cervical cancers.

Why are adults so behind on vaccinations? For one thing, the shots can be expensive (from $20 to $200 a dose for some, and some require three doses). But a bigger part of the problem is a lack of awareness. Doctors often fail to remind patients that they require booster shots, and consumers are not well informed about the need.

In a 2007 survey by the National Foundation for Infectious Diseases, 40 percent of respondents incorrectly stated that, if they had received vaccines as a child, they did not need them again; 18 percent said vaccines were not necessary for adults.

The new health care law should help get more adults to roll up their sleeves. Under the law, group and individual health plans, as well as Medicare, must provide preventive health services, including immunizations recommended by the C.D.C., free of charge. That means no co-payments, co-insurance or deductibles.

The hope is that since vaccines will be free, more doctors will suggest them and more patients will ask for them, said Jeffrey Levi, executive director of Trust for America's Health, a nonprofit group that works to prevent epidemics.

Here's the catch. If you are in a group or individual health plan, your plan must be new, or it must have undergone substantial changes, in order for the new requirements to apply. In addition, certain recent vaccine recommendations will not be covered right away. If you are uncertain, call your insurer.

Adult immunizations are not just an important way to prevent the spread of disease. Immunizations are also a phenomenally cost-effective way to preserve health.

"When you compare the cost of getting sick with these diseases to the cost of a vaccine, it's a modest investment," said Dr. Robert H. Hopkins, a professor of internal medicine and pediatrics at the University of Arkansas for Medical Sciences.

If you end up in the emergency room with a bad case of the flu or pneumonia, your bill could be thousands of dollars. A flu shot is just $20, or often free; the pneumonia vaccine is about $77.

Here is how to get up-to-date on your shots—whether you have a new insurance plan, an old plan or no plan at all.

THE VACCINES YOU NEED Tear out the immunization chart accompanying this article or print it out online. Note the vaccines you should be getting, based on your age and health status.

This year, for the first time, the C.D.C. recommends that everyone, regardless of age or health, get an influenza shot. Most people need only one. This year the flu shot provides protection against the H1N1 virus and two seasonal viruses.

Most other vaccines are intended for specific age groups or for those with particular risk factors. The zoster vaccine, for example, has been tested only in older people. There is little evidence that it could benefit younger people, whose immune systems are still strong.

Next, figure out which vaccines you have already received. Your doctor should be able to help. But if you have switched physicians a number of times, you may have to reconstruct your history on your own.

"When in doubt, get vaccinated," said Dr. Hopkins. "There's very little risk with getting a second dose of a vaccine."

IF YOU HAVE INSURANCE Call your primary care physician and explain that you would like to get your vaccinations updated.

Some offices do not stock vaccines, so it is wise to tell the staff in advance what you will need. You may find that certain vaccines are not available right away; your doctor can tell you where to find them, or how long the wait will be.

Next, call your insurer and ask if they will cover vaccines free of charge. If not, ask how much they charge. If the fees are high, see below for alternate options.

IF YOU LACK COVERAGE You can still pay out-of-pocket for immunizations at the doctor's office, of course. But the shots may be less expensive at other places.

YOUR HEALTH DEPARTMENT If money is tight, find out if your State or community health department provides vaccinations for adults. Unfortunately, there is no Federally funded program for adult immunizations, only for children.

The C.D.C. Web site provides an interactive map to help locate the health department or immunization clinic in your area.

YOUR LOCAL PHARMACY Many retail clinics administer vaccines, including CVS MinuteClinics and Walgreens Take Care Clinics. MinuteClinics offer 10 vaccines for adults, including shots for hepatitis A ($117) and B ($102), meningitis ($147), pneumococcal disease ($77) and DTaP, which protects you from diphtheria, tetanus and pertussis ($82).

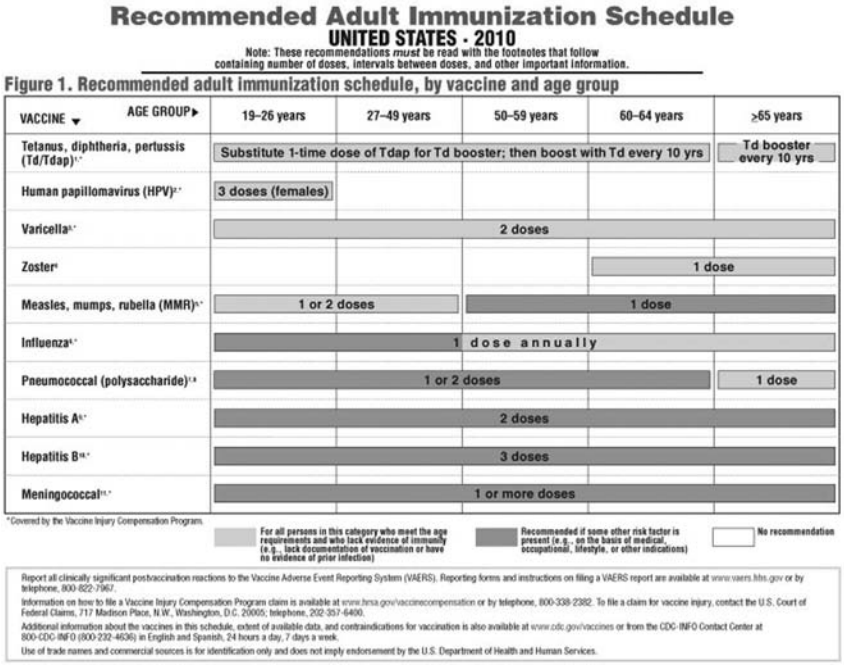
There are 500 CVS clinics across the country, and all are open seven days a week. No appointments or prescriptions are necessary. Walgreens clinics offer travel vaccines, like the one for typhoid fever, as well.

Even if your local pharmacy does not have a clinic, you may be able to get some of the shots you need there. In all States, pharmacists are licensed to give flu shots; in some States, they can administer other vaccines as well, like the one to protect against pneumonia.

Check with a local pharmacy and find out what shots they are licensed to provide and at what cost.

YOUR EMPLOYER Inquire at your company's human resources or wellness office. Some companies provide free flu shots for employees, as well as their families. Few companies provide other vaccines, but it can't hurt to ask.

Remember that when you get immunized, you are not only ensuring your own good health but the health of those around you.



Recommended Adult Immunization Schedule
UNITED STATES · 2010
Note: These recommendations *must* be read with the footnotes that follow containing number of doses, intervals between doses, and other important information.

Figure 1. Recommended adult immunization schedule, by vaccine and age group

VACCINE ▼ / AGE GROUP ▶	19–26 years	27–49 years	50–59 years	60–64 years	≥65 years
Tetanus, diphtheria, pertussis (Td/Tdap)[1,*]	Substitute 1-time dose of Tdap for Td booster; then boost with Td every 10 yrs				Td booster every 10 yrs
Human papillomavirus (HPV)[2,*]	3 doses (females)				
Varicella[3,*]	2 doses				
Zoster[4]				1 dose	
Measles, mumps, rubella (MMR)[5,*]	1 or 2 doses		1 dose		
Influenza[6,*]	1 dose annually				
Pneumococcal (polysaccharide)[7,8]	1 or 2 doses				1 dose
Hepatitis A[9,*]	2 doses				
Hepatitis B[10,*]	3 doses				
Meningococcal[11,*]	1 or more doses				

*Covered by the Vaccine Injury Compensation Program.

For all persons in this category who meet the age requirements and who lack evidence of immunity (e.g., lack documentation of vaccination or have no evidence of prior infection)

Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indications)

No recommendation

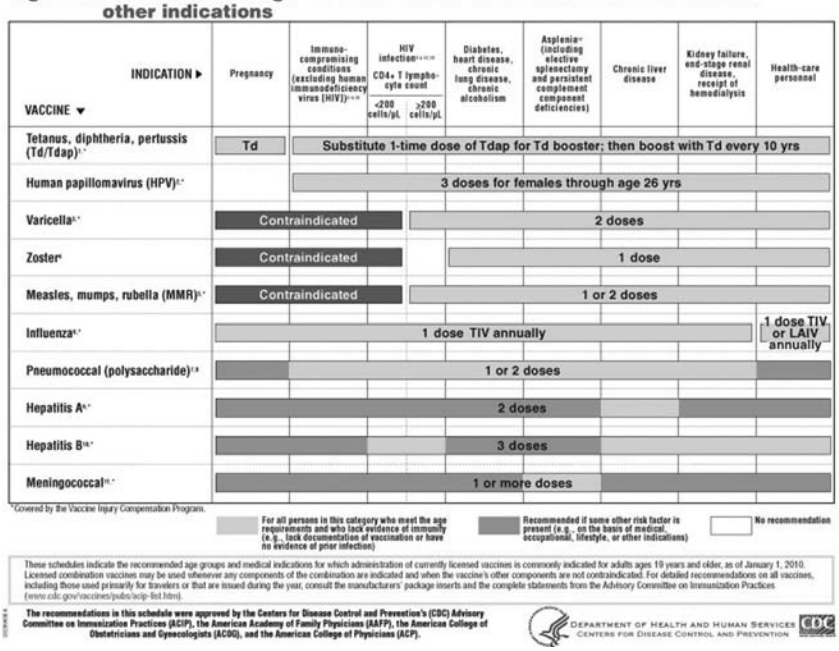
Report all clinically significant postvaccination reactions to the Vaccine Adverse Event Reporting System (VAERS). Reporting forms and instructions on filing a VAERS report are available at www.vaers.hhs.gov or by telephone, 800-822-7967.

Information on how to file a Vaccine Injury Compensation Program claim is available at www.hrsa.gov/vaccinecompensation or by telephone, 800-338-2382. To file a claim for vaccine injury, contact the U.S. Court of Federal Claims, 717 Madison Place, N.W., Washington, D.C. 20005; telephone, 202-357-6400.

Additional information about the vaccines in this schedule, extent of available data, and contraindications for vaccination is also available at www.cdc.gov/vaccines or from the CDC-INFO Contact Center at 800-CDC-INFO (800-232-4636) in English and Spanish, 24 hours a day, 7 days a week.

Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

Figure 2. Vaccines that might be indicated for adults based on medical and other indications



Footnotes
Recommended Adult Immunization Schedule—UNITED STATES 2010
For complete statements by the Advisory Committee on Immunization Practices (ACIP), visit www.cdc.gov/vaccines/pubs/ACIP-list.htm.

1. Tetanus, diphtheria, and acellular pertussis (Td/Tdap) vaccination

Tdap should replace a single dose of Td for adults aged 19 through 64 years who have not received a dose of Tdap previously.

Adults with uncertain or incomplete history of primary vaccination series with tetanus and diphtheria toxoid-containing vaccines should begin or complete a primary vaccination series. A primary series for adults is 3 doses of tetanus and diphtheria toxoid-containing vaccines; administer the first 2 doses at least 4 weeks apart and the third dose 6–12 months after the second; Tdap can substitute for any one of the doses of Td in the 3-dose primary series. The booster dose of tetanus and diphtheria toxoid-containing vaccine should be administered to adults who have completed a primary series and if the last vaccination was received ≧10 years previously. Tdap or Td vaccine may be used, as indicated.

If a woman is pregnant and received the last Td vaccination ≧10 years previously, administer Td during the second or third trimester. If the woman received the last Td vaccination <10 years previously, administer Tdap during the immediate postpartum period. A dose of Tdap is recommended for postpartum women, close contacts of infants aged <12 months, and all health-care personnel with direct patient contact if they have not previously received Tdap. An interval as short as 2 years from the last Td is suggested; shorter intervals can be used. Td may be deferred during pregnancy and Tdap substituted in the immediate postpartum period, or Tdap can be administered instead of Td to a pregnant woman.

Consult the ACIP statement for recommendations for giving Td as prophylaxis in wound management.

2. Human papillomavirus (HPV) vaccination

HPV vaccination is recommended at age 11 or 12 years with catch-up vaccination at ages 13 through 26 years.

Ideally, vaccine should be administered before potential exposure to HPV through sexual activity; however, females who are sexually active should still be vaccinated consistent with age-based recommendations. Sexually active females who have not

been infected with any of the four HPV vaccine types (types 6, 11, 16, 18, all of which HPV4 prevents) or any of the two HPV vaccine types (types 16 and 18, both of which HPV2 prevents) receive the full benefit of the vaccination. Vaccination is less beneficial for females who have already been infected with one or more of the HPV vaccine types. HPV4 or HPV2 can be administered to persons with a history of genital warts, abnormal Papanicolaou test, or positive HPV DNA test, because these conditions are not evidence of prior infection with all vaccine HPV types.

HPV4 may be administered to males aged 9 through 26 years to reduce their likelihood of acquiring genital warts. HPV4 would be most effective when administered before exposure to HPV through sexual contact.

A complete series for either HPV4 or HPV2 consists of 3 doses. The second dose should be administered 1–2 months after the first dose; the third dose should be administered 6 months after the first dose.

Although HPV vaccination is not specifically recommended for persons with the medical indications described in Figure 2, "Vaccines that might be indicated for adults based on medical and other indications," it may be administered to these persons because the HPV vaccine is not a live-virus vaccine. However, the immune response and vaccine efficacy might be less for persons with the medical indications described in Figure 2 than in persons who do not have the medical indications described or who are immunocompetent. Health-care personnel are not at increased risk because of occupational exposure, and should be vaccinated consistent with age-based recommendations.

3. Varicella vaccination

All adults without evidence of immunity to varicella should receive 2 doses of single-antigen varicella vaccine if not previously vaccinated or the second dose if they have received only 1 dose, unless they have a medical contraindication. Special consideration should be given to those who (1) have close contact with persons at high risk for severe disease (e.g., health-care personnel and family contacts of persons with immunocompromising conditions) or (2) are at high risk for exposure or transmission (e.g., teachers; child-care employees; residents and staff members of institutional settings, including correctional institutions; college students; military personnel; adolescents and adults living in households with children; nonpregnant women of childbearing age; and international travelers).

Evidence of immunity to varicella in adults includes any of the following: (1) documentation of 2 doses of varicella vaccine at least 4 weeks apart; (2) U.S.-born before 1980 (although for health-care personnel and pregnant women, birth before 1980 should not be considered evidence of immunity); (3) history of varicella based on diagnosis or verification of varicella by a health-care provider (for a patient reporting a history of or presenting with an atypical case, a mild case, or both, health-care providers should seek either an epidemiologic link with a typical varicella case or to a laboratory-confirmed case or evidence of laboratory confirmation, if it was performed at the time of acute disease); (4) history of herpes zoster based on diagnosis or verification of herpes zoster by a health-care provider; or (5) laboratory evidence of immunity or laboratory confirmation of disease.

Pregnant women should be assessed for evidence of varicella immunity. Women who do not have evidence of immunity should receive the first dose of varicella vaccine upon completion or termination of pregnancy and before discharge from the health-care facility. The second dose should be administered 4–8 weeks after the first dose.

4. Herpes zoster vaccination

A single dose of zoster vaccine is recommended for adults aged ≧60 years regardless of whether they report a prior episode of herpes zoster. Persons with chronic medical conditions may be vaccinated unless their condition constitutes a contraindication.

5. Measles, mumps, rubella (MMR) vaccination

Adults born before 1957 generally are considered immune to measles and mumps.

Measles component: Adults born during or after 1957 should receive 1 or more doses of MMR vaccine unless they have (1) a medical contraindication; (2) documentation of vaccination with 1 or more doses of MMR vaccine; (3) laboratory evidence of immunity; or (4) documentation of physician-diagnosed measles.

A second dose of MMR vaccine, administered 4 weeks after the first dose, is recommended for adults who (1) have been recently exposed to measles or are in an outbreak setting; (2) have been vaccinated previously with killed measles vaccine; (3) have been vaccinated with an unknown type of measles vaccine during 1963–1967; (4) are students in postsecondary educational institutions; (5) work in a health-care facility; or (6) plan to travel internationally.

Mumps component: Adults born during or after 1957 should receive 1 dose of MMR vaccine unless they have (1) a medical contraindication; (2) documentation of

vaccination with 1 or more doses of MMR vaccine; (3) laboratory evidence of immunity; or (4) documentation of physician-diagnosed mumps.

A second dose of MMR vaccine, administered 4 weeks after the first dose, is recommended for adults who (1) live in a community experiencing a mumps outbreak and are in an affected age group; (2) are students in postsecondary educational institutions; (3) work in a health-care facility; or (4) plan to travel internationally.

Rubella component: 1 dose of MMR vaccine is recommended for women who do not have documentation of rubella vaccination, or who lack laboratory evidence of immunity. For women of childbearing age, regardless of birth year, rubella immunity should be determined and women should be counseled regarding congenital rubella syndrome. Women who do not have evidence of immunity should receive MMR vaccine upon completion or termination of pregnancy and before discharge from the health-care facility.

Health-care personnel born before 1957: For unvaccinated health-care personnel born before 1957 who lack laboratory evidence of measles, mumps, and/or rubella immunity or laboratory confirmation of disease, health-care facilities should consider vaccinating personnel with 2 doses of MMR vaccine at the appropriate interval (for measles and mumps) and 1 dose of MMR vaccine (for rubella), respectively.

During outbreaks, health-care facilities should recommend that unvaccinated health-care personnel born before 1957, who lack laboratory evidence of measles, mumps, and/or rubella immunity or laboratory confirmation of disease, receive 2 doses of MMR vaccine during an outbreak of measles or mumps, and 1 dose during an outbreak of rubella.

Complete information about evidence of immunity is available at www.cdc.gov/vaccines/recs/provisional/default.htm.

6. Seasonal Influenza vaccination

Vaccinate all persons aged ≧50 years and any younger persons who would like to decrease their risk of getting influenza. Vaccinate persons aged 19 through 49 years with any of the following indications.

Medical: Chronic disorders of the cardiovascular or pulmonary systems, including asthma; chronic metabolic diseases, including diabetes mellitus; renal or hepatic dysfunction, hemoglobinopathies, or immunocompromising conditions (including immunocompromising conditions caused by medications or HIV); cognitive, neurologic or neuromuscular disorders; and pregnancy during the influenza season. No data exist on the risk for severe or complicated influenza disease among persons with asplenia; however, influenza is a risk factor for secondary bacterial infections that can cause severe disease among persons with asplenia.

Occupational: All health-care personnel, including those employed by long-term care and assisted-living facilities, and caregivers of children aged <5 years.

Other: Residents of nursing homes and other long-term care and assisted-living facilities; persons likely to transmit influenza to persons at high risk (e.g., in-home household contacts and caregivers of children aged <5 years, persons aged ≧50 years, and persons of all ages with high-risk conditions).

Healthy, nonpregnant adults aged <50 years without high-risk medical conditions who are not contacts of severely immunocompromised persons in special-care units may receive either intranasally administered live, attenuated influenza vaccine (FluMist) or inactivated vaccine. Other persons should receive the inactivated vaccine.

7. Pneumococcal polysaccharide (PPSV) vaccination

Vaccinate all persons with the following indications.

Medical: Chronic lung disease (including asthma); chronic cardiovascular diseases; diabetes mellitus; chronic liver diseases, cirrhosis; chronic alcoholism; functional or anatomic asplenia (e.g., sickle cell disease or splenectomy [if elective splenectomy is planned, vaccinate at least 2 weeks before surgery]); immunocompromising conditions including chronic renal failure or nephrotic syndrome; and cochlear implants and cerebrospinal fluid leaks. Vaccinate as close to HIV diagnosis as possible.

Other: Residents of nursing homes or long-term care facilities and persons who smoke cigarettes. Routine use of PPSV is not recommended for American Indians/Alaska Natives or persons aged <65 years unless they have underlying medical conditions that are PPSV indications. However, public health authorities may consider recommending PPSV for American Indians/Alaska Natives and persons aged 50 through 64 years who are living in areas where the risk for invasive pneumococcal disease is increased.

8. Revaccination with PPSV

One-time revaccination after 5 years is recommended for persons with chronic renal failure or nephrotic syndrome; functional or anatomic asplenia (e.g., sickle cell disease or splenectomy); and for persons with immunocompromising conditions. For persons aged ≧65 years, one-time revaccination is recommended if they were vac-

cinated ≧5 years previously and were younger than aged <65 years at the time of primary vaccination.

9. Hepatitis A vaccination

Vaccinate persons with any of the following indications and any person seeking protection from hepatitis A virus (HAV) infection.

Behavioral: Men who have sex with men and persons who use injection drugs.

Occupational: Persons working with HAV-infected primates or with HAV in a research laboratory setting.

Medical: Persons with chronic liver disease and persons who receive clotting factor concentrates.

Other: Persons traveling to or working in countries that have high or intermediate endemicity of hepatitis A (a list of countries is available at wwwn.cdc.gov/travel/contentdiseases.aspx).

Unvaccinated persons who anticipate close personal contact (e.g., household contact or regular babysitting) with an international adoptee from a country of high or intermediate endemicity during the first 60 days after arrival of the adoptee in the United States should consider vaccination. The first dose of the 2-dose hepatitis A vaccine series should be administered as soon as adoption is planned, ideally ≧2 weeks before the arrival of the adoptee.

Single-antigen vaccine formulations should be administered in a 2-dose schedule at either 0 and 6–12 months (Havrix), or 0 and 6–18 months (Vaqta). If the combined hepatitis A and hepatitis B vaccine (Twinrix) is used, administer 3 doses at 0, 1, and 6 months; alternatively, a 4-dose schedule, administered on days 0, 7, and 21–30 followed by a booster dose at month 12 may be used.

10. Hepatitis B vaccination

Vaccinate persons with any of the following indications and any person seeking protection from hepatitis B virus (HBV) infection.

Behavioral: Sexually active persons who are not in a long-term, mutually monogamous relationship (e.g., persons with more than one sex partner during the previous 6 months); persons seeking evaluation or treatment for a sexually transmitted disease (STD); current or recent injection-drug users; and men who have sex with men.

Occupational: Health-care personnel and public-safety workers who are exposed to blood or other potentially infectious body fluids.

Medical: Persons with end-stage renal disease, including patients receiving hemodialysis; persons with HIV infection; and persons with chronic liver disease.

Other: Household contacts and sex partners of persons with chronic HBV infection; clients and staff members of institutions for persons with developmental disabilities; and international travelers to countries with high or intermediate prevalence of chronic HBV infection (a list of countries is available at www.cdc.gov/travel/contentdiseases.aspx).

Hepatitis B vaccination is recommended for all adults in the following settings: STD treatment facilities; HIV testing and treatment facilities; facilities providing drug-abuse treatment and prevention services; health-care settings targeting services to injection-drug users or men who have sex with men; correctional facilities; end-stage renal disease programs and facilities for chronic hemodialysis patients; and institutions and nonresidential daycare facilities for persons with developmental disabilities.

Administer or complete a 3-dose series of HepB to those persons not previously vaccinated. The second dose should be administered 1 month after the first dose; the third dose should be administered at least 2 months after the second dose (and at least 4 months after the first dose). If the combined hepatitis A and hepatitis B vaccine (Twinrix) is used, administer 3 doses at 0, 1, and 6 months; alternatively, a 4-dose schedule, administered on days 0, 7, and 21–30 followed by a booster dose at month 12 may be used.

Adult patients receiving hemodialysis or with other immunocompromising conditions should receive 1 dose of 40 μg/mL (Recombivax HB) administered on a 3-dose schedule or 2 doses of 20 μg/mL (Engerix-B) administered simultaneously on a 4-dose schedule at 0, 1, 2 and 6 months.

11. Meningococcal vaccination

Meningococcal vaccine should be administered to persons with the following indications.

Medical: Adults with anatomic or functional asplenia, or persistent complement component deficiencies.

Other: First-year college students living in dormitories; microbiologists routinely exposed to isolates of *Neisseria meningitidis;* military recruits; and persons who travel to or live in countries in which meningococcal disease is hyperendemic or epidemic (e.g., the "meningitis belt" of sub-Saharan Africa during the dry season [De-

cember through June]), particularly if their contact with local populations will be prolonged. Vaccination is required by the government of Saudi Arabia for all travelers to Mecca during the annual Hajj.

Meningococcal conjugate vaccine (MCV4) is preferred for adults with any of the preceding indications who are aged ≤55 years; meningococcal polysaccharide vaccine (MPSV4) is preferred for adults aged ≥56 years. Revaccination with MCV4 after 5 years is recommended for adults previously vaccinated with MCV4 or MPSV4 who remain at increased risk for infection (e.g., adults with anatomic or functional asplenia). Persons whose only risk factor is living in on-campus housing are not recommended to receive an additional dose.

12. Selected conditions for which *Haemophilus influenzae* type b (Hib) vaccine may be used

Hib vaccine generally is not recommended for persons aged ≥5 years. No efficacy data are available on which to base a recommendation concerning use of Hib vaccine for older children and adults. However, studies suggest good immunogenicity in patients who have sickle cell disease, leukemia, or HIV infection or who have had a splenectomy. Administering 1 dose of Hib vaccine to these high-risk persons who have not previously received Hib vaccine is not contraindicated.

13. Immunocompromising conditions

Inactivated vaccines generally are acceptable (e.g., pneumococcal, meningococcal, influenza [inactivated influenza vaccine]) and live vaccines generally are avoided in persons with immune deficiencies or immunocompromising conditions. Information on specific conditions is available at www.cdc.gov/vaccines/pubs/acip-list.htm.

Prepared Statement of Jacob B. Gadd, Deputy Director, Veterans Affairs and Rehabilitation Commission, American Legion

Mr. Chairman and Members of the Committee:

Thank you for this opportunity for The American Legion to present our views on today's pending legislation.

H.R. 3843—"Transparency for America's Heroes Act"

This bill would direct the Secretary of Veterans Affairs to place medical quality-assurance records on the Department of Veterans Affairs (VA) Web site.

The American Legion has no position on this legislation.

H.R. 4041—To Authorize Certain Improvements in the Federal Recovery Coordinator Program

The purpose of this bill is to improve upon the Federal Recovery Coordinator (FRC) program by having VA establish recovery coordinator training at a qualified nursing or medical school selected by the Secretary of VA. The qualified nursing or medical school will lead a literature review and development of evidence-based guidelines for recovery coordination, development of training modules for care coordination and software that is compatible with VA systems for recovery coordination. It will also lead a consensus conference on evidence-based care coordination. Additionally, this bill authorizes the qualified nursing or medical school to train 45 recovery coordinators over the course of 3 years.

In 2007, The American Legion approved Resolution 29, Improvements to Implement a Seamless Transition, which fully supported legislation to designate a single Recovery Coordinator to ensure an efficient rehabilitation and transition from military to civilian life and eliminate delays and gaps in treatment and services. By the provisions of the National Defense Authorization Act, Public Law 110–181, the FRC program began in 2008. The program was designed to create individualized care coordination plans for severely injured servicemembers in order to ensure a warm handoff for severely wounded servicemembers transitioning between DoD and VA as well as coordinate state and local resources. With close to two million servicemembers having deployed in Operations Iraqi Freedom (OIF), Enduring Freedom (OEF) and New Dawn, VA only reported to date that less than 1,000 servicemembers have been assisted. The American Legion recommends 1) expanding the program areas of the FRC program to include program eligibility, 2) increasing FRC staff to one individual coordinator per state and 3) improved communication at the national, state and local levels.

The American Legion believes that coordination of care, especially for those who are severely wounded, is essential to ensure they receive the education and benefits they need and deserve. However, The American Legion believes efforts to improve care coordination must be directed at not only the severely wounded but any veteran transitioning to ensure they do not fall through the cracks. Currently, only

those servicemembers diagnosed with Traumatic Brain Injury (TBI), Post Traumatic Stress (PTS), visual impairment, amputation, burns or spinal cord injury are eligible for assistance through the program. The American Legion supports expansion of FRC program eligibility for any veteran transitioning from active duty, guard or reserve for any illness or injury.

VA reported in 2010 that five new FRCs are in the process of being hired, which will bring the total number of full-time FRC staff to 25 across the country. These FRCs are stationed at: Walter Reed Army Medical Center; National Naval Medical Center; Brooke Army Medical Center; Balboa Naval Medical Center; San Diego Naval Medical Center; Camp Pendleton, CA; Eisenhower Army Medical Center, GA; Michael E. DeBakey VA Medical Center, TX; Richmond VA Medical Center; and, Palo Alto VA Medical Center. The American Legion recommends having a FRC within each state to ensure all active duty, reserve and guard units receive the same education, outreach and benefits assistance.

The American Legion's flagship transition program, Heroes to Hometowns, seeks to coordinate national, State and local resources similar to the FRC program. The Heroes to Hometowns program assists veterans with filing VA claims or benefits, applying for Temporary Financial Assistance (TFA) as well as coordinating education or employment opportunities before the servicemember returns to his or her community. Even though FRC helped in the creation of the National Community Resource Directory, The American Legion recommends enhanced communication between national, state and local levels to ensure maximum awareness of benefits available. Many times, The American Legion has had difficulty contacting the FRCs through phone, email or mailing address. In addition, the program should increase its outreach through use of a dedicated Web page to update current contact information.

In regards to the development of a computerized tracking program, The American Legion applauds the new application created by VA in 2009, the Care Management and Tracking and Reporting Application (CMTRA). This tracking tool allows VA to coordinate care amongst a wide variety of providers such as the OEF/OIF care management team and specialty care providers to establish an individualized care plan for each veteran. The American Legion recommends consolidation and expansion of a single tracking tool between DoD, VA and the private sector to prevent redundancy or any veterans that may fall through the cracks.

H.R. 5428—To Direct the Secretary of Veterans Affairs to Educate Certain Staff of the Department of Veterans Affairs and to Inform Veterans about the Injured and Amputee Veterans Bill of Rights

This bill seeks to ensure print materials are created about the Injured and Amputee Veterans Bill of Rights and posted in VA prosthetics and orthotics clinics so that veterans are aware of their rights. In addition, staff of these clinics would be required to receive training on these patient rights and the Secretary would be responsible for providing outreach through Web sites or veteran service organizations.

Many veterans of Iraq and Afghanistan have been subjected to Improvised Explosive Devices (IEDs) which have resulted in a significant increase in the number of amputations from previous conflicts. DoD reported in 2010 that there have been a total of 1,552 servicemembers that suffered amputations. Promoting information about veterans' rights in the clinics as well as increases through targeted outreach will help VA improve their business processes and encourage veterans to receive their treatment at VA.

The American Legion continues to advocate for advancement in VA's outreach practices and stands ready to assist VA in promoting benefits and services.

The American Legion fully supports this legislation.

H.R. 5516—"Access to Appropriate Immunizations for Veterans Act of 2010"

The purpose of this bill is to ensure quality and timely scheduling of patient immunizations by VA. Specifically, this bill will "create quality measures and statistical metrics as well as an annual report to ensure VA is meeting its obligations in providing immunizations."

One of the provisions of this bill requires VA to keep metrics and measures in place to track influenza and pneumococcal vaccinations. The Veterans Health Administration (VHA) issued a VHA Directive on November 12, 2009 that stated, "Influenza vaccination rates of veteran patients are monitored in the VHA performance measurement system, under the 'seasonal outpatient influenza measure.'" The directive also mandates vaccination and documentation of the influenza immunization by all patients, staff and volunteers within VA Medical Centers. However, an overall performance measure for all immunizations provided by the Department of Veterans Affairs is not monitored by VA Central Office. In VA's FY 2009 Performance and

Accountability Report, two evaluation metrics–Clinical Practice Guidelines (CPGI) and Prevention Index (PI) are utilized to track VA's progress for this initiative. The results from Strategic Goal Three, "Prevention Index IV" reported an 89 percent goal attained by VA in "promoting healthy lifestyle changes with early identification of disease, immunizations and prevention screenings."

While The American Legion does not have a specific resolution supporting patient immunizations quality and scheduling, The American Legion supports quality and performance measures designed to enhance veterans' safety and quality of care.

H.R. 5543—To Repeal the Prohibition on Collective Bargaining with Respect to Matters and Questions Regarding Compensation of Employees of the Department of Veterans Affairs other than Rates of Basic Pay

This bill seeks to revoke the collective bargaining rules on open disclosure of compensation of VA employees, with the exception of employee's basic pay fee structure. It is the policy of The American Legion not to be involved with VA's management and employee relations.

The American Legion does not have a specific position on this piece of legislation.

H.R. 5641—To Authorize the Secretary of Veterans Affairs to Enter Into Contracts for the Transfer of Veterans to Non-Department Adult Foster Homes for Veterans Who Are Unable to Live Independently

VA is authorized under Title 38, Code of Federal Regulations (CFR) Section 17.38 (a)(1)(ix)) to provide a comprehensive array of medically necessary in-home services to enrolled veterans. This bill seeks to add a provision in title 38, United States Code (U.S.C.), Section 1720 that VA would be authorized to transfer veterans needing long-term care services to "Foster Homes," upon the request of the veteran or Secretary of Veterans Affairs.

VA issued VHA Handbook 1141.02, Medical Foster Home Procedures, in November 2009, which outlined the Department's policy on definition, responsibilities, selection, training, quality monitoring and financial arrangements for this program.

VA defines a Medical Foster Home (MFH) in VHA Handbook 1141.02 as: (1) MFH is an adult foster home combined with a VA interdisciplinary home care team, such as VA Home Based Primary Care (HBPC) or Spinal Cord Injury—Home Care (SCI–HC), to provide non-institutional long-term care for veterans who are unable to live independently and prefer a family setting. (2) MFH is a form of Community Residential Care (CRC) for the more medically complex and disabled veterans, and is generally distinguished from other CRC homes by the following: (a) the home is owned or rented by the MFH caregiver; (b) the MFH caregiver lives in the MFH and provides personal care and supervision, (c) There are not more than three residents receiving care in the MFH, including both veterans and non-veterans, (d) veteran MFH residents are enrolled in a VA HBPC or SCI–HC Program. Each VA Medical Center facility appoints a MFH Coordinator which oversees the recruitment of staff, new applications for MFH in the community, training, quality assurance and inspections, and maintaining files of patients and MFH caregivers.

While this program has been highlighted and encouraged because of the additional cost savings and access to care options for the veteran and VA, The American Legion seeks additional feedback from users of this MFH program about the level of patient safety and feedback on their quality of care that would be provided in a non-traditional care setting.

The American Legion does not have an official position at this time.

H.R. 5996—To Direct the Secretary of Veterans Affairs to Improve the Prevention, Diagnosis, and Treatment of Veterans with Chronic Obstructive Pulmonary Disease

The purpose of this bill is to improve patient care and treatment for Chronic Obstructive Pulmonary Disease (COPD) by: "(1) developing treatment protocols and tools for the prevention, diagnosis, treatment and management, (2) improving biomedical and prosthetic research, (3) entering into a pilot program with VA, Centers for Disease Control and Prevention (CDC), Indian Health Service, Health Resources and Services Agency to develop best practices in treatment of COPD and (4) VA and CDC research unique needs and develop smoking cessation tools and techniques."

The American Legion concurs with this piece of legislation to improve upon current knowledge, research and treatment of COPD.

H.R. 6123—To Amend Title 38, United States Code, to Improve the Provision of Rehabilitative Services for Veterans with Traumatic Brain Injury, and for other purposes

The purpose of this bill is to improve rehabilitation services for veterans suffering from traumatic brain injury (TBI). Because of ambiguities in current law, TBI treat-

ment at VA narrowly focuses TBI care on physical restoration. This legislation would clarify the definition of rehabilitation so veterans will receive care that adequately addresses their physical and mental health needs, as well as quality of life and prospects for long-term recovery and success.

The American Legion supports this bill as it seeks to provide comprehensive care instead of just physical rehabilitation for veterans suffering from TBI. The American Legion is very supportive of ensuring that the quality of life of our wounded servicemembers is addressed with as much fervor as the simple, physical aftereffects.

H.R. 6127—To Amend Title 38, United States Code, to Provide for the Continued Provision of Health Care Services to Certain Veterans Who Were Exposed to Sodium Dichromate While Serving as a Member of the Armed Forces At or Near the Water Injection Plant at Qarmat Ali, Iraq, During Operation Iraqi Freedom

During the spring and summer of 2003, about 800 servicemembers guarded a water injection facility in the Basrah oil fields at Qarmat Ali, Iraq. Servicemembers included National Guard, Reserve, and Active Duty Soldiers. This facility was contaminated with sodium dichromate dust, which is a source of hexavalent chromium, a chemical that is known to cause cancer. Health problems associated with such exposure include respiratory issues, skin lesions, burns, increased rates of lung cancer, and other ear, nose, throat, and skin disorders.

Some of the Qarmat Ali veterans who separated from service following their deployment in 2003 may no longer be eligible to enroll in VA health care under the 5-year open enrollment period Congress established for non-service connected veterans. As a result, they must first file a claim and seek a service-connected disability rating before enrolling in the VA health care system and gaining access to the comprehensive medical care VA provides.

H.R. 6127 would correct this unintended gap in services by extending the enrollment eligibility period for Qarmat Ali veterans by 5 years from the date of notification. This would allow them to immediately begin receiving services at VA medical facilities for any and all of their health care needs.

In 2010, the American Legion approved Resolution 12: *The American Legion Policy on Hazardous Environmental Exposures.* The resolution supports legislative and administrative actions by Congress and VA to properly study the long-term effects of all environmental exposures and ensure that veterans are properly cared for and compensated for diseases and other disabilities scientifically associated with a particular exposure. Included within the scope of this resolution are environmental exposures such as Agent Orange, Gulf-War related hazards, ionizing radiation, Project Shipboard Hazard and Defense (SHAD), ground water contamination at Camp Lejuene, multiple contaminants at Fort Drum, NY, Fort Dugway, UT and Fort McClellan, AL and overseas concerns related to sodium dichromate, toxic exposures at the Naval Air Facility in Atsugi, Japan and burn pits in Balad, Iraq and other locations which have all caused a variety of health problems.

While the American Legion supports H.R. 6127 as far as it goes, we would additionally recommend a comprehensive environmental exposures bill that would provide for the conduct of full studies to determine the health consequences of exposure to suspected environmental hazards so that veterans can receive the proper care and compensation due them as a result of their service to our Nation.

Draft Legislation to Amend Title 38, USC, to Make Certain Improvements in Programs for Homeless Veterans Administered by the Secretary of Veterans Affairs, and for Other Purposes

This bill seeks to expand the VA grant program for homeless veterans with special needs, which includes those seriously mentally ill, frail and elderly, terminally ill and homeless women veterans. This bill would also change reimbursement policy from a per diem rate to annual cost of furnishing services. This emphasis on these special subgroups and the reimbursement change would provide needed attention and resources that will enable Homeless Service Care Providers to assist these homeless veterans with needed care and services. For example, the number of homeless woman veterans has doubled in the past decade, up from 3 percent to 5 percent according to VA. This increase of women veterans is due to their exposure to combat related situations.

With the continuance of the wars in Iraq and Afghanistan, it is widely known that psychological stress, such as post-traumatic stress, TBI and other mental illnesses play a significant role in pushing a certain population of veterans into homelessness. Funding, along with grants that go to homeless veterans programs and organizations that assist this vulnerable demographic, are desperately needed. The American Legion understands that homeless veterans need a sustained coordinated effort

that provides secure housing and nutritious meals; essential physical health care, substance abuse aftercare and mental health counseling; as well as personal development and empowerment. If enacted, this grant program will provide necessary medical and rehabilitative services to homeless veterans with special needs that will allow them to readjust and live a better quality of life.

The American Legion supports improvements to VA's homeless programs but encourages Congress and VA to address the growing concern with homeless women veterans, especially those with children.

Draft Legislation to Amend Title 38, United States Code, to Ensure That the Secretary of Veterans Affairs Provides Veterans With Information Concerning Service-Connected Disabilities at Health Care Facilities

The purpose of this draft legislation is to ensure that the VA's Veterans Health Administration (VHA) provides veterans accessing their health care benefits with information or assistance in obtaining their claims and ratings benefits from the Veteran Benefit Administration (VBA). To accomplish this objective, this draft legislation suggests listing VBA claims information and benefits in various locations in VA Medical Centers, that VHA staff in the hospital discuss VBA benefits with each of their enrolled patients and provide contact information to help the veteran initiate their VBA claims and benefits.

Several American Legion Department (State) Service Officers have identified that VHA providers are not assisting veterans with questions the provider interprets as "claims-related." Additionally, there is a lack of awareness on the part of VHA providers that Veteran Service Organizations (VSO) are available for referral to assist veterans with the VA claims process. In a specific case, there was a lack of required training on veteran-specific health issues and potential benefits claims with Cold Injury Residuals, Agent Orange and other presumptive conditions. Also, Vietnam veterans diagnosed and treated for prostate cancer by a VA urologist were not advised to file a claim and missed an opportunity for 100 percent service connection as a result.

The American Legion is working with VA Central Office to understand the reasons for this disconnect between VHA and VBA and we intend to recommend a Fast Letter or new VHA directive be sent to the field to clarify VA's policy on treating physicians providing the necessary medical evidence on the veteran's behalf as the VA provider can act as an advocate in the claims process.

The American Legion supports this draft legislation and recommends each VA Medical Center Facility have a VHA/VBA training liaison position to facilitate biannual training and updates on VBA regulations for VHA providers so that these providers will inform veterans of their earned benefits and rights to file a claim for VBA compensation and pension.

Draft Legislation to Amend Title 38, United States Code, to Make Certain Improvements in Laws Relating to Health Care for Veterans, and for Other Purposes

This draft legislation seeks to make improvements to several health care matters. First, the legislation would allow VA's Under Secretary for Health to provide assistance in organizing and hosting the Association of Military Surgeons in the United States annual meeting. The American Legion does not have an official position or affiliation with this group but generally supports advances and benchmarking between DoD, VA and other Federal agencies in terms of research, provider training and education.

Secondly, the draft legislation recommends clarification to VA's regulations on contracting with Non-Department Facilities and that the Secretary of Veterans Affairs "provide individual authorization or act in such other manner as the Secretary determines appropriate." The American Legion has two positions on this section. First, The American Legion's Resolution 172: *GI Bill of Health,* adopted at the 2010 Convention states that veterans be authorized to utilize any appropriate government health care facility in order to reduce travel time, travel expense and undue stress on the veteran and/or their caregiver. Secondly, VA is authorized to contract or fee-base care into the community. The American Legion's System Worth Saving Task Force noted that in each of the 32 VA Medical Facilities visited this year, the facility Purchased Care budget continues to increase. In the last 4 years, VA's Purchased Care costs have doubled. The American Legion attributes this increase to the lack of specialty providers and access to care in rural communities. The American Legion believes that any veteran should be able to receive quality care close to their home but that VA must hire the needed specialty providers and increase access to prevent the rising costs of Purchased Care in the community.

Thirdly, the draft legislation would extend the life of the VA Advisory Committee on Homeless Veterans beyond its present termination date of December 30, 2011 to December 30, 2014. The American Legion supports this extension.

Fourth, this legislation seeks to amend the participating provider agreement to improve on collection of third-party reimbursements. Under the terms of the 1997 Balanced Budget Act, VHA was given the authority to bill, collect, and retain third-party reimbursements for outpatient medications, nursing home and hospital care. The American Legion supports improvements in VA's ability to recover third-party reimbursements for treatment of non-service medication conditions and supports the intent of this section.

Fifth, the draft legislation addresses a VA employment requirement for participants in the health professionals' educational assistance program. The American Legion does not have a resolution or comments on this provision of the legislation.

Six, the legislation recommended "on-call" pay for VHA employees in IT fields. In addition, the seventh recommendation from the draft legislation proposes that VA not be authorized to pay for more than 1,000 physicians and dentists employees within IT fields. The legislation stipulates that providers must have qualifying board certification and training and that their pay be tied to VA's pay schedules. It is the policy of The American Legion not to be involved with VA's management and employee relations and therefore does not have a position on these provisions.

The eighth section of the draft legislative seeks to extend VA's Joint Incentives Program from September 30, 2015 to September 30, 2020. The joint incentives program was designed to allow both DoD and VA Executive Committees to maintain a joint account to promote coordination, sharing and funding of programs between both agencies. The American Legion does not have a specific resolution but supports the general intent of this program and its extension.

The last provision of this draft legislation recommends creation of Franchise Fund to refund veterans whose third-party insurances were billed incorrectly. While there may be a delay in VA recouping third-party insurance payments, this Franchise Fund would allow VA to promptly fund the veterans' third party account until the veterans' third-party insurance company fixes the mistake. The American Legion supports this provision.

As always, the American Legion thanks this Committee for the opportunity to testify and represent the positions of the over 2.4 million veteran members of this organization.

Prepared Statement of Carl Blake, National Legislative Director, Paralyzed Veterans of America

Chairman Michaud and Members of the Subcommittee, on behalf of Paralyzed Veterans of America (PVA), I would like to thank you for the opportunity to present PVA's views on legislation pending before the Subcommittee. PVA appreciates the efforts of the Subcommittee to support the Department of Veterans Affairs (VA) and the care of our Nation's veterans. With the inevitable future budget challenges to come, PVA looks forward to your support to protect those who have done so much to protect us all, America's veterans. In particular, we hope for your continued support of those requiring specialized health care, a vital service that is often unmatched in the civilian health care sector.

H.R. 3843, the "Transparency for America's Heroes Act"

PVA cautiously supports H.R. 3843, the "Transparency for America's Heroes Act." Transparency is critical for the public to be able to see and understand what its government is doing. In the case of VA quality-assurance records, it only makes sense that this transparency is critical to veterans, and those who serve veterans such as Veterans Service Organizations (VSO), and their understanding of how well VA is doing its job. Requiring VA to publish redacted medical quality-assurance records on the VA's Web site will provide users of the VA a better understanding of the successes or failures of the VA in the quality of care they provide our veterans. This may encourage greater efforts on the part of VA employees, staff and leaders to ensure the best care is provided to veterans while ensuring openness. PVA's concern stems from the need for privacy in health care records. It is important that sufficient safeguards be put in place to prevent the unintended release of personal health information that may be detrimental to a VA patient.

H.R. 4041, to authorize improvements in the Federal Recovery Coordinator Program

PVA fully supports H.R. 4041 that will implement the Federal Recovery Coordinator Program. PVA agrees with the recommendation of the Dole-Shalala Commission that a nationwide Federal Recovery Coordinator Program will expand partnerships and collaborations to benefit veterans of Operation Iraqi Freedom and Operation Enduring Freedom. As specified in the legislation, there are a large number of services available to transitioning veterans, but no good mechanism for coordinating medical care for wounded warriors. There are so many programs that veterans can have a difficult time navigating through this sea of help. While this coordinator program may not solve all the challenges of coordinating care, it will go a long way to providing for knowledgeable health care professionals that can help wounded warriors navigate the often confusing maze of services.

In addition, provisions of the legislation that will establish a qualified nursing or medical school lead to review and develop evidence-based guidelines for recovery coordination should ensure that the program meets the needs of those being trained and the veterans that are served. While initially only 45 coordinators are authorized to be trained, PVA would recommend an expansion of the program dependent on its demonstrated success.

H.R. 5428, to direct the Secretary of VA to educate VA staff

PVA supports H.R. 5428 to better educate injured and amputee veterans on their rights and the requirement that VA staff who work at prosthetics and orthotics clinics or who work as patient advocates for veterans understand these rights as well. This bill would ensure that VA prosthetics clinics around the country prominently display the "Injured and Amputee Veterans Bill of Rights" and that VA employees understand it. This reaffirms the idea that a veteran in need of an assistive device or prosthetic gets the highest quality item available and in a timely manner. As expressed in previous testimony on this topic, PVA is concerned that this legislation's language seems to ignore veterans who may be in need of special equipment who suffer from a specific disease and not a physical injury.

H.R. 5516, the "Access to Appropriate Immunizations for Veterans Act of 2010"

PVA strongly supports H.R. 5516, the "Access to Appropriate Immunizations for Veterans Act of 2010." It is accepted fact that proper and timely administration of immunizations can prevent the onset of more significant medical issues. By requiring the Secretary to ensure these immunizations are administered in compliance with the recommended adult immunization schedule, and requiring quality measures to ensure this is done, it can be expected that veterans using the VA will be healthier and less likely to suffer potential medical ailments. The Department of Defense (DoD) follows these procedures to ensure a more ready military force. It only makes medical and economic sense that the health gains achieved by the DoD program for individuals prior to leaving service should be continued to maintain and benefit the health of veterans. Proper and timely immunizations are a guarantee of better medical health in the VA patient population.

H.R. 5543, to repeal the prohibition on collective bargaining

PVA supports H.R. 5543 to repeal the prohibition on collective bargaining with respect to compensation for VA employees which may improve the collective bargaining rights and procedures for certain health care professionals in the VA. As PVA testified in March of this year, these changes may be a positive step in addressing the recruitment and retention challenges the VA faces to hire key health care professionals, particularly registered nurses (RN), physicians, physician assistants, and other selected specialists. While PVA supports the repeal, this support is contingent on determinations that such repeal will in no way affect the care provided to veterans. This is the single purpose of the VA and its employees and must always remain so.

H.R. 5641, the "Heroes at Home Act"

PVA generally supports H.R. 5641, the "Heroes at Home Act." However, it is essential that proper protections are put in place to ensure that it is the desire of the veteran to be transferred to a non-VA nursing home and only in the case that the foster home meets VA standards at the time of transfer. It is critical that to support this program, VA verifies that the home is in compliance with VA standards before

a veteran is transferred. Too often a facility may have been in compliance in the past and the same certification is used to judge the current status of the facility. This must not be allowed to occur in the case of these vulnerable veterans.

H.R. 5996, to direct the Secretary to improve the treatment of veterans with pulmonary disease

PVA supports H.R. 5996 to direct the Secretary to improve the treatment of veterans with chronic obstructive pulmonary disease (COPD), develop a pilot program to demonstrate best practices for diagnosis and management of COPD, and develop improved techniques and best practices for smoking cessation. However, PVA is concerned with language in Section 1(a) that it is "Subject to the availability of appropriations provided for such purpose . . . " This legislation essentially establishes an unfunded mandate that Congress is telling the Secretary he can ignore. While this may be a result of the current tight budget environment, if this legislation is needed to provide for our Nation's veterans, the Secretary should be instructed to implement the programs and they should be appropriately funded by Congress. This legislation outlines excellent programs to improve the health of veterans. Without stronger requirements directing the Secretary to implement these programs, they may not be implemented by VA due to its other competing requirements.

H.R. 6123, "Veterans' Traumatic Brain Injury Rehabilitative Services' Improvement Act of 2010"

PVA supports H.R. 6123, the "Veterans' Traumatic Brain Injury Rehabilitative Services' Improvement Act of 2010." Together with Improvised Explosive Devices (IED), Traumatic Brain Injury (TBI) has become a signature wound of the current wars in Afghanistan and Iraq. Today, we still do not fully understand the impact or gravity of TBI. In April 2008, the RAND Corporation Center for Military Health Policy Research completed a comprehensive study titled *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery.* RAND found that the effects of TBI were poorly understood, leaving a gap in knowledge related to how extensive the problem is or how to handle it. RAND found 57 percent of those reporting a probable TBI had *not* been evaluated by a physician for brain injury. Military service personnel who sustain catastrophic physical injuries and suffer severe TBI are easily recognized, and the treatment regimen is well established. In recent testimony, PVA has raised continuing concerns about servicemembers who do not have the immediate outward signs of TBI getting appropriate care. The military has implemented procedures to temporarily withdraw individuals from combat operations following IED attacks for an assessment of possible TBI, creating a significant military impact, but believing it necessary for soldier health even if it reduced combat forces.

On July 12, 2006, the VA Office of the Inspector General (OIG) issued *Health Status of and Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation.* The report found that better coordination of care between DoD and VA health-care services was needed to enable veterans to make a smooth transition. While VA and DoD have done extensive improvements of coordination since that report, the OIG Office of Health Care Inspections conducted follow-on interviews to determine changes since the initial interviews conducted in 2006. The OIG concluded that 3 years after completion of initial inpatient rehabilitation, many veterans with TBI continue to have significant disabilities and, although case management has improved, it is not uniformly provided to these patients.

Because all the impacts of TBI are still unknown, this legislation to expand services and care, providing for quality of life and not just independence, and emphasizing rehabilitative services, is important to the ongoing care of TBI patients. It is imperative that a continuum of care for the long term be provided to veterans suffering from TBI. PVA believes this legislation is a step toward ensuring that care.

H.R. 6127

PVA generally supports this legislation; however, we do have some concerns with the issues surrounding this bill. While we see no real argument with granting these men and women who experienced the exposures outlined by this bill access to the VA health care system, we question why this is the only group singled out for enrollment. Given the longstanding discussions about Operation Iraqi Freedom veterans being exposed to burns pits or servicemembers exposed to hazardous mate-

rials in any number of settings, we believe proper consideration needs to be given to a broader spectrum of veterans and servicemembers.

H.R. 6188, the "Veterans Homelessness Prevention and Early Warning Act"

PVA also supports the draft legislation that outlines the VA's notice and response requirements for defaults in loan payments guaranteed by the VA. The recent collapse of the housing market coupled with the struggles that many veterans face in the employment market have created a situation where many veterans and their families are defaulting on home loans and often losing their homes. This legislation will ensure that veterans who are placed in this situation are quickly identified so that they may be provided needed assistance by the VA.

Draft Legislation on Ensuring VA Provides Veterans with Information Concerning Service-Connected Disabilities

PVA supports the draft legislation to ensure health care professionals of VA provide veterans with information concerning service-connected disabilities and information on submitting claims, establishing service connection for a disability and contact information of appropriate VA offices. The claims process can be cumbersome and daunting and information to ease this process will be helpful for the veterans. PVA would also hope that as part of this process, VA would inform veterans of the availability of help from congressionally chartered Veterans Service Organizations (VSO) that can provide free help to veterans in understanding their rights and pursuing any appropriate claims for service-connected injuries.

Draft Legislation on Improvements to VA Homeless Programs

PVA generally supports the provisions of the discussion draft on improvements to VA homeless programs. Too many veterans continue to live on the streets due to drug, mental health, financial and employment challenges. The expansion of grant programs for improvements to facilities and increased outreach to more homeless veterans may help them receive services and rehabilitation and achieve the Secretary's goal to end veterans' homelessness. In addition, the improvement of payments for providing services to homeless veterans may increase the number of veterans who can be served by homeless veteran providers. But as PVA testified last October, we do have some concerns about the long-term effects of the legislation.

PVA has always supported the idea of comprehensive care for homeless veterans. Seldom is there one issue that leads veterans to become homeless. Comprehensive care can be expensive. Additionally, often homeless veterans reside in urban areas where the cost of living is very high and there are limited opportunities for help. Section 3 of the discussion draft allows the Secretary to increase the rates of payment to reflect anticipated changes in the cost of services and takes into account the cost of providing these services in particular geographic areas.

While we welcome this consideration, PVA is concerned about the long-term effects on VA homeless program funding. By adjusting the payments for geographic areas, which we believe is aimed at providing greater funding to high cost localities, this may actually reduce the total number of homeless veterans that can be served if future increases in overall program funding are insufficient. While the argument could be made that "reductions" in funding for low cost areas may offset increases to high cost areas, the funding levels provided for homeless programs are seldom sufficient to provide for all the veterans who may need to take advantage of these critical services.

PVA would recommend a very cautious approach on this legislation to ensure the most vulnerable veterans are not inadvertently hurt in efforts to provide greater funds for some of them.

Draft Health Care Legislation

PVA supports the draft legislation that would address a number of items in the VA health care system. We are particularly pleased to see that the Subcommittee is considering the extension of the Advisory Committee on Homeless Veterans, particularly in light of the focus that the Administration has placed on eliminating homelessness among veterans.

We do have a question about Section 4 of the legislation. We are unclear about the additional authority beyond simple contracting for services in non-Department facilities outlined in Section 4 of the bill. Specifically, we would like to know what purpose this expansion of authorizing language serves and how it will serve to benefit the VA's processes?

PVA would like to thank the Subcommittee once again for allowing us to provide testimony on these important health care issues facing our veterans. We certainly appreciate the continued attention this Subcommittee has placed on these issues. I would be happy to answer any questions that you might have. Thank you.

Prepared Statement of Adrian M. Atizado, Assistant National Legislative Director, Disabled American Veterans

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting the Disabled American Veterans (DAV) to testify at this important hearing of the Subcommittee on Health. DAV is an organization of 1.2 million service-disabled veterans, and we devote our energies to rebuilding the lives of disabled veterans and their families.

Mr. Chairman, the DAV appreciates your leadership in enhancing Department of Veterans Affairs (VA) health care programs on which many service-connected disabled veterans must rely. At the Subcommittee's request, the DAV is pleased to present our views on eleven (11) bills before the Subcommittee today.

H.R. 3843—Transparency for America's Heroes Act

This measure would amend title 38, United States Code, § 5705 to make available on VA's Web site certain redacted records, documents, or parts of documents that are associated with the Department's medical quality-assurance program. It would also require such records or documents created during the 2-year period before the bill's enactment to be similarly made available. Current law specifies that such records "are confidential and privileged and may not be disclosed to any person or entity." 38 U.S.C. § 5705(a).

The existing restrictions protect the integrity of the VA's medical quality assurance program, carried out by or for VA for the purpose of improving the quality of medical care or improving the utilization of health care resources in VA medical facilities. These review activities may involve continuous or periodic data collection and may relate to the structure, process, or outcome of health care provided in the VA. 38 CFR § 17.500.

The Need for Confidentiality

H.R. 3843 would amend title 38, United States Code, § 5705 affecting disclosure of records and documents resulting from medical quality assurance activities and designated across a number of foci.[1] These records and documents are a crucial part of VA's health care quality and safety activities.

The VA has implemented nationwide internal and external reporting systems for organizational learning and improvement that supplement the existing accountability systems. These systems are designed around confidentiality to encourage maximal reporting of potential and actually occurring problems by non-punitive methods that would then be converted into corrective actions. Authoritative sources,[2,3] surveys, and focus groups of both VA and external health care workers found that health care providers' view of punitive actions extended beyond typical administrative punishment to include factors such as embarrassment, shame, and negative impact on professional reputation. Protection from these factors means emphasizing prevention—not punishment, and is essential for VA to continue receiving candid reports on adverse events and/or close calls from which it could then learn and undertake improvement and prevention efforts. Assuring non-punitive, confidential, and voluntary programs is necessary for the Department to receive reports to subsequently implement corrective actions.

Conversely, the Institute for Healthcare Improvement (IHI) has found that all employee reporting programs (voluntary and mandatory) result in substantial underreporting.[4] Several studies have shown that computer monitoring strategies have identified many times more potential adverse events than were reported through

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[1] Department of Veterans Affairs, *VHA Directive 2008–077: Quality Management (QM) and Patient Safety Activities That Can Generate Confidential Documents,* November 7, 2008.

[2] Institute of Medicine, "To Err is Human: Building a Safer Health System", November 1999.

[3] The Joint Commission, "2008 Comprehensive Accreditation Manual for Hospitals: The Official Handbook," PI–1.

[4] Institute for Healthcare Improvement, "Introduction to Trigger Tools for Identifying Adverse Events," Available at: http://www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/Tools/IntrotoTriggerToolsforIdentifyingAEs.htm, Accessed: August 25, 2010.

employee reporting mechanisms.[5,6,7] The IHI's "Trigger Tools" are also used to identify adverse events and detect safety problems.[8,9,10,11] Moreover, not having specific facility and patient information has caused frustration when VA Central Office and oversight bodies have requested Veterans Health Administration (VHA) data regarding adverse events. Facility patient safety managers have also had to create secondary, duplicative systems in order to capture the patient information needed for effective reviews and reports.

In this instance, consideration of H.R. 3843 requires a balance between confidentiality and transparency to maintain VA employees' perception that VA's quality and safety activities would not become punitive in nature, while continuing to allow for candid reporting.

The Need for Transparency: Health Care

Under Executive Order 13410, "[h]ealth care programs administered or sponsored by the Federal Government promote quality and efficient delivery of health care through the use of health information technology, [and] transparency regarding health care quality." Its purpose also includes making relevant information available to program beneficiaries, enrollees, and providers in a readily useable manner and in collaboration with similar initiatives in the private sector and non-Federal public sector. In addition, VA has been actively seeking ways for veteran patients and their families to take a more active role in their health care, and to help manage their health care rather than being advised what to do through a provider-centered system.[12,13]

There is a clear recognition that veterans and their families need accurate information about the quality of care in VA-owned or contracted facilities in order to make informed choices. These choices depend, in part, on the most complete, timely information available.

In the 111th Congress, VA testified on a succeeding bill, S. 1427, "Department of Veterans Affairs Hospital Quality Report Card Act of 2009." VA indicated that health care transparency is one of its major Strategic Transformation Initiatives this fiscal year and is working with the Centers for Medicare and Medicaid Services (CMS) to post VA comparable data on the CMS "Hospital Compare" Web site (http://www.hospitalcompare.hhs.gov). The Department reported it was similarly exploring other public reporting programs.[14]

In the 110th Congress, DAV testified before this Subcommittee on a similar bill, H.R. 1448, "The VA Hospital Quality Report Card Act of 2007." This bill sought to establish a "hospital report card" covering a variety of activities of inpatient hospital care occurring in the medical centers of the Department to provide increased disclosure and accountability in the VA system. The DAV supported this bill, because it was consistent with trends occurring in private sector health care enabling patients to review the quality and safety of their care.

Notably, VA at that time opposed the bill as written as too prescriptive in its requirements, and stated that much of the information required by H.R. 1448 is available through other avenues, such as The Joint Commission's (previously known as the Joint Commission on Accreditation for Healthcare Organizations) Web site that

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[5] David W. Bates, MD, MSc, et al., "Detecting Adverse Events Using Information Technology," *J Am Med Inform Assoc,* Vol. 10, No. 2, March–April 2003, pp. 115–128.

[6] M. K. Szekendi, et al., "Active surveillance using electronic triggers to detect adverse events in hospitalized patients," *Qual Saf Health Care,* Vol. 15, June 2006, pp. 184–190.

[7] C. W. Johnson, "How will we get the data and what will we do with it then? Issues in the reporting of adverse health care events," *Qual Saf Health Care,* Vol. 12, December 2003, p. ii64.

[8] Rozich JD, Haraden CR, Resar RK. Adverse drug event trigger tool: A practical methodology for measuring medication related harm. Quality and Safety in Health Care. 2003 Jun;12(3):194–200.

[9] Sharek PJ, Horbar JD, Mason W, et al. Adverse events in the neonatal intensive care unit: Development, testing, and findings of an NICU-focused trigger tool to identify harm in North American NICUs. Pediatrics. 2006 Oct;118(4):1332–1340.

[10] Griffin FA, Classen DC. Detection of adverse events in surgical patients using the Trigger Tool approach. Quality and Safety in Health Care. 2008 Aug;17(4):253–258.

[11] Classen DC, Lloyd RC, Provost L, Griffin FA, Resar R. Development and evaluation of the Institute for Healthcare Improvement Global Trigger Tool. Journal of Patient Safety. 2008 Sep;4(3):169–177.

[12] Department of Veterans Affairs. "Patient Centered Medical Home Model Concept Paper," March 15, 2010. Available at: http://www1.va.gov/PrimaryCare/docs/pcmh__ConceptPaper.doc; Accessed: August 26, 2010.

[13] http://www.patientsafety.gov/patients.html#intro; Accessed: August 26, 2010.

[14] Cross, Gerald M, Acting Under Secretary for Health, Department of Veterans Affairs. Statement to the Senate, Committee on Veterans Affairs. "Hearing on Pending Legislation," Hearing, October 21, 2009. Available at: http://www.veterans.senate.gov/hearings.cfm?action=release.display&release__id=faa07041-78f1-45c7-93f1-fff7b5a6f978; Accessed: August 26, 2010.

provides standardized comparative data in a form that has been tested for consumer understandability and usefulness.

S. 1427 (111th) and H.R. 1448 (110th), both sought to provide easily accessible reports published in acceptable lay terms on the quality of VA's medical centers that include quality-measures data that allow for an assessment of health care effectiveness, safety, timeliness, efficiency, patient-centeredness, and equity. In contrast, the bill now before the Subcommittee would simply make publicly available redacted versions of VA's medical quality-assurance records. It is uncertain whether making such documents available on VA's Web site would meet the needs of veterans and their families to make informed decisions.

Other key issues related to transparency must also be addressed in addition to availability of information via the Internet. Any such reports should be readable, understandable, and meaningful. Also, accommodation should be provided so individuals may gain access by telephone or mail requests, and during personal onsite visits. Finally, and equally important, VA should encourage wide public awareness of the availability of such information, how and where to access it, and appropriate limitations on its use. We ask the Subcommittee staff to address these shortcomings in the bill.

The Need for Transparency: Disability Compensation

Title 38, United States Code, § 5705 is also the basis for needed transparency in our organization's work representing service-connected disabled veterans' claim for disabilities suffered as the result of VA medical treatment governed by title 38, United States Code, § 1151.

According to VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook* (May 23, 2008), VHA facility staff have an obligation to inform—or disclose to—patients any adverse events consequent to their care. Routine disclosure of adverse events to patients has been VHA's national policy since 1995. However, a 2008 report by VA's Office of Inspector General (VAOIG) shows that only 21 (54 percent) of 39 audited facilities had provided full disclosure.[15]

Without such disclosure, many claims based on § 1151 have been denied because of confidentiality protections afforded to quality assurance records under title 38, United States Code, § 5705 and title 38, Code of Federal Regulations, §§ 17.500–17.511. Analysis of such records could demonstrate proximate causes of injury by carelessness, negligence, lack of proper skill, error in judgment, equipment failure, or similar instance of fault on the part of the Department's employees in furnishing the hospital care or medical services involved that caused the injuries.

According to title 38, United States Code, § 5705(b) and subject to protections in title 5, United States Code, 552a (the Privacy Act), title 38, United States Code, § 5701 (veterans' names and addresses), and title 38, United States Code, § 7332 (drug and alcohol abuse, sickle cell anemia, HIV infection), the Secretary must, upon request, disclose quality assurance documents to several branches of government, organizations, and persons. Moreover, the statute does not prohibit the release of medical quality assurance records within VA. *See* § 5705(b)(5) ("Nothing in this section shall be construed as limiting the use of [medical quality assurance records] within the Department."). DAV believes this authority includes VA employees such as regional office (RO) adjudicators and rating boards, physicians who conduct VA examinations, and Members of the Board of Veterans Appeals (Board) since these VA employees are clearly "within VA." However, we commonly find claims based on title 38, United States Code, § 1151 not fully developed because those claims do not contain quality assurance records to validate the injuries claimed.

In 2000, Congress passed the "duty to assist" legislation that requires the Department to assist a veteran in gathering all records relevant to a claim. 38 U.S.C. § 5103A(c)(2). In not exercising the authority provided under title 38, United States Code § 5705(b)(5), the RO or the Board as part of their duty to assist the claimant violates the statutory mandate to gather all relevant medical records set forth in title 38, United States Code, § 5103A(c)(2). Furthermore, DAV believes the VA adjudication manual instructions for medical quality-assurance records conflict with the statutory requirements of title 38, United States Code, §§ 5103a and 5705 and violates the duty to assist provisions in the development of a claim made pursuant to a law administered by the Secretary.

A note contained in the VA Adjudication Manual[16] that discusses quality-assurance records states:

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[15] Department of Veterans Affairs, Office of Inspector General, *Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2007,* May 2008.

[16] VA Adjudication Manual 21–1, Part IV, Chapter 22, Subchapter 1, § 22.03.

> Do not request quality assurance investigative reports. These reports are confidential under 38 U.S.C. § 5705 and cannot be used as evidence in adjudication of claims under 38 U.S.C. § 1151. If quality assurance investigative reports are received from a VA medical facility, return the reports immediately. Do not file copies of these reports in the veteran's folder.

At best, the Department's instructions are an erroneous interpretation of VA's statutory obligations, conflict with his duties and responsibilities set forth in title 38, United States Code, §§ 5103A and 5705, and are not entitled to any "*Chevron*" deference. *See Chevron U.S.A. Inc.* v. *Natural Resources Defense Council,* 467 U.S. 837 (1984); *see also Timex V.I., Inc.* v. *United States,* 157 F.3d 879 (Fed. Cir. 1998) at 881–882.

In these instances, our organization must argue for a determination as to whether medical quality-assurance records relevant to a veteran's claim exist, then collect the records if they do exist, and consider the veteran's claim in light of such records. We believe it should be held that this VA Adjudication Manual provision violates the duty to assist provisions in the development of a claim made pursuant to a law administered by the Secretary. In this light, and with our stated caveat relating to access to this information by means other than the Internet, we support the purposes of this bill and urge the Subcommittee to advance this legislation in an amended form. Also, we ask the Subcommittee to work with your colleagues on the Disability Assistance and Memorial Affairs Subcommittee to address our concerns with respect to the non-availability of quality assurance records to assist disabled veterans with their claims under § 1151 of title 38, United States Code.

H.R. 4041—To authorize certain improvements in the Federal Recovery Coordinator Program, and for other purposes.

This measure would require VA to identify a qualified nursing or medical school to develop a literature review and evidence-based guidelines for recovery coordination, establish a consensus conference, and develop training modules for care coordination. The bill would authorize $1.2 million for that effort. Also, the bill would authorize $500,000 for training 45 recovery coordinators by the designated nursing or medical school, and would authorize $1.2 million for the development, validation and piloting of technology tools and software that is compatible with VA and Department of Defense (DoD) systems for recovery coordination.

DAV remains concerned about the gaps that exist in the Federal Recovery Coordination Program (FRCP) and social work case management. These gaps were highlighted by disabled veterans and their families in hearings held by the House Veterans' Affairs Subcommittee on Oversight and Investigation in 2009 and 2010 and warrant continued oversight and evaluation by this Subcommittee.

Issues discussed during those hearings include a multilayer bureaucracy of clinical case managers at VA, DoD and private facilities, Wounded Transition Unit (WTU) Liaisons, DoD Military Liaisons, VA Clinical Rehabilitation Nurses, Transition Patient Advocates, Veterans Benefits Administration (VBA) Counselors, transition support coaches, multiple health care providers, and Federal Recovery Coordinators (FRCs) to make and facilitate key referrals and consultations to manage the patient's needs toward achieving Federal Individualized Recovery Plan (FIRP) goals. Another is the integration of Information Technology (IT) access within VA and the Military Training Facility (MTF)—although DoD and VA state that these challenges will be overcome with the implementation of more IT integration between VA and DoD through such initiatives as the single common personal identifier, which is a significant step toward making the complex Virtual Lifetime Electronic Record (VLER).

The capacity for individual attention paid by FRCs to each client in their caseload to meet individual needs and achieve FIRP goals is a primary concern for DAV. We believe caseload standards should be based on the scope of professional responsibilities, the volume of clients to be served, the amount of time the FRC needs to spend with clients, the breadth and complexity of client problems or services, and the length and duration of case mix in determining case manager-client involvement. The number of cases an FRC can realistically handle is limited to the degree to which caseloads consist of acute, high-risk, multi-need clients—that is, the degree of acuity of the medical condition and complexity of non-medical needs of their clients.

Further, as part of *The Independent Budget,* the DAV recommends DoD and VA must outline the requirements for assigning new or additional FRCs caring for severely injured servicemembers in concert with tracking workload, geographic distribution, and the complexity and acuity of injured servicemembers' medical conditions.

A September 16, 2008, report to Congress on the development of a comprehensive policy for DoD and VA on the care, management, and transition of recovering servicemembers addresses the maximum number of recovering servicemembers whose cases may be assigned to a recovery care coordinator as required by the Wounded Warrior Act. It states that the appropriate workload or case ratio for FRCs is not known. These are new positions for which there are no comparable data or ratios. Currently, all FRCs are tracking time utilization. New cases are distributed based on existing caseloads. In the near future, the FRCP will implement acuity based measures to more precisely balance caseloads.[17]

According to VA testimony in April 2009 about the FRCP, predicting the total number of FRCs required for the program at any point in time depends on the number of eligible servicemembers and veterans enrolling and workload criteria based on intensity of needs. The program supervisor located in VA's Central Office in Washington, D.C. monitors time utilization statistics and the program has developed a hiring plan based on estimates of eligible populations and a variety of estimated workloads. If referral and enrollment rates are higher or lower than projected, the number of new FRCs hired can be adjusted accordingly.[18]

DAV believes FRC caseload size must realistically allow for meaningful opportunities for face-to-face client contact. As caseload size increases, the FRC has a declining capacity to perform ongoing comprehensive coordination of care and support activities such as follow-up, monitoring, and reassessment. However, flexibility of caseload should exist but only for a limited time frame as is provided in the Wounded Warrior Act. Overburdened FRCs do not serve the program mission, the veteran, servicemembers, or their families. It is the joint responsibility of VA, DoD, and the FRCP to address and remedy caseload issues and concerns. To this end, we encourage the Subcommittee to work with both VA and DoD to determine whether additional FRCs are needed and if so, what the appropriate number would be.

FRCP Education, Training, and Technology Tools

The Wounded Warrior Act requires a comprehensive policy on improvements to care, management, and transition of recovering servicemembers that includes standard training requirements and curricula for recovery care coordinators under the program. The requirement for successful completion of the training program before a person may assume the coordinator duties.

We understand there are efforts underway to explore whether the Medical College of Georgia (MCG) School of Nursing Clinical Nurse Leader curriculum could be adapted for the needed national training program for FRCs. The MSC School of Nursing has proposed a 6-month, post-Master's certificate program using their clinical nurse leader program to help train and certify VA and DoD's recovery coordinators. Notably, the Charlie Norwood VA Medical Center, the Eisenhower Army Medical Center at Fort Gordon, and the MCG School of Nursing, are currently collaborating in the treatment of severely injured servicemembers. The Charlie Norwood VA hosts an active duty rehabilitation facility for military personnel.

Although the FRCP is operated as a joint DoD and VA program, VA is responsible for the administrative duties, and program personnel are employees of the agency. VA support includes technical and information technology support, human resources management, and programmatic support from both VBA and VHA. DoD provides assistance to the program through the Line of Action Co-Lead and the Strategic Oversight Committee and staff. This support includes assistance with development of appropriate tools, and coordination of activities. FRCs are also supported by their host facilities as determined by a Memorandum of Agreement with each facility. These are in addition to the financial requirements for both DoD and as noted in the Memorandum of Understanding of October 30, 2007.

DAV urges the Subcommittee to work with both VA and DoD to determine whether the provisions of H.R. 4041 to require a literature review, evidence-based guidelines for recovery coordination, consensus conference, and training modules for care coordination would enhance the FRCP.

Also, the bill seems ambiguous in both the purpose and intended uses of the care coordination software and the language in Section 2(c)(1)(A), which would require

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[17] Report to Congress on the Comprehensive Policy Improvements to the Care, Management and Transition of Recovering Servicemembers (NDAA Section 1611 and 1615), September 16, 2008. Available at: http://prhome.defense.gov/WWCTP/docs/09–16–08__1900__Final__Report__to__Congress__-__1611__and__1615.pdf; Accessed: September 2, 2010.

[18] Guice, Karen, Executive Director of the Federal Recovery Coordination Program, Department of Veterans Affairs. Statement to the Subcommittee on Oversight and Investigations, House Committee on Veterans Affairs. "Leaving No One Behind: Is the Federal Recovery Coordination Program Working?" Hearing, April 28, 2009. Available at: http://www4.va.gov/OCA/testimony/hvac/soi/090428KG.asp; Accessed: September 2, 2010.

the VA to enter into relationship with a subcontractor. Further, we urge the Subcommittee to include a public reporting requirement summarizing the results of the software pilot program. Finally, we recommend technical changes to the language, since the program to which it refers is the Federal Recovery Coordination, not *Coordinator,* Program.

H.R. 5428—To direct the Secretary of Veterans Affairs to educate certain staff of the Department of Veterans Affairs and to inform veterans about the Injured and Amputee Veterans Bill of Rights, and for other purposes.

This bill would ensure that an "Injured and Amputee Veterans Bill of Rights" is printed on signage and displayed prominently in every VA prosthetics and orthotics clinic, while requiring VA employees at the clinics and patient advocates serving veterans receiving care there to receive training on such Bill of Rights.

The bill would require the Secretary of Veterans Affairs to conduct outreach to inform veterans of such Bill of Rights, and would direct VA to monitor and resolve related complaints from veterans. VA would be required to collect information relating to alleged mistreatment of injured and amputee veterans at each VA medical center and to submit such information quarterly to the VA's Chief Consultant in Prosthetics and Sensory Aids for the purposes of investigation and resolution of such complaints.

Although DAV has no specific resolution calling for an Injured and Amputee Bill of Rights, DAV fully supports VA's Amputee System of care. DAV, as part of *The Independent Budget,* strongly supports full implementation of the VA amputation system of care program and encourages Congress to provide adequate resources for the staffing and training of this important program. *The Independent Budget* recommends that VA expeditiously implement the proposed system providing proper staffing levels and training to ensure VA provides superior health services for aging and newly injured veterans who need these unique services. Also, the VISN prosthetics representatives should maintain and disseminate objectives, policies, guidelines, and regulations on all issues of interpretation of prosthetics policies, including administration and oversight of VHA's Prosthetics and Orthotics Laboratories. The overall goals of this bill appear to be in line with these stated recommendations and objectives; therefore, we have no objection of the passage of this measure.

H.R. 5516—Access to Appropriate Immunizations for Veterans Act of 2010

This measure would require the Secretary of Veterans Affairs to make available periodic immunizations against certain infectious diseases as adjudged necessary by the Secretary of Health and Human Services through the recommended adult immunization schedule established by the Advisory Committee on Immunization Practices. The bill would include such immunizations within the authorized preventative health services available for VA-enrolled veterans. The bill would establish publicly reported performance and quality measures consistent with the required program of immunizations authorized by the bill. The bill would require annual reports to Congress by the Secretary confirming the existence, compliance and performance of the immunization program authorized by the bill.

Although DAV has no adopted resolution from our membership dealing specifically with this matter of immunizations for infectious diseases, the delegates to our most recent National Convention in Atlanta, Georgia, July 31–August 3, 2010, adopted Resolution No. 036, calling on VA to maintain a comprehensive, high quality, and fully funded health care system for the Nation's sick and disabled veterans, specifically including preventative health services. Preventative health services are an important component of the maintenance of general health, especially in elderly and disabled populations with compromised immune systems. If carried out sufficiently, the intent of this bill could also contribute to significant cost avoidance in health care by reducing the spread of infectious diseases and obviating the need for health interventions in acute illnesses of those without such immunizations. Therefore, DAV is pleased to support this bill and urges its enactment.

H.R. 5543—To amend title 38, United States Code, to repeal the prohibition on collective bargaining with respect to matters and questions regarding compensation of employees of the Department of Veterans Affairs other than rates of basic pay, and for other purposes.

Mr. Chairman, this bill would restore some bargaining rights for clinical care employees of the VHA that were eroded by the former Administration. The bill would amend subsections (b) and (d) of section 7422 of title 38, United States Code, by

striking "compensation" both places it appears and inserting "basic rates of pay" in its place. The intent of the bill would be to authorize employee representatives of recognized bargaining units to bargain with VHA management over matters of employee compensation other than rates of basic pay.

DAV does not have an approved resolution from our membership on the specific issues addressed by this bill. However, we believe labor organizations that represent employees in recognized bargaining units within the VA health care system have an innate right to information and reasonable participation that result in making the VA health care system a workplace of choice, and in particular, to fully represent VA employees on issues impacting their working conditions.

Congress passed section 7422, title 38, United States Code, in 1991, in order to grant specific bargaining rights to labor in VA professional units, and to promote effective interactions and negotiation between VA management and its labor force representatives concerned about the status and working conditions of VA physicians, nurses and other direct caregivers appointed under title 38, United States Code. In providing this authority, Congress granted to VA employees and their recognized representatives a right that already existed for all other Federal employees appointed under title 5, United States Code. Nevertheless, Federal labor organizations have reported that VA severely restricted the recognized Federal bargaining unit representatives from participating in, or even being informed about, a number of human resources decisions and policies that directly impact conditions of employment of the VA professional staffs within these bargaining units. We are advised by labor organizations that when management actions are challenged, VA officials (many at the local level) have used subsections (b), (c) and (d) of section 7422 as a statutory shield to obstruct any labor involvement to correct or ameliorate the negative impact of VA's management decisions on employees, even when management is allegedly not complying with clear statutory mandates (e.g., locality pay surveys and alternative work schedules for registered nurses, physician market pay compensation panels, etc.).

We believe this bill, which would rescind VA's ability to bargain on matters of compensation other than rates of basic pay, is an appropriate remedy to address part of the bargaining problem in the VA professional ranks. We understand recently VA has given Federal labor organizations some indication of additional flexibility in negotiating labor-management issues such as some features of compensation, and we are hopeful that this change signals a new trend in these key relationships that directly affect sick and disabled veterans. We endorse the intent of this bill and urge its enactment, while continuing to hope that VA and Federal labor organizations can find a sustained basis for compromise.

H.R. 5641—Heroes at Home Act

Since 1951, the VA's Community Residential Care (CRC) Program has provided health care and sheltered supervision to eligible veterans not in need of acute hospital care, but who, because of medical and/or psychosocial health conditions, are not able to live independently and have no suitable family or significant others to aid them.

The CRC Program is an important component in VA's continuum of long-term care services operating under the authority of title 38, United States Code, Section 1730. Any veteran who lives in an approved CRC residence in the community is under the oversight of the CRC Program. This program has evolved through the years to encompass Medical Foster Home (MFH), Assisted Living, Personal Care Home, Family Care Home, and Psychiatric CRC Home.

New partnerships between Home Based Primary Care (HBPC) and the MFHs and CRCs have allowed veterans to live independently in the community, as a preferred means to receive family-style living with room, board, and personal care. Under the MFH Program, the administrative costs for VHA are less than $10 per day, and the cost of Home Based Primary Care, medications and supplies averages less than $50 per day. Understandably, VA perceives this program as a cost-effective alternative to nursing home placement, and it is gaining popularity as evidenced by the program's expansion.

DAV is pleased with VA's innovation by offering the MFH program as part of its long-term care program. Notably, patient participation in this program, while voluntary, yields very high satisfaction ratings from veterans. But because MHF operates under the CRC authority, participating veterans must pay the MFH caregiver approximately $1,500 to $4,000 per month for room and board, 24-hour supervision, assistance with medications, and whatever personal care may be needed.[19] Even

[19] 38 U.S.C. § 1730(a)(3).

veterans who are otherwise entitled to nursing home care fully paid for by VA under the Veterans Millennium Health Care and Benefits Act (Millennium Act)[20] or under VA's policy on nursing home eligibility[21], must pay to live independently in a CRC or MFH. According to VA, MFH is appropriate for certain veterans whose conditions warrant a nursing home level of care but who prefer a non-institutional setting. In other words, were it not for MFH, veterans who meet the nursing home level of care standards would qualify for VA paid care to receive it. In addition, veterans who do not have the resources to pay the MFH caregiver are not able to avail themselves of this benefit.

We applaud the intent of H.R. 5641, a bill that would allow VA to contract with a certified MFH and pay for care of veterans already eligible for VA paid nursing home care. As part of *The Independent Budget,* DAV is greatly concerned that veterans living in the MFH environment are required to pay for their stays using personal funds, including their VA disability compensation.

Given the purposes of this bill and its probable cost, we are concerned VA will not enter into such contracts. In VA's Geriatrics and Extended Care (GEC) Strategic Plan,[22], VA acknowledges the eligibility mismatch between inpatient and non-institutional long-term care and possible adverse impact on VA's extended care program. Similarly, DAV recognizes VA long-term care services, especially alternative, non-bed, community and home-based programs, are not uniformly available in all VA health care facilities. Accordingly, the delegates to our most recent National Convention assembled in Atlanta, Georgia, July 31–August 3, 2010, passed National Resolution No. 209, calling for legislation to expand the comprehensive program of long-term care services for service-connected disabled veterans regardless of their disability ratings.

In a special article written for the State of the Art Planning Committee by Kenneth Shay, DDS, MS, Director of VA Geriatric Programs, and James F. Burris, MD, Chief Consultant for VA Geriatrics and Extended Care, they note there are three fundamental building blocks of long-term care for chronically ill elders. They are personal care, housing, and chronic disease care. Meaningful goals for long-term care relate to maintaining and improving function and quality of life while maximizing safety and autonomy. Because these goals are not always compatible, there need to be tradeoffs and ranked priorities. In addition, they cite the most-rapid growth in non-VA extended care options has been in "assisted living," a loosely defined and minimally regulated set of residential and care services that VA does not have statutory authority to provide or pay for. Yet suitably supportive housing is a key component of non-institutional long-term care, so VA has sought to implement alternative, creative solutions to facilitate disabled veterans' access to supportive living options without the agency actually paying the costs of room and board.[23]

Assisted living bridges the gap between home care and nursing homes. Assisted living is a general term that refers to a wide variety of residential settings that provide 24-hour room and board and supportive services to residents requiring minimal need for assistance to those who require some ongoing assistance with personal care and activities of daily living. VA's MFH program is commonly known as adult foster care homes in the private sector and some residences that are licensed as adult foster care homes may call themselves "assisted living." An adult foster care is a residential setting that provides 24-hour room and board, personal care, protection and supervision for adults, including the elderly who require supervision on an ongoing basis but do not require continuous nursing care.

Clearly, VA's MFH program should be realigned under a more appropriate statutory authority. Public Law 106–117 authorized an Assisted Living Pilot Program (ALPP) carried out in VA's VISN 20. Conducted from January 29, 2003, through June 23, 2004, and involving 634 veterans who were placed in assisted living facili-

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[20] P.L. 106–117, 113 Stat. 1545 (1999) required that through December 31, 2003, VA provide nursing home care to those veterans with a service-connected disability rated at 70 percent or greater, those requiring nursing home care because of a condition related to their military service who do not have a service-connected disability rating of 70 percent or greater, and those who were admitted to VA nursing homes on or before the effective date of the act. Subsequent law extended these provisions.

[21] VA's policy on nursing home eligibility required that VISNs provide nursing home care to veterans with 60 percent service-connected disability ratings who are also classified as unemployable or Permanent and Total Disabled.

[22] U.S. Department of Veterans Affairs. Patient Care Services. *Geriatrics and Extended Care Strategic Plan.* Washington DC, December 24, 2008.

[23] Shay K, Burris JF. *Setting the stage for a new strategic plan for geriatrics and extended care in the Veterans Health Administration: summary of the 2008 VA State of the Art Conference, "The changing faces of geriatrics and extended care: meeting the needs of veterans in the next decade".* J Am Geriatr Soc. 2008 Dec;56(12):2330–9.

ties, the pilot project yielded an overall assessment report submitted to Congress stating, "the ALPP could fill an important niche in the continuum of long-term-care services at a time when VA is facing a steep increase in the number of chronically ill elderly who will need increasing amounts of long-term care."[24] Unfortunately, VA's transmittal letter that conveyed the ALPP report to Congress stated that VA was not seeking authority at that time to provide assisted living services, because VA considered assisted living to be primarily a housing function.

Despite VA's reticence, the 2004 ALPP report seemed most favorable, and assisted living appears to be an unqualified success. In fact, Title XVII, Section 1705, of the National Defense Authorization Act for Fiscal Year 2008, Public Law 110–181, authorizes VA to provide assisted living services.

Current estimates show more than 900,000 Americans live in approximately 39,500 assisted living residences in the United States.[25] The 2009 MetLife survey put the average cost of assisted living providing 10 or more services at $41,628 annually in 2009, but found that private room nursing home rates average $79,935 per year, and semi-private room rates average $72,270 per year.[26] In fiscal year (FY) 2009, VA spent over $5.2 billion—about 12 percent of its total health care spending—to provide for veterans' long-term care needs. Nearly 82 percent ($4.2 billion) of VA's total long-term care spending in FY 2009 was for nursing home care. For FY 2011, VA expects to spend over $6.8 billion—over 13 percent of its total health care budget—to provide for veterans' long-term care needs. Over 78 percent ($5.4 billion) of VA's total long-term care spending in FY 2011 will be for nursing home care.

While DAV would not oppose favorable consideration of this measure, we ask this Subcommittee to address our concerns and the glaring hole in VA's long-term care program considering the Department's stated long term care mission is to "continue to focus its long-term care treatment in the least restrictive and most clinically appropriate setting by providing more non-institutional care than ever before and providing Veterans with care closer to where they live."[27] This is not the case today.

H.R. 5996—To direct the Secretary of Veterans Affairs to improve the prevention, diagnosis, and treatment of veterans with chronic obstructive pulmonary disease.

This bill would require VA to develop treatment protocols and related tools for the prevention, diagnosis, treatment, and management of chronic obstructive pulmonary disease (COPD), and improve biomedical and prosthetic research programs regarding COPD.

The bill would require VA to develop pilot programs to demonstrate best practices for the diagnosis and management of COPD, in coordination with the Director of the Centers for Disease Control and Prevention (CDC), the Director of the Indian Health Service, and the Administrator of the Health Resources and Services Administration. Moreover, the bill would require VA to develop improved techniques and best practices, in coordination with the Director of the CDC, for assisting individuals with COPD in smoking cessation.

DAV has no specific resolution adopted by our membership to support this particular measure; however, we recognize that until 1976, cigarettes were routinely included free of charge in military field rations and for decades were sold at deeply discounted prices in commissaries and exchanges. Except for Navy and Marine bases, tobacco products are still sold at discounted prices in military exchanges and commissaries. Military-induced smoking accounts for a significant percentage of the higher lung cancer rates, perhaps as high as 50 percent to 70 percent of the excess deaths. The percentage of active duty military who ever smoked was highest during the Korean and Vietnam Wars (75%). Currently overall 32.2 percent of active duty military personnel smoke versus 19.8 percent of adults in the civilian population and 22.2 percent of veterans overall.

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[24] Susan H, Marylou G, et al., *Evaluation of Assisted Living Pilot Program.* Report to Congress. Washington, DC, Office of Geriatrics and Extended Care, VHA, July 2004.

[25] American Association of Homes and Services for the Aging. *Aging Services: The Facts.* Available at: www.aahsa.org. Accessed on:

[26] MetLife Mature Market Institute. *The 2009 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs.* New York, NY 2009. Available at: http://www.metlife.com/assets/cao/mmi/publications/studies/mmi-market-survey-nursing-home-assisted-living.pdf. Accessed on: September 8, 2010.

[27] Department of Veterans Affairs. *FY 2011 Budget Submission: Medical Programs and Information Technology Programs.* Vol. 2:1A–8. Washington, DC. February 2010.

In terms of maintaining and improving the general health of veterans and of our membership, and consistent with VA's health maintenance mission, DAV would offer no objection to the enactment of this bill.

H.R. 6123—Veterans' Traumatic Brain Injury Rehabilitative Services' Improvements Act of 2010

If enacted this bill would sharpen rehabilitative requirements within the VA to ensure that veterans with traumatic brain injury (TBI) under VA care are afforded opportunity for maximal rehabilitation, including in their behavioral and mental health care needs, and to sustain improvements they have made during the acute rehabilitative period following injury, and hopefully leading to independence and a better quality of life. The bill would redefine the term "rehabilitative services" as it appears in section 1701(8) of title 38, United States Code, by including elements that address sustenance of VA efforts to prevent loss of functional gains achieved early in the rehabilitative process, and to maximize an injured individual's independence. Finally, the bill would amend section 1710E(a) of title 38, United States Code, to clarify that in the instance of the Secretary's execution of a cooperative agreement with a public or private entity with long-term neurobehavioral rehabilitation and recovery programs, for hospital care or medical services for a brain-injured veterans, that such cooperative agreements would also include rehabilitative services for these veterans.

We appreciate the intentions of the sponsors of this bill to fill an existing gap in current law affecting the treatment of brain injured veterans. Our members adopted DAV National Resolution No. 215 at our most recent convention, held in Atlanta, Georgia July 31–August 3, 2010. That resolution urges Congress and the Department of Veterans Affairs to establish a comprehensive rehabilitation program, and to sustain effective programs for veterans with traumatic brain injury. This legislation is fully consistent with our resolution; therefore, we endorse the bill and urge Congressional enactment.

H.R. 6127—To amend title 38, United States Code, to provide for the continued provision of health care services to certain veterans who were exposed to sodium dichromate while serving as a member of the Armed Forces at or near the water injection plant at Qarmat Ali, Iraq, during Operation Iraqi Freedom.

This measure would provide access to VA health care for veterans who were in and around the water injection facility in the Basrah oil fields at Qarmat Ali, Iraq, during the spring and summer of 2003. These veterans would be able to enroll, within a 5 year window of notification of exposure from the VA, into the VA health care system under the Department's "special treatment" authority of Priority Group 6 to receive VA health care.

DAV supports this bill in accordance with our Resolution No. 298 calling for congressional oversight and Federal vigilance to provide for research, health care, and improved surveillance of disabling conditions resulting from military toxic and environmental hazards exposures. We also ask for the Subcommittee's consideration to afford the same eligibility to those veterans who were exposed to toxic substances as a result of disposing a poisonous mixture of plastics, metals, paints, solvents, tires, used medical waste and asbestos insulation in open-air trash burn pits in Iraq and Afghanistan. Tests on the burn pits in the war zones have shown that the fires released dioxins, benzene and volatile organic compounds, including substances known to cause cancer.

Exposure to these toxic substances is not in question since VA is already gathering data to monitor potential health problems in troops who say they were made ill by exposure to smoke from open-air burn pits in Iraq and Afghanistan with the goal of establishing potential correlations with health problems among affected veterans.

Draft Legislation—To amend title 38, United States Code, to ensure that the Secretary of Veterans Affairs provides veterans with information concerning service-connected disabilities at health care facilities.

DAV supports the intention of this bill in particular ensuring the availability of information at readily accessible locations. We urge the Subcommittee to include contact information of congressionally chartered Veterans Service Organizations (VSO) that can provide free counseling and assistance to veterans and their dependents in pursuing claims for compensation of service-connected conditions. We are concerned however, with the administrative burden on VA employees orally being

required to ask each veteran who visits a VA facility if the veteran would like to receive information when the total number outpatient care encounters in FY 2009 was 92,892,834.[28] While we support the good intentions of this bill, this notification requirement may prove impossible to implement.

Draft Legislation—To amend title 38, United States Code, to make certain improvements in programs for homeless veterans administered by the Secretary of Veterans Affairs, and for other purposes.

Veterans are over-represented in the homeless population. According to the VA, about one-third of the adult homeless population has served in uniform. Current population estimates suggest that over 130,000 veterans are homeless on any given night and twice as many experience homelessness at some point during the course of a year. Homelessness is also a growing problem for our veterans returning from Iraq and Afghanistan, especially as they face higher rates of unemployment, and often carry the effects of posttraumatic stress disorder (PTSD) and traumatic brain injury (TBI) into their post-service years. Statistics from VA and the National Coalition for Homeless Veterans (NCHV) indicate two-thirds of homeless veterans do not receive the help they need to transition from homelessness to become productive citizens.

Section 2 of this draft bill would expand the existing special needs grant program by including new eligible public or nonprofit private entities that meet prescribed criteria and requirements as well as authorize increased appropriations levels for this program. Those homeless veterans with special needs include women, women with minor dependents, frail elderly; terminally ill; or chronically mentally ill.

Mr. Chairman, there is a great need for specific emphasis on the needs of homeless women veterans, homeless veterans with children, and homeless veterans suffering from serious mental illness. We have greater numbers of women veterans coming to VA with post-deployment mental health needs due to combat exposure, which puts them at higher risk for becoming homeless. Likewise, many homeless veterans with minor children have been unable to avail themselves of VA's excellent programs because no support for their children is available in VA programs. It is clear this measure will provide comprehensive services to this vulnerable population including homeless veterans who are frail elderly, terminally ill, or suffering from serious mental illness.

Section 3 of this draft bill would increase the amount authorized to be appropriated for the Grant and Per Diem (GPD) program for homeless veterans to reflect anticipated changes in the cost of furnishing services and to take into account the cost of providing services in a particular geographic area. It would also make these payments based on annual costs instead of daily costs. This section is identical to Section 3 of H.R. 4810, the End Veterans Homelessness Act of 2010, which was unanimously passed by the House on March 22, 2010. H.R. 4810 includes provisions addressing VA's concern outlined in testimony submitted to this Subcommittee on October 1, 2009, by allowing the Department to make payments to per diem grant recipients on a quarterly basis, and would create a quarterly reconciliation process where adjustments are made to increase or decrease payments. DAV believes Section 3 of the draft bill would provide organizations serving homeless veterans the flexibility to look at their program designs to provide the full range of supportive services in the most economical manner.

The delegates to our most recent National Convention in Atlanta, Georgia, July 31–August 3, 2010, adopted Resolution No. 223, which urges Congress to sustain sufficient funding to support the VA's initiative to eliminate homelessness among veterans in the next 5 years and strengthen the capacity of the VA Homeless Veterans program.

Furthermore, our resolution urges Congress to continue to authorize and appropriate funds for competitive grants to community-based and public organizations including the Department of Housing and Urban Development to provide health and supportive services to homeless veterans placed in permanent housing. Accordingly, DAV supports this measure but urges the Subcommittee to ensure adequate funding levels are appropriated for VA homeless programs, which historically have been seldom sufficient to provide for all the veterans who may need to take advantage of these critical services.

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[28] Department of Veterans Affairs, Office of Inspector General, *Health care Inspection Review of Inappropriate Copayment Billing for Treatment Related to Military Sexual Trauma,* February 2008.

Mr. Chairman, this concludes DAV's testimony on these measures. DAV appreciates the opportunity to offer our positions on these bills. I would be pleased to address any questions from you or other Members of the Subcommittee.

Prepared Statement of Ralph Ibson, Senior Fellow for Policy, Wounded Warrior Project

Chairman Michaud, Ranking Member Brown and Members of the Subcommittee:

Thank you for inviting Wounded Warrior Project (WWP) to offer our views on legislation pending before the Subcommittee.

Wounded Warrior Project was founded on the concept of warriors helping warriors. From our outstanding service programs to advocacy, we work to help ensure that this generation of wounded warriors thrives—physically, psychologically and economically. WWP's policy objectives are targeted to filling gaps in programs or policies—and eliminating barriers—that impede warriors from thriving. As such, we bring an important perspective to this morning's hearing.

Our public policy positions reflect the experiences and concerns of those wounded warriors and family members we serve on a day to day basis around the country. Several of the issues that would be addressed by legislation under consideration today are of great interest to our constituency, and we look forward to discussing those bills. Several other bills address concerns that our warriors and families have simply not encountered, and we will not offer a position on those issues.

One of the bills before you, H.R. 6123, addresses some of the deepest concerns we have heard from warrior's families, and we are very pleased to be able to enthusiastically support this important bill.

Traumatic Brain Injury Rehabilitation

Impressive military logistics and advances in military medicine have saved the lives of OEF/OIF combatants who would likely not have survived in previous conflicts. As a result, servicemembers are returning home in unprecedented numbers with severe polytraumatic injuries. Among the most complex are severe traumatic brain injuries. Each case of traumatic brain injury is unique. Depending on the injury site and other factors, individuals may experience a wide range of problems—from profound neurological and cognitive deficits manifested in difficulty with speaking, vision, eating, or incontinence to marked behavioral symptoms. While individuals who have experienced a mild or moderate TBI may experience symptoms that are only temporary and eventually dissipate, others may experience symptoms such as headaches and difficulty concentrating for years to come. Those with severe TBI may face such profound cognitive and neurological impairment that they require a lifetime of caretaking. As clinicians themselves recognize, it is difficult to predict a person's ultimate level of recovery.[1] But to be effective in helping an individual recover from a brain injury and return to a life as independent and productive as possible, rehabilitation must be targeted to the specific needs of the individual patient. In VA parlance, rehabilitation must be "veteran-centered."

While many VA facilities have dedicated rehabilitation-medicine staff, the scope of services actually provided to veterans with a severe TBI can be limited, both in duration and in the range of services VA will provide or authorize. It is all too common for families—reliant on VA to help a loved one recover after sustaining a severe traumatic brain injury—to be told that VA can no longer provide a particular service because the veteran is no longer making significant progress. Yet ongoing rehabilitation is often needed to maintain function,[2] and veterans with traumatic brain injury who are denied maintenance therapy can easily regress and lose cognitive, physical and other gains made during earlier rehabilitation.

Some do make a good recovery after suffering a severe TBI. But many have considerable difficulty with community integration even after undergoing rehabilitative care, and may need further services and supports.[3] Medical literature has documented the need to use rehabilitative therapy long after acute care ends to maintain

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[1] Sharon M. Benedict, PhD, "Polytrauma Rehabilitation Family Education Manual," Department of Veterans Affairs Polytrauma Rehabilitation Center, McGuire VA Medical Center, Richmond, Virginia; http://saa.dva.state.wi.us/Docs/TBI/Family__Ed__Manual112007.pdf (accessed April 27, 2010).

[2] Ibid.

[3] Nathan D. Cope, M.D., and William E. Reynolds, DDS, MPH; "Systems of Care," in *Textbook of Traumatic Brain Injury* (4th ed.), American Psychiatric Publishing (2b), 533–568.

function and quality of life.[4,5,6] While improvement may plateau at a certain point in the recovery process, it is essential that progress is maintained through continued therapy and support. The literature is clear in demonstrating the fluctuation that severe TBI patients may experience over the course of a lifetime. One study found that even 10 to 20 years after injury individuals were still suffering from feelings of hostility, depression, anxiety, and further deficiencies in psychomotor reaction and processing speed.[7] While some are able to maintain functional improvements gained during acute rehabilitative therapy, others continue to experience losses in independence, employability, and cognitive function with increasing intervals of time.[8] Given such variation in individual progress rehabilitation plans must be dynamic, innovative, and long term—involving patient-centered planning and provision of a range of individualized services.[9]

For this generation of young veterans, reintegration into their communities and pursuing life goals such as meaningful employment, marriage, and independent living may be as important as their medical recovery. Yet studies have found that as many as 45 percent of individuals with a severe traumatic brain injury are poorly reintegrated into their community, and social isolation is reported as one of the most persistent issues experienced by such patients.[10] Yet research has demonstrated that individuals with severe TBI who have individualized plans and services to foster independent living skills and social interaction are able to participate meaningfully in community settings.[11] While improving and maintaining physical and cognitive function is paramount to social functioning, many aspects of community reintegration cannot be achieved solely through medical services. Other non-medical models of rehabilitative care—including life-skills coaching, supported employment, and community-reintegration therapy—have provided critical support for community integration. But while such supports can afford TBI patients opportunities for gaining greater independence and improved quality of life, VA medical facilities too often deny requests to provide these "non-medical" supports for TBI patients. While such services could often be provided under existing law through other VA programs,[12] it is troubling that institutional barriers stand in the way of meeting veterans' needs under a "one-VA" approach. Instead, rigid adherence to a medical model and foreclosing social supports is, unfortunately, a formula for denying veterans with severe traumatic brain injury the promise of full recovery. This barrier must be eliminated.

H.R. 6123 would amend current law to clarify the scope of VA's responsibilities in providing rehabilitative care to veterans with traumatic brain injury. While current law (codified in sections 1710C and 1710D of title 38, U.S. Code) directs VA to provide comprehensive care in accord with individualized rehabilitation plans to veterans with traumatic brain injury, in some instances warriors with severe traumatic brain injury are not receiving services they need, and in other instances, VA has cut off rehabilitative services prematurely.

Ambiguities in current law appear to contribute to such problems. For example, while the above-cited provisions of law do not define the term "rehabilitation," the phrase "rehabilitative services" is defined for VA health-care purposes (in section 1701(8)) to mean "such professional, counseling, and guidance services and treatment programs as are necessary to restore, to the maximum extent possible, the physical, mental, and psychological functioning of an ill or disabled person." That provision could be read to limit services to *restoring* function, but not to *maintaining* gains that had been made. (Yet limiting TBI rehab care in that manner risks setting back progress that has been made.) The definition is also limited to services to restore "physical, mental and psychological functioning." In our view, rehabilitation from a traumatic brain injury should be broader, to include also cognitive and voca-

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[4] Hoofien D, Gilboa A, Vakils E, et al. "Traumatic brain injury (TBI) 10–20 years later: a comprehensive outcome study of psychiatric symptomatology, cognitive abilities and psychosocial functioning." *Brain Injury* 15.3(2001):189–209.

[5] Sander A, Roebuck T, Struchen M, et al. "Long-term maintenance of gains obtained in postacute rehabilitation by persons with traumatic brain injury." *Journal of Head Trauma Rehabilitation* 16.4(2001): 356–373.

[6] Sloan S, Winkler D, Callaway L. "Community Integration Following Severe Traumatic Brain Injury: Outcomes and Best Practice." *Brain Impairment* 5.1(May 2004): 12–29.

[7] Hoofien, et al. 201

[8] Sander, et al. 370

[9] Sloan, et al. 22

[10] Sloan, et al. 12

[11] Nathan D. Cope, M.D., and William E. Reynolds, DDS, MPH; "Systems of Care," 533–568.

[12] See VA's program of independent living services (administered by the Veterans Benefits Administration) under 38 U.S.C. sec. 3120, and VA's authority under 38 U.S.C. sec. 1718(d)(2) to furnish supported employment services as part of the rehabilitative services provided under the compensated work therapy program (administered by the Veterans Health Administration).

tional functioning, and, should not necessarily be limited to services furnished by health professionals.

In essence, H.R. 6123 would provide that in VA's planning for and providing care to veterans with traumatic brain injuries—

1. rehabilitative services must be directed not simply to "improving functioning" but to sustaining improvement and preventing loss of functional gains that have been achieved (and, as such, rehabilitation may be continued indefinitely); and
2. rehabilitative services are not limited to services provided by health professionals but include any other services or supports that contribute to maximizing the veteran's independence and quality of life.

WWP strongly supports this legislation. It would eliminate barriers too many have experienced. Most importantly, it would offer the promise of making good on the profound obligation we owe those who struggle with complex life-changing brain injuries.

Prosthetic and Orthotic Services

Turning to another area of keen importance, H.R. 5428 would establish new requirements regarding VA provision of prosthetic and orthotic care. Specifically, it would direct VA to disseminate, display, and educate department employees on an Injured and Amputee Veterans Bill of Rights; and establish a process for collecting, monitoring and resolving complaints. We applaud this bill's focus on provision of high quality prosthetic and orthotic technology and service, and concur that the proposed bill of rights aptly captures many concerns voiced by warriors we serve. But we do not believe that H.R. 5428 goes far enough to resolve those concerns, and would be pleased to work with the Subcommittee to explore avenues for bolstering the bill.

To illustrate the concerns we have encountered, let me share a perspective from retired Army captain Jonathan Pruden, who in 2003 became one of the first IED casualties of Operation Iraqi Freedom. After 20 operations at 7 different hospitals that included amputation of his right leg, he works with hundreds of wounded warriors in Florida, Georgia, South Carolina and Alabama as one of our Area Outreach Coordinators. Reflecting his own experience, Captain Pruden reported that—

> "VA had attempted three times to make an orthotic for me, but I'm still wearing the delaminating pair I received at Walter Reed in 2004. I receive my care from a private prosthetist because I feel that the VA practitioners I met were not going to be able to provide the level of expertise, fit, or care I desired.
>
> "For many years now the majority of VA patients have been middle-aged to elderly. I can't tell you how many times I was asked if I lost my leg due to diabetes or vascular disease. When I went in to my local prosthetics clinic and started to ask about a Renegade foot vs. a flex foot or a Ceterus, I got blank stares and a few 'Oh, yea, I've heard about those. They're pretty cool aren't they?' As of October about 30 percent of VA prosthetists had no national certifications. The technology and funding seem to be there but without practitioners who really care it won't matter."

He described the experience of having been asked recently by the head of his local VA prosthetics lab to come in and have a socket made using a new computer-aided design (CAD) device. "I was happy to do it," he said, "and went in for a training session with the company technician. Unfortunately, the only ones who learned how to use the device were the chief and me. The other prosthetists were present but clearly showed no interest in learning how to use the new device. Their attitude seemed to be, that they had been doing this for a long time and could do what they needed without all this high-tech gadgetry."

While there have been substantial improvements in VA prosthetic and orthotic care over the years, the VA-launched *Survey for Prosthetic Use* highlights the need for further changes. It showed, for example, that overall only 16 percent of Vietnam veteran survey participants and 9 percent of OIF/OEF survey participants received prostheses directly from VA, while 78 percent of Vietnam participants and 42 percent of OIF/OEF participants used prostheses from private sources under contract with VA.[13] Among its other findings were that participants experienced lower satisfaction when VA was compared with private and DoD care except for participants with upper-limb loss for whom satisfaction with prosthetic providers was similar across all conflicts. A concern across all survey participants was the dearth of infor-

[13] D.G. Smith and G.E. Reiber, "VA paradigm shift in care of veterans with limb loss," Journal of Rehabilitation Research and Development, vol. 47, number 4 (2010).

mation on new prosthetic devices. The study's findings on differences in satisfaction between sources of care suggest a need for continued provider education and system evaluation.[14]

H.R. 5428, in listing rights that VA should provide to veterans who have lost a limb, identifies many important expectations VA should be meeting, and unfortunately, often is not—ranging from continuity and comparability of care in the transition from DoD to VA to consistent services and technology at all VA medical facilities. We share some of the frustration underlying this legislation, and welcome Chairman Filner's spotlighting these issues. But we are not confident that enacting this measure would resolve the problems it highlights. Directing VA to disseminate and display a list of "rights" does not make those expectations enforceable; nor does it require VA to take the kind of steps that would convert amputees' expectations into reality. Accordingly, we recommend that the bill be expanded to direct the Department to institute the kind of changes needed to realize the measure's objectives.

The Federal Recovery Coordinator Program

H.R. 4041 would direct VA to fund the training of recovery coordinators through a school of nursing or medicine. We know from the experience of severely wounded warriors and their families how singularly important the Federal Recovery Coordinator (FRC) Program has been. We have also testified to the need to "grow" that program—to ensure, for example, that those who sustained profound injuries prior to the creation of the FRC program, and who still need such help be assigned a qualified FRC. The number of FRC's has not grown commensurately with the need for such support. So we welcome the vision inherent in the bill that there is a need for additional trained recovery coordinators. Given the requirements of these demanding positions, FRC's must be highly experienced health professionals who are knowledgeable about the health and benefits systems on which warriors and their families may depend. As such, FRCs may need specialized education and training. But it is not clear that VA needs legislation to mount such training; further we defer to the Director of the FRC program as to whether the model called for under that bill is necessarily the optimal way to meet the program's training needs.

Other Legislation

H.R. 5641 would provide specific authority for VA's medical foster-home program—an initiative under which VA both places veterans who need long-term daily care in family-like settings under contract arrangements and provides those veterans with home-health services. Such arrangements can provide a good option for chronically ill or severely disabled veterans who cannot live with their own families and do not want to be institutionalized. While we understand that this program was designed to help older veterans, it may meet a need on the part of some number of much younger OEF/OIF veterans as well. We support this provision.

H.R. 6127 would provide VA health care eligibility to veterans who have received government notification of possible exposure to a particular carcinogen at or near a specific site in Iraq in 2003 and have enrolled in the VA health care system within 5 years after such notification. H.R. 6127 is generally consistent with prior laws, under which Congress has extended health care eligibility to veterans presumed to have been exposed to toxic substances (including herbicides in Vietnam, radiation, and chemical and biological warfare testing). We have no objection to extending that principle, but question legislating on an incident by incident basis. Given the potential range of toxic substances to which veterans might have been exposed in Iraq and Afghanistan—we recommend that consideration be given to a systematic approach to addressing toxic exposures that are the subject of VA or DoD notifications to veterans or servicemembers.

Homeless Veterans' draft bill: The Subcommittee has before it a draft bill that would make revisions to certain grant programs designed to assist homeless veterans. Among its provisions, the bill would clarify that any public or nonprofit private entity with the capacity to administer a grant is eligible for grant support to assist homeless "special needs'" veterans; would establish specific requirements for such grants; and increase the authorized funding levels for such grants. It would also revise the framework of the current "grant and per diem" comprehensive service program to eliminate the requirement that payments to grantees be based on a daily cost of care, and would provide for annual adjustments in rates of payment.

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[14] G.M. Berke, J. Fergason, J.R. Milani, J. Hattingh, M. McDowell, V. Nguyen, G.E. Reiber; "Comparison of satisfaction with current prosthetic care in veterans and servicemembers from Vietnam and OIF/OEF conflicts with major traumatic limb loss," Journal of Rehabilitation Research and Development, vol. 47, number 4 (2010) 361–71.

WWP applauds the goal of eliminating homelessness among veterans, and recognizes the benefits of VA's partnering with public and nonprofit entities that are dedicated to helping homeless veterans. We have no objection to fine-tuning these grant programs, though we have no position on the specific changes proposed in this measure.

H.R. 3843 would require VA to publish on its Web site an easily accessible, redacted version of all medical quality-assurance records, no later than 30 days after the record is created, to include all such records created during the 2 years prior to the date of enactment. As we understand it, such records would be redacted to delete the names and other identifying information of any individual patient or employee.

This Committee has a long record of concern for ensuring the quality of the care afforded veterans in the VA health care system—a concern WWP certainly shares. A vibrant, healthy medical quality-assurance program is one important element in fostering a culture of quality-improvement in health-care delivery. Certainly, transparency is an important element in sustaining confidence in the quality of VA care. At the same time, confidentiality has long been deemed a critical element of ensuring the integrity of an effective medical quality-assurance program. This bill raises questions in that regard. Would redacted records still contain enough information to lead to unwarranted identification of patients or clinicians, particularly at smaller facilities? Would providers, fearful of such disclosures, be more likely to compromise the quality-assurance process? WWP has no position on how best to balance the inherent conflict this bill raises between transparency and ensuring robust systemic health care reviews, but believes this is an area in which to proceed cautiously.

Thank you for considering our views on these bills. WWP has no position on the other bills under consideration this morning.

Prepared Statement of Hon. Chellie Pingree, a Representative in Congress from the State of Maine

Chairman Michaud, Ranking Member Brown, thank you for having me here today. I am happy to be here in front of the Veterans Affairs Subcommittee on Health to talk about a bill I recently introduced, the Inform All Veterans Act, H.R. 6220. This bill will ensure that veterans are given complete information about service connected benefits at all VA Medical Centers.

All too often, a veteran will visit a VA Medical Center, ask how to file a claim for service connection, and are either not given the correct information on how to pursue their claim, or worse they leave the Medical Center thinking that their claim is under way when it is not.

This is a symptom of the Veterans Health Administration and Veterans Benefits Administration not communicating with each other effectively and operating as silos. Interagency communication is a necessity, especially when we are talking about basic, earned services.

Under this bill, the VHA would be required to ask during the check-in process if a veteran would like information about the disability claims process. If the answer is yes, then straightforward, easy to understand literature is shared which will outline how to contact VBA or a Veterans Service Officer to start the disability claims process.

Congress has a responsibility to take care of our veterans. We cannot do that if we do not inform them about the health care and compensation their service has earned. This common sense approach will help veterans avoid the bureaucratic red tape that prohibits many veterans from even filing a claim.

Again, thank you Chairman Michaud and Ranking Member Brown for allowing me to be here today, and for all you have done on behalf of our Nation's veterans. I am happy to answer any questions the panel has about this bill.

Prepared Statement of Robert L. Jesse, M.D., Ph.D., Principal Deputy Under Secretary for Health, Veterans Health Administration, U.S. Department of Veterans Affairs

Good Morning Mr. Chairman and Members of the Subcommittee:

Thank you for inviting me here today to present the Administration's views on several bills that would affect the Department of Veterans Affairs' programs of benefits and services. With me today is Walter A. Hall, Assistant General Counsel. Un-

fortunately, we do not yet have views and estimates for H.R. 6123, H.R. 6127, or the draft bills on homeless programs, homeless prevention, and requirements for providing Veterans with information regarding compensation claims and service-connected disabilities. We will forward these as soon as they are available.

H.R. 3843—"Transparency for America's Heroes Act"

Public Law 96–385, enacted on October 7, 1980, established the confidentiality of medical quality-assurance records now codified at 38 U.S.C. 5705. H.R. 3843 would amend section 5705 to dramatically limit the scope of this confidentiality. Specifically, the bill would limit confidentiality to records containing the name or other identifying information of a patient, employee, or other individual associated with VA for purposes of a medical-quality assurance program if disclosure would clearly constitute an invasion of personal privacy. However, this provision would permit the wholesale release of information if the name or other identifying information is redacted. Moreover, H.R. 3843 would require VA to make quality-assurance records available on the Department's Web site within 30 days of their creation. The bill would also require VA to make available on the Internet all quality-assurance records created in the 2-year period preceding enactment of this Act.

VA strongly opposes this legislation. Confidentiality is a fundamental and critical element of quality-assurance programs. It improves patient safety outcomes by creating an environment in which providers may report and examine patient safety events without fear of recrimination or an increased risk of liability. As with VA, the Department of Defense, all 50 states and the District of Columbia have statutory restrictions on disclosure of quality-assurance information. The public reporting requirements in H.R. 3843 would require a dramatic departure from this widely held standard and would create an abrupt and highly disruptive reversal of long-standing and successful VA policy. VA policy currently provides confidentiality for certain records that contain discussions of quality of health care, even if they do not identify an individual. If this information were released, employees may be less willing to be forthcoming about quality issues that arise at their facilities. In addition, implementing the legislation would be both costly and logistically challenging.

While opposed to H.R. 3843, VA is committed to transparency regarding the quality and safety of the care it provides. Since 2008, VA has published a Hospital Report Card containing extensive quality and safety performance data for each of our 153 medical centers. In addition, select quality data from VA medical centers is posted on the Centers for Medicare and Medicaid Services' Hospital Compare Web site. This transparency allows Veterans and other stakeholders to compare the quality of VA medical centers with other hospitals in their communities. Due to both logistical and legal reasons, not all VHA quality data is available on Hospital Compare. VA has created its own Hospital Compare site to address this gap, although VA's site provides comparisons among VA medical centers rather than other hospitals in a Veteran's community. VA also hosts an additional Web site which publishes industry-standard quality scores developed by The Joint Commission and the National Committee on Quality Assurance. While targeting a more technical audience, this site allows readers to compare VA to other facilities, both locally and nationally. An enhanced version of this Web site is expected to launch in October 2010.

We understand that some of the interest in transparency is to promote accountability. VA strongly believes that our employees must be held to the highest standard when delivering care; however, it is also imperative that employees know that they can report information fully and completely so that changes can be made and care can be improved. The agency is concerned that the release of quality-assurance documents may create a chilling effect, deterring our employees from providing accurate information and resulting in poorer quality care. VA welcomes the opportunity to meet with the Committee to discuss employee accountability as well as additional approaches to increasing the transparency in VA's quality-assurance programs.

VA estimates the cost of this provision to be $22 million in FY 2011, $47.9 million over 5 years, and $88.5 million over 10 years.

H.R. 4041—"Improvements in the Federal Recovery Coordinator Program"

H.R. 4041 would require VA to train recovery coordinators at a qualified nursing or medical school. This school would also lead a literature review and a consensus conference and develop training modules for care coordination as well as software that is compatible with VA systems. H.R. 4041 would authorize appropriations of $1.2M to carry out these elements of the bill and direct the Secretary to subcontract for the development of care-coordination software. It would also require VA to convene a conference for care coordinator tool validation and to conduct a software pilot program. $1.2M would be authorized to carry out these provisions. Section 2(d)

would authorize the qualified nursing or medical school to train 45 recovery coordinators, and authorize $500,000 for this training for each of fiscal years 2010, 2011, and 2012.

VA does not support H.R. 4041. VA has established measures in place that address the goals of this legislation. The Federal Recovery Coordination Program (FRCP) was created in 2007 in response to a recommendation from the President's Commission on Care for America's Returning Wounded Warriors. The program has been successfully implemented in 13 sites around the country and there are currently 20 Federal Recovery Coordinators (FRCs) Newly hired FRCs come to VA's Central Office for intense training and orientation. During this training, subject-matter experts provide in-depth reviews of topics frequently encountered by FRCs in the course of assisting their clients. Topics range from Social Security Disability Insurance to the Department of Defense (DoD) disability evaluation system. After completion of orientation, the new FRCs return to their station where they complete all necessary training and paperwork unique to their host facility. They also engage in a mentor/mentee relationship with another more experienced FRC, which helps with process questions and resource identification. Weekly supervisor calls also provide a structured review of cases and one-on-one problem solving is available during the week if needed. In addition to the initial orientation, FRCs also receive quarterly training (4 weeks total) and have standard educational requirements for the program and to meet their state license standards. Training topics are identified by the FRCs for these events to maximize their learning around specific information needed to assist clients.

The language of section 2(b) of H.R. 4041 would require recovery coordinators to be trained at a nursing or medical school; however, it is unclear what that training would add to the current content-focused training provided by subject matter experts. Moreover, this section would also require the school to lead a literature review and develop evidence-based guidelines for recovery coordination. A structured evidence-based review is unlikely to produce much insight or definition as there is a lack of supporting data. The cost of implementing this section is estimated to be $1.2 million.

Section 2(c) of the bill would require the development of a care coordination software tool and a program piloting the software. It is unclear whether this tool is intended to be used for training or for functional data management. FRCP already has a functional data management tool that is sufficiently flexible to meet the growing needs of the program. It is contained within the Veterans Tracking Application (VTA) and iterative enhancements to the system over the past 2 years have provided increasingly easier data entry and report-writing capabilities. Through a related effort, FRCP is also part of an information sharing initiative which will improve efficiency and accuracy by enabling information transfer among facilities. It is estimated that the software and pilot required by this section would cost $1.2 million. We note that the word "subcontractor" in section 2(c)(1) should be "contractor."

Section 2(d) of H.R. 4041 would authorize training for 45 coordinators. We do not understand the rationale for this specific number. Current staffing is based on the need for additional personnel through monitoring of referrals to the FRCP program. As discussed above, there are currently 20 coordinators in the system and we are in the process of hiring an additional five FTE's to serve in facilities in CA, TX, VA, and Washington D.C. The cost of section 2(d) is estimated to be $500,000 in FY 2010, 2011, and 2012.

VA estimates the total cost of H.R. 4041 to be $3.9 million over 3 years.

H.R. 5428—"Injured and Amputee Bill of Rights"

H.R. 5428 would require the Secretary to establish a Bill of Rights for injured and amputee Veterans that would be displayed prominently in prosthetic and orthotics clinics throughout VA. H.R. 5428 would also require the Veteran liaison at each medical center to collect information relating to the alleged mistreatment of injured and amputee Veterans. Each quarter this information would have to be reported to the Department's Chief Consultant, Prosthetic and Sensory Aids who would be required to investigate and address the alleged mistreatment.

We recognize the unique needs of injured and amputee veterans. Across the country, VA clinics and Prosthetic and Orthotic Services provide specialized care and treatment to these brave men and women. We understand that injured and amputee veterans have clinical and medical needs that set them apart from other patients at VA facilities—but they are not set apart in their rights. The basic tenets of patient care should not vary based either on the condition or injury experienced by a Veteran or the type of medical services a Veteran receives. VA does not support H.R. 5428, because this legislation would confer unique rights upon a limited group of Veterans. Giving special rights to amputee patients that are not available to

other enrolled Veterans would result in inconsistent and inequitable treatment among our Veteran-patients.

VA adheres to strict standards of patient treatment. VA regulations require that a comprehensive list of patient's rights be posted prominently in all VA facilities. Patients who are concerned about the quality of their care have a number of options already available for addressing these issues. Every VA medical center has a patient advocate dedicated to addressing the clinical and non-clinical complaints and concerns of our Veterans and their families. Many facilities also include a "Letter to the Director" drop box where Veterans can communicate directly with the Director and raise issues and concerns. In addition, VA's Prosthetic and Sensory Aid Service maintains a Web site that offers Veterans and family members an opportunity to ask questions or raise concerns directly with VA Central Office Staff. The Department also works closely with Veterans Service Organizations to identify and respond to any concerns with quality and access to care.

If extended to the entire patient population, the Department would support the majority of "rights" that are included in this 'Bill of Rights,' e.g., the right to receive appropriate treatment, the right to participate meaningfully in treatment decisions, etc. However, a few of the "rights" raise serious concerns. Specifically, the Veteran's "right to select the practitioner that best meets his or her orthotic and prosthetic needs, including a private practitioner with specialized expertise," is not sound from a medical perspective. VA's practitioners are highly qualified, and VA is able to continually monitor their performance through its rigorous quality management programs. As part of those programs, VA has an extensive credentialing and privileging program, which surpasses those found in the private sector. VA, generally, does not have ready and efficient access to Veterans' non-VA medical records, as few private providers, if any, employ an electronic medical record. Were these Veterans permitted to choose their own private providers, VA could not oversee the quality of their care, ensure their private providers possess adequate qualifications, and ensure they receive a continuum of services. One must also bear in mind that VA's legal privacy and confidentiality requirements exceed those applicable to the private sector.

In short, VA has the needed expertise in managing Veterans' unique issues, including unparalleled expertise in managing and caring for amputee patients, particularly those wounded in combat. What we cannot provide through our own clinics and Prosthetic and Orthotic Services, we readily purchase through contractual arrangements with more than 600 vendors and providers who are approved by the Department. Although our Prosthetics and Orthotics Service labs are top-notch and very successful in timely meeting Veterans' needs, we actively evaluate our programs to identify any areas in need of improvement. With respect to our contractor-prosthetists, we conduct quality-management programs to oversee their performance, thereby protecting our Veterans and assuring they receive quality services. These efforts would be significantly hindered were Veterans permitted to self-refer to private prosthetists and practitioners. Veterans could become a vulnerable marketing target by those holding themselves out as having special expertise in this field.

Moreover, including that "right" in a "bill of rights" would be misleading. Congress has very carefully limited our authority to pay for non-VA care and services. Stating that a Veteran has the "right" to choose one's own provider would still not make the Veteran eligible for private care at VA-expense if he or she does not otherwise meet the eligibility terms of 38 U.S.C. 1703. This "right" could mislead Veterans into believing they are entitled to seek prosthetic or orthotic care or services from a non-VA provider at VA-expense. As a result, some could incur private medical expenses for which they would be personally liable.

There would be no additional costs associated with enactment of H.R. 5428.

H.R. 5516—"Access to Appropriate Immunizations for Veterans Act of 2010"

H.R. 5516 would amend the definition of "preventive health services" in 38 U.S.C. 1701 to specifically include immunizations. This bill would further amend section 1701 to include the term "recommended adult immunization schedule" and define it to mean the schedule established by the Advisory Committee on Immunization Practices (ACIP). H.R. 5516 would also amend section 1706 of title 38, to require the Secretary to develop quality measures and metrics to ensure that Veterans receive immunizations on schedule. These metrics would be required to include targets for compliance and, to the extent possible, should be consistent and implemented concurrently with the metrics for influenza and pneumococcal vaccinations. Moreover, the bill would require that these quality standards be established via notice and comment rulemaking. H.R. 5516 would also require that details regarding

immunization schedules and quality metrics be included in the annual preventative services report required by 38 U.S.C. 1704 beginning in January of 2011.

VA does not support H.R. 5516. VA currently conducts ongoing initiatives that address the goals of this legislation. The current definition of "preventive health services" at 38 U.S.C. 1701 includes immunization against infectious disease. Moreover, these immunizations are specifically included in VA's medical benefits package. VA is an *ex-officio* member of the ACIP and develops its clinical guidance on immunizations in accordance with ACIP recommendations. All ACIP-recommended vaccines, which include hepatitis A, hepatitis B, human papillomavirus, influenza, measles/mumps/rubella, meningococcal, pneumococcal, tetanus/diphtheria/pertussis, tetanus/diphtheria, varicella, and zoster, are currently available to Veterans (as clinically appropriate) at VA medical facilities.

The delivery of preventive care, which includes vaccinations, has been well-established in the VA Performance Measurement system for more than 10 years with targets that are appropriate for the type of preventive service or vaccine. VA updates these performance measures to reflect changes in medical practice over time. Requiring that the quality metric, including targets for compliance, be established via notice and comment rulemaking would limit VA's ability to respond quickly to new research or medical findings regarding a vaccine. Moreover, because the clinical indications and population size for vaccines vary by vaccine, blanket monitoring of performance of all vaccines could be cost prohibitive and may not have a substantial positive clinical impact at the patient level.

Accurately costing this bill is difficult as it will depend on the current use of individual vaccines and the specific performance measures that would be established by VA for those vaccines. If H.R. 5516 results in a 10 percent increase in the use of vaccines by VA than we estimate the cost of H.R. 5516 would be $5 million in 2012, $32.3 million over 5 years, and $90.7 million over 10 years.

H.R. 5543—"Collective Bargaining Regarding Compensation Other Than Rates of Basic Pay"

H.R. 5543 would amend 38 U.S.C. 7422 by replacing the word "compensation" in sections (b) and (d) with the words "rates of basic pay."

VA has serious concerns with this bill as it would repeal the prohibition on collective bargaining with respect to compensation of title 38 employees.

VA would like to stress to the Committee that we deeply value the contributions of our employees, and enjoy a collaborative, positive working relationship with unions across the country. We hold retention of employees as a critically important goal, and encourage the management teams of VA facilities to offer professional development opportunities and encourage personal growth.

Currently, 38 U.S.C. 7422(b) and (d) exempt "any matter or question concerning or arising out of . . . the establishment, determination, and adjustment of [title 38] employee compensation" from collective bargaining. This bill would replace the word "compensation" with the phrase "rates of basic pay." This change would apparently make all matters relating to the compensation of title 38 employees (physicians, dentists, nurses, et al.) over which the Secretary has been granted any discretion subject to collective bargaining. In order to provide the Secretary with the flexibility necessary to administer the title 38 system, Congress has granted the Secretary significant discretion in determining the compensation of VA's health care professionals. When Congress first authorized title 38 employees to engage in collective bargaining with respect to conditions of employment, it expressly exempted bargaining over "compensation" in recognition of the U.S. Supreme Court's ruling in *Ft. Stewart Schools* v. *FLRA,* 495 U.S. 641 (1990). In that case the Court held that the term "conditions of employment," as used in the Federal Service Labor-Management Relations Statute (5 U.S.C. 7101), included salary, to the extent that the agency has discretion in establishing, implementing, or adjusting employee compensation. *Id.* at 646–47. Thus, Congress sought to make clear in 38 U.S.C. 7422(b) that title 38 employees' right to bargain with respect to "conditions of employment" did *not* include the right to bargain over compensation. Over the years, Congress has authorized VA to exercise considerable discretion and flexibility with respect to title 38 compensation to enable VA to recruit and retain the highest quality health care providers.

The term "rates of basic pay" is not defined in title 38. However, the Agency has defined "basic pay" as the "rate of pay fixed by law or administrative action for the position held by an employee before any deductions and exclusive of additional pay of any kind." VA Handbook 5007, Part IX, par. 5. Such additional pay includes market pay, performance pay, and any other recruitment or retention incentives. *Id.* Accordingly, H.R. 5543 would subject many discretionary aspects of title 38 compensation to collective bargaining. For example, there are two discretionary components of compensation for VA physicians and dentists under the title 38 pay system—mar-

ket pay and performance pay. Market pay, when combined with basic pay, is meant to reflect the recruitment and retention needs for the specialty or assignment of the particular physician or dentist in a VA facility. Basic pay for physicians and dentists is set by law and would remain non-negotiable under this bill, but the Secretary has discretion to set market pay on a case-by-case basis. Market pay is determined through a peer-review process based on factors such as experience, qualifications, complexity of the position, and difficulty recruiting for the position. In many cases, market pay exceeds basic pay. In those situations, this bill would render a large portion or even the majority of most physicians' pay subject to collective bargaining. The Secretary also has discretion over the amount of performance pay, which is a statutorily authorized element of annual pay paid to physicians and dentists for meeting goals and performance objectives. Under this bill, performance pay would also be negotiable. Likewise, pay for nurses entails discretion because it is set by locality pay surveys. Further, Congress has granted VA other pay flexibilities involving discretion, including premium pay, on-call pay, alternate work schedules, Baylor Plan, special salary rates, and recruitment and retention bonuses. The ability to exercise these pay flexibilities is a vital recruitment and retention tool. It is necessary to allow VA to compete with the private sector and to attract and retain clinical staff who deliver health care to Veterans. As described below, this flexibility would be greatly hindered by the collective bargaining ramifications of H.R. 5543.

This bill would obligate VA to negotiate with unions over all discretionary matters relating to compensation, and to permit employees to file grievances and receive relief from arbitrators when they are unsatisfied with VA decisions about discretionary pay. If VA were obligated to negotiate over such matters, it could be barred from implementing decisions about discretionary pay until it either reaches agreements with its unions or until it receives a binding decision from the Federal Service Impasses Panel. This potential barrier could significantly hinder our ability and flexibility to hire clinical staff as needed to meet patient care needs both qualitatively and in a timely manner. Additionally, VA may be required to pay more than is necessary to recruit and retain title 38 employees.

Moreover, any time an employee was unsatisfied with VA's determination of his or her discretionary pay, he or she could grieve and ultimately take the matter to binding arbitration. This step would allow an arbitrator to substitute his or her judgment for that of VA and, with regard to physician market pay, to override peer review recommendations. This bill would allow independent third-party arbitrators and other non-VA, non-clinical labor third parties who lack clinical training and expertise to make compensation determinations. VA would have limited, if any, recourse to appeal such decisions.

Importantly, H.R. 5543 would result in unprecedented changes in how the Federal Government operates. It would permit unions to bargain over, grieve, and arbitrate a subject—employee compensation—that is generally exempted from collective bargaining even under title 5. Although Congress has built much more Agency discretion into the title 38 compensation system both to achieve the desired flexibility and because the system is unique to VA, permitting title 38 employees to negotiate the discretionary aspects of their compensation would simply be at odds with how other Federal employees are generally treated. Further, collective bargaining over discretionary aspects of pay is unnecessary. VA's retention rates for physicians and dentists are comparable to private sector retention rates, while retention rates for VA registered nurses significantly exceed those of the private sector, strongly suggesting that the lack of bargaining ability over discretionary aspects of pay has minimal impact on VA's ability to retain title 38 employees.

We are not able to estimate the cost of H.R. 5543 for two reasons. First, if VA is required to negotiate over compensation matters, and if the Agency is unable to reach agreements with the unions, the final decisions on pay will ultimately rest with the Federal Service Impasses Panel. The Panel has discretion to order VA to comply with the unions' proposals. Second, if pay issues become grievable and arbitrable, the final decisions on pay will rest in the hands of arbitrators.

On the whole, our efforts to recruit and retain health care professionals have been widely successful, notwithstanding the exclusion of matters concerning or arising out of compensation from collective bargaining. We would be glad to share applicable data with the Committee and brief the members on our continuing efforts in this area.

H.R. 5996—"Prevention, Diagnosis, Treatment and Management of Chronic Obstructive Pulmonary Disease"

Subject to the availability of appropriations, H.R. 5996 would require the Secretary to develop treatment protocols and related tools for the prevention, diagnosis, treatment, and management of Chronic Obstructive Pulmonary Disease (COPD) as

well as to improve biomedical and prosthetic research programs on this disease. Moreover, in conjunction with the Centers for Disease Control and Prevention (CDC), the Indian Health Service, and the Health Resources and Service Agency, VA would be required to develop a pilot program to demonstrate best practices for the diagnosis and management of COPD. The bill also specifies that the Secretary and the CDC shall develop improved techniques and best practices for assisting individuals with COPD in quitting smoking.

VA supports the intent of H.R. 5996 as it has significant potential to improve the health care outcomes of Veterans, but it already has the authority to develop the treatment protocols and related tools and to improve the research programs on this disease. COPD is currently the 4th leading cause of death in the United States, and it currently impacts more than 500,000 Veterans. The primary cause of COPD, smoking, also remains prevalent among Veterans. More than 30 percent of Veterans are active smokers, and among those diagnosed with COPD, the rate of active smoking is approximately 50 percent.

VA has long maintained smoking cessation as a major focus for health promotion and disease prevention. VA's national performance measure on tobacco use requires that all Veterans seen in outpatient settings be screened once a year for smoking; if they are currently using tobacco, they are provided with brief counseling, offered prescriptions for nicotine replacement therapy and other smoking-cessation medications, and provided with referrals to VA smoking cessation programs. VA has also been working with DoD to identify areas for collaboration to establish tobacco use cessation programs that would provide a seamless transition in care and reduce the impact of smoking-related illnesses among both Servicemembers and Veteran populations.

VA supports the bill's focus on the special needs of COPD patients who struggle with their smoking addictions. The knowledge gained would benefit the population at large. VA believes this focus would particularly improve care and outcomes for Veterans with COPD, improve rates of smoking cessation among patients with COPD, and reduce the risk and incidence of other smoking-related illnesses (e.g., lung cancer, heart disease).

The cost of this bill is estimated to be $25.9 million over 5 years.

Draft Bill 1—Improvements in Programs for Homeless Veterans

Section 2 of the draft bill would amend 38 U.S.C. 2061 to grant VA permanent authority to offer capital grants for homeless Veterans with special needs on the same basis as the grants currently made to homeless Veteran providers under the VA Homeless Grant and Per Diem (GPD) Program pursuant to 38 U.S.C. 2011. Veterans with special needs are: those who are women, including women who have care of minor dependents; frail elderly; terminally ill; or chronically mentally ill homeless veterans. Section 2 would further amend section 2061 by removing the requirement that VA make grants to VA health care facilities.

Section 3 of the draft bill would amend 38 U.S.C. 2012 to change grant payments for furnishing services to homeless Veterans from a per diem basis to the annual cost basis. It would also remove the prohibition on VA providing a rate in excess of the rate authorized for State domiciliaries and grant the Secretary the discretion to set a maximum amount payable to grant recipients. Section 3 would also direct the Secretary to adjust the rate of payment to reflect anticipated changes in the cost of furnishing services and take into account the cost of services in different geographic areas. It would also make the requirement that the Secretary consider other available sources of funding discretionary. Section 3, paragraph E would require the Secretary to make quarterly payments based on the estimated annual basis and would further require recipients to declare the actual amount paid by quarter for services provided and repay any outstanding balances if the amount spent by the recipient is less than the estimated quarterly disbursement. Similarly, if recipients spend more than the estimated amount, determined on a quarterly basis, the Secretary would be required to make an additional payment equal to that sum. Payment to recipients would be limited to the amount of the annual grant payment as determined by the Secretary. Finally, section 3 would allow grant recipients to use VA grants to match other payments or grants from other providers.

While there are some similarities between this draft bill and a recent VA legislative proposal, VA needs additional time to evaluate this bill in conjunction with the Administration's focus on permanent housing models for the homeless. We will provide views and costs as soon as they are available.

Draft Bill 2—"Miscellaneous Health Care Provisions"

Annual Meeting of the Association of Military Surgeons in the United States

Section 3 would permit the Under Secretary for Health to assist the Association of Military Surgeons of the United States in organizing and hosting the annual meeting of the Association. The military services are able to assist the Association with its annual meeting due to Public Law 39 (enacted January 30, 1903), which incorporated the Association of Military Surgeons of the United States. That law made the Secretaries of Treasury, War, and Navy and the Surgeons General of the Army, Navy, and Marine—Hospital Service ex officio members of the Association. VA would like an authorization to also assist with the annual meetings. These meetings are valuable to VA because they permit sharing with other Federal health-care entities and provide learning opportunities for VA employees through lectures, panel discussions, and poster discussions.

The cost associated with enactment of this section will be insignificant.

Hospital Care and Medical Services in Non-Department Facilities

Section 4 would grant VA increased flexibility in entering into fee-basis arrangements to obtain hospital care and medical services for eligible Veterans. These arrangements would be authorized when VA is unable to furnish economical hospital care or medical services due to geographical inaccessibility, or when VA facilities are unavailable to furnish needed care or services. The statute as currently written states that these arrangements be accomplished by "contracts" with non-VA "facilities." This bill would expressly provide that VA, notwithstanding any other law, may "purchase, enter into a contract, provide individual authorization or act in such other manner as the Secretary determines appropriate" with non-VA facilities in order to furnish hospital and outpatient care to eligible Veterans.

VA supports section 4. There are no costs associated with this section as it would be consistent with VA's current practice under current law.

Extension of the Advisory Committee on Homeless Veterans

Section 5 would amend 38 U.S.C. 2066 to extend Congressional authority to continue the Advisory Committee for Homeless Veterans for an additional 3 years until December 30, 2014.

This Committee was Congressionally mandated by Public Law 107–95. The mission of the Committee is to provide advice and make recommendations to the Secretary on issues affecting homeless Veterans and determine if the Department of Veterans Affairs (VA) and other programs and services are meeting those needs. It has proven valuable, and VA has implemented many of the Committee's recommendations through policy and regulatory changes to enhance access and services for homeless Veterans.

The cost of the Advisory Committee on Homeless Veterans was $141,000 in FY 2009 and VA estimates that this cost will increase by three to 5 percent for the additional 3 years of operation and is estimated to be $.5 million.

Authority to Recover Medical Care Costs from Third Party Providers

Section 6 would amend section 1729(f) of title 38, United States Code, to make clear that the absence of a participating provider agreement or other contractual arrangement with a third party may not operate to prevent, or reduce the amount of, any recovery or collection by the United States under this section. Subsection (b) would amend section 1729(i)(1)(A) of title 38, United States Code, to clarify the definition of a "health-plan contract" by specifying health maintenance organizations, competitive medical plans, health care prepayment plans, preferred or participating provider organizations, individual practice associations, and other medical benefit plans are included. These amendments would apply only to care and services furnished under chapter 17 of title 38, United States Code, on and after the date of the enactment.

There are no direct costs associated with this section, other than administrative costs associated with collecting revenue. VA supports this provision and estimates the adoption of this section would increase collections beginning in fiscal year 2012 by $87.7 million and $1.04 billion over a 10-year period.

Health Professionals Educational Assistance Programs

Section 7 would amend 38 U.S.C. 7675 to impose on full-time student participants in the Employee Incentive Scholarship Program (EISP) who leave VA employment prior to completion of their education program the same liability as is currently imposed on part-time students. The current statute clearly limits part-time student participants' liability for breach of the EISP agreement. This proposal would make

both full- and part-time students liable for breach of the EISP agreement. Currently, all other employee recruitment/retention incentive programs have a service obligation and liability component.

VA supports this provision and estimates enactment would result in savings of approximately $36,000 in fiscal year 2010 and a total approximate savings of $189,000 over a 4-year period.

On-Call Pay for VHA IT Specialists

Section 8 would amend 38 U.S.C. 7457 and authorize the Secretary to pay on-call pay to Information Technology ("IT") Specialists whose primary responsibilities are to perform services incident to direct patient-care services at VHA health care facilities. Prior to 2006, title 5 IT staff working in VA health care facilities were employed by the Veterans Health Administration ("VHA") and were authorized to receive on-call pay under title 38. In 2006, the Department's Office of Information and Technology ("OI&T") was reorganized as a separate staff office and, as a result, title 5 IT staff were transferred out of VHA, and lost their authorization for on-call pay. On-call coverage is needed because the Department is unable, given staffing availability and cost, to staff OI&T on a 24-hour basis. This proposal would allow the Department to properly support patient care operations on a 24-hour basis. This is crucial, as VHA's delivery of health care is dependent upon the electronic health record.

VA estimates the cost of this section to be $6.3 million for FY 2011, $37.3 million over 5 years, and $93.9 million over 10 years.

Pay for Physicians and Dentists Employed by the Office of Information and Technology

Section 9 would amend 38 U.S.C. 7431 to authorize the Secretary to pay physicians and dentists employed by the Department's Office of Information and Technology ("OI&T") in accordance with title 38 pay authorities. Prior to 2006, physicians and dentists who served in information technology ("IT") positions providing support to the Veterans Health Administration ("VHA") worked in VHA units and were covered by title 38 pay authorities. In 2006, OI&T was reorganized as a separate Department staff office and, as a result, IT personnel were transferred out of VHA, and lost their authorization for title 38 pay. This provision would allow VA to recruit and retain physicians and dentists in OI&T leadership positions by inserting a new subsection into section 7431. Title 38 pay authorities are specifically designed to allow VA to recruit and retain highly qualified health care personnel for Veterans. The ability to offer title 38 pay to physicians and dentists within OI&T is crucial in maintaining the Department's position as a world leader in health care information technology because it would allow the Department to recruit and retain senior IT executives who, because of their experience as physicians and dentists, possess intimate knowledge and expertise in both health care processes and information technology.

While VA believes that 25 positions would be sufficient, this draft bill would permit 100 positions at any time. To be eligible, a physician or dentist must be board-certified. The Secretary would ensure that the authority is used only for physicians and dentists serving in key executive positions in which experience as a physician or dentist is critical to accomplishment of the Department's mission. Covered physicians and dentists must be paid using the pay schedules established for executives in the Veterans Health Administration whose primary duties are to manage personnel and programs rather than perform clinical duties as a physician or dentist—currently, Pay Table 6 for Executive Assignments, which has three tiers: Tier 1: $145,000–$265,000, Tier 2: $145,000–$245,000, and Tier 3: $130,000–$235,000.

Section 9 includes conforming amendments to title 5 that make clear that physicians and dentists receiving rates of basic pay under title 38, including those covered by proposed section 7431(i), are not covered by the provisions governing the General Schedule and the Senior Executive Service. Section 9 also amends 5 U.S.C. 5371 (OPM's statutory authority to provide title 38 pay authority to other agencies) so that OPM may authorize other agencies to apply title 38 pay provisions to employees who would otherwise be in the Senior Executive Service.

The Department estimates the cost of the 100 employees allowed for in the bill to be $13.7 million in FY 2011, $71.9 million over 5 years, and $153.23 million over 10 years. If VA employed 25 of these employees, the costs are estimated to be $3.4 million in FY 2011, $17.96 million over 5 years, and $38.3 million over 10 years.

Extension of the Joint Incentives Program

Section 10 would change the termination date for the DoD–VA Joint Incentives Program from September 30, 2015 to September 30, 2020, enabling both agencies to contribute to the Joint Incentive Fund, which fund funds creative coordination

and sharing initiatives at the facility, intraregional, and nationwide levels. VA supports this extension. There are no costs associated with this provision.

Use of the Franchise Fund to Expedite Collection of Erroneous Payments

Section 11 would amend the paragraph under the heading "Franchise Fund" in title I of the Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, 1997 (Public Law 104–204), which was amended by section 208 of title II of the Military Quality of Life and Veterans Affairs Appropriations Act, 1996 (Public Law 109–114), to authorize the VA Franchise Fund to use amounts available to cover its operating expenses to correct erroneous or improper payments made by Franchise Fund employees.

The Government Management Reform Act (GMRA) of 1994 (Public Law 103–356) and the Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, 1997 (Public Law 104–204) authorize VA to provide certain common administrative services to VA and other government agencies on a fee-for-service basis. One such service is payment processing. As a service provider, the VA Franchise Fund acts as an agent for its customers by processing payments on their behalf. The Franchise Fund has service level agreements (SLAs) with VA customers to pay vendor invoices using the customer's appropriated funds. Occasionally, the Franchise Fund makes a payment error, e.g., payment issued to an incorrect vendor. Currently, customers provide additional funds to the Franchise Fund to make the correct payment, pending recovery of the improper payment.

This section would authorize the customer involved with the improper payment to establish a refund receivable from the Franchise Fund and immediately recover the related budget authority. The Fund would in turn establish a refund receivable from the vendor and record it in its accounting records. The budget authority would not accrue to the VA Franchise Fund until funds are recovered from the vendor.

Under this approach, the customer's appropriation would remain whole. The Franchise Fund, acting as the agent, would set up a refund receivable and use resources from the Fund to immediately refund the corrected payment to its customers. This would occur while the Fund is pursuing recovery of the improper payment from the vendor. VA supports this provision. The VA Franchise Fund has established effective processes to recover funds through bills of collection, payment offsets, the Treasury Offset Program, or civil court collection. The Franchise Fund's collection experience demonstrates a high percentage of collections and a low risk for loss of improper payments.

There are no costs associated with this provision.

Mr. Chairman, this concludes my prepared statement. I would be pleased to answer any questions you or any Members of the Committee may have.

Statement of American Federation of Government Employees, AFL–CIO, and AFGE National Veterans Affairs Council

Mr. Chairman and Members of the Subcommittee:

The American Federation of Government Employees (AFGE) and the AFGE National VA Council (NVAC) appreciate the opportunity to submit a statement for the record on H.R. 5543.

AFGE and NVAC represent nearly 200,000 employees in the Department of Veterans Affairs (VA), more than two-thirds of whom are employees of VA's world class health care system. They are proud of the care they provide to veterans every day. They also take great pride in the Veterans Health Administration's (VHA) best practices and state-of-the-art health care information technology that was developed through the joint input of labor and management.

Sadly, in 2003, the highly effective joint labor-management agreement on bargaining rights of VA's Title 38 health care professionals was nullified. In its place, the VA implemented a new policy that deprives Title 38 clinicians of basic rights to grieve and negotiate over matters related to compensation, patient care and peer review.

Seven years and many, many wasted VA health care dollars later, it is urgent that this unfair treatment of VA's Title 38 clinicians cease and that the VA return to a bargaining rights policy that resolves labor-management disputes more efficiently. As a first step, AFGE and NVAC urge the Committee to approve H.R. 5543 to restore equal rights to bargain over compensation matters. This bill will restore Congressional intent in enacting Title 38 bargaining rights in 1991 and will also allow these clinicians to enforce their rights under important VA recruitment and retention laws over the past decade.

Under current VA policy, Title 38 clinicians—including physicians, dentists, registered nurses (RN), physician assistants, chiropractors, optometrists and podiatrists—face work environments plagued by arbitrary and unfair pay policies. Many of these clinicians bring to the VA invaluable experience as military personnel providing care on the battlefield. Yet, they are singled out for unfair treatment. They cannot challenge management pay policies that violate Federal law or VA regulations simply because they are "pure Title 38 employees" appointed under Section 7401(1) of Title 38, instead of "Hybrid Title 38 employees" appointed under Section 7401(3) with full Title 5 bargaining rights.

As a result, a Title 38 RN has no recourse if she or he is denied overtime pay, while a Hybrid Title 38 licensed practical nurse can file a grievance over the same issue. Similarly, the union cannot negotiate over retention pay criteria for a Title 38 psychiatrist, but can negotiate over the implementation of similar pay policies for a Hybrid Title 38 psychologist.

If these Title 38 health care professionals decide to leave the VA to work at a another Federal facility, such as a military hospital or a Federal prison clinic, they will acquire full collective bargaining rights under Title 5.

Thus, the choice is clear: if the VA wants to be an employer of choice in today's health care market and compete effectively for health care professionals in short supply, it must provide equal compensation bargaining rights to its Title 38 clinicians.

H.R. 5543 offers a very modest change to Section 7422, the bargaining rights provision of Title 38. It simply clarifies that, like all Federal employees, VA Title 38 clinicians can bargain over the implementation of pay laws and regulations, but that only Congress and the VA Secretary can set basic rates of pay.

The narrow scope of H.R. 5543 addresses opponents' assertions that employees will try to bargain over Federal pay scales. The language of this bill limits bargaining to compensation issues *other than basic rates of pay* that Congress has specifically addressed in legislation to help the VA recruit and retain health care personnel such as RN locality pay and physician and dentist market pay and performance pay. H.R. 5543 would also protect Title 38 clinicians from violations of routine pay laws that all public and private sector registered nurses count on, such as the right to additional pay for working evenings and weekends.

AFGE and NVAC note that the VA has *never* offered this Committee an example of an employee's attempt to use bargaining rights to set Federal pay rates, and that there is not a single Undersecretary of Health "7422" case involving such an attempt.

To address another concern raised by some opponents, the recommendations of the recent "7422 workgroup" that are pending before the Secretary are no substitute for legislative change. Yes, they have the potential to improve Title 38 labor-management relations to some extent and we appreciate the Secretary's willingness to review current policy. However, even if the recommendations are adopted, they cannot take the place of legislation that clarifies the scope of the law. These recommendations very modest in scope, and would not provide Title 38 clinicians with equal bargaining rights. Also, they lack the force of law; Courts and arbitrators will continue to defer to the Secretary's discretion under Title 38 absent legislation. Finally, as we saw in 2003, policies issued during one administration can be easily tossed out by the next. If the VA is to effectively compete with other health care employers, it must assure current and prospective hires that they can count on fair treatment and the ability to enforce pay laws and regulations.

VA's current policy on compensation bargaining rights has weakened critical legislation that Congress passed in recent years to recruit and retain a strong health care workforce. For example, Congress enacted legislation in 2004 to use local panels of physicians to set market pay that would be competitive with local markets (P.L. 108–445). The USH ruled that AFGE's national grievance over the composition of the pay panels was barred by the "compensation" exception. (Decision dated 3/2/07). Currently, VA physicians in numerous facilities are unable to challenge unfair performance pay criteria that penalize them for hospital-wide performance even though P.L. 108–445 specifically refers to "individual achievement."

Finally, how dangerous can this simple clarification in the law be? The VA has already agreed to full bargaining rights for new Title 38 clinicians at the new joint VA–Navy facility at North Chicago. Section 1703 of Public Law 111–84 provides that Navy civilian health care professionals who are transferring to the VA workforce after completion of this facility merger will retain full Title 5 collective bargaining rights for 2 years in matters related to compensation, as well as patient care and peer review. AFGE and NVAC look forward to working with the VA to implement this 2 year pilot project when it begins next month.

Thank you for the opportunity to share the views of AFGE and NVAC on this important legislation for maintaining a strong VA health care workforce.

Statement of Hon. Steve Buyer, Ranking Republican Member, Full Committee on Veterans' Affairs, and a Representative in Congress from the State of Indiana

Upon introduction of H.R. 5641, I made the following introductory statement:

"Today, I am introducing H.R. 5641, a bill to allow the Department of Veterans Affairs (VA) to enter into contracts with adult foster homes to provide life-long care to veterans unable to live independently.

Adult foster homes are designed to provide non-institutional long-term care to veterans who prefer a more personalized, familial setting than traditional nursing homes are able to provide.

VA has been helping to place veterans in adult foster homes since 2002 and over time more than 600 veterans in need have paid to receive such care. As we speak, 219 veterans are living in these special homes.

The need for long term care is increasing as veterans from past conflicts get older, and it will continue to grow as wounded warriors return home from Iraq and Afghanistan with severe injuries that require life-long assistance. While nursing homes will always be a valuable tool for providing lasting care, for some the individualized, home-like atmosphere of an adult foster home is a much more attractive alternative than the prospect of moving into a traditional nursing home.

The advantages of adult foster homes are clear. Veterans who opt for foster home care will move into a home owned or rented by their chosen foster home caregiver. The caregiver—who has passed a VA screening, Federal background check, and home inspection and agreed to undergo annual training– resides with the veteran and provides them with 24-hour supervision and personalized care. For as long as that veteran resides in the home, VA adult foster home coordinators and members of a VA Home Care Team will make both announced and unannounced visits at least three times every month to ensure the veteran is safe and the home and caregiver are in compliance with VA's high quality standards.

Additionally, the Home Care Team will provide veterans with comprehensive, interdisciplinary primary care and provide the caregivers with supportive education and training.

Many veterans who choose to reside in an adult foster home would otherwise be in need of nursing home care and would qualify for VA benefits to receive it. However, because VA is not authorized to provide veterans with assisted living benefits, these veterans must pay for the care they receive in adult foster homes out of their own pockets.

Twenty-four percent of veterans who have received care in a Medical Foster Home qualify for VA's highest priority group due to having disabilities rated 50 percent or more service connected or having otherwise been found unemployable due to service connected conditions. Given that many of the veterans who are benefitting from this individualized, non-institutional care are disabled, afflicted with chronic disease, often elderly, and frequently 70 percent or more service connected, placing the entire cost burden for adult foster homes on their backs is no way to thank them for their valiant years in service. What's more, it creates an inequity of benefits between those who can afford to pay for such care and those that cannot.

The legislation I am introducing today would give VA the authority to enter into a contract with a certified adult foster home to pay for care for certain veterans already eligible for VA paid nursing home care. By doing so, it would ensure more veterans have the option to choose a treatment setting that best suits their needs free of financial constraints.

Our veterans in need of life-long care have earned the right to decide which long-term care environment would make them feel most at home. And, I encourage my colleagues to join with me in cosponsoring this legislation to make that decision easier.

Thank you and I yield back the balance of my time."

Further, upon introduction of H.R. 6127, I made the following introductory statement:

"Today I am introducing a bill, H.R. 6127, the Extension of Health Care Eligibility for Veterans who Served at Qarmat Ali Act, to extend the VA health care enrollment period for certain veterans who served in the Qarmat Ali region of Iraq.

Soon after the conflict in Iraq began in 2003, Army National Guard units from my home state of Indiana as well as units from Oregon, West Virginia, and South Carolina and National Guardsmen mobilized as individual augmentees from across

the Nation were called up and tasked with guarding the Qarmat Ali water treatment facility.

For 6 months—from April to September—these National Guardsmen from across the Nation bravely guarded the plant, located just outside Basra. Their mission was to secure the facility and provide protective services for the independent contractors who were working throughout the region to restore Iraqi oil production.

Recently, they have been notified of their possible exposure to a toxic chemical known as sodium dichromate and are being asked to come forward, be evaluated, and enroll in VA's Gulf War Registry. Health problems associated with such exposure include respiratory issues, skin lesions, and burns. Contact may cause increased rates of lung cancer and other ear, nose, throat, and skin disorders.

The men and women of these National Guard units completed their mission—and served our country—well. It was hard for me to discover that despite their safe return, their service may continue to be put them at risk. In particular, I am very sensitive to the Hoosiers who may have been injured.

Under current law, combat veterans who served on active duty in a theater of combat operations during a period of war after the Persian Gulf War or in combat against a hostile force during a period of "hostilities" after November 11, 1998 are eligible to enroll in the VA health care system, notwithstanding sufficient evidence of service-connection, for 5 years following separation from service.

This includes members of the National Guard and Reserve who were activated and served in combat support or direct operations as long as they meet certain requirements.

When Congress established the 5 year period of open enrollment for VA health care it was with the understanding that some wounds of war may not manifest themselves until years after a veteran leaves military duty.

But despite our best intentions, we are finding that some veterans are faced with combat-related health problems that were not apparent even 5 years after the veteran re-entered civilian life. This creates a gap in services that unfairly penalizes these men and women for conditions out of their control.

I commend the VA for their efforts to contact these veterans and create the Qarmat Ali Registry to aggressively track and treat veterans exposed to this toxic chemical as part of the Gulf War Registry.

However, it is also important for them to have immediate access to VA's high quality health care system. The use of VA health care will help to identify potential medical conditions, and provide counseling, immunizations, and medications to prevent illness. Appropriate preventative care can substantially improve health outcomes and the quality of life for our honored heroes.

But, some of the Qarmat Ali veterans who separated from service following their deployment in 2003 may no longer be eligible to enroll in VA health care under the 5-year open enrollment period. As a result, they must first file a claim and seek a service-connected disability rating before enrolling in the VA health care system and gaining access to the comprehensive medical care VA provides.

Unfortunately, the claims process can be both time-consuming and daunting. It is unacceptable that the Qarmat Ali veterans, already subjected to harmful toxins during service to our country, must now await the outcome of a lengthy and sometimes adversarial claims processing system before they can enroll in VA health care.

The VA was established expressly to care for veterans like these who willingly left their homes, families, and lives to protect and defend our Nation and may find themselves sick or injured as a result of such selflessness

H.R. 6127 would correct this unintended gap in services by extending the enrollment eligibility period for Qarmat Ali veterans by 5 years from the date of notification. This would allow them to immediately begin receiving services at VA medical facilities for any and all of their health care needs.

Breaking down barriers to needed care is the very least we, as a grateful Nation, can do for the men and women who fight for our freedoms, in Qarmat Ali and around the world.

I urge my colleagues to join me in supporting H.R. 6127 and these brave American heroes. Thank you, and I yield back the balance of my time."

Statement of Hon. Bob Filner, Chairman,
Full Committee on Veterans' Affairs, and a Representative in Congress
from the State of California

Chairman Michaud, thank you for the opportunity to testify before the Subcommittee on Health on H.R. 5428, a bill of rights for injured and amputee veterans and H.R. 5543, a collective bargaining rights bill for VA clinicians.

We are all too familiar with the wide-spread use of improvised explosive devices (IEDs) in Operation Enduring Freedom and Operation New Dawn. Many of our servicemembers are returning home with amputations as a direct result of blast injuries and this is why I have introduced H.R. 5428.

H.R. 5428 directs VA to display and educate VA employees about the injured and amputee veterans' bill of rights at each VA prosthetics and orthotics clinic. In addition, my bill requires VA to monitor and resolve complaints from injured and amputee veterans alleging mistreatment.

I believe that this bill will go a long way in not only protecting the rights of our injured and amputee veterans, but will also play an important role in ensuring consistency in the quality of orthotic and prosthetic care that our veterans receive throughout the VA health care system.

Next, I would like to discuss H.R. 5543, a bill which would allow collective bargaining over compensation related labor-management disputes. Examples of such disputes include locality pay, overtime pay, shift differential pay, and performance pay.

I would like to emphasize that my bill continues to protect the basic rates of pay so that VA employees cannot bargain over the Federal pay scales. However, I have heard stories where a VA nurse's overtime pay is miscalculated but there is no recourse for addressing this inaccuracy.

H.R. 5543 would also help VA with their recruitment and retention efforts since prospective employees would have the assurance that they will be treated fairly when it comes to the enforcement of pay laws and regulations.

Thank you again for the opportunity to share my thoughts with you, and I hope that I can count on your support for H.R. 5428 and H.R. 5543.

Independence Through Enhancement of Medicare and Medicaid Coalition
September 24, 2010

The Honorable Bob Filner
Chairman, House Veterans Affairs Committee
United States House of Representatives
Washington, DC 20515

RE: ***Support for H.R. 5428; the Injured and Amputee Veterans Bill of Rights***

Dear Chairman Filner:

The undersigned members of the Independence Through Enhancement of Medicare and Medicaid (ITEM) Coalition write to strongly support your legislation, H.R. 5428, the Injured and Amputee Veterans Bill of Rights, and ask that you help pass this legislation in this Congress as expeditiously as possible.

This bill would establish a written list of rights that all injured and amputee veterans have access to high quality orthotic and prosthetic (O&P) care. O&P care, consisting of orthopedic braces, artificial limbs, and the clinical services necessary to treat the patient, is vital to veterans who have lost limbs or have sustained injuries or disorders of the arms, legs, back and neck.

The rights created by this legislation are currently available to veterans but are inconsistently applied throughout the VA health system. This inconsistency leads to a lack of access to appropriate O&P care in different areas of the country. This legislation would make veterans aware of their right to high quality care provided by qualified practitioners, to appropriate technology to meet their specific needs, and to a second opinion regarding treatment options. Veterans also have a right to a continuum of care when transferring from the Department of Defense to the VA, and to a functional spare prosthesis or orthosis if necessary, to name a few.

With the national spotlight on injured and amputee veterans in the wake of the Iraq and Afghanistan wars, veterans often receive the care they need. But when the spotlight dims, it is critical that veterans' rights to high quality O&P care are well established and well understood by veterans themselves. To help enforce these rights, the Veterans Administration would be required to post this "Bill of Rights"

in every VA O&P Clinic across the country, to post it on the VA Web site, and to create a complaint mechanism where disputes can be resolved.

The ITEM Coalition urges Congress to pass the Injured and Amputee Veterans Bill of Rights to give all veterans access to consistent, high quality orthotic and prosthetic care. We thank you for your leadership in introducing this important bill and look forward to working with you and your staff to enact H.R. 5428 into law this year.

For more information, please contact Peter Thomas, ITEM Coalition Counsel, at (202) 466–6550.

Sincerely,

Advanced Medical Technology Association
American Academy of Physical Medicine and Rehabilitation
American Association of People with Disabilities
American Association on Health and Disability
American Congress of Rehabilitative Medicine
American Medical Rehabilitation Providers Association
American Music Therapy Association
American Therapeutic Recreation Association
Amputee Coalition of America
Association of Assistive Technology Act Programs
Association of Rehabilitative Nurses
Blinded Veterans Association
Brain Injury Association of America
Christopher and Dana Reeve Foundation
Disability Health Access, LLC
Disability Rights Education and Defense Fund
Easter Seals
Harris Family Center for Disability and Health Policy
Hearing Loss Association of America
Helen Keller National Center
National Association for the Advancement of Orthotics and Prosthetics
National Association of County Behavioral Health and Developmental Disability Directors
National Association of State Head Injury Administrators
National Council on Independent Living
National Disability Rights Network
National Down Syndrome Society
National Multiple Sclerosis Society
National Rehabilitation Hospital
National Spinal Cord Injury Association
Paralyzed Veterans of America
Rehabilitation Engineering and Assistive Technology Society of North America
Spina Bifida Association
TASH
United Spinal Association
VetsFirst

Cc: The Honorable Nancy Pelosi
The Honorable Steny Hoyer
The Honorable John Boehner
The Honorable Steve Buyer

Statement of National Coalition for Homeless Veterans

Chairman Michaud, Ranking Member Brown, and distinguished Members of the Subcommittee:

Thank you for the opportunity to present this statement to the U.S. House Committee on Veterans' Affairs, Subcommittee on Health. The National Coalition for Homeless Veterans (NCHV) is honored to do so and pleased to convey its support and recommendations for the draft legislation on homelessness to amend title 38, United States Code, to make certain improvements in programs for homeless veterans administered by the Secretary of Veterans Affairs, and for other purposes.

NCHV proudly represents over 2,300 community- and faith-based homeless veteran service providers nationwide. These groups, whom U.S. Department of Vet-

erans Affairs (VA) Secretary Eric Shinseki calls "the real creative geniuses" in ending veteran homelessness, are largely responsible for the drastic reduction in homeless veterans over the past 6 years—from 250,000 on any given night in 2004 to 107,000 in 2010, according to annual VA CHALENG reports.

VA reaches an incredible number of homeless veterans through its Homeless Providers Grant and Per Diem Program (GPD)—a transitional housing program that is the foundation of VA and community partnerships. In 2005, the department introduced the "grant program for homeless veterans with special needs," as it is called in statute, into the GPD in order to serve four critical demographics:

- Women, including those with dependent children
- Frail elderly
- Terminally ill
- Chronically mentally ill

The draft legislation in question would directly affect the GPD and the special needs grant program.

Background

On Oct. 1, 2009, NCHV President and CEO John Driscoll testified before this Subcommittee on the need for four bills: H.R. 2504, H.R. 2559, H.R. 2735 and H.R. 3073. An amended version of the third bill, H.R. 2735, became wrapped into Section 3 of H.R. 4810, the End Veteran Homelessness Act of 2010. That language appears identical to Section 3 of the current draft legislation, "Improvement of Payments for Providing Services to Homeless Veterans." H.R. 4810 passed in the House by a 413–0 vote and was referred to the Senate.

Improving Grant and Per Diem Payments

GPD grantees are reimbursed for providing transitional housing and supportive services based on the reimbursements provided to state veterans' homes. Depending on the amount of other Federal funding that service providers receive, these rates—which peak at $35.84 per veteran, per day—may be reduced. This policy is outdated considering the cost of comprehensive services that individuals need to rebuild their lives. By striking "per diem" from current statute and inserting "annual cost of furnishing services," this bill would enable organizations to better serve homeless veteran clients with serious mental illness, substance abuse issues, histories of incarceration and disabilities.

Community-based organizations serving these populations need round-the-clock clinical staff, medications handlers, security personnel and unique facility safety enhancements. Our concern is that without this provision, community-based organizations will continue to struggle to provide transitional housing and supports for these hard-to-serve homeless veterans.

Section 3 of the draft legislation would allow providers to use GPD funds to match other Federal funding sources. Other Federal service grants not only allow but encourage cross-agency collaboration. Penalizing GPD providers—who currently cannot draw GPD funds in anticipation of allowable, budgeted program expenses—by reducing per diem payments based on other income is counterproductive and impairs the delivery of services to homeless veterans. If service providers are going to end veteran homelessness in the next 4 years, they must be afforded every opportunity to make their projects work.

VA deserves commendation for its increased investment in the GPD. However, since its inception the program has undergone significant changes in complexity, scope of services and targeted populations. This draft legislation would provide several modifications needed to advance the program's success preparing homeless veterans for transition to permanent housing and independent living.

Expanding the Special Needs Grant Program

The other major section of this draft bill, Section 2, "Enhancement of the Grant Program for Homeless Veterans with Special Needs," would modify and expand VA's special needs grant program. The program is currently limited to GPD recipients and authorized at $5 million through fiscal year (FY) 2011. This legislation would open the program to new eligible public or nonprofit entities, and increase its authorization to $21 million by FY 2013.

NCHV recognizes this as an opportunity to widen the availability of services to homeless veterans whom the VA and its community partners have identified as needing specialized care. Women veterans, the fastest-growing subgroup of the homeless veteran population, will particularly benefit from these changes to the GPD. By VA's estimates, women will account for about 15 percent of the Nation's veterans within 10 years. Although we do not yet know the full service needs of the latest generation of servicemembers returning from operations in Iraq and Afghani-

stan, we do know that specialized care will be required for single-parent homeless families and those at high risk of homelessness due to health and economic challenges.

Despite NCHV's overall support for this bill, we recommend Sec. 2 (g) (5)—which requires special needs grant recipients "to seek to employ homeless veterans and formerly homeless veterans in positions created for purposes of the grant for which those veterans are qualified"—be removed.

The meaning of this provision is not clear. The VA Special Needs Grants are primarily to provide transitional housing and supportive services to homeless veterans in specialized settings, but are not specifically designed to ensure employment. Most organizations that receive GPD funds from the VA provide employment preparation, job search and placement assistance, but those are funded through Department of Labor programs, including the Homeless Veterans Reintegration Program, and the Disabled Veterans Outreach Program and Local Veterans Employment Representatives at all one-stop career centers across the Nation. This provision seems to go against the universal objective of avoiding costly duplication of services.

In Summation

The Health Subcommittee has provided leadership for the most significant pieces of homeless veterans legislation advanced in the 111th Congress. Its members and staffs have played a powerful role in the newfound campaign to end veteran homelessness in 5 years. With one of those years already behind us, there is an even greater sense of urgency for action: We must ensure that our programmatic approaches are adaptable so that service providers' efforts are not stunted by outdated policies.

From the House Committee on Veterans' Affairs to the thousands of community- and faith-based organizations NCHV represents across this Nation, we share a common goal of ending veteran homelessness. We are honored to be a part of this historic undertaking, and we look forward to continuing to work with this Subcommittee in order to achieve that reality.

National Association for the Advancement of Orthotics and Prosthetics
Washington, DC.
September 24, 2010

The Honorable Bob Filner
Chairman
House Veterans Affairs Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Michael Michaud
Chairman
House VA Health Subcommittee
U.S. House of Representatives
Washington, DC 20515

RE: ***Testimony for the Written Record: Strong Support for H.R. 5428, the Injured and Amputee Veterans Bill of Rights***

Dear Chairman Filner and Chairman Michaud:

The National Association for the Advancement of Orthotics and Prosthetics ("NAAOP") strongly supports H.R. 5428, the Injured and Amputee Veterans Bill of Rights. We thank you for your leadership on this important issue and look forward to working with you to enact this key legislation *this year* for all veterans with amputations and other orthopedic injuries who require orthotic and prosthetic ("O&P") care.

As servicemembers return from the conflicts of the past decade with amputations and musculoskeletal and neuromuscular injuries, they are joining many other veterans who receive services from the Veteran's Administration ("VA") health care system who require artificial limbs and orthopedic braces. In order to ameliorate the impact of these potentially debilitating injuries and to ensure consistent access to O&P patient care, the VA should establish a written set of standards that outline the expectations that all veterans should have with respect to their prosthetic and orthotic needs.

The Injured and Amputee Veterans Bill of Rights, H.R. 5428, accomplishes this by proposing the establishment of a written "Bill of Rights" for recipients of VA health care who require orthotic and prosthetic care. This Bill of Rights will help inform and ensure that veterans across the country have comparable access to the highest quality O&P care regardless of their geographic location. It will ensure that

veterans know they are entitled to the most appropriate O&P technology provided by a skilled practitioner of their choosing (whether or not that practitioner has a formal contract with the VA). They will know they have the right to a second opinion with respect to treatment decisions and to continuity of care when being transferred from the Department of Defense health program to the VA health system, as well as other rights and protections.

Overall, the VA has provided quality orthotic and prosthetic care to veterans over the years, whether or not their underlying impairment has been service-connected. But there are many areas where inconsistencies across the country are apparent and require improvement. As the national focus on those injured by war begins to wane in the coming years, we are concerned that these inconsistencies will intensify across the country. That is why enactment of this legislation in the 111th Congress is so important.

Your bill proposes a straightforward mechanism for "enforcement" of this "Bill of Rights," an explicit requirement that every O&P clinic and rehabilitation department in every VA facility throughout the country be required to prominently display this Bill of Rights. The VA Web site is also required to post the Bill of Rights. In this manner, veterans with amputations and other injuries across the country will be able to read and understand what they can expect from the VA health care system. And if a veteran is not having their orthotic or prosthetic needs met, they will be able to avail themselves of their rights and work through the VA system to access the care they require.

The Bill of Rights would help educate injured and amputee veterans of their rights with respect to O&P care, and would allow them an avenue to report violations of that set of standards to the VA central office. In this manner, Congress would have easy access to the level of compliance with this Bill of Rights across the country and could target particular regions of the country where problems persist.

Again, we thank you for your leadership on this important issue and look forward to working with you to enact this legislation by the end of the 111th Congress.

Sincerely,

Thomas Guth, C.P.
President

Statement of National Nurses United

Thank you for the opportunity to comment for the record on H.R. 5543, a bill to improve the collective bargaining rights and procedures for certain employees of the Department of Veterans Affairs. National Nurses United, the Nation's largest nurse union, represents nurses at 22 VA facilities throughout the United States. However, this bill is incredibly important not just to our nurses who work at the Department of Veterans Affairs (VA), but to our entire 155,000 national membership. Denying the most basic protections to one nurse is an injustice to all nurses.

We thank Chairman Filner for introducing this important legislation, and for his work on the broader legislation, H.R. 949. We appreciate your commitment to fair treatment for all VA health care workers. It's simply unacceptable that nurses would be treated as second-class citizens for the purposes of collective bargaining.

This bill fixes one way in which nurses collective bargaining rights are different than the rights of other clinicians at the VA and other Federally employed nurses by allowing them to bargain over pay issues not related to the setting of base pay.

One need only look to the disparate treatment of nurses at a newly merged VA/Navy Hospital in Chicago to see how irrational it is to apply more restrictive collective bargaining rights on the VA nurses who are working side by side with the Navy nurses. It begs the question of what the difference is between the care given to active duty members of the United States Navy and veterans. Members of the armed services of the United States should and do receive excellent health care, and they get it from nurses with collective bargaining rights that all nurses should have, at a minimum.

National Nurses United is confident that if private employers and other Federal employers can negotiate with nurses without the restrictions in 38 U.S.C. 7422, it should be well within the capacity of the VA to manage basic collective bargaining rights for its nurses.

We appreciate the formation of a working group to address the grievances that nurses have had with the Department's interpretation of section 7422. We hope that this workgroup will help to demonstrate the reality that when leadership of any organization is willing to bring workers to the table, everybody wins. However, such

a working group can only hope to resolve worker complaints about the system as long as the Administration decides to honor their end of the bargain. Without a legislative solution, any future Administration can roll back such an agreement with impunity.

The collective bargaining process is entirely consistent with the concept of "patient centered medicine". Nurses, as the front line workers in the health care system, have a right and a duty to be patient advocates. As such, they are quite motivated and well qualified to advocate for the highest quality care available for the heroic men and women who have laid their lives and health on the line in defense of our Nation.

Delivering the best quality care means providing nurses and other health care workers the support that they need so that they can spend their time advocating for patients. When that's not the case, everyone loses. For example, a nurse in Buffalo, New York recently volunteered to give up home and family time to work through the weekend to provide flu shots to veterans. Her contract clearly stated that she was to be paid premium pay for those overtime hours. However, in addition to never receiving the compensation she was entitled to, she was told that she could also not file a grievance through her union for that overtime pay, because of the exemptions in section 7422. Most rational observers would make the determination that the pay exemptions in 7422 would only apply to the setting of salary levels, not filing grievances over violations of an existing employment contract.

Passing H.R. 5543 would mean that a nurse like the one in Buffalo would be able to focus on taking care of patients rather than arguing with the boss over her paycheck. That is good for nurses and the heroes they heal.

We ask that the Committee work to pass H.R. 5543 to ensure that hard-working front line nurses at the VA are treated fairly—not only in comparison with other government nurses and VA clinicians—but with the respect due any worker. Nurses choose to devote their careers to helping the sick and the wounded, and to preventing illness. This is not a choice made out of greed, cynicism, or self-concern. Once made, this choice leads a practicing nurse to bear witness to pain and suffering, but also hope and triumph the likes of which are nearly impossible to describe in a few pages of Congressional testimony. It is simply remarkable that anyone would choose to characterize their desire for adequate representation for themselves and their patients as self-interested and harmful to patient care. That is why the broader bargaining rights in H.R. 949 have the support of the Disabled American Veterans, Paralyzed Veterans of America, and Vietnam Veterans of America. If the veterans who have come to rely on VA nurses can back our rights to advocate for ourselves and our patients, then so should the VA, and so should Congress.

Statement of Michael O'Rourke, Assistant Director,
National Veterans Service, Veterans of Foreign Wars of the United States

CHAIRMAN MICHAUD, RANKING MEMBER BROWN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.1 million members of the Veterans of Foreign Wars of the United States and our Auxiliaries, the VFW would like to thank this Committee for the opportunity to present our views on today's pending legislation.

H.R. 3843, To amend title 38, United States Code, to direct VA to publish redacted medical quality-assurance records of the Department of Veterans Affairs on the Internet Web site of the Department

VFW supports the *Transparency for America's Heroes Act.* This bill would require VA to publish and make available inspection reports of VA facilities thirty-days after completion of the review on its Web site.

Recent reports of contaminated instruments, unsupervised medical procedures and adverse conditions at a Philadelphia long-term care facility erode faith in the VA health care system. We believe that having information easily available to patients and stakeholders renews the emphasis on quality, accountability and sound health care procedures provided by all staff in every VA facility.

By providing quality assurance records on VA's Web site you will close the gap between patient, VA and quality health care. It also offers a sense of accountability and willingness by VA to clarify procedures within its health care system.

We would ask that resources and funding for VA's IT Department remain at appropriate levels to ensure continued efforts are made toward providing the information needed to implement this new effort toward transparency.

H.R. 4041, To authorize certain improvements in the Federal Recovery Coordinator Program, and for other purposes

VFW supports this bill as it would improve the current Federal Recovery Coordinator Program (FRCP) by authorizing and funding forty-five recovery care coordinators to be trained at qualified nursing and medical schools selected by VA. It would also provide for the development of evidence-based guidelines for care coordination and best practices for models of care used as part of the FRCP.

The FRCP was established to assist recovering servicemembers and their families by providing information with access to care, services and benefits within VA and DoD.

In 2007, DoD and VA partnered to create a Federal Recovery Coordination Program to coordinate clinical and nonclinical care for the most severely injured and ill servicemembers. Today, the program is up and running at six military treatment centers and two VA medical centers, but predicting the total number of coordinators needed is difficult. The program itself has struggled with referrals as it depends on the number of eligible servicemembers and veterans enrolling and their specifics needs.

VFW believes that utilizing nursing and medical schools to train coordinators is a positive step forward and highlights the need for *fundamental changes* in care management. Today's injured servicemembers deserve greater coordination as they struggle with complex injuries that often hinder their transition from military to civilian life. Having someone trained properly to guide the way is only the first step toward recovery.

H.R. 5428, To direct the Secretary of VA to educate certain staff of the Department of Veterans Affairs and to inform veterans about the Injured and Amputee Veterans Bill of Rights, and for other purposes

The VFW supports this legislation, which would require the display of an injured and amputee veterans bill of rights. The display reaffirms and clarifies the rights of these injured servicemen and women, letting them know what they can expect from VA.

We believe that this bill would ensure consistency in the orthotic and prosthetic (O&P) benefit program under the VA health care system. It would also allow veterans to select the practioner that best meets their needs, and provide them ample access to vocational rehabilitation, employment and housing assistance. The bill also goes one step further by requiring all VA O&P clinics to post the bill of rights and create a mechanism of enforcement by establishing a complaint system so that veterans can report mistreatment or a lapse in care.

H.R. 5516, The Access to Appropriate Immunizations for Veterans Act of 2010

VFW supports legislation that would improve health outcomes for veterans by expanding VA performance measures to cover vaccines recommended by the Center for Disease Control and Prevention (CDC). The recommended adult immunization schedule is periodically reviewed and revised so that vaccinations are scheduled at the time in which they are needed most.

Currently VA only administers the influenza and pneumococcal vaccinations. Congressman Stearns' legislation would authorize VA performance measures to cover *all* vaccinations recommended by VA and CDC so veterans, especially those in "high risk" categories, would receive timely access to vaccines that may help prevent diseases and long-term hospital stays. By following suggested vaccine protocols, we see a win-win in the delivery of health care and improved health care outcomes within VA.

H.R. 5543, A bill to alter collective bargaining rights of VA employees

This bill would permit VA employees to contest aspects of their pay. Under this legislation, employees would be able to file grievances and negotiate all compensation that is not considered basic pay, to include bonuses, merit pay, and other compensable items. It would still bar VA employees from petitioning for a basic pay structure that differs or is inconsistent with the General Schedule or other Federal basic pay structures; it would merely give them the option to file a grievance with respect to additional pay. The VFW has no position on this legislation.

H.R. 5641, Legislation that would authorize the Secretary of Veterans Affairs to enter into contracts to transfer veterans that are unable to live independently into adult foster homes.

The VFW supports this bill, which would add language to Section 1720 of Title 38 to allow veterans who receive VA care and require a protracted period of nursing home care to transfer into an adult foster home. Under the bill, such homes must have the goal of providing non-institutional, long-term, supportive care. VA currently has the authority to reimburse institutional care facilities such as nursing homes for long-term domiciliary care, but veterans living in adult foster homes must do so at their own expense. To grant VA authority to reimburse adult foster homes

would provide veterans with an additional residency choice and improve the quality of life for those who would prefer this option.

The language protects veterans who may wish to reside in such a setting by requiring caregivers to reside on premises, to receive annual training, and to provide 24-hour care. The adequacy of their living conditions would be ensured through language that would grant needed devices in the home, such as lifts or closed captioning devices. As part of the contracting process, adult foster homes would be required to accept announced and unannounced visits, and the caregivers who run them would be screened by the VA in addition to being required to pass a Federal background check.

We believe this language defines what and who can serve veterans through an adult foster home in an adequately narrow way, while also responsibly providing the chance to live in a family setting that will be more beneficial for the physical and mental health of veterans of all ages.

H.R. 5996, Legislation to direct the Secretary of Veterans Affairs to take a more aggressive posture in its treatment of Chronic Obstructive Pulmonary Disease.

The VFW supports this effort. Chronic Obstructive Pulmonary Disease (COPD) affects our veterans at a rate approximately three times higher than their civilian counterparts, and it is the fourth most common diagnosis among hospitalized veterans. And among veterans age 65–74, it is the most common diagnosis leading to hospitalization.

This legislation would improve our response to COPD by requiring VA to develop treatment protocols to prevent, diagnose, treat and manage the disease and also to improve biomedical and prosthetic research. It also requires the VA to develop pilot programs to gain a better understanding of best practices in this area of medicine. Finally, the bill contains provisions that require VA to develop better smoking cessation programs to improve techniques and best practices to assist veterans who want to improve their health outlook by successfully quitting smoking.

H.R. 6123, To amend title 38, United States Code, to improve the provision of rehabilitative services for veterans with Traumatic Brain Injury

The VFW supports this legislation, as it would make significant improvements to Chapter 17 of Title 38 by expanding the plan for rehabilitation and reintegration of TBI patients to account for the individual's independence and quality of life.

It expands objectives for the rehabilitation of veterans suffering from a TBI to include behavioral and mental health concerns. As a result of this bill, the phrase 'rehabilitative services' vice treatments would be an overarching theme in Chapter 17, thereby conforming the code to the prevailing wisdom that TBI patients deserve more than mere treatment of their injuries—rather, they deserve ongoing evaluation and additional intervention where necessary to ensure a full recovery. We believe the changes in this bill would make it easier for veterans struggling with the aftermath of a TBI to receive such coverage.

Finally, this bill would also support TBI patients by associating sections of the law related to TBI rehabilitation and community reintegration to a broader definition of the term 'rehabilitative services' in Title 38 that comprises a range of services such as professional counseling and guidance services. Our veterans deserve an optimal chance to lead productive lives, and this bill would help to ensure our response to Traumatic Brain Injuries consists of more than just healing the physical wounds of war.

H.R. 6127, A bill to provide for the continued provision of health care services to certain veterans who were exposed to sodium dichromate while serving as a member of the Armed Forces at or near the water injection plant at Qarmat Ali, Iraq, during Operation Iraqi Freedom.

Over the course of the last several months, information has surfaced revealing that approximately 800 servicemembers were exposed to harmful chemicals while guarding sensitive infrastructure in Iraq during the first half of 2003. These servicemembers, Guardsmen and women from a number of different states, were not exposed to a quantity of contaminant considered to be causal to any harmful effects; however, the VFW fully supports taking extraordinary precautions in this case.

This legislation would extend enrollment eligibility into the VA health care system for all veterans exposed to sodium dichromate at Qarmat Ali by 5 years from the day they were notified of their exposure. We have been assured that the VA is reaching out to inform those exposed of their options for care and to advise them on VA recommended examinations and treatments, and the VFW appreciates this effort on their behalf. We support this legislative effort to give them every reasonable opportunity to seek VA health care as a result of their sacrifice and selfless service to our country.

Draft bill, To amend title 38, United States Code, to make certain improvements in programs for homeless veterans administered by the Secretary of Veterans Affairs and for other purposes.

VFW supports draft legislation that would enhance many homeless veterans programs. This bill greatly increases funding for various homeless programs and expands the availability of resources needed by homeless veterans, while including provisions that encourage treatment facilities providing care to homeless veterans to use the available funding effectively.

The bill also addresses the shortfall in funding for aiding homeless veterans. Prior to this bill funding for health care facilities for treatment of homeless veterans was $5 million a year. With this bill funding would increase in FY 2011 to $10 million, $15 million in FY 2012, and top out at $21 million in FY 2013. The increase in funding is needed and would help to expand services across the board for homeless veterans programs.

The VFW commends the Committee for taking a step in the right direction; however, we are concerned that the structure of this temporary increase does not adequately reflect the needs of our veterans. Thousands of Iraq and Afghanistan veterans are returning home to tough economic conditions, often having to give up homes and housing to support the mission, and we believe there is a clear preponderance of data that demonstrates the need for scrutiny of these programs in addition to this supplemental funding. All veterans should have access to every resource they are entitled to when they are in need, and the VFW is convinced that in order to meet that need, funding levels should not be reduced to levels prior to FY 2011.

The VFW recognizes the many challenges our Nation faces in addressing homelessness among our veterans. For many, the road to homelessness is littered with complications related to medical conditions such as post-traumatic stress disorder, traumatic brain injury, or drug and alcohol addiction. The provision of temporary housing and/or job placement is only a treatment of some of the symptoms of homelessness, and is far from a cure.

By striking the term "health care facilities" and amending it to read "eligible entities for the purpose of establishing programs, or expanding or modifying programs that provide assistance to homeless veterans" they would have at their disposal an improved array of options. Specifically, rehabilitation facilities, work placement services, and homeless shelters that do not necessarily provide medical care would be authorized to receive funding in exchange for their services. This multi-pronged approach represents a long overdue tactical change that will help to combat homelessness among the veteran population.

We also applaud the changes in Section 2061 that will institute various safeguards to ensure that funding is used properly by approved facilities. Proper use of funding and proper oversight—wise stewardship of the taxpayer's dollar—should never be an ancillary concern, particularly in this fiscally constrained environment. Making sure that the funds available are spent wisely or be returned to the VA encourages programs to use every available dollar to improve and expand their services. With countless veterans suffering from both the visible and invisible wounds of war completing their overseas tours and separating from the military with bleak job prospects at home, we must ensure an adequate safety net for those veterans who are experiencing hard times.

Draft bill, To amend title 38, United States Code, to ensure that health care professionals of VA provide veterans with information concerning service-connected disabilities.

VFW supports draft legislation that would encourage VA health care professionals to furnish information to veterans about benefits provided by the Veterans Health Administration, including guidance on how to apply for compensation relating to a service-connected disability. Far too many veterans seeking health care services from VA are not aware of the full range of their earned benefits or how to acquire them. VA health care professionals should be providing needed information, advice and assistance. We believe such a change would help facilitate the acquisition of earned and needed compensation, pension, and other benefits. We believe that this is an important opportunity for VA to continue to improve upon their outreach services on behalf of those who have worn the uniform and served our great Nation.

Thank you for the opportunity to present our views before this Subcommittee.

Prepared Statement of Richard F. Weidman, Executive Director for Policy and Government Affairs, Vietnam Veterans of America

Mr. Chairman, Ranking Member Brown, and distinguished members of the House Veterans' Affairs Subcommittee on Health, Vietnam Veterans of America appreciates the opportunity to present our views on nine bills up for your consideration this morning.

H.R. 3843, the "Transparency for America's Heroes Act," would direct the Secretary of Veterans Affairs to publish on the VA Web site redacted medical quality-assurance records and documents (but not personal identifying information) created by the VA.

In general, despite lapses in care at individual medical centers, the VA—actually, the Veterans Health Administration—provides good to excellent care at medical centers and community-based outpatient clinics for more than five million veterans annually. If the VA is to achieve and retain the confidence of the veterans it serves, opening for ease of public inspection quality-assurance records makes good managerial sense. If passage of H.R. 3843 can help bring a measure of transparency to what has, for the most part, been a cloistered process, it has VVA's full endorsement.

H.R. 4041 would direct the Secretary of Veterans Affairs to provide collaborative recovery coordinator training at a "qualified" nursing or medical school, and would authorize said nursing or medical school to train 45 recovery coordinators.

While this bill, on the surface, sounds important, and while it addresses a very real need, VVA believes it is in the purview of the VA Secretary to determine how best to set up recovery coordinator training and train whatever number of recovery coordinators he deems fit.

At the same time, Congress needs to exercise its powers of oversight to ensure that the VA does all that is necessary to coordinate the treatment and recovery of badly wounded or injured veterans. We do not believe that a prescriptive bill such as H.R. 4041 will necessarily be an effective way to get VHA to comply with its national mandate, although we certainly understand your frustration with the VHA on this and other issues that should be "no-brainers" for the VHA to accomplish.

We would respectfully point out that provisions in H.R. 4041, specifically for the development of "care coordination software," open the possibility of a boondoggle, and seem at odds with the centralization of IT within the VA.

H.R. 5428 would direct the Secretary of Veterans Affairs to ensure that an Injured and Amputee Veterans Bill of Rights is printed on signage in accessible formats and displayed prominently and conspicuously in each VA prosthetics and orthotics clinic. It would require that VA employees who work at such clinics, as well as patient advocates for veterans who receive care there, receive training on the elements in said Bill of Rights. It also would direct the Secretary to conduct outreach to inform veterans of this Bill of Rights.

The difficulty we have with this piece of legislation is elemental: If Congress sees fit to enact a Bill of Rights for injured and amputee veterans, why not enact a similar Bill of Rights for blinded veterans, and one for homeless veterans, and one for women veterans? Or perhaps one Bill of Rights for ***all*** veterans? (This latter VVA would heartily endorse.)

We also quibble with the provision that would direct the Secretary to conduct outreach to inform veterans of the provisions in an Injured and Amputee Veterans Bill of Rights. The VA needs to do a far better job in informing ***all*** veterans, and their families, about the health care and other benefits earned by veterans by virtue of their service in uniform, and about health conditions that may derive from a veteran's time in service. Under the leadership of Secretary Shinseki, the VA is finally moving in this direction, although it admittedly has little expertise with marketing and advertising.

We would quibble, too, with the provision of submitting a quarterly report to the VA's Chief Consultant of Prosthetics and Sensory Aids on information collected relating to alleged mistreatment of injured and amputee veterans. If this is to be done for one subgroup of veterans, why not for ***all*** subgroups of veterans? Or, better yet, simply for ***all*** veterans?

H.R. 5516, the "Access to Appropriate Immunizations for Veterans Act of 2010," would include within authorized preventive health services available to veterans through the Department of Veterans Affairs immunizations against infectious diseases on the recommended adult immunization schedule established by the Advisory Committee on Immunization Practices established by the Secretary of Health and Human Services and delegated to the Centers for Disease Control and Prevention.

This bill makes good sense insofar as it focuses on vaccinations for infectious diseases with vaccines approved by the FDA. We would hope, however, that it doesn't

do for veterans what was done for active-duty troops in the all too recent past, who were forced to be inoculated against smallpox and then anthrax in a panic over the possibility that rogue enemies could somehow unleash these viruses on an unsuspecting American military and public.

VVA also urges this distinguished Committee to take similar action for all pharmaceutical treatments approved by the FDA, and automatically list them on the VA formulary unless it is demonstrated through open hearings that a product is not effective or potentially harmful. The VA formulary process needs to be brought out into the light of day, exposed to the sunshine, and codified in statute to end the backroom deals in the "dead of night" non-transparent process that the VA currently uses. This President has often emphasized his Administration's commitment to "Open Government." VVA lauds that principle, and urges the Congress to bring that open government process to listing of pharmaceuticals. Enacting a process that mirrors the DoD formulary process into Title 38 for VA is appropriate, and should be a high priority for the Congress to get done within the next year.

VVA supports the enactment of H.R. 5516.

H.R. 5543 would repeal the prohibition on collective bargaining with respect to matters and questions concerning compensation of employees of the Department of Veterans Affairs other than rates of basic pay.

VVA sees no legitimate reason why VA clinicians and other health care professionals are barred from bargaining over additional compensation issues such as overtime pay and physician performance bonuses. VVA sees no credible rationale why these professionals are not accorded the same rights as are other Federal employees when it comes to seeking redress in disputes with management.

Frankly, the VA nursing service has for far too long been plagued by a destructive mind-set that favors "nurse executives" and is disdainful of bedside nurses and other actual caregivers who actually touch patients and are the heart of the provision of good medical care. This inappropriate and ugly attitude manifests in the treating of the staff members who provide actual "hands-on" care virtually as chattel who should have no say in working conditions. This must end.

Because enactment of H.R. 5543 would bring a long-needed measure of justice for health care professionals at VA medical facilities, VVA strongly supports its passage.

H.R. 5641, dubbed the "Heroes at Home Act," would authorize the Secretary of Veterans Affairs to enter into contracts for the transfer to non-Department adult foster homes for veterans who are unable to live independently.

If such a veteran who is eligible to be transferred to a non-VA nursing home prefers to be transferred instead to a home designed to provide non-institutional, long-term, supportive care in a family setting, VVA sees no reason why policy—and the legal foundation for such policy—would not facilitate this. Nursing homes, even well run facilities, can be oppressive places. Adult foster homes, with proper oversight by the VA, can be attractive alternatives. As such, VVA supports enactment of this legislation.

VVA also notes that much more attention overall needs to be paid to our most vulnerable veterans, especially in regard to those with guardians and whose funds are controlled by someone else who is supposed to be looking out for those who cannot care for themselves. A GAO report that examines all aspects of fiduciaries would be useful in this regard.

H.R. 5996 would direct the Secretary of Veterans Affairs to improve the prevention, diagnosis, and treatment of veterans with chronic obstructive pulmonary disease "subject to the availability of appropriations provided for such purpose."

While we have no problem with the intent of this legislation, the only way it will realistically happen is if Congress does in fact appropriate funds for its implementation. That said, Congress ought to mandate the VA to develop techniques and strategies to encourage veterans who smoke to cease smoking, whether they have developed COPD or not, and to prioritize an anti-smoking campaign at the top of its preventive health programs. If passed without specifically targeted funding, H.R. 5996 will be little more than another item on a laundry list of "Things to Do" at VA medical facilities.

VVA specifically notes that there are pharmacological treatments and other treatment modalities available in the private sectors that are difficult if not virtually impossible to get on the VA formulary. We suspect that much of the problem here is the "blame game" that goes "It is his own fault he is sick, so we should not do much to help him." That attitude has no place in veterans' health care.

H.R. 6123, the "Veterans' Traumatic Brain Injury Rehabilitative Services' Improvements Act of 2010," would in essence tweak Section 1710C of title 38 to more broadly define provisions for assisting veterans afflicted with Traumatic Brain

Injury (TBI), the "signature injury" of the wars in Afghanistan and Iraq. VVA supports the intent of this legislation.

H.R. 6127 would provide for the continued provision of health care services to veterans who were exposed to sodium dichromate while serving in the U.S. Armed Forces at or near the water injection plant at Qarmat Ali, Iraq, during Operation Iraqi Freedom.

Toxic substances can be insidious; often their effects do not manifest till health conditions develop years after a veteran's exposure in the military. As Vietnam veterans, we know this to be the case vis a vis exposure to dioxin, to Agent Orange, when we served in Southeast Asia. Because we are still learning about the effects of exposure to sodium dichromate to troops who were stationed at or near Qarmat Ali, extending their eligibility for VA health care would be a prudent investment in maintaining their health and treating maladies that may have derived from their service in Operation Iraqi Freedom.

We would submit, however, that the VA has an obligation to track the health status of all veterans thus exposed so as to better determine what health conditions may, in fact, be attributed to exposure to sodium dichromate. There may also be other toxins that emanate from these same or similar sources, so VVA urges more complete epidemiological tracking of health problems in returning warriors, depending on when and where they served. Ensuring such tracking ought to be an added provision of H.R. 6127.

H.R. 6188, **the Veterans' Homelessness Prevention and Early Warning Act of 2010**, would amend paragraph (4) of subsection (a) of section 3732(a)(4)(A) of title 38, United States Code, to ensure that a case manager develops a plan to provide alternate housing for the veteran in the event that the veteran loses the veteran's home. VVA supports enactment of this bill.

Draft legislation to make certain improvements in programs for homeless veterans administered by the Secretary of Veterans Affairs contains many very well-thought out facets that should assist Secretary Shinseki and his staff in their efforts to end homelessness among veterans by 2015.

Ending homelessness among veterans surely is a worthy goal. If policies, processes, and practices by the VA and other entities of three levels of government—local, state, and Federal—can function in concert, to create a continuum of care, we would hope that homelessness among veterans can continue to be reduced significantly, although some veterans for whatever reasons will choose to live their life on the streets, in flophouses, or out in the woods.

This legislation does contain some particularly important clauses. For instance, it would direct grant recipients, as a condition of accepting a grant, to "maintain referral networks . . . for establishing eligibility for assistance and obtaining services, under available entitlement and assistance programs."

We do believe, however, that the schedule of appropriations for grants—$10 million for FY 2011, $15 million for FY 2012, and $21 million for FY 2013—perhaps ought to be reversed. Why? Because if the programs and services currently in existence, and additional programs and services as established by this and other legislation succeed in achieving their stated purpose, there will be fewer veterans to avail themselves of these programs and services. Hence, we would suggest that appropriations be at a constant level, e.g., $15 million for each of the next three fiscal years.

It should be noted that VVA continues to urge that VA Homeless Grant and Per Diem (HGPD) funding must be considered a *payment* rather than a reimbursement for expenses, a key distinction that will enable the community-based organizations that deliver the majority of these services to operate more effectively.

This legislation attempts to make the funding provided to HGPD providers more accessible by creating a vehicle to enable them to better access reimbursement. If a provider is able to draw from the available funds on a monthly basis with program expenditures for reconciliation on a quarterly basis, then VVA supports this language.

If funds are available on a "short turnaround" drawdown that is directly deposited into provider accounts, monies would be more immediately available. The current method of voucher submissions through local medical centers creates a lag in payment for weeks. With the monthly drawdown, a non-profit agency would not have to utilize its line of credit (if it even has one) to make payroll or pay program expenses. Also, the fees associated with this practice cannot be charged back as an expense to the program.

VVA also supports allowing greater than quarterly expenditures in any given quarter if a need for these additional expenses exists.

Community non-profit providers, most of them small, that serve homeless veterans cannot survive if they are permitted to draw down from the quarterly amount only on a quarterly basis. Creditors, purveyors, utilities, and the like must be paid monthly. Non-profits held to a quarterly payment method would be hard-pressed to meet their financial obligations in a timely fashion. If bill language means that the providers can only draw down from the quarterly amount on a quarterly basis, then VVA must oppose this provision.

VVA also supports the submission of future anticipated expenses rather than past spent program expenses.

One of the most effective front-line outreach operations funded by VA HGPD is the Day Service Center, sometimes referred to as a Drop-In-Center. Few even remain in the HGPD system because of limited per diem funding support. These service centers are an indispensable resource for VA outreach. They can reach deep into the homeless veteran population on the streets and in the shelters of our cities and towns. They are the portal from the streets and shelters to substance abuse treatment, job placement, job training, VA benefits, VA medical and mental health care and treatment, homeless domiciliary placement, and transitional housing. They are the first step to independent living. They can be the first step to ending homelessness. But this can only happen if they are able to operate in an effective environment.

Under the VA HGPD program, non-profits receive per diem at rates based on an hourly calculation per diem (one-eighth of the allowable per diem for residential programs) for the time that the homeless veteran is physically in the center. While this may cover the cost of the coffee and food that the veteran receives, it does not come close to paying for the professional staff that must provide the assistance and comprehensive services long after that veteran leaves the facility, and the demands on staff require a significant amount of time, energy, and manpower in order to be effective and, hence, successful.

It is unfortunate that the current per diem funding model is simply not sufficient to sustain the operations of many community-based service centers. Many have either closed or never opened after being funded by VA HGPD. The VA acknowledges and understands that this situation exists.

At the very least, VVA hopes that Service Centers are also included in the annual set-aside program funding available monthly with quarterly reconciliation. If not, we believe that it is necessary to create "Service Center Staffing/Operational" grants, much like the VA "Special Needs" grants that were previously legislated, although this is hardly an optimal solution, particularly with regards to funding programs that work with some of the hardest to place and most chronic of our homeless veteran population.

Draft legislation to ensure that the Secretary of Veterans Affairs provides veterans with information concerning service-connected disabilities at health care facilities makes sense insofar as it goes. However, it does not go far enough.

VVA would like to see Congress orient a major outreach campaign to *all* veterans, not only to those veterans who already use VA health care facilities. Seven out of ten veterans do not obtain health care at VA facilities, and far too many of them are unaware not only of the benefits to which they are entitled by virtue of their service to this Nation, but of health conditions that may derive from their time in service because of exposure to toxic substances.

The VA needs to conceptualize and coordinate an outreach and information campaign that avails itself of public service announcements featuring real veterans as well as recognizable stars like Gary Sinise and Dennis Franz; signage on billboards; point-of-purchase displays in hardware stores, sporting emporiums, doctors' offices, and other places patronized by veterans and their families (because more often than not veterans are reached through their families).

Thanks you for the opportunity to appear here this morning to express the views of VVA. I will be pleased to answer any questions, Mr. Chairman.

MATERIAL SUBMITTED FOR THE RECORD

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
October 4, 2010

Mr. Jacob B. Gadd
Deputy Director, Veterans Affairs and Rehabilitation Commission
The American Legion
1608 K Street, NW
Washington, DC 20006

Dear Mr. Gadd:

Thank you for your testimony at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health legislative hearing on H.R. 3843, H.R. 4041, H.R. 5428, H.R. 5516, H.R. 5543, H.R. 5641, H.R. 5996, H.R. 6123, H.R. 6127, H.R. 6220, Draft Legislation on Homelessness, and Draft Legislation on VA Health care Provisions, which took place on September 30, 2010.

Please provide answers to the following questions by Monday, November 15, 2010, to Jeff Burdette, Legislative Assistant to the Subcommittee on Health.

1. In their testimony, DAV questioned whether making quality assurance medical records available on a VA Web site would be easily understandable and meaningful for our veterans and their families to make informed decisions. Do you share this concern? Do you have any specific recommendations on ways to improve this bill so that the quality assurance medical records that VA posts on their Web site are meaningful and useful?
2. Many of the witnesses on the second panel emphasized the need to balance confidentiality and transparency. In fact, VA explains that it is precisely the confidential nature of the quality-assurance program that allows providers to report and examine patient safety events without fear of recrimination or liability. What specific barriers and challenges must VA overcome before they can make quality assurance records available to the public without compromising patient confidentiality?
3. In your written testimony, you recommended enhanced communication between national, state and local levels to ensure maximum awareness of benefits that are available. Could you expand on this point and provide more detailed recommendations on ways to enhance communication?
4. Some have raised concerns about limiting the bill of rights to injured and amputee veterans. What are your thoughts on a bill of rights for all veterans which encompasses rights for injured and amputee veterans?
5. PVA raised concerns with H.R. 5428 ignoring veterans who may be in need of special equipment who suffer from a specific disease and not a physical injury. Do the other witnesses of this panel share this concern? Why or why not?
6. VVA raises some caution with H.R. 5516 by stating that they hope that the bill "doesn't do for veterans what was done for active-duty troops in the all too recent past, who were forced to be inoculated against smallpox and then anthrax in a panic." Do you share this concern? Why or why not?
7. VA explains that H.R. 5543 would "result in unprecedented changes in how the Federal Government operates. It would permit unions to bargain over, grieve, and arbitrate a subject—employee compensation—that is generally exempted from collective bargaining." There was unanimous support for this bill by the witnesses on the second panel. How do you respond to VA's concerns?
8. In addition to the provisions of H.R. 6123, the TBI Improvement Act, please share your insight on additional authorities that would be helpful in ensuring better health outcomes for our veterans with TBI.
9. PVA recommends that a broader spectrum of veterans is targeted instead of singling out the Qarmat Ali veterans for enrollment in H.R. 6127. Do the other witnesses of this panel share PVA's recommendation? Why or why not?
10. In your testimony, you recommended that each VA medical center create a VHA/VBA training liaison position to facilitate biannual training and updates on VBA regulations for VHA providers. Which VHA providers should participate in this training and should other, non-providers who work at the VA medical centers partake in this training?
11. In your testimony, you identified the need for "Congress and VA to address the growing concern with homeless women veterans, especially those with children." The draft homeless veterans bill is targeted to the special needs

population, which include women veterans with children. In addition to the creation of a new capital grants program as specified in the draft bill, what other programs and services should VA provide to help women veterans with children?

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers by November 15, 2010.

Sincerely,

MICHAEL H. MICHAUD
Chairman

American Legion
Washington, DC.
November 15, 2010

Honorable Michael Michaud, Chairman
Veterans' Affairs Subcommittee on Health
U.S. House of Representatives
A335 Cannon Office Building
Washington, DC 20515–6335

Dear Chairman Michaud:

Thank you again for allowing The American Legion to testify at the September 29th hearing regarding pending legislation affecting veterans' health issues. This letter is in response to your Post-Hearing Questions:

Question 1: In their testimony, DAV questioned whether making quality assurance medical records available on a VA Web site would be easily understandable and meaningful for our veterans and their families to make informed decisions. Do you share this concern? Do you have any specific recommendations on ways to improve this bill so that the quality assurance medical records that VA posts on their Web site are meaningful and useful?

Response: The American Legion has a number of concerns regarding the publication of quality assurance medical records online. Even a cursory examination of VA data security over the last several years will show a troubling pattern of data breaches and compromised security of veterans' personal information. Obviously, this would remain a primary concern of the Legion, the protection of veterans' personal information. While it is possible to redact this information towards the end of protecting patient privacy, it is unclear as to whether this redacted information could be of use. The American Legion does support more clarity and transparency from VA in all aspects of quality assurance, but to be of real benefit there would need to be more detail concerning making this information useful to a layman such as a veteran or their family. The most helpful information for veterans would be an indication of what common errors and deficiencies are at a particular medical institution.

Question 2: Many of the witnesses on the second panel emphasized to balance confidentiality and transparency. In fact, VA explains that it is precisely the confidential nature of the quality assurance program that allows providers to report and examine patient safety events without fear of recrimination or liability. What specific barriers and challenges must VA overcome before they can make quality assurance records available to the public without compromising patient confidentiality?

Response: To begin with, The American Legion must reiterate that data security has been a major issue for VA over the last several years, and it will take time to rebuild confidence in data security. VA can help with this by adopting even more transparency in the measures they are taking to protect patient information. At the very least, all potential identifying information must be stripped away to prevent possible identification and exploitation of that information.

Question 3: In your written testimony, you recommended enhanced communication between national, State and local levels to ensure maximum awareness of the benefits that are available. Could you expand on this point and provide more detailed recommendations on ways to enhance communication?

Response: One of the largest concerns that The American Legion has recognized through the System Worth Saving visits made annually to VA medical facilities is that there is a lack of consistency from VISN to VISN in the implementation of policy. More control through Central Office to ensure standardization should be the starting point. Following on from there, VA should target individual communities through public awareness campaigns to let veterans know of the resources in their area and the availability of these benefits. Rather than worrying about how to reach veterans, VA should adopt the attitude that veterans are an integral part of every community and simply seek to reach out to the general public and increase awareness. Many veterans may not know they can receive treatment at CBOC clinics or pharmacy benefits, yet through public service advertising on TV and on the Internet, veterans can be directed to VA Web sites and facilities to determine the benefits to which they are entitled.

Furthermore, on numerous occasions The American Legion experienced difficulties in contacting the Federal Recovery Coordinators (FRCs). As a result, we would like to recommend increasing the FRC staff to one coordinator in each state as opposed to only 25 coordinators throughout the country. This effort should alleviate the workload and enhance communication across the National and local levels.

Question 4: Some have raised concerns about limiting the bill of rights to injured and amputee veterans. What are your thoughts on a bill of rights for all veterans which encompasses rights for injured and amputee veterans?

Response: The American Legion believes that the intent of this legislation is to focus on a certain group of veterans with certain life-altering conditions. Veterans with amputations and other severe injuries face unique issues and barriers compared to veterans with minor injuries. In essence, the Injured and Amputee Veterans' Bill of Rights is to alleviate some of the barriers that these veterans encounter. Therefore, the American Legion believes it should remain as such.

Question 5: PVA raised concerns with H.R. 5428 ignoring veterans who may be in need of special equipment who suffer from a specific disease and not a physical injury. Do the other witnesses of this panel share this concern? Why or why not?

Response: The American Legion stands by its position that the Injured and Amputee Bill of Rights should focus on injured and amputee veterans. However, we would like to emphasize that VA should continue to provide the best quality of health care to our veterans. Simply because one bill provides for a specific group of veterans does not alleviate VA's responsibility of care for the rest of the veterans that they serve.

Question 6: VVA raises some caution with H.R. 5516 by stating that they hope the bill "doesn't do for veterans what was done for active duty troops in the all too recent past, who were forced to be inoculated against smallpox and anthrax in a panic." Do you share this concern? Why or why not?

Response: The American Legion fully supports VA's efforts to provide for necessary immunization and vaccination. However, we do believe that this effort should be voluntary and not mandatory. It would impose on a patient's right to choose their treatment course if they had no say in whether they were vaccinated or not. For an example of how this is sensibly implemented, consider the current annual flu shots, which are provided for those veterans who choose to partake in them, yet are not required treatment in any way.

Question 7: VA explains that H.R. 5543 would "result in unprecedented changes in how the Federal Government operates. It would permit unions to bargain over, grieve and arbitrate a subject—employee compensation—that is generally exempted from collective bargaining." There was unanimous support for this bill by the witnesses of the second panel. How do you respond to VA's concerns?

Response: The American Legion has no position and therefore does not support or oppose the legislation.

Question 8: In addition to the provisions of H.R. 6123, the TBI Improvement Act, please share your insight on additional authorities that would be helpful in ensuring better health outcomes for our veterans with TBI.

Response: In addition to the provisions of H.R. 6123, The American Legion would recommend that VA incorporate more holistic approaches as a part of the rehabilitative care administered to veterans who suffer from Traumatic Brain Injury. The holistic treatment can include more herbal remedy instead of pharmaceutical drugs, as well as other avenues such as massage therapy and meditation.

Question 9: PVA recommends that a broader spectrum of veterans is targeted instead of singling out the Qarmat Ali veterans for enrollment in H.R. 6127. Do other witnesses of the panel share PVA's recommendation? Why or why not?

Response: The American Legion fully concurs with this recommendation. As stated previously in testimony, The American Legion's policy on Hazardous Environmental Exposure requires that *all* veterans who were exposed to environmental hazards are afforded the necessary health care and compensation due to the extent of any lasting effects of the exposure.

Question 10: In your testimony, you recommend that each VA Medical Center create a VHA/VBA training liaison position to facilitate biannual training and updates on VBA regulations for VHA providers. Which VHA providers should participate in this training, and should other, non-providers who work at the VA medical centers partake in this training?

Response: During the American Legion System Worth Saving site visits, The American Legion found that veterans are not receiving information from VHA providers about their rights to file claims through VBA. Furthermore, during American Legion Quality Review visits to VBA Regional Offices, it became apparent that communication of information between medical centers and the offices processing veterans' claims were vastly improved when there was a dedicated individual set to facilitate this task. Based on these findings, The American Legion recommends that VA hire a VHA/VBA Liaison within each VA Medical Center to initiate biannual training to VHA primary care providers so that they are educated on VBA regulations and can pass on that information to their patients during their routine visits. In addition, The American Legion recommends that the same VHA/VBA bi-training also be provided to a single primary care provider at the Community Based Outpatient Clinics (CBOCs) who will then train their other staff members. Furthermore, enhanced communication between VBA and those VHA staff responsible for Compensation and Pension examinations is essential to ensure that VHA better understands the information required to fairly adjudicate a claim, the applicable law and how the examinations must be conducted, and any recent law changes or court decisions which might alter the way that these examiners conduct the exams. Often VHA C&P exam providers are unaware of what the courts have found regarding veteran rights in these exams, and this only contributes to inadequate exams which must be repeated and thus add lengthy delays to the problem and contribute to the rising VA backlog of claims.

Question 11: In your testimony, you identified the need for "Congress and VA to address the growing concern with homeless women veterans, especially those with children." The draft homeless veterans' bill is targeted to the special needs population, which includes women veterans with children. In addition to the creation of a new capital grants program as specified in the draft bill, what other programs and services should VA provide to help women veterans with children?

Response: In addition to the provisions of the draft legislation, the American Legion would like to urge VA to provide childcare to women veterans with children. According to the VA, women veterans are one of the fastest growing populations in the VHA system. A significant amount of these women veterans are of child-bearing age and are utilizing the VA on a more frequent basis than in the past. This is especially necessary for the female veterans with mental health appointments as children are not allowed to accompany their parents to these appointments.

While this is obviously a benefit for those women veterans receiving health care, enhancing shelter facilities for homeless veterans to accommodate the needs of children is also essential, as well as the provision of childcare for women veterans in the vocational rehabilitation programs. The ability to know that children are being safely cared for during job interviews and essential training to enhance marketable job skills can be a difference maker for women veterans seeking employment that can lead to a stable income and the ability to provide for their own housing needs.

Again, The American Legion would like to thank you and the Committee for the opportunity to expand on the views presented at the hearing and further clarify the position of the nearly 2.5 million members of the Nation's largest veterans' service organization. Thank you for your continued commitment to America's veterans and their families.

Sincerely,

Jacob Gadd
Deputy Director, National Veterans Affairs and Rehabilitation

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
October 4, 2010

Mr. Carl Blake
National Legislative Director
Paralyzed Veterans of America
801 18th Street, NW
Washington, D.C. 20006

Dear Mr. Blake:

Thank you for your testimony at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health legislative hearing on H.R. 3843, H.R. 4041, H.R. 5428, H.R. 5516, H.R. 5543, H.R. 5641, H.R. 5996, H.R. 6123, H.R. 6127, H.R. 6220, Draft Legislation on Homelessness, and Draft Legislation on VA Health care Provisions, which took place on September 30, 2010.

Please provide answers to the following questions by Monday, November 15, 2010, to Jeff Burdette, Legislative Assistant to the Subcommittee on Health.

1. Many of the witnesses of this panel emphasized the need to balance confidentiality and transparency. In fact, VA explains that it is precisely the confidential nature of the quality-assurance program that allows providers to report and examine patient safety events without fear of recrimination or liability. What specific barriers and challenges must VA overcome before they can make quality assurance records available to the public without compromising patient confidentiality?
2. Some have raised concerns about limiting the bill of rights to injured and amputee veterans. What are your thoughts on a bill of rights for all veterans which encompasses rights for injured and amputee veterans?
3. VVA raises some caution with H.R. 5516 by stating that they hope that the bill "doesn't do for veterans what was done for active-duty troops in the all too recent past, who were forced to be inoculated against smallpox and then anthrax in a panic." Do you share this thought? Why or why not?
4. VA explains that H.R. 5543 would "result in unprecedented changes in how the Federal Government operates. It would permit unions to bargain over, grieve, and arbitrate a subject—employee compensation—that is generally exempted from collective bargaining." There was unanimous support for this bill by the witnesses on second panel. How do you respond to VA's concerns?
5. In addition to the provisions of H.R. 6123, the TBI Improvement Act, please share your insight on additional authorities that would be helpful in ensuring better health outcomes for our veterans with TBI.
6. In your testimony, you raised concerns about the feasibility of implementing the draft legislation on VHA outreach to veterans on VBA benefits. Do you have specific recommendations on ways to improve this draft bill so that we can more realistically expect VHA to implement the provisions of this bill?

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers by November 15, 2010.

Sincerely,

MICHAEL H. MICHAUD
Chairman

Paralyzed Veterans of America
Washington, DC.
November 15, 2010

Honorable Michael Michaud
Chairman
House Committee on Veterans' Affairs
Subcommittee on Health
338 Cannon House Office Building
Washington, DC 20515

Dear Chairman Michaud:

On behalf of Paralyzed Veterans of America, I would like to thank you for the opportunity to present our views pending legislation considered by the House Vet-

erans' Affairs Subcommittee on Health at the hearing held on September 29, 2010. We appreciate the continued emphasis that the Subcommittee places on the unique health care needs of a diverse veterans population.

We have included with our letter a response to each of the questions that you presented following the hearing. If you need additional information, please feel free to contact us. Thank you very much.

Carl Blake
National Legislative Director

Question 1: Many of the witnesses of this panel emphasized the need to balance confidentiality and transparency. In fact, VA explains that it is precisely the confidential nature of the quality assurance program that allows providers to report and examine patient safety events without fear of recrimination or liability. What specific barriers and challenges must VA overcome before they can make quality assurance records available to the public without compromising patient confidentiality?

Answer: As we stated in our testimony, in the case of VA quality-assurance records, it only makes sense that transparency is critical to veterans, and those who serve veterans such as Veterans Service Organizations (VSO), and their understanding of how well VA is doing its job. Requiring VA to publish redacted medical quality-assurance records on the VA's Web site will provide users of the VA a better understanding of the successes or failures of the VA in the quality of care they provide our veterans. This may encourage greater efforts on the part of VA employees, staff and leaders to ensure the best care is provided to veterans while ensuring openness.

As we also stated, PVA's concern stems from the need for privacy in health care records. As we have seen in recent years, carelessness and bad decisions have led to the release of critical personal information of millions of veterans, particularly as a result of mishandling of information technology (IT) assets. As such, focused training for the VA personnel responsible for publishing this information will be essential to ensure that seemingly simple mistakes do not lead to the disclosure of a veteran's personal information. The VA must specifically prescribe to its staff what information is suitable for public viewing and what information must be redacted from records. Additionally, safeguards should be locked in to the VA's IT system to ensure that personal information cannot be accessed through outside sources.

Question 2: Some have raised concerns about limiting the bill of rights to injured and amputee veterans. What are your thoughts on a bill of rights for all veterans which encompasses rights for injured and amputee veterans?

Answer: As we stated in our testimony, PVA supports H.R. 5428 which seeks to better educate injured and amputee veterans on their rights as well as the VA staff who work at prosthetics and orthotics clinics or who work as patient advocates for veterans. However, as we also mentioned, PVA is concerned that this legislation's language seems to ignore veterans who may be in need of special equipment who suffer from a specific disease and not a physical injury. For example, many PVA members face significant hardship associated with a diagnosis for Multiple Sclerosis (MS). Similarly, veterans who have been diagnosed with Amyotrophic Lateral Sclerosis (ALS) and Parkinson's disease face similar problems. And yet, they are equally reliant on prosthetics and sensory aids to function in as normal a manner as possible. We believe that the legislation, as written, excludes veterans such as those mentioned here who have significant limitations brought on by diseases, and not just direct injuries or amputations.

PVA certainly supports the idea of a bill of rights for all veterans. In fact, if such a legislative proposal is considered, we do not believe any special mention is necessary for injured and amputee veterans. Legislation should be all-encompassing so that veterans who have experienced illness or disease or injury or amputation are included.

Question 3: VVA raises some caution with H.R. 5516 by stating that they hope the bill "doesn't do for veterans what was done for active-duty troops in the all too recent past, who were forced to be inoculated against smallpox and then anthrax in a panic." Do you share this thought? Why or why not?

Answer: PVA has no specific position on the concerns raised by Vietnam Veterans of America in their official statement. As explained in the PVA's statement to the Subcommittee, we support the legislation as introduced.

Question 4: VA explains that H.R. 5543 would "result in unprecedented changes in how the Federal Government operates. It would permit unions to bargain over, grieve, and arbitrate a subject—employee compensation—that is generally exempted from collective bargaining." There was unanimous support for this bill by the witnesses on the second panel. How do you respond to VA's concerns?

Answer: In trying to understand the concerns regarding labor relations in the Department of Veterans Affairs (VA), PVA has reached out to the various labor organizations that represent different segments of the health care workforce. It seems that the VA is often concerned about the expansion of bargaining rights under Title 38 hiring authorities, as they may be inconsistent with the rights available to Federal employees under Title 5. However, the language included in H.R. 5543 seems to be consistent with similar authorities provided under Title 5.

The American Federation of Government Employees (AFGE) has also informed us about the inconsistencies they see with the consolidation of the workforce associated with the Department of Defense (DOD) and VA joint health care facility in North Chicago. The Navy doctors, nurses, and physician assistants who became Title 38 employees were granted full bargaining rights (as though they were Title 5 employees) for 2 years as a part of the merger agreement with the VA. This simply makes no sense as they will be working hand-in-hand with VA staff who do not have the same rights. Moreover, it demonstrates that the VA does not ultimately believe there is any real harm to the provision of health care services by granting these employees rights. Simply put, if it is good enough for one group of health care professionals, it seems that it would be good for another.

Lastly, we have been told by the AFGE that the VA may be working towards some solutions to ease labor-management relations. In fact, in September, the VA Secretary approved a recommendation that allows bargaining over violations of VA directives about nurse overtime and premium pay, physician market pay and performance pay and other pay rules in VA directives and handbooks. We hope that this signals a move towards better labor-management relations across the VA which will only benefit the veterans who depend on the VA health care system for their care.

Question 5: In addition to the provisions of H.R. 6123, the TBI Improvement Act, please share your insight on additional authorities that would be helpful in ensuring better health outcomes for our veterans with TBI.

Answer: As stated in our testimony, PVA supports H.R. 6123, the "Veterans' Traumatic Brain Injury Rehabilitative Services' Improvement Act of 2010." In recent testimony, PVA has raised continuing concerns about servicemembers who do not have the immediate outward signs of TBI getting appropriate care. The military has implemented procedures to temporarily withdraw individuals from combat operations following IED attacks for an assessment of possible TBI, creating a significant military impact, but believing it necessary for soldier health even if it reduced combat forces.

Because all the impacts of TBI are still unknown, this legislation to expand services and care, providing for quality of life and not just independence, and emphasizing rehabilitative services, is important to the ongoing care of TBI patients. It is imperative that a continuum of care for the long term be provided to veterans suffering from TBI. PVA believes this legislation is a step toward ensuring that care.

Additionally, as referenced in The Independent Budget for FY 2011, PVA believes greater emphasis needs to be placed on research into the long-term consequences of brain injury and the development best practices in its treatment. Moreover, this research should include veterans of past military conflicts who may have experienced brain injury that has gone undetected, undiagnosed, or untreated.

The impact on the family of a veteran who has experienced a brain injury also cannot be overstated. And yet, in many cases immediate family members will become the lifelong caregivers of these significantly disabled veterans. As such, it will be imperative that as the VA implements the caregiver provisions of P.L. 111–163, the "Caregivers and Veterans Omnibus Health Services Act of 2010," that the difficulties these families will face be considered. Any training provided to the caregivers will most certainly require specialized focus on the unique needs of veterans with traumatic brain injury and associated mental health problems. We encourage the Subcommittee to continue to monitor the progress of implementation of P.L. 111–163 to ensure that the VA is addressing this concern.

Question 6: In your testimony, you raised concerns about the feasibility of implementing the draft legislation on VHA outreach to veterans on VBA benefits. Do you have specific recommendations on ways to improve this draft bill so that we can more realistically expect VHA to implement the provisions of this bill?

Answer: PVA expressed no real concerns about the implementation of the legislation in our written statement. However, we must emphasize the need to ensure that correct and consistent information is provided when a veteran seeks benefits information at a VA medical facility.

As we mentioned in our statement, we would also hope that VA will direct veterans seeking benefits information to veterans service organizations who have service programs to benefit these men and women. PVA maintains a highly skilled and well-educated service officer staff at many VA medical facilities around the country who can assist veterans with certain health care concerns as well as the broad range of benefits available. It certainly makes sense for the VA to tap into this resource.

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
October 4, 2010

Mr. Adrian M. Atizado
Assistant National Legislative Director
Disabled American Veterans
807 Maine Avenue, SW
Washington, DC 20024

Dear Mr. Atizado:

Thank you for your testimony at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health legislative hearing on H.R. 3843, H.R. 4041, H.R. 5428, H.R. 5516, H.R. 5543, H.R. 5641, H.R. 5996, H.R. 6123, H.R. 6127, H.R. 6220, Draft Legislation on Homelessness, and Draft Legislation on VA Healthcare Provisions, which took place on September 30, 2010.

Please provide answers to the following questions by Monday, November 15, 2010, to Jeff Burdette, Legislative Assistant to the Subcommittee on Health.

1. Many of the witnesses of this panel emphasized the need to balance confidentiality and transparency. In fact, VA explains that it is precisely the confidential nature of the quality-assurance program that allows providers to report and examine patient safety events without fear of recrimination or liability. What specific barriers and challenges must VA overcome before they can make quality assurance records available to the public without compromising patient confidentiality?
2. Some have raised concerns about limiting the bill of rights to injured and amputee veterans. What are your thoughts on a bill of rights for all veterans which encompasses rights for injured and amputee veterans?
3. PVA raised concerns with H.R. 5428 ignoring veterans who may be in need of special equipment who suffer from a specific disease and not a physical injury. Do you share this concern? Why or why not?
4. VVA raises some caution with H.R. 5516 by stating that they hope that the bill "doesn't do for veterans what was done for active-duty troops in the all too recent past, who were forced to be inoculated against smallpox and then anthrax in a panic." Do the rest of the witnesses on this panel share this thought? Why or why not?
5. VA explains that H.R. 5543 would "result in unprecedented changes in how the Federal Government operates. It would permit unions to bargain over, grieve, and arbitrate a subject—employee compensation—that is generally exempted from collective bargaining." There was unanimous support for this bill by the witnesses on second panel. How do you respond to VA's concerns?
6. In addition to the provisions of H.R. 6123, the TBI Improvement Act, please share your insight on additional authorities that would be helpful in ensuring better health outcomes for our veterans with TBI.
7. PVA recommends that a broader spectrum of veterans is targeted instead of singling out the Qarmat Ali veterans for enrollment in H.R. 6127. Do you share PVA's recommendation? Why or why not?
8. In your testimony, you raised concerns about the feasibility of implementing the draft legislation on VHA outreach to veterans on VBA benefits. Do you have specific recommendations on ways to improve this draft bill so that we can more realistically expect VHA to implement the provisions of this bill?

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers by November 15, 2010.

Sincerely,

MICHAEL H. MICHAUD
Chairman

POST-HEARING QUESTIONS FOR ADRIAN M. ATIZADO OF THE DISABLED AMERICAN VETERANS FROM THE COMMITTEE ON VETERANS' AFFAIRS, SUBCOMMITTEE ON HEALTH UNITED STATES HOUSE OF REPRESENTATIVES SEPTEMBER 29, 2010

Post-hearing questions for the record from House Subcommittee on Health's legislative hearing on H.R. 3843, H.R. 4041, H.R. 5428, H.R. 5516, H.R. 5543, H.R. 5641, H.R. 5996, H.R. 6123, H.R. 6127, H.R. 6220, and Draft Legislation, held September 29, 2010.

Question 1: Many of the witnesses of this panel emphasized the need to balance confidentiality and transparency. In fact, VA explains that it is precisely the confidential nature of the quality-assurance program that allows providers to report and examine patient safety events without fear of recrimination or liability. What specific barriers and challenges must VA overcome before they can make quality assurance records available to the public without compromising patient confidentiality?

Answer: We again ask as we did in our written testimony whether the release of all the information contained in quality assurance records in redacted form addresses the following pertinent questions, and if so, at what cost.

The central question in the particular case of the events surrounding the Department of Veterans Affairs (VA) Philadelphia Community Living Center is the appropriate notification of the public, including Congress, when substandard VA care is identified, and why such care was not identified by routine inspections. Other essential questions include whether different metrics are used in routine health care inspections and quality management programs, and if so, why.

As to the Subcommittee's question, if redacted quality assurance records are to be made public, the VA must revisit its quality assurance program to sustain its effectiveness by emphasizing prevention—not punishment, which is essential for VA to continue receiving candid reports on adverse events and/or close calls from which it could then learn and undertake improvement and prevention efforts. As indicated in DAV's written testimony, "[t]he Institute for Healthcare Improvement (IHI) has found that all employee reporting programs (voluntary and mandatory) result in substantial underreporting. Several studies have shown that computer monitoring strategies have identified many times more potential adverse events than were reported through employee reporting mechanisms. The IHI's 'Trigger Tools' are also used to identify adverse events and detect safety problems. Moreover, not having specific facility and patient information has caused frustration when VA Central Office and oversight bodies have requested Veterans Health Administration (VHA) data regarding adverse events. Facility patient safety managers have also had to create secondary, duplicative systems in order to capture the patient information needed for effective reviews and reports." [1]

We consider information from VA quality assurance records as raw data that VA or some other entity will need to make into a format that is readable, understandable, and meaningful to the target audience. Also, accommodations should be provided so individuals may gain access by telephone or mail requests, and during personal onsite visits. Finally, and equally important, VA should encourage wide public awareness of the availability of such information, how and where to access it, and appropriate limitations on its use.

On a broader scale, if such transparency through release of redacted quality assurance records are deemed by Congress to carry such weight as to overcome the concern by DAV and others that such actions may jeopardize VA's quality and safety activities, Congress must also address the circular deference problem between the Health Insurance Portability and Accountability Act (HIPAA) and the Freedom of

[1] http://www.dav.org/voters/documents/statements/Atizado20100929.pdf.

Information Act (FOIA) and other Federal and state open records laws in which determination of which statute controls the public nature of the health care related information.

There are existing rules, policies, and laws that favor closure of quality assurance records. The HIPAA Privacy Rule defines in eighteen criteria the type of information that would identify a patient (personally identifiable information) and offers standards of protection of the privacy of individually identifiable health information created or maintained by health care providers who engage in certain electronic transactions, health plans, and health care clearinghouses. The HIPAA Security Rule sets national standards for the security of electronic protected health information; and the confidentiality provisions of the Patient Safety Rule, which protect identifiable information being used to analyze patient safety events and improve patient safety.

Other Federal law protects health care quality assurance information of the Department of Veterans Affairs [2] and of the Department of Defense [3] from both public disclosure under the FOIA and from discovery in litigation. In addition, the courts interpret the FOIA exemptions to protect from public disclosure information that would be exempt from discovery. All of these protections reflect a general Federal policy that protects health care quality assurance information from disclosure.

In addition to these laws favoring protection of quality assurance records from disclosure, Recommendation 6.1 in the Institute of Medicine's 2000 report, To Err is Human: Building a Safer Health System, recommended reporting systems for quality of care and health care errors should be privileged. It states: "Congress should pass legislation to extend peer review protections to data related to patient safety and quality improvement that are collected and analyzed by health care organizations for internal use or shared with others solely for purposes of improving safety and quality." [4]

On the other hand, there are rules, policy, and laws favoring disclosure of quality assurance records. FOIA embodies the notion that citizens of this Nation have a right to access documents created by the government. This right however is not unconditional, evidenced by including exemptions to the FOIA, state open record laws and Federal Governments. Such exemptions signify that not all government documents should be public for several reasons, including the principle that some government functions will be harmed by disclosure.

In this vein, however, the courts have read the exemptions narrowly. The courts holding in *Anderson* v. *Health & Human Services*, 907 F.2d 936, 941 (10th Cir. 1990) is that "[t]he FOIA is to be broadly construed in favor of disclosure and its exemptions are to be narrowly construed," and that "The Federal agency resisting disclosure bears the burden of justifying nondisclosure."

This burden on Federal agencies is buttressed by Executive Order 13410, "[h]ealth care programs administered or sponsored by the Federal Government promote quality and efficient delivery of health care through the use of health information technology, [and] transparency regarding health care quality." Its purpose also includes making relevant information available to program beneficiaries, enrollees, and providers in a readily useable manner and in collaboration with similar initiatives in the private sector and non-Federal public sector. [5]

If Congress concurs, or rather defers, to the Department of Health and Human Services' (HHS) interpretation implementing HIPAA in the preamble of the 2000 regulations, then FOIA should control access to a record covered by HIPAA and FOIA. [6] If left unaddressed then we urge this Subcommittee to continue to oversee VA's actions to make system and/or policy changes to ensure the issue of why the Department's quality management failed to identify substandard care and timely notifying the public. Furthermore, we ask the Subcommittee to ensure VA addresses the need for transparency of quality assurance records in the disability claims process described in our written testimony.

Question 2: Some have raised concerns about limiting the bill of rights to injured and amputee veterans. What are your thoughts on a bill of rights for all veterans which encompasses rights for injured and amputee veterans?

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[2] 38 U.S.C. § 5705—Confidentiality of medical quality assurance records.

[3] 10 U.S.C. § 1102—Confidentiality of medical quality assurance records: qualified immunity for participants.

[4] http://www.nap.edu/openbook.php?record_id=9728.

[5] http://edocket.access.gpo.gov/2006/pdf/06-7220.pdf.

[6] Standards for Privacy or Individually Identifiable Health Information, 65 Fed. Reg. 82,462, 82,482 (December 28, 2000).

Answer: With regards to the provision of comprehensive VA health care services, DAV has a National Resolution, which I have included below, which will most likely be our primary guide on a veterans bill of rights:

RESOLUTION NO. 036
SUPPORT THE PROVISION OF COMPREHENSIVE DEPARTMENT OF VETERANS AFFAIRS HEALTH CARE SERVICES TO ENROLLED VETERANS

WHEREAS, it is the policy of the Disabled American Veterans that veterans should be afforded quality and timely health care services by the Department of Veterans Affairs (VA) because of their honorable service to our Nation; and
WHEREAS, it is the conviction of the Disabled American Veterans that quality health care for veterans is achieved when health care providers are given the freedom and resources to provide the most effective and evidence-based care available; and
WHEREAS, the Veterans Health Administration plays a critical role in the delivery of health care services to our Nation's sick and disabled veterans, is the largest direct Federal provider of health care services, the largest clinical training ground for the health professions, and a leader in medical research; and
WHEREAS, although the veterans' health care system is provided an advance appropriation for medical care, it is still at the discretion of Congress to provide sufficient funding; and
WHEREAS, in the past, because of restricted appropriation levels, VA has been forced at times to restrict, ration and deny access to health care implicitly promised in connection with veterans' military service; and
WHEREAS, the VA health care system must be provided sufficient funding to ensure, at a minimum, the following standards are met:

- Promote and ensure health care quality and value, and protect veterans' safety in the health care system;
- Guarantee access to a full continuum of care, from preventive through hospice services;
- Receive adequate funding through appropriations for care of all enrolled veterans;
- Fairly and equitably distribute resources to treat the greatest number of veterans requiring health care;
- Furnish the gender-specific, quality and quantity of services necessary to meet the needs of a growing population of women veterans;
- Provide all medications, supplies, prosthetic devices and over-the-counter medication necessary for the proper treatment of service-connected disabled veterans;
- Preserve VA's mission and role as a provider of specialized services in areas such as blindness, burns, amputation, spinal cord injury and dysfunction, mental illness, and long-term care;
- Maintain the integrity of an independent VA health care delivery system as representing the primary responsible entity for the delivery of health care services to enrolled veterans;
- Modernize its human resources management system to enable VA to compete for, recruit and retain the types and quality of VA employees needed to provide comprehensive health care services to sick and disabled veterans;
- Maintain a strong and veteran-focused research program; NOW

THEREFORE, BE IT RESOLVED that the Disabled American Veterans in National Convention assembled in Atlanta, Georgia, July 31–August 3, 2010, supports legislation that embodies the concepts and principles enumerated above and establishes certainty to clearly defined VA health care services for enrolled veterans.

Question 3: PVA raised concerns with H.R. 5428 ignoring veterans who may be in need of special equipment who suffer from a specific disease and not a physical injury. Do you share this concern? Why or why not?

Answer: PVA's written testimony states, "As expressed in previous testimony on this topic, PVA is concerned that this legislation's language seems to ignore veterans who may be in need of special equipment who suffer from a specific disease and not a physical injury."

As inferred in the Subcommittee's previous question above and the statement to the Subcommittee from the sponsor of the bill,[7] the veteran patient population the bill is intended to primarily serve is the Operation Enduring Freedom and Operation New Dawn who suffer from blast injuries due to the widespread use of improvised explosive devices (IEDs) by ensuring veterans in need of an assistive device or prosthetic gets the highest quality item available and in a timely manner.

Moreover, not all treatment for all diseases and injuries require VA's Prosthetics and Sensory Aids Service. While DAV supports VA's Amputee System of care, we would generally agree the measure seems to ignore other veteran patients who seek care at VA.

Question 4: VVA raises some caution with H.R. 5516 by stating that they hope that the bill "doesn't do for veterans what was done for active-duty troops in the all too recent past, who were forced to be inoculated against smallpox and then anthrax in a panic." Do the rest of the witnesses on this panel share this thought? Why or why not?

Answer: The possibility exists, however improbable. It would depend on how VA would implement the bill's requirement if passed by Congress.

Question 5: VA explains that H.R. 5543 would "result in unprecedented changes in how the Federal Government operates. It would permit unions to bargain over, grieve, and arbitrate a subject—employee compensation—that is generally exempted from collective bargaining." There was unanimous support for this bill by the witnesses on second panel. How do you respond to VA's concerns?

Answer: DAV does not have an approved resolution from our membership on this specific VA labor-management dispute, but we believe labor organizations that represent employees in recognized bargaining units within the VA health care and benefits systems have an innate right to information and reasonable participation that result in making VA a workplace of choice, and particularly to fully represent VA employees on issues impacting working conditions and ultimately patient care.

The issue at hand is an imbalance between VHA and its title 38 employees, which is undermining Congress' intent when it passed section 7422 of title 38, United States Code, in 1991. In granting specific bargaining rights to labor in VA professional units, Congress recognized such rights promote effective interactions and negotiation between VA management and its labor force representatives concerned about the status and working conditions. In providing this authority, Congress granted to VA employees and their recognized representatives a right that already existed for all other Federal employees appointed under title 5, United States Code. Nevertheless, Federal labor organizations have reported that VA has severely restricted the recognized Federal bargaining unit representatives from participating in, or even being informed about, human resources decisions and policies that directly impact conditions of employment of the VA professional staffs within these bargaining units.

We are advised by labor organizations that when management actions are challenged, VA officials (many at the local level) have used subsections (b), (c) and (d) of section 7422 as a statutory shield to obstruct any labor involvement to correct or ameliorate the negative impact of VA's management decisions, even when management is allegedly not complying with clear statutory mandates (e.g., locality pay surveys and alternative work schedules for nurses, physician market pay compensation panels, etc.).

Facing VA's refusal to bargain, the only recourse available to labor organizations is to seek redress in the Federal court system. However, recent case law has severely weakened the rights of title 38 appointees to obtain judicial review of arbitration decisions. Title 38 employees also have fewer due process rights than their title 5 counterparts in administrative appeals hearings.

The alternative for labor organizations is to seek legislative action in the absence of reasonable compromise. DAV is sensitive to the realities of VA's human resource challenges on which this issue has a direct impact. Certainly retention rates are important, but this is only one factor that must be considered in determining whether the current status of this particular issue is sustainable.

VHA is facing the challenge of an increasing percentage of workers becoming eligible for retirement. VHA has identified registered nurses (RNs) as its top occupational challenge because 40.7 percent of the current registered nurse (RN) workforce will be eligible or will take retirement by 2014. VA also reports that by FY 2014,

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[7] http://www.veterans.house.gov/hearings/Testimony__Print.aspx?newsid=625&Name=The__Honorable__Bob__Filner

approximately 40.7 percent of the current workforce will be eligible for (or will take) retirement.

With respect to turnover for VHA nurses, the lowest rates occur in the VA Central Office among nurses who perform administrative, policy, and management functions. The highest rates occur along the Pacific coast and in the Appalachian region along the Atlantic coast. Many RNs resign early in their VHA careers. For example, in FY 2006, 16.3 percent resigned in the first year of employment, compared with VA physicians, 13.2 percent of whom departed the VHA in their first year of employment. Overall in VHA, 12.9 percent of newly hired personnel resign in their first year.

According to the American Federation of Government Employees, in 2007, 77 percent of all RN resignations within VA occurred in the first 5 years of employment, and the average VA-wide cost of turnover is $47 million per year for nurses. Given the loss of productivity, risks to patient care, and waste represented by such early departures from VA employment, VA simply cannot afford to ignore the concerns of its nurses in the areas of job satisfaction, compensation, and other conditions of employment. It appears that the often hostile environment consequent to these disagreements diminishes VA as a preferred workplace for many of its health care professionals. Likewise, veterans who depend on VA and who receive care from VA's physicians, nurses and others can be negatively affected by that environment.

VA has recently given Federal labor organizations some indication of additional flexibility in negotiating labor-management issues such as some features of compensation, and we are hopeful that this change signals a new trend in these key relationships that directly affect sick and disabled veterans. As VHA is indeed a unique system wherein its employees are driven first and foremost by their commitment to serve our Nation's disabled veteran, we hope that VA and Federal labor organizations can find a sustained basis for compromise.

Question 6: In addition to the provisions of H.R. 6123, the TBI Improvement Act, please share your insight on additional authorities that would be helpful in ensuring better health outcomes for veterans with TBI.

Answer: One additional specific authority that we believe would prove helpful to the most severely injured TBI cases and their immediate family members would be the provision of off-site long-term therapeutic residential facilities that would be near but clearly separated from the intensity found in the polytrauma rehabilitation centers themselves. DAV testified on this matter before the Subcommittee at its July 22, 2010 hearing. We ask that your professional staff review our testimony and further consider the merits of this proposal, as well as other concerns DAV expressed about VA's TBI programs during that particular hearing.

Question 7: PVA recommends that a broader spectrum of veteran is targeted instead of singling out the Qarmat Ali veterans for enrollment in H.R. 6127. Do you share PVA's recommendation? Why or why not?

Answer: Yes. In our written testimony we stated, "We also ask for the Subcommittee's consideration to afford the same eligibility to those veterans who were exposed to toxic substances as a result of disposing a poisonous mixture of plastics, metals, paints, solvents, tires, used medical waste and asbestos insulation in open-air trash burn pits in Iraq and Afghanistan. Tests on the burn pits in the war zones have shown that the fires released dioxins, benzene and volatile organic compounds, including substances known to cause cancer."

Question 8: In your testimony, you raised concerns about the feasibility of implementing the draft legislation on VHA outreach to veterans on VBA benefits. Do you have specific recommendations on ways to improve this draft bill so that we can more realistically expect VHA to implement the provisions of this bill?

Answer: Our key concern in implementing the provisions of this bill is that correct and consistent information is provided to a veteran seeking assistance at VA medical facilities on their claim or filing a claim for VA disability compensation, pension, and other ancillary benefits.

We believe serious consideration must be given to a single-point-of-entry into the Veterans Benefits Administration at VA medical facilities to carry out the provisions of this bill. The individual(s) located at a VA medical facility charged with assisting veterans in this regard should have the necessary tools to discharge his or her responsibility by receiving proper training and testing, appropriate time if other than a part-time duty, authority, responsibility, and accountability.

Any signage that provides cursory information about submitting a claim for compensation, establishing service connection for a disability, and contact information (including address, telephone number, and Internet Web site address) of the appro-

priate offices that may offer assistance with respect to service-connected disabilities should include the single-point of entry at that VA medical facility.

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
October 4, 2010

Ralph Ibson
Senior Fellow for Policy
Wounded Warrior Project
1120 G Street, NW, Suite 700
Washington, DC 20005

Dear Mr. Ibson:

Thank you for your testimony at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health legislative hearing on H.R. 3843, H.R. 4041, H.R. 5428, H.R. 5516, H.R. 5543, H.R. 5641, H.R. 5996, H.R. 6123, H.R. 6127, H.R. 6220, Draft Legislation on Homelessness, and Draft Legislation on VA Healthcare Provisions, which took place on September 30, 2010.

Please provide answers to the following questions by Monday, November 15, 2010, to Jeff Burdette, Legislative Assistant to the Subcommittee on Health.

1. Many of the witnesses of this panel emphasized the need to balance confidentiality and transparency. In fact, VA explains that it is precisely the confidential nature of the quality-assurance program that allows providers to report and examine patient safety events without fear of recrimination or liability. What specific barriers and challenges must VA overcome before they can make quality assurance records available to the public without compromising patient confidentiality?
2. Mr. Ibson, you note that the Federal Recovery Coordinators "may need specialized education and training. However it is not clear that VA needs legislation to mount such training." If not for this legislation, what suggestions do you have to encourage VA to enhance the training that FRCs receive?
3. Some have raised concerns about limiting the bill of rights to injured and amputee veterans. What are your thoughts on a bill of rights for all veterans which encompasses rights for injured and amputee veterans?
4. PVA raised concerns with H.R. 5428 ignoring veterans who may be in need of special equipment who suffer from a specific disease and not a physical injury. Do you share this concern? Why or why not?
5. VA explains that H.R. 5543 would "result in unprecedented changes in how the Federal Government operates. It would permit unions to bargain over, grieve, and arbitrate a subject—employee compensation—that is generally exempted from collective bargaining." There was unanimous support for this bill by the witnesses on second panel. How do you respond to VA's concerns?
6. Mr. Ibson, WWP believes that H.R. 5428 does not go far enough in "converting amputees' expectations into reality". There are provisions in this bill that require follow-up action so that the Chief Consultant of Prosthetics and Sensory Aids must investigate and address the reported complaints and allegations. Doesn't this ensure that the bill of rights goes beyond posting a piece of paper at VA medical centers? What other changes would you make to translate the bill of rights into reality for our injured and amputee veterans?
7. VVA raises some caution with H.R. 5516 by stating that they hope that the bill "doesn't do for veterans what was done for active-duty troops in the all too recent past, who were forced to be inoculated against anthrax and smallpox in a panic". Do you share this thought? Why or why not?
8. In addition to the provisions of H.R. 6123, the TBI Improvement Act, please share your insight on additional authorities that would be helpful in ensuring better health outcomes for our veterans with TBI.
9. PVA recommends that a broader spectrum of veterans is targeted instead of singling out the Qarmat Ali veterans for enrollment in H.R. 6127. Do you share PVA's recommendation? Why or why not?
10. In your testimony, you raised concerns about the feasibility of implementing the draft legislation on VHA outreach to veterans on VBA benefits. Do you have specific recommendations on ways to improve this draft bill so that we can more realistically expect VHA to implement the provisions of this bill?

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers by November 15, 2010.

Sincerely,

MICHAEL H. MICHAUD
Chairman

Subcommittee on Health
House Veterans Affairs Committee
September 29, 2010—Legislative Hearing
Wounded Warrior Project
Responses to Questions for the Record

Question 1: Many witnesses emphasized the need to balance confidentiality and transparency. In fact, VA explains that it is precisely the confidential nature of the quality assurance program that allows providers to report and examine patient safety events without fear of recrimination or liability. What specific barriers and challenges must VA overcome before they can make quality assurance records available to the public without compromising patient confidentiality?

WWP Response: The issue, in our view, is not solely or even principally a matter of ensuring against breaches of patient confidentiality. VA is required by law (38 U.S.C. sec. 7311) to conduct a quality-assurance program, that is, a comprehensive program to monitor and evaluate the quality of health care furnished by the Veterans Health Administration. In establishing that requirement, Congress adopted a widely accepted principle (reflected in section 5705 of title 38, protecting the confidentiality of quality-assurance records) that in order to evaluate adverse or potentially adverse events in health care, discussions must be frank, open, and complete, and must be conducted under circumstances that support such discussions. It is difficult to imagine that VA could gain the level of trust and participation of clinicians needed to operate an effective quality assurance program if those records (even redacted) were to become readily accessible.

Question 2: You note that the Federal Recovery Coordinators "may need specialized education and training. However it is not clear that VA needs legislation to mount such training." If not for this legislation, what suggestions do you have to encourage VA to enhance the training FRC's receive?

WWP Response: WWP agrees that by virtue of their responsibilities, Federal Recovery Coordinators (FRC's) require specialized skills. It has not been our experience, however, that there is any apparent systemic deficit in the educational background or experience of FRC's, or the training VA provides those selected to carry out these important responsibilities.

Question 3: Some have raised concerns about limiting the bill of rights to injured and amputee veterans. What are your thoughts on a bill of rights for all veterans which encompasses rights for injured and amputee veterans?

WWP Response: WWP does not find fault with legislation that focuses on remedying problems encountered by injured and amputee veterans. Our concern regarding H.R. 5428 is with its heavy reliance on a "bill of rights" which appears likely to fall short of being as effective a remedial mechanism as the term "rights" suggests. Given our concern regarding the limitations of the proposal, we would not recommend expanding the bill to provide for a "bill of rights" addressing all veterans. In addition, VA regulations (at 38 C.F.R. sec. 17.33) already establish patients' rights regulations applicable to all VA patients.

Question 4: PVA raised concerns with H.R. 5428 ignoring veterans who may be in need of special equipment who suffer from a specific disease and not a physical injury. Do you share this concern?

WWP response: Given the population it serves, WWP has not encountered such problems. But it is understandable that proposing a "bill of rights" as a partial remedy for problems encountered by veterans with amputations might spark advocates' concerns regarding other disabled veterans who are not covered by such legislation.

Question 5: WWP believes that H.R. 5428 does not go far enough in "converting amputees' expectations into reality." There are provisions in the bill that require fol-

low-up action so that the Chief Consultant of Prosthetics and Sensory Aids must investigate and address the reported complaints and allegations. Doesn't this ensure that the bill of rights goes beyond posting a piece of paper at VA medical centers? What other changes would you make to translate the bill of rights into reality for our injured and amputee veterans?

WWP response: The bill does propose establishment of a mechanism for monitoring and complaint-resolution. But, as drafted, the bill raises questions regarding the nature and number of complaints that VA would actually investigate and address. Specifically, the bill calls for investigating and addressing information "relating to the alleged mistreatment of injured and amputee veterans." The term "mistreatment" could be read to cover only the most serious kinds of allegations, such as patient neglect or abuse. (See "Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging America," The National Academy of Sciences, http://www.nap.edu/openbook.php?isbn=0309084342.) It is not clear from the language that the term would apply to a complaint of failure to provide access to a practitioner of one's choice or to a second opinion or to comparability of benefits with DoD, for example. Since the bill would not appear to establish enforceable "rights" in law, VA could reasonably conclude that its failure to meet veterans' expectations would not amount to "mistreatment."

WWP recommends that the Committee give consideration to amending the bill in a manner that imposes more substantial requirements on VA. Rather than directing simply that a "bill of rights" be posted, the legislation could direct VA to amend its patient rights' regulations to establish certain fundamental aspects of prosthetics care as substantive, enforceable veterans' rights. So, for example, it would be reasonable to direct VA to amend that regulation to provide with respect to veterans who have suffered an amputation (1) a right to the most appropriate technology, (2) a right to be fully informed of, and to participate fully in decisions regarding, all applicable prosthetic treatment options; and (3) a right to receive both a primary prosthesis and a functional spare. Other issues raised by the bill that are more difficult to enforce as "rights" might better be addressed in a different manner. An amended bill might direct the VA to (1) develop and implement a plan (to be submitted to Congress) to improve the level of expertise of its prosthetics and orthotics staff, (2) establish and implement standards for timeliness of prosthetics and orthotics care; and (3) establish and enforce requirements to ensure that veterans receive comparable benefits relating to prosthetic and orthotic services in transitioning from DoD to VA care. An amended bill could also clarify that the proposed complaint resolution process covers complaints regarding any of the issues addressed in the bill (vs. "mistreatment").

Question 6: In addition to the provisions of H.R. 6123, the TBI Improvement Act, please share your insight on additional authorities that would be helpful in ensuring better health outcomes for veterans with TBI.

WWP Response: While H.R. 6123 would close the gaps in law that appear to limit veterans with severe traumatic brain injury from getting needed rehabilitative services, Congress could certainly take additional steps to foster improved care and better health outcomes for these veterans. For example, while numbers of VA facilities have received additional staffing, equipment and training to improve TBI care, there appears to be a relative dearth of state-of-the-art clinical expertise—in VA and nationally—in treating serious behavioral-health effects experienced by some who have suffered severe TBI. These behavior changes can include impulsivity, impaired judgment, inability to control anger, lack of inhibition, etc. Given the profound implications these troubling TBI consequences have for the wounded warrior and family, there is urgency to closing the knowledge and expertise-gap. Scholars have recognized this need, but medicine has yet to move in this direction. As discussed in "The Integration of Neurology, Psychiatry, and Neuroscience in the 21st Century" (American Journal of Psychiatry, 159: 695–704, May 2002), there is a clear need for more practitioners with extensive experience integrating neurology and psychiatry. As its author, Dr. Joseph Martin of Harvard Medical School, writes, scientific advances have made it clear that there is no scientific basis for the separation of neurology and psychiatry, and that it is counterproductive for these fields to continue to follow the divergent paths they have taken. Yet, he notes, there are very few training programs that foster collaboration and integration. Finally, Dr. Martin observes in writing about the role of U.S. medical schools, a "major concern for academic leaders in neurology and psychiatry is the paucity of interest among medical students and residents in pursuing careers in the clinical neurosciences. . . . At a time when neuroscience research promises so much to our understanding of the brain in its normal and abnormal conditions, it comes as a shock that we have failed

to instill more excitement in our students" to pursue residency programs in neurology and psychiatry.

VA can do more for those veterans struggling with behavioral-health changes associated with a severe traumatic brain injury. Through the affiliations between its medical centers and major medical schools, VA plays a major role in training American physicians. As such, VA is ideally situated to help foster the development of clinical-neuroscience teaching programs—particularly at polytrauma centers—whose aims would include achieving better outcomes for TBI patients. Congress could, and should, provide incentives to spur that needed development.

Question 7: PVA recommends that a broader spectrum of veterans is targeted instead of singling out the Qarmat Ali veterans for enrollment in H.R. 6127. Do you share PVA's recommendation? Why or why not?

WWP Response: WWP recommends that given the potential range of toxic substances to which veterans might have been exposed in Iraq and Afghanistan, rather than legislating on an incident-by-incident basis, consideration be given to a systematic approach to addressing toxic exposures.

Question 8: VVA raises some caution with H.R. 5516 by stating that they hope that the bill "doesn't do for veterans what was done for active-duty troops in the all too recent past, who were forced to be inoculated against anthrax and smallpox in a panic." Do you share this thought? Why or why not?

WWP Response: While WWP has no position on H.R. 5516, we do not read this legislation as opening a door to forced inoculations, particularly in light of the requirement for full and informed patient consent in 38 U.S.C. section 7331 and 38 C.F.R. section 17.34.

Question 9: VA explains that H.R. 5543 would "result in unprecedented changes in how the Federal Government operates. It would permit unions to bargain over, grieve, and arbitrate a subject—employee compensation—that is generally exempted from collective bargaining." There was unanimous support for this bill by the witnesses on the second panel. How do you respond to VA's concerns?

WWP response: WWP, a participant on the second panel, respectfully expressed no position on H.R. 5543 or on a number of other bills on the agenda that addressed issues wounded warriors and their families have simply not encountered.

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
October 4, 2010

Hon. Eric K. Shinseki
Secretary
U.S. Department of Veterans' Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary Shinseki:

Thank you for the testimony of Robert L. Jesse, Principal Deputy Under Secretary for Health, and Walter A. Hall, Assistant General Counsel, at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health legislative hearing on H.R. 3843, H.R. 4041, H.R. 5428, H.R. 5516, H.R. 5543, H.R. 5641, H.R. 5996, H.R. 6123, H.R. 6127, H.R. 6220, Draft Legislation on Homelessness, and Draft Legislation on VA Healthcare Provisions, which took place on September 30, 2010.

Please provide answers to the following questions by Monday, November 15, 2010, to Jeff Burdette, Legislative Assistant to the Subcommittee on Health.

1. In light of recent lapses in certain medical centers using dirty reusable medical equipment, why does VA oppose H.R. 3843? What steps has VA taken to inform bring transparency to the patient safety lapses at certain VA medical centers?
2. VA opposes H.R. 4041. How can VA ensure that the current training provided to FRCs is evidence-based and will yield positive outcomes for our veterans who receive assistance from FRCs?
3. DAV identified a number of continuing gaps that exist in the FRC program. This includes integration of IT access across VA and DOD, manageable case-

load, and a multilayer bureaucracy of VA and DOD staff. How do you respond to DAV's concerns? What steps has VA taken to address these gaps?

4. VA has serious concerns with a few of the "rights" in H.R. 5428. This includes the right to select the practitioner that best meets the veterans' needs and the right to receive comparable services and technology at any VA medical facility. Do you have recommendations on ways to modify these "rights" so that they are not problematic for the VA?
5. VA does not support H.R. 5516 because "clinical indications and population size for vaccines vary by vaccine, blanket monitoring of performance of all vaccines could be cost prohibitive and may not have a substantial positive clinical impact at the patient level". It is my understanding that VA has seen positive health outcomes as a result of increased vaccinations for influenza and pneumococcal vaccinations. Additionally, a recent article in the New York Times highlighted the importance of adult vaccinations explaining that C.D.C. recommends adults ages 19 and older receive immunizations against as many as 14 infectious diseases. In light of this information, why would VA oppose efforts to increase and monitor vaccinations among our veterans?
6. VA has serious concerns with H.R. 5543 because it would subject many discretionary aspects of title 38 compensation to collective bargaining. This bill is intended to allow collective bargaining over compensation related labor-management disputes such as locality pay, overtime pay, shift differential pay, and performance pay. I have heard stories of VA nurses who have no recourse if they are denied overtime pay, which may negatively impact VA's retention efforts. Does VA have administrative solutions for dealing with these issues if not through H.R. 5543? Please explain.
7. VA explains that H.R. 5543 would "result in unprecedented changes in how the Federal Government operates. It would permit unions to bargain over, grieve, and arbitrate a subject—employee compensation—that is generally exempted from collective bargaining." However, it is my understanding that H.R. 5543 makes modest changes by allowing VA clinicians the same rights as the rest of Federal employees so that they can bargain over the implementation of pay laws and regulations. How do you respond to this disconnect?
8. I understand that VA is in the process of developing the Department's views on H.R. 5641, which would allow veterans to be placed in medical foster homes. In the meanwhile, could you comment on the number of veterans who currently pay out of pocket to be placed in medical foster homes? What is your understanding of the need or demand for medical foster homes among our veterans?
9. H.R. 5996 addresses the prevention, diagnosis, and treatment of veterans with Chronic Obstructive Pulmonary Disease. What treatment protocols does VA currently have in place and what tools do VA clinicians currently have? What gaps in treatment protocols and tools need to be addressed?
10. VVA explains that "there are pharmacological treatments and other treatment modalities available in the private sectors that are difficult if not virtually impossible to get on the VA formulary." How do you respond to these concerns?
11. Section 4 of the draft legislation on general health care matters would provide additional authority beyond simple contracts for services at non-VA facilities. Would you explain what additional authorities are needed by providing some concrete examples?

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers by November 15, 2010.

Sincerely,

MICHAEL H. MICHAUD
Chairman

Questions for the Record
The Honorable Michael Michaud, Chairman
House Committee on Veterans' Affairs, Subcommittee on Health
"Health Legislative Hearing"
September 29, 2010

Question 1: In light of recent lapses in certain medical centers using dirty reusable medical equipment, why does VA oppose H.R. 3843? What steps has VA taken to inform, bring transparency to the patient safety lapses at certain VA medical centers?

Response: Had they been in effect, the provisions of H.R. 3843 would not have prevented a VA medical center from failing to precisely follow manufacturers' sterilization or disinfection instructions. VHA is openly and candidly identifying the causes for these regrettable lapses. Further, where significant events occur, administrative investigations are conducted which are subject to the Freedom of Information Act, and therefore publicly available. It appears that H.R. 3843 would supersede the Freedom of Information Act, creating a standard for disclosure for VA that is not applied to other agencies or entities throughout the government. The impact and interaction of this bill with the Freedom of Information Act would need to be further explored by all relevant committees of jurisdiction.

In addition, VA is concerned about the impact of this legislation on the willingness of employees to bring forward concerns regarding the quality of care provided by VA. VHA's quality assurance programs work as well as they do because we strive to maintain a culture where employees at all levels feel free, if not obligated, to report even potential lapses in quality so fact-finding and remediation can occur. We discovered the sterilization and disinfection problems precisely because of this culture and specifically because our employees came forward with their concerns.

VHA is opposed to H.R. 3843 because it would repeal almost all of the quality assurance and peer review disclosure protections in current 38 U.S.C. 5705 and require posting of all VHA quality assurance documents on the Internet. Confidentiality is critical to the protection of Veterans' private information on which quality assurance depends. In addition, long experience in clinical quality improvement programs has taught the entire medical community that confidentiality in reporting and internal fact-finding is critical to establishing a culture where errors and close calls are openly identified, acknowledged and addressed. All 50 states protect their hospitals and health systems from disclosure of quality improvement or peer review proceedings through state statutes similar to current 38 U.S.C. 5705 or by judicial precedent. The effect of H.R. 3843 would change VHA's current culture of openness and potentially diminish error reporting.

VHA publicly posts[1] its standards for transparency about its clinical lapses. Forthright and open disclosure is required as a routine part of medical care. When an individual patient is involved, providers disclose directly to their patient. When serious injury or death occurs, medical center leadership makes a formal disclosure to the patient, his or her personal representative, or designated family members and, if requested, their lawyer. When a large number of patients are involved, we disclose a medical lapse to all potentially affected patients unless the clinical risk is insignificant (defined as fewer than 1 in 10,000 patients) and there are no ethical or institutional principles which warrant disclosure). If there is a question whether we should disclose, we err on the side of Veterans' safety and make the disclosure.

A recent article in the New England Journal of Medicine notes that large scale adverse events are not uncommon in the industry. What appears to be "a notable exception" is VHA's approach to being transparent about those mistakes. The article suggests that VHA's policy of "disclosure should be the norm, even when the probability of harm is extremely low."[2]

VHA is known as an industry leader in systemic programs that reduce the number of medical mistakes that occur such as the issuance of the "Hospital Quality Report Card." The Hospital Quality Report Card provides a snapshot of the quality of care provided at all VA health care facilities. The report includes information about waiting times, staffing levels, infection rates, surgical volumes, quality measures, patient satisfaction, service availability and complexity, accreditation status, and patient safety. Repealing the confidentiality provisions of 38 U.S.C. 5705 would jeopardize the current culture of openness that drives VHA's ability to identify errors and their causes and, more importantly, prevent future occurrences.

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[1] VHA Directive 2008–002, "Disclosure of Adverse Events to Patients," http://www1.va.gov/vhapublications/ViewPublication.asp?pub__ID=1637.

[2] Dudzinski DM, et. al, The Disclosure Dilemma—Large-Scale Adverse Events, N Engl J Med 2010; 363:978–986; http://www.nejm.org/doi/full/10.1056/NEJMhle1003134.

VHA is willing to work with the sponsors of H.R. 3843 to identify alternatives to the effective repeal of Sec. 5705 while at the same time enhancing VHA's ability to make meaningful quality improvement information more available to the public.

Question 2: How can VA ensure that the current training provided to FRCs is evidence-based and will yield positive outcomes for our Veterans who receive assistance from FRCs?

Response: The term "evidence-based" generally refers to the practice of medicine. It involves using evidence to make clinical decisions about the care and treatment of an individual patient. The Federal Recovery Coordination Program (FRCP) does not provide direct medical care or treatment. Instead, Federal Recovery Coordinators (FRCs) coordinate the delivery of services and serve as a resource for Servicemembers, Veterans and their families.

Care coordination removes the barriers between organizations and systems of care. It is a recognized step in the movement toward a truly integrated system. Currently, there is no body of evidence that identifies best practices for this approach.

FRCs are Masters-prepared registered nurses and licensed social workers who bring to the position strong educational and practical backgrounds. The additional training provided to FRCs is based on the knowledge and skills they require to assist clients. This includes in-depth training on VA, DoD, other governmental benefits, and private sector services for this population. FRCs also receive training on current medical treatment and management of a variety of medical conditions, such as traumatic brain injury, PTSD, spinal cord injury, amputee care and rehabilitation, as well as how to access health care in the Military or VA health systems and the private sector. FRCP uses subject matter experts in delivering this training to the FRCs in a variety of ways (quarterly training, on-line educational opportunities, conferences, weekly staff meetings, and orientation).

FRCP recently conducted its first (baseline) satisfaction survey. The overall satisfaction score across all clients and caregivers was 79 percent positive, indicating that most respondents rated the overall quality of care and services provided by FRCP as very good. Many of the respondents stated they found FRCs to be resourceful, knowledgeable, and strong advocates for their clients.

Question 3: DAV identified a number of continuing gaps that exist in the FRC program. This includes integration of IT access across VA and DoD, manageable caseload, and a multilayer bureaucracy of VA and DoD staff. How do you respond to DAV's concerns? What steps has VA taken to address these gaps?

Response: The integration or interoperability of IT systems across VA and DoD is a recognized challenge, involving technological, clinical and organizational complexity. To address the need for improved information sharing, particularly among case/care management/coordination programs, FRCP has been a driving force behind an effort to develop business requirements for an IT solution. These requirements are now completed and ready for identification of a pilot project to show feasibility. This project has been included under the Virtual Lifetime Electronic Record (VLER) initiative at VA.

Having an appropriate tool that measures the time impact of an injured or ill Servicemember or Veteran enrolled in FRCP is critical for determining staffing requirements, appropriate caseloads and measuring outcomes. Over time, using an intensity tool should also provide a way to document outcomes for each client (if FRCP is effective, the intensity of need should decrease with repeated measurement). Development of this tool is a high priority for FRCP and has the full support of VA. However, it is a complicated task that will require time and iterative testing to ensure validity and reliability.

To coordinate each client's particular needs and goals, the FRCs work with military liaisons, members of the Services Wounded Warrior Programs, service recovery care coordinators, TRICARE beneficiary counseling and assistance coordinators, VA vocational and rehabilitation counselors, military and VA facility case managers, VA Liaisons, VA specialty care managers, Veterans Health Administration (VHA) and VBA OEF/OIF case managers, VBA benefits counselors, and others. FRCs understand DoD and VA benefits, as well as access to health care. They use this knowledge to assist their clients in navigating the various transitions associated with recovery without duplicating services.

Question 4: VA has serious concerns with a few of the "rights" in H.R. 5428. This includes the right to select the practitioner that best meets the Veteran's needs and the right to receive comparable services and technology at any VA medical facility. Do you have recommendations on ways to modify these "rights" so that they are not problematic for the VA?

Response: VHA does not believe rephrasing the proposed rights in H.R. 5428 will provide a higher level of flexibility or quality of care than is already provided through VA's current processes and oversight of care. Veterans are evaluated by a team of qualified practitioners who are highly knowledgeable and have access to a complete medical history and treatment plan. All VA Orthotic and Prosthetic (O&P) Services and more than 600 contracted O&P providers are accredited by one of two national accrediting bodies. All amputee Veterans receive care at a nationally accredited O&P Service from practitioners that meet the requirements of VHA's extensive credentialing and privileging program. The Veteran, and as appropriate, their family, is part of the decision-making and prescription process when receiving VA amputation care services.

Altering the current process to allow Veterans to self-refer to a prosthetist or orthotist poses many risks to our Veterans. Providers whose credentials are unknown and not monitored through VA quality management programs, and providers who do not have access to the Veteran's medical information and cannot provide a team approach to the care of the Veteran both pose significant risks. In addition, Veterans could incur private medical expenses for which they would be personally liable if not eligible for private care at VA expense under 38 U.S.C. 1703. Finally, although injured and amputee Veterans have needs that set them apart from other patients at VA facilities, the basic tenets of patient care should not vary based on the condition or injury experienced by a Veteran.

Question 5: VA does not support H.R. 5516 because "clinical indication and population size for vaccines vary by vaccine, blanket monitoring of performance of all vaccines could be cost prohibitive and may not have a substantial positive clinical impact at the patient level." It is my understanding that VA has seen positive health outcomes as a result of increased vaccinations for influenza and pneumococcal vaccinations. Additionally, a recent article in the New York Times highlighted the importance of adult vaccinations explaining that C.D.C. recommends adults ages 19 and older receive immunizations against as many as 14 infectious diseases. In light of this information, why would VA oppose efforts to increase and monitor vaccinations among our Veterans?

Response: VA fully supports the provision of all recommended adult vaccines to its patients. As noted, VA provides influenza and pneumococcal vaccines to a high percentage of Veterans and has seen a positive impact on health as a result. Those two vaccines are recommended for all (influenza) or a large proportion (pneumococcal) of our Veterans. Therefore, setting targets and tracking how well we are doing in providing them is critically important.

Most of the other recommended adult vaccines are recommended for smaller subsets of our Veteran population; some vaccines are recommended for only a few patients who have specific conditions or reasons for getting the vaccines. Setting targets for and tracking the delivery of those vaccines is much more difficult because of the variability in the indications for the vaccines. For example, the varicella (chicken pox) vaccine is recommended for adults but only for those who do not already have immunity to varicella (either from previous vaccination or from having had the disease). Decisions about these non-universally recommended vaccines should be made between patients and their providers on a case-by-case basis.

Question 6: VA has serious concerns with H.R. 5543 because it would subject many discretionary aspects of title 38 compensation to collective bargaining. This bill is intended to allow collective bargaining over compensation related labor-management disputes such as locality pay, overtime pay, shift differential pay and performance pay. I have heard stories of VA nurses who have no recourse if they were denied overtime pay, which may negatively impact retention efforts. Does VA have administrative solutions for dealing with these issues if not through H.R. 5543? Please explain.

Response: Title 38 U.S.C. 7422 does not preclude unions or employees from seeking redress, including filing a grievance, when VA fails to follow its own policies or comply with regulatory or statutory obligations regarding employee compensation. In addition, unions have the right to request that the Under Secretary for Health provide a written determination as to whether a specific issue is properly excluded from bargaining or grieving under 38 U.S.C. 7422.

In connection with proposed legislation concerning section 7422, VA and the unions formed a Work Group to work collaboratively to formulate recommendations to improve knowledge, and correct misunderstanding, misinterpretation, and inconsistent use of section 7422. Both of these points are included in Work Group recommendations submitted to the Secretary. In addition, VA has an Administrative Grievance Procedure which generally permits employees to pursue disputes over

perceived misapplication of VA compensation statutes and regulations, including those that might be covered by section 7422. H.R. 5543 is not necessary to enable title 38 employees to pursue such disputes.

VA's concern with H.R. 5543 is that it is much broader than allowing employees a means to resolve labor-management disputes involving perceived misapplication of VA compensation statutes and regulations. The bill would give title 38 employees and the unions that represent them the right to grieve *any* decision made by the Department relating to discretionary pay matters, not just disputes involving regulatory or policy-related compensation issues. Title 38 has a number of pay systems that have significant discretionary aspects. For example, basic pay for physicians and dentists is set by law, but the Secretary of Veterans Affairs has discretion to set market pay for these positions above established basic rates based on factors such as experience, qualifications, complexity of the position and difficulty recruiting for the position. Pay for nurses is largely discretionary because it is set by locality pay surveys in accordance with the locality pay statute and its regulations.

Further, Congress has granted VA other pay flexibilities involving discretion for nurses and certain other health care workers, including premium pay, on-call pay, alternate work schedules, special salary rates, and recruitment and retention bonuses. If VA was obligated to negotiate with unions over discretionary pay, we would not be able to implement decisions about discretionary pay until we either reach agreements with our unions or until we receive a binding decision from the Federal Service Impasses Panel. This could significantly delay our ability to hire clinical staff.

Question 7: VA explains that H.R. 5543 would "result in unprecedented changes in how the Federal Government operates. It would permit unions to bargain over, grieve, and arbitrate a subject—employee compensation—that is generally exempted from collective bargaining." However, it is my understanding that H.R. 5543 makes modest changes by allowing VA clinicians the same rights as the rest of Federal employees so they can bargain over the implementation of pay laws and regulations. How do you respond to this disconnect?

Response: In general, Federal employees covered by title 5 pay systems do not have the right to bargain or grieve over aspects of their compensation. As noted, VA title 38 compensation has significant discretionary aspects, in contrast to title 5 pay systems. The pay for VA nurses, for example, is almost entirely discretionary because it is based upon locality surveys. H.R. 5433 would give title 38 employees the right to bargain or grieve over these discretionary aspects of compensation. As a result, title 38 employees would be allowed to bargain or grieve over significant aspects of their pay, which other Federal employees cannot do. For that reason, negotiating over compensation on such a large scale would be unprecedented in the Federal Government. As discussed above, title 38 employees have the same rights as other Federal employees to resolve labor-management disputes involving perceived misapplication of compensation statutes and regulations.

Question 8: I understand VA is in the process of developing the Department's views on H.R. 5641, which would allow Veterans to be placed in medical foster homes. In the meanwhile, could you comment on the number of Veterans who currently pay out of pocket to be placed in medical foster homes? What is your understanding of the need or demand for Medical Foster Homes among our Veterans?

Response: As of August 30, 2010, there were 274 Veterans residing in Medical Foster Homes. All Veterans residing in Medical Foster Homes pay out of pocket to live there. Projections through 2019 from the VHA demand model indicate that as many as 5,000 Veterans could meet the requirements and potentially elect to reside in Medical Foster Homes.

Question 9: H.R. 5596 addresses the prevention, diagnosis, and treatment of Veterans with Chronic Obstructive Pulmonary Disease. What treatment protocols does VA currently have in place and what tools do VA clinicians currently have? What gaps in treatment protocols and tools need to be addressed?

Response: VHA has many treatment protocols and tools for the diagnosis of Chronic Obstructive Pulmonary Disease (COPD). In 2007 VHA and DoD published an update for the COPD evidence-based Clinical Guideline and similar guidelines, such as the American Medical Association COPD Guideline published by the National Quality Forum. The VHA/DoD edition of this guidance is one of the most current available. The guideline was accompanied by provider "pocket cards," reference materials available using online links, and patient education tools. VHA also has many tools available for the treatment of COPD, including extensive home oxygen

guidelines that have proven their utility and effectiveness under Joint Commission review.

Prevention of smoking is critical in patients with COPD. VHA has implemented a number of evidence-based national initiatives, including adoption of a population-health approach to smoking cessation; increased access to nicotine replacement therapy and/or smoking cessation medications; elimination of outpatient copayments for smoking cessation counseling; clinical practice guidelines; and collaboration with mental health and substance use disorder health care providers to promote integration of smoking cessation into routine treatment of psychiatric populations. VA has metrics regarding screening, counseling, and offering of medication support as well as enrollment in smoking cessation classes and support groups.

Historically, the prevalence of smoking and smoking-related illnesses has been higher among Veteran patients in the Veterans Health Administration (VHA) in comparison to that of the general population. Although rates of tobacco use have remained high, smoking cessation interventions continued to be greatly underutilized in VHA clinical settings just as they have been nationally.

Moreover, VHA is implementing Patient Aligned Care Teams, expanding access to care management for patients suffering from chronic diseases such as COPD. A component of this effort will be the development and implementation of metrics to trend and drive improvement. We will be studying the use of externally developed models and metrics such as the Ambulatory Care Sensitive Conditions (ACSC) model for COPD metrics as well as internal development of metrics tailored to our Veteran population. At this time, there are no identified gaps.

Question 10: VVA explains that "there are pharmacological treatments and other treatment modalities available in the private sector that are difficult if not virtually impossible to get on the VA formulary." How do you respond to these concerns?

Response: The VA believes that statement is an inaccurate and misleading representation of the VA National Pharmacy program. While it is true that not every commercially available drug is listed on the VA National Formulary, the same can be said for virtually any formulary in use in the United States today. VA is not unique in this regard.

What is unique about VA's formulary process is that if a VA provider determines that a commercially available drug is medically necessary, then the commercially available drug will be made available via the VA National Formulary process for that individual patient, regardless of whether it is a brand or generic drug, whether it is or is not listed on the VA National Formulary, or whether it is costly or inexpensive. By contrast, in private sector health plans, there are numerous examples of drugs that a patient cannot get regardless of the medical need.

The philosophy for VA's formulary management process is an unwavering reliance on well-researched, well-documented clinical evidence demonstrating that a specific drug can provide an expected, cost-effective benefit for the Veteran population. According to an analysis of the VA National Formulary (VANF) in 2001, the Institute of Medicine (IOM) stated:

> *"The VA National Formulary and formulary system that enable the VHA to make quality choices among drugs and negotiate favorable prices should be maintained . . . . The VHA should continue to make careful choices among drugs, based first on quality considerations but with an understanding of cost implications, and should negotiate the best prices possible using the leverage of committed use and the ability to drive market share."*

VA's primary motivation in formulary management has always been and always will be to ensure highest quality care for Veterans. Economic considerations, though important, are secondary compared to safety and efficacy. VA has often been criticized for not adding recently approved medications to the VANF, or for unduly restricting medications, and has been the subject of inquiries and investigations prompted by these criticisms by the Institute of Medicine, the Government Accountability Office and the Office of the Inspector General. To date, these external reviews have only provided suggestions for some minor process improvements, concluding that VA's processes were safe and cost-effective and that formulary decisions were based on sound reviews of the medical evidence.

Questions 11: Section 4 of the draft legislation on general health care matters would provide additional authority beyond simple contracts for services at non-VA facilities. Would you explain what additional authorities are needed by providing some concrete examples?

Response: 38 U.S.C. 1703, as currently written, provides that fee-basis arrangements will be accomplished by contracts with non-VA facilities. The proposed lan-

guage in Section 4 of the draft legislation would make it clear that VA is able to furnish fee-basis care through mechanisms other than contracts, such as an individual authorization and other industry standard tools such as provider agreements (similar to Center for Medicare and Medicaid (CMS) provider agreements)) for authorizing services for veterans. An individual authorization is used when services are sporadic in nature where contracting in accordance with Federal acquisition law and regulation would be cumbersome and not timely. Also, many providers, including many individual and small practice groups, are unfamiliar with Federal acquisition regulations which could adversely affect their interest in being a provider to VA potentially impacting care to Veterans. Further, pricing could be determined reasonable by other established rates such as Medicare as opposed to competitive acquisitions.

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
November 16, 2010

The Honorable Eric K. Shinseki
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary Shinseki:

On Wednesday, September 29, 2010, Dr. Robert L. Jesse, Principal Deputy Under Secretary for Health, Veterans Health Administration testified before the Subcommittee on Health during a legislative hearing on a number of bills relating to veterans health care, including H.R. 5516 and H.R. 5996.

As a follow-up to the hearing, I request that Dr. Jesse respond to the following questions in written form for the record.

H.R. 5516—"Access to Appropriate Immunizations for Veterans Act of 2010"

1. The Department's testimony stated that ". . . blanket monitoring of performance of all vaccines could be cost prohibitive and may not have a substantial positive clinical impact at the patient level." However, VA currently has performance measures for influenza and pneumococcal vaccines. How has implementing such performance measures affected the rates of vaccination and hospitalization for these two illnesses? Do you believe that adult immunizations are an important way to prevent the spread of disease and are a cost-effective way to preserve health?
2. A recent New York Times article on adult vaccinations rates states that only 7 percent of Americans over age 60 have received the herpes zoster vaccine, developed by VA researchers to prevent shingles. How many VA patients have received the herpes zoster vaccine? Has VA seen a corresponding decline in the number of veteran patients with shingles?
3. The Department's testimony stated that H.R. 5516 would ". . . limit VA's ability to respond quickly to new research or medical findings regarding a vaccine." However, the legislation requires VA to use the immunization schedule established by the Center for Disease Control (CDC) Advisory Committee on Immunization Practices. Is this schedule inappropriate for veterans? Does VA believe that H.R. 5516 would prevent new vaccines from being added to the performance measures if the CDC has not adopted them?
4. In the Department's statement, it is written that "VA currently conducts ongoing initiatives" regarding vaccination rates. What are these initiatives? How does VA ensure that all veterans have access to vaccines and is such data reported? Will VA commit to increasing immunization rates?
5. VA added the T-dap vaccine to the VA National Formulary as an adult booster vaccine. However, in 2007 VA purchased less than 48,000 doses, enabling the vaccination of less than 1 percent of VA patients. How did VA formulate this vaccine strategy? What is the target vaccine rate for veterans with this vaccine?
6. When VA increased the rate for pneumococcal vaccinations, pneumonia hospitalization rates decreased by about 50 percent, a savings of about $117 for each vaccine administered. Does VA have any estimate on how much money

would be saved through preventing future hospitalization? Do the costs that VA estimated for this bill include any potential savings from diminishing hospitalization rates for preventable diseases?

H.R. 5996—To direct the Secretary of Veterans Affairs to improve the prevention, diagnosis, and treatment of veterans with chronic obstructive pulmonary disease.

1. Various veteran service organizations (VSOs) testified to the need and their support for improving the prevention, diagnosis and treatment of veterans with chronic obstructive pulmonary disease (COPD). The Paralyzed Veterans of America expressed some concern that because this authorization is subject to appropriation, the Secretary could choose not to implement the bill if enacted. Can we expect the VA to implement this legislation if enacted?
2. In their written statement, the Department expressed support for the intent of H.R. 5996. How could H.R. 5996 be adjusted to gain the support of VA?
3. What COPD-related programs currently exist at VA?
4. The Department's statement references existing VA authority to conduct treatment protocols and further research into COPD. Is VA currently developing treatment protocols and related tools to improve research programs on COPD, as mandated in H.R. 5996? If so, please discuss this work.
5. How much of the Veterans Health Administration's budget is allocated to COPD-related conditions?
6. How did VA estimate the cost of H.R. 5996?

The attention to these questions by the witness is much appreciated and I request that they be returned to the Subcommittee on Health no later than close of business Friday, December 17, 2010. If you have any further questions, please call (202) 225–3527.

Sincerely,

Cliff Stearns
Republican Member

Questions for the Record
The Honorable Cliff Stearns
House Committee on Veterans' Affairs, Subcommittee on Health
"Health Legislative Hearing" September 29, 2010

H.R. 5516—"Access to Appropriate Immunizations for Veterans Act of 2010"

Question 1: The Department's testimony stated that ". . . blanket monitoring of performance of all vaccines could be cost prohibitive and may not have a substantial positive clinical impact at the patient level." However, VA currently has performance measures for influenza and pneumococcal vaccines. How has implementing such performance measures affected the rates of vaccination and hospitalization for these two illnesses? Do you believe that adult immunizations are an important way to prevent the spread of disease and are a cost-effective way to preserve health?

Response: VHA exceeds other health care providers in the delivery of influenza and pneumococcal immunizations (Trivedi A. et al. *Medical Care.* E-pub November 2010). The implementation of performance measures for these two immunizations contributed to VHA's high rate of use; however, other implementation strategies, including clinical reminders for providers, standing orders, immunization campaigns, and wellness providers for patients, have also contributed to this success. VHA agrees that adult immunizations are an important way to prevent the spread of disease and are a cost-effective way to preserve health. Yet, most of the adult immunizations other than influenza and pneumococcal are recommended for smaller subsets of the Veteran population; some vaccines are recommended for only a few patients who have specific conditions or reasons for getting the vaccine. Setting targets for and tracking the delivery of those vaccines is much more difficult because of the variability in the indications for the vaccines.

Question 2: A recent New York Times article on adult vaccination rates states that 7 percent of Americans over age 60 have received the herpes zoster vaccine, developed by VA researchers to prevent shingles. How many VA patients have re-

ceived the herpes zoster vaccine? Has VA seen a corresponding decline in the number of Veteran patients with shingles?

Response: Data from VHA's Pharmacy Benefits Management shows that a total of 193,917 doses of the herpes zoster vaccine have been purchased since October 2007. VHA does not uniformly systematically record the number of Veterans who have received the vaccine from their non-VA providers. Validated data about the incidence or prevalence of shingles in VA patients since the vaccine was released are not available.

Question 3: The Department's testimony stated that H.R. 5516 would ". . . limit VA's ability to respond quickly to new research or medical findings regarding a vaccine." However, the legislation requires VA to use the immunization schedule established by the Center for Disease Control (CDC) Advisory Committee on Immunization Practices. Is this schedule inappropriate for Veterans? Does VA believe that H.R. 5516 would prevent new vaccines from being added to the performance measures if the CDC has not adopted them?

Response: Overall, VHA supports the immunization schedule established by the Advisory Committee on Immunization Practices (ACIP). VHA Handbook 1120.05, Coordination and Development of Clinical Preventive Services (http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2095), requires that "the evidence-based recommendations of the . . . ACIP must be included [in VHA Clinical Preventive Services Guidance Statements], *unless there are reasons to differ from these recommendations, such as: existing VHA policy, unique characteristics of the VHA population, VHA specific implementation issues, or more recent compelling evidence* [emphasis added]." VHA is represented as an *ex-officio* member of the ACIP and several VHA staff are members of various ACIP workgroups. So while VHA recognizes ACIP as the authoritative source for immunization recommendations for the general U.S. population, and participates in the development of its recommendations, VHA requires the flexibility to adapt ACIP recommendations as needed for its specific population of Veteran patients.

Question 4: In the Department's statement, it is written that "VA currently conducts ongoing initiatives" regarding vaccination rates. What are these initiatives? How does VA ensure that all Veterans have access to vaccines and is such data reported? Will VA commit to increasing immunization rates?

Response: VHA promotes immunizations for its Veteran patients by providing general information about immunizations on My HealtheVet and on the VHA National Center for Health Promotion and Disease Prevention Web site (http://www.prevention.va.gov/Resources_Immunizations_Vaccines_for_Veterans_and_the_Public.asp). Veterans who are "in-person authenticated" on My HealtheVet receive electronic reminders about influenza and pneumococcal immunizations when they are due. Every year, the Office of Public Health and Environmental Hazards, through its award-winning multidisciplinary "Infection: Don't Pass It On" project, develops an influenza campaign that promotes the use of influenza immunization to Veterans and employees (http:/www.publichealth.va.gov/flu/index.asp); in addition to influenza, campaign materials for pneumococcal immunization are provided through this project. Many facilities have clinical reminders about immunizations for staff in the electronic medical record, so that when patients are seen for appointments, staff are prompted to discuss appropriate immunizations with the patients. Nurses, social workers and case managers play an important role in promoting use of vaccinations with Veterans. Some VA medical centers have arrangements with local Veteran Rehabilitation Centers to provide immunizations at the Centers. The VHA Office of Rural Health has funded and established over 40 new outreach clinics in rural communities and also 4 mobile health units, which serve the states of Colorado, Maine, Washington, and West Virginia, all of which provide primary care for rural Veterans, including adult immunizations.

VA reports rates of influenza and pneumococcal immunization use, compared with non-VA rates, on its Quality of Care Web site, www.qualityofcare.va.gov. VA is committed to providing high quality, appropriate preventive care, including immunizations, to all its Veterans. The VHA National Center for Health Promotion and Disease Prevention is developing an interactive public Web site that will allow users to search for age-and gender-appropriate recommendations for preventive care, including immunizations. Currently, the www.prevention.va.gov site has a link to a questionnaire that helps people determine which immunizations are recommended for them (http://www.immunize.org/catg.d/p4036.pdf), based on their individual risk factors and health status.

Question 5: VA added the T-dap vaccine to the VA National Formulary as an adult booster vaccine. However, in 2007 VA purchased less than 48,000 doses, enabling the vaccination of less than 1 percent of VA patients. How did VA formulate this vaccine strategy? What is the target vaccine rate for Veterans with this vaccine?

Response: The ACIP recommendation for use of a single dose of T-dap in adults ages 19–64 was published in the Morbidity and Mortality Weekly Report (MMWR) in December 2006. The recommendation was to replace the next booster dose of tetanus and diphtheria toxoids vaccine (Td) for adults whose last dose of Td was 10 or more years earlier and who had not previously received T-dap. The number of doses needed each year is much less than the total number of VA patients and is based on an estimate of the number who would be due for the vaccine that year and who had not received it outside VA. The vaccine is not FDA-approved for use in adults age 65 or older; nearly half of the population served by VHA is in that age range. Only recently, at its latest meeting in October 2010, the ACIP voted to recommend off-label use for older adults. Since 2007, VA has purchased a total of 288,940 doses of T-dap, enabling the vaccination of more than 10 percent of VA patients in the target age group.

Question 6: When VA increased the rate for pneumococcal vaccinations, pneumonia hospitalization rates decreased by about 50 percent, a savings of about $117.00 for each vaccine administrated. Does VA have any estimate on how much money would be saved through preventing future hospitalization rates for preventable diseases?

Response: The cost-effectiveness estimates for adult vaccinations vary by vaccine, depending on the incidence of the vaccine-related disease and the cost and effectiveness of the vaccine. While many adult vaccines have been shown to be reasonably cost-effective under usual circumstances, few are actually cost-saving (unlike childhood immunizations, most of which are estimated to be cost-saving). VA has not estimated any potential savings from prevention of hospitalizations from the increased use of adult immunizations.

H.R. 5996—To direct the Secretary of Veterans Affairs to improve the prevention, diagnosis, and treatment of Veterans with chronic obstructive pulmonary disease.

Question 1: Various Veterans Service Organizations (VSOs) testified to the need and their support for improving the prevention, diagnosis and treatment of Veterans with chronic obstructive pulmonary disease (COPD). The Paralyzed Veterans of America (PVA) expressed concern that because this authorization is subject to appropriations, the Secretary could choose not to implement the bill if enacted. Can we expect the VA to implement this legislation if enacted?

Response: VA is committed to the continuous improvement of care to our Nation's Veterans. The foundation work related to the standardization of diagnosis and care for Veterans suffering from COPD has been completed. The results are supported by existing initiatives targeting smoking cessation and prevention. Operation of pilot sites as prescribed by the bill was not included in the President's budget; however, the overall intent of the bill could be met through a continued focus on current initiatives.

Question 2: In their written statement, the Department expressed support for the intent of H.R. 5996. How could H.R. 5996 be adjusted to gain the support of VA?

Response: VA would offer full support of this bill if the bill were crafted to allow more flexibility with the execution model and plans. VA believes it is important to develop pilot programs within VA prior to partnering with other agencies. Medicine is ever changing and the need to have the flexibility to change with the advances in medicine is crucial to success.

Question 3: What COPD-related programs currently exist at VA?

Response: COPD care is integrated into the Patient Aligned Care Teams (PACT), the primary care system in the Veterans Health Administration.

At the Pharmacy Benefits Management group, a clinical pharmacist with experts from the field review current data regarding status of the best medical therapy for COPD in addition to other pulmonary diseases.

Smoking and tobacco use cessation is organized through the Public Health Office of the Veterans Health Administration (VHA). Smoking continues to be the leading cause of preventable death and disease in the United States (US). Quitting smoking

is the most important public health approach to minimize risk of emphysema and other smoking-related illnesses, such as cardiovascular disease, in the aging Veteran population. Smoking cessation care is currently provided at every VA health care facility nationally, with access to first-line FDA-approved smoking cessation medications. VA also has a national performance measure that requires that all Veterans seen in outpatient primary care and mental health settings be screened yearly for current tobacco use and provided with brief counseling and offered assistance in the form of medications and additional counseling. The rate of smoking cessation care has increased and the prevalence of smoking among Veterans in care has decreased from 33 percent in 1999, to 19.7 percent in 2008.

Question 4: The Department's statement references existing VA authority to conduct treatment protocols and further research into COPD. Is VA currently developing treatment protocols and related tools to improve research programs on COPD, as mandated in H.R. 5996? If so, please discuss this work.

Response: The Department of Veterans Affairs (VA) and The Department of Defense (DoD) have developed guidelines for treatment of COPD http://www.healthquality.va.gov/Chronic__Obstructive__Pulmonary__Disease__COPD.asp.

These guidelines include algorithms for the management of COPD and for the management of acute exacerbations of COPD. The guidelines also include tools to facilitate implementation; a pocket card for quick reference and a summary in addition to the full guidelines.

Research Programs—The cooperative studies program (CSP) has as an objective to initiate new multi-site clinical trials in chronic disease. COPD and its relationship to bacterial infections, environmental exposure, and rehabilitation are included in that objective's priorities. VA investigators recognize that COPD is an important chronic disease. VA and DoD have developed a joint Clinical Practice Guideline (CPG) for COPD. This guideline This guideline was updated in 2007 based on best practices and available clinical research. VA and DoD continue to collaborate on revisions to this CPG.

VA has funded thirty-five research projects specific to COPD over the last 2 years. These projects range from molecular investigation through practical application of science in rehabilitating patients with COPD.

VA has over 340 research publications on COPD over the last 3 years, which demonstrates VA's commitment to research and knowledge sharing.

VA is pleased to announce that Dr. Christine M. Freeman, PhD, has been nominated for the Presidential Early Career Award for Scientists and Engineers (PECASE) Award for her work on the role of the immune system in COPD. Dr. Freeman's work on immunologic mechanisms involved in COPD pathogenesis holds great potential that could lead to novel treatment approaches for this very common and devastating disease.

Question 5: How much of the Veterans Health Administration's budget is allocated to COPD-related conditions?

Response: In FY 2010, VA provided Home Respiratory Care to 128,000 Veterans at a cost of more than $139 million. The VA spends approximately $5693 (2004 data)/Veteran with COPD as a primary or secondary condition. Approximately, 19 percent of Veterans are afflicted with COPD. An estimate of expenditures for COPD for a population of about 969,000 Veterans with COPD finds that the VA commits $5,516,517,000 (2004 data).

Question 6: How did VA estimate the cost of H.R. 5996?

Response: The cost for H.R. 5996 was estimated based on funding a person to build the COPD program in each VA medical center and resources for a training program which would include two full time national coordinators.

The cost of this bill is estimated to be $25.9 million over 5 years.