THE STATE OF THE VA HEALTH CARE SYSTEM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

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CONTENTS

April 3, 2001

OPENING STATEMENTS

	Page
Chairman Moran	1
Hon. Bob Filner	2
Hon. Michael K. Simpson	29
Hon. Lane Evans, prepared statement of	43
Hon. Luis V. Gutierrez, prepared statement of	44
Hon. Cliff Stearns, prepared statement of	44
Hon. Ander Crenshaw, prepared statement of	45

WITNESSES

Bollinger, John C., Deputy Executive Director, Paralyzed Veterans of America	24
Prepared statement of Mr. Bollinger	89
Clarkson, John G., M.D., Senior Vice President Medical Affairs and Dean, University of Miami School of Medicine, on behalf of Association of American Medical Colleges	7
Prepared statement of Dr. Clarkson	61
Fischl, James R., Director, National Veterans Affairs and Rehabilitation Commission, The American Legion	22
Prepared statement of Mr. Fischl	83
Garthwaite, Hon. Thomas L., M.D., Under Secretary for Health, Department of Veterans Affairs; accompanied by Frances M. Murphy, M.D., MPH, Deputy Undersecretary for Health, Department of Veterans Affairs	4
Prepared statement of Dr. Garthwaite	47
Gerace, Elaine, R.N., Divisional President, VA Medical Center, Syracuse, NY, Local 200B, on behalf of Service Employees International Union	35
Prepared statement of Ms. Gerace	109
Harnage, Sr., Bobby J., National President, American Federation of Government Employees	33
Prepared statement of Mr. Harnage	103
Hayden, Paul A., Associate Director, National Legislative Service, Veterans of Foreign Wars	19
Prepared statement of Mr. Hayden	73
Ilem, Joy J., Assistant National Legislative Director, Disabled American Veterans	20
Prepared statement of Ms. Ilem	76
Jones, Richard, National Legislative Director, AMVETS	17
Prepared statement of Mr. Jones	67
Pitts, Ellen M., R.N., President, VA Medical Center, Brockton, MA, Local R1–187, on behalf of National Association of Government Employees	31
Prepared statement of Ms. Pitts	96
Thibault, George, M.D., Chairman, Special Medical Advisory Group, Department of Veterans Affairs, Vice President and Chairman of Clinical Affairs, Partners Health Care, Inc.	8
Prepared statement of Dr. Thibault	65

MATERIAL SUBMITTED FOR THE RECORD

Written committee questions and their responses:	
Congressman Evans to Dr. John Clarkson on behalf of American Association of Medical Colleges (AAMC)	115

Page

Written committee questions and their responses—Continued
Congressman Evans to Dr. George Thibault, Chairman, Special Medical Advisory Group 116
Congressman Evans to Ms. Ellen Pitts, National Association of Government Employees (NAGE) 118

THE STATE OF THE VA HEALTH CARE SYSTEM

TUESDAY, APRIL 3, 2001

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

The subcommittee met, pursuant to call, at 2 p.m., in room 334, Cannon House Office Building, Hon. Jerry Moran (chairman of the subcommittee) presiding.

Present: Representatives Moran, Simpson, Simmons, Crenshaw, Brown, Filner, Peterson, Shows, and Rodriguez.

OPENING STATEMENT OF CHAIRMAN MORAN

Mr. MORAN. Good afternoon. Our Subcommittee on Health of the Committee on Veterans' Affairs will come to order. I am pleased to be here and holding this hearing today on the current status of the health care delivery system for our veterans across the country. This is our first hearing of the 107th Congress of this subcommittee, and I think this is an appropriate topic for us to begin our work on in this subcommittee.

We have a new administration, with a new VA Secretary, Mr. Principi, and we have a new Under Secretary for Health, Dr. Garthwaite, who has just been confirmed in September 2000 as the Under Secretary for Health. He is certainly no stranger to this committee, but we welcome him in his most recent capacity. And we have a new subcommittee chairman and a new ranking member, although certainly Mr. Filner is not at all new to this topic or to the subcommittee, and I am delighted to have him join me this afternoon. Mr. Filner, the gentleman from California.

I look forward to working closely with Mr. Filner and the other members of the subcommittee to attempt to achieve goals that we think are important for veterans and for the delivery of their health care.

I am a new chairman and I welcome the opportunity that has been given to me by my colleagues to become more involved in this topic and to help, with Dr. Filner's assistance, set a course for this subcommittee that is right for veterans who need health care and to make this a better system for all those who served our Nation when our country needed them.

Again, the focus of today's subcommittee hearing is on health, and I appreciate the attendance of our witnesses who are here to testify on this vital topic. The system has been completing a journey of change over the last 5 years. It has restructured head-

quarters, field operations and delegated substantial management authority to regional offices who have themselves lifted authority from the VA medical centers. The workforce has been cut by nearly 30,000 personnel. We have adapted a managed care model into the VA clinical and financial practices. We have activated over 350 primary care clinics, with 100 more to be open very soon, and open enrollment has occurred to VA care for nearly 2 million new veterans.

Congress has played a role with the Department of Veterans Affairs.

While approving of the basic design reform in 1995, the so-called Vision for Change, Congress has passed key legislation to encourage even more changes at the VA. Importantly, Congress has invested $3 billion in the VA's health care budget for the fiscal years 2000 and 2001. Again this year Congress is poised to appropriate an additional significant increase. The House has approved a new increase in the budget for VA health care based upon this committee's recommendations. That is good news.

On the other hand, with over 180,000 health care employees and staff now operating with a $121 billion in hundreds of sites, there are still numerous changes about which we will hear more today; for example, long waiting times despite VA standards that call for no more than a 30-day waiting period, issues related to the quality of care, concerns about the future. Many veterans worry a lot on whether their health care needs are going to be met in old age and, if so, how. We have another looming VA nursing shortage, dissatisfaction with the special program areas, especially in VA mental health programs and disagreements on whether the VA is meeting capacity requirements.

So despite the good news these challenges do not make up an insignificant list. I welcome our witnesses and the other people in attendance today and look forward to their testimony to assist this subcommittee in better appreciating the true state of the VA health care system. Despite the challenges and uncertainties that lie ahead, we want to do what is right for the veterans of this country.

I now turn to our subcommittee's ranking member, the gentleman from California, Mr. Filner, for any opening remarks he might have.

OPENING STATEMENT OF HON. BOB FILNER

Mr. FILNER. Thank you, Mr. Chairman, and on behalf of the other members who are not here I would just ask for the record, ask unanimous consent that members of the subcommittee have 5 days to submit statements for the record.

Mr. MORAN. So ordered.

Mr. FILNER. You have stated our job here well. This is the first meeting under your leadership, and I am looking forward to working with you on these issues.

We have met as member and ranking member to set the stage for a bipartisan working relationship in looking at the issues. This hearing today, where all the vital stakeholders are here, is important to help us all get a grasp of some of the issues that we are going to be looking at over the course of the year.

I guess it is axiomatic to state that in order to provide the highest quality of care to our Nation's veterans we need to have the highest quality providers and work force, and we have a couple of panels of speakers here today that will address the issues associated with the provision of health care and services to veterans.

We have unions, of course, which represent VA's work force, and without this work force, there would be no VA health care system. We must recognize that all the good things we are able to achieve for the Nation's veterans are due to them. As we begin the discussion, I would like us to also keep in mind that all of our goals and plans and initiatives must be implemented by this work force. They are the panel number 3.

We started a new tradition, Mr. Chairman, in the full committee that if VA goes first, they stay to hear the following panels and Dr. Garthwaite, you have remained in the last couple of meetings and I appreciate that. You have set a standard that I hope you will follow today. It doesn't do much for morale when the first panel walks out, and our veterans groups and our stakeholders are all here and nobody, in their view, is listening to them, although I guess you have got it on tape and you will see it later. But I appreciate your personal listening to what they will have to say.

I think the employees represent the heart and soul of our work force, be it nurses or allied health professionals, nursing assistants, cooks, the security force, custodial and ground maintenance staff. From their perspective there are some problems, and we have to address them if we are going to be able to keep them around, and recruit the valued workers that we need. With these problems, our workers can't deliver high quality health care, and as they retire and we face even more severe shortages, we have to keep their morale and working conditions in mind.

Many times they feel they are not valued, that management overlooks concerns about their welfares and has not pursued in a proactive way initiatives to improve their working conditions, even when you have the authority to do so. They criticize decisions to use more contract services without management fully understanding the real cost of that in terms of both dollars and the quality of service delivered. So I share some of those concerns, and I am eager to hear the testimony of the various groups.

We are always pleased to have the veteran service groups here, the veteran service organizations. They represent the people who we are trying to serve. They are intimately acquainted with the VA system. They understand both the strengths and the shortcomings of that system in ways that come from firsthand observation, and they are concerned about the erosion of health care in many areas, whether it be long-term care, special services like spinal cord injury services, mental health care, programs for homeless.

And I know this subcommittee and our committee is concerned about accountability of the VA. We have passed a Millennium Health Care Act, which we have not seen quickly implemented. We have diseases like hepatitis C which we confront, it seems, all of the sudden, and we don't seem to be prepared to handle its full impact.

We passed a law, I guess partially included in the Millennium Health Care Act, that said chiropractic services shall be provided

to our veterans, and we don't see that happening. I can go on and on, but we intend to be very much concerned with oversight from this committee.

So, Mr. Chairman, thank you for holding this hearing. We look forward to all the panels and I think everyone is committed, whether it is the VA, the VSOs or the employees, to making this health care system worthy of the veterans who have worked and fought so valiantly for our country.

Mr. MORAN. I thank the gentleman from California and appreciate his opening statement and share the sentiments expressed.

We have three panels of witnesses this afternoon. The first panel has already come forward and is seated: VA Under Secretary Dr. Thomas Garthwaite, accompanied by his Deputy, Dr. Frances Murphy, and Dr. John Clarkson, who is the Senior Vice President Medical Affairs and Dean at the University of Miami School of Medicine, who is testifying today on behalf of the Association of American Medical Colleges, and Dr. George Thibault, Senior Vice President of Partners Health Care Boston. Dr. Thibault serves as Chairman of the Congressionally chartered Special Medical Advisory Group, the only committee that by law advises the Secretary on a broad array of VA health care matters that are important to veterans and the VA system. Welcome to you all.

Dr. Garthwaite has been invited to testify for 10 minutes and the other witnesses today for 5. All of your written statements will be made a part of the subcommittee record. Dr. Garthwaite, Mr. Secretary, thank you for being here.

STATEMENTS OF HON. THOMAS L. GARTHWAITE, M.D., UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY FRANCES M. MURPHY, M.D., MPH, DEPUTY UNDERSECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; JOHN G. CLARKSON, M.D., SENIOR VICE PRESIDENT MEDICAL AFFAIRS AND DEAN, UNIVERSITY OF MIAMI SCHOOL OF MEDICINE, ON BEHALF OF ASSOCIATION OF AMERICAN MEDICAL COLLEGES; AND GEORGE THIBAULT, M.D., CHAIRMAN, SPECIAL MEDICAL ADVISORY GROUP, DEPARTMENT OF VETERANS AFFAIRS, VICE PRESIDENT AND CHAIRMAN OF CLINICAL AFFAIRS, PARTNERS HEALTH CARE, INC.

STATEMENT OF HON. THOMAS L. GARTHWAITE, M.D.

Dr. GARTHWAITE. Thank you, Mr. Chairman and members of the subcommittee. I am pleased to be here today to discuss the progress, challenges and future direction of health care in the Department of Veterans Affairs.

I would like to use my 10 minutes to make three points: First, that VA employees deserve the credit for our dramatic progress in restructuring VA health care; secondly, to say that we have set aggressive goals for the next 5 years. We call them the "Six for 2006." and thirdly, that we believe we have creative strategies to allow us to achieve those goals.

First, I would like to talk a bit about our employees. Since 1995, we have dramatically transformed the VA health care system. We have moved from an inpatient model of care characterized by lim-

ited facilities often far from patients' homes to an outpatient model with more than 350 additional sites of care. While we still provide comprehensive specialty services, we now also emphasize the coordination of care through the universal assignment of primary care providers and teams. We emphasize disease prevention and early intervention, allowing veterans to avoid illnesses and complications and allowing us to avoid unnecessary treatment costs.

As a result of these strategies, VA today is able to provide higher quality care to more than a half million additional veterans with 25,000 fewer employees and at 24 percent less cost per patient than just 6 years ago.

None of this dramatic transformation would have been possible if our employees had not changed, adapted and embraced new ways of delivering care. They are the heroes of the transformation and they are the engines that will propel us forward into the future. Our challenge is to harness more of their intelligence and energy than we have thus far, and we have harnessed a significant amount already. I think this challenge is especially true of our academic partners.

Secondly, I would like to briefly review our goals. The goal that underlies VA's transformation and will continue to drive our strategies for the future is our quest for health care value. We have defined health care value as quality divided by cost. The quality and cost measures that we have are directly translated into our value framework and the "Six for 2006" goals.

Our first goal is to put quality first until we are first in quality. Our first priority is that the quality and safety of our care is second to none. To that end we will continue to measure our performance in quality and safety and to compare our results to all other available data. To date our outcomes are equal to or better than comparable outcomes in non-VA systems and our approach to improving patient safety is viewed as exemplary.

Our second goal is to provide easy access to medical knowledge, to expertise and to care. We will address traditional measures of access, including travel times, waiting times and the payment for care. But we will also improve access to knowledge by facilitating appropriate specialty consultation and by the creative use of telemedicine and the Internet.

Our third goal is to enhance, preserve and restore patient function. Rehabilitation, which is the restoration of function, is the cornerstone of VA's health care mission, and it targets our highest priority veterans, those with service-connected disabilities, those in need of specialized services and those who are poor. VA has nationally recognized programs for the rehabilitation of veterans who are blind, who suffer from spinal cord injury, traumatic brain injury or amputation. We also provide comprehensive mental health services, from intensive inpatient mental health units for acutely ill veterans to comprehensive outpatient care in residential settings.

In addition to the restoration of function, our recent initiatives in health promotion and disease prevention aim to enhance and preserve the functional capacity of all our patients.

Our fourth goal is to exceed our patients' expectations. While VA's satisfaction score was 78 on the 100-point scale of the American Customer Satisfaction Index, 8 points above the scores for pri-

vate hospitals, we know we still have a lot of work to do. In addition to improving waiting times in pharmacy and for specialty and primary care appointments, we will also enhance our performance of medical examinations for compensation and pension rating purposes.

Our fifth goal is to maximize resource use for the benefit of veterans. I used to call this save more to serve more. Although VHA has reduced the cost of care per veteran treated by 24 percent, we will continue to pursue additional efficiencies through strategies that include joint purchasing, automation, minimizing administrative overhead, energy conservation, the efficient clinical evaluation and treatment of our patients, continued enhancement of our MCCF collections and improved partnership with the Department of Defense.

And finally, we aim to build healthy communities. Veterans can only reach their maximum health potential if they live in healthy communities and healthy environments and only if we continue to invest in medical research and high quality education. In addition, we cannot hope to cure homelessness or coordinate care for mental illness without strong community partnerships.

My third and final point is an overview of our strategies to attain the "Six for 2006" goals. These strategies include such things as a comprehensive work force development strategy and program, which we have already undertaken and which we are reviewing internally. It also includes departmental integration, systemization and expansion of our clinical information technologies, including expanded implementation of our computerized medical record. We will continue to emphasize performance measurement. We will enhance our attention to the quality and capacity in our special emphasis programs, and we will begin a systematic process of assuring quality in mental health programs similar to what we have done in surgical programs in our national surgical quality improvement program.

We will look for creative synergies among patient care, teaching and research. In my mind it is an evolution from academic health center to academic health systems, and we will challenge our academic partners to build such a program. We will continue to implement the Veterans Health Initiative. We will look to continue our efforts at rationalizing and modernizing our facilities via the CARES process. We will continue to examine our equitable distribution of funding through the continuous assessment and improvement of VERA. And finally, we will seek to learn about ourselves by the continuous self-assessment process using the Baldrige criteria.

In summary, Mr. Chairman, I am proud of our organization, its accomplishments, especially of our employees. While we have accomplished a great deal, we cannot rest. We must continue to change and adapt as information technology, biotechnology, health care financing and public accountability impact all health care systems. VHA has chosen goals that would challenge any organization. But I believe additional gains in health care value are possible, especially if we are able to manage health information more effectively, to improve the coordination of care and the communication with our patients, to eliminate variability in care, and to change

our infrastructure as needed to meet current needs. As we look to the future of VA health care, we are very optimistic that VA will meet the challenges it faces and will increasingly be viewed as a model health care system.

Thank you for holding this hearing and for inviting us, and I look forward to your questions.

[The prepared statement of Dr. Garthwaite appears on p. 47.]

Mr. MORAN. Mr. Secretary, thank you. I think we will hold those questions until the entire panel has testified.

Dr. Clarkson, welcome to you and we anticipate your testimony.

STATEMENT OF JOHN G. CLARKSON, M.D.

Dr. CLARKSON. Thank you, Mr. Chairman, Mr. Vice chairman, members of the subcommittee. As you indicated, I am John Clarkson. I am Dean of the University of Miami School of Medicine and Senior Vice President for Medical Affairs, and I am here today representing the Association of American Medical Colleges, the organization that is the national voice for the 125 accredited allopathic medical schools, over 400 major teaching hospitals and health systems, including over 70 veterans affairs medical centers, 92 academic and scientific societies representing 87,000 faculty members, and the Nation's medical students and residents and fellows, house staff. Currently, 139 VA medical centers are affiliated with 107 medical schools. Each year more than 30,000 medical residents and 22,000 medical students rotate through the VA hospitals and clinics to receive a portion of their medical training.

The WAMC appreciates the opportunity to testify today on the state of the VA health care system and, in particular, on its relationships with and policies affecting affiliated medical schools. Additionally, the Association is keenly interested in the state of the VA research program.

I have submitted my formal statement for the record. I would like to highlight a few points and offer some examples from my experiences at the University of Miami School of Medicine.

All medical centers have a tri-part mission. That is to provide excellence in medical education, to expand medical knowledge through research, and provide high quality care to those who need it. The affiliation with VA hospitals at the academic medical centers throughout the country is critical to fulfillment of that mission. At the University of Miami slightly more than one-third of our clinicians spend most of their time at the VA hospital. At any one time about a third of our 900 house staff; that is, physicians in training beyond medical school, are at the VA hospital. And I might add that the supervisory capacity of the faculty at the VA medical center is identical to what it is everywhere else in our training system.

Our medical students rotate through the VA system, and in our situation, where the public hospital is our main teaching facility, the environment for medical education is actually more advantageous at the VA hospital than it is in our public hospital in some instances.

Our research programs, combined research programs, are critically important at our medical center. Our geriatrics research, supported in large part by the NIH, is conducted through the VA medi-

cal center. Our AIDS research program, addressing prevention, treatment and long-term behavioral effects, is centered at and its outreach is from the VA medical center. We have an important research initiative in neurodegenerative diseases, such as Alzheimer's and behavioral medicine research affecting blood pressure and cardiovascular diseases as it applies particularly to the African American community.

I want to point out in a constructive way that the funding for VA research has not increased in proportion to the changes even in inflation since the mid-1980s, and a lot of what we do at the VA is through NIH support, clearly some of it related to VA support, but the infrastructure required for research at the VA lags behind because of the lack of keeping pace with inflationary pressures.

I have already addressed medical education. We believe, and I hope you concur, that the quality of health care is critically important for our veterans, and we think the ability to recruit high quality physicians to an academic medical center which work at the VA hospital in conjunction add to that quality of care.

Finally, I simply want to say that the affiliations are critical for both partners, but most importantly for our veterans. We think that the affiliation with academic medical centers increases the quality of care, and as realignment occurs through the VA system, consideration must be given to the importance of the research and education missions which ultimately translates to better care for our veterans.

Thank you very much for the opportunity to participate.

[The prepared statement of Dr. Clarkson appears on p. 61.]

Mr. MORAN. Dr. Clarkson, thank you, appreciate your comments and testimony. We look forward to further dialogue on that testimony.

Dr. Thibault, welcome to you and we appreciate your testimony as well

STATEMENT OF GEORGE THIBAULT, M.D.

Dr. THIBAULT. Thank you, Mr. Chairman, members of the committee. I am George Thibault. I am currently Professor of Medicine at Harvard Medical School and Vice President for Clinical Affairs for Partners Health Care System in Boston, which was founded by Massachusetts General Hospital and Brigham and Women's Hospital.

For the past 3 years I have been privileged to be the Chairman of the Special Medical Advisory Group of the Department of Veterans Affairs. I am a Harvard Medical School graduate, trained in internal medicine and cardiology at the MGH and at the NIH. I have been a Harvard Medical School faculty member for 25 years, which included 7 years as Chief of Medicine at the Harvard affiliated Brockton/West Roxbury VA Medical Center. I have also served the Veterans Health Administration as chair of the 1994 Task Force on the Reorganization of VA Central Office, which provided the blueprint for Dr. Kizer's reorganizational changes.

The Special Medical Advisory Group is composed of members of medical, podiatry, optometry, nursing and allied science professions, who provide advice and consultation to the Secretary and the Under Secretary on matters relating to the care and treatment of

disabled veterans and other matters pertinent to the operation of VHA. A list of the SMAG members is attached with the written testimony.

SMAG is advising Under Secretary of Health through the dramatic transformation of the VA health system from inpatient care to the outpatient model of care. This transformation has had an impact on medical education, research and the aligning of capital assets to veterans needs.

Through this transformation, the Under Secretary for Health appointed an expert committee, the Residency Realignment Review Committee, to advise them on changes that were needed to ensure that VHA's graduate medical education would meet present and future health needs, both for the VA and for the Nation. Implementing VHA's residency realignment goal of reducing specialty training was phased in over 3 years and completed with the beginning of the academic year 1999–2000. This process was reviewed and monitored by SMAG and overseen by the Office of Academic Affiliations.

On an ongoing basis, SMAG has been updated on the capital assets realignment for enhancement of services, CARES process. Members of SMAG have consistently recognized the need to realign capital assets and agree that there must be established and clearly defined criteria when making decisions. In reviewing the objective criteria developed to measure future realignment options, SMAG has cautioned that values of weights needed to be adjusted for regional variations as a purely numerical approach without qualified judgments could be a problem because it does not allow for the unique situations in specific regional areas, particularly as they pertain to academic affiliations.

The members of SMAG want to specifically recognize the outstanding accomplishments of VHA in the areas of patient safety and the computerized medical record. Both of these initiatives have been reviewed by SMAG in the recent year. It is refreshing to have VHA take the lead in developing a patient safety program that is organized in a way that increases feedback to the staff, encourages teamwork and drives out the fear and blame mentality. Medical errors that are not due to intentional wrongdoing or criminal acts need to be viewed as system errors, not as individuals' fault.

The members of SMAG reviewed the VHA system that asked questions of why an error occurred. The system allows the formulation of corrective action that prevent recurrence rather than just seeking to assign fault. This safety program that emphasizes prevention of error and not punishment has the potential to change the culture of health care in creating a safer environment for patients. Even prior to the publication of the landmark Institute of Medicine study, To Err Is Human, VHA had identified patient safety as an important priority. It has had a leadership role in developing blame free reporting systems modeled after those that had been successful in the aeronautics industry. It has also been a leader in applying technologies such as bar coding and computerized order entry to make the environment safer for patients.

Many other health care organizations have acknowledged this leadership role of VHA, and they are looking to VHA to lead the changes that need to take place in the health care system nation-

ally. Just last week in Massachusetts at a meeting called to review the patient safety progress, three different speakers, including Ken Shine, the President of the IOM, cited the VHA as a model of what should occur in the private sector.

SMAG has also reviewed VHA's use of information technology through the computerized patient record and telemedicine. Again, VHA is leading the private sector in developing this computerized medical record. This allows the retrieval of data for clinicians at any time and any place. It also makes information available to patients in a timely fashion. Access to a computerized patient record will allow clinicians to review clinical records remote from the facility or the site of care.

VHA has the unique mission to deliver care to veterans in their home and in their community clinics, as well as in hospital, and with the tools of the computerized patient record and with telemedicine there is opportunity to provide care in a variety of settings. In using these tools, again, VHA is setting a model for the private sector of how information technology can be used to improve patient care.

The contributions of SMAG over the years have influenced the agenda of the VHA research program, brought closer affiliations with medical schools and led to improvement in medical care programs. At this crucial juncture in the evolution of VHA, SMAG wishes to particularly note the importance to the VHA and to the Nation of the close relationship between the VHA and the Nation's medical schools, which has already been alluded to.

General Omar Bradley was a visionary in realizing that a close affiliation between the veterans health care system and academic medicine would benefit veterans. I think even he underestimated the degree to which that association would benefit society in general.

As the VHA has transformed itself from a hospital-based system to an ambulatory-based system, it is leading the way in thinking about changes that need to take place in the training of physicians and other health care professionals to adapt to the changing societal needs in health care. Similarly, VHA research priorities, which have long emphasized the needs of an aging population with a large burden of chronic illness, and which have emphasized health services and translational research, are helping to set a national agenda for health research priorities.

The members of SMAG look forward to continuing to offer the perspective of their professional disciplines, their professional affiliations, and their geographic areas in advising Mr. Principi and Dr. Garthwaite as they meet the challenges of the future.

Thank you very much.

[The prepared statement of Dr. Thibault appears on p. 65.]

Mr. MORAN. Thank you very much. We will now go to the portion of our hearing in which we get to ask a few questions and, Dr. Garthwaite, my first one is for you. Perhaps more specific than the broad nature of your testimony, the President signed the Millennium Act in November of 1999, and I think there is a number of provisions which are of benefit to our veterans, and yet those issues await administrative implementation, and I wondered if you

would tell us today where we are in the implementation of Public Law 106–117.

Dr. GARTHWAITE. I will be happy to. We are somewhat frustrated as well the time it takes to do the background work on relatively complex policy issues, to get the background data and then to get it through the regulatory process. The long-term care regulations, which comprise a significant amount of the work, were pulled back at the change of administrations but have gone forward to the Secretary's office for review and hopefully forwarding on to OMB in the very near future. The same is true of our emergency room regulations and emergency provision regulations.

Our State home grant program is in the final stages of development with the general counsel and our geriatrics folks, and we hope to publish that in interim final form in time to be used this year for granting of funds. And we are currently hard at work on both the outpatient and pharmacy copay. Both of those again were pulled back at the change of administration and have undergone significant policy discussion with the Secretary, and we are, I think, close on the pharmacy decision paper and have several teams hard at work on the outpatient copays. Those were originally ready to go forward, but got caught up in the change.

I think that is it.

Mr. MORAN. Mr. Secretary, thank you and, Dr. Clarkson, you indicate in your testimony that many deans feel that the VISN directors view the affiliations as something that needs to be accommodated only after other factors are satisfied. I think that is relatively close to a quote. There is a sense that the VISN directors are not uniformly supportive of the VA's research mission. Would you expand upon those statements and indicate what you think needs to be done to restore that faith?

Dr. CLARKSON. Thank you, Mr. Chairman. I actually omitted part of my testimony when I saw the time lapsing, so I am pleased to have the opportunity to answer the question now.

I think it varies from VISN to VISN. I will give you my own experience in the relationship with our VISN director in VISN 8, which is the State of Florida. The affiliation between the medical school and the VA used to be governed, if you will, by what is called a dean's committee, which consisted of individuals from the VA hospital and medical schools sitting down together to discuss issues. In our particular medical center that still happens, but the authority to make decisions is no longer with the director of the hospital and the chief of staff, but it is with the VISN director. And so when we come up against issues, if the VISN director isn't there, isn't on board, those issues may be discussed but implementation of potential resolutions doesn't occur. I will give you an example in point.

A relatively new VA hospital was built in West Palm Beach, Florida, which is about 80 miles north of Miami. It was built as a primary care facility. Miami has been a tertiary referral center for the VA for some time, and we have been working to combine the two hospitals, whose missions are slightly different, primary care versus tertiary care, both institutions attempting to respond to the VA's initiative to have primary care outreach. And in the course of doing that clearly the person that can pull that together is the

VISN director. We have determined we are going to have a single chief of surgery, a single chief of medicine. We wanted to work together to do that. It got done by the VISN director really without input from the School of Medicine. That is really his prerogative. We would have liked, however, to have had an opportunity to have a process to identify the very best person to help combine those two things. It didn't happen.

So it is a matter of addressing the need to communicate the vital interests of the academic mission as well as the patient care mission with the VISN director when we are making those kinds of decisions, and that was my example from my own experience. That has been expressed unevenly across the country from other medical school deans.

I don't mean to say it is the same in every VISN, but there is a separation now geographically from the local community that doesn't always afford the most timely and most effective communication.

Mr. MORAN. Dr. Garthwaite, would you care to briefly respond?

Dr. GARTHWAITE. Well, I think I would agree that it probably does vary by network. There is no particular reason that the network director can't delegate significant authority or shouldn't delegate significant authority to a facility director where that is appropriate. However, when it does involve more than one facility and will impact two facilities, then I think it is very appropriate for the network director to be involved in trying to make sure that whatever is done between two facilities actually serves the needs of the veterans involved.

I think overall that we have noticed some improvement in the workings of our network structure with academic partners. We know when we met with AAMC and deans and network directors in New Orleans at a meeting, there were considerable problems. When we met next again in Washington at the AAMC meeting, we found that most of the network directors and deans were sitting together and there were significantly fewer issues. I would assume though that there are still some communication problems because those plague all organizations.

Mr. MORAN. Thank you. Mr. Filner.

Mr. FILNER. Thank you, Mr. Chairman, and thank you, Mr. Secretary, and the panel. Mr. Garthwaite, are you familiar with the Independent Budget?

Dr. GARTHWAITE. I am.

Mr. FILNER. This budget is put together by many of our veteran service organizations. They spend a lot of time in doing it, and I find their recommendations most useful. Is there anything in there that they recommended for the VA health care that you wouldn't support?

Dr. GARTHWAITE. I don't remember anything particularly that I wouldn't support. Before I would say anything, I would want to go back and reread it with that in mind, but I think we attempt to be in close contact with the veterans service organizations and try to listen to their concerns. In fact, we have a monthly veteran service organization meeting where we are point by point taking each of the concerns they raised by health care system and addressing

those, and we are having a dialogue specifically about the things raised in the Independent Budget.

So we take the document very seriously. We take any complaints raised and their concerns raised very seriously and continue to work on fixing them.

Mr. FILNER. And yet if you use a common baseline for comparisons, the Independent Budget for health care is $2.6 billion above what the administration recommended. Do you agree with that recommendation from the administration or would you try to have it higher?

Dr. GARTHWAITE. Through the budget process we submit a number to start and then we have various discussions, and we end up—the administration has the unenviable role of having to make it all balance out in the end and propose their broad agenda. And so our goal is to deliver the maximum amount of high quality care with the money we finally get appropriated.

Mr. FILNER. If you were as good a doctor as you are at not answering these questions, you must have been a great doctor! Let me just say, again, the Independent Budget was about $2.6 billion above the administration. It is $1.7 billion above what was recommended in the House budget resolution. I think the Independent Budget was very responsible, they just didn't say give me everything, give me more. They outlined exactly what their figures would do for enhancing the quality of care in areas that we are lacking in, for reducing waiting times for appointments, and on and on. There were very measurable things in their budget and they understand they can't get everything, but they came up with a reasonable figure, especially based on a 10-year situation where we have straight-lined your budget in real terms.

So I find that the budget that we are recommending or that the President has recommended and the House has recommended to be under what we ought to be doing, and do you want to comment on that?

Dr. GARTHWAITE. I guess what I maybe could say is I believe that although the details aren't final yet, but they are close to final, that the budget will propose fewer veterans overall, some veterans moving to TRICARE for life, assumes increase in copays, and you know it will be harder for us to implement certain other initiatives that we would prefer to do more quickly. I mean it will take us longer, I think, to find the efficiencies to open certain access points and a variety of other things. I think that is probably what I can say.

Mr. FILNER. I can't wait to read the transcript of that answer! I asked, do you support the budget? and I don't know where you went with that.

Is it because you don't have enough money in what the Congress or the administration is recommending that you can't implement as rapidly as you would like the Millennium Health Care Act? Is the problem with resources? I talked to the chairman earlier, and I think we have agreed to have some special meeting just on the Millennium Health Care Act, but I mean what is it that prevents you from doing what we required in law?

Dr. GARTHWAITE. No, I don't believe it is a financial issue in terms of implementation of the Millennium Health Care Act. I think that several of the provisions that could have been imple-

mented already have been implemented, and so we just sent directives out and changed immediately in the things that we could implement without regulations. Those things that required regulation have required a significant amount of policy development, the writing of the regulations, which is a long process.

Mr. FILNER. Do you have the authority to hire chiropractic professionals?

Dr. GARTHWAITE. Yes.

Mr. FILNER. Have you hired any?

Dr. GARTHWAITE. I don't believe we have hired chiropractic professionals, but I don't believe the Act required us to hire them. It requires us to have a policy.

Mr. FILNER. The Act required you to provide the full range of chiropractic services to our patients. You haven't moved at all to do that, as I understand it.

Dr. MURPHY. Mr. Filner, we have published a national policy on chiropractic care in VA. That was done within 120 days of the publication of the Millennium Health Care Act. We can provide chiropractic services as needed by fee basis. We do not hire chiropractors in the VA at this point. We are tracking the utilization of chiropractic care at our medical centers, and if there is a justification and the need to hire chiropractors, we will do so.

Mr. FILNER. Are you telling me that a veteran walking into any of our health care centers has available to him or her the full range of chiropractic services; is that what you are saying?

Dr. MURPHY. VA cam purchase spinal manipulation for musculoskeletal conditions through fee basis.

Mr. FILNER. What does that mean? I mean, anybody can go to anything they want on a fee basis, I assume. We don't have to go to the VA. Does the VA give any benefits for that?

Dr. GARTHWAITE. When we say purchase by a fee basis we mean the VA pays the fee.

Mr. FILNER. VA pays the fee. All right. Mr. Chairman, I hope we will look into that. From testimony I have heard from people in my district and around the country, I don't believe that answer. It is not available. Nobody knows that it is available. If you are saying it is up to the veteran to ask for something that nobody tells them they can ask for, then of course they are not going to ask and you are going to say, well, they didn't ask. A provision of a benefit has to be well understood by people, and as I understand it, this is not happening, but we will have a full hearing on that issue, I hope.

Mr. MORAN. Mr. Filner, thank you. I share your interest in that topic and hope that this subcommittee will explore this issue of chiropractic care further.

Mr. Simmons.

Mr. SIMMONS. Thank you, Mr. Chairman. Welcome. Four doctors at one table, gosh. It is extraordinary. I have a question about the MIRECCs, which were apparently established a couple of years ago as a, if you will, an experimental effort to deal with veterans mental illness and I was curious to know how they are working out and what recommendations you might have for them in the near future.

Dr. GARTHWAITE. I don't have any formal reports. I have had a couple of conversations with several committees that oversee them and my understanding is that they are working out well, that they

are up and running, that they have recruited staff, that they are developing—they are pursuing the research focus, applying for additional grants and in general working out quite well. I would like to have the opportunity to look and see if we have a formal report yet and, if not, get you one that would give you more detail than that because I actually need to know that as well.

Mr. SIMMONS. And have you or any member of the panel had an opportunity to visit those facilities or to be briefed on them? I know that West Haven, CT is participating in the New England initiative. Have you had an opportunity to either visit or be briefed?

Dr. GARTHWAITE. No, I haven't visited them. I have visited several GRECCs and other similar research and education centers that we have initiated. It is a good idea though. I actually will put that on my schedule.

Mr. SIMMONS. Well, good. The weather is getting better. In that regard, and you said they were applying for grants, have you received any feedback on the cost effectiveness of the program at this point in time?

Dr. GARTHWAITE. I don't have that information. We will look to see what we have.

Dr. MURPHY. The MIRECCs are relatively new, sir. Therefore, to judge the cost effectiveness or the outcomes of the clinical, education, and research programs of the MIRECCs, would, I expect, take another year or so. We look forward to providing that report to the committee.

Mr. SIMMONS. I thank you for that. I think it is an interesting and somewhat exploratory concept. Mental illness among veterans is increasing actually, not decreasing, which in and of itself is an interesting phenomenon, but I would welcome a visit from somebody from VA so that we could perhaps sit down together and see how this program is working.

Dr. GARTHWAITE. Look forward to doing that.

Mr. SIMMONS. Thank you, Mr. Chairman.

Mr. MORAN. Mr. Simmons, thank you very much. Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman. Thank you, Mr. Secretary, appreciate you coming today and expressing some concerns that we are concerned with. In the First Congressional District of South Carolina we have a goodly number of veterans there. We have a hospital and a veterans nursing home under construction, and so we certainly have followed both of those real close. We certainly appreciate your interest in the veterans and being committed to this task. We certainly look forward to working with you in the future.

Dr. GARTHWAITE. Thank you very much. The same goes for me.

Mr. MORAN. Mr. Brown, thank you. Mr. Shows.

Mr. SHOWS. I apologize for being late, Mr. Chairman. I represent the Fourth Congressional District in Mississippi. You have recently established an outpatient center in Hattiesburg. I guess it is being used pretty well there because there is a waiting period. We have gotten complaints about their wives not being able to use it. Are there any plans to expand it so that the wives may be treated there also? Do you think we will ever get to that point?

Dr. GARTHWAITE. Well, currently we can't provide care to spouses. We don't have legislative authority to do that. I suppose

in a few areas there may be partnerships that we have where the wives could get care and our partners care, but they would have to provide that funding from their own private insurance.

Mr. SHOWS. How do you plan to address the waiting period? Are we going to be able to get them staffed up a little bit so they wouldn't have to wait so long?

Dr. GARTHWAITE. We certainly hope so. We have a multipronged approach to improving waiting times. Certainly part of that has to do with staffing appropriate to the demand and use of those clinics, and in smaller clinics, where there is a sudden increase in demand, it is not easy necessarily to go out and immediately hire another clinician. So sometimes there has been delays in the appropriate staffing.

In addition, we have a large national initiative to improve waiting times. That is a partnership with the Health Care Institute out of Boston, and what we have done is we have found that individual medical centers and clinics have found administrative and other glitches that, once you improve them, have improved waiting times, and we are working very hard to spread that knowledge across to all clinics when we learn it in any given one.

We have also just been frankly very popular, especially among Priority 7 veterans. We have gone from enrollment of about 400,000 veterans to 1.4 million in a little over a year, and I think that sudden demand was a little more than perhaps was predicted and we are having to hustle to keep up.

Mr. SHOWS. That is one of the problems you have because for instance, you have one in Jackson and one on the Gulf Coast and there is a lot of room in between. Our men and women are often not able to drive very far. So when you open one in Hatiesburg, which is halfway between the Gulf Coast and Jackson, I think it is going to be used constantly. There are a lot a military retirees and veterans in that area which will make it consistently busy. So, I guess you will be taking a look at these as the study continues, and you will be able to see the consistent number of patients they see?

Dr. GARTHWAITE. All of our executives, the network directors particularly, have in their performance agreements the reduction of waiting time as a prominent component. Everyone is extremely interested in not only continuous monitoring but continuous improvement in those areas.

Mr. SHOWS. Thank you.

Mr. MORAN. Mr. Shows, thank you very much. There may be additional questions by the committee, and if we could submit those to you and have a response back in the next 2 weeks we would be appreciated. This concludes our first panel.

Mr. FILNER. Can I just ask one technical question, Mr. Moran?

Mr. MORAN. Mr. Filner.

Mr. FILNER. We both used the word, both of us, "waiting times." I have learned that to deal in these areas we better define our terms. How do you define "waiting time?".

Dr. GARTHWAITE. I probably should be more clear. There is a waiting time. When you go in, have an appointment at 1 o'clock and you are seen at 1:30, you waited an extra half an hour. There

is also a wait for an appointment where you would like to be seen at the next available appointment.

Mr. FILNER. I assume Mr. Shows was asking the latter and I assume you answered that.

Dr. GARTHWAITE. Right.

Mr. FILNER. What I am about to say is the honest truth. Last year we met with the head of OMB, this is in the previous administration, and we said waiting times had increased dramatically, and he said, no, they haven't, they have decreased—and we went around and around and it turned out that they were basing—this is the OMB of the United States of America—were basing their analysis of the veterans budget on the waiting times after you got into the clinic or the hospital. They had no idea what we were talking about, but we are talking about years, they are talking about minutes, and they couldn't figure out why we were yelling for $2 billion more.

Dr. GARTHWAITE. We track and aim to improve both probably its the next available——

Mr. FILNER. Anyway, would you make sure that OMB in this administration has the definition of waiting time that you are using, please?

Dr. GARTHWAITE. To the best of our ability we will.

Mr. MORAN. Thank you, Mr. Filner, appreciate the clarification.

Mr. Brown, I apologize, I am unaccustomed to members not taking their full 5 minutes.

We will proceed with the next panel. Please come forward and be seated. We look forward to testimony by Mr. James Fischl, Deputy Director of the National Veterans Affairs and Rehabilitation Commission for the American Legion; Ms. Joy Ilem, Assistant National Legislative Director of the Disabled American Veterans; Mr. Paul Hayden, Associate National Legislative Director for the Veterans of Foreign Wars; Mr. John Bollinger, Deputy Executive Director, Paralyzed Veterans of America; and Mr. Richard Jones, the National Legislative Director for AMVETS. Welcome to each of you and let's proceed with the testimony from Mr. Jones.

STATEMENTS OF JAMES R. FISCHL, DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION; PAUL A. HAYDEN, ASSOCIATE DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS; JOY J. ILEM, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; JOHN C. BOLLINGER, DEPUTY EXECUTIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; AND RICHARD JONES, NATIONAL LEGISLATIVE DIRECTOR, AMVETS

STATEMENT OF RICHARD JONES

Mr. JONES. Thank you, Mr. Chairman. Mr. Chairman and members of the subcommittee, it is an honor to appear before you and the distinguished members of the subcommittee on the current state and future challenges of the VA health care system.

The VA health care system is a unique and irreplaceable national investment. Access to high quality health care remains essential to veterans. In fact, many veterans consider health care to

be one of the most important benefits they receive. In the decade since the Gulf War, veterans have faced a sea of change in VA's health care delivery. Many of these changes have been for the better. However, there remains serious concern. For example, it is simply unacceptable when the delivery of veterans medical care is denied, rationed or unduly delayed due to the lack of resources. This is not what our Nation intended as its grateful response to the millions of men and women who have defended and continue to defend freedom throughout the world.

Frankly, we do not believe these circumstances represent what you, your subcommittee and full committee have fought for on behalf of veterans. AMVETS truly appreciates the support you have provided in your attempt to fund the Department of Veterans Affairs at levels adequate to allow for the delivery of world class services for which it is capable. We commend the full committee's recent call for a $2.1 billion increase in VA's discretionary spending. It is the right thing to do, and we thank you for taking the initiative. The result was a significant increase in the House budget approved last week.

Mr. Chairman, the greatest health care challenge ahead is the sustained availability of quality care. It is central to VA's mission, and one of the first elements of successful VA health care is its research arm. We believe VA's research arm is a true national resource. Its efforts directly benefit veterans and nonveterans alike. Budget inadequacies, however, continue to challenge VA's overall capacity to maintain its position as a high quality health care provider. We have watched as overworked medical staff attempt to do their job, but the bottom line unfortunately is that veterans are waiting longer to be seen. Vital services have been reduced or eliminated, and in the process, the veterans population has been underserved.

While VHA is currently well led by Dr. Tom Garthwaite and his team, adequate funding will remain central to their capacity to deliver quality health care to our veterans. For the future, we believe the following initiatives need to be incorporated, funded and responsibly managed within VHA's overall health care program.

First, sharing agreements between VA and DOD medical facilities need to be increased to allow veterans better access to the health care that their military service entitles them.

Second, facilities and resources should be dedicated to the diagnosis and treatment of women veterans at all VA facilities. Women are a growing veterans population and today represent about 14 percent of our current Armed Forces.

Third, VA's ongoing medical care and mental health treatment programs for homeless veterans requires iterative review and adequate funding.

Fourth, Emergency and long-term care need to be included within VA's health care service.

And, fifth, Congress should provide adequate funding for respite, homemaker and State home grants not covered in the millennium care initiative.

Regarding long-term care, it is important to note that despite more than a year since enactment of the Veterans Millennium Care and Benefits Act, VA has yet to implement regulations on institu-

tional and noninstitutional long-term care. Mr. Chairman, AMVETS firmly believes, as stated in The Independent Budget, that adequate funding is the central issue challenging the future of the VA health care system. In March 13 testimony, we stated our serious concern about the steep decline in VA's medical care facilities, due mainly to inadequate funding over the past years.

Your action, in concert with House leadership, is commendable in making H.R. 811, the Veterans Hospital Emergency Repair Act, one of the first pieces of legislation for veterans approved by the House in the new Congress. Of course, without Senate action to accept their stewardship responsibility, declining conditions will pose ever more serious problems for veterans and VA employees alike.

This concludes my testimony. Thank you for extending the opportunity to appear before you today, and thank you for your support of veterans. We believe the price is not too great for the value received.

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

Mr. MORAN. Mr. Jones, thank you very much. Mr. Hayden.

STATEMENT OF PAUL A. HAYDEN

Mr. HAYDEN. Thank you, Mr. Chairman, members of the subcommittee. On behalf of the 2.6 million members of the Veterans of Foreign Wars of the United States and our Ladies Auxiliary, I would like to express our gratitude for the opportunity to participate in today's hearing. It is indeed a privileged role that the VFW takes quite seriously.

The VFW believes that the mission of the VHA is, simply stated, to provide all veterans with timely access to quality health care. Therefore, we will focus our attention on what we believe are the most critical obstacles facing the VHA.

The first major obstacle facing VHA is the ability to sustain and enhance its physical infrastructure. Successive years of shortfalls of major construction funding and virtually flat-lined allocation for minor construction have seriously eroded VHA's ability to maintain the facilities and the state-of-the-art equipment necessary to provide modern health care services.

A recent visit by VFW field representatives to the Atlanta Veterans Affairs Medical Center highlights the lack of available construction funds in determining that that facility is still not completely handicapped accessible. As the VHA attempts to better allocate their physical assets through the implementation of the capital asset realignment for enhanced services process, we are concerned that as this process unfolds a moratorium on needed new construction and renovation projects will result. We strongly urge VHA and Congress to continue funding critically needed construction programs until the CARES process can be fully executed.

In tandem with the CARES process is the need for VHA to ensure open channels of communication with local veterans and/or their representatives who may be affected by proposed local closures or renovated projects.

The second major issue of concern we would like to address is veterans timely access to health care. It is an outrage that there are areas of the country where veterans must wait up to 6 months or a year before receiving their first health care appointment. It is

our understanding that one such area of note is the Lebanon VMC in Pennsylvania that currently has a backlog of 4,000 applicants seeking initial enrollment into the VA health care system. Once scheduled for an appointment, access continues to be a problem for some veterans.

Even though the VA has had measurable success in reaching out to veterans by building and staffing community based outpatient clinics, there are still veterans residing in places such as Montana who must drive over 200 miles one way for an appointment. Additionally, veterans needing specialty services such as orthopedics are averaging 6 months to 1 year for an appointment and follow-up appointments can average more than 90 days in places such as the Boise VMC in Idaho.

These problems represent an ineffective and inefficient stewardship of limited resources and what amounts to be in some cases a denial of care. Our Nation's veterans deserve better.

Furthermore, we are trouble d by Secretary Principi's recent comments before the Senate Veterans Affairs Committee that a cost saving option being considered by the VA would cap enrollment of Category 7 veterans. We are adamantly opposed to this course of action and feel that all veterans regardless of category should receive care.

We also understand that VHA can only provide health care to the extent that resources are available. We believe the financial situation presented by Veterans Integrated System Network 1, 3, 13 and 14 this past year demonstrates the weaknesses of the Veterans Equitable Resource Allocation, or VERA, process. Each one of those VISNs required supplemental funding.

Finally, we turn our concern to the implementation of the Veterans Millennium Health Care Benefits Act, Public Law 106–117. Aside from the emergency services provisions, the much needed long-term care provisions have yet to be fully implemented. We strongly recommend that Secretary Principi expedite the implementation of all recommendations or regulations pertaining to the Millennium Act.

This concludes my statement, and I will be happy to respond to any questions you may have.

[The prepared statement of Mr. Hayden appears on p. 73.]

Mr. MORAN. Thank you very much, Mr. Hayden. Ms. Ilem.

STATEMENT OF JOY J. ILEM

Ms. ILEM. Thank you, Mr. Chairman and members of the subcommittee. Good afternoon. I am Joy Ilem with the Disabled American Veterans.

Over the past several years the DAV, along with the other Independent Budget service organizations and its endorsers, have expressed serious concerns about the state of the Veterans Healthcare Administration. Although VA has made great strides in improving health care delivery to our Nation's sick and disabled veterans, it has experienced difficulty in providing quality and timely care and the specialized services veterans need consistently nationwide.

We believe that adequate funding is the central issue governing VA's ability to deliver high quality and accessible services to veter-

ans. VA's programs must be adequately funded to support its congressionally mandated mission.

We acknowledge and sincerely appreciate the efforts of the House Veterans' Affairs Committee in recent years to provide additional funding for veterans health care. However, years of flat-line budgets have taken their toll on VA's medical care system and threaten its viability. Repeated budget shortfalls coupled with restructuring of VA's health care delivery system have had a direct impact on veterans' ability to access care.

The restructuring of VA's health care delivery system from predominantly inpatient hospital-based care to one focused on outpatient treatment and health care maintenance has been successful to an extent. However, it has had an erosive effect on many of the specialized programs.

Especially troubling and of major concern to DAV is that despite statutory requirements that VHA maintains its capacity to provide for specialized treatment and rehabilitative needs of disabled veterans with spinal cord dysfunction, blindness, amputations and mental illness, many programs have been dismantled or severely compromised by staff shortages or reorganization.

For example, with the shift to a primary care model and community-based outpatient clinics we have seen cutbacks and closures of many of VA's specialized inpatient mental health and substance abuse programs. Unfortunately, there has not been adequate development throughout the system of necessary mental health services to replace those traditional inpatient programs.

VA's blind rehabilitation service programs have also experienced reduction in capacity and staffing levels directly impacting on veterans' access to these important rehabilitative services.

Likewise, VA's specialized programs for spinal cord injury or disease have been seriously degraded over the past 5 years by substantial staff reductions and resulting in lower capacity levels. Although VA has required local managers to identify the additional resources necessary to restore mandated staffing levels in centers for spinal cord injury, these objectives have not been fully accomplished. This has resulted in delayed or denied care and threatens the quality of care these veterans receive.

Equally disturbing are reports that some veterans continue to find it difficult to receive high quality prosthetics and sensory aids in a timely manner. Staff shortages and excessive workloads have resulted in delay in filling some orders.

Although the issues I have just addressed focus on VA specialized programs, we also have concerns about excessive waiting times, access to long-term care, programs for homeless veterans and women veterans, construction and maintenance needs, billing concerns and patient safety issues.

The DAV recognizes that VA has made significant efforts to address problems associated with management of its health care system, but clearly more needs to be done, specifically in the area of oversight. VHA must be held accountable for ensuring at the local level that statutory requirements are followed and that health care policies are expeditiously implemented.

In turn, VISN directors and local managers must be held accountable for providing an accurate assessment of patient need at

their facilities and acknowledge problems they encounter when implementing new initiatives. Clearly the Veterans Health Administration faces many new challenges. Unfortunately, problems will likely be compounded in the future if action is not taken now to correct these deficiencies and restore congressionally mandated system capacity for specialized programs.

We are hopeful that with sufficient resources and appropriate oversight VA can resolve many of its problems and work not only to strengthen but to improve the quality and efficiency of health care services delivered to our Nation's sick and disabled veterans.

In closing, we appreciate the opportunity to appear before you today and look forward to any questions you may have. Thank you.

[The prepared statement of Ms. Ilem appears on p. 76.]

Mr. MORAN. Thank you very much. Mr. Fischl.

STATEMENT OF JAMES R. FISCHL

Mr. FISCHL. Thank you, Mr. Chairman and members of the subcommittee. The American Legion appreciates the opportunity to comment on the current state and future challenges facing the VA health care system. The current state of VA health care varies from one Veterans Integrated Service Network to another and from facility to facility within the individual networks. Funding increases provided by Congress over the past 2 years have enabled the Veterans Health Administration to recoup some of the fiscal losses sustained through several years of flat-line budgets. These increases, although extremely helpful, have not fully resolved VHA's total budgetary requirements.

There are still too many concerns reported by veterans involving poor access to care and long scheduling delays. VA medical care staffs report being overextended and overworked and are seriously concerned about the quality of care implications of continued staff reductions. The American Legion acknowledges that funding increases are not the sole answer to VHA's future success. Technological improvements will play an ever increasing role in all future strategic planning. The continued restructuring of VHA's medical care assets also plays an important role in improving access to quality care.

While there are many internal adjustments that have been made and will continue to be made to improve VA health care value, Congress must continue to play an active role in assessing VHA's sufficiencies and in crafting creative solutions to many complex issues. The American Legion views the recent legislative actions taken by Congress to restructure VA health care as essential to adjusting today's health care environment. There are still, however, many important steps that Congress must take to strengthen VA health care.

In our view, these are to set the veterans health care system on a sound financial footing for meaningful long term strategic planning and program performance; to enact equitable medical care subvention legislation; to establish pilot programs to provide health care to certain dependents of eligible veterans; to improve clinic appointment scheduling for access to medical care; to improve cooperative arrangements between VA and the Department of Defense TRICARE system; and to enact legislation that will allow VA to bill

and receive medical care cost fund reimbursements from health care maintenance organizations.

The American Legion supports the fiscal Year 2002 VA budget recommendations reported by this committee. These recommendations reflect critical insight into the current state of VA health care. The American Legion, however, believes that Congress must seriously focus on creating new nonappropriated revenue sources to ensure the future success of VA health care.

For the foreseeable future the Veterans Health Administration will require annual increases of approximately $1.5 billion to meet new congressionally mandated program requirements and its annual fixed costs increases. The question we face today is whether Congress is prepared to provide these annual funding adjustments.

The American Legion's blueprint for the Veterans Health Administration is outlined in its proposed GI bill of health. By adopting the recommendations contained in this proposal, Congress could develop new revenue sources for VHA and effectively place less reliance on appropriated funding to provide VHA with the means to meet all of its increasing fiscal demands.

The GI bill of health is a serious proposal. The American Legion respectfully requests this subcommittee develop sound pilot programs to test the proposals contained in the GI bill of health. Recently President Bush campaigned on a promise to strengthen the VA medical system. This promise must be kept.

The American Legion is eager to work with the subcommittee and with the administration to undertake a comprehensive examination of the Veterans Health Administration and to determine what course of action must be taken to permanently strengthen VA health care for current and future generations of America's veterans.

The world is still a dangerous place and VA must be prepared today and always to provide timely, quality and comprehensive health care to those men and women who served in harm's way.

And, Mr. Chairman, if I could summarize some of my remarks by reading in part from a letter that an 82-year-old veteran wrote to the Secretary of Veterans Affairs. She also sent a copy of this letter to our National Commander, and I will just briefly read a few excerpts. She begins with:

"May I introduce myself. Thank you. I am an 82-year-old veteran of World War II, also a patient at the VA Medical Center in Houston, Texas. I enrolled in Women's Army Auxiliary Corps just as soon as President Roosevelt signed the bill. I was sent to Daytona Beach, Florida for basic training and then Scott Field, Illinois, San Francisco for overseas training and then to Philippines and to New Guinea. When Congress passed legislation for veterans to pay for their VA hospital treatment, provision was not included for us to use Medicare. That is to say, I pay $50 for each VA visit plus medication. I also pay $68 a month for Medicare, but according to law VA does not accept Medicare.".

And then she goes on to say:

"At 82, I do not think that I will see the day when veterans will be allowed to use Medicare at the VA hospital. Suggestion that I go elsewhere is insolent. Abraham Lincoln instituted care for the

veterans. I want to be with my own kind. I trust that this matter will merit your attention.".

And Mr. Chairman, I think that letter says it in a very eloquent manner, and I think she and thousands of other veterans deserve to be treated at the VA medical center and deserve to use their Medicare.

Mr. Chairman, I appreciate your listening to me and I thank you very much.

[The prepared statement of Mr. Fischl appears on p. 83.]

Mr. MORAN. Mr. Fischl thank you. Mr. Bollinger.

STATEMENT OF JOHN C. BOLLINGER

Mr. BOLLINGER. Thank you, Mr. Chairman, Ranking Member Filner, members of the subcommittee. I am John Bollinger. I am Deputy Executive Director of Paralyzed Veterans of America.

Due to the complex nature of spinal cord dysfunction, paralyzed veterans truly depend on the VA health care system. We must rely on a lifetime of specialized care and rehab services from VA. Specialized services are the core mission of VA, and it represents VA's responsibility to veterans. It is for that reason I would like to focus my comments this afternoon on three areas.

First, VA's specialized services are incomparable resources that simply can't be duplicated in the private sector. There is no system outside the VA, for example, that can provide lifetime care for paralyzed veterans as well in as many places as VA can. To provide this level of care, it is essential that SCI centers be operated in the venue of a tertiary care center. This core center is where VA can excel in providing the multidisciplinary team approach needed to properly administer spinal cord injury medicine.

Over the past several years we have seen a major shift from inpatient to outpatient services. We have seen hundreds of new outpatient clinics open, bringing primary care services closer to communities where veterans live. This trend, the shifting of resources away from the core centers, is a fact of life and will surely continue as VA attempts to realign and potentially close some facilities. Most importantly, though, this trend could represent a major threat to VA's spinal cord injury system unless resource allocation remains in balance and continues to support the VA's medical hospital center approach to health care.

That is why it is so essential that VA perfect the hub and spoke system and proper formal referral protocols, so that when a veteran who goes to an outpatient clinic with a severe pressure sore, they know the people who are at that outpatient clinic are trained to refer that individual for appropriate care at a VA SCI center.

The second matter I want to address is that of capacity, which is the number of staff and beds that the VA is required to mandate under Public Law 104–262. Although we have a ways to go, we have seen good progress in many SCI centers since October. There are clearly some VISNs that still have a long way to go. We are hopeful that through the direct leadership from VA's top leadership and the oversight of this subcommittee VA will ensure that the proper number of SCI beds are staffed and operated.

Finally, I would like to briefly comment on proposed legislation introduced from last year to shift certain medical services from VA

to the private sector. On the surface, providing access points in the private sector for veterans who live too far away from VA seems like the right thing to do, but for the very reasons I mentioned earlier about proper referral protocols and hubs and spokes, we believe it could be the wrong thing to do, at least without adequate contractual controls, allowing VA to be held accountable for these services.

Efforts to voucher VA health care will strike at the core of the hub and spoke system and will ultimately jeopardize VA's ability to maintain its full range of specialized inpatient services.

For spinal cord injury medicine, VA needs to be able to monitor, to evaluate and to influence the provision of care. We would oppose efforts to turn VA into an insurer of health care rather than a provider of health care. VA has a hard enough time being the VA, let alone HCFA or Blue Cross and Blue Shield, too. VA's expertise in specialized services is far too valuable.

Mr. Chairman, veterans with spinal cord dysfunction rely on VA's health care system on a daily basis for prescription s, for prosthetics, for supplies and for treatment. We need strong centers of care, an airtight system of referral protocols and full compliance with capacity mandates to ensure that these specialized services remain the corner stone of VA medical care.

Thank you.

[The prepared statement of Mr. Bollinger appears on p. 89.]

Mr. MORAN. Mr. Bollinger, thank you very much. I want to explore with the entire panel for a moment your marching orders. As Mr. Filner pointed out, we have the Under Secretary of Health, Dr. Garthwaite, and Dr. Murphy present. I wondered if you would tell the subcommittee any suggestions you have for administrative or management changes within the VA for the delivery of health care. It seems to me that there are three areas, and for a number of them you talked about funding. It seems to me that is clearly a responsibility of Congress and the administration to work together for adequate and appropriate funding. Clearly, how those dollars are delivered is a management or administrative decision, and I am interested in what suggestions you have on how we could improve the management or administration of the Department of Veterans Affairs. Finally, Mr. Fischl talked about legislative changes for the delivery of health care. So perhaps I am being simplistic, but if you could put in the box for me these three items, funding, which I assume all of you would agree upon that there is some level that is appropriate and necessary, but then specifically administratively and managementwise, what is it the VA should be doing differently and what should we as a Congress be doing in the third category as legislative changes that would either assist the VA or assist the veterans who are the recipients of the health care delivery system. Any suggestions?

Mr. BOLLINGER. Mr. Chairman, John Bollinger, from PVA. VA has a mandate under Public Law 104–262 to achieve capacity as far as beds and staffing are concerned. I guess what I find and my organization finds somewhat puzzling is that for several years now we have come to Congress and we have been able to achieve, you have been generous to give VA additional moneys over the administration's budget request. And yet in some VISNs, it seems to be dif-

ficult to hire a nurse to place on a ward so that a person with spinal cord injury can be taken care of.

I guess my answer to your question would be that we need to encourage VA to ensure that VISN directors and hospital directors are fully aware of what this public law mandates for them and that they should do things like specialty pay, bonuses, different innovative ideas to not only attract nurses and doctors but keep them on board once they are there.

Mr. MORAN. Thank you very much. I somewhat share the frustration of knowing that we continue to appropriate additional dollars and yet my veterans will tell me that when they talk to the hospital administrator or facility administrator the continual explanation is we simply don't have the money, and I know that is part of it, but I also want to know what on a management level we can do differently to make sure that needs are met. Anyone else?

Mr. JONES. I would just comment that it is extremely difficult for a management team to develop future programs for veterans when the budget-driven programs they are currently asked to administer are short of funds. The cuts that they have seen over the last several years make it very difficult to make good decisions in that sort of environment. It is extremely important, we believe, that the budget be adequate to serve the needs of veterans so that the administration can see its way clearly into the future. The road to the future is not well marked, but we do know where we have been, and over the past decade we have been short sheeted in funding.

Mr. MORAN. Thank you, Mr. Jones. Ms. Ilem.

Ms. ILEM. I would think with regard to the management question that oversight is key. I think when policies are developed at the top or here in Washington, it seems to be there is a disconnect down at the VISN level or the local manager level, and you know it seems that in Washington here they are addressing the problem, they are listening to our needs, that if we feel that there is a problem, we let them know. They seem to come up with a good idea how to resolve it and put something out to the field, but when we contact the field they also have a responsibility of letting Washington know what the problems are, why aren't they able to mandate it, is it purely a funding issue or you know are there some other concerns that they may be able to help. So I think it has to work both ways.

Mr. MORAN. Mr. Hayden.

Mr. HAYDEN. Yes, Mr. Chairman. I would like to mention two. As a part of the Independent Budget and as partner in that, we definitely support the idea of better collection of medical care cost recovery on the VA. We don't feel that has been done well enough to recover the money that they have lost, and I think that is something that Congress has allowed them to do, which will not offset from appropriation, we would hope, and I think that is an issue we would like to see addressed as well.

Mr. FISCHL. Mr. Chairman, you indicated you were concerned about VA hospitals not operating at full capacity all the time. We feel that part of the solution might be that veterans often seek treatment through DOD when they would prefer actual treatment from VA, but then their dependents cannot be treated at VA, and we believe that if dependents—and there could be third party bill-

ing involved there where they are able to be treated at VA—that that would solve much of the problem.

Mr. MORAN. Thank you. Mr. Jones, you did indicate in your testimony in addition to increased funding, the sharing agreements between VA and Department of Defense. Would you like to expand upon the importance of that?

Mr. JONES. Well, the importance of it was recognized I believe in 1982, when Senator Charles Percy began the effort with an amendment in the Senate. We have recognized how difficult it is because of the difference in culture, the difference in professionals. No one really has unified control over the management of records, for example. We are heartened and encouraged by Secretary Principi's words and his statements that he has already met with Secretary Rumsfeld to heighten and strengthen this relationship. We think there is a need to smooth out the relationship, to get together with stakeholders, with Congress, but certainly to start the process with Secretary Principi and Secretary Rumsfeld. There are many areas that could be ironed out between these two if there was a commitment with the Department of Defense and Department of Veterans Affairs to work in unison on some of these issues. But it has been a long, long time going back to 1982, as you know.

Mr. MORAN. I thank you for your testimony and the response to my questions. I appreciate your presence here today and particularly your service to other veterans. Mr. Filner.

Mr. FILNER. Thank you, Mr. Chairman. Thank you all for your helpful testimony. As I have said on many occasions, I appreciate the organizations that participated in the formation of the Independent Budget. Some day the American Legion may see the light and maybe the others will support the GI bill of health, so we will all get together and talk with one voice. But Mr. Jones made a very pointed statement about how funding drives the quality and most of these decisions that you have all been talking about. Forgive my stress on the budget, but it is the basis on which we have to work, and since I am so free in giving advice to Dr. Garthwaite, I want to give you some advice too, if I may, and get your reaction to it.

The budget process is a long process. It starts with the administration suggestions. The administration suggestion, if you again compare on a common baseline, was approximately $2.6 billion under the Independent Budget, but that was only a suggestion. This committee, through its views and estimates, upped that considerably, and the chairman of our full committee and the chairman of the subcommittee were very aggressive about trying to up that, and yet, again comparing it with apples and apples, they were $1.4 billion below the Independent Budget. Then the Congress acted through its Budget Committee, the budget resolution, and they are $1.7 billion under the Independent Budget.

I think you are all too quick to praise folks for increasing budget because we are still way under the Independent Budget. You spent a lot of time on that Independent Budget. It is a very professional job. You ought to stick with it a lot longer because when you compliment us for doing something good, but it is not near what you need, then we take that as support. The budget committee chairman on the floor of the House during the debate that I participated in claimed that you all supported his budget. I appreciate the letter

that came from all of you afterwards that said, no, you didn't, but he heard and this committee heard your attempt to be cooperative in working with the committee that we did a fine job.

Well, you have come off your Independent Budget way too quickly in this process. We still have got to go through a whole long year that includes, you know, the appropriations subcommittees. It includes the floor votes—in both Houses—and then the conference committee.

I think you should stay with the $25.9 billion for your discretionary figure a lot longer and keep saying we have not fulfilled it. We have not fulfilled it because we still have a chance at every stage in this process to fight for you, and you have grassroots organizations that could help that fight. But if you say too early that we have done such a great job, then nobody is going to go up any higher, and we have not done the job we need to do, that you all pointed out.

It would help us who are trying to fight for a bigger budget, and I know Mr. Garthwaite would love to see a bigger budget even though he can't say he didn't support the administration budget. But those of us who want to fight for a bigger budget need you to stick with the Independent one, and get your membership to understand what they are doing. So when people come during Memorial Day recess and we all give speeches, how we love our veterans and then after the budget vote the Veterans' Day services, I want you guys to say, well, how did you vote on that budget and why didn't you vote for the Independent Budget? But if we have given it up way early in the process in your attempts to be cooperative and work with the committee—you are also in the context of American politics a pressure group and you have leverage through your membership and through your political activism to influence this process, and you should do it, in my opinion.

I can't tell you what you all do. I am not a member of your organizations, but I want you to stay with that figure so those of us who say you are not matching it won't be told by the budget chairman, hey, they said it is okay.

Any reaction?

Mr. BOLLINGER. Mr. Filner, for the record, my compliments about your generosity were retroactive to the last 2 years. The jury I think is still out on this year, and I can assure you that between now and appropriation time we will be working hard from the grassroots level to achieve the level set forth in the Independent Budget.

Mr. FILNER. That is great, thank you.

Ms. ILEM. I would just also mention we appreciate your comments and suggestions and certainly we want to state for the record that we will continue to stand firm on those figures that are outlined in the Independent Budget, and you will be hearing from our members and we will continue to push for that.

Mr. FILNER. That is great, you did a great job and we ought to stay with it.

Mr. HAYDEN. I would echo that as well, Mr. Filner. We definitely still stick to those numbers in the Independent Budget and we will have our membership be contacting plenty of members of this panel's office, I am sure, and others in the House and Senate.

Mr. FILNER. Thank you.

Mr. JONES. Mr. Filner, it is as the chairman of the committee said, the budget is a work in progress, but with regard to thanking people who help us along the way we think that is important. We think it is important to gather strength and express our gratitude to people who are willing to help us move in the right direction. It's a little like interest rates, Alan Greenspan is moving in the right direction but maybe he hasn't moved quite far enough. We will be working on veterans funding to see that it moves far enough.

Mr. FILNER. And the economy is collapsing. I agree with you. It would help some of us if your praise could not be interpreted as support, that you want us to go a lot further even though we are moving in the right direction.

Mr. JONES. It is my understanding, Mr. Filner, that Senator Wellstone and Senator Johnson are introducing an amendment this week in the Senate to mark the veterans health care budget to the independent level, an increase over current spending of $2.67 billion. We have, together with other veterans' service organizations, supported that effort with a letter to members of the Senate, so we will be working to increase veterans funding further.

Mr. FILNER. Great, and I will be happy to introduce that in the House if you need it.

Mr. MORAN. Dr. Filner, thank you. Dr. Simpson.

OPENING STATEMENT OF HON. MICHAEL K. SIMPSON

Mr. SIMPSON. Thank you, Mr. Chairman. I feel like I have just been recruited to play for Duke or something. I really appreciate that. The ranking member has done a great job. It is all something we fight for to make sure we get as much in the VA as we possibly can.

Mr. Hayden, in your comments—well, as the chairman of the subcommittee mentioned, there are really three issues: The budget, which you all agree we agree we need to continue to increase; the administration of the current laws; and the legislation that might be necessary. And Mr. Hayden, in your comment, first of all, you said that in Montana you must drive—there are places—people who must drive over 200 miles one way for an appointment. In Montana there are places you have got to drive 200 miles to find your neighbor, but as you said, you mentioned in here that and a couple of other things. You said these problems are ineffective and inefficient stewardship of limited resources in what amounts to be in some cases denial of care.

I would like to know what are those inefficient and ineffective stewardship of limited resources. That is what we are all asking, is how do we improve the administration of those limited resources.

Mr. HAYDEN. I wish I knew, honestly. If I did, Dr. Garthwaite might give me a job, but what I think we are really looking at is when we are rolling out, I think it is a question of what we are all grappling with is how do we provide, especially in the case of Montana and things like that, I think CBOCs could be more effective to get out there and take care of veterans out in the rural areas. We are searching for alternatives to help these people in the rural communities, veterans reside there, and so I think it is a

matter of just focusing our efforts there. I think it maybe ties back to possibly even VERA, where do we—how they delegate the funding in the first place to certain areas like that. I know VISNs 13 and 14, which are sort of rural areas of the country, they needed extra funding during last year. They needed a supplemental, and I think what you are looking at is getting more attention in those areas and I think clearly the age of a region's veterans population and particular health care needs need to be more addressed in those areas.

Mr. SIMPSON. Do any of the rest of you have any other comments? Is there any way to improve the inefficiencies? Do you see inefficiencies in the Veterans Health Administration that ought to be improved that we ought to use our dollars more wisely?

Mr. BOLLINGER. John Bollinger of PVA. I think there are inefficiencies. I think that oftentimes the VA finds itself in a position where it is spinning its wheels, and I think to some degree, like I said about—I think it is a problem across the country. It is not just the VA as far as nurses, for example, but I do believe that the VA could do a better job in recruiting and retaining those important employees that actually provide the hands-on health care that veterans need.

So I think in addition to things like special pay, specialty pay for those health care professionals that deal with specialized programs, efforts to recruit and retain would go a long way to hopefully avoiding inefficiencies in other areas of health care.

Mr. SIMPSON. But as a general rule.

Mr. JONES. Well, I think one of the inefficiencies that is clear is inherent in the structure of VA's health care delivery system. It is a decentralized system. It is very difficult to manage a system of that sort from the top down. That is inherently inefficient. But then again, VA health care is also responsive, perhaps because it is decentralized, it is more responsive than it might otherwise be if it were a top-down model. These sorts of things need to be balanced, and I am not sure that there are other inefficiencies more significant than this one.

I do hope that the Veterans Administration continues to suggest and recommend change within the VISN structure, and I am hopeful that people within the VISN structure respond appropriately and share their ideas, too. Perhaps improved communication could help iron out some of the inefficiencies that are inherent to the structure of VA's VISN delivery system.

Ms. ILEM. I would just add to some of the things that have already been said, you know, the accountability issue, once again, if you can have more centralization and accountability at all levels to be able to look and have good communication and not a disconnect and just to look at what the actual inefficiencies are going on, why is there waiting times in this particular facility or why is this VISN doing great and we are getting good reports on them treating these particular groups and not over here, I mean there just seems to be a disconnect. It varies from area to area. So certainly the better the communication level between VHA and its local managers and VISN directors working together in some way to tie that in together to try to get rid of those inefficiencies because some places have great systems in place for managing different areas and/or

billing or particular areas. In other places they are not doing a good job. So it just differs, and they need to, when somebody is doing it good, to take that as a model. It is working there, it may work in another place as well.

Mr. SIMPSON. I thank you all for your testimony, and I just want you to know that I am certain that the ranking member's comments were not meant to indicate that you had given up on your unified budget, that you were still going to fight for it, and it is okay from my point of view if you still say nice things about us.

Mr. MORAN. Mr. Simpson, thank you. Thank you all very much for your testimony, appreciate you being here today and look forward to working with you over the next several years as we work on the issues that we have discussed at today's hearing. Thank you.

We will proceed with the third panel. This panel represents the people who provide directly the services to our veterans. We welcome Mr. Bobby Harnage, National President of the American Federation of Government Employees, the largest Federal union; Ms. Elaine Gerace, a registered nurse from Syracuse VA Medical Center, testifying on behalf of the Service Employees International Union; and Ms. Ellen Pitts, testifying for the National Association of Government Employees, who is also a registered nurse at Brockton VA Medical Center in Massachusetts. Welcome to the three of you.

Collectively, the organizations represented by these three individuals represent over 150,000 VA health employees, including trades and crafts, white collar and clerical professional fields. We welcome you. I might point out that my theory in this hearing today was to provide us an overview. We have heard from the management at the top at the Department of Veterans Affairs. We have heard from the patients and those who represent veterans, and now we will hear from those who provide services directly to those patients, and we are delighted to have you here and look forward to your testimony and your suggestions. Ms. Pitts.

STATEMENTS OF BOBBY J. HARNAGE, SR., NATIONAL PRESIDENT, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES; ELLEN M. PITTS, R.N., PRESIDENT, VA MEDICAL CENTER, BROCKTON, MA, LOCAL R1-187, ON BEHALF OF NATIONAL ASSOCIATION OF GOVERNMENT EMPLOYEES; AND ELAINE GERACE, R.N., DIVISIONAL PRESIDENT, VA MEDICAL CENTER, SYRACUSE, NY, LOCAL 200B, ON BEHALF OF SERVICE EMPLOYEES INTERNATIONAL UNION

STATEMENT OF ELLEN M. PITTS, R.N.

Ms. PITTS. Good afternoon, Mr. Chairman, members of the subcommittee. NAGE wishes to thank you for allowing me the opportunity to come to you today to address the current state of the veterans health care system. I believe my 23 years as a VA employee gives me a unique perspective on the many changes that have currently gone through the VA system.

In addition, as a member of the National VA Partnership Council I have concerns and talked with hundreds of VA employees across the country concerning quality care issues. The people I represent

are literally on the front line of the debate regarding the future of delivering quality care at the VA.

I have submitted my entire statement, and I will address key points at this time.

The Department of Veterans Affairs has been historically viewed as a stable, secure and a desirable workplace. Changes to our systems and its programs have diminished our ability to attract and retain employees. We continue to struggle and maintain adequate staffing and resources to provide necessary care to our veterans. We are no longer the employee of choice.

As our resources diminish, the VA has attempted to disguise shortfalls by administrative means. Oftentimes our programs appear to be sound on paper but in reality short of our goal to provide quality care.

The VA has created several methods that determine staffing levels to care for our veterans. As the saying goes, figures don't lie but liars do figures. The methods can be manipulated and have been, counting or combining nurse managers in the staff mix when they are not providing hands on to our veterans, classifications can and are also being changed. This practice provides a false number of patient care hours needed, which then impacts the staffing mix.

Recently the VA mandated staffing levels for the paralyzed veterans units. Now we need to mandate staffing levels for all. NAGE believes that every veteran deserves good care. The VA has experienced increasingly severe staffing shortages in both direct patient care and support staff. Lack of staff to provide support services further reduce patient care by shifting workload to an already depleted clinical staff. The staffing problems have resulted directly in an increase in work-related and nonwork-related injuries and illnesses.

The VA has continued the antiquated practice of rotating staff instead of hiring for permanent tours of duty or providing for alternative work schedules, among other options. The private sector has either eliminated or capped mandatory overtime and has allowed and encouraged staffing practices favorable to employee and family needs. While OPM has championed these positive changes, the VA has yet to embrace them fully.

Due to shortages in staff, the VA has utilized volunteers in patient programs, such as compensated work therapy, to fill full time vacant positions, oftentimes without benefits and compensation, and have become a shadow of a work force. This inappropriate use of these individuals was never intended and must cease.

Rewards and recognitions for the employees in the field is nonexistent. A new addition of the qualification standard for registered nurses, which makes changes in promotion, will be driven by classroom degree and not by performance. Limiting promotion to strict educational criteria will create recruitment and retention problems. Thousands of VA nurses will be faced with being placed in a frozen ingrate status.

Many of the changes that the VA has incorporated in the last several years show little positive effect on the delivery of health care to our veterans. Initially the Veterans Integrated Service Network, VISNs, were created, although it was unclear as to the spe-

cific role of VISN organizations. These entities engage in self-definition and self-preservation.

Initially VISNs were comprised of minimal staff with general statistical and administrative functions. As VISNs increased, they increased their own scope of operation and became bloated and intrusive. The VISNs have become the proverbial middleman devouring funds with little or no productivity. Many times the VISNs have hidden staff and resources through creative and deceptive accounting practices. NAGE believes a review of the mission of the VISNs is needed, since many of them are nothing more than a redundant layer of management whose costs are unjustified.

Our union believes that we need to have consistency and avoid duplication of services. However, NAGE views service lines as another means of layering, absorbing budget dollars and depleting front line employees.

Programs and initiatives, some of which are very supportive of patient care, either have no funding or funding is send out to the VISNs. Many times funding is not utilized for its intended purpose, but rather directed as determined by the VISNs. Feedback of the initiatives are often not solicited or captured. With many technology issues the mentality will be sink or swim. Whether the technology is necessary or not or beneficial to the agency, our employees will have to adapt on their own with little or no assistance or training.

Mr. Chairman, we as a union will continue to identify areas of concern, advising and consulting over solutions and improving the delivery of care to our veterans. Our members' views and opinions need to be heard and given full consideration and should not be quickly dismissed or discarded. When we speak, we speak on behalf of the majority of employees and express their needs and their aspirations for our organization and our commitment to improving health care for our veterans.

Thank you, Mr. Chairman. I look forward to any questions that you may have.

[The prepared statement of Ms. Pitts appears on p. 96.]

Mr. MORAN. Thank you, Ms. Pitts. Mr. Harnage.

STATEMENT OF BOBBY J. HARNAGE, SR.

Mr. HARNAGE. Chairman Moran and Ranking Member Filner and members of the subcommittee, my written testimony covers in detail AFGE's concern about the state of the veterans affairs. Thank you for entering the testimony in the record, and I appreciate this opportunity today to be here in person.

I am the National President of the American Federation of Government Employees. I am also a veteran. AFGE represents over 600,000 Federal and DC Workers throughout the Nation and overseas. Among those are 135,000 VA employees in more than 170 AFGE locals. Our members are doctors and nurses who strive to keep the promises made to veterans by our government. They are nursing assistants and food service workers who bathe and feed veterans. Our members work in virtually every job and profession needed to run a VA hospital. They care deeply about the VA and the VA's mission.

The veterans health care system is in a state of shock. It has suffered many traumatic blows in the past years, flat-line budgets, cuts in staff, shutting down wards, restructuring and contracting out. My comments this afternoon will focus on the combined trauma from staffing cuts and contracting out.

From 1995 to 2000, the VA reduced positions for registered nurses by 10 percent, licensed practical nurses by 13 percent and nursing assistants by 30 percent. These cuts mean a loss of one in six direct patient care givers. The impact of these cuts to patient care are significant and are snowballing into a big problem in patient safety and quality of care. Because VA cuts nearly a third of the nursing assistants, by necessity LPNs and RNs must accept an increased workload just to help patients with rudimentary activities, or daily living, like bathing, eating and going to the bathroom.

These additional duties for registered nurses and LPNs are occurring when staffing for LPNs is 87 percent and staffing for RNs is at 90 percent. The reduction of nursing staff has condemned veterans to the indignity and frustration of waiting and waiting just for someone to bring them a bed pan. When a worker can finally answer the call button, the veteran sees a caring worker who is harried, overworked, fatigued and has little time to spend on bedside care.

The reduction in staff also means delays in appointments and reductions in medical services. Without adequate direct patient care staff and support staff, VA has reduced or eliminated inpatient care programs for severely mentally ill patients. Such programs like inpatient detoxification are labor intensive, and when staff is cut, veterans lose access to the care they need. VA management copes with these cuts in staff by using mandatory overtime, fee basis nurses and shunting off veterans to non-VA hospitals. These quick fixes are penny-wise and pound-foolish. At a time when VA is seriously trying to reduce and prevent medical errors, it doesn't make much sense to mandate that RNs work two shifts in a row day after day.

Fee basis or "rent-a-nurses," no matter how professional, do not have the same familiarity with VA patients and procedures as dedicated, reliable VA employees. Increasing contract hospitalization increases VA's expenses but does nothing to address the long-term staffing problems.

AFGE's written testimony discusses in detail our recommendations for addressing these problems.

When VA contracts out work, it is affecting the quality and cost of patient care. During the same period that VA cut its staff, it increased its use for fee nurses and other medical professionals by nearly a third. VA also increased its use of professional service contracts by 54 percent. Rather than to hire the staff it needs, VA is turning to contractors. VA use of contractors will increase in fiscal year 2002.

OMB has directed all agencies to compete or directly convert at least 5 percent of their positions listed on their FAIR Act inventories. Virtually every single job in every VA hospital is considered to be exempt from public-private competition and OMB cost analysis comparison requirements. The exemption from public-private competition applies to work traditionally considered to be subject

to OMB A–76 studies, such as housekeeping, food service and ground maintenance.

OMB has directed VA to simply contract out the work of some 9,000 VA hospital employees without letting them compete for their own jobs or proving that it will save taxpayers money or that it will maintain at least the same level of patient care.

Depending on their occupation, between 25 and 40 percent of VA hospital employees themselves are veterans. It is a shame and wrong that VA would contract out the work performed by veterans without even giving them a chance to compete for their jobs. To add insult to injury, these employees will lose their job and VA will not have saved any taxpayer dollars. The odds are that it will increase costs and not maintain the quality of care for veterans. There should be a public-private competition to ensure that contracting out is more cost effective and in the interest of veterans.

For example, the Boston VA decided to contract out the VA's home-based primary care program. This was a good program. VA nurses knew their patients' individual needs and VA RNs knew that refilling insulin syringes for the veterans meant that they would be more likely to control their diabetes and less likely to visit an emergency room. The visiting nurses contractor will not perform these tasks.

VA should be prohibited from contracting out any additional work until it can document that its current contracts are saving money and in the best interest of the veteran. VA should be required to use public-private competition for support services that have traditionally been subject to A–76.

Thank you very much for this opportunity. That concludes my testimony, and I will be glad to answer any questions you might have.

[The prepared statement of Mr. Harnage appears on p. 103.]

Mr. MORAN. Thank you Mr. Harnage. Ms. Gerace.

STATEMENT OF ELAINE GERACE, R.N.

Ms. GERACE. Mr. Chairman, members of the subcommittee, thank you for giving me this opportunity to address you today on how we can improve the delivery of health care to our Nation's veterans.

I am a registered nurse at the Syracuse VA Medical Center and I have been in the VA system for 12 years. I am also a veteran. But I am here today representing the 6,000 members of the Service Employees International Union, America's largest health care union who are VA employees. SEIU is made up of 1.4 million workers nationwide, including over 710,000 health care employees.

First, I would like to thank the members of the subcommittee for approving the pay adjustment last year for nurses. That helped us improve recruitment and retention in our facilities and went a long way toward improving morale.

VA nurses are committed to providing top quality care, the kind of care that our country's veterans deserve, but today quality care in the VA system is threatened by nurse understaffing. Approximately 10 years ago the VA established an expert panel that determined the minimum amount of staff each unit should adopt. Unfortunately, these minimum staffing levels, which vary from one medi-

cal to another, have become the maximum levels and they are no longer adequate to provide quality care.

Today's patients are much sicker. There is less ancillary support so nurses are required to juggle duties that were once handled by others. In addition, we are changing over to a computerized system of documentation and have implemented bar code medication administration, both of which take more time away from our patients.

In my hospital and other VA hospitals across the country, we do not have enough nurses to give our patients the time and attention they deserve. Many facilities are trying to deal with staffing problems by requiring nurses to work mandatory overtime, but instead of solving the problem, mandatory overtime makes the situation worse. A nurse working 4 or 8 extra hours on top of his or her 8 or 12-hour shift is more likely to make a medical error or be unable to properly assess patients. And imagine finding out 2 hours or even less before the end of your shift that you are required to work another 4 or 8 hours.

Medication errors can also be directly linked to inadequate staffing. The VA should be commended for taking the lead in attempting to prevent medication errors with the implementation of bar code medication administration, or BCMA. However, the BCMA has essentially doubled the amount of work that the medication nurse and the charge nurse must do, yet staffing levels have not been adjusted. I believe that BCMA has the potential to become a very useful tool to prevent medication errors, but we must increase staffing to ensure other aspects of care are not sacrificed in order to accomplish this.

Nursing, as practiced in most health care facilities in the United States, is a very physical job, requiring a lot of lifting. The most common injury is back strain, which can result in lost time claims and/or light duty. Syracuse VA was part of a pilot program that instituted lift teams. Four VA hospitals took part in this pilot, and there were no back injuries during the test period except in Syracuse, when the lift team was not being utilized.

Although I have concentrated my comments on the staffing crisis for licensed nurses, many of the same problems exist for nursing assistants and wage grade employees in our VA health facilities. From 1995 to 1999, there was a cutback in wage grade employees of 15 percent. When support staff such as housekeeping and dietary workers are cut back, nursing staff must take away time from our patients to perform the tasks that ancillary workers once did.

Having addressed some serious problems cause d by understaffing throughout the VA system, I hope this subcommittee takes the necessary legislative action that would result in improved quality care for our veterans. Specifically SEIU urges that the VA establish Federal staffing standards that would mandate each VA facility develop a staffing plan that sets minimal staffing requirements and determines the specific nursing staff and skill mix needed to carry out these requirements.

The plan should be developed in consultation with direct care nursing staff or the collective bargaining representative.

We also urge you to limit mandatory overtime for bedside nurses in the VA hospitals. Although voluntary overtime should be permitted, we also urge that the VA consider setting a maximum

hours limitation beyond which a licensed nurse should not be on a duty status.

Federal laws and regulations set maximum hours in the interest of public safety for airline pilots, train engineers and truck drivers. Why not for nurses, who are responsible for critically ill patients in our VA hospitals? Setting systemwide nursing staffing standards that include a prohibition on mandatory overtime will go a long way to correcting some of the workplace problems that are driving nurses away from the VA. It would also ensure staffing levels that will result in better quality patient care and fewer medical errors.

Furthermore, we urge that the VA more aggressively address some of the health and safety problems such as the vast number of back injuries that are directly related to understaffing. I have outlined some of our recommendations in my full testimony.

We do commend the committee for recommending a budget that exceeds this administration's proposed budget. The fact is that the VA continues to lose ground, because in terms of adequate staffing for nurses, other health professionals, and support staff funding, the VA has failed to keep up with medical inflation.

The VA should be funded at a higher level, and we would hope that any increase in the medical care budget for the VA is earmarked for staffing and for essential services that have suffered some severe cutbacks. This includes mental and substance abuse services, long-term care and other specialized rehabilitative services.

Again, thank you for the opportunity to testify. I would be happy to take any questions.

[The prepared statement of Ms. Gerace appears on p. 109.]

Mr. MORAN. Thank you three very much for your testimony. I indicated in my opening statement that the Congress has invested more than 3 billion new dollars in the VA health care delivery system in the last 2 fiscal years. Is there any evidence that those dollars are being seen? Can you see that in the work environment such that staffing ratios, the number of support staff or nursing, for example, is increasing? Or is there a continual deterioration, from your point of view, in the amount of dollars available for providing personnel for patient care?

Ms. GERACE. My personal opinion is that the staffing has decreased. We continue to have lists of mandatory overtime. We continue to hear that there is not enough funding to hire new nurses, even in some cases that there is not enough money in the budget for overtime, and nurses are continually forced to work short staffed.

Mr. MORAN. Ms. Pitts.

Ms. PITTS. I just wanted to add onto Elaine is the fact that we do not see the money at that level. We do not have secretaries. We do not have janitorial support. Many times, as I have stated, you know, we are using other programs to supplement. So if there is money, I would like to know where it is.

Mr. HARNAGE. Yes, I will just add that I travel around the country, so my experience is not limited to one hospital. I usually see two or four or five hospitals a year; and so far this year I have toured more than that. I haven't been anywhere that I wasn't proud to see the work that our people do and the veterans being

taken care of and the skill level of our people. But I haven't been anywhere either that they didn't complain about there being a shortage of staff.

Mr. MORAN. And in response to—what I want to understand is the trend is not improving despite additional dollars being put into the system; is that true?

Ms. GERACE. That is true.

Mr. HARNAGE. That is true.

Ms. PITTS. It is true. And you know, Mr. Chairman, you can't attract people until you clean up your own house. We have so many problems at that level with workers and issues that until you clean it up, the more people you bring in and they see what is there and what they have to do, they walk out the next day.

Mr. MORAN. Let me ask, then, if there is a difference between VISN to VISN. I'm again trying to figure out if there is a management issue here that certain regions of the country, certain VISNs do a better job where the ratio for patients to employees is better than elsewhere. Or is the facts that you describe systemwide?

Ms. GERACE. I believe they are systemwide.

Mr. HARNAGE. Systemwide.

Ms. PITTS. Systemwide.

Mr. MORAN. And, Ms. Pitts, I was especially interested in your comments about awards and recognition are nonexistent. I don't know how anyone can manage employees without adequate recognition for a job well done. Is there any—you are unaware of any program—and part of my question is I assume that you all have suggestions of how the VA could perform its duties better. And are those suggestions—you know, I think some of the most successful changes that can be made in any organization are made by those who work on a day-to-day basis with the people that they are caring for.

My question is: Is there no one listening? And if we were listening, do you have suggestions about how the VA can do its job better in caring for patients?

Ms. PITTS. Well, every time that we have asked management, they tell us that there is no money in the budget. Even if we were looking for a small amount of money that we could then look at as a committee and say how can we use this money the best way, even $50 to an employee who is at the frontline makes a difference. It can mean an extra meal, paying a bill, et cetera. It is not there. And nobody will share with us whether they want to put some money aside or if there is money, they are using it for something else. We haven't figured it out. And if you can do it for us, I would appreciate it.

Mr. MORAN. I appreciate the suggestion. I mean, it seems awfully important to me that this is not—we smile as we have this conversation, but it is a significant——

Ms. PITTS. It is sad.

Mr. MORAN (continuing). Important issue about attracting and retaining quality employees who, therefore, provide quality services to the veterans that are the patients, and it is clear to me that only when employees are consulted can we achieve greater success in that patient care.

And so my smile is in no way to diminish the role that I think that employees should play in reaching the right decision for how to manage an organization.

I want to just—my time has expired. But I want to know by—I think this is for you, Ms. Gerace, the amount of time that a nurse spends filling out paperwork, administrative duties as compared to actual patient care. I assume it is—I see in the rest of the health care field that that is an increasing burden that is placed upon nursing staff. I assume you will tell me that is true in the VA. I am curious, if you can quantify that, how much time is spent in caring for patients versus being an administrator?

I think one of the problems we face in attracting and retaining nurses in the health care system is nursing isn't nursing anymore, it is something different. It is not saving lives and caring for patients, it has become a bureaucratic job of filling out paperwork. Can you confirm and tell me that I am wrong if I am?

Ms. GERACE. Mr. Chairman, that is very true, especially for registered nurses, who very seldom see the bedside anymore. The majority of their job is paperwork, transcribing orders, admitting patients. But very seldom do they do the bedside nursing, and that is what most nurses went into nursing for, was to do bedside nursing.

Mr. MORAN. I happen to chair a coalition of Republican and Democrat Members of Congress on rural health care here, and I live in a very rural district. Health care is a significant issue for us, and our ability to attract health care professionals into rural communities in particular.

I have visited nursing schools, for example, and asked students why they want to be a nurse. The answers are tremendous, make you feel good, give you goose bumps. They have the right reasons for why they want to be a nurse. I am afraid that the result of, once you are in the profession, that there is a significant opportunity for dissatisfaction because it is something different than what we envision nursing to be. And it is an awfully important issue that we figure out how nurses provide patient care. It is what they are trained to do.

I look forward to working with you to see if we can find solutions. Mr. Filner.

Mr. FILNER. Thank you, Mr. Chairman. Thank you for your penetrating questions, and I think they are very important. It is my own experience, both in my hospital in San Diego and other parts of the country, what you say has general applicability. This is not just some, you know, wild-eyed union people saying one thing. My experience is that the things you have hit on are true and systemwide.

And I am particularly concerned about, and think Mr. Harnage spent a lot of time on contracting out. This is a false economy in so many ways. And I hope we can do something about that. I assume the TRAC Act, Mr. Harnage, is something that would go to alleviating some of the abuses of that?

Mr. HARNAGE. That is correct. It would address most of them.

Mr. FILNER. So I hope that we can end up supporting that. I know I do.

The contracting out and the legislation and the way agencies have responded are very troubling for me. How many people in the audience work for VA, by the way?

Dr. Garthwaite, you didn't raise your hand. Actually, I am going to get at you again. But if you didn't exist, I would have to invent you.

As I understand it, and correct me if I am wrong, virtually every job that is represented by people who raised their hand is on the list which can be contracted out?

Mr. HARNAGE. Correct.

Ms. PITTS. Correct.

Mr. FILNER. But those who work in the central office are not on any list?

Ms. PITTS. They are essential.

Mr. HARNAGE. They are on a list, it is a protected list.

Mr. FILNER. Right. And now, you know, I think we have got it exactly backwards. I mean, I have been taught—I won't say your name, Mr. Garthwaite, here—that management services are particularly interchangeable in other areas, and we can bring the guy who runs General Motors in to run the VA. But the medical people and the on-line people are the folks whose commitment and quality and service is something you can't replace by just a dollar figure. I see everybody shaking their heads, so thank you for confirming.

So I think we have got it backwards. I would hope—I am not sure it is going to happen with this particular Congress, but I think we need to put pressure on that this is a false economy, this contracting out. You see it across the board. VA is particularly affected. But, you know, wherever we look at this contracting, this privatization: yes, we have to be efficient, yes, we have to be concerned about dollars and cents. But the virtue of American systems that we have, whether it is the Post Office or the VA, is that we give service to everybody, hopefully quality service and hopefully efficiently implemented. But we serve everyone.

And the dollar and cents calculation that private industry has to make does not make sense when we are talking about public service, except when it comes to central management. Then I think we could apply it there.

So I think this Nation is taking a wrong turn. But we need, all of us, to begin to defend it and be aggressive about it and not defensive about it. We have allowed some of the rhetoric that government is evil and government is bad and public service is, you know, pure bureaucrats, that we have to talk about how we deliver service to the vast numbers of people in a way that no other society has ever tried to do. And that may not be cost efficient in some accountant's classification, but allows us to say that we are a nation that has a humanistic view of service, and that we just can't use that same measure that someone who is providing for shareholders do.

So I appreciate your saying we need to say it louder and clearer and all over the country. And anything you want to add to that, I will be happy to hear it.

Mr. HARNAGE. Well, I would like to add to it, because you are right on the mark with your comments. The Veterans' Administration provides a different care to a different degree than the general

population or the county or State hospitals or private hospitals. The diseases, the injuries, the psychological problems are different for veterans than they are the general population. It takes a special type person to serve veterans.

And in addition to that, if somebody goes to a private hospital, they are paying for those services, and they can leave. In a veterans hospital, it is a promise made to those veterans that they would receive this service for having served their country, and in a lot of cases they don't have an option. You know, they have to depend upon the Veterans Administration. And, therefore, that has to be taken into consideration. And privatization does not take that into consideration. You are just looking at the bottom line.

And if I might, I didn't get to answer the chairman's question a while ago concerning incentives. I really appreciate the effort that this committee made last year in addressing the pay problem we were having with the registered nurses. The law allowed the hospital directors discretion in setting nurse's pay, and we found out it was being terribly abused. And you took action to correct that. But we still have areas where they have the discretion to apply locality pay but failing to do so.

And then we have the situation where we have what is called a hybrid employee that works side by side with the nurses that receives premium pay on Saturday, but they do not. But it is at the discretion of the hospital director. So I am not looking for bonuses, I am looking for the pay they are entitled to to start with, and then we will start talking about bonuses.

Mr. FILNER. Thank you. Thank you, Mr. Harnage. Thank you, Mr. Chairman.

Mr. MORAN. I appreciate this panel's testimony as well, and I appreciate the employees that are with us today. I have certainly learned a lot and look forward to working with you as well as we try to address issues, problems, and challenges we face in the delivery of health care for our Nation's veterans.

So thank you on behalf of the people you represent, and I thank you and them for the service they provide to the veterans, certainly in my State and across the country. I am delighted that you took the time to be with us this afternoon and give us your insight. Thank you.

I believe that our committee is about ready to conclude. I think this has been a good start, certainly for me, to get a better appreciation for the issues that we face. Again, we have heard from the Department of Veterans Affairs. We have heard from those who represent the patients and residents within the VA system, and now the people who provide that care directly to those individuals, and I appreciate the education that you provided to me this afternoon.

I appreciate Mr. Filner and the other members of the committee who have been here with us.

We will continue to work to improve quality in the delivery of health care for our country's veterans. As many of the witnesses have indicated, it was a commitment made and not yet a commitment kept, and we are about that of keeping commitments. I look forward to working with Secretary Principi and you, Mr. Undersecretary, as we attempt to achieve that.

Mr. Filner, any concluding comments. I appreciate your presence and look forward to continuing to work with you. And this subcommittee meeting is adjourned.

[Whereupon, at 4:17 p.m., the subcommittee was adjourned.]

APPENDIX

PREPARED STATEMENT OF CONGRESSMAN EVANS

Thank you, Chairman Moran and Ranking Member Filner. This hearing on the state of the VA Health Care System will provide an excellent backdrop to many of the issues with which you will grapple in the upcoming months. I have every confidence that your leadership of this Subcommittee will produce great effects in terms of both the legislation you develop and oversight in which you engage.

I am pleased that you have chosen to hear from many of VA's important stakeholders in your debut hearing—veterans, VA employees' representatives, the academic community and finally, the veterans' health care system's management team led by its Under Secretary for Health, Tom Garthwaite. These are the parties that are integral to the success of the Veterans Health Administration. Together these witnesses provide a wide variety of perspectives on the state of VA's health care system.

In the past few years, VA has undertaken a comprehensive effort to restructure VA's health care delivery system. We are just beginning to appreciate the results of this effort—both good and bad. There are more clinics, but longer waiting times. There are more veterans being served, but arguably less breadth in some of the services like mental health and longterm care that the system offers. There have been savings in the cost of each veteran served, but employees say they have been stretched too thin and this has begun to take a toll on quality. Fewer employees have also resulted in a need for using additional contract services and contractual employees. It seems to me, we understand little about these contracted relationships, including whether they actually result in savings for VA. The CARES (Capital Assets Restructuring for Enhanced Services) Initiative may be even more divisive.

I have read Dr. Garthwaite's testimony and appreciate his vision of the "6 for '06". Most of us can agree that these are admirable goals, but I also understand that *how* we accomplish goals can be as important as the goals themselves. Additionally, "success" is in the eye of the beholder. For example, VA's management, eager to rid itself of a costly and poorly sited facility and replace it with new community outpatient clinics, hailed the recent conversion of Ft. Lyons VA Medical Center to the State's prison system. Alternatively, veterans and employees may not have viewed this transaction as "successful".

Likewise, contracting for VA services may be problematic in many instances. In the last Congress, I supported a provision in the Personnel Act approved by the House that would have authorized a demonstration project allowing VA to reimburse veterans with insurance for the copayments they incurred while using community hospital inpatient services. This approach certainly holds appeal for many veterans, but it may come at the cost of maintaining the fragile balance between access and service breadth in many locations around the country. Would it be successful to offer a service (even a popular one) to veterans who have more than one insurance option if the cost was the erosion of a critical mass needed to maintain a high-cost service like magnetic resonance imaging within VA? These "cost" factors must be weighed in our deliberation of policy affecting the Department of Veterans Affairs' health care system.

In all of the matters open for debate in this Subcommittee during this Congress, we must assess both the costs and benefits of our policy decisions. I believe our employee representatives offer some cautionary tales in VA's pursuit for increased efficiency—fewer employees *may* allow short-term savings (and even this is questionable), but reducing employment levels can also create some diseconomies of scale—particularly in hospital system with a growing patient population. I think the Office of Management and Budget and VA's assessment of these sensitivities has been weak. Are we really saving money if letting all of the nursing aides go means you

have to use additional contract employees, additional contract hospital services and additional mandatory overtime for more expensive registered nurses? What is the "cost" of this initiative in terms of the loss in quality of services received? I understand that the Office of Management and Budget may be mandating federal agencies to convert a portion of its "commercial activities". Given our current understanding of the benefits of such a proposal, I sincerely hope this is not the case.

Chairman Moran and Ranking Member Filner, again, I appreciate your holding this hearing today. I hope we will have many additional opportunities to discuss some of these issues. Thank you for allowing me to participate.

PREPARED STATEMENT OF CONGRESSMAN GUTIERREZ

Mr. Chairman, I am very pleased to be here today to hear the testimony from the Department of Veterans Affairs and the many distinguished organizations who have come before our subcommittee today to discuss the state of the VA Health Care System, the Nation's largest single health provider. The enormous pressure and responsibility of the VA Health Care System continues to grow as more than two million veterans visit VA facilities each year. For this reason, each time you visit us, each time you share your concerns with us, each time you remind us of what is needed and how much more we need to do, each time you do this you become our partners in trying to offer veterans the best health care system—which is what they deserve.

In the many years that I have served in this subcommittee, I always look forward to this opportunity. I believe that it is crucial to hear from our pro-veteran advocate groups who are out there and who experience the problems first hand, regarding serious issues that plague the VA health care system today. Issues that range from timely access to quality care and staffing cutbacks, to the need to set minimum staffing levels, the shortage of programs for veterans with special needs, the need appropriate mental health care, and the importance of maintaining the capacity of the spinal cord injury and disease health care system, among others.

Those of us who have been here for a long time understand what frustrations you experience in your efforts to bring the best health care possible to the VA health care system. I too become frustrated when in a country as prosperous as ours, we cannot find the appropriate federal resources to meet the health needs of all veterans in this country. I too share your frustrations and look forward to working together, as we have in the past, to ensure adequate funding for the VA healthcare system.

I look forward to the testimony of our witnesses.

PREPARED STATEMENT OF CONGRESSMAN STEARNS

Thank you, Chairman Moran, for holding this important hearing today. The scope of the hearing is an ambitious undertaking. The witnesses represent a broad cross section and should provide us with valuable information about the current state of the VA health care delivery system.

Mr. Chairman, it was indeed a tremendous honor for me to serve as Chairman of the VA Health Subcommittee over the past 4 years. During the 106th Congress we were able to pass with a bipartisan consensus two very important pieces of legislation to improve health care for our Nation's veterans.

I speak of course of the Millennium Health Care Act and the VA Health Care Personnel Act. I am troubled, however, about what I am hearing about the length of time it is taking to implement these important measures.

Let me speak first about the Millennium Act, specifically about the emergency services provision. I guess I just don't understand why that particular provision won't have regulations written until November of this year. Would you accept veterans if you were a health care provider knowing that you might not get paid for the services rendered? I doubt it very seriously. But that is what is happening. That November date represents a full eighteen months after the date the benefit went into effect. Just yesterday I got a call from State Representative Lee Constantine's office in Florida. Rep. Constantine represents the Tampa Bay area. His office wanted to let us know about the number of complaints they have received from providers and others, including veterans about the difficulties involved in receiving such emergency services because regulations mandated by the Millennium Act have not yet been finalized. Mr. Chairman, that isn't good enough.

Another area of concern is the need for the VA to fully implement the long-term care provision of the Millennium Act. Florida has the oldest and sickest veterans in the Nation and many of them require specialized care. I want to ensure that vet-

erans in Florida and throughout the Nation will find the care they need when the time comes.

Mr. Chairman, the other area I want to talk about is the VA Personnel Act. The purpose of this legislation was to ensure that the VA will have the means available to attract nurses and other health care professionals to its system. In reviewing the testimony of the witnesses I noted that staffing requirements at the VA are not being met. The VA continues to have difficulty in retaining and recruiting health care personnel. This is especially true when it comes to nursing staff. I was very disappointed to learn that several medical directors have chosen to deny nurses a locality pay increase. Could someone explain to me the rationale behind this?

I think everyone in this room will acknowledge that VA has a problem when it comes to attracting qualified nurses. I thought my bill took a much needed and long overdue step in right direction. I call upon the VA to follow the intent of the law. I don't think I need to tell you that the stress on the system will only get worse and the problems associated with a lack of qualified health care personnel, especially nurses will not get any easier or less problematic.

Mr. Chairman, I also have concerns about our Gulf War veterans. I believe we must call upon the VA to provide the Gulf War veterans with access to non-traditional health care treatment to help restore their physical and mental health. They have suffered long enough and deserve no less. If current treatment available through the VA system is not working, we should allow these men and women to receive alternative treatments that may work for them.

There is one last issue that I feel compelled to talk about today. That is the situation with recent actions that have transpired concerning the Veterans Equitable Resources Allocation or VERA. VERA was established to ensure that the dollars being spent followed the veterans. For years Florida was not compensated for veterans from other States who visit Florida during the winter. These groups are commonly referred to as "snow bird' It has come to light that an adjustment in funding in the Veterans Health Administration resulted in a recall of eleven million dollars from the current budget in the Florida Veterans Integrated Service Network (VISN 8) and similarly sixteen million dollars in VISN 16. These two VISNs serve veterans in my home State of Florida. I find this not only troubling but also wrong. How can VA possibly justify this when the number of veterans receiving care in VISN 8 has increased by 67 percent since 1995? As it is veterans in my home State must wait as long as 1 year before receiving treatment in some parts of the State. This recent loss of money will cause further delays and cut backs. I hope this egregious action is corrected immediately.

I have touched upon a few of my major concerns and because I want to hear from our witnesses I will conclude by saying that I believe that together we can resolve the problems that we will hear about today. I want you to know that I am committed to doing whatever is necessary to provide our veterans with access to the best care available.

Thank you, Mr. Chairman.

PREPARED STATEMENT OF CONGRESSMAN CRENSHAW

Mr. Chairman and Mr. Filner, I want to thank you for holding this important hearing. Though I have spoken to many veteran patients and providers in my district about the benefits and drawbacks of the VA health system, I have never had a thorough introduction to the system in a broader and more clinical sense. And, as a new member of this Subcommittee, I look forward to learning more about it.

I would be remiss, Mr. Chairman, if I did not take a moment to remark to my colleagues and our guests on the recent nomination of Under Secretary Garthwaite's counterpart for Memorial Affairs. Lieutenant Colonel Robin Higgins has served Florida's veterans well for several years as the Executive Director of our state VA, and I am certain that she will serve our Nation's veterans well in her new role at the U.S. Department of Veterans Affairs.

That said, our mission today is the health care system. I was struck as a I read through the testimony prepared by Under Secretary Garthwaite at a part that indicates that the satisfaction level of the veterans who use the health care system is very high - between 65 and 88 percent on different scales and using different criteria. The testimony of the service organizations that follows it is in stark contrast, as are the personal comments I have heard from veterans in my district. In fact, I typically hear that waiting times for getting an appointment and for getting in to see a doctor or provider are still too long. I also hear that once a patient gets in to see a provider, the visit is very short because the provider has a string of other patients who have waited equally long times for an appointment.

I know that these providers are doing as good a job as they can with the limited resources and ever-growing population of patients that overwhelms the system. They are caring doctors, nurses, specialists, and assistants. And we, both at the VA and on this Committee, must continue to listen to them and learn about what works on the most basic levels of service.

In that vein, in my first months of office, I have established veterans' advisory council so that I may speak directly to those who give and receive care at the veterans' health facilities. Their counsel is invaluable.

Thank you, again, Mr. Chairman, for this opportunity today.

APPENDIX

Statement
of

Thomas L. Garthwaite, MD
Under Secretary for Health
Department of Veterans Affairs

Before the

Subcommittee on Health
Committee on Veterans' Affairs
U. S. House of Representatives

April 3, 2001

Mr. Chairman and members of the Subcommittee, I am pleased to be here today to discuss the progress, challenges, and future direction of health care in the Department of Veterans Affairs (VA).

Since 1995, we have dramatically transformed the VA health care system. We have moved from an inpatient model of care characterized by limited facilities often far from patients' homes to an outpatient model with more than 350 additional sites of care. While we still provide comprehensive specialty care, we now also emphasize the coordination of care through the universal assignment of primary care providers and teams. We emphasize disease prevention and early intervention, allowing veterans to avoid illnesses and complications and allowing us to avoid the added costs of their treatment. As a result of these strategies, VA today is able to provide higher quality care to more that 500,000 additional veterans with 25,000 fewer employees than it did just six years ago. Moreover, since 1997, VHA has reduced the cost per patient by 24 percent.

The key goal that underlies VA's transformation and continues to drive our strategies for the future is a quest for health care value. We have defined value as quality divided by cost. While we do not yet have a perfect system to measure either quality or cost, we have made significant progress in measuring both. We have defined and developed measures across four domains of quality (technical quality, access, patient satisfaction, and functional status) and continue to improve our measurement of cost. The quality and cost measures are directly translated into our value framework and the "six for 2006" goals.

Before I detail our progress and current strategies toward the "six for 2006," I would like to comment on some of the overarching themes and strategies that pertain to most or all of the 2006 goals. The following issues are important areas of concentration for us and will directly impact our success in achieving our key goals. They are workforce development, information technology, performance measurement, quality and capacity in our special emphasis programs, enhancement of our academic missions of teaching and

research, the Veterans Health Initiative, rationalization and modernization of our facilities (CARES), distribution of funding (VERA), and continuous self assessment using the Baldrige process.

Workforce Development. VA's health care workforce is the key to achieving all of our goals. We must recruit, retain, and develop the best staff if we are to continue to improve. Recently, we have noted shortages of nurses and pharmacists in some parts of the country and the projected shortages in these and other professions are alarming. Increasingly, we have difficulty matching private sector pay levels in such critical areas as physician specialists and computer experts. We also must continuously invest in the education of our workforce to allow them to keep pace with changing patient needs and rapid changes in health care technology. Last year, I established a taskforce to recommend a comprehensive set of actions to address these and other workforce issues. The recommendations of this taskforce are currently under review.

Information technology. Information technology is at the heart of most changes in VHA. We use technology to process clinical and administrative information, to automate previously manual processes, to deliver care across distances, to train staff, and to conduct research. Examples of the use of technology include the computerized patient record, a cost accounting and analysis system (DSS), consolidated mail out pharmacy (CMOP), simulated patient training in surgery and anesthesia, gamma-knife radiation therapy, advanced neuro-imaging, bar-coding to aid in the accuracy of medication administration, tele-health, and many others.

Two key principles in the development of our computerized medical record are that it is owned by the veteran and that it must be compatible with emerging and established standards such that a veteran can take his/her electronic record to or bring it from any other health care service provider. If a veteran chooses VA to maintain the health record, we must preserve its integrity and security and use it only for the benefit of the veteran or society – and only with his/her permission. We call our initiative for a veteran-controlled health data repository and associated functionalities "HealtheVet."

Performance measurement. The performance measurement system used in VA has played a key role in the transformation of the system and will continue to be a key strategy in the continued evolution of the system. Each year, approximately twenty key measures are selected for emphasis and become the significant component of a performance contract between network directors

or chief officers and the Under Secretary for Health. Some of the detailed results are presented below. The power of the system is derived from the focus on defining the most important goals for the year, the development of measures to chart progress toward those goals, the open feedback about the progress (or lack of progress) toward those goals and the necessity that administrators must team with front line staff to make the outcomes for patients change.

Quality and capacity in special emphasis programs. Since 1996, we have moved from inpatient care to outpatient models in medicine, surgery, and mental health. The numbers of patients seen with serious mental illness, for homelessness, or suffering with PTSD have increased. The number of patients with substance abuse treated has decreased, especially between FY 1999 and FY 2000. We are working to understand the reasons for this drop and to assure access to substance abuse programs in our clinics as well as in our larger facilities. To this end, I plan to establish a National Mental Health Improvement Program (NMHIP). This program will be modeled after a number of well-established VA data-driven improvement programs, such as the Continuous Improvement in Cardiac Surgery Program (CICSP), the National Surgical Quality Improvement Program (NSQIP), the VA Diabetes Program, the Pharmacy Benefits Management Program (PBM), and the Spinal Cord Injury/Dysfunction National Program. This new program will use validated data collection, expert analysis, and active intervention by an oversight team to continuously improve the access, outcomes, and function of patients in need of our mental health programs. These programs include those for patients who are Seriously Chronically Mentally Ill, or who suffer from Post Traumatic Stress Disorder, Substance Abuse, or Homelessness. This program will draw upon existing resources in our Health Services Research and Development Service (HSR&D) including existing initiatives in our Quality Enhancement Research Initiative (QUERI) and our Mental Health Strategic Health Care Group (MHSHG) including the Northeast Program Evaluation Center (NEPEC).

The number of patients treated for spinal cord injury and dysfunction, blind rehabilitation, and traumatic brain injury has increased over the 1996 baseline. Fortunately, the number of patients needing amputation has decreased due to our aggressive management of vascular disease and diabetes.

Academic missions. The academic missions of research and health professions education are part of our "six for 2006" goal to "build healthy communities." However, they are also a critical strategy to deliver high quality and efficient care. These missions allow us to attract the very best and brightest clinical staff and enable us to be early adopters of new advances in medical

knowledge and practice. We must challenge our academic staff to turn their creative talent loose on the development of new care delivery models that can simultaneously address quality, convenience, research, and education. We will engage them in that quest.

Veterans Health Initiative. The Veterans Health Initiative was established in September 1999 to recognize the connection between certain health effects and military service, prepare health care providers to better serve veteran patients, and to provide a data base for further study. The development for this initiative began with the Military Service History project, which involved a pocket card for medical residents. This card details the important components of a military service history, summarizes some of the health risks associated with various periods of service, addresses more generic health issues of concern to all veterans, and specifies Web sites containing references relevant to the issues.

The components of the initiative will be a provider education program leading to certification in veterans' health; a comprehensive military history that will be coded in a registry and be available for education, outcomes analysis, and research; a database for any veteran to register his military history and to automatically receive updated and relevant information on issues of concern to him/her (only as requested); and a Web site where any veteran or health care provider can access the latest scientific evidence on the health effects of military service.

Aligning capital assets to veterans' needs. CARES (Capital Asset Realignment for Enhanced Services) will affect every network in VHA. We have embarked on a significant new planning process with the goal of enhancing health care services to veterans by realigning capital assets. The CARES process starts with the objective assessment of veterans' current and future health care needs within each network and proceeds with the identification of service delivery options to meet those needs and the strategic realignment of capital assets and related resources to better serve the needs of veterans. Through CARES, networks will develop plans for enhanced services that are based upon objective criteria and analysis, cost-effectiveness and may include capital asset restructuring. These plans will take into account future directions in health care delivery, demographic projections, physical plant capacity, community health care capacity and workforce requirements. Network capital asset realignment proposals will be evaluated and ranked by VHA using a structured decision methodology. All savings generated through implementation of CARES will be reinvested in meeting veterans' health care needs.

Resource allocation. To date, no ideal system to allocate resources in health care has been devised. Fee for service plans lead to overuse of procedures and high costs while managed care plans are criticized for restriction of choice of provider and of access to specialty care. VA uses a risk adjusted, capitated model called VERA (Veterans Equitable Resource Allocation) to allocate resources among VHA's 22 networks. Distribution within each network is based on a set of principles, but in the absence of an ideal system, we have not mandated a single method for all networks. Ideally, VERA would be simple, fair, and promote quality of care. We do not believe that any models have been able to drive quality, therefore, we keep the allocation system simple and work hard to measure the quality of care provided.

VERA has undergone extensive scrutiny since VHA implemented it in 1997. The effectiveness of VERA has been assessed by PricewaterhouseCoopers and by two GAO reviews. All three studies viewed VERA in positive terms. PricewaterhouseCoopers reported that VERA, which allocates resources based on objective measures of need, is ahead of other budget allocation systems, which typically depend on historical allocations with periodic adjustments.

We reviewed the recommendations from PricewaterhouseCoopers and GAO and implemented many of them. For FY 2001, the following VERA policy changes or refinements were approved for the network budget allocations:

- VERA Basic and Complex patient classes and criteria were developed for hepatitis C patients.
- The Complex Care projection methodology was adjusted to delete the veteran population factor in favor of historical utilization.
- Research support funds were passed through VERA directly to each VA medical center.
- VHA changed the workload factor for computing the labor index that weights Basic and Complex Care workload consistent with recent costs.
- The three-year phase-in of Non-Recurring Maintenance (NRM) based fully on patient care workload and the cost of construction was completed.

We are currently examining several additional areas of possible refinements to VERA for implementation in FY 2002 or later, but no conclusions have been made yet. These areas include patient classifications, priority 7 veterans and market share, the cost impact of treating patients above age 75, the existing geographic price adjustment formula to include contracted salary rates and energy expenditures, and the use of risk adjustment models to account for differences in age and disease burden in the population served. We remain

committed to the evaluation of all reasonable explanations for variance in the model.

Baldrige and the future. VHA will apply for the President's Quality Award in the fall of 2001 and for the Malcolm Baldrige National Quality Award in May of 2002. We do not undertake these processes for the awards themselves, although we aim to win. Rather, we seek the experience, the outside feedback, and the development of skills in critical self-assessment. We have been struck by the economic success of previous award winners and by their achievements in service quality. We believe that we can identify gaps in our systems and can improve the integration of all we do. The Baldrige criteria will provide a structured and integrated framework for many of the processes we perform today. In the end, sober self-assessment is a skill that should benefit any organization.

Within the last year we have updated VHA's strategic framework to reflect six organizational goals that closely match our six domains of health care value. I will now review our progress and plans for achieving these goals, which are known as the "six for 2006."

Put Quality First until First in Quality. A major force in the transformation of the VA health care system was the implementation of the Performance Measurement System. This system was initiated to meet challenges of improving health care quality, patient satisfaction, and economic efficiencies. The foundation of the Performance Measurement System is broad, statistically reliable, ongoing measurement of performance objectives. As a result of this system, VHA is increasingly able to measure and report on quality. Moreover, the ability to measure allows us to identify areas for improvement.

VHA's quality is not merely good -- in many areas it surpasses government targets and private sector performance. VHA's record regarding post-operative morbidity and mortality is as good as or better than that found in any published study of non-VA surgical programs. Our immunization rates for pneumococcal pneumonia and for influenza far exceed the goals established for the U.S. population. Our breast and cervical cancer screening rates are also well above the national average performance in these areas. VA patients receive life-saving aspirin and beta-blocker administration after heart attacks 96 percent of the time, whereas Medicare patients receive this therapy in only 68 percent of cases.

VHA recognized that the use of evidence-based, clinical practice guidelines would have an appreciable impact on patient care and initiated development of National Clinical Practice Guidelines in 1995. Guidelines were

established for many high volume, high risk diseases. A joint effort between VA and DoD has led to the development of more than a dozen clinical practice guidelines intended to assure quality and continuity of care.

VHA's strides in quality and its leadership in health care quality management were specifically cited at the recent Institute of Medicine briefing accompanying the publication of their report, "Crossing the Quality Chasm." To further our efforts in quality improvement, we will continue to use and update our extensive quality and performance measurement tools. For example, the expanded Prevention Index and the Chronic Disease Care Index, which now encompasses the clinical practice guidelines, were recently revised on the basis of the current medical literature and expert opinion.

In 1998, VA launched the Quality Enhancement Research Initiative (QUERI). The QUERI mission is to translate research discoveries and innovations into better patient care and systems improvements. It is founded on the principle that practice needs determine the research agenda, and research results determine interventions that improve the quality of patient care. The Institute of Medicine, in its report "Crossing the Quality Chasm," specifically noted QUERI as a model for translating the best research evidence into the best patient care.

VHA has also been recognized as a leader in efforts to prevent health care errors and improve patient safety. Improved patient safety requires reporting systems to identify and understand adverse events and close calls and the design and deployment of systems that reduce such vulnerabilities. VHA has introduced a mandatory reporting system for adverse events and close calls that is coupled with rigorous root cause analysis. This system has been operational for over a year and has resulted in a 900-fold increase in close calls reported. Close call analysis is the preferable way to learn of system vulnerabilities, because they can be identified without patient injury.

VA also believes that health care will discover additional vulnerabilities by instituting a separate, voluntary, and anonymous reporting system. To that end, VA formed an agreement with NASA to develop a Patient Safety Reporting System (PSRS) patterned after one that has been used successfully in aviation. The system's guiding principles are voluntary participation, confidentiality protection, and non-punitive reporting. It is designed to be a complementary external system to our current internal reporting system. VA's National Center for Patient Safety and NASA have been working on the design and development of this system. Pilot testing will begin this year with the entire system on line by the beginning of FY2002.

The discovery of system weaknesses must be followed by system redesign. Examples of system improvements include: national implementation of

Bar Code Medication Administration (BCMA) that improves the accuracy of medication administration, extensive deployment of computerized order entry that eliminates handwriting and other common errors, the removal of bulk medications from nursing wards to minimize mixing errors, and working through an interactive fix of a design flaw in a temporary transvenous pacemaker with the manufacturer.

Provide Easy Access to Medical Knowledge, Expertise, and Care. Traditionally, access to care has addressed issues of travel times, waiting times, and insurance. This goal includes those issues as well as access to knowledge via the telephone or Internet and access to the knowledge of specialists where appropriate.

As VA has shifted from an inpatient-focused system to one that is outpatient-based, we have extended care to 350 additional sites, for a total of more than 1,300. Approximately, 100 additional community-based outpatient clinics have received congressional approval and are slated to be phased in over the next several months. Telephone triage and advice programs have been implemented at all hospitals, and health education is available on the Internet. Last year, VA did more than 350,000 consultations via telemedicine (the patient or a diagnostic image and the provider were connected via voice and usually video). Telemedicine and home-care teleconsultation initiatives have also been implemented for spinal cord injury patients. In 1998 and 1999, the Vet Center program implemented the Vet Center-Linked Primary Care project. Telemedicine is used in 20 Vet Centers to promote access to primary care for high-risk, under-served veterans in locations closer to their respective communities.

Applying for VA health care has never been easier. We have eliminated almost three-fourths of the health care-related forms we once required. Veterans can now obtain applications for enrollment and medical care over the Internet. Veterans may send the forms electronically to the VA health care facilities they have selected or they can print out the completed forms and mail them.

Eligibility reform and community clinics have enhanced access but in some areas demand has preceded recruitment resulting in extended waiting times for appointments. VHA is committed to providing timely care to the veterans enrolled in our health care system. We have recently developed a data system and performance expectations with regard to waiting times for primary care and specialist consultation. We believe that our performance goals for waiting times, commonly known as "30-30-20," are industry leading and fully support patient expectations for timely access to care. Our strategic goal is to provide 90 percent of new primary care and specialty care visits within 30 days, and see 90 percent of patients within 20 minutes of their scheduled appointment

time. Of course, patients with emergencies or urgent needs are seen as quickly as is medically appropriate. VHA is now working with the Institute for Healthcare Improvement (IHI) on a major initiative that will focus on the rapid spread of the most successful actions underway within each VISN to achieve the "30-30-20" performance goals. VHA has already seen system-wide improvements in average clinic waiting times between the start in April 2000 to December 2000.

While the early progress on waiting times is encouraging, we have more to do in the broader field of access. We must eliminate barriers to care which result from such things as poverty, race, gender, geography, language, age, and bias. We will evolve strategies to provide care to vulnerable populations including the homeless, the mentally ill, the aged, and those infected by the Hepatitis C virus. We also have developed a body of knowledge about veterans' health issues that we will make available to any veteran or any health care provider.

VHA has been faced with access issues in extended and long term care. VA has expanded programs targeted for the elderly, including Geriatric Evaluation and Management (GEM) Programs, home-based primary care initiatives, and pilot programs in long-term care and assisted living as authorized by the Veterans Millennium Health care and Benefits Act, Public Law 106-117.

Enhance, Preserve, and Restore Patient Function. The restoration of function (rehabilitation) is the cornerstone of VA's health care mission. VA has nationally recognized programs for the rehabilitation of veterans who are blind, suffering from brain dysfunction, afflicted with spinal cord injuries, or who are amputees. Notable progress is being made in the development of outcome measures that evaluate functional improvements in each of these special programs. Amputation rates in VA are lower than age-matched private sector populations and continue to decrease. Activities are underway to further integrate all of VA's low vision and blind programs to improve the continuity of care. A recent report comparing VA spinal cord care with that in the U. S. private sector and in Sweden concluded that the totality of VA's benefits package is unmatched. VA provided far greater continuity and breadth of care than did the private sector. Life-long, integrated, and comprehensive care for spinal cord patients is provided in VA and Sweden, but not in other venues. The Traumatic Brain Injury (TBI) Network of Care provides case-managed, comprehensive, specialized rehabilitation spanning the period from discharge from the acute surgical treatment unit until permanent living arrangements can be made. A significant number of these patients are referred to VA facilities from the military. Nine research centers of excellence conduct studies emphasizing wheelchair design and technology, brain rehabilitation, spinal cord injury and multiple sclerosis,

early detection of hearing loss, orientation techniques for blind persons, and amputation prevention and joint replacement.

VA also provides comprehensive mental health services across a continuum of care, from intensive inpatient mental health units for acutely ill persons to residential care settings, outpatient clinics, Day Hospital, and Day Treatment programs. The number of veterans receiving mental health care in the VA health care system has steadily increased since 1996. VHA will continue to monitor care and work with networks to improve and maintain both the capacity and the quality of care for all veterans with serious mental illness. Recent initiatives have been undertaken to increase mental health treatment in community-based outpatient clinics, increase use of assistive community treatment for the most seriously mentally ill veterans, and increased use of opiate substitution clinics in major urban centers. It is also worth noting that VA is the only federal agency that provides substantial hands-on assistance directly to homeless veterans and has the largest network of homeless assistance programs in the country.

The primary objective of all special programs is to provide the best possible care and achieve the maximum independence for patients by restoring lost function or decreasing the impact of their disabilities. We will continue to enhance our programs in rehabilitation, sharpening our focus on improved functional capacity for veterans who suffer from spinal cord injury, blindness, amputations, brain dysfunction, and mental illness. To improve the integration of activities and to assure VA has adequate capacity to meet the specialized health care needs of veterans, VHA has created a position in headquarters to serve as the coordinator for special disability programs and has designated a clinical coordinator in each VISN to work with individual facilities and headquarters offices to monitor capacity and maintain specialized services.

Exceed Patients' Expectations. VA created the National Customer Feedback Center (now the National Performance Data Feedback Center, or NPDFC) in 1993 to measure and improve patient satisfaction with care and to allow comparison with other health care systems. Annual inpatient and outpatient patient satisfaction surveys based on the Picker instrument were developed using focus groups of patients and their families. Patient service standards were also developed, and specialty surveys, such as long-term care, have been added over the years. Beginning in FY 2001, VHA's new Performance Analysis Center for Excellence (PACE) will refine and expand the data feedback, satisfaction surveying, and other objectives accomplished by the NPDFC. PACE will use clinical literature and VA data to identify new clinically and operationally important

performance improvement opportunities, aligning activities with the strategic objectives of VHA's "6 for 2006."

The overall customer satisfaction scores from VHA's inpatient and outpatient surveys have remained relatively flat for the last several years, with approximately 65 percent of patients rating VA's services as "very good" and "excellent." However, when we consider the significant structural and programmatic realignments the VA health care system has undergone in the last six years, it is gratifying that veterans continue to show a high level of satisfaction and confidence in VA health care. Nonetheless, we believe that a more focused approach will have a strong impact on improving our performance. Therefore, in FY 2001 VHA will begin to focus on three key areas of patient satisfaction: patient education, visit coordination, and pharmacy services. These are areas in which our surveys indicate that we have the greatest opportunity and need for improvement. In addition, we will further focus the system on the patient by emphasizing the goal of ensuring that veterans participate fully in decisions affecting their health care and understand those decisions completely.

The American Customer Satisfaction Index (ACSI) provides an independent assessment to be used with VA's own data. This Index, a cross-industry/government measure of customer satisfaction released December 22, 2000 asked questions about veterans' overall satisfaction with their experiences in a recent visit to a VA medical center. Overall, VA's customer satisfaction index was 78 on a 100-point scale, seven points above the customer satisfaction score of 71 given by the general public for all sectors of business, and eight points above the score for private hospitals. Customer service, perceived in terms of courtesy and professionalism, was the highest of VA's three measurement areas, an average score of 87. ACSI considers scores above 80 to be "high." On questions about patients' likely return to VA medical centers and willingness to say positive things about VA, VA scored an 88.

Maximize Resource Use to Benefit Veterans. Since 1997, VHA has reduced the cost of care per veteran treated by 24 percent. But while a reduction in costs is a significant accomplishment, it does not, by itself, assure that we are obtaining or providing the best health care value for the dollars we spend. Therefore, we have developed a VALUE index that includes both cost and other domains of value such as quality, access, and satisfaction in order to express meaningful outcomes for VHA's resource investments. Unlike a simple cost measure that can lead to false impressions of efficiency, the VALUE measure demonstrates a balanced perspective of cost efficiency along with desired outcomes. The measure portrays the desired outcomes that VHA purchases with its budgeted resources by establishing a value relationship of Quality-

Access-Satisfaction to dollars (QAS/cost). The use of the QAS/Cost VALUE measure will establish an understandable value relationship of outcomes to dollars.

We must also expand our partnerships with federal, state, local, and private entities to minimize redundancy in programs and services and to leverage our buying power. Through multiple partnerships, VA will be in a position to manage its services in such a way as to enhance the quality and coordination of care provided to veterans.

Build Healthy Communities. Veterans can only reach their maximum health potential if they live in healthy communities and healthy environments. We will continue our work in detecting emerging pathogens, in the immunization of large populations, and in the understanding of the long-term effects of toxic agents on health. Our research and educational roles will continue to benefit veterans and non-veterans alike. Our pioneering work in patient safety has the potential to improve health care for all. We will work with community partners to combat homelessness and to coordinate care for veterans. VA's influence on the nation's health goes well beyond its primary mission of providing care for veterans.

We will continue our efforts to integrate our research and educational roles with our rapidly changing care delivery system. VA's research program, the recipient of three Nobel Prizes and a plethora of other awards, concentrates on health care concerns that are prevalent among veterans. VA fosters multidisciplinary research, pilot studies, and research training for teams of investigators unraveling questions concerning such health issues as cancer, multiple sclerosis, Hepatitis C, kidney disease, depression, stroke, Alzheimer's disease, heart attack, lung disease, bone disease, Parkinson's disease, diabetes, gastrointestinal disorders, and wound healing. VA's research program also pursues research at the interface of health care systems, patients, and health care outcomes. The priorities have expanded to include access to health care, managed care strategies, the effect of facility integrations, changes in clinical services organization with line management, and ethnic, cultural, and gender issues as they relate to health services use. Many VA research studies have been used within and outside VA to assess new technologies, explore strategies for improving health outcomes, and evaluate the cost-effectiveness of services and therapies.

VA's research program will continue its decidedly clinical focus as a unique national asset. To this end, VA Research intends to lead the nation in multi-site clinical trials, rehabilitation research and development, and health services research and development. The majority of research allocations will

continue to be devoted to health services research and research with potential clinical applications. Lastly, VA's research program, through the high quality of its research offerings, will attract and retain highly trained clinician researchers who will continue to enhance the VA's patient care mission.

VA's training mission is accomplished through academic affiliations with many of the nations' medical schools and other schools in health sciences, an important and unique characteristic of the VA health care system. VA remains the nation's largest provider of graduate medical education. Affiliations with 107 of the nation's 125 medical schools provide the context for training that annually affects over one-third of the nation's medical resident trainees, including half the nation's third and fourth year medical students. In addition, over 54,000 associated health trainees in nursing, psychology, pharmacy, and over 40 other disciplines receive part or all of their clinical training in VA facilities. We currently fund approximately 9,000 positions in graduate medical education. As residents rotate through these positions, they are exposed to the best evidence-based medical practices in the country. They take this knowledge with them as they complete their training and begin their careers in the care of veterans and non-veterans. VA can claim it has trained, at least in part, more than half of the nation's practicing physicians.

VA's academic affiliations are robust and provide vigorous opportunities for providing the best approaches for continuous improvement of health care for veterans while contributing to strengthened academic medical institutions throughout the country. We must work hard to keep them healthy.

In providing medical contingency backup for the Department of Defense, VA supports DoD's medical system during wartime. VA also assists the Public Health Service, The Federal Emergency Management Agency (FEMA) and the National Disaster Medical System (NDMS) in providing emergency care to victims of natural and other disasters. Under Presidential Decision Directive 62 (Combating Terrorism), VA works with the Department of Health and Human Services to procure stockpiles of antidote and other necessary pharmaceuticals, and to train medical personnel in NDMS hospitals for responding to the health consequences of the use of weapons of mass destruction. VA is uniquely positioned to do this training since it represents a large portion of the Nation's medical capability and has facilities located throughout the country. I cannot stress too much the importance of VA's role in emergency preparedness and response, and I will work to ensure that VA remains able to meets its obligations.

In summary, Mr. Chairman, VHA has chosen goals that would challenge any organization. Our organization has undertaken a profound transformation and should be justifiably proud of its accomplishments. However, we must

continue to change and adapt as changes in information technology, biotechnology, health care financing, and public accountability impact all health care systems. Additional gains in health care value are possible if we are able to manage health information more effectively, improve care coordination and communications with our patients, eliminate variability in care and change our infrastructure as needed to meet current needs. As we look to the future of VA health care, we are very optimistic that VA will meet the challenges it faces and will be viewed as a model health system for its many accomplishments.

STATEMENT

OF THE

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On

The State of the VA Health Care System

Presented By

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Before the

Subcommittee on Health
Committee on Veterans' Affairs
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Good Morning, I am John Clarkson, senior vice president for medical affairs and dean of the University of Miami School of Medicine. I am here today representing the Association of American Medical Colleges (AAMC). The AAMC serves as the national voice for the country's 125 accredited allopathic medical schools, over 400 major teaching hospitals and health systems, including over 70 veterans affairs medical centers, 92 academic and scientific societies representing 87,000 faculty members, and the nation's medical students and residents. Currently, 139 VA medical centers are affiliated with 107 medical schools. Each year, more than 30,000 medical residents and 22,000 medical students rotate through the VA hospitals and clinics to receive a portion of their medical training.

The AAMC greatly appreciates the opportunity to testify today on the state of the VA health care system, and in particular on its relationships with, and policies affecting, affiliated medical schools. Additionally, the Association is keenly interested in the state of the VA research program and this testimony will also address this important program.

Academic Affiliations

The VA health care system has three major missions: providing quality medical care to our nation's veterans; advancing medical, rehabilitation, and health services research; and training health care professionals. I would argue, as most people would, that the provision of health care to veterans is, and should be, the VA's number one priority However, the VA's education and research missions contribute substantially to both the quality and accessibility of VA health care services. Academic medicine shares these three missions of health care delivery, education, and research, and the affiliation agreements between the VA and medical schools are critical to achieving all three missions for both partners.

Over the more than 50-year history of affiliations between VA medical centers and medical schools, abundant evidence has accumulated of the advantages these partnerships provide to these three missions. The VA's ability to recruit and retain high-quality physicians and the access of veterans to the most advanced medical technology and cutting edge research are just two of the unique benefits derived from these relationships.

Affiliations are symbiotic relationships that benefit both the VA and the affiliated medical schools. Aside from the enriched patient care environment at the VA, both the educational and research programs of the medical schools are enhanced. Medical education depends, in part, on the hands-on experience by students and residents under careful supervision. In return for their participation in medical education, patients at VA medical centers gain access to talented faculty and state-of-the-art treatment options.

Over the last decade, hospital, medical and other health care services have undergone a shift in the way they are organized and provided. The advent of managed care and the associated new economic and price competitive realities have required medical schools and teaching hospitals to review their priorities and improve efficiency. The VA health care system has seen similar problems stemming from the relatively stagnant federal funding levels, which have not kept pace with the considerable increases in the cost and complexity of health care.
In response to these imperatives for change, both medical schools and teaching hospitals, as well as the VA health care system have made substantial shifts to a health care delivery model that emphasizes care in ambulatory and non-hospital clinic sites. At the same time, the VA health care system has seen a migration of veterans from the North and East to the West and South. Realignment of facilities and resources is inevitable; however, the effects of realignment on the affiliations must not be overlooked. Although the VA health care system can adjust to this demographic change through the VERA system, because academic affiliates have longer term commitments such as established residency programs, tenure of jointly appointed faculty, etc., it is essential that adequate lead-time is built in to any potential realignment proposals. Similar problems exist when VA looks to privatize service lines such as tertiary care centers. The drop in patient base and reduced support of specialties adversely affects not only the veterans who must utilize additional service sites, but the academic affiliate who must reassign faculty, find alternative training sites, and attempt to recoup lost financial resources.

Under the leadership of former VA Under Secretary for Health Kenneth Kizer, M.D., M.P.H., the VA reorganized its complement of medical centers around 22 regional systems known as Veterans Integrated Service Networks (VISNs). Under each VISN umbrella, several VA medical centers and affiliated medical schools work collaboratively to deliver health care to

veterans in their region. The new structure was designed to eliminate inefficiencies and duplication of services, and to maximize the effectiveness of limited health care dollars and resources.

The new structure also caused some strain on the VAMC medical center affiliations with medical schools. Rather than dealing with medical center directors who oftentimes were situated across the street, medical school deans now must deal with VISN directors who are sometimes hundreds of miles away. Certain growing pains associated with the VISN structure are inevitable given the large numbers of new individuals recruited to leadership positions from outside the VA and the rapidity and magnitude of the changes required. Compounding these communication problems, many of the new VISN directors lacked experience in the academic environment or with the needs of the academic affiliate. I believe it is only fair to say that some affiliate relationships between VISN directors and medical school deans have evolved more smoothly than others. In the past, Dean's Committees were the place that complaints could be aired and all the important decision-makers were at the table. Through the deans committees, medical school deans and local VA leadership regularly and effectively addressed problems associated with the affiliation. While Academic Partnership Councils (APCs) essentially replaced these committees, however the new APCs do not function in exactly the same way. Affiliate representation on the APCs is often at the university level and responsible for all the health professions, and the VA membership is at the facility level, rather than the VISN level, where the authority to make decisions on behalf of VA resides.

These issues combine to give many deans the impression that the welfare of the affiliation is not a critical success factor for the VISN Director. Deans vary widely in their views as to how supportive VISN Directors are of the affiliations, but many feel the VISN Directors view the affiliations as something that needs to be accommodated only after other factors are satisfied. The VA has recently implemented a pilot program as a performance measure for VISN Directors with regard to the affiliations. This "Learners Perception Study" is a good start; however, there are still no performance measures related to research or patient care collaborations. There is also a sense that VISN Directors are not uniformly supportive of the VA's research mission. Recently, the VA has begun implementing a new accounting system to account for research dollars through the Veterans Equitable Resource Allocation system and require the funds be re-invested in research rather than offset other VISN operations. The AAMC supports full implementation of this system.

The AAMC believes that the academic affiliations between the VA and medical schools are an important and valuable factor to both partners. As the national health care environment changes and the two partners restructure accordingly, it is essential that both parties and Congress take the affiliations into account when decisions are made regarding the realignment of facilities. Because the education and research missions of both VA and academic medicine rely so heavily on the affiliation agreements, it is essential that these missions are afforded adequate weight in the decision-making process.

VA Research and Development

The VA Research and Development program is one of the nation's premier research endeavors. The program was established to improve health care for veterans and to stress research into injuries and illnesses specifically relevant to the veteran population. A primary goal of the VA research program is to translate research results into clinical practice. To accomplish this goal, nearly 80 percent of VA scientists are clinical investigators, and approximately 70 percent of all VA dollars spent on research goes to clinical research. Additionally, because VA grantees must be VA employees – many of whom hold joint appointments at the affiliated medical school – the VA research program offers a dedicated funding source to attract and retain high-quality physicians and clinical investigators. This in turn ensures that our nation's veterans receive the highest quality health care.

However, the VA research program – through the medical and prosthetics appropriations line item – has been chronically underfunded and still does not have the buying power the program had in the mid-1980s. Although Congress rewarded the program with a generous $30 million increase in FY 2001 for a total budget of $351 million, a conservative estimate suggests that there is over $80 million worth of peer-reviewed merit-based research literally sitting on a shelf due to lack of funding. The list of approved but unfunded projects includes some related to quality of care, patient safety, telemedicine and alcoholism just to name a few. Additionally, VA

successfully leverages the appropriated dollars with other VA medical care funds and outside funding from other federal agencies and private sources to bring the total VA research enterprise to approximately $1.2 billion. With the obvious positive effects of VA research on the quality of health care, the AAMC recommends that additional funds be appropriated to the VA research program.

Conclusion

The AAMC believes that the academic affiliations between the VA and medical schools will play a vital role in securing a strong future for the VA health care system. Because of the obvious benefits – the access to high-quality faculty and treatments for the VA and enhanced education and research opportunities for the schools – both partners of the academic affiliations have come to rely on each other for activities directly related to their missions. As the national health care environment evolves and changes are necessary at the VA, it is essential that these affiliations are afforded adequate consideration in the decision making process. The AAMC sees the affiliations as essential to both the VA and the affiliated medical schools to achieve their respective missions. The AAMC will continue to work with VA officials in Washington on issues related to the affiliations through the Association's VA-Deans Liaison Committee which brings together VA and medical school leadership to discuss national issues of particular concern to the VA-medical school partnerships.

I would like to thank the Subcommittee for this opportunity to testify on these two important aspects of the VA health care system. I would be happy to answer any questions you may have.

Statement
of

George Thibault, MD
Chairman, Special Medical Advisory Group

Before the

Subcommittee on Health
Committee on Veterans' Affairs
U. S. House of Representatives

April 3, 2001

The Special Medical Advisory Group (SMAG) is composed of members of the medical, podiatric, optometric and allied science professions who provide advice and consultation to the Secretary and the Under Secretary for Health on matters relating to the care and treatment of disabled veterans, and other matters pertinent to the operations of Veterans Health Administration.

The SMAG has reviewed and advised the Under Secretary for Health through the dramatic transformation of the VA Health System from the inpatient care to outpatient model of care. This transformation has had an impact on the medical education, research, and aligning capital assets to veterans' needs.

Through this transformation the Under Secretary for Health appointed an expert committee, the residency Realignment Review Committee to advise him on changes that were needed to ensure that VHA's graduate medical education would meet present and future health care needs of both the VA and the Nation. Implementation of VHA's residency realignment goal of reducing specialty training was phased in over three years and completed with the beginning of academic year 1999-2000. This process was reviewed and monitored by the SMAG and members recognized the Office of Academic Affiliations for executing a plan based on the residency Realignment Review Committee recommendations.

On an ongoing basis the SMAG is updated on the Capital Assets Realignment for Enhanced Services (CARES) process. Members of the SMAG have consistently recognized the need to realign capital assets and agree that there must be established and clearly defined criteria when making decisions. In reviewing the objective criteria developed to measure future realignment options, the SMAG cautioned that values of weights need to be adjusted for regional variations and that a purely numerical approach, without qualified judgments,

could be a problem because it does not allow for unique situations in specific regional areas.

The members of the Special Medical Advisory Group are listed below:

Benjamin L. Cohen, D.O.
Vice President for Health Affairs for the Health Sciences Center
Executive Dean, Texas College of Osteopathic Medicine
University of North Texas Health Sciences Center

Jordan J. Cohen, M.D.
President
Association of American Medical Colleges

Joel A. DeLisa, M.S., M.D.
Professor and Chairman
Department of Physical Medicine and Rehabilitation
UMDNJ-New Jersey Medical School

Sue Karen Donaldson, Ph.D., R.N., F.A.A.N.
Dean and Professor of Nursing
Professor of Physiology, School of Medicine
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Alden N. Haffner, O.D., Ph.D.
President
College of Optometry
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Lawrence B. Harkless, D.P.M.
Professor and Director, Podiatry Residency Program
Department of Orthopedics/Podiatry Service
The University of Texas

Spero M. Manson, Ph.D.
Professor and Director
Division of American Indian and Alaska Native Programs
Department of Psychiatry
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Gordon T. Moore, M.D., M.P.H.
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Vice President and Chairman of Clinical Affairs
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John E. Wennberg, M.D.
Center for the Evaluative Clinical Sciences
Dept. of Community & Family Medicine
Dartmouth Medical School

SERVING
WITH
PRIDE

TESTIMONY

of

RICHARD JONES
AMVETS NATIONAL LEGISLATIVE DIRECTOR

before the

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

regarding

THE CURRENT STATE AND FUTURE CHALLENGES
OF THE VA HEALTHCARE SYSTEM

Tuesday, April 3, 2001
2:00 P.M.
Room 334
Cannon House Office Building

A M V E T S

NATIONAL
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MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

It is an honor to appear before you and the distinguished members of the Committee on Veterans' Affairs Subcommittee on Health regarding the current state and future challenges of the VA healthcare system. For the record, AMVETS has not received any federal grants or contracts during the current fiscal year or during the previous two years in relation to any of the subjects I will discuss today.

Mr. Chairman, at an earlier time in our history, one of our most revered leaders said, "The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive the veterans of earlier wars were treated and appreciated by their nation." It is indeed interesting today to note how perceptive George Washington's observations were.

At a time in our history when America is prosperous and when the national debate seems increasingly focused on handling budget surpluses rather than dealing with deficits, we find ourselves in a curious dichotomy.

Notwithstanding our prosperity, for the past several years, vital VA healthcare programs keyed to assisting veterans have, in the main, received benign neglect. These trends deeply trouble us because we believe, like you, that a sacred commitment to those—both past and present—who wear this nation's uniform is not being honored to the extent our forebears intended.

The VA healthcare system is a unique and irreplaceable national investment, critical to the nation and its veterans. Access to high quality health care remains essential to veterans. In fact, many veterans consider health care to be one of the most important benefits they receive. And, it is our obligation to provide it.

If we are to honor our obligation to the brave and dedicated men and women who have worn this nation's uniform, we should clearly understand their legacy – which is freedom. And, in this understanding, we must come to grips with the fact that freedom is not free. Its costs are measured in terms of lives lost and citizen soldiers who, together with their families, bear the scars and infirmities of their service throughout the remainder of their adult lives.

Mr. Chairman, there are numerous challenges confronting us today—not the least of which is the future of veterans' health care. In the decade since the Gulf War, veterans have faced a sea of change in VA's healthcare delivery. Many of these changes have been for the better, but there remain serious concerns in the government administered programs created to support veterans in their times of need. There is something wrong when the delivery of veterans' medical care is denied, rationed, or unduly delayed due to the lack of resources.

This is not what our Nation intended as its "grateful" response to the millions of men and women who have defended, and continue to defend, freedom throughout the world.

Indeed, we do not believe these circumstances represent what you, your subcommittee and full committee have collectively fought for on behalf of veterans. AMVETS truly appreciates the support you have provided in your attempt to fund the Department of Veterans Affairs at the necessary levels to allow it to deliver the world-class services of which it is capable.

As you know, AMVETS—together with the Disabled American Veterans, the Paralyzed Veterans of America, and the Veterans of Foreign Wars—coauthored *The Independent Budget* for fiscal year 2002. We believe it is a balanced and responsible analysis of VA's funding requirements, and, in years past, we have been dismayed by administration budget submissions that fell woefully short of these requirements.

Last year, thanks in large measure to House leadership and commitment VA fared better. Still, there are serious funding shortfalls in the president's fiscal year 2002 proposal, which we hope can be responsibly addressed this year.

For example, the full Committee's recent call for a $2.1 billion increase in VA's discretionary spending in FY02 is the right thing to do, and we thank you for taking the initiative. Its result is a significant increase in the House budget approved last week.

Mr. Chairman, as we continue to move forward together in this new millennium, the sustained availability of quality health care is central to VA's mission.

And, one of the first elements of successful VA health care should be its research arm.

With years of discipline and dedication, VHA has become a world-class leader in advancing medical science. It has consistently pioneered R&D initiatives in areas that have directly benefited, not only veterans, but also our entire population.

It was VA researchers who developed the modern protocols for tuberculosis following World War II; VA researchers who led the nation in developing geriatric medicine and research; they set the standard for better-fitting, lighter, artificial limbs through development of the Seattle limb system; and they are recognized for their leadership in studying post-traumatic stress disorder.

In other areas, VA's research produced the cardiac pacemaker; they performed the first successful kidney and liver transplants; they pioneered home dialysis techniques; and they developed the nicotine patch and other therapies to assist smokers. We believe VA's research arm is a true national resource whose efforts directly benefit veterans and non-veterans alike.

Nevertheless, inadequacies within VA's budgets in recent years have truly challenged its ability to sustain its enviable position as a high quality healthcare provider. We have watched as overworked medical staffs attempted to carry on, but the bottom line is that veterans are waiting longer to be seen; vital services have been reduced or eliminated and in the process, the veterans' population has been woefully underserved.

We believe that VHA is currently well led by Dr. Tom Garthwaite and his team, but adequate funding will remain central to their ability to sustain the timely delivery of quality health care to our veterans.

We believe the following initiatives need to be incorporated, funded, and responsibly managed within VHA's overall health care program:

- Increase sharing agreements between VA and DoD medical facilities to allow veterans better access to health care to which their military service entitles them.
- Establish appropriate facilities and resources dedicated to the diagnosis and treatment of women veterans at all VA facilities. Women veterans represent nearly two million of the veterans' population and about 14 percent of our current armed forces.
- Eliminate the means test for veterans who served their country during periods of national emergency or war. A veteran is a veteran. We do not apply a means test when we send him or her into harm's way. Why then should we impose a post service price?
- Ensure adequate funding is provided for VA's ongoing medical care and mental health treatment programs for homeless veterans.
- Include emergency and long-term care within VA's healthcare services.

Mr. Chairman, it is important to note that despite more than a year passing since enactment of the Veterans Millennium Care and Benefits Act, VA has yet to implement regulations on institutional and non-institutional long-term care. In fact, VHA continues to reduce its impatient long-term care capacity and enrolled veterans do not know they may have access to these programs. We re-emphasize our support of *The Independent Budget* recommendation that Congress cover the costs of long-term care mandated in

Public Law 106-117. Additionally, Congress should provide adequate funding for respite, homemaker, and state home grants not covered in the millennium care initiative.

Mr. Chairman, the common theme in our efforts to provide appropriate health care for our veterans today and into the future is that our veterans are indeed special. They are a unique national resource to whom we owe an enormous debt of gratitude for their service, their sacrifice, their patriotism and their unswerving dedication to America.

In sum, AMVETS firmly believes, as stated in *The Independent Budget*, that adequate funding is the central issue challenging the future of the VA healthcare system.

In March 13 testimony, for example, we stated our serious concern about the steep decline in VA's medical care facilities due mainly to inadequate funding over past years. And, we gave full support to HR 811, the Veterans Hospital Emergency Repair Act.

Your action, in concert with House leadership, is commendable in making the Veterans Hospital Emergency Repair Act one of the first pieces of veterans' legislation approved by the House of Representatives in the new Congress. Of course, the Senate also needs to accept their stewardship responsibility before declining conditions result in more serious problems for veterans and VA employees alike.

This concludes my testimony. Thank you for extending the opportunity to appear before you today and thank you for your support of veterans. We believe the price is not too great for the value received.

VETERANS OF FOREIGN WARS

OF THE UNITED STATES

STATEMENT OF

PAUL A. HAYDEN, ASSOCIATE DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO THE
STATE OF THE VETERANS AFFAIRS' HEALTH CARE SYSTEM

WASHINGTON, DC APRIL 3, 2001

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.6 million members of the Veterans of Foreign Wars of the United States and our Ladies Auxiliary, I would like to express our gratitude for the opportunity to participate in today's hearing. It is indeed a privileged role that the VFW takes quite seriously.

Rather than inundate the committee with a laundry list of concerns, I would reiterate our support for the Medical and Construction Programs sections of the Independent Budget, while focusing our attention on what we believe are the most critical obstacles facing the Veterans Health Administration (VHA).

The VFW believes that the mission of the VHA, simply stated, is to provide all veterans with timely access to quality health care. As we all know, this is easier said, than done, as VHA must maintain the United States' largest health care system while serving an increasingly aged veterans population that demands more specialized long-term care.

The first major obstacle facing VHA is the ability to sustain and enhance its physical infrastructure. Successive years of shortfalls in major construction funding and virtually flat-lined allocations for minor construction, even as the population of veterans seeking health care is rapidly on the rise, have seriously eroded VHA's ability to maintain the facilities and state-of-the-art equipment necessary to provide modern health care services. A recent visit by VFW Field Representatives to the Atlanta Veterans Affairs Medical Center (VAMC) highlights the

lack of available construction funds in determining that that facility is still not completely handicapped accessible.

While the VFW currently enjoys an open dialogue with the VHA as they attempt to better allocate their physical assets through the implementation of the Capital Asset Realignment for Enhanced Services (CARES) process, we are concerned that as this process unfolds a moratorium on needed new construction and renovation projects will result. We strongly urge VHA and Congress to continue funding critically needed construction programs until the CARES process can be fully executed.

In tandem with the CARES process is the need for VHA to ensure open channels of communication with local veterans and/or their representatives who may be affected by proposed local closures or renovation projects.

The second major issue of concern we would like to address is veterans' timely access to health care. It is an outrage that there are areas of the country where veterans must wait up to six months or a year before receiving their first health care appointment. It is our understanding that one such area of note is the Lebanon VAMC in Pennsylvania that currently has a backlog of 4,000 applicants seeking initial enrollment into the VA Health Care system. These veterans and others like them around the country cannot even schedule an appointment with a health care professional until their paperwork is processed.

Once scheduled for an appointment, access continues to be a problem for some veterans. Even though the VA has had measurable success in reaching out to veterans by building and staffing such effective and popular non-institutional health care venues as Community Based Outpatient Clinics (CBOCS), there are still veterans residing in places such as Montana who must drive over 200 miles one-way for an appointment. Additionally, veterans needing specialty services such as orthopedics or prosthetics are averaging six months to one year for an appointment and follow-up appointments can average more than 90 days in places such as the Boise VAMC in Idaho. These problems represent an ineffective and inefficient stewardship of limited resources and what amounts to be in some cases a denial of care. Our nation's veterans deserve better.

Furthermore, we are troubled by Secretary Principi's recent comments before the Senate Veterans Affairs Committee that a cost saving option being considered by VA would cap

enrollment of Category 7 veterans. We are adamantly opposed to this suggestion and feel that all veterans, regardless of category, should receive care.

We also understand that VHA can only provide health care to the extent that resources are available. We believe the financial situation presented by Veterans Integrated System Network (VISN) 1, 3, 13 and 14 this past year demonstrates the weaknesses of the Veterans Equitable Resource Allocation (VERA) process. Each one of these VISN's required supplemental funding. Clearly, the age of a region's veteran's population and their particular health needs must be more carefully weighed.

Finally, we turn our concern to the implementation of the Veterans Millennium Health Care and Benefits Act, PL 106-117. A main component of the Act authorizes VA to reimburse certain veterans for emergency services at a non-VA facility, when VA facilities are not readily available. This provision became effective May 29, 2000, however, claims will not be paid until regulations have been published. Veterans are being hounded for collections even though the VA provides letters to private providers claiming intent to pay. Aside from the emergency services, the much-needed long-term care provisions have yet to be implemented. We strongly recommend that Secretary Principi expedite the implementation of all regulations pertaining to the Millennium Act.

As the VHA moves forward to implement improvements to the overall health care delivery system, we continue to urge better outreach and communication with the veteran and their representatives. Communicating changes to veterans is key to garnering their support and input.

This concludes my statement and I will be happy to respond to any questions you or the members of this subcommittee may have for me at this time.

STATEMENT OF
JOY J. ILEM
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
HOUSE VETERANS' AFFAIRS COMMITTEE
SUBCOMMITTEE ON HEALTH
April 3, 2001

Mr. Chairman and Members of the Subcommittee:

I am pleased to present the views of the Disabled American Veterans (DAV) regarding the current state and future challenges facing the Department of Veterans Affairs (VA) health care system. Many severely disabled veterans utilize VA's health care services and are directly affected by the quality of care they receive. Therefore, this issue continues to be one of our foremost concerns and is of great importance to the DAV's more than one million members and their families.

The Veterans Health Administration (VHA) operates the largest health care system in the United States, with 173 medical centers, 771 ambulatory care and community-based outpatient clinics, 134 nursing homes, 42 domiciliary-care facilities, 206 readjustment centers, and 72 comprehensive home-care programs. In fiscal year 2000, VA provided care to nearly 3.8 million of the 4.8 million enrolled individuals, the vast majority of whom have service-connected disabilities or qualify on the basis of low income. VHA provides a wide range of services, including specialized services and treatment for blind rehabilitation, spinal cord injury, brain trauma, post traumatic stress disorder (PTSD) and amputations.

The DAV, in concert with the other *Independent Budget* Veterans Service Organizations (IBVSOs), AMVETS, Paralyzed Veterans of America, and Veterans of Foreign Wars, have expressed serious concerns about the current state of VHA. The system is experiencing serious difficulties in providing quality and timely care and the specialized services veterans need consistently nationwide. We believe that adequate funding is the central issue governing VA's ability to deliver high-quality and accessible services to veterans.

Three years of flat-line appropriations have taken their toll on VA's medical care system and threatened its viability. Repeated budget shortfalls have had a direct impact on veterans' ability to access care. As the Nation's largest direct provider of health care services, VA's programs must be adequately funded to support its congressionally mandated missions.

We acknowledge and sincerely appreciate the efforts of the House Veterans' Affairs Committee in recent years to provide additional funding for VHA. However, years of inadequate budgets have negatively impacted the system and prevented VHA from delivering the continuum of health care services veterans need. VA health care is a Federal responsibility that must be met fully by Congress and the Administration through adequate appropriations.

Appropriately managing the VA health care system is understandably a difficult task, given its size and variability. It faces ever increasing problems as funding shortfalls continue, new laws are passed, and additional demands are placed on the system. Unless VHA is provided sufficient resources, it will be unable to fulfill its primary mission. Below, we address some of the problems VHA is facing and briefly outlines areas of major concern to DAV.

WAITING TIMES

A significant increase in demand for care has resulted in many veterans being denied access to timely health care services at VA facilities. We repeatedly hear complaints from veterans that they have to wait too long for the health care they need. VHA has set reasonable timeliness goals for itself but has fallen short of providing equal and timely access to routine and specialty care for its enrolled veteran population throughout the system. Unacceptable waiting times in many cases are directly related to resource limitations.

DAV asks its Hospital Service Coordinators to provide information on a monthly basis concerning waiting times for routine primary care visits, follow-up appointments, and specialty clinic appointments in VA facilities nationwide. We have received notice that many facilities have a 30-60 day waiting period for primary care and specialty care appointments.

The DAV feels that VA management at headquarters and in the field should be held accountable for identifying and addressing problems related to delivery of timely quality care at VA facilities.

LONG-TERM CARE

The Veterans Millennium Health Care and Benefits Act was signed into law on November 30, 1999. This legislation expanded VA's mission to maintain capacity for specialized care for aging veterans. However, more than a year has passed since the passage of the law and we are still waiting for implementing regulations.

Some facility administrators are apparently reluctant to fulfill the Millennium Act's mandate and restore inpatient long-term care programs. In the meantime, lengths of stay in inpatient long-term care units are limited and veterans in most need of this service are shuffled out of the system. Additionally, because of the reduction in inpatient long-term care capacity, enrolled veterans are not confident that VHA will be able to provide the long-term care services they need.

The shift to primary care has negatively impacted on specialized care programs for age-related conditions such as dementia, psycho-geriatric evaluation and treatment, and end of life care. These programs associated with advanced age are essential in providing a full continuum of health care services. Given a rapidly aging veteran population, VHA should address the likely increase in demand for these types of services.

VHA must meet its obligations and ensure that the Millennium Act is fully implemented in fiscal year 2001. Congressional oversight is necessary to ensure VHA is maintaining capacity

of its in-house extended care staffing and services. Additionally, new appropriations are needed to cover the costs of long-term care mandated by Public Law 106-117.

EMERGENCY CARE

The 1999 Veterans Millennium Health Care and Benefits Act also authorized VA to reimburse veterans for the cost of emergency care services provided at non-VA facilities if they lack health insurance and are enrolled in the veterans health care system. However, no implementing regulations have been issued, nor has information been disseminated informing eligible veterans of access to these services.

Speedy implementation of emergency care regulations mandated by the Millennium Bill are imperative to ensure that veterans are well informed about access to emergency care and receive reimbursement when appropriate for such care.

SPECIALIZED SERVICES

The DAV views VHA's programs for veterans with special needs as the core of the VA health-care system. Many VA programs, directed at certain disability groups affected by blindness, serious mental illness, traumatic brain injury, spinal cord injury, amputation and post traumatic stress disorder, are unmatched in excellence. Unfortunately, there has been a continuing erosion of VHA's specialized services for veterans suffering from these severely disabling conditions.

Despite statutory requirements that VHA maintain the capacity to provide specialized services, many specialized programs have been dismantled or severely compromised by staff shortages or reorganization.

Mental Health/Substance-Use Disorders

VHA has not maintained its capacity to provide services to veterans with serious mental illness, post traumatic stress disorder, and substance-use disorders. We have seen cutbacks and closures of many of VA's specialized inpatient programs.

The shift to primary care has had an erosive effect on VA's premiere mental health programs. Although VA has provided better access to community-based primary care, many community-based outpatient clinics (CBOCs) do not provide mental health care services. There has not been adequate development throughout the system of necessary mental health services to replace traditional inpatient programs. Some seriously mentally ill patients may be at risk without the structured support of an inpatient program and routine monitoring by mental health professionals. Without appropriate VA services, these patients may experience homelessness and other related problems and have to rely on other community resources for assistance. It is essential for VHA to maintain equal access to a full continuum of mental health services across the VISNs for veterans.

Additionally, outpatient care is not always appropriate for all veterans with specialized needs. In the past, VA was well known for its excellent programs for veterans dealing with substance-use disorders. These lengthy and intensive inpatient programs were highly successful and helped many veterans to overcome their addictions and once again lead productive healthy lives. However, due to cutbacks many of these programs are no longer available. Some counselors believe that veterans seeking treatment for substance-use disorders are at a higher risk for relapse if they do not have access to traditional long-term inpatient programs. Likewise, shifting serious chronic mentally ill veterans to primary outpatient care settings is not always providing satisfactory care/treatment for these patients.

Decisions about specialized services must be based on patient need and appropriateness of care rather than cost driven. Adequate funding is necessary to staff specialized programs with qualified individuals. Congressional oversight to maintain these specialized services is necessary to protect our Nation's most vulnerable veterans.

Prosthetics and Sensory Aids

Veterans who require prosthetics and sensory aids continue to encounter obstacles to receiving timely and appropriate services and equipment, despite program enhancements. We applaud the decision to centralize and fence VHA's entire prosthetics budget and impose accountability on key personnel for budget execution decisions. These measures help to alleviate the inappropriate pressures placed on clinicians to find cost-savings at the expense of disabled veterans. However, we still have concerns about the prosthetics programs.

Facility directors must be held accountable for ensuring that prosthetic services within their VISNs are appropriately supported and staffed. Additionally, VHA officials must remain diligent to ensure that national prosthetic policies are properly followed. Quality and accuracy of prosthetic prescriptions must take precedence over cost-saving measures.

Veterans continue to report that orders for prosthetic devices are not being delivered in a timely manner. Staff shortages and excessive workloads have resulted in a delay in filling orders. Delayed prosthetics orders can potentially lead to grave or morbid outcomes for at-risk patients. Congress and the Administration must provide adequate resources to ensure there are appropriate staffing levels in prosthetic departments and qualified representatives who have the requisite training and experience to fill critical positions. VHA must provide oversight and guidance on the restructuring of its prosthetics programs to ensure consistency nationwide.

Blinded Veterans

VA's Blind Rehabilitation Service (BRS) is a comprehensive program to rehabilitate our nation's blinded veterans. Unfortunately, because of funding reductions, this excellent program is in danger. Funding for critical staff positions have been frozen, postponed indefinitely, or eliminated. These and other factors have resulted in delayed access to this specialized service for some veterans. Existing comprehensive programs must not be dismantled until other alternative models of service delivery are identified and tested. VHA must restore the bed capacity in blind rehabilitation centers to the level that existed at the time of the passage of Public Law 104-262.

VHA must ensure appropriate staffing levels are maintained and rededicate itself to the excellence of programs for blinded veterans.

Spinal Cord Dysfunction

The comprehensive care provided at VA's specialized centers for spinal cord injury/disease (SCI/D) is second to none. Unfortunately, these programs have been seriously degraded over the past five years by substantial staff reductions. Despite a congressional mandate to maintain system capacity, local officials reduced staff and were only able to operate 65 percent of the SCI/D beds reported as operational in 1996. This has resulted in delayed or denied care to veterans with SCI/D and threatens the quality of care these veterans receive.

Last year local managers were required to identify the additional resources necessary to restore mandated staffing levels for SCI/D centers. However, this objective has not been accomplished. VHA must provide sufficient funding for additional extended care beds and the more than 400 additional medical professionals required to restore capacity of the SCI/D health care system.

Homeless Veterans

It is estimated that, on any given night, approximately 275,000 veterans are homeless. Access to VA benefits and specialized services is essential for many homeless veterans to regain and hold steady employment. A comprehensive care approach, including specialized programs for mental health care and substance abuse problems, offer homeless veterans a hand up and an opportunity to break the cycle of homelessness.

We need an accurate assessment from VHA as to the staffing and funding levels dedicated to homeless services in each medical center and the types of programs currently functioning to address the complex needs of the homeless veteran population.

Women Veterans

Since the restructuring of the Veterans Health Administration and implementation of a primary care model throughout the system, we have seen the discontinuation of several dedicated women's health clinics. The DAV is seriously concerned about the incidental impact of the primary care model on the quality of health care delivered by VHA to some women veterans.

Information from a January 2000, VA conference report noted that women veterans comprise less than 5 percent of VA's total population and, as a result, VA clinicians are generally less familiar with women's health issues and less skilled in routine gender-specific care. With the advent of primary care in VA, clinicians see a reduced ratio of women. Therefore, it is unlikely that they will gain the clinical exposure necessary to develop and maintain expertise in women's health.

Women's clinics should be maintained to ensure women veterans are not subjected to lower standards of clinical expertise in their health care, and VA Women Veterans Health Programs must be adequately funded to avoid a decline in services.

We also have concerns about privacy issues at VA facilities for women veterans, and about their ability to access specialty care services for mental health disorders, sexual trauma, and eating disorders.

Gulf War Veterans

Many Persian Gulf War (PGW) veterans have suffered tremendously for the last decade with ill-defined health problems. Scientists and medical researchers continue to search for answers and contemplate the various health risk factors associated with service in the Persian Gulf. However, no single cause has yet been determined. Some PGW veterans face challenges in obtaining appropriate health care and many are dissatisfied with what they consider limited treatment regimes/options available at VA to treat their chronic debilitating symptoms.

These veterans must have access to health care services and treatment regimens that will help them regain their good health and mental well-being. VA must tailor its health care services to meet the unique needs of PGW veterans.

CONSTRUCTION/MAINTENANCE

VA has neglected its health care facilities nationwide to the point that the system's infrastructure has fallen into decay. Annual appropriations for major and minor construction projects have decreased sharply, from $600 million in fiscal year 1993 to only about $200 million in fiscal year 2000. Additionally, there has been a resistance to funding any major projects before the Capital Assets Realignment for Enhanced Services (CARES) process has been completed. We fear that continued neglect of the system's facility assets may compromise the quality of veterans' medical care.

VA must maintain and improve its existing health-care infrastructure. As the House Veterans' Affairs Committee has pointed out, the CARES project will take many years to bear fruit. In the meantime, VHA must protect its assets and ensure that the delivery of health care services to sick and disabled veterans is not interrupted or that that their lives are not put at risk because of needed repairs, outdated structures, or unsafe buildings.

We appreciate the recent action taken by the full Committee on the Veterans' Hospital Emergency Repair Act (H.R. 811). This legislation would authorize immediate measures to begin a course to reverse the deterioration of facilities and the inevitable consequent decline in the quality of health care for veterans. While we believe this is a good first step, more must be done through regular appropriations in the annual budget for VA construction.

BILLING ISSUES

We continue to receive complaints from disabled veterans regarding billing problems within VHA. Veterans and insurers are constantly frustrated by inaccurate and inappropriate billing for health care services. We are especially troubled about reports of billing for care that is secondarily related to a service-connected condition. Some facilities have used these unscrupulous methods to compensate for inadequate funding and less than satisfactory collection practices. To function properly and efficiently, VHA must adopt and adhere to appropriate billing practices. Inappropriate billing practices for care of conditions directly associated with service-connected conditions is unacceptable and must stop immediately. Billing for secondary conditions forces veterans to reopen their claims and causes an unnecessary burden on the Veterans Benefits Administration.

NURSING SHORTAGES

There are simply not enough nurses to care for the growing number of VA patients. Failure to address the impact of inflation has led to serious problems with recruitment and retention of vital health care professionals, especially VA's registered nurse staff. The long overdue pay raise provided to VA nurses by Congress last year will help to ease the shortage of this critical VA resource. However, the impact of a stressful work environment on an aging nursing workforce, coupled with mandatory overtime requirements, cross training, and other factors, could have a serious effect on the quality of care registered nurses are able to provide to our Nation's veterans. VHA must act responsibly and address these concerns.

CONCLUSION

The DAV recognizes that VA has made a genuine effort to address problems associated with management of its health care system. But clearly, more needs to be done. VHA must honestly assess and request accurate funding levels needed to fulfill its mission of providing quality and timely health care services to our Nation's veterans.

VHA will continue to face the same problems in the future if adequate resources are not provided. In fact, its problems will most likely be compounded in the future unless aggressive steps to correct deficiencies are taken now. It is truly disgraceful that the Nation's largest health care system has been allowed to fall into a state of disrepair and overall decline. We may be serving our veterans, but are we serving our veterans well?

Once again, veterans' priorities face serious competition for Federal resources. The new Administration and Congress have the opportunity and the ability to make good on the Nation's historic obligation to those who served in the Armed Forces. We need to not only strengthen but improve the quality and efficiency of services delivered to our Nation's veterans. To do less is counter to the very reason the department was established "To Care For Those Who Have Borne the Battle."

STATEMENT OF JAMES R. FISCHL, DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
THE CURRENT STATE AND FUTURE CHALLENGES OF
THE VA HEALTH CARE SYSTEM

APRIL 3, 2001

Mr. Chairman and Members of the Subcommittee:

The American Legion welcomes the opportunity to communicate its views on the current state of and future challenges facing the Department of Veterans Affairs (VA) health care system. The American Legion appreciates the Committee's report on the Fiscal Year (FY) 2002 budget for veterans' benefits and services. Today's hearing provides an occasion to familiarize the Subcommittee with an overview of The American Legion's recommendations to improve and strengthen the medical care services provided by VA

With the support of this Subcommittee, the VA health care system has made significant improvements in the delivery of medical care to the nation's veterans over the past several years. Eligibility reform, enrollment, the Veterans' Millennium Health Care and Benefits Act, and recent funding increases have all helped VA begin the necessary transition to modernize its medical care delivery system. The American Legion and the nation's veterans appreciate these efforts. The American Legion testified about the need for these changes before this Subcommittee previously. Today, the transformation of VHA to a more modern health care delivery system, although much further along than five years ago, is still unfinished.

The American Legion's blueprint for modernization of the Veterans Health Administration (VHA) is contained in the proposed GI Bill of Health. Once completely enacted, the GI Bill of Health will provide improved access to veterans' health care, provide medical care to dependents of eligible veterans, provide expanded choices for obtaining medical care to the nation's retired military members and to their eligible dependents, and develop new appropriated and non-appropriated funding sources for VHA.

President Bush is heading in the right direction by directing Secretary Principi to convene a task force to study methods to improve VA health care. The American Legion supports this effort and is committed to working with the task force to find the right formula to strengthen VA health care for both the short-term and the long-term.

Veterans Health Administration

The size and complexity of VHA requires a nearly $900 million annual funding increase to offset the cost of medical care inflation and provide employee pay raises. This year, greater energy costs nationwide have also created an unexpected drain on available funding. For these reasons, along with the expanded service mandates of the Millennium Bill, The American Legion believes the President's proposed increase of $1 billion in VA funding for FY 2002 is insufficient. The American Legion testified before this Committee in September 2000 and again earlier this month for a minimal increase of $1.3 billion in VA health care for FY 2002.

In our view access to quality care is directly related to available funding. The additions in VA health care funding of the past few years were needed to surmount the negative effects of several years of flat-line funding. The American Legion has adopted the GI Bill of Health as a guide for long-term funding improvements within VHA. By adopting the recommendations contained within the GI Bill of Health, Congress would develop new revenue sources for VHA and place less reliance on appropriated funding to provide VHA with the means to meet all of its increasing demands.

Congress must continue to support improvements in VHA funding to maintain a world-class health care system. There are precious little additional efficiency savings expected throughout VHA. Yet, those veterans now enrolled and receiving VA health care will continue to rely on VHA for the foreseeable future. The American Legion believes that Congress must examine how to balance the annual appropriations process with additional funding that will not be offset by the Office of Management and Budget (OMB). The American Legion believes that one of the strategic goals of VHA should be to continue seeking opportunities to increase non-appropriated funding sources.

The American Legion is concerned about the impact of a lack of needed funding in specific Veterans Integrated Service Networks (VISNs). As you may be aware, the West Texas VA Health Care System is planning on closing all inpatient psychiatric beds and contracting for this level of care with the State Hospital in Big Spring, Texas. Before VHA implements this plan, The American Legion recommends a thorough review of the proposal to determine the impact on care provided to eligible veterans.

The overall guiding principle for VA must be enhanced service to veterans, their dependents, and survivors. This requires improving access to health care and the quality and timeliness of care. Specific American Legion objectives to strengthen VA health care include:

- **Set the veterans' health care system on a sound financial footing for meaningful long-term strategic planning and program performance,**
- **Improve clinic appointment scheduling for access to medical treatment,**
- **Enact equitable Medicare subvention legislation,**
- **Establish pilot programs to provide health care to certain dependents of eligible veterans,**
- **Improve cooperative arrangements between VA and DoD's TRICARE system,**
- **All third-party reimbursements collected by VA should be used to supplement, rather than offset, the annual Federal discretionary appropriations.**

Millennium Bill

In 1999, Congress enacted the Veterans' Millennium Health Care and Benefits Act (Public Law 106-117). The legislation authorized the Secretary of Veterans Affairs to reimburse veterans' costs for non-emergency care, provided they are enrolled in VHA and lack health insurance. When fully implemented, this provision will cost nearly $500 million annually. The bill also expanded VA's mission to maintain specialized capacity to care for aging veterans. The demands of the aging veterans' population will create further funding pressure on VHA. The American Legion believes that Congress must fully fund the costs of these new mandates.

Hepatitis C and Type 2 Diabetes

Hepatitis C has become a national public health challenge and The American Legion is deeply concerned by the prevalence of the Hepatitis C virus in the veteran population. According to government estimates, there are approximately 4 million Americans with this virus and many have serious health problems, such as cirrhosis of the liver and liver cancer. According to VA estimates, 400,000 veterans may be infected with this disease. The reason why veterans are more likely to have Hepatitis C than the non-veteran population is because of the presence of a variety of risk factors inherent in military life and the increased risk of exposure by those serving on active duty.

The American Legion is generally pleased by VA's responsiveness to the Hepatitis C problem. In light of study data showing an increased incidence of this disease among the veteran population, The American Legion asked the VA Secretary to consider issuing regulations providing for presumptive service connection. Proposed regulations are now under development and will be available for public comment later this year. When finalized, these are expected to result in a substantial influx of claims for disability compensation and VA medical care. While these regulations will assist veterans in establishing entitlement to disability and medical care benefits, we believe that Congress should codify by statute the presumptions, which will apply to Hepatitis C claims. This will ensure VA has the necessary resources to fully and fairly adjudicate this type of claim and provide the support needed for its outreach, information, and treatment programs.

VA also expects to receive 105,000 new claims for service-connection of Vietnam veterans who have been diagnosed with Type 2 diabetes. Both Hepatitis C and Type 2 diabetes will add significant cost and workload to the VA health care system.

Medicare Subvention

Public Law 105-33, the Balanced Budget Act of 1997, established VA's Medical Care Collection Fund (MCCF) and requires that amounts collected or recovered after June 30, 1997, be deposited in this account. Beginning October 1, 1997, amounts collected in the fund are available only for furnishing VA medical care and services during any fiscal year; and for VA expenses for identifying, billing, auditing, and collecting of amounts owed the Federal government for such care. Public Law 105-33 also extended to September 30, 2002, the following Omnibus Budget Reconciliation Act (OBRA) provisions:

- Authority to recover co-payments for outpatient medications, nursing home and hospital care;
- Authority for certain income verification; and
- Authority to recover third-party insurance payments from service-connected veterans for nonservice-connected conditions.

The Health Service Improvement Fund was established to serve as a depository for amounts received or collected under the following areas as authorized by title 38, U.S.C., Section 1729B:

- Reimbursements from DoD for TRICARE-eligible military retirees;
- Enhanced-use lease proceeds; and
- Receipts attributable to increases in medication co-payments.

The Extended Care Revolving Fund was also established to receive per diems and co-pays from certain patients receiving extended care services authorized in title 38, U.S.C., Section 1710B. Amounts deposited in the fund are used to provide extended care services.

Congress is providing VA with the authority to bill, collect, retain, and use revenues from sources other than Federal appropriations. However, the country's largest health care insurer (Medicare) is exempt from billing; yet, its beneficiaries are welcomed and encouraged to receive treatment in VA medical facilities.

Currently, approximately 10.1 million veterans are Medicare-eligible solely based on their age. Criteria for Medicare-eligibility are different than eligibility for treatment in VA. In the VA health care network, certain veterans are eligible for treatment at no cost for medical conditions determined to be service-connected. Medicare-eligibility is ***not*** a priority or criteria for health care at no cost in the VA health care system. Other veterans are eligible for treatment at no cost, because they are economically indigent. All other veterans must pay for treatment received.

Medicare subvention would allow VA to seek reimbursement from the Health Care Financing Administration (HCFA) for treatment of nonservice-connected medical conditions of Medicare-eligible veterans. VA and HCFA should explore either the Fee-For-Service or Medicare+Choice options or both. Medicare-eligible veterans should not forfeit their Medicare health care dollars because they prefer VA health care to health care offered in the private sector.

More than 734,000 Medicare beneficiaries have lost HMO coverage over the past two years and another 934,000 seniors will be dropped by their HMO plans this year. Many VA-eligible beneficiaries are included in those dropped from coverage and will eventually come to VA for care. The argument that VHA is already reimbursed for its Medicare population and that Medicare subvention will result in double funding is mistaken. VHA is now mandated to provide care to all seven-priority groups. As more Medicare-eligible veterans seek first time care in VHA, health care costs and subsequent waiting times will increase. It is imperative that

Congress examine this issue and take the actions necessary to ensure that VHA receives all funding necessary to execute its health care mission with quality and in a timely manner.

Medicare subvention for VA must be included in any planned Medicare reform legislation passed in the 107th Congress. Access to VA health care is an earned benefit. No Medicare-eligible veteran, treated for a nonservice-connected medical condition, should be deprived of his or her Federal health care insurance dollars to pay for the care received in a VA medical facility.

TRICARE

The most significant recent change in military health care is the introduction of TRICARE - DoD's regional managed care program. TRICARE is facing many challenges in providing and maintaining a quality health care delivery system for active duty military personnel, military retirees, and dependents.

DoD continues to confront severe administrative problems with TRICARE. The American Legion is extremely concerned how these problems will be fixed and if DoD can guarantee TRICARE's long-term success.

Some reasons why TRICARE is failing to meet the expectations of its beneficiaries include:

- Infrastructure and financial problems,
- Problems with provider networks – resulting in weak network links to subcontractors,
- The inability to attract and retain qualified health care contractors,
- No financial tracking system outside of the military treatment facilities,
- Difficulties in processing claims in a timely manner,
- TRICARE lacks portability between all 12 regions, and
- Military retirees and their dependents are required to pay an annual enrollment fee.

The American Legion believes that VHA can greatly assist DoD through expanded authority to provide care to TRICARE beneficiaries. With limited budgets, both VA and DoD must discover innovative ways to provide care to active duty personnel, to all veterans and military retirees, and to eligible dependents.

Five years ago, it was impractical to suggest that VA was capable of assisting DoD in resolving many of its patient treatment problems. Today, VHA is in a much better position organizationally, to assist with the delivery of health care to DoD beneficiaries. The American Legion believes that VA and DoD should better coordinate medical care and services to the extent possible, thereby eliminating duplication of effort and achieving greater cost efficiencies. With proactive planning, VHA can become the largest single provider of health care to America's veterans, military retirees, and their dependents. DoD could then assume the responsibility of providing health care to active duty servicemembers, Reserve Component members, and their dependents.

Congress recognized the utility of having VHA play a greater role in the treatment of TRICARE beneficiaries when it passed the Veterans' Millennium Health Care and Benefits Act (PL 106-117). This legislation requires VA and DoD to enter an agreement to reimburse VA for the cost of care provided to retired servicemember's who are eligible for TRICARE and who are enrolled as Priority 7 veterans. These veterans would not be required to pay VA inpatient and outpatient copayments. The latest information received show that DoD has been in arrears reimbursing contract providers for care provided to TRICARE beneficiaries. The American Legion recommends that this Subcommittee closely examine this matter.

SUMMARY

In this statement, The American Legion addresses some of the important issues facing the 107th Congress with regard to veterans' health care services. America's veterans deserve no less than a world-class health care system. The difficult issues facing VHA today call for creative, timely and permanent solutions. Although progress is being made in meeting the changing health care needs of America's veterans, a great deal remains to be accomplished. Achieving the required solutions to these pressing needs must be elevated to a national priority status. Until these numerous challenges are met in a comprehensive manner as recommended in the proposed GI Bill of Health, VHA's course will remain unsteady and its future uncertain. This nation and America's veterans cannot afford continued erosion in VA health care value.

The American Legion eagerly looks forward to working with Congress and with the President's Task Force on VA Health Care in achieving long-lasting solutions to VHA's persistent problems. Now is the time to address these issues in a systematic and effective manner.

Mr. Chairman, that completes my statement.

STATEMENT OF

JOHN C. BOLLINGER, DEPUTY EXECUTIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS,

HEALTH SUBCOMMITTEE

CONCERNING

THE CURRENT STATE AND FUTURE CHALLENGES OF THE

VA HEALTH CARE SYSTEM

APRIL 3, 2001

Chairman Moran, Ranking Democratic Member Filner, members of the Subcommittee, the Paralyzed Veterans of America (PVA) is pleased to present our views on the current state and future challenges of the Department of Veterans Affairs' (VA) health care system. As we stated in our Annual Testimony, which we presented last month, the provision of health care to veterans is our primary mission. To our members, the existence of a viable system that provides the highest quality of health care directed toward the special needs of veterans is a matter of life and death. We could spend days and weeks discussing the current state, and the future challenges facing this system, but the long and the short of it can be summed up in a quote from a congressional report from 1951: that the VA health care system "represents an attempt on the part of Congress to

partially discharge our obligation to the men and women who have offered their lives in defense of our country."

PVA members utilize VA health care at a higher percentage than any other veterans service organization. All of PVA's members are veterans with spinal cord injury or dysfunction. Due to the complex nature of these disabilities PVA members must rely on a lifetime of specialized health care and continuing rehabilitation services. Fortunately for us, since World War II, the VA has developed an extensive network of spinal cord dysfunction care second to none. Specialized services, such as spinal cord dysfunction care, are the core of the VA's mission and responsibility to veterans. VA's specialized services are incomparable resources that often cannot be duplicated in the private sector.

An independent study released last Spring produced by the widely recognized consulting firm Booz-Allen & Hamilton compared VA's SCI services to SCI services funded by Medicare, Medicaid, Aetna, Kaiser, Alliance, Blue Cross/Blue Shield and the Swedish medical systems.

The study found that the VA provided more comprehensive coverage for SCI than any other health care program. It determined that the VA's benefits met, or exceeded, those provided by each of the plans reviewed. It concluded that VA's services were uniquely organized and that no other health care provider was as involved in the full continuum of care for SCI patients.

To provide this high-quality health care it is essential that a spinal cord injury center be operated in the venue of a tertiary medical center. The clear advantage of the SCI system is that it incorporates the multi-disciplinary team approach of many medical specialties, from neurology to social work, from initial stabilization post injury to long-term care. These are services that can only be found in the hospital setting, and only provided by highly trained and highly motivated health care professionals. Likewise, for the VA to reap the full benefits of its restructuring efforts over the last number of years, and to

realize its efforts to provide cutting-edge 21st century health care, it is essential that the integrity of the hub and spoke method be maintained, and strengthened. This model relies upon the tertiary care facility serving as the hub, with outpatient clinics and other facilities that ease access into the system serving as the spokes. Without the hub, the spokes will fail.

The VA has undergone extraordinary change in recent years, marked primarily by a major shift from inpatient to outpatient services. This change in the direction of care has been brought about by the need to cut costs. It also has had the intended result, through the opening of hundreds of outpatient clinics, of bringing primary care services closer to the communities where veterans live. This trend, the shifting of resources away from medical centers, will continue as the VA attempts to realign and, potentially, to close many medical centers. This trend, absent coordinated planning, represents another major threat to the SCI system unless resource allocation remains in balance and continues to support the medical center approach to health care.

VA Secretary Principi stated recently in an interview, in regards to the sentiment that it was time to close the VA system, that this "would be such a tragedy because I do believe that the VA is part of the safety net in this country for people who have few other options. We are a leader in specialized programs, and without a robust health care system around them, they will collapse and die." PVA could not agree more. It is clear, that PVA members cannot find the specialized care they need at a community-based outpatient clinic that provides only basic general primary care services. We have discovered that some of these community-based clinics are not even wheelchair accessible. These clinics may provide ice packs and aspirin, but they cannot provide the health care needed by PVA members – health care provided in specialized settings supported by tertiary care hospitals.

A crucial component of maintaining and improving the VA's ability to provide specialized services, is that the VA must retain its essential capacity to provide these

services. Congress recognized the importance of maintaining capacity with the passage of P.L. 104-262, the "Veterans Health Care Eligibility Reform Act of 1996," which required the VA to maintain its SCI capacity by statute. Even with this statutory mandate it has been an on-going struggle for us to see that VA Veterans Integrated Service Network (VISN) and local managers live up to the requirement to maintain SCI beds and staffing.

Last year we were able to finally reach agreement with the VA on a template for the entire SCI system. This template sets numbers for beds and staff at each SCI center. This template can serve as a benchmark for maintaining capacity. Although we are encouraged by this agreement, we are ever mindful that the numbers are only as good as the good faith required by local hospital managers and VISN directors to see that these beds are in place and properly staffed. In addition, this agreement will only work with the direct supervision of top VA leadership and the oversight of this Subcommittee. We look forward to working with you to see that the promises made to protect spinal cord medicine are kept.

PVA members cannot find the quality services within the general community as well, either by contract or by any vouchering scheme that would send PVA members to places where specialized care services do not exist. What could be looked at as a boon to some veterans strikes at the heart of the VA inpatient specialized services we rely upon. This boon could very well be the disguised death knell that we so very much fear.

The threat to the VA health care system represented by the push to voucher the VA health care system is ever-present. PVA remains deeply opposed to these efforts. Well-meaning attempts to address the problems faced by veterans who do not reside near VA facilities could very well have the practical effect of destroying the VA system. We hope that this is not the purpose of those who support these vouchering efforts. We need to find solutions for these veterans, but the solutions we find should not fundamentally subvert the system.

PVA is troubled by legislation put forth in the last Congress that would have created a pilot program to shift medical services and veteran patients from the VA to the private sector. The care afforded these veterans would have been paid for by the veteran's own private or public insurance with the VA acting only as a secondary payer. It is important to note that we are not opposed to contracting out medical services when there is a demonstrable lack or availability of certain services within the VA. What we do oppose, and oppose strongly, are efforts that would turn the VA into an insurer of health care rather than a provider of health care. These efforts would not only represent a major departure from the usual delivery of VA health care services, but would provide disparate treatment of veterans depending on whether or not they have private insurance, undermine the VA's ability to maintain its specialized services programs by eroding the VA's patient and resource base, and endanger the well-being of veteran patients.

Efforts to voucher the VA would strike at the core of the structure of the VA health care system, the structure of the VA hospital serving as the hub, or locus, of inpatient services, and the outpatient clinics serving as the spokes of the wheel, feeding patients to that hub. Proposals, such as those from the last Congress, do just the opposite. They would attract veterans to the VA outpatient clinic, only to send them out of the VA system for their care. Veteran patients would be lost to the system, undercutting the VA hospital's patient base, its budget and resource requirement justification, and any potential benefit the veteran's third party reimbursement could bring to the system if that care had been provided in a VA facility. These proposals set a very dangerous precedent which, if allowed to expand, could endanger the viability of a VA facility maintaining its full range of specialized inpatient services for all other veterans in the area as those resources go elsewhere.

Although the final version of a vouchering proposal in the last Congress included language calling for the inclusion of a certain percentage of veterans without private insurance, we have grave concerns over how such a mandate would be carried out. Even with the inclusion of such language, these provisions would effectively allow only veterans who have the means to pay for their own health insurance to be referred from

VA or VA contracted outpatient clinics to private sector facilities for inpatient care. The vast majority of those without health insurance, potentially those with the most financial need, would still have to travel to the VA hospital to get their care. By authorizing non-service connected care in private sector facilities, proposals such as those brought forward in the last Congress would create an entirely new eligibility category. Veterans' groups and Congress worked for years to reform the patchwork eligibility system then in place. This would represent a step backward.

Finally, vouchering proposals represent the abrogation of the VA's, and the federal government's, direct responsibility to discharge the obligation to provide health care to veterans. The VA, in sending the patient to the private sector to use the veteran's own health insurance, would be washing its hands of the veteran patient. As a payer of only co-payments and deductibles, the VA would have very little recourse to monitor the quality of the care provided. It would not have the responsibility to provide any follow up care or continuing treatment. Even though the proposal forwarded in the last Congress contained language stating that the VA would coordinate care through the provision of case management, PVA believes that, lacking a formal contractual or regulatory relationship with the providing hospital or the private or public insurer, the VA would have no right or even incentive to monitor, evaluate or influence the care provided once that patient has been referred. In addition, veterans would lose all recourse to the VA for the consequences of the care they receive once they are referred out of the system.

Another challenge facing the VA system, the challenge of a crumbling infrastructure and a lack of investment in the system was recognized by this Committee, and acted upon by the House of Representatives. For too many years, the VA has faced dwindling construction budgets. This pattern is an explicit indication of poor stewardship over the medical system's facility assets. The VA must remain flexible in order to provide the highest quality of care to veterans and to protect the provision of specialized services, but

a health care system that lacks safe structures, that has been allowed to "realign through neglect," is a health care system in name only.

It is easy to be lulled into believing that veterans are dying off and that there is no need for a VA health care system. This is undoubtedly false. It is true that we are facing, in a demographic sense, an increasingly graying population of veterans, but the simple fact remains that as long as we have a military we will continue to have veterans. The VA must look to meeting the specialized health care needs of all veterans. This is especially true in meeting the needs of elderly veterans, and why it is essential that the VA implement the long-term care provisions of the "Veterans Millenium Health Care and Benefits Act," P.L. 106-117. The VA can be a tremendous asset as we, as a Nation, begin to address the long-term care needs of all of our citizens.

Earlier, I quoted from a congressional report from 1951. That report also states that at that time "the quality of medical care available to the beneficiaries of the [VA] has been raised to a point where it unquestionably represents the best medical care available anywhere in the world at any time in the world's history." This statement should remain our goal, and light the path of our efforts to face the promises and challenges of the present, and the uncertainty of the future.

PVA appreciates this opportunity to present our views on the current state and future challenges confronting VA health care. I will be happy to respond to any questions.

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TESTIMONY OF

ELLEN PITTS, R.N.
PRESIDENT, NAGE LOCAL R1-187

"CURRENT STATE OF THE VETERANS HEALTH CARE SYSTEM"

BEFORE THE COMMITTEE ON VETERANS AFFAIRS
SUBCOMMITTEE ON HEALTH

APRIL 3, 2001
2:00 PM

334 CANNON OFFICE BUILDING

GOOD AFTERNOON MR. CHAIRMAN, MEMBERS OF THE SUBCOMMITTEE MY NAME IS ELLEN PITTS AND I AM PRESIDENT OF THE NATIONAL ASSOCIATION OF GOVERNMENT EMPLOYEES (NAGE), LOCAL R1-187, WHICH REPRESENTS OVER 300 NURSES EMPLOYEES AT THE VETERANS AFFAIRS MEDICAL CENTER, BROCKTON, WEST ROXBURY MASSACHUSETTS. ON BEHALF OF NAGE PRESIDENT KENNETH T. LYONS AND THE OVER 13,000 VETERAN ADMINISTRATION (VA) EMPLOYEES

REPRESENTED BY NAGE I WISH TO THANK YOU FOR ALLOWING ME THE OPPORTUNITY TO APPEAR BEFORE YOU TODAY.

I APPEAR BEFORE YOU TO ADDRESS THE CURRENT STATE OF THE VETERANS HEALTH CARE SYSTEM. I BELIEVE THAT MY TWENTY PLUS YEARS AS A VA EMPLOYEE GIVES ME A UNIQUE PERSPECTIVE ON THE CHANGES THAT HAVE RECENTLY TAKEN PLACE WITHIN THE VA HEALTH CARE SYSTEM. IN ADDITION AS A MEMBER OF THE VA NATIONAL PARTNERSHIP COUNCIL I HAVE SPOKEN WITH HUNDREDS OF VA EMPLOYEES ACROSS THE COUNTRY CONCERNING QUALITY CARE ISSUES FOR OUR VETERANS. THE PEOPLE I REPRESENT, ARE LITERALLY ON THE "FRONTLINE" OF THE DEBATE REGARDING THE FUTURE OF DELIVERING QUALITY CARE AT THE VA.

THE DEPARTMENT OF VETERANS AFFAIRSHAS BEEN HISTORICALLY VIEWES AS A STABLE, SECURE AND DESIRABLE WORKPLACE. FOR POTENTIAL EMPLOYEES LOOKING TO ENTER THE WORKFORCE. CHANGES TO OUR SYSTEM AND ITS PROGRAM HAS DIMINISHED OUR ABILITY TO ATTRACT AND RETAIN THE BEST AND THE BRIGHTEST. WE CONTINUE TO STRIGGLE TO MAINTAIN ADEQUATE STAFFING AND THE RESOURCES TO PROVIDE NECESSARY OPTIMAL CARE FOR OUR VETERANS. WE DO NOT LOOK LIKE THAT ANYMORE, WE ARE ASKED TO DO MORE WITH LESS. WE ARE ASKED TO DO MORE WITH LESS. WE HAVE RECRUITMENT AND RETENTION PROBLEMS. WE HAVE FEWER HANDS ON EMPLOYEES AND MORE MANAGEMENT IN OUR SYSTEM. AS OUR RESOURCES DIMINISH, THE VA HAS ATTEMPTED TO DISGUISE SHORTFALLS BY ADMINISTRATIVE MEANS, OFTEN TIMES OUR PROGRAMS APPEAR TO BE SOUND "ON PAPER" BUT IN REALITY FALLS SHORT OF OUR GOAL TO PROVIDE QUALITY CAR TO OUR VETERANS.

OUR VETERANS TODAY, JUST LIKE THE PUBLIC IN GENERAL, HAVE A HIGHER ACUITY (SICKER) WHEN ADMITTED INTO THE MEDICAL CENTER FOR TREATMENT. THE VETERANS HEALTH ADMINISTRATION (VHA) HAS CREATED SEVERAL METHODS THAT DETERMINE STAFFING LEVELS TO CARE FOR OUR VETERANS. THE FIRST IS CALLED CLASSIFICATION, VETERANS ARE CLASSIFIED INTO CERTAIN LEVELS TO DETERMINE THE NECESSARY AMOUNTS OF NURSING CARE IN A DAY FOR THAT PARTICULAR PATIENT. THE SECOND CLASSIFICATION, "EXPERT PANEL-BASED METHODOLOGY" IS A MEANS TO ENSURE THAT THE RIGHT STAFF MIX (NUMBERS, TYPES AND GRADES) OF NURSING PERSONNEL IS AVAILABLE TO PROVIDE ADEQUATE SERVICES. IT IS CLEAR THAT INBOTH OF THESE METHODS MANIPULATION IS EVIDENT. AS THE SAYING GOES, "FIGURES DON'T LIE, BUT LIARS DO FIGURES." THESE METHODS TO DETERMINE HOW MUCH CARE A PATIENT ACTUALLY NEEDS HAS BEEN TOUCHED UP BY COUNTING NURSE MANAGERS IN THE MIX.

RECENTLY, THE VHA DISTRIBUTED DIRECTIVE, 2000-022, WHICH MANDATES SPECIFIC STAFFING LEVELS IN SPINAL INJURY UNITS. THE PARALYZED VETERANS OF AMERICA SHOULD BE PROUD OF THEIR WORK TO OBTAIN THESE STAFFING LEVELS. NOW THAT SPINAL CORD INJURY PATIENTS ARE ADEQUATELY TAKEN CARE OF WE NEED TO MANDATE SAFE STAFFING LEVELS FOR ALL VETERANS. NAGE BELIEVES THAT EVERY VETERAN DESERVES THE BEST CARE WE ARE ABLE TO PROVIDE.

ON STAFFING, THE VA HAS EXPERIENCED INCREASINGLY SEVERE ACROSS THE BOARD STAFFING SHORTAGES IN BOTH DIRECT PATIENT CARE AND SUPPORT STAFF. LACK OF SUPPORT STAFF (WARD SECRETARYS, ESCORT SERVICES, LAB, JANATORIAL SERVICES) HAS FURTHER REDUCED EFFECTIVE PATIENT CARE BY SHIFTING WORK TO AN ALREADY DEPLETED CLINCAL STAFF. THE STAFFING PROBLEMS HAVE RESULTED DIRECTLY IN AN INCREASE IN WORK RELATED AND NON-WORK RELATED INJURIES.

STRESS, LACK OF PROPER EQUIPMENT AND MANDATORY OVERTIME ALL CONTRIBUTE TO THESE INJURIES.

The VHA HAS CONTINUED THE ANTIQUATED PRACTICE OF ROTATING STAFF INSTEAD OF HIRING FOR PERMAMENT TOURS OF DUTY OR ALLOWING STABILIZED TOURS OR PROVIDE FOR ALTERNATIVE WORK SCHEDULES. THESE PRACTICES WOULD ALLOW STAFF TO BE MORE CREATIVE IN THEIR SCHEDULING TO ACCOMADATE THEIR FAMILIES AND OTHER OBLIGATIONS. THE PRIVATE SECTOR HAS EITHER ELIMINATED OR CAPPED MANADATOTY OVERTIME AND HAS BECOME MOR FAMILY FRIENDLY. WHILE OPM HAS CHAMPIONED THESE POSITIVES CHANGES, THE VA HAS YET TO EMBRACE THEM FULLY. WHEN IS THE VA GOING TO MOVE INTO THE 21ST CENTURY?
DUE TO SHORTAGES IN STAFF, THE VA HAS UTILIZED UNCOMPENSATED VOLUNTEERS AND PATIENT PROGRAMS SUCH AS COMPENSATED WORK THERAPY, TO "FILL" FULL TIME VACANT POSITION. OFTEN TIMES, THESE DE FACTO EMPLOYEES OCCUPY FULL TIME POSITIONS WITHOUT BENEFITS AND COMPENSTAION. THIS SHADOW WORKFORCE MUST BE EXPOSED.

REWARDS AND RECOGNITION FOR THE EMPLOYEES IN THE FIELD ARE DISAPPEARING. OUR MEMBERS ARE TOLD THERE IS NO MONEY AVAILABLE FOR BONUSES. THE FACT IS THAT DIRECTORS RECEIVE UP TO $20,000 PER YEAR BONUSES IF THEY MEET THEIR PERFORMANCES. DOCTORS CONTINUE TO RECEIVE UP TO A $10,000 BONUS. WHEN WILL THE VA START TO RECOGNIZE THE EMPLOYEES ON THE FRONTLINE AND REWARD THEM FOR A JOB WELL DONE?

ANOTHER EXAMPLE OF THE VA SHORTSIGHTEDNESS IN DEALING WITH RECRUITMENT AND RETENTION CENTERS ON A NEW EDITION OF THE QUALIFICATION STANDARDS FOR REGISTERED NURSES WHICH MAKES SWEEPING CHANGES IN THE PROMOTION CRITERIA FOR NURSES. THE

MOST SIGNIFICANT CHANGE IS THAT PROMOTION WILL BE DRIVEN BY CLASSROOM DEGREE AND NOT BY PERFORMANCE. IT IS CLEAR THAT CLASSROOM DEGREE DOES NOT GUARANTEE PERFORMANCE. BASED ON A STUDY CONDUCTED BY THE UNIVERSITY OF CALIFORNIA IN 1990, THE AUTHOR FOUND LITTLE IF ANY DIFFERENCE IN THE PERFORMANCE OF AN ASSOCIATE DEGREE (AD) AND BACCALAUREATE NURSE (BSN). NAGE BELIEVES THAT A PURE BSN WORKFORCE DISCRIMINATES AGAINST MINORITY POPULATIONS WHO COMPROMISE A LARGE NUMBER OF ASSOCIATE DEGREE NURSES. LIMITING PROMOTION TO STRICT EDUCATIONAL CRITERIA WILL CREATE RECRUITMENT AND RETENTION PROBLEMS. THE DEPARTMENT OF DEFENSE EXPERIMENT WITH A BSN ENTRY REQUIREMENT HAS FAILED TO ATTRACT NURSES TO MEET THEIR PATIENT CARE NEEDS. THE VHA, IF IT IS TO CONTINUE TO PROVIDE QUALITY CARE FOR OUR VETERANS MUST INCREASE ITS EDUCATIONAL RESOURCES TO ALLOW VA NURSES TO PURSUE BSN OR MASTERS DEGREES. IF THIS DOES NOT HAPPEN, THOUSANDS OF VA NURSES WILL BE FACED WITH BEING PLACED IN A "FROZEN-IN-GRADE" STATUS.

MANY OF THE CHANGES THAT THE VA HAS INCORPORATED IN THE LAST SEVERAL YEARS HAVE SHOWN LITTLE POSITIVE EFFECT ON THE DELIVERY OF HEALTHCARE TO ITS PATIENTS. INITIALLY THE VETERANS INTEGRATED SERVICE NETWORK (VISNS) WERE CREATED IN 1995, THE TWENTY-TWO VISNs ACROSS THE COUNTRY WERE TO REPLACE THE VA REGIONAL OFFICES. ALTHOUGH IT WAS UNCLEAR AS TO THE SPECIFIC ROLE OF VISN, THESE ENTITIES ENGAGE IN SELF-DEFINITION AND SELF-PRESERVATION. INITIALLY, VISNs WERE COMPRISED OF MINIMAL STAFF. THEY NOW HAVE BECOME BLOATED AND INTRUSIVE. THE VISNs HAVE BECOME THE PROVERBIAL "MIDDLE MAN" DEVOURING FUNDS WITH LITTLE OR NO PRODUCTIVITY. OUR UNDERSTANDING WAS THAT EACH VISN WOULD EMPLOY APPROXIMATELY 10 EMPLOYEES WITH A BUDGET OF ONE MILLION DOLLARS PER YEAR. MANY OF THE TWENTY-TWO VISNs

HAVE GROWN TO OVER THIRTY FULL TIME STAFF AND BUDGETS IN EXCESS OF THREE MILLION DOLLARS. MANY TIMES VISNs HAVE HIDDEN STAFF AND RESOURCES THROUGH CREATIVE ACCOUNTING PRACTICES. NAGE BELIEVES A REVIEW OF THE MISSION OF THE VISN IS NEEDED SINCE MANY OF THEM ARE NOTHING MORE THAN A REDUNDANT LAYER OF MANAGEMENT WHOSE COSTS ARE UNJUSTIFIED.

IN THE SAME VEIN AS TO THE CREATION OF VISNS , SO ARE SERVICE LINES. OUR UNION BELIEVES THAT WE NEED TO HAVE CONSISTENCY AND AVOID DUPLICATION OF SERVICES, HOWEVER NAGE BELIEVES SERVICE LINES AS JUST ANOTHER MEANS OF CREATING JOBS FOR MANAGEMENT "LAYERING" AND LESS ABSORBING BUDGETS, THEREBY DEPLETING FRONTLINE EMPLOYEES. SERVICE LINES HAVE NOT ONLY LESSENED EFFICIENCY AND EFFECTIVENESS, IT HAS BEEN SHOWN TO LACK FLEXIBILITY IN CASES OF EMERGENCIES. RECENTLY, BECAUSE OF INCLEMENT WEATHER, CLINICS AND SURGERIES (SERVICE LINES) WERE CANCELLED AND STAFF WERE GIVEN THE DAY OFF WITH AUTHORIZED ABSENCE. HOWEVER, THE MEDICAL CENTER EMPLOYEES WERE REMINDED THAT THEY WERE ESSENTIAL EMPLOYEES AND NEEDED TO COME TO WORK. THEY HAD TO USE EMERGENCY ANNUAL LEAVE IF THEY WERE UNABLE TO REPORT. THE POLICY STATES THAT ALL EMPLOYEES ARE ESSENTIAL AND MAY HAVE TO PERFORM DUTIES OUTSIDE OF THEIR JOB DESCRIPTIONS DURING EMERGENCIES. THEREFORE, THE SERVICE LINES HAVE CREATED ARTIFICIAL AND DIVISIVE CATEGORIZATION OF EMPLOYEES WHICH HAS NEGATIVELY IMPACTED MORAL AND EFFECTIVENESS OF THE VA EMPLOYEE.

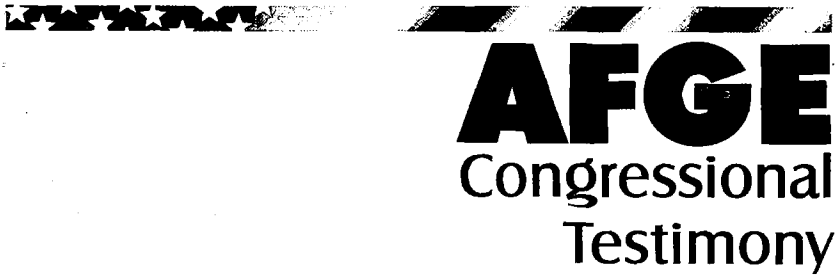
ON PROGRAMS AND INITIATIVES, AS CENTRAL OFFICE ROLLS OUT NEW INITIATIVES INTO THE FIELD, SOME OF WHICH ARE VERY SUPPORTIVE OF SAFE PRACTICES OF PATIENT CARE. WE EITHER HAVE NO FUNDING OF FUNDING IS SENT OUT TO THE VISN FOR DISTRIBUTION TO FIELD

STATIONS. MANY TIMES FUNDING IS NOT UTILIZED FOR ITS INTENDED PURPOSE BUT RATHER DIRECTED FOR OTHER PURPOSES AS DETERMINED BY THE VISN.

CENTRAL OFFICE HAS ALSO MANDATED EACH EMPLOYEE RECEIVES 40 HOURS OF TRAINING EACH YEAR. CREDIT IS GIVEN FOR REVIEWING POSTERS SET UP IN A ROOM, ATTENDING STAFF MEETINGS, AND REVIEWING TAPES WITH NO INSTRUCTOR SUPERVISION. STAFF HAS BEEN INTIMIDATED INTO TAKING TAPES AND VIDEOS HOME TO REVIEW SINCE SHORTAGE OF STAFF DICTATES THE NEED NOT TO ATTEND THESE PROGRAMS. MANY OF THESE EDUCATIONAL PROGRAMS ARE RUN OUT OF THE VISN OFFICE. THE VISNs HAVE CREATED AN EDUCATIONAL SERVICE LINE, THEY PROVIDE EDUCATIONAL SERVICES FOR A FEE AND EXPECT THE STAFF TO TRAVEL TO THEM INSTEAD OF THE VISN EMPLOYEE TRAVELLING TO THE EMPLOYEES.

MR. CHSIRMAN, WE AS A UNION WILL CONTINUE TO IDENTIFY AREAS OF CONCERN THAT THE VA MUST ADDRESS. OUR MEMBERS KNOW THAT SLOGANS AND GIMMICKS WILL NOT IMPROVE THE VA HEALTHCARE SYSTEM. IMPROVEMENT MUST COME FROM WITHIN. WE WILL CONTINUE TO URGE TH VA TO BE INCLUDED IN ANY DECISION-MAKING PROCESS THAT AFFECTS THE CARE OF THE PATIENTS WE SERVE, AMERICA'S VETERANS.

THANK YOU, MR. CHAIRMAN. I LOOK FORWARD TO ANY QUESTIONS THAT YOU MAY HAVE.



STATEMENT BY

BOBBY L. HARNAGE, SR.
NATIONAL PRESIDENT

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

BEFORE

THE HOUSE COMMITTEE ON VETERANS' AFFAIRS
HEALTH SUBCOMMITTEE

REGARDING

THE STATE OF THE VETERANS HEALTH CARE SYSTEM

APRIL 3, 2001

Chairman Moran, Ranking Member Filner, and members of the Subcommittee: my name is Bobby L. Harnage, Sr. I am President of the American Federation of Government Employees, AFL-CIO (AFGE). AFGE is the largest federal employee union representing over 600,000 federal employees. In the Department of Veterans' Affairs (DVA) AFGE represents 135,000 workers in more than 170 Locals.

Our members are doctors, Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Nursing Assistants (NAs), custodial workers, medical clerks, food service workers, medical technologists, pharmacists, social workers, health technicians, police officers, laundry workers, dieticians, medical instrument technicians, and other workers who strive to keep the promises made to veterans by our government. DVA workers care deeply about the mission of DVA.

AFGE appreciates your recognition that the employees who heal, treat, care for, bathe and feed veterans and maintain the DVA facilities, have an important perspective on the current state of the veterans health care system.

I must tell you that the veterans health care system is in a state of shock from the combined traumas of flat-line budgets, staffing cuts, bed closures, restructuring, and contracting out. Because so much of DVA's ability to deliver quality of care is driven by staffing AFGE's testimony will focus on this issue. My testimony will also address contracting out because in the future it will greatly impact DVA core capacity.

Staffing Cutbacks

From September 1995 to September 2000, DVA cut Registered Nurses (RNs) by 10 percent, Licensed Practical Nurses (LPNs) by 13 percent and Nursing Assistants (NAs) by 30 percent. In combination these cuts meant a loss of 1 in 6 direct caregivers.

The impacts of these cuts are significant and snowball over time. On a scale of 100, the scope of nursing practice for RNs is 100; for LPNs 75-80, and for NAs 50. NAs help patients with activities of daily living. They help veterans eat, bathe, take a walk, and go to the toilet. Cutting back on NAs condemns veterans to the indignity, frustration and anger associated with waiting and waiting and waiting for someone to help them. Because nearly a third of the NAs are gone, by necessity LPNs and RNs must take on an increased workload to help patients with these activities. This additional workload occurs when nurses are providing care with only 87 percent of the LPNs and 90 percent of the RNs working on the wards.

The cumulative impact of DVA's staffing cuts is that RNs and other nursing staff are overworked, overwhelmed, and fatigued from working excessive mandatory overtime. Under these working conditions RNs are more likely to make medical errors. Even when medical errors are avoided, patients still suffer. Medications, basic care, and critical medical interventions are delayed, forgotten or mixed up because staff are spread too thin.

The cuts to nursing staff also represent delays in appointments and reductions in medical services. Without adequate nursing staff DVA has reduced or eliminated labor-intensive inpatient care programs for severely mentally ill veterans. Programs for the homeless and substance abuse programs also have been cut back due to the nursing cuts and a 12 percent cut in social workers. Indeed, virtually every occupation in the Veterans Health Administration has been cut since September of 1995 and has adversely impacted on the delivery of the full range of care DVA provides.

DVA covers for these shortages in nursing through the use of excessive mandatory overtime, registry or fee basis nurses, and shunting veterans off to non-DVA hospitals for care when DVA doesn't have beds or staff to treat them. These "fixes" to staffing levels are penny-wise and pound-foolish. At a time when DVA is seriously trying to reduce and prevent medical errors it is counterproductive to regularly mandate that RNs work two shifts in a row. Fee basis or "rent-a-nurses" are usually unfamiliar with DVA's procedures and often refuse to perform certain procedures. They do not really fill a staff vacancy. Increasing contract hospitalization costs does nothing to address the long-term staffing problem.

Recommendations on Personnel Policies and Administration Affecting Adequate staffing levels.

1. Require DVA to rebuild its capacity by setting minimum staffing levels.

We appreciate that the House Veterans Affairs Committee has taken important steps to ensure that DVA's funding keeps pace with medical care inflation. But we have seen

that increasing appropriations alone is not a guarantee that DVA will hire additional staff. AFGE asks that you require DVA to fill all vacancies for RNs, LPNs and NAs with new DVA employees rapidly. If DVA is to maintain its core capacity in specialized services and provide quality care, then DVA must set a goal to rebuild its staffing levels back to 1995 levels. AFGE urges you to set a statutory floor on minimum staffing levels for nurses and the support staff they rely upon, including medical clerks.

Another approach is to develop and implement nursing staff methodologies that establish minimum nurse-to-patient ratios and support staff-to-RN ratios. DVA has tried to develop such methodologies but has not been able to effectively implement them.

2. Address the abusive and dangerous use of mandatory overtime.

To our knowledge, DVA has no nationwide policy or data collection on the use of mandatory overtime. DVA takes no disciplinary actions against Medical Directors or nurse managers who rely upon mandatory overtime excessively to cover staffing shortages. Only the patient and the RN suffer the consequences when a bleary-eyed RN makes a medical error at the end of two consecutive tours of duty. Your encouragement and guidance to DVA to establish a national policy to address this urgent situation is warranted.

3. Curb DVA's use of fee basis nurses.

Fee basis or agency nurses, no matter how professional, do not have the same familiarity with DVA patients and DVA procedures as dedicated, reliable, and responsible DVA RNs. DVA should limit its use of contract or fee basis nurses.

4. Aggressively encourage DVA employees to become registered nurses.

Given the current nursing shortage DVA must aggressively recruit new nurses in anticipation of the retirement of a significant amount of its nursing workforce. The DVA has a pool of eager and qualified staff that with the proper encouragement and support would become registered nurses. AFGE urges Congress to establish a comprehensive DVA education program to help LPNs and NAs and others who currently work at the DVA get a degree in nursing and become RNs. We also believe that DVA would benefit from an employee education program that permits NAs and other employees to become LPNs. Such programs would help employees pay for and get their education while they are being paid their salaries. Once a DVA employee completes his or her educational and licensing requirements, he or she would be required to continue to work at the DVA or pay back such educational assistance.

DVA has a current education program that is underutilized because it is administered on an ad hoc basis at each facility. Parts of DVA's Health Professionals Educational Assistance programs are up for reauthorization this year. We would welcome the opportunity to work closely with this subcommittee to develop a more comprehensive and functional upward mobility educational program for DVA employees.

5. Increase flexibility in the education requirements of the nurse qualification standards.

Under DVA's nurse qualification standards, a RN cannot be promoted to a Nurse Level II unless he or she has a Bachelor in Nursing Science (BSN). A licensed RN of 15 years who does not possess this type of degree, but has an Associate Degree in Nursing, is expected to work at the DVA at the Nurse I level solely because of her or his educational degree. We are concerned that an absolute adherence to the education standard may disadvantage DVA in competing for highly qualified, experienced, licensed RNs, who happened to choose a difference course of education. DVA does

permit a waiver for RNs who do not have their BSN degree, but we are concerned that this waiver is not being fully used.

6. Pay Policies

- Nurse Locality Pay

If DVA wants to be the employer of choice its working conditions must improve. In addition to staffing and mandatory overtime, a key area in need of improvement is pay. We appreciate this subcommittee's hard work in reforming the nurse locality pay system last year. The guarantee of an annual nationwide raise was welcome relief to DVA nurses. Unfortunately, some medical directors continue to exercise their discretion to deny nurses a locality pay increase. We urge your continued oversight into this issue.

- Saturday Premium Pay

DVA's ability to provide veterans with the highest quality of health care depends on its ability to retain and recruit sufficient staff for evening and night shifts and the weekend.

One key to retaining staff to support around-the-clock care, seven days a week is to increase pay for employees who must work during weekends. Currently under Title 38, only RNs are guaranteed premium pay for working on the weekends. The premium is not for overtime but for working a regular shift on the weekends. This pay is well deserved but most DVA hospitals reduce the number of RNs on duty during the evening and night shifts and rely on increased numbers of LPNs and NAs.

The current law on weekend pay for LPNs and NAs, and similarly situated employees, is unfair, arbitrary, and unnecessarily complex.

By law LPNs are paid Sunday premium pay when they work on Sundays pursuant to 5 U.S.C. 5546. Their Saturday premium pay, however, is at the option of the Medical Director. This is because in the 1980's Congress created a category of employees considered "hybrid employees". LPNs, Pharmacists, Physical Therapists, Occupational Therapists and Respiratory Therapists are hybrid employees. For hybrid employees their pay can follow, but is not required to follow, Title 38 rules. Medical Directors have a significant amount of discretion concerning the pay for hybrid employees, and frequently this discretion is not used to proactively retain hybrid employees.

Title 5 employees who must work on Saturdays are also short-changed. Nursing assistants, medical technologists, food service workers, and housekeeping staff are some of the Title 5 employees who must work on Saturdays. The law prohibits them from being paid premium pay for working a regular shift on Saturdays. The law, 5 U.S.C. 5546, only provides for Sunday premium pay. It is wrong and unfair that these workers do not get paid Saturday premium pay.

AFGE urges this committee to make the law on premium pay more consistent and fair. We ask for your help to change the laws on weekend pay. The law should guarantee that all DVA employees get premium pay for their work on Saturdays and Sundays.

- Canteen Service Workers

The Veterans Canteen Service (VSC) continues to propose utilizing lower paid VCS workers to do the work currently performed by DVA food service workers in order to save DVA money on wages and benefits. Under this plan, the food preparation for patients would be consolidated with the VCS fast food service. VSC workers would work side-by-side with wage grade food service workers and cooks, who are also low-

paid workers. As wage grade employees resign from the DVA a VSC employee, who makes a little more than minimum wage, would fill their position.

It is incredible that DVA would consciously pursue a strategy to reduce the pay of the low level federal employees who provide some of the most basic and important care to our nation's ailing veterans. While this work is admittedly not glamorous, it cannot be argued that it is unimportant. Preparation of nutritious meals is only one side of inpatient food provision. Such a proposal both literally and figuratively devalues this important work and as such is beneath contempt.

We urge Congress not to encourage DVA to pursue this "management efficiency."

Contracting Out

During the same period that DVA cut its staff, DVA increased its use of personal service contracts by 54 percent, its use of fee nurses and other medical professionals by 32 percent. DVA also increased its dependence on private hospitals for inpatient care by 26 percent. It appears that rather than hire the staff it needs, DVA is turning to contractors.

AFGE is concerned that contracting out will increase in the coming years. The Office of Management and Budget (OMB) has directed agencies to compete or directly convert at least 5 percent of positions listed on their FAIR Act inventories in the next fiscal year. Virtually every single job in the Veterans Health Administration is considered exempt from public-private competition under OMB Circular A-76 and its requirements for comparing an in-house cost estimate with the lowest private sector bidder.

The exemption from public-private competition applies to work DVA traditionally considered subject to public-private competition, such as grounds maintenance, food service operations, laundry services and housekeeping. This means that DVA will simply contract out the work of some 9,000 Veterans Health Administration employees without letting them compete for their jobs.

Depending upon their occupation, between 25-40 percent of the DVA employees are veterans themselves. It is shameful and wrong that DVA would contract out the work performed by veterans without giving them a chance to compete for their jobs through a public-private competition or using a process that acknowledges their status as veterans.

To add insult to their injury, these employees would lose their jobs and DVA might not save any taxpayer dollars. Without a public-private competition DVA will not be held accountable to ensure that the contractor it selects is more cost effective than reliable and experienced federal employees, who are already performing this work, and very satisfactorily so.

Why is DVA being required only to contract out work and not bring work back in-house? It is critical that DVA be required to offer employees an opportunity to compete for their jobs. This is particularly important for employees whose work that has traditionally been considered subject to public-private competition (e.g., housekeeping, grounds maintenance, food service operations).

This January NBC ran a *Fleecing of America* report that highlighted the waste, fraud and abuse of a DVA contractor for laundry services. The DVA hospital was supposed to save $80,000 by contracting out to a private laundry service. But instead of saving money the DVA had to pay an extra $750,000. Without adequate accountability and oversight, service contracts frequently cost more than expected. OMB would have DVA send more work into the contractor abyss. Shouldn't the DVA being required to bring work back in-house when contractors fail to perform or are no longer cost effective?

DVA is currently required to report on its cost savings through contracting out. This report lacks credibility. The current central office review process on the quality of services and care provided by contractors and cost to the taxpayer is very thin.

DVA should be prohibited form contracting out work traditionally subject to public-private competitions until it can fully document current cost savings.

AFGE urges you to direct DVA not to contract out any patient care support services, until it has conducted a public-private competition. We also urge you to require DVA to contract in work.

Thank you again for the opportunity to share our views with you. This concludes my testimony.

Testimony of
Elaine T. Gerace, RN

On behalf of the Service Employees International Union (SEIU), AFL-CIO

Before the
U.S. House of Representatives
Health Subcommittee of the
Committee on Veterans' Affairs

On the

"Current State of the Veterans' Health Care System"

April 3, 2001

Mister Chairman, Members of the subcommittee, thank you for giving me the opportunity to address you here today regarding the current state of the Veterans Health Care System and any recommendations we may have to improve the delivery of health care to our nation's veterans.

My name is Elaine Gerace. I am a registered nurse at the Syracuse VA Medical Center and I have been in the VA system for 12 years. I am also a veteran. But I am here today representing the Service Employees International Union. SEIU represents 1.4 million workers nationwide. This includes over 700,000 health care workers, of which approximately six thousand are VA workers.

Before I begin I would like to thank the members of this Subcommittee and the full committee for approving the pay adjustment last year for nurses. This pay increase meant a great deal to our nurses and went a long way to improve morale.

The first issue I would like to focus on today is the nurse staffing crisis that exists in the VA system. Understaffing of registered nurses has reached a critical level in this country and it is only expected to worsen. The so-called "shortage" is not causing short staffing. It's the other way around. Inadequate staffing created poor conditions for nurses as well as patients, leading nurses to seek jobs elsewhere. Nursing is no longer the desirable career that it once was. This is evidenced by the decreased enrollments in nursing schools across the country. Nurses are also leaving the profession for careers in other fields that offer higher salaries, better working conditions and better hours. Currently the average age of VA nurses is 47 years old and is increasing. In 8 to 15 years, the VA will have to replace the majority of its current registered nurse workforce due to retirements. The VA is facing a crisis. This crisis in staffing is directly related to the quality of care that the veterans receive.

The health and well being of veterans around the country depends on safe staffing levels. Specifically, we sufficient numbers of appropriately qualified nursing staff to meet the individualized quality care needs of the patients. We must not just look at the number of nurses per unit but also at the staffing mix, RN's, LPN's, and nursing assistants. We must also consider the acuity of the patients and the intensity of the care that is required.

Approximately 10 years ago the VA established an expert panel to develop minimum staffing levels that determined the *minimum* amount of staff each unit should adopt. These minimum staffing levels, which vary from VA to VA, have become the maximum levels and are no longer adequate to provide quality care to today's patients. When these standards were developed there was ancillary support for the nursing staff and the acuity of the patients was much lower. Today, nurses are required to perform the duties that were once assigned to others such as blood draws, inserting IV's, doing EKG's etc. In addition to these duties, we are changing over to a computerized system of documentation and have implemented Bar Code Medication Administration, both of which put additional burdens on the nurses. At the same time, the patients that are admitted to the hospital now are much sicker and require much more complicated care. In addition to these increased responsibilities, the current nursing shortage has pushed nurses to their limit. They are no longer able to provide the care that they were trained to give and that our veterans deserve.

All of these factors have resulted in several problems for the nursing staff. Mandatory overtime is one of the most troublesome. Imagine going to work and not knowing when you will be going home. Finding out two hours before the end of your shift that you are required to work 4 more hours, or maybe 8, leaves you frantic to figure out how you are going to pick up your child at day care or be home to take care of a sick parent. This one factor alone causes severe morale problems for the staff. In addition, it also contributes to increased stress levels, as well as an increased risk for medication errors and the inability for nurses to properly assess the patients. It has been documented in many studies that a nurse's judgement and reaction time is reduced after an eight hour shift, after 12 hours it is severely impaired. For those nurses working mandatory overtime, they are usually required to work an additional mandatory 8-hour shift for a total of 16 hours.

The fear of making a medication error or an in incorrectly assessing the status of a patient causes constant stress for the nurse and obviously can be disastrous for the patient. Requiring mandatory overtime has also resulted in increased use of sick leave, which only compounds the staffing problem. During a 6 month period, from October 1,1999 to March 31, 2000, I monitored the overtime use on the medical and surgical inpatient units at the Syracuse VA hospital. This study did not include the other units in the hospital or the outpatient clinics. The total number of overtime hours worked by 80 nurses was 4,589. I am certain that this number would have been much higher if all of the units had been included. Nurses cannot refuse to work overtime or they can be charged with abandonment of duty and be disciplined and/or fired. Mandatory overtime has been the reason that many nurses have left the VA, which we can ill afford. I cannot stress enough how important nurses feel about providing good care, the kind of care they are trained to provide. Nurses are leaving because of the stress and because they too often feel they cannot provide the level of care that our veterans have a right to receive.

In order to minimize the use of overtime, floating nurses from one unit to another has become a standard practice. This is also demoralizing to nurses. Nurses are very aware of the staffing on the floor. When staffing is adequate for the floor, which seldom happens, the nurses look forward to going to work because they know that they will be able to provide the care that they should be giving. If other units have sick calls or increased acuity, then nurses will be floated to that unit. It is particularly difficult for registered nurses that are at times expected to do charge on an unfamiliar unit. Competencies must also be considered. Nursing has become specialized and although nurses are all taught the same curriculum in school, once they begin working they hone certain skills and lose others depending on what unit they work on. Would you want a nurse who is very competent in nursing home care unit working on your father who just had surgery when they have no experience in post-surgical care, or vice versa?

Members of SEIU in conjunction with management representatives conducted a survey of the registered nurses at the Syracuse VA concerning the effects that understaffing and floating had on their respective units. Fifty percent of the respondents said they knew of injuries on their unit that may have resulted from decreased staffing. Seventy-two percent stated they were not able to take lunch or other breaks on a daily basis. Ninety-one percent said that they were not able to meet the 30-hour continuing education requirements (this requirement has since been increased to 40 hours) because they had no time with 83% of that number stating they were only able to complete 8 hours or less. Eighty-eight percent of the respondents felt that their work group had the potential to produce better work. These are very sad statistics. Each and every one of these issues can and does effect patient care to some degree. This survey was done in the first quarter of 2000 and these same conditions continue to persist. Although I have highlighted the conditions at the Syracuse VA, the same problems related to understaffing can be found at any VA hospital.

The VA does not allow its nurses to work permanent day shifts. They must rotate to the evening and/or night shift. Nurses can bounce from one shift to another. Studies have also shown that this practice is not only detrimental to a nurse's health but also to their performance. Community hospitals allow nurses to work permanent shifts and in some cases will also provide permanent days off. This allows nurses to have a life outside of the hospital and allows them the ability to arrange for the care of their children, schedule doctors' appointments and do the things that most people with a nine to five job take for granted. The VA needs to meet these community standards as well. If we do not we will continue to lose qualified nurses to area hospitals.

Medication errors and be directly linked to inadequate staffing. The VA should be commended for taking the lead in attempting to prevent medication errors with the implementation of Bar Code Medication Implementation (BCMA). However, the demands that BCMA puts on the nurses must be addressed. Initially, users of BCMA require extensive training in order to access and use the system. This training is a continuous process as the system is frequently being updated. Currently, Version I software is being used but it will soon be updated with Version II software that will include an IV package. The training time for Version II for the "trainers" is expected to be 40 hours (Version I was 23 hours). The "trainers" bring back the information to their

respective hospitals and teach the staff nurses how to use the software. Usually, the nurses are given 4 hours of instruction to learn what the trainers learned in 40 hours. This training is usually conducted on the units where there are numerous interruptions and distractions. Adequate training is negatively impacted by the inability of nurses to leave the floor for classroom training due to inadequate staffing.

BCMA requires additional staff to pass medications. Prior to the implementation of BCMA, one nurse could pass medications for 30 patients within the required timeframe. BCMA requires 2 nurses to pass the same amount of medications because the system is not user friendly and is cumbersome. The software/hardware has been found to be unreliable and frequently breaks down. Because of this unreliability, it is necessary to document medications using the traditional paper records while also using the BCMA system. This system also has a negative impact on charge nurses as they must also do double documentation. Medications need to be verified on each patient in the computer and then the orders must be transcribed to the paper medication administration record. As a charge nurse, it would take me approximately 3 hours to take off all of the orders written during a shift. Since the implementation of BCMA, that number is now closer to 6 hours.

This takes time away from assessing the patients and giving them the care they require and deserve. BCMA has essentially double the amount of work that both the medication nurse and the charge nurse must do; yet staffing levels have not been adjusted. Although BCMA can reduce the number of medication errors made, it is also having a negative impact on other aspects of direct patient care. I believe that BCMA has the potential to become a very useful tool to nursing and will prevent medication errors but we cannot sacrifice other aspects of care in order to accomplish this. Staffing must be increased in order to provide the kind of care that veterans expect and deserve.

VERA (Veterans Equitable Resource Allocation) Funding has also negatively affected staffing. VISN's are budgeted according to the number of patients that are seen each year. Most VISN's function within budgetary restraints but some have found it necessary to request supplemental increases for various reasons. These supplemental increases are given at the expense of the remaining VISN's. VISN 2, which includes Syracuse, lost $2.9 million dollars this fiscal year due to supplemental increases. These budget cuts put an incredible strain on those VISNs that work hard to reduce patient costs while at the same time increasing the number of new patients utilizing the VA. The VISNs that have been able to operate successfully within their budgets are being punished for being fiscally responsible. These budget cuts put restrictions on the ability to hire additional staff, on the range of services provided to the veterans, and in some cases can result in the reduction of beds or the closing of wards. All VISNs should be held accountable to operate effectively and efficiently within their budget allocations. If supplemental allocations are necessary then there should be another mechanism in place to finance them rather than taxing VISNs that have made the hard decisions in order to operate efficiently.

Another important aspect of understaffing is the increased risk for occupational injuries and illnesses. In the survey I discussed earlier, 50% of the nurses responding reported a direct link between low staffing levels and increased on-the-job injury rates. This is supported by that latest data from the US Bureau of Labor Statistics (BLS) that found that healthcare workers report a rate of work-related injuries greater than that of construction workers, farmers, miners, or manufacturing workers.

Nursing as practiced in most healthcare facilities in the US is a very physical job, requiring a lot of lifting. Manually lifting patients is a difficult task even when staffing is good, with reduced staffing it becomes immeasurably harder. Injuries can and do occur on a more frequent basis. Perhaps this is why in one-third of all workplace ergonomic-related injuries; the victim is a healthcare worker.

The most common injury is back strain which can result in lost time claims (worker's compensation) and/or light duty status. This puts an additional burden on the remainder of the staff that now must also pick up the duties of the injured nurse. Although lift equipment is available, it is limited in numbers and most lift equipment requires two

nurses in order to be operated safely. The minimum staffing levels requires nurses to lift significantly more patients each day, which increases the likelihood of injury. These injuries are compounded by the aging workforce.

Yet we know the solution. We know that lift teams using mechanical lifting and transfer equipment can have a profound impact on reducing injuries to nurses and other healthcare workers. One published study that looked at ten hospitals found that such ergonomic programs can reduce the incidence of back injuries by an average of 70%, reduce lost workdays by an average of 90% and pay for themselves many times over by reducing workers compensation costs by an average of 75%.

In addition to back injuries, we are beginning to see more repetitive motion injuries due to the increased use of computers in the workplace. A nurse can use a keyboard everyday day between Bar Code Medication Administration, charting on patients and verifying orders. Yet most computer workstations are not properly designed, and therefore cases of tendonitis and carpal tunnel injuries will only increase.

Although I have concentrated my comments on the staffing crisis as it impacts licensed nurses and quality care, the fact is many of the same problems exist for nursing assistants and wage grade employees in our VA health facilities. From 1995 to1999, there was a cutback in wage grade employees of 15%. Not only do support staff, such as housekeeping and dietary workers, feel the stress resulting from understaffing, but it puts additional burdens on nursing staff who must take time away from critical patient care to do other tasks that should be done by overworked service and maintenance staff.

The VA should be commended for instituting a safe needle program years before the federal safer needle that passed last year. However needlesticks continue to happen because the VA is not evaluating and selecting the best "safer" needles due to their increased costs. But what is the cost to the nurse that is infected with hepatitis or HIV? One case of hepatitis C can cost up to $750,000, and is the leading reason for liver transplants today. The solution is the purchase of the best, not the cheapest, safer needles. There are safer needles on the market that retract the needle inside the syringe immediately after the injection, virtually eliminating most needlesticks and the associated health risks. However, these are not available to my co-workers and me.

On-the-job assault is another leading threat facing nurses and other healthcare workers. According to the BLS, thirty-eight percent of all workers who are assaulted at on-the-job are healthcare workers. The threat of violence is always present in hospitals as we deal with agitated, confused, and intoxicated patients daily. Where I work, due to understaffing, nurses has been required to work alone on a locked psychiatric on several occasions. This not only puts the other patients at risk, but it endangers nurses as well. When staff request extra help they are usually told that there is no other help available, and that there is no money in the budget for overtime. Again the nurse cannot refuse to work under these conditions but can only report injuries after the fact.

Having addressed some of the serious staffing issues that exist throughout the VA system, we would hope that this Subcommittee will use its authority to explore these issues in more depth and take the necessary legislative action that would result in improved quality care for our veterans and in retaining and attracting more licensed nurses into the VA system. Specifically, SEIU urges that the VA:

- Establish federal staffing standards that would ensure sufficient, appropriately qualified nursing staff to meet the individualized care needs of the patients. Such standards should require that each VA facility develop a staffing plan that:

    1. Sets minimal staffing requirements based on number of patients, level of acuity, and intensity of care needed to ensure quality of care and good patient outcomes. The VA should examine the possibility of requiring standards based on specific nurse-to-patient ratios for different types of service.

2. Determines the specific nursing staff and skill mix needed to carry out the requirements. The skill mix reflected in a staffing plan must assure that all of the following elements of the nursing process are performed in the planning and delivery of care for each patient: assessment, nursing diagnosis, planning, intervention, evaluation and patient advocacy.

3. Is developed in consultation with the direct-care nursing staff or where such staff is represented, with the applicable recognized or certified collective bargaining representative.

- Require that each VA facility post and make public the staffing plan, including both the mandated and actual staffing levels.

- Eliminate the use of mandatory overtime for bedside nurses. We recommend that no mandatory overtime could be required beyond a previously determined workshift schedule or no more than 12 hours in a 24-hour period with a cumulative limit of no more than 80 Hours in a 14-day consecutive day period. Although voluntary overtime should be permitted, we also urge that the VA consider set a maximum hours limitation, beyond which a licensed nurse should not be on duty status. Federal laws and regulations set maximum hours in the interest of public safety for airline pilots, train engineers, and truck drivers. Why not for nurses who are responsible for critically ill patients in our VA hospitals.

Setting system-wide nurse staffing standards that includes a prohibition on mandatory overtime will go a long way to correcting some of the workplace problems that are driving nurses away from the VA. It would also ensure staffing levels that can result in better quality patient care and fewer medical errors. We are doing the veterans of our country, who have sacrificed so much, a disservice by allowing understaffing to continue at the present rate.
We do commend the Committee for recommending a budget that exceeds the Administration's proposed budget. That fact is that the VA continues to lose ground because in terms of adequate staffing for nurses, other health professionals, and support staff funding for the VA has failed to keep up with medical inflation. The VA should be funded at a higher level and we would hope that the any increase in the medical care budget for the VA is earmarked for staffing and for essential services that have suffered some severe cutbacks. This includes mental and substance abuse services, long-term care, and other specialized rehabilitative services.

In the area of health and safety, SEIU recommends that

1. To protect nurses and other healthcare workers from needlestick injuries, the VA should amend their policies on the evaluation and selection of safer needles to ensure that purchasing decisions are based first and foremost on safety, not just on cost.

2. To prevent the epidemic of back injuries, and until we have an OSHA ergonomics standard, the VA should dramatically expand their current pilot programs to implement the use of lift teams with mechanical lifting and transfer equipment.

3. To prevent on-the-job assault of their employees, the VA should require that written workplace violence prevention plans be developed and implemented at each VA facility.

Finally, I would like to address the issue of contracting out. Last year Congress considered legislation to create a pilot program that would have allowed certain veterans to receive inpatient medical care at private sector hospitals. To make matters worse the VA would pay the out-of-pocket costs not covered by the veteran's own health insurance. This legislation did not pass. SEIU is opposed to such efforts that would contract out medical services that should continue to be provided by the VA. Such efforts undermine the VA health system and sets a dangerous precedent to further whittle away VA health services. We must continue to support the specialized veterans' health care services that is the cornerstone of VA medical services.

Again, thank you for the opportunity to testify. I would be happy to take any questions

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

CONGRESSMAN EVANS TO DR. JOHN CLARKSON ON BEHALF OF AMERICAN ASSOCIATION OF MEDICAL COLLEGES (AAMC)

Follow-up Question(s) for John Clarkson, M.D.
Senior Vice President for Medical Affairs and Dean
University of Miami School of Medicine

1. Dr. Clarkson, I assume you are familiar with the CARES (Capital Assets Restructuring for Enhanced Services) initiative. What do you believe is the appropriate role for academic affiliates whose corresponding medical facilities may be affected by this process in selecting options?

The restructuring of the VA health care system into a clinic-based outpatient system from a traditional hospital-based, inpatient system has required a number of beds to close and buildings to shut down. Additionally, recent GAO reports concluded that VA spends significant resources maintaining empty and under-used facilities. The VA CARES program is designed to analyze the most efficient use of VA's capital assets and recommend the realignment and perhaps closure of certain facilities. The AAMC is supportive of the CARES initiative and agrees with the premise that some buildings will need to be realigned or even closed. However, the Association's main concern is that, as VA proceeds with their analysis, the effects of realignment on the unique characteristics of the VA's education and research programs will not be adequately weighted. As stated in the Association's formal statement, the VA and their academic affiliates have a symbiotic relationship. VA medical care is enhanced by the state-of-the-art technology and high-quality faculty of the medical school, while the medical schools gain invaluable education opportunities for their students and residents, and unique research opportunities for their scientists. Additionally, both the educational and research missions of the VA contribute greatly to the quality of care provided to our nation's veterans. For this reason, we feel it is essential that there be significant collaboration between the VA and its academic partners to ensure the integrity of the education and research programs. We would recommend early involvement of the VA's academic partners in any restructuring discussion so that they may participate as partners in the process rather than as respondents to foregone conclusions.

PARTNERS

May 8, 2001

George E. Thibault, M.D.
Vice President of Clinical Affairs
Partners HealthCare System, Inc.

Professor of Medicine
Harvard Medical School

Sandra McClellan
Room 333
Cannon House Office Building
Washington, DC 20515

An integrated health care system founded by Brigham and Women's Hospital and Massachusetts General Hospital

Dear Ms. McClellan,

In answer to the correspondence of April 3, 2001 from Representative Lane Evans:

1. From your perspective, does the Special Medical Advisory Group have enough influence on the policies adopted by the Department of Veterans Affairs?

   Yes, as Chairman of the SMAG, I have always had direct access to the Under Secretary for Health to discuss policies and other matters concerning the Veterans Health Administration (VHA). The Under Secretary and Deputy Under Secretary for Health attend the SMAG meetings and the committee members have advised and made recommendations on VHA policies. The Secretary of Veteran Affairs appointed me to serve on the committee that made recommendations for the selection of the Under Secretary for Health when there was a vacancy.

2. Can you give an example of how recommendations of the Special Medical Advisory Group have affected VHA policy or practice?

   At each meeting of the SMAG, the Under Secretary for Health provides the committee with information about the most current policy initiatives that are being developed. The SMAG members have provided advice and recommendations on VHA policy and practice. On a number of occasions, the SMAG has established subcommittees to review and recommend on specific issues. An example would be the subcommittee that was established to make recommendations about establishing service lines. The SMAG subcommittee recommendations to assure that the service line structure will improve the academic missions of research and education were reviewed by the larger group and incorporated into VHA policy. At the most recent meeting, members reviewed the implementation of service lines within Network 13 to assure that the recommendations regarding service lines were being followed. Within recent years, the SMAG has advised the Under Secretary for Health in the following areas: board certification of physicians, research compliance and assurance, information strategy, computerized patient record system, telemedicine, the advisability of developing national scopes of practice for non-physician providers, quality improvement agenda and the research program.

3. What are your specific concerns about the CARES (Capital Assets Restructuring for Enhanced Services) initiative?

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The CARES process has been discussed and reviewed at all the SMAG meetings since the Options Study of Network 12 was conducted. The members of the SMAG have consistently recognized the need to realign capital assets and agree that there must be established and clearly defined criteria to evaluate options. The criteria that CARES options will be measured by were reviewed by the SMAG. I have specifically recognized VHA for developing a system that will quantify the options but cautioned that the value of the weights may vary between regions. I have also cautioned that a purely numerical approach of measuring future realignment options could be a mistake. The SMAG also feels that the importance of the academic affiliations should be reflected with a higher weighting than has been developed for Phase I of the CARES process.

Sincerely,

George E. Thibault MD

George E. Thibault, M.D.

NATIONAL ASSOCIATION OF GOVERNMENT EMPLOYEES
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April 27, 2001

Honorable Lane Evans
Ranking Democratic Member
US House of Representatives
Veterans' Affairs Committee
335 Cannon House Office Building
Washington, DC 20515

Dear Representative Evans:

In reference to the letter that you have sent requesting responses to two questions, pertaining to the Congressional Hearing dated April 3, 2001:

1. I share your concerns about VA's overuse of Mandatory overtime for Nurses, But I am also concerned that the VA remains able to staff beds and provide care to veterans on the brink of severe nursing shortage? What can VA do to address these two compelling problems more fairly?

2. Your testimony suggests that VA employ safe staffing levels, but I think there is a lot of disagreement about what those levels might be. How would VA determine what its optimal staffing levels are for its many services?

It is interesting that you addressed your questions as separate issues, they are interrelated to the point of requiring the same solutions. While I would agree that there is room for people to disagree on optimal levels of staffing, there needs to be a consensus reached as to a standard, this has been accomplished already within VA. A representative group looked at various civilian and federal sector models and came to agreement as to what would be required, once this study has been accomplished and a standard developed, we should do everything within our ability to maintain at least those established levels. The standard could be routinely reviewed to address changes in medicine or other matters, which would impact staffing.

The ability to maintain optimal staffing levels is effected primarily by budget, but also by events, such as market issues, hiring practices, internal administrative controls, leave, and others. If we do not make budget exceptions or allow flexibility in the budgetary process, the issue of recruitment and retention will drive, and in fact dictate, our staffing levels, this is where we are today. Whether it is possible or not there should be an ability to provide both immediate budgetary relief, and long range budgetary planning beyond the unit, facility, or VISN level.

If a shortage in standard staffing exists, it may be short term, caused by illness or injury, family concerns; or permanent in nature, retirement or resignation. The shortages can be cured by different means. When we know that the staffing will be reduced permanently hiring for replacement should start if possible before the incumbent leaves. Often the move to recruit occurs long after staff depart and relates more to the overall facility budget than the immediate need to provide patient care. The failure to fill vacancies places an increasing burden on remaining staff, and creates a greater likelihood that additional loss of staff will follow.

In some short term situations involving staff shortages we have used intermittent staff or contract nurses. While this has been a successful approach it has two drawbacks. First the pool of intermittents has shrunk with the ever-increasing nationwide shortage of nurses; secondly like permanent hires, our ability to contract nurses is driven by budgetary restraints. Contracts develop loyalties to user facilities, creating the expectation of continued need. In other words the longer, and more competitive the contract, the greater the chance of ensuring availability of intermittent nurses.

Along the same lines as intermittent staff is the area of flexible work environment. Several options are available to attract prospective employees. For example, job sharing, stabilized tours, stabilized days, flexiplace arrangements, Baylor plans (condensed tours), flexitime, overlapping tours, etc. Many if not all of these options exist today but few if any are practiced. Unions are being hamstrung in attaining these options for employees through collective bargaining due to Title 38 issues.

The VA has also looked at developing existing staff through education, this "grow your own" policy has the draw back of requiring time and money, and because it occurs over time is effected by such issues as reorganization, mission changes, downsizing, etc. Even with the drawbacks this option should not be abandoned, and should be under continual review, and targeted for the greatest benefit.

Lastly I will address pay. As with other patient care issues nursing pay has long been tied to the overall budget, even where authority existed for long periods of time for beneficial pay adjustment those possessing the authority rarely if ever exercised it. The failure over time to adjust pay lessens competitive ability, causes extreme swings in pay rates, and guarantees failure in recruitment of the best and brightest employees. When pay improvements are authorized they must also be mandated or they will not be given, there is a clear and unmistakable track record on this issue. I chose to address pay last because pay is often the most enticing short term remedy, but even with pay improvements without long term constructive changes in the work environment, pay alone will not "hold" employees.

Sincerely,

Ellen M. Pitts, RNC.
National VHA Representative