

**LEGISLATIVE HEARING ON H.R. 4089, H.R. 4463,
H.R. 5888, H.R. 6114 AND H.R. 6122**

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
ONE HUNDRED TENTH CONGRESS
SECOND SESSION

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**LEGISLATIVE HEARING ON H.R. 4089, H.R. 4463
H.R. 5888, H.R. 6114, AND H.R. 6112**

THURSDAY, JUNE 5, 2008

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

The Subcommittee met, pursuant to notice, at 10:09 a.m., in Room 334, Cannon House Office Building, Hon. Michael Michaud [Chairman of the Subcommittee] presiding.

Present: Representatives Michaud, Snyder, Hare, Salazar, Doyle, Miller, Stearns, and Moran.

Also present: Representatives Filner and Walz.

OPENING STATEMENT OF CHAIRMAN MICHAUD

Mr. MICHAUD. I would like to call this public hearing to order, and I would like to thank everyone for coming today. Today's legislative hearing is an opportunity for Members of Congress, veterans and the U.S. Department of Veterans Affairs (VA) and other interested parties to provide their views on, and discuss, recently introduced legislation within the Subcommittee's jurisdiction in a clear and orderly fashion. I do not necessarily agree or disagree with any bills before us today, but I believe that this is an important part of the legislative process and will encourage frank and open discussions of these ideas.

We have five bills today. Congressman Filner, the distinguished Chairman of the full Veterans' Affairs Committee, has two of the bills. And without further ado, I would like to recognize Chairman Filner on H.R. 4089 and H.R. 5888. Mr. Filner.

[The prepared statement of Chairman Michaud appears on p. 16.]

STATEMENTS OF HON. BOB FILNER, CHAIRMAN, COMMITTEE ON VETERANS' AFFAIRS, AND A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA; HON. TIMOTHY J. WALZ, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MINNESOTA; AND HON. MICHAEL F. DOYLE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

STATEMENT OF HON. BOB FILNER

Mr. FILNER. Thank you, Mr. Chairman. And I want to thank you and Mr. Miller and all the Members of the Subcommittee for a very active year. You have done a tremendous job, passed quite a lot of legislation, and we really thank you for what you have done in this Congress.

I would like to speak first on H.R. 5888, which comes from an incident that came to my attention in October 9th of last year. Stephen Brady, a 60 percent service-connected veteran, was in a serious motorcycle accident. Following the accident, Stephen was transported to a non-VA medical facility for emergency care. But, the VA has refused to pay for any of his emergency medical care in the non-VA facility because he carried an auto insurance policy which paid for \$10,000 of that care.

The law, in its current form, does not allow the VA to pay for emergency treatment for nonservice-connected conditions in non-department facilities if a veteran has third-party insurance that pays for any portion, of the emergency care. This creates an inequity that penalizes veterans with insurance, including auto insurance, which is oftentimes mandated by law. A veteran with an insurance policy which covers any portion of the cost for emergency treatment would be burdened with the remaining amount not covered by insurance. This has caused many veterans undue stress and has placed them in unnecessary financial hardship.

H.R. 5888 eliminates this inequity by requiring the VA to pay for emergency care in non-VA facilities for eligible veterans unless the veteran has other insurance that will pay for the full cost of the emergency care. In short, this bill would require the VA to pay for emergency care in a non-VA facility even if the veteran holds a policy that will pay for a portion of it.

I look forward to the comments from other witnesses today and interested stakeholders to make sure that what happened to Stephen Brady does not happen to other veterans.

If I may move to H.R. 4089. The background of this bill is that in 1991, Congress passed legislation to provide VA healthcare professionals, such as registered nurses (RNs), physicians, physician assistants, dentists, podiatrists and optometrists, with essentially the same labor rights held by other Federal employees under title 5 of the United States Code. Under this law, VA healthcare professionals are able to negotiate, file grievances and arbitrate disputes over working conditions. The law does not make an exception for disputes arising from issues such as direct patient care and clinical confidence, peer review and the establishment, determination or adjustment of employee compensation. The Secretary has the authority to determine whether an issue or concern falls under the previous exceptions. This determination by the Secretary is not subject to collective bargaining or review by any other agency.

Healthcare professionals have complained to this Committee that the VA is interpreting these narrow exceptions in law very broadly and consequently is negatively affecting areas such as schedules and floating assignments for nurses and retention allowances for physicians. From a broader perspective, these labor issues may adversely impact VA's ability to recruit and retain high quality healthcare professionals, particularly nurses. Almost 22,000 of the RNs caring for our veterans will be eligible for retirement by 2010, while 77 percent of all RN resignations occur within the first 5 years.

So I have introduced this bill to address these issues. It amends the law and repeals the three exceptions to the rights of VA healthcare professionals to engage in collective bargaining. It also requires the VA to make a final decision with respect to the review

of an adverse personnel action against a VA employee not later than 60 days after such action has been appealed.

Further, these decisions may be subject to judicial review in the appropriate U.S. District Court or, if the decision is made by a labor arbiter, in the U.S. Court of Appeals for the Federal Circuit.

Again, I look forward to the comments from the following panels and interested stakeholders. We need to be sure that VA healthcare professionals are afforded the appropriate collective bargaining rights. I hope this will ultimately lead to improved recruitment and retention of healthcare providers within the VA.

Again, thank you, Mr. Chairman. I appreciate all the work you have done in this Congress.

[The prepared statement of Congressman Filner appears on p. 16.]

Mr. MICHAUD. Once again, thank you, Mr. Chairman. And you have done a phenomenal job over the last year and a half. I really appreciate your leadership on veterans' issues and look forward to working with you.

Are there any questions for Mr. Filner on H.R. 5888 or H.R. 4089? Mr. Miller.

Mr. MILLER. Thank you, Mr. Chairman. Mr. Chairman, thank you for introducing both these pieces of legislation. I think we all think that veterans, whether insured or not insured, should be covered in any emergency situation, but I have a couple of questions. What would VA's obligation be if the rate billed by the non-VA provider is higher than the VA authorized rate?

Mr. FILNER. We split up the money. You and I split the money. That was a joke.

Mr. MILLER. I understand.

Mr. FILNER. Lighten up. Chill out, guys. Come on.

Mr. MILLER. It is not so easy on that side, is it?

Mr. FILNER. Especially with a guy with no sense of humor. Cathy, do you have a quick answer for that?

Ms. WIBLEMO. I don't. I would have to look into that further.

Mr. FILNER. If the insurance covers more than the cost of the problem? Well, the third party covers it.

Mr. MILLER. Is it the intent of this bill for VA payment to fully extinguish the veteran's responsibility to the provider so that the veteran wouldn't be liable for any outstanding balance and at the same time, would the VA be required to cover any co-payments or deductible that the veteran may owe to a third payer?

Mr. FILNER. That is a good question. Cathy, do you have that?

Ms. WIBLEMO. The original intent would be for the VA to cover what was not covered by the partial coverage of whatever third-party insurance they had. That was the original intent.

Mr. MILLER. Including deductibles, right?

Ms. WIBLEMO. That is right.

Mr. MILLER. If I could on H.R. 4089, under title 5, employee compensation cannot be subjected to collective bargaining. Would this allow unions to bargain over the amount of a title 38 employee's compensation?

Mr. FILNER. It moves the three exceptions, but the total compensation is not subject to this.

Ms. WIBLEMO. I want to say no, it is not. But, again, I would have to answer that—

Mr. MILLER. I have a couple more questions for the record, but because we have a couple of folks that want to ask some questions too, I will submit them. Thank you, Mr. Filner.

Mr. FILNER. The idea here, is to bring into the collective bargaining procedures the working conditions, which have been taken out or used as an exception by the Secretary. The idea is to bring those back in.

Mr. MICHAUD. Are there any other questions for Mr. Filner?

Mr. STEARNS. Yes.

Mr. MICHAUD. Mr. Stearns.

Mr. STEARNS. Thank you, Mr. Chairman. It is not often that we have the distinguished full Chairman that we can ask questions to, so I am asking you a question and I am understanding if it is a little difficult to answer. I say that at the outset so you don't feel too intimidated here. At our legislative hearing 2 weeks ago, the Nurses Association—

Mr. FILNER. I have another appointment.

Mr. STEARNS. Okay. The Nurses Organization of Veterans Affairs (NOVA) testified and on this bill, H.R. 4089, they expressed concern that if clinical matters were subject to bargaining, then critical clinical programs such as extending the hours of mental health clinics or mandating traumatic brain injury training for all providers, could be impacted and subject to protracted negotiations, which in the end would delay the implementation for patients at risk and, in fact, affect their safety.

So I guess the question is, in light of what the Nurses Organization of Veterans Affairs had said about this bill, and particularly the fact that implementation would affect the safety, as well as the efficient responding to veterans, I was hoping that you could perhaps allay our concerns.

Mr. FILNER. Obviously we hope that does not happen.

Mr. STEARNS. Right. They should know. They are the experts. I am just telling you that if they present these fears—obviously they have high credibility and we as Members of Congress, I think, should take their concerns into effect and take them seriously.

Mr. FILNER. With your permission, Mr. Stearns.

Mr. STEARNS. Sure.

Mr. FILNER. The third panel, the employee groups are going to testify. I would like for them to give the more precise answer.

Mr. STEARNS. And that is probably—

Mr. FILNER. It is an important question and obviously we want to continue high quality and not interfere in a medical decision, but there is a balance here and this is trying to right a balance.

Mr. STEARNS. They are the experts. So maybe the next panel they can also provide a bit better.

Mr. FILNER. Okay. Thank you.

Mr. STEARNS. Just another question. It is my understanding, Mr. Chairman, that the VA is not in favor of this bill; is that correct? Does the bill provide the VA any recourse if they feel that a non-clinical labor arbitrator has made an error in its consideration of a clinical or patient care issue? I think that is an important thing that is probably one of the reasons why the VA is against this bill.

Mr. FILNER. This is subject to appeal, if an arbitrator is involved with a Court of Appeals, a Federal District Court, or a Federal Cir-

cuit Court. Again we will hear some testimony from better experts than me, but I believe it is subject to appeal.

Mr. STEARNS. All right. Thank you, Mr. Chairman.

Mr. MICHAUD. Thank you very much. Any other questions? If not, thank you very much, Mr. Filner. The next bill is H.R. 6122 from Representative Walz, the "Veterans Pain Act of 2008."

STATEMENT OF HON. TIMOTHY J. WALZ

Mr. WALZ. Well, thank you, Mr. Chairman, Ranking Members and Members of the Subcommittee. I appreciate the thoughtful nature you put into this incredibly important component of veterans care, and thank you for the opportunity to present this piece of legislation.

This piece of legislation, H.R. 6122, the "Veterans Pain Care Act of 2008," I introduced on May 21, 2008. And basically what this bill does is require the Secretary of the VA to implement a comprehensive policy on pain management for all members enrolled in the VA system and to carry out a program of research, training and education on pain and acute chronic pain.

Pain is a leading cause of disability among our veterans. Modern warfare often leads to serious but survivable injuries. And while advances in medical technology have saved lives, many veterans are afflicted with acute and chronic pain. As a result, providing adequate pain management is a crucial component of improving the quality of life.

The VA recognizes that chronic and acute pain amongst our veterans is a serious problem, and I am here today to make very clear I applaud the work that our VA has done. They have been exemplary in providing this and they have taken a lead role on this. This piece of legislation simply clarifies, streamlines and brings the concerns of many of our veterans and our researchers into pain management to a tighter focus, and this legislation will give the VA the necessary tools to do exactly that.

By making it clear that Congress considers pain a priority and putting it into law, VA's pain care programs will be less subject to the winds of political change and budget cuts. At the same time, this bill is not duplicative of any efforts the VA is already making. It will not be cumbersome, especially since the bill is not overly prescriptive, a concern with earlier versions of the bill that I think this one has rectified.

On that note, I have made a special effort to make sure that this bill is virtually identical to the one that the Senate worked. It had the support of Chairman Akaka and Ranking Member Burr, and on Tuesday night, I am pleased to say, it passed unanimously in the Senate. So I am hopeful that this bill, the companion version, will be as bipartisan and will move as quickly through the House and become law.

The bill is part of an effort to provide pain care for our servicemembers across their careers, and I would like at this point to highlight the work that Congressman Dave Loebsack from Iowa is doing on the Armed Services Committee of making sure his legislation was included in the National Defense Authorization Act that passed.

In this way, these two bills will help provide the seamless transition we talk about of care from the battlefield, back to the rehabilitation facility, into the VA system.

This bill is supported by a broad coalition of groups who are involved in pain management, including the Pain Care Coalition and the American Pain Foundation. And without objection, I would like to submit the letters of support from those two and other organizations.

Mr. MICHAUD. Without objection, so ordered.

Mr. WALZ. I am pleased that a number of veteran service organizations will be here today to express their support for this bill. There is a role for them in this bill. The VA will work with our veteran service organizations and other experts in pain management to continually improve its comprehensive policy.

There is also an oversight mechanism so that Congress can ensure that this happens. The VA is required to report regularly to Congress on the progress it is making in implementing some of these strategies. With these oversight mechanisms and by directing the VA to update its management using best practices, as well as carrying out extensive research, the ultimate aim of this bill is to lay a foundation for the ongoing improvement in pain management. In this way, we are going to work toward what I feel is that moral obligation to care for our veterans. It is going to bring innovative techniques. It is going to streamline the system, and it is going to make sure our veterans have the highest quality of life possible with the new innovations that come forward.

So I thank you for being able to introduce this piece of legislation. I thank you for your consideration of it. And I would sure answer any questions that you might have.

[The prepared statement of Congressman Walz, and the attached Pain Care Coalition letter of support, appear on page 18.]

Mr. MICHAUD. I want to thank you very much, Mr. Walz, for your testimony and not only for your service here in Congress, but your service to this great Nation of ours.

Are there any questions for Mr. Walz?

Mr. Miller.

Mr. MILLER. The VA says they oppose the bill basically because it is duplicative in some of the efforts that are ongoing. I understand that there is not really a fiscal impact in what is going on. My question would be, do you think that it might be beneficial for us, we as a Committee, to request that the Inspector General (IG) conduct a review of VA's pain management policy currently to see what the effectiveness is of what VA already has in place?

Mr. WALZ. And I appreciate it. And I think it is a very valid question, one that we asked very early on. And one of the concerns I had I asked the same thing, Mr. Miller, is the duplicative nature of this. I don't believe it does that, but I am open to that if this Committee believes that is the best way to ensure this. We have talked extensively with the VA. And again I applaud them for the work they have already done on pain management.

One of the things that we have seen and the reason for introducing this piece of legislation is what we have seen from our veteran service organizations and their testimony, and some of the

data seems to back this up. It may be the role of the IG to verify that. There is not a consistency across the system. And what we think this bill will do is bring a consistency across the system to making sure that a veteran is not at the whims of geographic location where their pain management is taken care of, but it is simply going to be uniform across.

So I think and my reason for initiating this is because I believe that is happening, but I am more than open to look at that.

Mr. MILLER. So, your idea is not necessarily that the VA is doing a good job with pain management, but basically how they offer it, where they offer it and that it be provided in an adequate location for—

Mr. WALZ. Yes. I think there is a lack of consistency and a lack of direct focus and one that I think again can change according to maybe some of the top people at the VA. I am very pleased with the work they are doing in this and I know our veterans are receiving great care. But it is still somewhat arbitrary on where it is delivered and how it is delivered, and I think this brings it better into focus.

Mr. MILLER. Thank you for your efforts. I yield back.

Mr. MICHAUD. Any other questions? If not, thank you very much, Mr. Walz.

Mr. WALZ. Thank you, Mr. Chairman.

Mr. MICHAUD. The last panelist, which is Mr. Doyle, on H.R. 6114. I also want to thank you for what you are doing for our veterans and for serving on this Committee as well.

Mr. Doyle.

STATEMENT OF HON. MICHAEL F. DOYLE

Mr. DOYLE. Thank you, Mr. Chairman and Ranking Member Miller and Members of the Subcommittee, for including H.R. 6114 in today's hearing. I introduced the "Simplifying and Updating National Standards to Encourage Testing of the Human Immunodeficiency Virus Act of 2008," also known as the "Sunset Act," with my friend and colleague, Charlie Dent of Pennsylvania, to correct an anachronism in our veterans' healthcare laws.

Congress does not often step in and tell the Veterans Health Administration how to diagnose and treat patients in the system, and I think we can all agree that is wise. However, in 1988 Congress passed a law that requires the VA to obtain a patient's written consent before being tested for Human Immunodeficiency Virus (HIV), the virus that causes Acquired Immune Deficiency Syndrome (AIDS). While that might have been a best practice in 1988, it is now outdated and needs to be repealed.

According to the VA's Public Health Strategic Working Group, 55 percent of HIV positive veterans had already suffered significant damage to their immune system by the time they were diagnosed as HIV positive. These veterans have been to VA to get medical care an average of six times prior to diagnosis. That same panel says, and I quote, "the bottom-line here is that we are likely dealing with a situation where there are thousands of HIV infected veterans who are unaware" that they are HIV positive.

This is unacceptable to me and it should be unacceptable to anyone else who cares about the public's health and the well-being of our veterans.

The face of a person with HIV/AIDS has also changed since 1988. Today, 53 percent of VA patients have a risk factor indicating a higher prevalence of HIV, but only 35 percent of that higher risk population is tested. The barriers in current law make testing a disturbingly rare occurrence.

In 2006, the Centers For Disease Control and Prevention (CDC) released guidelines that recommended HIV testing become a normal part of medical care where appropriate. After reviewing all of the clinical data, CDC strongly believes that separate written consent for HIV screening should no longer be required.

In the Administration's budget request this year, the VA identified this issue as a problem that needs to be fixed quickly. Concerns have been raised that the CDC's new guidelines don't go far enough to promote HIV prevention counseling. That debate is reasonable, and I understand that the VA is open to discussing that issue with veterans and other stakeholders.

That is why I drafted my bill to be agnostic on how the VA should proceed after the current regulations are repealed. The VA has pledged to follow the CDC's guidelines and protect patients' privacy by ensuring their right to an informed, verbal consent before screening as they do with any test for a serious condition.

Perhaps the current guidelines will be in place for the foreseeable future, but as the profile of HIV changes, the VA should be as free as any other medical provider to update their screening standards without future congressional intervention.

I am grateful to the Veterans of Foreign Wars of the United States (VFW) and American Veterans (AMVETS) for their strong support of the Sunset Act. I would also like to offer letters of support from AIDS Action, the AIDS Institute and OraSure Technologies for the record.

And finally, I want to thank the Committee staff for their help. The "Sunset Act" strikes an outdated law that puts veterans at risk, and it encourages medical professionals to create appropriate HIV screening standards after consultation with veterans, prevention groups and other stakeholders. I believe that it should be reported out of Committee and passed without delay.

I thank you for giving me the opportunity to speak today.

[The prepared statement of Congressman Doyle appears on p. 17.]

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

Mr. Miller.

Mr. MILLER. Thank you, Mr. Chairman. I think this is a perfect example of why some things don't need to be put in legislative form, so that it doesn't require it coming back before this particular body. I thank you very much, Mr. Doyle, and also our friend and colleague, Mr. Dent, who has made clear to me his support of this particular piece of legislation. I hope that we can move this legislation forward quickly.

I yield back the balance of my time.

Mr. MICHAUD. Thank you very much.

Mr. Hare.

Mr. HARE. Thank you, Mr. Chairman. And I thank my friend, Mr. Doyle, for introducing this legislation. It is a great bill and I wholeheartedly support it. I just had a couple of questions.

There is still a stigma with HIV, let alone getting the test. And it is seen as a sign of weakness if you have to take the test by some people. And should the separate written consent regulation be removed? And if so, what will the process be to get consent for the test?

Mr. DOYLE. It is going to be verbal consent. And I liken this with any other serious test. So basically when they want to perform the test, they make an informed consent. The doctor has a conversation with the patients. There is protections in there following the CDC guidelines to make sure that privacy concerns are addressed. And then once the person gives a verbal consent, then they can proceed with the test.

Mr. HARE. Then how will the results be recorded in the patient's record then?

Mr. DOYLE. Well, I think the results will be part of that patient's file, subject to the privacy protection, so that would only be information available to the patient and his doctor.

Mr. HARE. And then just last, currently patients who get tested in the non-VA world get an anonymous identifier to ensure their confidentiality. And how will this confidentiality be assured for the vets?

Mr. DOYLE. What the VA has done is pledge to follow the CDC guidelines that incorporates privacy concerns into it, And they have pledged in our conversations with them to work with CDC to make sure they follow those guidelines so that patient privacy is protected.

Mr. HARE. Once again, let me just thank you, Mr. Doyle, for a great piece of legislation. And you and Congressman Dent are to be commended. And I support this. And hopefully we can get this done and done quickly. And I yield back, Mr. Chairman.

Mr. MICHAUD. Thank you very much, Mr. Hare. Well, once again, thank you very much, Mr. Doyle, for your testimony today, and we will look forward to moving this legislation as soon as possible.

I would like to call the second panel up. Dr. Cross is the Deputy Under Secretary for Health, who is accompanied by Mr. Hall, as well as Kathryn Enchelmayer.

I would like to thank you for coming this morning, and I look forward to hearing your testimony. Dr. Cross.

STATEMENT OF GERALD M. CROSS, M.D., FAAFP, PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY WALTER A. HALL, ASSISTANT GENERAL COUNSEL, OFFICE OF THE GENERAL COUNSEL; AND KATHRYN ENCHELMAYER, DIRECTOR, QUALITY OF STANDARDS, OFFICE OF QUALITY AND PERFORMANCE, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. CROSS. Good morning, Mr. Chairman and Members of the Subcommittee. Thank you for inviting me to present the Administration's views on five bills that would affect the Department of

Veterans Affairs programs providing veterans healthcare. With me today are Walter Hall, Assistant General Counsel, and Kathryn Enchelmayer, Director of Quality Standards from the Office of Quality and Performance. I would like to request my written statement be submitted for the record.

Mr. MICHAUD. Without objection, so ordered.

Dr. CROSS. And I thank the Committee for its continued efforts on behalf of VA and our veterans. This Committee and this Congress have given serious consideration to many ideas that would improve the healthcare services of America's veterans. I thank the Committee for your attention and interest, and I am grateful for this opportunity to provide views on some of the proposals being considered.

Mr. Chairman, all of us know that prompt testing of HIV infection saves lives. Not only does it enable HIV positive patients to get treatment earlier, improving their prognosis and quality of life, but it also keeps patients with the virus from unknowingly spreading it to sexual partners. By repealing outdated informed-consent and counseling guidelines, H.R. 6114 will allow us to test our patients more quickly and allow VA's testing procedures to align with current guidelines from the CDC and other healthcare organizations.

We support this legislation. When veterans require emergency care, they need to focus on recovery, not on how they are going to pay for that care. VA recognizes that providing for emergency care is part of our obligation to our enrollees, and we want to make sure that enrolled veterans and their families do not need to worry about how it will be paid for. We also recognize that the current law governing payments for emergency care needs revision in order to fully meet that goal.

Unfortunately, in our opinion on H.R. 5888, we cannot support the proposed legislation without further clarification. As an example, under the current proposal, the VA is not only the payer of last resort, but also the only payer. We recommend the bill be modified to clarify that VA should be a secondary payer after private entities and other Federal programs, such as Medicare, have been billed.

Mr. Chairman, chronic pain persists for long periods in those who are afflicted by it. It is resistant to many treatments and can cause severe problems for sufferers. While we appreciate H.R. 6122's focus on that vital issue, I want to make sure that the Committee is aware that pain management is already an important priority for our department. VHA's national pain management strategy sets out our objectives in this area. We are developing a comprehensive, multicultural, integrated systemwide approach that will reduce the pain and suffering associated with a wide range of injuries and illness, including terminal illness. We have established an interdisciplinary Committee to oversee the strategy implementation responsible for ensuring that every veteran and every network has access to pain management services and for making certain our clinicians are properly educated on how to provide proper pain management care. I would be pleased to meet with you to discuss the activities in this area in greater detail.

Mr. Chairman, allowing the Secretary of Veterans Affairs and the Under Secretary for Health to establish standards of profes-

sional conduct and competency is vital to the future success of VA healthcare. Because of this, VA strongly opposes H.R. 4089, which would make matters relating to direct patient care, matters relating to clinical competence, clinical healthcare providers subject to collective bargaining. We believe the current restriction on collective bargaining rights is a sound compromise between the VA's mission to serve America's veterans with the honor and care they deserve and the interests of Title 38 physicians, dentists and nurses in bargaining over conditions of their employment.

I cannot overstate how important it is to continue to allow those responsible for the care and safety of our veterans to establish standards for professional conduct and competency at our hospitals and clinics. The VA very much believes that this proposed legislation should not become law.

Finally, VA also has serious concerns about H.R. 4463, which would mandate State licensure for physicians in specific States of practice. As the Committee knows, VA is a national healthcare system that crosses State boundaries and uses progressive technologies, such as telemedicine, to reach veterans in remote areas or in States outside of the base station. H.R. 4463 would make these practices difficult, if not impossible to continue. Our physicians who practice at VA Medical Centers in one State would not be able to care for veterans at a satellite community-based outpatient clinic located across a State border without having multiple licenses. Requiring multiple licenses would put VA at a competitive disadvantage in recruiting physicians. In addition, the bill would also severely limit VA's ability to support the Nation during periods of emergency, as the VA did in Hurricane Katrina.

Mr. Chairman, this concludes my prepared statement. And once again, I thank you and your Committee for your continued support of veterans and our Department. And at this time, I would be pleased to answer any questions that the Members have.

[The prepared statement of Dr. Cross appears on p. 21.]

Mr. MICHAUD. Thank you very much, Dr. Cross. On H.R. 6122, the "Veterans Pain Care Act of 2008," you mentioned the VA is already doing that. How effective is the national pain management strategy in creating a systemwide standard for pain management? And the second part of that question is do all of VHA clinicians receive the same employee education regarding pain assessment, as well as treatment?

Dr. CROSS. The consistency is derived from the directive that we have developed and put into practice several years ago. By the way, I should mention I have with me today a copy of the revised directive that we are about to publish, which even further moves this forward. We are proud of the work that we are doing on pain management. We consider it very important.

Let me tell you how we maintain consistency. We use our electronic health record, for instance, to do screening. We do records review to go back and look at how well we did after the fact. And as I recall, the percentages of compliance with some of these standards, including education, including the screening, is at the 95 percent level.

We are doing research on this. We are leaders in research in the United States. We support pain management. We feel it is very im-

portant. Some of the research that we are doing right now I think will lead the Nation in the future for best practices of care of everyone.

Mr. MICHAUD. And how often are the strategy pain management protocols reviewed and revised? Is it an ongoing process or—

Dr. CROSS. The directives are reviewed typically every several years, but we don't wait for that. We have an interdisciplinary Committee that meets periodically several times a year in one form or another to review what we are doing and to recommend changes. And so because we have this ongoing effort, we stay current.

Mr. MICHAUD. And is this a policy when you look at pain management that the Secretary or yourself has made a priority and that is why you are doing it without legislation?

Dr. CROSS. I think that we did it because we heard from our patients, we heard from our providers that this was important. We recognized a need that existed in the past that we needed to pay more attention to this. And this was created, as I said, several years ago. Certainly with Operation Iraqi Freedom and Operation Enduring Freedom veterans returning to us, we do see cases of chronic pain requiring special techniques to manage it, and we wanted to make sure that we were taking care of that.

Mr. MICHAUD. And do you have any concerns—this being an election year, there definitely will be a change of administration next year, whichever administration it might be no one knows yet—that actually this might not be a priority? And even though you are doing it now, that it might not happen next year or the year after?

Dr. CROSS. I don't have any such concern. I can't imagine that there would be any letup on the emphasis related to this.

Mr. MICHAUD. Thank you.

Mr. Miller.

Mr. MILLER. Thank you, Mr. Chairman. I can assure you when Senator McCain is elected he will make it a high priority. I have some questions—

Mr. MICHAUD. Which office is—

Mr. MILLER. Wait a minute now. I have some questions for the record.

The one thing I did want to know, I may be looking for something in the dark that is not there. In one of your comments regarding the emergency pay situation, I just hope we don't ever get to—I think it is something that is very important. You also said that we want to make VA the secondary payor. I hope we don't get to a point where VA thinks that in certain situations that it would be okay to not refer, but to cause veterans not to be able to go to a veterans' facility for emergency care and then require them to go to a non-VA facility so that VA does not have to make that payment. I know that is not the intent, clearly it could happen. I just think it is important that we address that on the record, that that would—I mean, it can be done in many different ways. We have heard it where it has happened before—not for that reason—where they have been required or an ambulance has taken them in error or for one reason or another to another facility. I just want to make sure that VA never considers that.

Dr. CROSS. I agree with you, Congressman. That would be very unfortunate. If I heard of such a case being carried out by one of my staff, they would have a bad day.

Mr. MILLER. Thank you, Dr. Cross.

Mr. MICHAUD. Mr. Hare.

Mr. HARE. Thank you, Mr. Chairman. I can understand the concerns that the VA has regarding H.R. 4463, the "Veterans Health Care Quality Improvement Act." And I am deeply concerned over the 10 deaths that occurred at the hospital in Marion, Illinois. However, I also understand the importance for VA doctors to be able to be transferred across State lines and for the VA to continue the use of telemedicine. But patient care and safety should never be compromised. What kind of compromise can be reached, do you think, to ensure that physicians and other medical personnel have high levels of credentials and are properly certified while still allowing the VA to operate as a national health system? Because clearly there are flaws in the system.

Dr. CROSS. I am going to ask Ms. Enchelmayer to support me on this. But before that, I want to say there was a misunderstanding about one case that probably gave origin to this bill. The individual in question was licensed in the State of Massachusetts and moved to Illinois. What is often not pointed out is he was also licensed in Illinois.

Ms. ENCHELMAYER. Thank you, Dr. Cross. And we do appreciate the question. VA actually has a very high standard of credentialing its practitioners, much higher than in the private sector of healthcare. We already verify all current and previously held licenses of our physicians. That is not something that is standard in the industry at this point in time. Most people just verify current licensure. But we do go back and look at a licensure history of a practitioner and we obtain information from the primary source.

But we also recognize that that has not been enough. We monitor the disciplinary action of physicians. I actually personally receive from the Federation of State Medical Boards whenever a disciplinary action is taken against a physician and we refer that out for followup to the facilities. We are tightening up that process, and my staff and I will be monitoring those actions until closure by the facility, at which time they will have to have obtained the primary source information from the State licensing board of that action.

We are changing our release of information form for all licensed practitioners, and we will be requiring a written verification from all State licensing boards of all of our healthcare practitioners, and this release of information form is now going to actually authorize the State licensing boards to provide not only the closed or public information that is already currently available when we seek that information, but also make a request of the State licensing boards to provide information to us that is pending or open claims against the practitioners.

And the last thing that we are putting in place is there has been some concern as to whether or not practitioners' memory is the best. And we have been working with the Federation of State Medical Boards, and we will shortly be implementing a query that will go to the Federation of State Medical Boards that will give us information on all State licenses of the physicians current and pre-

viously held. So it is a secondary system for us to follow up and make sure that we are aware of all current and previously held licenses of our practitioners.

Additionally, we do continue to do the queries to the National Practitioner Data Bank and Health Integrity and Protection Data Bank on licensure actions, medical malpractice payments, and other adverse actions. They have in pilot a proactive disclosure service similar to the disciplinary alert service at the Federation of State Medical Boards. We will be implementing that process, too, over the summer. And what happens with that is whenever a new report is filed with the National Practitioner Data Bank, we will also automatically receive that report and again implement the processes we have on the physician licensure actions, which will allow us to follow those actions to closure with the facilities, making sure again that they have the primary source information.

Our standards are actually much higher than the private industry, and we are just going to take them even higher.

Mr. HARE. Doctor, just one quick question on the pain care legislation we are talking about. I understand that the VA's position is that it is duplicative. Given that, why do you think all these pain care organizations are strongly in support of the bill and believe that more can be done by the VA to make pain care a national priority?

Dr. CROSS. I would like to clarify that I wouldn't use the term that we are in opposition to the bill. The phrase that we are using today is that we don't support it. The intent is clearly in line with what we want to do and what we are doing. So that should be clear. The issue was an additional bureaucratic, perhaps, mechanism that would be put in place with additional reports, and so forth, that we didn't think were necessary and would not add value.

Having said that, we do consider it a very high priority. We do understand the interest from organizations, and if there are additional things that we can do, we listen, and we will take those along and bring those forward as we have already done in the past with this initiative.

I should point out one caution. There were certain medicines that were put on the—available in the Nation that are well-known that had to be recalled a couple of years ago and you see those in the news frequently. Those were never part of our national formulary. So the safeguards and protections that we have in place at the VA I am very proud of and have served us well.

Mr. HARE. I know my time is out. I was just wondering what the difference is between being opposed and not supporting?

Dr. CROSS. It is the intent. We clearly understand the intent behind the legislation, I believe, and we find that our intent is very much the same.

Mr. HARE. Thank you, Doctor. Thank you, Mr. Chairman.

Mr. MICHAUD. Hopefully you can work with the Committee staffs to try to get you to that support area. Mr. Doyle, do you have any questions?

Mr. DOYLE. Just a couple. Thank you, Mr. Chairman. Dr. Cross, my colleague, Mr. Hare, had expressed some concern about informed consent and I thought maybe you could share with us if the

Sunset Act becomes law. Could you sort of walk us through what would happen to a veteran who seeks care at VA, will there be any different screening for veterans at higher risk and will the provider seek informed consent from a patient?

Dr. CROSS. I might say that the witness before me I thought did a very good job in answering those questions.

Mr. DOYLE. That is a great answer. That is better than I support you but I don't oppose you.

Dr. CROSS. It would be a verbal consent. The results would come back into our electronic health record system. We deal with sensitive information all day long on all of our patients. We have to abide by all of the regulations that Congress has put in place related to privacy. It is very important. This information would have to abide by those as well. We just don't want things getting in the way that create in effect a barrier to testing.

The nature of HIV has changed dramatically since 1988, and this is not the kind of frightening disease that it was at that time. Much progress has been made. We need to recognize that and let us go on and test more effectively and perhaps prevent some spread of the disease and also perhaps improve quality of life.

Mr. DOYLE. Great. And just one last question on the counseling aspect. There has been some concerns raised that the CDC guidelines don't go far enough in demanding HIV prevention counseling. And I think that reflects a desire for flexibility across types of providers and across the populations. But I want to make sure that VA is doing what is best for veterans. If the law requiring counseling is lifted, will the VA continue to offer prevention counseling for patients in its care, especially for those veterans at higher risk of contracting HIV?

Dr. CROSS. Yes. We consider, of course, prevention to be vital and fundamental to what we do. In our primary care clinics prevention is part of what we do, and not just for HIV, but for smoking and substance abuse and so forth.

I don't have a more detailed answer at this time. I would be happy to provide that for the record.

[The VA submitted an Information Letter from Hon. Jonathan B. Perlin, M.D., Ph.D., MSHA, FACP, Under Secretary for Health, U.S. Department of Veterans Affairs, entitled, "Need for Routine Human Immunodeficiency Virus (HIV) Risk Assessment and Testing," dated September 2, 2005, which appears on p. 47.]

Mr. DOYLE. Great. Thank you, Dr. Cross. Mr. Chairman, thank you.

Mr. MICHAUD. Once again, I want to thank you, Dr. Cross, and this panel for coming forward today. I look forward to working with you as we move forward on these pieces of legislation, and I want to thank everyone for coming. If there are no further questions, the hearing is closed.

[Whereupon, at 10:57 a.m., the Subcommittee was adjourned.]

A P P E N D I X

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

I would like to thank everyone for coming today.

Today's legislative hearing is an opportunity for Members of Congress, veterans, the VA and other interested parties to provide their views on and discuss recently introduced legislation within the Subcommittee's jurisdiction in a clear and orderly process.

I do not necessarily agree or disagree with the bills before us today, but I believe that this is an important part of the legislative process that will encourage frank discussions and new ideas.

We have five bills before us today.

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

I also look forward to working with everyone here to improve the quality of care available to our veterans.

Prepared Statement of Hon. Jeff Miller, Ranking Republican Member, Subcommittee on Health

Thank you, Mr. Chairman.

I appreciate your holding this legislative hearing to review five bills that have been referred to our Subcommittee.

I know we have a lot to cover this morning, so I will be brief with my opening remarks.

Clearly all of the bills we will discuss were introduced with the best intentions and have potential value. However, I am concerned that several of the legislative proposals contain provisions that are less than optimal and could unintentionally create more issues than they seek to resolve.

This hearing is an excellent opportunity to focus on specific issues, and I will have some questions on a few of the bills. Addressing the concerns of all the Members of this Subcommittee will allow us an important chance to continue improving the delivery of the very best health care possible to our veterans.

I look forward to hearing from our colleagues and the other witnesses and engaging in a thoughtful dialog about these important initiatives.

Thank you Mr. Chairman and I yield back.

Prepared Statement of Hon. Bob Filner, Chairman, Full Committee on Veterans' Affairs, and a Representative in Congress from the State of California

Statement on H.R. 4089

In 1991, Congress passed legislation to provide VA health care professionals such as registered nurses, physicians, physician assistants, dentists, podiatrists and optometrists with essentially the same labor rights held by other federal employees under Title 5. Under this law, VA health care professionals are able to negotiate, file grievances and arbitrate disputes over working conditions.

This law makes an exception for disputes arising from issues such as direct patient care and clinical competence, peer review, and the establishment, determination, or adjustment of employee compensation.

The Secretary has the authority to determine whether an issue or concern falls under the previous exceptions. This determination by the Secretary is not subject to collective bargaining or review by any other agencies.

Health care professionals have complained that VA is interpreting these narrow exceptions in the law very broadly, and consequently is negatively impacting areas such as schedules and floating assignments for nurses and retention allowances for physicians.

From a broader perspective, these labor issues may be adversely impacting VA's ability to recruit and retain high quality health care professionals, particularly nurses. Almost 22,000 of the RNs caring for our veterans will be eligible to retire by 2010 while 77% of all RN resignations occur within the first five years.

I introduced H.R. 4089 to address these important labor issues.

H.R. 4089 amends 38 USC, Section 7422 and repeals the three exceptions to the rights of VA health care professionals to engage in collective bargaining.

It also requires the VA to make a final decision with respect to the review of an adverse personnel action against a VA employee not later than 60 days after such action has been appealed.

Further, these decisions may be subject to judicial review in the appropriate U.S. District Court or, if the decision is made by a labor arbitrator, in the U.S. Court of Appeals for the Federal Circuit.

I appreciate the comments from the witnesses today. I look forward to working with the VA, my colleagues and interested stakeholders to ensure that VA health care professionals are afforded the appropriate collective bargaining rights. I hope that this will ultimately lead to improved recruitment and retention of health care providers within the Department.

Thank you and I would be happy to answer any questions you may have regarding H.R. 4089.

Statement on H.R. 5888

On October 9, 2007, Stephen Brady, a 60% service connected veteran, was in a serious motorcycle accident. Following his accident, Stephen was transported to a non-VA medical facility for emergency care. VA has refused to pay for any of his emergency medical care in the non-VA facility because he carried an auto insurance policy which paid for \$10,000 of his medical care.

The law in its current form does not allow the VA to pay for emergency treatment for non-service connected conditions in non-Department facilities if a veteran has third party insurance that pays for any portion, either in full or in part, of the emergency care.

This creates an inequity that penalizes veterans with insurance, including auto insurance which is oftentimes mandated by law. A veteran with an insurance policy which covers any portion of the cost for emergency treatment would be burdened with the remaining amount not covered by insurance. This unfair policy has caused many veterans undue stress and has placed them in unnecessary financial hardship.

H.R. 5888 eliminates this inequity in the law by requiring the VA to pay for emergency care in non-VA facilities for eligible veterans unless the veteran has other insurance that will pay for the full cost of the emergency care. In short, this bill would require the VA to pay for emergency care in a non-VA facility, even if the veteran holds a policy that will pay for any portion of their care.

I appreciate the comments from the witnesses today. I look forward to working with the VA, my colleagues and interested stakeholders to ensure that what happened to Stephen Brady does not happen to other veterans.

Thank you and I would be happy to answer any questions you may have regarding H.R. 5888.

Prepared Statement of Michael F. Doyle, a Representative in Congress from the State of Pennsylvania

Thank you, Chairman Filner, Chairman Michaud, Ranking Member Miller, and members of the Subcommittee, for including H.R. 6114 in today's hearing. I introduced the Simplifying and Updating National Standards to Encourage Testing of the Human Immunodeficiency Virus Act of 2008, also known as the SUNSET Act, with my friend and colleague Charlie Dent, to correct an anachronism in our veterans' health care laws.

Congress does not often step in and tell the Veterans Administration how to diagnose and treat patients in the system. I think we can all agree that this is wise. However, in 1988, Congress passed a law that requires the Veterans Administration to obtain a patient's written consent before being tested for HIV, the virus that causes AIDS.

While that might have been a best practice in 1988, it is now outdated and must be repealed.

According to the VA's Public Health Strategic Working Group, 55% of HIV positive veterans had already suffered significant damage to their immune system AIDS by the time they're diagnosed as HIV positive. Those veterans had been to the VA to get medical care an average of 6 times prior to diagnosis.

That same panel says that quote "the bottom line here is that we are likely dealing with a situation where there are thousands of HIV-infected veterans who are unaware" that they are HIV positive. That is unacceptable to me, and should be to anyone else who cares about public's health, and the wellbeing of our veterans.

The face of a person with HIV/AIDS has also changed since 1988. Today, 53% of VA patients have a risk factor indicating a higher prevalence of HIV, but only 35% of that higher-risk population is tested. The barriers in current law make testing a disturbingly rare occurrence.

In 2006, the Centers for Disease Control released guidelines that recommend that HIV testing become a normal part of medical care when appropriate. After reviewing all the clinical data, CDC strongly believes that separate written consent for HIV screening should no longer be required. In the Administration's budget request this year, the VA identified this issue as a problem that needs to be fixed quickly.

Concerns have been raised that the CDC's new guidelines don't go far enough to promote HIV-prevention counseling. That debate is reasonable, and I understand that the VA is open to discussing that issue with veterans and other stakeholders. That is why I drafted my bill to be agnostic as to how the VA should proceed after the current regulations are repealed. The VA has pledged to follow the CDC's guidelines and to protect patients' privacy by ensuring their right to an informed, verbal, consent before screening—as they do with any test for a serious condition.

Perhaps the current guidelines will be in place for the foreseeable future, but as the profile of HIV changes, the VA should be as free as any other medical provider to update their screening standards without future Congressional intervention.

I am grateful for the VFW and AMVETS's strong support for the SUNSET Act. I would also like to offer letters of support from AIDS Action, the AIDS Institute and OraSure for the record. Finally, I would like to thank the Committee's staff for their help.

The SUNSET Act strikes an outdated law that puts veterans at risk, and it encourages medical professionals to create appropriate HIV screening standards after consultation with veterans, prevention groups, and other stakeholders. I believe that it should be reported out of this Committee and passed without delay.

Thank you.

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

Chairman, Ranking member, members of the Subcommittee, thank you. I am here today to testify about H.R. 6122, the Veterans Pain Care Act of 2008, which I introduced on May 21, 2008. This bill requires the Secretary of the VA to develop and implement a comprehensive policy on pain management for veterans enrolled in the VA health care system and to carry out a program of research, training and education on acute and chronic pain.

Pain is a leading cause of disability among veterans. Modern warfare also often leads to serious but survivable injuries to the central nervous system. And while advances in medical technology have saved the lives of many wounded soldiers, many veterans of our Armed Forces are afflicted by acute and chronic pain. As a result, providing adequate pain management is a crucial component of improving veteran health care.

VA recognizes that chronic and acute pain among our veterans is a serious problem, and I applaud VA's existing pain care programs. But comprehensive pain care is not consistently provided on a uniform basis throughout the VA's health care system. My legislation will give VA the necessary tools to serve the needs of our veterans, building on the work VA is already doing. By also making clear that Congress considers pain care a priority, and putting it in law, VA's pain care programs will be less subject to the winds of politics and its unpredictability.

At the same time, the bill is not duplicative of the efforts VA is making— though by building on what VA is already doing means that my bill should not be expensive nor cumbersome. It will not be cumbersome especially since the bill is not overly prescriptive either—a concern with earlier versions of the bill but which I believe has been rectified in the version before you.

On that note, I have made a special effort to make my bill virtually identical to a bill in the Senate that was reworked in cooperation with the minority and now has the support of both the Chairman and the Ranking member on the Senate Veterans Affairs Committee. This bill, rolled into a larger bill, just passed the Senate by unanimous consent on Tuesday. I am hopeful that my bill, which also has bipartisan support, will move quickly through Congress and become law.

This bill is also part of an effort to provide pain care for our service members across their careers, and nicely complements a companion measure on pain care among the military which was originally introduced by Congressman Loebbeck and has now passed the House as part of the National Defense Authorization Act for FY2009. In this way, the two bills will help provide that seamless transition for our service members that we know is so important.

This bill has the support of a broad coalition of groups who are involved in pain care management, including the Pain Care Coalition and the American Pain Foundation.

I am also very pleased that a number of Veterans Service Organizations are here today to express their support for the bill. There is also a role for them in the implementation of this bill, as VA will work with veterans service organizations and other experts in pain management to continually improve its comprehensive pain care policy. There is also an oversight mechanism, so that Congress has a role in ensuring that this happens: the VA is required to report regularly to Congress on the progress it is making in implementing and improving its pain management policy.

With these oversight mechanisms, and by directing VA to update its pain management policy in light of experience and evolving best practices as well as to carry out a research component, the ultimate aim of the bill is to lay a foundation for the ongoing improvement in pain care treatment of our veterans and, in combination with the companion military bill, for our service members across their careers. In that way, we can work towards fulfilling what I believe is a moral obligation to care for these veterans with the most innovative pain management techniques, so that they can have the highest quality of life possible.

I urge you to support our veterans by supporting this bill. Thank you.

Pain Care Coalition
Washington, DC.
May 15, 2008

Pain Care Coalition—A National Coalition for Responsible Pain Care
American Academy of Pain Medicine, American Headache Society,
American Pain Society, American Society of Anesthesiologists

The Honorable Tim Walz
1529 Longworth House Office Building
Washington, D.C. 20515

Dear Congressman Walz,

Re: Veterans Pain Care Act of 2008

The Pain Care Coalition applauds your leadership in championing the Veterans Pain Care Act. We enthusiastically support the measure, and pledge the assistance of our organizations as you move the bill forward in the House. As your bill mirrors bi-partisan legislation under consideration in the Senate, and complements a DoD pain care initiative included in the House FY 2009 Defense Authorization bill, we are optimistic that it will receive wide support.

Pain is a huge public health problem for veterans. Virtually every service member injured in current and past conflicts experienced acute pain at the time of injury. Many others suffered acute pain in connection with non-combat related injury or disease. For too many, the acute pain progresses to a chronic pain condition that threatens the veteran's basic quality of life. These same chronic pain conditions can be cost "drivers" in VA health and disability systems. With prompt and aggressive treatment, much acute pain can be alleviated, and much chronic pain avoided or managed.

The Department of Veterans Affairs is doing much to provide good pain care and advance important pain research, but much, much more remains to be done. Your

bill will make pain care a national priority within the VA health care programs. Millions of veterans who have served our country deserve no less.

Respectfully submitted,

Richard Rosenquist, M.D.
Chair

Consensus Statement Supporting the Congressional Military Pain Bill and the Veterans Pain Bill

Acute and chronic pain afflicts both military personnel and veterans in proportions far exceeding the general population. Pain is the leading cause of disability among veterans. Characteristics of modern warfare produce serious, but survivable, injuries to the central and peripheral nervous systems that inflict terrible acute pain and lead to chronic pain in many cases. Providing adequate pain management is a crucial component to improving military and veteran health care. A growing number of wounded veterans are experiencing long-term problems with chronic pain; left untreated, pain can have lifelong consequences.

As members of organizations dedicated to improving the lives of veterans and military personnel and organizations dedicated to improving the quality of pain management, the undersigned organizations support and urge passage of legislation to improve pain care for active duty military and veterans. In particular we support legislation which:

- Requires Uniformed Service Secretaries to implement a comprehensive pain care initiative to require prompt assessment and reassessment of pain in all health setting; emphasizes assessment, diagnosis, treatment & management of pain as an integral part of military health care; and deploys acute pain services to all combat support hospitals and, where feasible, on the battlefield.
- Requires Tricare plans to provide pain care services that ensure appropriate assessment, diagnosis, treatment and management of acute and chronic pain and provide comprehensive interdisciplinary services for hard to treat chronic pain patients.
- Requires the Department of Veterans Affairs to implement in VA health facilities and programs a pain care initiative comparable to that required for DoD programs.
- Requires the VA to increase its research effort in the areas of acute and chronic pain, including identifying priority research areas most relevant to veterans.
- Requires the VA to emphasize education and training of VA personnel in pain management.
- Establishes cooperative research center for acute and chronic pain, including one with a special focus on central and peripheral nervous system damage.
- Directs the GAO to evaluate the consistency of military and veteran pain care services across different programs, facilities, demographic groups and geographic areas; and
- Assesses the adequacy and appropriateness of pain care services based on performance measures previously adopted by the VA.

Signed,

Air Compassion for Veterans
Alliance of State Pain Initiatives
Alpharma Pharmaceuticals LLC
American Academy of Pain Medicine
American Association of Diabetes Educators
American Cancer Society
American RSDHope
Ava Mina Pain Clinic
The American Chronic Pain Association
American Headache Society
American Pain Foundation
American Pain Society
American Pharmacists Association
American Society of Anesthesiologists
American Society for Pain Management Nursing
Amputee Coalition of America
AVANCEN LLC
Boston Scientific
Brave New Foundation
Cause

Cephalon, Inc.
 Comfort Care Unlimited
 Coming Home Project
 Endo Pharmaceuticals
 Florida Pain Initiative
 HealthSouth Valley of the Sun Rehabilitation Hospital
 Homes for Our Troops
 Jacob's Light Foundation, Inc.
 Indiana Hospice and Palliative Care Organization
 Indiana Pain Initiative
 Iraq and Afghanistan Veterans of America
 Medtronic, Inc.
 Michigan Cancer Pain Initiative
 Missouri Pain Initiative
 Montana Cancer Control Coalition
 National Fibromyalgia Research Association
 National Pain Foundation
 National Veterans Legal Services Program
 National Vulvodynia Association
 One Freedom, Inc.
 Operation Helmet
 Operation Home Front
 Pain Care Coalition
 Pain Connection
 Pain Treatment Topics
 P.A.N.D.O.R.A.
 Project Return to Work, Inc.
 Purdue Pharma L.P.
 Reflex Sympathetic Dystrophy Syndrome Association
 South Dakota Injured Workers Coalition
 St. Jude Medical's Neuromodulation Division Advanced Neuromodulation Systems
 Swords to Plowshares
 The Pathway Home (Veterans Home of California)
 There is Hope . . . for Chronic Pain
 Veterans for America
 Washington-Alaska Pain Initiative

**Prepared Statement of Gerald M. Cross, M.D., FAAFP,
 Principal Deputy Under Secretary for Health,
 Veterans Health Administration, U.S. Department of Veterans Affairs**

Good morning, Mr. Chairman and Members of the Subcommittee:

Thank you for inviting me here today to present the Administration's views on several bills that would affect Department of Veterans Affairs (VA) programs that provide veterans benefits and services. With me today are Walter A. Hall, Assistant General Counsel, and Kathryn Enchelmayer, Director, Quality Standards, Office of Quality and Performance. Thank you for the opportunity to provide VA's views on the five bills before us today. We strongly support H.R. 6114, which will remove a barrier to VA modernizing its HIV testing policy. We would like to discuss the need for further clarification of the terms of H.R. 5888, which concerns reimbursement or payment of a veteran's expenses for non-VA emergency treatment. Although we appreciate the goals of H.R. 6122, we believe we are already meeting the requirements of the bill and, as a result, the legislation is unnecessary. I also welcome this opportunity to explain our serious objections to two bills on today's agenda: H.R. 4089 and H.R. 4463. Those bills have troubling implications for VA and we urge the Subcommittee to give them thorough and measured consideration in view of our comments.

H.R. 4089—Collective Bargaining Rights for Review of Adverse Actions

Mr. Chairman, the major provision of H.R. 4089 would make matters relating to direct patient care and the clinical competence of clinical health care providers subject to collective bargaining. It would repeal the current restriction on collective bargaining, arbitrations, and grievances over matters that the Secretary determines concern the professional conduct or competence, peer review, or compensation of Title 38 employees. The Secretary would also be required to bargain over direct patient care and clinical competency issues, the processes VA uses to assess Title 38

professionals' clinical skills, and the discretionary aspects of Title 38 compensation, including performance pay, locality pay, and market pay. Because they would be negotiable these matters would also be subject to non-clinical, non-VA third party review.

VA strongly opposes this provision. Prior to 1991, Title 38 professionals did not have the right to engage in collective bargaining at all. The current restriction on collective bargaining rights is a sound compromise between VA's mission—best serving the needs of our Nation's veterans—and the interest of Title 38 physicians, nurses, and other professionals in engaging in collective bargaining. Importantly, Congress recognized that the Secretary, as the head of the VA healthcare system, would be in the best position to decide when a particular proposal or grievance falls within one of the statutory areas excluded from bargaining. Such determinations should not be legislated. Neither should they be made by a non-clinical third party who is not accountable for assuring the health and safety of the veterans for whom the Department is responsible. If the Secretary and the Under Secretary for Health are going to be responsible and accountable for the quality of care provided to and the safety of veterans, they must be able to determine which matters affect that care. They must be able to establish standards of professional conduct by and competency of our clinical providers based on what is best for our veterans rather than what is the best that can be negotiated or what an arbitrator decides is appropriate. The Under Secretary for Health has been delegated the authority to make these discretionary determinations. VA has not abused this discretionary authority. Since 1992, there have been no more than 13 decisions issued in a one-year period and, in most cases, even far fewer decisions than that. This is particularly striking given the number of VA healthcare facilities and bargaining unit employees at those facilities. We are therefore at a loss to understand the need for this provision.

H.R. 4089 would also transfer VA's Title 38 specific authorities, namely the right to make direct patient care and clinical competency decisions, assess Title 38 professionals' clinical skills, and determine discretionary compensation for Title 38 professionals, to independent third-party arbitrators and other non-VA non clinical labor third parties who lack clinical training and understanding of health care management to make such determinations. For instance, labor grievance arbitrators and the Federal Service Impasses Panel would have considerable discretion to impose a clinical or patient care resolution on the parties. VA would have limited, if any, recourse if such an external party erred in its consideration of the clinical or patient care issue. The exceptions to collective bargaining rights for Title 38 employees identify areas that directly impact VA's ability to manage its healthcare facilities and monitor the professional conduct and competence of its employees; management actions concerning these areas must be reserved for VA professionals.

This bill would allow unions to bargain over, grieve, and arbitrate subjects that are even exempted from collective bargaining under Title 5, including the manner by which an employee is disciplined and the determination of the amount of an employee's compensation. That would be unprecedented in the Federal government. Such a significant change in VA's collective bargaining obligations would adversely impact VA's budget and management rights; it would also skew the current balance maintained between providing beneficial working conditions for Title 38 professionals and meeting patient care needs, jeopardizing the lives of our veterans.

H.R. 4463—"Veterans Health Care Quality Improvement Act"

We recently provided the Committee with our official views on H.R. 4463. Our views letter included a very detailed discussion of each of the bill's provisions and implications. We will therefore take this important opportunity to discuss only the bill's provisions that we find objectionable and deleterious to the fundamental operations of the Veterans Health Administration (VHA).

First, the requirement that within one year of appointment each physician practicing at a VA facility (whether through appointment or privileging) be licensed to practice medicine in the State where the facility is located is particularly troubling and we believe harmful to the VA system. VA therefore strongly objects to enactment of this provision. VHA is a nationwide health care system. By current statute, to practice in the VA system, VA practitioners may be licensed in any State. If this requirement were enacted, it would impede the provision of health care across State borders and reduce VA's flexibility to hire, assign and transfer physicians. This requirement also would significantly undermine VA's capacity and flexibility to provide telemedicine across State borders. VA makes extensive use of telemedicine. In addition, VA's ability to participate in partnership with our other Federal health care providers would be adversely impacted in times such as the aftermath of Hurricanes Katrina and Rita, where we are required to mobilize members of our medical staff in order to meet regional crises.

Currently, physicians who provide medical care elsewhere in the Federal sector (including the Army, Navy, Air Force, U.S. Public Health Service Commissioned Corps, U.S. Coast Guard, Federal Bureau of Prisons and Indian Health Service) need not be licensed where they actually practice, so long as they hold a valid State license. Requiring VA practitioners to be licensed in the State of practice would make VA's licensure requirements inconsistent with these other Federal healthcare providers and negatively impact VA's recruitment ability relative to those agencies. In addition, many VA physicians work in both hospitals and community-based outpatient clinics. Many of our physicians routinely provide care in both a hospital located in one State and a clinic located in another State. A requirement for multiple State licenses would place VA at a competitive disadvantage in recruitment of physicians relative to other health care providers.

Although the provision would allow physicians one year to obtain licensure in the State of practice, many States have licensing requirements that are cumbersome and require more than one year to meet. Such a requirement could disrupt the provision of patient care services while VA physicians try to obtain licensure in the State where they practice or transfer to VA facilities in States where they are licensed. The potential costs of this disruption are unknown at this time.

Further, we are not aware of any evidence of a link between differences in State licensing practices and quality of patient care. In 1999, the General Accounting Office reviewed the effect on VA's health care system that a requirement for licensure in the State of practice would have. The GAO report concluded, in part, that the potential costs to VA of requiring physicians to be licensed in the State where they practice would likely exceed any benefit, and that quality of care and differences in State licensing practices are not directly linked. See GAO/HEHS-99-106, "Veterans' Affairs Potential Costs of Changes in Licensing Requirement Outweigh Benefit" (May 1999).

Second, the bill includes a provision that would prohibit VA from appointing physicians to VHA unless they are board certified in the specialties of practice, although this requirement could be waived (not to exceed one year) by the Regional Director for individuals who complete a residency program within the prior two year period and provide satisfactory evidence of an intent to become board certified. VA strongly opposes this provision of H.R. 4633. Current law does not require board certification as a basic eligibility qualification for employment as a VA physician. VA policy currently provides that board certification is only one means of demonstrating recognized professional attainment in clinical, administrative or research areas, for purposes of advancement. However, we actively encourage our physicians to obtain board certification. Facility directors and Chiefs of Staff must ensure that any non-board certified physician, or physician not eligible for board certification, is otherwise well qualified and fully capable of providing high-quality care for veteran patients. VA should be given considerable flexibility regarding the standards of professional competence that it requires of its medical staff, including the requirement for specialty certification. Were this measure enacted, it could have a serious chilling effect on our ability to recruit very qualified physicians. At this point in time, VA has physician standards that are in keeping with those of the local medical communities.

Moreover, the bill would provide that the board certification and in-State licensure requirements would take effect one year after the date of the Act's enactment for physicians on VA rolls on the date of enactment. This would at least temporarily seriously disrupt VA's operations if physicians are unable to obtain board certification and in-State licensure within one year, or are unable to transfer to a State where they are licensed.

Mr. Chairman, we want to emphasize that we support the intent of several provisions of H.R. 4633 and have already been taking actions to achieve many of the same goals. We would welcome the opportunity to meet with the Subcommittee to discuss recent actions we have undertaken to improve the quality of care across the system, including program oversight related measures.

H.R. 5888—Expansion of Eligibility for Reimbursement for non-VA Emergency Care

H.R. 5888 would modify the eligibility requirements for receiving payment or reimbursement of expenses incurred in receiving unauthorized emergency treatment from a non-VA provider for a non-service connected disability. Currently, to be eligible for reimbursement of such expenses, a veteran must meet a number of criteria, including that he or she not have "other contractual or legal recourse against a third party that would, in whole or in part, extinguish such liability to the provider." H.R. 5888 would amend that requirement so that eligibility would be extended to a veteran who has no other contractual or legal recourse against a third party that would

in whole extinguish the veteran's liability to the provider. For purposes of this benefit, the relevant law defines a "third party" as:

- A Federal entity.
- A State or political subdivision of a State.
- An employer or an employer's insurance carrier.
- An automobile accident reparations insurance carrier.
- A person or entity obligated to provide or to pay the expenses of health services under a health-plan contract.

Mr. Chairman, we recognize and appreciate the gap in VA benefits that this bill seeks to correct. We welcome the opportunity to work with you and the Subcommittee to meet the desired end. However, we cannot support H.R. 5888 as currently drafted. Under existing law, VA is the payor of last resort; as such, we are the only payor. It is not clear whether H.R. 5888 would require VA to be a secondary payor in cases where a veteran receives payment from a third party that covers only part of the veteran's outstanding liability to the non-VA provider. The bill should therefore be modified to clarify that VA should be the secondary payor among private entities and other Federal programs (e.g. Medicare). It is also unclear what VA's obligation would be if the rate billed by the non-VA provider is higher than the rate that VA is authorized to pay under the program, i.e. 70 percent of the Medicare rate. The bill should be modified to clarify whether VA would be required to pay only the difference between the amounts paid by the third party and the VA allowable amount. We believe that VA's obligation should be limited to the VA-authorized amount, including any payment made by a third party payment. Specifically, VA's liability (up to 70% of the applicable Medicare rate) should be offset by any third party payment. Further, the bill should clarify whether the veteran would be liable for any remaining balance still due the provider after a responsible third party and VA have made their respective payments. Currently, VA's payment under this authority, unless rejected and refunded by the provider within 30 days of receipt, extinguishes any liability on the part of the veteran for that treatment. We believe the bill should be modified to make clear that VA payment under this section, as amended by the bill, would still fully extinguish the veteran's liability to the provider so that the veteran would not be liable for any remaining outstanding balance above the VA-authorized amount.

Interpretation of H.R. 5888 is further complicated by the fact that the definition of a "third party" includes a person or entity obligated to provide or pay the expenses under a health-plan contract. Thus, there is potential overlap between H.R. 5888 and another statutory requirement that the veteran have "no entitlement to the services under a health-plan contract" for the emergency treatment at issue. Lastly, we believe H.R. 5888 could be interpreted to require that VA pay any copayments the veteran owes to the third party.

Mr. Chairman, we are still in the process of developing costs for this bill. As soon as they are available we will forward them for the record.

H.R. 6114—"Simplifying and Updating National Standards to Encourage Testing of the Human Immunodeficiency Virus of 2008"

Mr. Chairman, H.R. 6114 is identical to an Administration proposal we recently submitted to the Congress. We strongly support this bill, which would repeal outdated statutory requirements that require VA to provide a veteran with pre-test counseling and to obtain the veteran's written informed consent prior to testing the veteran for HIV infection. Those requirements are not in line with current guidelines issued by the Centers for Disease Control and Prevention and other health care organizations, which, with respect to the issue of consent, consider HIV testing to be similar to other blood tests for which a patient need only give verbal informed consent. According to many VA providers, the requirements for pre-test counseling and prior written consent delay testing for HIV infection and, in turn, VA's ability to identify positive cases that would benefit from earlier medical intervention. As a result, many infected patients unknowingly spread the virus to their partners and are not even aware of the need to present for treatment until complications of the disease become clinically evident and, often, acute. Testing for HIV infection in routine clinical settings no longer merits extra measures that VA is now required by law to provide. Many providers now consider HIV to be a chronic disease for which continually improving therapies exist to manage it effectively. Repealing the 1988 statutory requirements would not erode the patient's rights, as VA would, just like with tests for all other serious conditions, still be legally required to obtain the patient's verbal informed consent prior to testing.

VA estimates the discretionary costs associated with enactment of H.R. 6114 to be VA \$73,680,000 for FY 2009 and \$301,401,000 over a 10-year period.

H.R. 6122—"Veterans Pain Care Act of 2008"

H.R. 6122 would require the Secretary, not later than October 1, 2008, to develop and implement a comprehensive policy on pain management for enrolled veterans. The bill would require this policy to address:

- System-wide management of veterans' acute and chronic pain.
- A national standard of care for pain management.
- Consistent application of pain assessments.
- Assurance of prompt and appropriate pain care treatment and management, when medically necessary.
- Research related to acute and chronic pain, including pain attributable to central and peripheral nervous system damage characteristic of injuries incurred in modern warfare.
- Pain care education and training for VA health care personnel.
- Pain care education for veterans and their families.

H.R. 6122 would also require the Secretary to revise the comprehensive policy periodically based on experience and evolving best practice guidelines. It would additionally require the Secretary to develop that policy in consultation with veterans service organizations and other organizations with expertise in the assessment, diagnosis, treatment, and management of pain. Finally, the bill would establish detailed reporting requirements.

VA does not support H.R. 6122 because it is duplicative of on-going efforts. Effective clinical management of our patients' pain is fundamental to the delivery of patient-centered medicine. To that end, in 2003 we established a national Pain Management Strategy to provide a system-wide approach to pain management to reduce pain and suffering for veterans experiencing acute and chronic pain associated with a wide range of illnesses. The national strategy uses a system-wide standard of care for pain management; ensures that pain assessment is performed in a consistent manner; ensures that pain treatment is prompt and appropriate; provides for continual monitoring and improvement in outcomes of pain treatment; uses an interdisciplinary, multi-modal approach to pain management; and ensures VA clinicians are prepared to assess and manage pain effectively. VA's national strategy also called for pain management protocols to be established and implemented in all clinical settings and directed all VHA medical facilities to implement processes for measuring outcomes and quality of pain management. The national strategy is regularly updated based on best-practices and evidence-based medical findings.

To oversee implementation of the National Pain Management System, VHA established an interdisciplinary committee. Part of the committee's charge is to ensure that every veteran in every network has access to pain management services. The committee is also responsible for making certain that national employee education is provided to VHA clinicians so that they have the needed expertise to provide high quality pain assessment and treatment and for identifying research opportunities and priorities in pain management. It also facilitates collaborative research efforts and ensures that VHA pain management standards have been integrated into the curricula and clinical learning experiences of medical students, allied health professional students, interns, and resident trainees. Moreover, VA already provides education and educational materials to veterans and their families on how to best manage the veterans' acute or chronic pain. We continually seek to ensure all patients and families who could benefit from patient education receive all the assistance they need.

Because pain management is already a subject of systematic and system-wide attention in the VHA health care system, H.R. 6122 is not necessary. We would be very happy to meet with the Committee to discuss VA's ongoing pain management program and activities. We estimate there would be no additional costs associated with enactment of H.R. 6122.

Mr. Chairman, this concludes my prepared statement. I would be pleased to answer any questions you or any of the members of the Subcommittee may have.

Statement of American Federation of Government Employees, AFL-CIO

Mr. Chairman and Members of the Subcommittee:

The American Federation of Government Employees (AFGE) appreciates the opportunity to submit a statement for the record on H.R. 4089 and other bills under consideration today. AFGE represents nearly 160,000 employees in the Department of Veterans Affairs (VA), more than two-thirds of whom are Veterans Health Ad-

ministration (VHA) professionals on the frontlines treating the physical and mental health needs of our veteran population.

H.R. 4089

H.R. 4089 would clarify that “pure Title 38” providers (hereinafter “providers”), i.e., registered nurses (RN), physicians, physician assistants, dentists, chiropractors, optometrists, podiatrists and expanded-duty dental auxiliaries, have the same rights as other health care professionals working at the VA, military hospitals and other federal government facilities, specifically:

- *Collective bargaining rights*: Section 1 would clarify that these providers have equal rights to challenge management personnel actions through grievances, arbitrations, labor-management negotiations, unfair labor practices (ULPs) and litigation before the Federal Labor Relations Authority (FLRA) and courts.
- *Judicial review*: Section 2 would clarify that these providers have the right to appeal to federal court the final decision of a labor arbitrator or the Department with respect to review of an adverse action.
- *Disciplinary Appeals Board (DAB)*: Section 3 would clarify the right of these providers to a full and correct copy of the hearing transcript in advance of the deadline for submitting post-hearing briefs, in administrative appeals of major adverse actions involving professional conduct or competence under 38 USC § 7462.

H.R. 4089 is an *essential* enforcement tool for past and future VHA recruitment and retention legislation. Section 1 would close a harmful loophole in 38 USC § 7422 (“7422”) that the VA has repeatedly used to undermine Congressional intent. More specifically, VA management at the national and local levels regularly invoke the three exclusions to bargaining in section 7422 to block virtually every provider grievance over conditions of employment: professional conduct and competence (defined as direct patient care or clinical competence); peer review; and compensation.

The VA’s Assertion That H.R. 4089 Will Interfere With Management’s Title 5 Rights to Carry Out its Mission is Unfounded

The VA contends that amending section 7422 would interfere with the agency’s mission to serve the needs of our nation’s veterans, by requiring the Secretary to bargain over direct patient care, clinical competency and discretionary aspects of Title 38 compensation.

Yet, the VA does not, and cannot, point to a single attempt by employees or their representatives to interfere with medical procedures, the assessment of clinical skills or pay scales set by the agency.

Even if there was such an attempt, Title 5 already protects against such interference in VA health care settings. More specifically, section 7106(a) of Title 5 clearly makes an agency’s determination of its mission and organization a “management right” not to be affected by the grievance or arbitration process. In contrast, Section 7103(a)(14) of Title 5 describes matters that can be modified at the bargaining table (or grieved) as “conditions of employment”. In other words, Title 5 management rights render the exclusion language in section 7422 redundant and unnecessary.

A review of decisions by the Federal Labor Relations Authority makes clear that if section 7422 were amended to repeal the current exclusions to bargaining, *labor would still be prohibited from negotiating with the agency on how it fulfills its mission*, i.e., caring for veterans.¹ If the union cannot require negotiations on even “when” services are to be provided to the public for “mission” reasons, it follows that

¹See *Department of the Air Force, Lowry AFB, Colo.*, 16 FLRA 1104, 1004–05 (1984) (hours that a base commissary will be open not subject to an agency’s duty to bargain for mission reasons); *AFGE Local 3231 and SSA*, 22 FLRA 868, 869–70 (1986) (bargaining proposal seeking to establish hours that SSA district office is open to the public is outside the agency’s statutory duty to bargain under the “mission” management right); *West Point Elementary School Teachers Ass’n, NEA and U.S. Military Academy Elementary School, West Point, N.Y.*, 29 FLRA 1531, 1536–38 (1987) (bargaining proposal on what dates shall constitute the school calendar outside the agency’s duty to bargain under the “mission” management right because it determined the days on which children will attend school); *Fort Bragg Ass’n of Educators, NEA and Dep’t of the Army, Fort Bragg Schools*, 30 FLRA 508, 516–17 (1987) (bargaining proposal on what times on each day a school shall be open found to be outside the agency’s duty to bargain under the “mission” management right because it determined the times of the day at which children will attend school); *National Labor Relations Board Union Local 21 and NLRB, Washington, D.C.*, 36 FLRA 853, 857–58 (1990) (bargaining proposal seeking to establish hours that an NLRB office is open to the public is outside the agency’s statutory duty to bargain under the “mission” management right). See also *U.S. Immigration and Naturalization Service and AFGE Local 1917*, 20 FLRA 391 (1985) (“INS”) (holding section 7106(a) may serve to bar a remedy ordered by an arbitrator that impermissibly infringes on the agency’s right to determine mission.)

a union lacks the right, under Title 5 provisions, to force discussion on the substance of what care is provided to its public.

VA's 7422 Policy Undermines Congressional Efforts to Improve Recruitment Retention

VA's 7422 policy has severely weakened legislation that Congress passed in recent years to recruit and retain a strong health care workforce:

- *VA's 7422 policy weakens recruitment and retention legislation on nurse locality pay:* Congress enacted legislation in 2000 to authorize directors to conduct third party surveys to set competitive nurse pay (P.L. 106-419). The Undersecretary of Health (USH) has ruled that the "compensation" exception blocks employees' access to third party survey data. (Decision dated 1/06/05.)
- *VA's 7422 policy weakens recruitment and retention legislation limiting mandatory nurse overtime:* Congress enacted legislation in 2004 to require facilities to establish policies limiting mandatory overtime except in cases of "emergency" (P.L. 108-445). The USH ruled that an AFGE national grievance over the definition of "emergency" is barred by the "professional conduct or competence" exception. (Decision dated 10/22/07.)
- *VA's 7422 policy weakens recruitment and retention legislation on physician market and performance pay:* Congress enacted legislation in 2004 to use local panels of physicians to set market pay that would be competitive with local markets (P.L. 108-445). The USH ruled that AFGE's national grievance over the composition of the pay panels was barred by the "compensation" exception. (Decision dated 3/2/07). (Local management in many facilities also asserted 7422 to block challenges to pay panel grievances.) Similarly, with regard to performance pay provisions in the 2004 law, VA physicians across the nation are unable to challenge management policies that set arbitrarily low bonuses and impose unfair performance measures based on factors beyond the physicians' control. Local management also regularly asserts 7422 to deny physicians' requests to have input into development of performance criteria.
- *VA's 7422 policy weakens recruitment and retention legislation on nurse alternative work schedules:* Congress enacted legislation in 2004 to authorize facility directors to offer full-time pay for three 12-hour work days, to become competitive with the private sector. The USH has ruled that disputes over compressed work schedules and alternative work schedules are barred by the "patient care" exception. (For example, see decisions dated 10/11/05, 8/22/05 and 3/15/05.)

VA's 7422 Policy Undermines Other Statutory Rights

Since the VA does not inform AFGE of pending cases or unpublished decisions, we are only aware of a portion of all 7422 decisions made at the USH level or below. The following are examples of other cases where the VA also invoked 7422 in ways that undermined important rights established by Congress:

- *No right to challenge performance rating based on use of approved leave:* Management invoked 7422 when a nurse tried to grieve the lowering of her performance rating that was based on her authorized absences using earned sick leave and annual leave. Management's actions were carried out without any written justification.
- *No right to challenge error in pay computation:* Management invoked 7422 when a nurse was incorrectly denied a statutory within-grade pay increase because she lost work time due to a work-related injury covered by workers compensation.
- *No right to pursue grievance alleging employment discrimination:*
 - In a case involving a VA physician who lost his surgical privileges and specialty pay, a federal appeal court upheld the barring of his grievance alleging unlawful age and gender discrimination on the basis of the "professional conduct or competence" exception in 7422. The union had contended that management's 7422 assertion was a mere pretext for unlawful discrimination. *AFGE Local 2152 v. Principi*, 464 F.3d 1049 (9th Cir. 2006).
 - A nurse who alleged that management's denial of specialized skills pay to her was racially motivated was not allowed to pursue a grievance. (USH decision dated 6/1/07).

VA's 7422 Policy Contradicts Congressional Intent to Provide Full Collective Bargaining Rights to Title 38 Providers

When Congress enacted the Civil Service Reform Act (CSRA) in 1978, it viewed Title 38 and Title 5 employees as having the same collective bargaining rights.

A decade later, in a decision involving annual nurse "comparability pay" increases, the U.S. Court of Appeals for the D.C. Circuit held that the VA could not

be compelled by the CSRA to engage in collective bargaining over conditions of employment for Title 38 providers. *Colorado Nurses Ass'n v. FLRA*, 851 F.2d 1486 (D.C. Cir. 1988).

Congress enacted section 7422 three years later in direct response to the court's ruling. The 1990 House Committee report on the underlying bill defined the "direct patient care" exception as "medical procedures physicians follow in treating patients." This report also cited guidelines for RNs wishing to trade vacation days as falling outside the exception. (H. Rep. No. 101-466 on H.R. 4557, 101st Cong., 2d Sess., 29 (1990)).

The plain language of section 7422 confirms Congress' intent to give these providers broad rights to challenge management personnel actions (as opposed to medical procedures) through the negotiated grievance process, by specifying that nongrievable matters relate to "*direct patient care*" or "*clinical competence*."

VA's 7422 Policy is Unsound and Inconsistent

VA Title 38 policy is inconsistent with the rights of other VA and DoD providers.

The VA is using section 7422 to block routine grievances over conditions of employment by Title 38 providers that are regularly filed by other federal employees, including employees at VA medical facilities. These inconsistencies are harmful to recruitment and retention, and administration of hospital affairs. For example:

- A VA psychologist has more grievance rights than a VA psychiatrist.
- A VA Licensed Practical Nurse has more grievance rights than a VA Registered Nurse.
- A physician treating active duty personnel at Walter Reed has more grievance rights than a physician treating veterans at the VA.

Federal employees working in health care settings use their collective bargaining rights every day without disrupting patient care. As already discussed, Title 5 safeguards against the improper use of grievance rights by Title 38 and Title 5 employees.

Section 7422 is invoked in an inconsistent manner.

At the national level, VA's application of the law is inconsistent and unsupported. For example:

- The VA is currently negotiating with AFGE over reimbursement of physician continuing medical education expenses but refused to negotiate over the composition of pay panels to set physician market pay.
- The VA negotiated a Memorandum of Understanding with AFGE over the role of the Clinical Nurse leader. Yet the VA refused to negotiate over the right of a union local to have input into the drafting of medical staff bylaws that impact personnel policies.

Inconsistency is rampant at the local level. Human resources personnel regularly make unauthorized 7422 decisions instead of seeking a proper USH ruling, and without adequate legal oversight. It is also common practice for local management to threaten to invoke 7422 in order to discourage employees from using their grievance rights, rather than seek an USH ruling.

Current VA policy contradicts its own past policy on 7422.

In 1996, the VA and labor unions entered into a detailed agreement regarding the scope of 7422's exceptions. Sadly, the VA unilaterally abandoned this useful, inclusive agreement seven years later as well as its commitment to resolve labor-management disputes in a less adversarial manner. For example, in that agreement:

- **The VA recognized the narrow scope of the direct patient care exception**, i.e., it does not extend to "many matters affecting the working conditions of Title 38 employees [that] affect patient care only *indirectly*" (emphasis provided).
- **The VA agreed that pay matters other than setting pay scales are grievable**: "Under Title 38, pay scales are set by the agency, outside of collective bargaining and arbitration. Left within the scope of bargaining and arbitrations over such matters as: procedures for collecting and analyzing data used in determining scales, alleged failures to pay in accordance with the applicable scale, rules for earning overtime and for earning and using compensatory time, and alternative work schedules."
- **The VA agreed that scheduling matters may be grievable**: "For example, scheduling shifts substantially in advance so that employees can plan family and civic activities may make it more expensive to meet patient care standards under certain circumstances. That does not relieve management of either the

responsibility to assure proper patient care or to bargain over employee working conditions.”

- **The VA acknowledged that providers provide valuable input into medical affairs:** “We recognize that the employees have a deep stake in the quality and efficiency of the work performed by the agency.”; “The purpose of labor-management partnership is to get the front line employees directly involved in identifying problems and crafting solutions to better serve the agency’s customers and mission.”

The VA’s 7422 Review Process is Biased in Favor of Management

The VA recently testified that the current restriction on collective bargaining rights is a “sound compromise” between the VA’s mission and the interest of Title 38 providers. Compromise? Management wins almost all the time: of all USH posted decisions since December 2001, 94% were in favor of management.

It is interesting to note that shortly after this Subcommittee’s May 22nd hearing, VA issued its first USH ruling in favor of the employee since December 2004.

Current 7422 Policy Limits the VA’s Accountability to Congress, Taxpayers and Veterans

When the VA perpetually invokes 7422 in matters such as nurse scheduling and assignment, it does not have to answer for chronic short staffing, which in turn leads to costly contract care, longer patient waiting lists and diversion to non-VA hospitals.

For example, in one nurse alternative work schedule (AWS) case that went before the USH, the hospital ward staff was continuously “scheduled” to be shorted of coverage a minimum of 4 hours at least 3 days a week. In a reassignment case, the employee experienced retaliation for requesting orientation.

Similarly, VA uses 7422 to avoid being held accountable for noncompliance with physician pay laws, which makes it more difficult to hire physicians in scarce supply. For example, an orthopedic surgeon was entitled by VA regulations to a \$15,000 increase in his market pay. He was notified of this raise six months ago but he has still not received his pay increase.

The VA’s use of 7422 to block grievances relating to mandatory nurse overtime prevents ward nurses from challenging work schedules that are unsafe for patients.

H.R. 4463

AFGE has no specific position on this legislation.

H.R. 5888

AFGE supports H.R. 5888. This bill will enable veterans with partial coverage from a private insurer, including veterans with very limited private coverage, to receive reimbursement from the VA for emergency care provided at a non-VA facility. This bill will also assist veterans recently denied reimbursement due to current restrictions in the law.

H.R. 6114

AFGE has no specific position on this legislation.

H.R. 6122

AFGE supports H.R. 6122. Chronic pain is a leading cause of disability among veterans. Pain management is an essential component of quality health care. This bill will ensure that VA facilities across the country have the resources to improve and expand their pain care services.

Thank you.

Statement of Joseph L. Wilson, Deputy Director, Veterans Affairs and Rehabilitation Commission, American Legion

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to submit The American Legion’s views on these various pieces of legislation: H.R. 4089, H.R. 4463, H.R. 5888, H.R. 6114, and H.R. 6122.

H.R. 4089

This bill seeks to amend title 38, United States Code, to improve the collective bargaining rights and procedures for review of adverse actions of certain employees of the Department of Veterans Affairs (VA), and for other purposes.

The American Legion has no position on this bill.

H.R. 4463

This bill seeks to amend title 38, United States Code, to improve the quality of care provided to veterans in VA medical facilities, to encourage highly qualified doctors to serve in hard-to-fill positions in such medical facilities, and for other purposes.

The American Legion believes medical school affiliations have been a major factor in VA's ability to recruit and retain high quality physicians, and provide veterans access to the most advanced medical technology. When implementing this bill, The American Legion encourages VA to continue to strengthen its affiliation with surrounding medical schools in order to recruit and retain highly qualified doctors who are accustomed to the VA medical care environment.

The American Legion also believes VA should offer incentives to new hires and employees who maintain certifications or continue training in areas above and beyond hospital credentialing and privileging processes. The American Legion supports the Veterans Health Care Quality Improvement Act.

H.R. 5888

This bill seeks to expand veteran eligibility for reimbursement by the Secretary of VA for emergency treatment furnished in a non-Department facility.

The American Legion believes it is essential for veterans to receive emergency medical care from non-VA facilities in the absence of available VA health care, or when traveling presents a hazard or hardship for the veteran in accessing care. The American Legion supports the reimbursement of costs incurred by veterans who must receive emergency care at a non-VA facility

H.R. 6114

This bill seeks to simplify and update national standards to encourage testing for the Human Immunodeficiency Virus of 2008.

The American Legion has no position on this bill.

H.R. 6122

This bill seeks to direct the VA Secretary to develop and implement a comprehensive policy on the management of pain experienced by veterans enrolled for health care services provided by VA, and for other purposes.

Section 2 proposes the development and implementation of a comprehensive policy on the management of pain experienced by veterans enrolled for health care services provided by VA.

This policy will cover various issues to include:

- VA's programs on research related to acute and chronic pain suffered by veterans, as well as pain attributable to central and peripheral nervous system damage characteristic of injuries incurred in modern warfare;
- The assurance of prompt and appropriate pain care treatment and management by VA, system wide, when medically necessary;
- Consistent application of pain assessments to be used throughout VA;
- Pain care education and training for VA's health care personnel; and
- Patient education for veterans suffering from acute or chronic pain and their families.

To ensure every veteran who suffers from some form of pain receives adequate and seamless treatment and care, The American Legion recommends the continued collaboration between the Department of Defense (DoD) and VA coupled with their increase of education, research, treatment, and therapy best practices by improving accelerating clinical trials at military and VA treatment facilities and affiliated medical centers and research programs.

Additionally, The American Legion urges Congress to increase Federal funding for pain management research, treatment, and ongoing therapies to ensure the success of such programs.

Conclusion

Mr. Chairman and Members of the Subcommittee, The American Legion sincerely appreciates the opportunity to submit testimony and looks forward to working with you and your colleagues on these very important issues. Thank you.

Statement of Raymond C. Kelley, National Legislative Director, American Veterans (AMVETS)

Chairman Michaud, Ranking Member Miller, thank you for holding this important hearing today. AMVETS is pleased to provide our views on pending health care legislation.

AMVETS opposes amending section 7422 by removing subsections (b), (c) and (d) that is outlined in H.R. 4089. Allowing VA employees who are directly involved in patient care to have collective bargaining rights could have direct negative impact on the care our veterans receive. Patient care managers need to have the authority to make decisions on clinical competence and the flexibility to arrange his/her staff in a way that will benefit the veterans who are receiving care the most.

Allowing collective bargaining will undoubtedly remove the authority of those who are tasked with managing the highest level of care of our veterans. Clinical care issues are often very fluid and decisions on staffing needs or the quality of care that is provided to the patient cannot be tied up in protracted collective bargaining hearings. Even if the bargaining process is only two months long the quality of care our veterans receive could be impeded.

H.R. 4463 provides provisions that will enhance recruitment for hard-to-fill positions within VA, as well as ensure that during the recruitment process that only the best qualified doctors are hired. AMVETS supports this legislation. When veterans welfare is at stake, verifying work history and understanding the career history of a potential employee is vital. Practicing medicine is a high-risk profession and VA needs to have every tool necessary to ensure they hire the best qualified so the care our veterans receive will continue to be the highest quality.

H.R. 5888 expands veteran eligibility for reimbursement for emergency treatment furnished in a non-Department facility. Under section 1725 of title 38, veterans are not compensated if emergency care is paid for in whole by a third party. Veterans receiving emergency care in a non-Department facility are not being reimbursed fully if services are paid for in part by another entity, as is the case with Medicare and other insurance companies. H.R. 5888 removes the provision "or in part" to allow the Department to reimburse veterans who have unpaid medical bills after partial coverage by their insurance companies. This helps improve the lives of veterans who are unable to pay medical bills without help from the VA and for this reason, AMVETS wholly supports this legislation.

AMVETS wholly supports 6114 the "Simplifying and Updating National Standards to Encourage Testing of the Human Immunodeficiency Virus of 2008" or "SUNSET Act of 2008". Current Veterans Affairs health care standards, which have been in place since 1988, are outdated and inconsistent with the new CDC guidelines issued in September 2006. A recent study conducted by the Public Health Strategic Health Care Group at the Veterans Health Administration showed that 55% of HIV positive veterans had already suffered significant damage to their immune system and developed full blown AIDS. In addition, 40% of these veterans had accessed the VA system an average of 6 times before being diagnosed. The VA system is the largest in the United States, also making it the largest provider of HIV care. Conversely, compared to the general population, veterans are disproportionately affected by the lack of routine HIV testing. Increasing the frequency of testing will facilitate early detection, treatment, reduce HIV and AIDS related death while improving the health of veterans living with these diseases.

AMVETS wholly supports H.R. 6122 "Veterans Pain Care Act of 2008". This bill seeks to implement department-wide standards of the management of pain experienced by veterans through the assurance of prompt and appropriate pain care treatment, education and training on veteran pain care, and the creation of an annual report by the Secretary to the Committee on Veterans' Affairs. Acute and chronic pain is experienced disproportionately to the general public by military personnel and veterans. Serious, but survivable injuries acquired in modern warfare can lead to long term problems associated with chronic pain and left untreated, can have lifelong consequences. It is important for the Department of Veterans Affairs to have a comprehensive policy on the management of pain experienced by veterans enrolled in health care services provided by the Department. Helping veterans manage pain can lead to an improved quality of life for them and their families.

Chairman Michaud, this concludes my testimony. I am happy to respond to any questions the Subcommittee may have.

**Statement of Hon. Jerry F. Costello,
a Representative in Congress from the State of Illinois**

Mr. Chairman, I want to thank you for the Subcommittee's consideration of legislation that Representatives Mitchell, Shimkus, Whitfield and I have introduced to implement reliable controls within the Veterans Health Administration (VHA) to ensure that VA physicians are sufficiently qualified. H.R. 4463, the Veterans Health Care Quality Improvement Act, would make needed reforms to current VA policies that pertain to health care quality assurance measures. This legislation is the necessary result of unfortunate events that occurred at the Marion Veteran's Administration Medical Center (VAMC) in my Congressional district. Investigations performed by the VA Inspector General's office and the Office of the Medical Inspector discovered faulty leadership at the Medical Center and significant institutional problems which directly resulted in the tragic deaths of at least nine individuals in the past two years and in significant health problems for numerous others. While the Marion VAMC continues to be reformed and reviewed, it is unlikely that Marion VAMC is the only facility where such problems have occurred. Healthcare quality assurance procedures across the board must be improved to ensure that this does not happen to any veteran again.

Our legislation does several things to improve the quality of care at Veterans' hospitals. H.R. 4463 would mandate a more thorough and standardized process for reviewing physician qualifications. Prospective and current physicians would have to provide a complete history of any lawsuits, civil action, or other claim that was taken against them, a complete disclosure of the history of their license to practice in each state, and the status of licenses. Regional Directors of Veterans Integrated Services Networks (VISN) would have responsibility of investigating these records and deciding if it would disqualify a candidate from becoming a VA physician. Having physicians give a full account of their professional history will ensure that those treating our veterans are fully qualified.

To oversee this program, the bill requires the Under Secretary of Health to appoint a national Quality Assurance Officer. One of the most significant problems that contributed to the incidents at the Marion VAMC was that quality management responsibilities were divided among multiple groups at the facility and, in some cases, there was no oversight provided. The National Quality Assurance Officer will be responsible for full oversight of quality assurance programs within the VA. The National Quality Assurance Officer will also be responsible for policies regarding peer review, confidential reporting by VA personnel, and the accountability of medical facility leadership.

In addition, the bill would require the appointment of a quality assurance officer for each VISN to be responsible for the Network and a quality assurance officer to be responsible for each medical facility. These individuals would have responsibility for coordinating, monitoring, and overseeing the quality assurance programs for their designated areas. Instituting clear accountability for quality management responsibilities will be an important reform to current VHA practice.

This legislation also addresses the need for recruiting and retaining highly qualified physicians to Veteran health care facilities. Certain areas of the country, such as our rural areas, have difficulty in attracting skilled physicians. The bill includes provisions establishing a loan repayment program for qualified physicians in exchange for three years of service in hard to fill positions, as well as a health benefit program for part time physicians.

Finally, the bill requires the Secretary of the VA to conduct a comprehensive review of current policies pertaining to health care quality and patient safety at VA medical facilities. At the conclusion of their investigations into the events at the Marion VAMC, the Office of Inspector General and the VHA's Office of the Medical Inspector made proposals addressing institutional weaknesses pertaining to quality management. They are a useful starting point and it is good the VA has begun implementing some of them. For instance, the VHA is currently establishing criteria to define which surgery procedures can be performed at each medical facility. However, more can and should be done. That is why I am glad the Committee is reviewing H.R. 4463 so that we can bring it to the House floor for consideration. The Veterans Health Care Quality Improvement Act addresses the fundamental problem of a lack of standardized methods for determining quality assurance while designating officials within the VA to be responsible for this oversight.

Mr. Chairman, it is not enough that we only provide the resources for veterans' health care. We must be equally committed to providing that care in a responsible, professional manner. We owe these reforms to the veterans who trust us to provide them with the quality care they have earned. Mr. Chairman, thank you for continuing to hold hearings on this important issue and legislation.

**Statement of Joy J. Ilem,
Assistant National Legislative Director, Disabled American Veterans**

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting the Disabled American Veterans (DAV) to submit testimony at this hearing, and for the opportunity to present the views of our organization on the health care legislation pending before the Subcommittee today. DAV is an organization of 1.3 million service-disabled veterans and devotes its energies to rebuilding the lives of disabled veterans and their families.

The measures before the Subcommittee today cover a range of issues important to DAV, to veterans and to their families. This testimony includes a synopsis of each of the bills being considered, along with DAV's position or other commentary on them. Our comments are expressed in numerical sequence of the bills.

H.R. 4089—To amend title 38, United States Code, to improve the collective bargaining rights and procedures for review of adverse actions of certain employees of the Department of Veterans Affairs

DAV does not have an approved resolution from our membership on this specific VA labor-management dispute that prompted the introduction of this bill. However, we believe labor organizations that represent employees in recognized bargaining units within the VA health care and benefits systems have an innate right to information and reasonable participation that result in making VA a workplace of choice, and particularly to fully represent VA employees on issues impacting working conditions and ultimately patient care.

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

Facing VA's refusal to bargain, the only recourse available to labor organizations is to seek redress in the federal court system. However, recent case law has severely weakened the rights of title 38 appointees to obtain judicial review of arbitration decisions. Title 38 employees also have fewer due process rights than their title 5 counterparts in administrative appeals hearings.

It appears that the often hostile environment consequent to these disagreements diminishes VA as a preferred workplace for many of its health care professionals. Likewise, veterans who depend on VA and who receive care from VA's physicians, nurses and others can be negatively affected by that environment.

We believe this bill, which would rescind VA's refusal to bargain on matters within the purview of section 7422, through striking of subsections (b), (c) and (d), and that would clarify other critical appeal and judicial rights of title 38 appointees, is an appropriate remedy, and would return VA and labor to a more balanced bargaining relationship on issues of importance to VA's professional workforce. Therefore, DAV commends the bipartisan sponsors for introducing this bill, and appreciates the work of the Subcommittee in considering it today. DAV would offer no objection to the enactment of this bill.

H.R. 4463—Veterans Health Care Quality Improvement Act

This bill would direct the Secretary of Veterans Affairs to prescribe standards for appointment and practice for a physician within the Veterans Health Administration of the VA. The bill would require appointees to VA physician positions, and physicians already employed by VA at the time of enactment, to disclose certain private information, including each lawsuit, civil action, or other claim made against the individual for medical malpractice or negligence, and the results or status of those claims. Also under this bill, each appointee would be required to disclose any judgments that had been made for medical malpractice or negligence and any payments made. The bill would require all new physician appointments to be approved by the responsible director of the Veterans Integrated Services Network (VISN) in which the individual would be assigned to serve and require all VA specialty physicians to be board certified in the specialties in which the individuals would practice. Also the bill would require State licensure by VA physicians in the particular State of VA practice.

The measure would establish new requirements and accountabilities in quality assurance at the local, VISN and VA Central Office levels, and would direct the Secretary to review VA policies for maintaining health care quality and patient safety at VA medical facilities. The bill also would establish loan repayment programs for physicians in scarce specialties, a tuition reimbursement program for physicians and medical students in exchange for commitments to serve in VA, and enrollment of part-time VA physicians in the Federal Employees Health Benefits Program. The bill would admonish the Secretary to undertake additional incentives to encourage individuals to serve as VA physicians.

DAV has no adopted resolution from our membership on these specific issues. Under current policy, VA is required to investigate the background of all appointees, including verifying citizenship or immigration status, licensure status, and any significant blemishes in appointees' backgrounds, including criminality or other malfeasance, medical or otherwise. The facility in question that likely stimulated the sponsor to introduce this legislation was not in compliance with those existing requirements, thus raising questions about VA's ability to oversee its facilities in the area of physician employment. It is our understanding that corrective action has been taken by the VA Central Office but only after some unfortunate incidents related to these lapses came to light. VA has advised that it has strengthened its internal policies to ensure no such recurrence.

We appreciate and strongly support the intent of the bill to stimulate recruitment and to promote VA physician careers with various new incentives, and, while it seems clear that additional oversight in physician appointments is necessary, we trust that the new reporting, State licensure and certification requirements in the bill would not serve as obstacles to physicians in considering VA careers in the future. We note that in testimony on May 21, 2008 to the Senate Committee on Veterans' Affairs on S. 2377, the Senate companion to this bill, VA raised a number of valid concerns with respect to State licensure limitations this bill would impose on practicing VA physicians. We ask the Subcommittee to take those concerns into account as you consider the merits of this bill.

H.R. 5888—To amend title 38, United States Code, to expand veteran eligibility for reimbursement by the Secretary of Veterans Affairs for emergency treatment furnished in a non-Department facility.

This bill would amend subparagraph (b)(3)(C) of section 1725 of title 38, United States Code, by striking the words "or in part" where they appear in current law. In 1999, Congress enacted the Veterans Millennium Health Care and Benefits Act, Public Law 106-117. That act provided the authority sought by VA at the time to complete its role as a comprehensive health care system for all veterans who are enrolled, by giving VA authority to reimburse costs of emergency private care under certain circumstances. Prior to passage of the Millennium Act, VA was essentially without authority to pay emergency expenses in private facilities for its own patients, unless generally they were service-connected veterans. Under prior law VA was authorized to pay for non-VA emergency treatment for a veteran's service-connected disability, a nonservice-connected disability aggravating a veteran's service connected condition, any condition of a veteran rated permanently and totally disabled from a service-connected condition(s), and a veteran enrolled in a VA vocational rehabilitation program.

The intent of this bill would enable a nonservice-connected veteran, enrolled in VA health care, who otherwise is eligible for VA reimbursement of certain private emergency health care expenses under the Millennium Act authority but for the existence of coverage "in part" by a form of private health insurance (no matter how major or minor such private coverage might be), to be reimbursed as otherwise au-

thorized under the Millennium Act emergency care reimbursement program. Rescission of the words “or in part” in section 1725 would open the door for a veteran with minimal insurance coverage, such as a small medical rider on a State-required automobile insurance plan, to gain VA reimbursement for emergency care under the existing authority. Today, that veteran would be denied reimbursement, because he or she is covered “in part.”

The bill would be effective as of October 6, 2007, presumably to take into account any individuals who may have recently been denied VA reimbursement because of these current restrictions.

Mr. Chairman, we note that the House, on May 21, 2008 passed H.R. 3819, the Veterans Emergency Care Fairness Act of 2007, by a recorded vote of 412–0. Enactment of that bill, strongly supported by DAV, would also clarify and expand the circumstances in which the Secretary must pay for expenses incurred in connection with an eligible veteran’s authorized emergency treatment in a non-VA facility, including a redefinition of the term “emergency” on a reasonable layman basis. A unanimous recorded vote on that measure gives us assurance that it is the Congress’s intent to give the benefit of the doubt to a veteran who is caught in an emergency medical situation and needs VA’s assistance with issues of doubt. We believe the circumstances presented here in H.R. 5888 bear a resemblance to those that countenanced the introduction and House passage of H.R. 3819.

As in the case of H.R. 3819, DAV supports the intent of this bill. This bill’s purposes are in accord with the mandate from our membership and consistent with the recommendations of the *Independent Budget* to improve reimbursement policies for non-VA emergency health care services for enrolled veterans. We urge the Subcommittee to approve this bill for further consideration by the Full Committee, and we endorse its enactment into law. The DAV thanks those involved for their efforts to ensure the improvements to this essential emergency relief benefit as originally contemplated in the Millennium Act and in this bill are properly implemented.

H. R. 6114—The Simplifying and Updating National Standards to Encourage Testing of the Human Immunodeficiency Virus of 2008, or, the SUNSET Act of 2008

This bill would repeal the statutory enactment from 1988 dealing with human immunodeficiency virus (HIV) testing.

DAV has no adopted resolution from our membership dealing with this specific provision; thus, we take no position with respect to this bill.

H.R. 6122—The Veterans Pain Care Act of 2008

This measure would amend title 38, United States Code, to establish a mandatory pain care initiative throughout the VA health care system for enrolled veterans.

Both the medical literature and media reflect a growing interest by health care providers in the specialized field of pain management. A number of advances in medicine and technologies from that interest are benefiting severely wounded service personnel and veterans. A recent study of Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) service personnel receiving treatment in VA Polytrauma Centers found that pain is highly prevalent. The study also noted in its clinical implications that pain should be consistently assessed, treated, and regularly documented. The report concluded that polytraumatically injured patients are at potential risk for development of chronic pain, and that aggressive and multidisciplinary pain management (including medical and behavioral specialists) is a necessity. The report suggested the phenomenon of pain is a new opportunity for VA research in evaluating long term outcomes; developing and evaluating valid pain assessment measures for the cognitively impaired; and, developing and evaluating education or policy initiatives designed to improve the consistency of assessment and treatment of pain across the VA continuum of care.

VA has been a leader in assessment and treatment of pain. In fact in 1998 VA issued its inaugural National Pain Management Strategy (the current iteration of VA’s policy is VHA Directive 2003–021). We understand that the overall objective of VA’s national strategy is to develop a comprehensive, multicultural, integrated, system-wide approach to pain management that reduces pain and suffering for veterans experiencing acute and chronic pain associated with a wide range of illnesses, including terminal illnesses. However, we are concerned that implementation of pain management programs has not been consistent throughout VA’s nationwide health care system.

Given our concerns about implementation and standardization across the VA system, this bill is welcome. It would require, by October 1, 2008, the establishment of a VA system-wide policy on the management of pain. Under the bill, VA’s plan would be required to cover pain management; related standards of care to treat

pain; consistency across the VA system of care; assurance to VA's patients who need care for pain; conduct of research initiatives in pain; establishment of educational and training programs in pain for VA clinical staffs, and the provision of patient education in pain. The bill would require VA to report to the Committees on Veterans' Affairs its progress and status on its required pain policy within 180 days of initial implementation. The required report would disclose VA's progress on each of the areas of the bill's emphasis in respect to VA's policy and program on pain.

While DAV has no specific resolution adopted by our membership in support of establishing a legislated VA system-wide pain initiative, we believe the goals of the bill are laudable and in accord with providing high quality, comprehensive health care services to sick and disabled veterans. We believe this bill would be strongly supported by our membership; therefore, we have no objection to this measure and look forward to its enactment.

Mr. Chairman, this concludes my testimony on these bills. DAV appreciates the opportunity to provide this statement for the use of the Subcommittee, and we are pleased to address any questions you or other members may have concerning the measure under consideration.

**Statement of David J. Holway, National President,
National Association of Government Employees, SEIU/NAGE Local 5000**

Mr. Chairman and Members of the Subcommittee:

On behalf of the National Association of Government Employees (SEIU/NAGE), and the more than 100,000 workers we represent, including 20,000 at the Department of Veterans Affairs (VA), I would like to thank you for the opportunity to submit testimony regarding H.R. 4089.

SEIU/NAGE supports H.R. 4089. This bill would restore a meaningful scope of bargaining for Title 38 health care providers at the VA, a critical necessity to boost morale and strengthen recruitment and retention at the agency. Giving health care providers a meaningful voice in their workplace will lead to better care for the American veteran.

In 1991, Congress amended Title 38 to provide VA medical professionals with collective bargaining rights (which include the rights to use the negotiated grievance procedure and arbitration). Under Sec. 7422 of Title 38, covered employees can negotiate, file grievances and arbitrate disputes over working conditions, except for matters concerning or arising out of professional conduct or competence, peer review, or compensation. Increasingly, VA management is interpreting these exceptions very broadly, and refusing to bargain over virtually every significant workplace issue affecting medical professionals. The broad interpretation of Sec. 7422 is leading to significant dissatisfaction among rank-and-file VA health care providers.

We have heard from our local members across the country who have urged our union to make passage of H.R. 4089 our top legislative priority for legislation impacting the VA workforce. Their concern is that too many highly qualified, outstanding health care professionals have left the VA for other employment because they were unsuccessful in getting someone of authority at the agency to listen to or address legitimate concerns because the issue fell under the ever-growing umbrella of 7422.

The agency has increasingly been unwilling to address those issues that are most important to Title 38 employees, including time schedules, shift rotations, evaluations, fair and equal opportunity to be considered for a different position within the facility, and fair treatment among colleagues. Rather than suffer under a system where they have no mechanism to provide input or air grievances, disenfranchised VA employees simply move on to other employment. It has gone on too long, and it has to stop.

VA medical professionals have extremely limited collective bargaining rights in the first place, and the broad interpretation of Sec. 7422 of Title 38 is narrowing the scope of bargaining to the point that it is practically meaningless. As a result, RNs, doctors, and other impacted employees at the VA are experiencing increased job stress, low morale and burnout. This in turn exacerbates the VA's well-documented recruitment and retention problems. Chronic short-staffing has been shown to adversely impact quality of care, patient safety, and workplace safety, leading to costly stopgap measures such as the overuse of contract nurses and doctors.

Passing H.R. 4089 would help to address many of these concerns. This bill would restore a meaningful scope of bargaining for Title 38 VA professionals by eliminating the "7422 exceptions" (conduct, competence, compensation, and peer review) under the law.

Eliminating these exceptions will provide these health care providers with the same rights as other VA providers, including psychologists, LPNs, and pharmacists, as well as other federal employees. Title 5 health care providers at the VA have full collective bargaining rights. Even nurses and doctors at Army Medical Centers such as Walter Reed, who perform the same exact function as nurses and doctors at the VA, have full collective bargaining rights. Many private sector health care providers have a meaningful voice in their working conditions and participate in hospital affairs. There is no reason for Title 38 VA workers to have these critical rights taken away.

Restoring meaningful bargaining rights will greatly increase morale at the VA. It will also address recruitment and retention issues, which are critical at this time, given the veterans returning home from conflicts abroad. All this will lead to better care for our nation's veterans.

SEIU/NAGE greatly appreciates the Subcommittee's decision to hold a hearing on this matter. I thank the Subcommittee for the opportunity to provide testimony.

**Statement of Patricia LaSala, First Vice President,
National Federation of Federal Employees**

Thank you, Chairman and distinguished Subcommittee members, for the opportunity to submit the following testimony.

My name is Patricia LaSala. I serve as the First Vice President of the National Federation of Federal Employees, an affiliate of the IAMAW. I am also the president of NFFE Local 1, located at the San Francisco VA Medical Center. I am providing testimony on behalf of the 100,000 federal workers our union represents nationwide, including 5,000 Department of Veterans Affairs health care providers.

After almost 30 years of Federal Service during which Title 38 has driven how I am to exist within the Department of Veterans Affairs, I say with great certainty, change is long overdue for Section 7422. When Congress amended Title 38 in 1991 to allow professionals to have collective bargaining rights similar to our colleagues in the private sector, never did we expect to see it as prohibitive as it has been interpreted during the last administration. When you take away the right to collectively bargain over conduct, competence, peer review, and compensation, you make our use of the negotiated grievance procedure all but meaningless.

The professional Title 38 employee comes to federal service out of a deep sense of commitment to care for the wounded American veteran, as well as to keep other veterans well and treat those who become ill. We also treat those veterans whose conditions are exacerbated by war or their service experience. Most of us knew we would not be paid equal to our counterparts in the private sector. Compensation is not why we came to the VA or to other federal health agencies. Just speak to a VA nurse, doctor, dentist, physician's assistant, podiatrist, or optometrist. They will tell you that to care for and give back to those who gave so much was a major motivator in seeking employment at the VA.

When you allow a person to stand up for themselves, seek justice, and ask for recognition for a job well done, you add a sense of pride to their personal persona and it plays itself out in their professional practice. When a professional is allowed to defend his or her conduct, explain the circumstances concerning a complaint, and seek and receive redress, we provide them with the basic rights that this country was built on. No more, no less. However, "7422" has become the Draconian battle cry for supervisors when they are asked to decide an issue relating to conduct, competence, peer review and compensation. Logic, fairness, respect, and simple kindness are tossed out in place of these oft-used numbers.

Often a simple discussion of circumstances that drove the outcome or issue never takes place. Instead a complaint goes unheard, and questions about a performance review are dismissed or claimed to be outside the purview of the bargaining agreement. Just imagine what that does to a professional, or for that matter anyone who has sincere questions or concerns about their treatment or their career.

Complicating this unfairness is the fact there are two Titles for professional employees in federal service: Title 38 professionals as identified, and Title 5 professionals. The latter are psychologists, social workers, pharmacists, dieticians, addiction therapists, and probably 15 to 20 more professional job titles. Unlike Title 38 professional employees, they can use the grievance process as well as other appeal avenues, such as the MSPB, when issues arise. They can appeal their classifications, unlawful terminations, and performance reviews that are incorrect or unfair. These professionals work side-by-side caring for the same veterans, yet they have different rights and privileges based on whether they are appointed by Title 38 or

Title 5. I ask you if that makes any sense or whether it contributes to a cohesive health care team.

Our children are coming home from war. They expect and deserve competent health care professionals to be there for them. If you do not think that the lack of rights of nurses or doctors and all Title 38 professionals affects recruitment or retention of employees, please think again. It absolutely does impact the ability of the agency to attract and keep qualified health care providers.

Hospitals, in my view, are like small towns. Hospital workers from one small town have friends and professional colleagues in another. While they share scientific news and research findings, pay parity, workers' rights and working conditions are also spoken about. The absence of these basic worker rights can, and often does, dissuade potential applicants from a professional career in the federal service, namely the VA.

So I ask, the next time you are visiting a town that has a VA or if there is one in your hometown, walk in. If you can make an authorized visit during the night shift this is even better. Walk those halls and corridors and see that registered nurse comforting a distraught family of a critically ill veteran, a nurse tending a veteran in pain or one that is anxious or fearful. Watch those blessed hands changing a complicated dressing, or an IV, bathing or massaging a war torn body, and then tell us that nurse cannot question decisions that guide and govern her career. I doubt that will be your response.

Please support H.R. 4089. This is a critical piece of legislation that will bring a much-needed sense of fairness to the Title 38 workforce at the VA. I can assure you that this legislation will do so much to improve the morale of the workers caring day-in and day-out for the American veteran, and that will help us give American veterans the care they deserve.

God bless that American treasure called the American veteran and God bless those who chose to care for them. Once again, I thank the Subcommittee for their attention to this important matter and for the opportunity to give testimony.

Statement of Richard Rosenquist, M.D., Chair, Pain Care Coalition

Pain Care Coalition
Washington, DC.
June 4, 2008

Pain Care Coalition—A National Coalition for Responsible Pain Care
American Academy of Pain Medicine, American Headache Society,
American Pain Society, American Society of Anesthesiologists

Hon. Michael H. Michaud
Chairman, Health Subcommittee
Committee on Veterans' Affairs
United States House of Representatives
335 Cannon House Office Building
Washington, DC 20515

Re: *H.R. 6122—Veterans Pain Care Act of 2008*

Dear Chairman Michaud:

The Pain Care Coalition enthusiastically supports H.R. 6122, a bill to improve pain care and research for the benefit of America's veterans. I submit the enclosed statement of the Pain Care Coalition outlining the need for and benefits of this important legislation, and request that it be included in the record of the Subcommittee's June 5th hearing.

Mr. Chairman, virtually every wounded soldier returning from the current conflicts will experience acute pain attributable to their battlefield injuries. Far too many will go on to live a life burdened with chronic pain, frequently so severe as to affect their function, their relationships with their families, their ability to work productively, and often their self esteem. With prompt and aggressive treatment, much of that pain can be managed and alleviated, but without substantial research efforts leading to improved treatment options, much of it will never be truly cured.

The VA is doing much to promote good pain care within its health system, but much, much more remains to be done. Please ensure that pain care and research are, and continue to be, national priorities on which the country's veterans can rely.

Respectfully submitted,

Richard Rosenquist, M.D.
Chair

Enclosure

**STATEMENT OF PAIN CARE COALITION IN SUPPORT OF H.R. 6122—
VETERANS PAIN CARE ACT OF 2008**

The Pain Care Coalition is pleased to support H.R. 6122, the Veterans Pain Care Act of 2008. The Pain Care Coalition is a national advocacy effort of the American Academy of Pain Medicine, American Pain Society, American Headache Society and American Society of Anesthesiologists. Collectively, these organizations represent more than 50,000 physicians and other clinicians, researchers, and educators who provide clinical leadership in the increasingly specialized field of pain management. Some of these individuals work directly in the VA health system, and many others are involved in collaborative relationships with research and clinical care programs throughout the VA system.

As professionals in the pain care field, members of these organizations are committed to assuring that those who serve the country in times of war get the very best pain care possible during all stages of their service, and in all settings of the military and veteran health and medical systems. These settings range from the battlefield to the clinics, hospitals, rehabilitation centers and long term care facilities of the VA. As a complement to these clinical care responsibilities, members of the Coalition have a continuing interest and responsibility in pain care research within the VA's Medical and Prosthetic Research Program, as well as other public and private research efforts with which the VA collaborates.

THE SCOPE OF THE PAIN PROBLEM

Pain is a very large public health problem in this country. It is the most common reason people access the medical care system, a major cause of lost productivity in the workplace, and a substantial contributor to short and long term disability. It affects Americans at all stages of life and in all walks of life. For example, 26 million Americans of working age have frequent back pain, and chronic back pain is the leading cause of disability for those under 45 years of age. 25 million suffer from migraine headaches. 4 million, mostly women, suffer from a complex pain syndrome known as fibromyalgia. 40 million have arthritis pain.

Pain imposes a terrible burden on those who suffer and on their families, and it imposes large costs on the health care and disability income systems. Medical costs and lost productivity alone are estimated to top \$100 Billion annually. Pain is often poorly understood by those who suffer and by those around them. It is often undiagnosed or misdiagnosed, and under-treated or mistreated. Sometimes pain is the symptom of other diseases as in the case of cancer, arthritis, heart disease, and diabetes. Other times, pain is the disease itself as with migraine, chronic back pain and various diseases associated with damage to the nervous system, such as post-herpetic neuralgia, diabetic neuropathy, or injuries to the nervous system such as commonly occur in combat, including phantom limb pain, post-injury or post-surgery neuralgias, and traumatic brain injury.

The most recent complete study of soldiers enrolled in VA Polytrauma Centers shows that more than 90% have chronic pain, that most have pain from more than one part of the body, and that pain is the most common symptom in returning soldiers. Advances in neuroscience, such as neuroimaging, now demonstrate that unrelieved pain, regardless of its initial cause, can be an aggressive disease that damages the nervous system, causing permanent pathological changes in sensory neurons and in the tissues of the spinal cord and brain.

Pain can be acute and effectively treated by short term interventions, or it can be chronic, often without effective "cures," and sometimes without consistent and effective means of alleviation. Those who suffer severe chronic pain see their daily lives disrupted—sometimes forever. Their pain and their constant search for relief affects their function, their relationships with those they love, their ability to do their work effectively, and often their self esteem. Chronic pain is often accompanied by or leads to sleep disorders, emotional distress, anxiety, depression, and even suicide.

Pain is a major health problem in the military and veteran populations. The phys-

ical and emotional stresses of military service make inevitable the disproportionate incidence of both acute and chronic pain among active duty personnel. The incidence of acute pain among those injured in the current conflicts will be virtually 100%, and for far too many, the original short term trauma will be followed by chronic pain of significant dimension and duration. For example, virtually all who lose limbs as a result of combat injury will suffer from phantom limb pain. While this can be managed with varying degrees of effectiveness, there is no known "cure." Virtually all veterans fitted with prostheses will suffer pain at the device/body "interface." This can also be managed to some degree, but rarely eliminated.

Far less visible, but even more prevalent, is the extensive damage to the central and peripheral nervous systems resulting from the horrific explosive devices deployed in the current conflicts. Unlike broken bones, flesh wounds and burns, many of which will eventually heal after aggressive treatment, extensive nerve damage may only be manageable, not curable, given the current state of science and clinical practice. Most returning veterans with extensive nerve damage will be chronic pain sufferers and will require long term pain management, with varying prognoses for success. Ironically, the proportion of these chronic pain sufferers among returning wounded servicemen and women will be far greater in the current conflicts than in previous wars because of the remarkable successes of military medicine which now keep so many of the very severely injured alive.

THE STATE OF PAIN CARE AND RESEARCH AT THE VA

Perhaps more than any other federal agency, the VA has been a leader in focusing institutional resources on the assessment and treatment of pain. Under a "National Pain Management Strategy" initiated in November 1998 ("Strategy"), and pursuant to VHA Directive 2003-021, the Veterans Health Administration has made pain management a national priority. Among the specific objectives of the Strategy are:

- Providing a system-wide standard of care to reduce suffering from "preventable" pain;
- Ensuring consistency in the assessment of pain;
- Ensuring prompt and appropriate treatment for pain;
- Promoting an inter-disciplinary approach to pain management; and
- Providing adequate training to and resources for clinicians in VA healthcare to achieve these objectives.

The Pain Care Coalition applauds the Strategy and generally supports its specific goals and objectives. At the same time, the Coalition has significant concerns with the current VA effort:

- Directive 2003-021 was only a 5-year plan. It needs revision and renewal this year;
- There has been, to the Coalition's knowledge, no comprehensive assessment of the Strategy's strengths, weaknesses and accomplishments; and
- Reports from the field suggest that implementation has been far from consistent. Some VA facilities have made great strides in improving pain care, while for others it is more an aspirational goal than an operating reality. As a result, veterans get widely different treatment for pain depending on the expertise and resources of the particular VA facility at which they receive their care.

The Pain Care Coalition believes that, in order to ensure effectiveness, the VA's pain management Strategy must be accompanied by and integrated with a significant research and training commitment to advancing the science of pain care, and to translating developments in the science to improved clinical care throughout the system.

On the one hand, the VA has had a long and continuing research interest in the phenomenon of phantom limb pain, with current work focused at the molecular level. It also has current research efforts in neural repair, which might some day lead to improvements in therapy for those veterans currently returning with significant damage to the nervous system. And it recently completed a successful study of the effectiveness of a shingles vaccine in older veterans which validated research findings elsewhere, and will improve care in the general population. Other important pain research initiatives are scattered amongst NIH research institutes.

In 2006, through an initial grant funded privately, the VA brought together research investigators with interests in pain as part of a VA sponsored conference on pain and palliative care. That meeting identified several research interest groups including post-deployment pain, primary care pain programs, and opioid analgesics. These groups generated a number of new research projects, several of which have earned Merit Award funding through the peer-review process of the VA's Office of Research Development ("ORD"). Work from these groups also spawned important

articles in major journals and a special issue of the Journal of Rehabilitation Research and Development devoted to pain research. Based on this success, the VA's ORD funded a second meeting of pain researchers just held in September of 2007. At this meeting, researchers identified other important projects which demonstrated the breadth and depth of research that is possible if a focused effort is made to organize and promote a VA research agenda dedicated to the basic and clinical sciences of pain medicine.

It is imperative that pain research be placed high on the list of current VA research priorities. While recent developments suggest an increasing awareness among VA researchers of the importance of pain in the veteran populations, the resources to make a significant difference have not yet been committed. The proportion of the VA research budget devoted to pain is unknown, or at least not systematically reported. A significant internally generated proposal to expand research, training and care in a coordinated fashion was apparently tabled for lack of funding.

Pain is not an area where the VA's leveraged research approach can rely on leadership from research partners at the NIH or in private industry. For example, despite documentation that chronic pain is one of the most costly of all health problems to the U.S. economy, a review of the NIH pain research portfolio in the early years of this decade showed that only 1% of NIH's annual research funding was devoted to projects with a primary focus on pain. When projects with pain as a secondary concern were added, it only rose to 2%. There is no Institute or Center at NIH to provide a central home for pain research, and efforts to coordinate pain research across the various institutes and centers are in the very early stages of development.

While private industry has significantly advanced drug and device therapies for particular types of pain or classes of pain patients, industry alone can not be expected to carry the load of long term basic science research needed to better understand the mechanisms of pain, and in particular how chronic pain syndromes develop despite successful treatment of the original trauma.

HOW H.R. 6122 WOULD HELP THE COUNTRY'S VETERANS

The Pain Care Coalition applauds Cong. Walz for his leadership in introducing H.R. 6122 in the House and urges the Subcommittee to act favorably on the bill at the earliest opportunity. The legislation is a companion to bi-partisan legislation developed in the Senate by Senators Akaka and Burr which now awaits Senate passage as Title II of S. 2162. While not a complete solution to all shortcomings in pain care in the VA health system, the bill represents an important and manageable first step in moving the VA toward more effective—and particularly more consistent—pain care assessment, diagnosis and treatment. The bill:

- requires “fast track” development and implementation of a comprehensive system-wide policy on pain management in VA facilities;
- specifies the essential elements of such a policy, including among others, standards of assessment and treatment, assurance of prompt treatment when medically necessary, research, education and training for health professionals, and patient education for veterans and their families;
- requires consultation with both VSOs and professional experts outside the VA in developing the policy; and
- requires annual reporting to the VA Committees of the Congress on the key elements of the policy, ensuring ongoing oversight.

The Pain Care Coalition believes that these features will provide the building blocks upon which major improvements in pain care for veterans will ultimately be constructed.

CONCLUSION

Pain is often characterized as an invisible disease—we can not see it, and unlike such diseases as cancer, diabetes, and heart disease, there are no affordable and widely available lab or imaging tests to confirm its presence and quantify its severity. But that's no excuse for letting research and treatment efforts lag behind those of other priorities.

The Pain Care Coalition is committed to advancing the practice of pain management to ensure that the brave men and women returning from combat receive the best pain care possible. The Coalition, along with each of the organizations it represents, stands ready to work with the House and Senate Committees on Veterans' Affairs and the Department of Veterans Affairs toward that end.

For Further Information Contact: Richard Rosenquist, M.D. Chair, Pain Care Coalition, Richard-Rosenquist@uiowa.edu, (319) 353-7783, or Robert Saner, Washington Counsel, Pain Care Coalition, rsaner@ppsv.com, (202) 466-6550.

Statement of Paralyzed Veterans of America

Mr. Chairman and members of the Subcommittee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to submit a statement for the record on H.R. 4089, a bill to improve collective bargaining rights and procedures for review of adverse actions on certain employees of the Department of Veterans Affairs (VA); H.R. 4463, the "Veterans Health Care Quality Improvement Act;" H.R. 5888, a bill to expand veteran eligibility for reimbursement by the VA for emergency treatment furnished in a non-Department facility; H.R. 6114, the "SUNSET Act;" and H.R. 6122, the "Veterans Pain Care Act." We hope that addressing the issues outlined in this legislation will better benefit today's veterans and the veterans of tomorrow.

H.R. 4089, Collective Bargaining

PVA generally supports the provisions of H.R. 4089, a bill that would improve the collective bargaining rights and procedures for review of adverse actions for certain health care professionals in the VA. These changes would be a positive step in addressing the recruitment and retention challenges the VA faces to hire key health care professionals, particularly registered nurses (RN), physicians, physician assistants, and other selected specialists.

As we understand current practice, certain specific positions (including those mentioned previously) do not have particular rights to grieve or arbitrate over basic workplace disputes. This includes weekend pay, floating nurse assignments, mandatory nurse overtime, mandatory physician weekend and evening duty, access to survey data for setting nurse locality pay and physicians' market pay, exclusion from groups setting physicians' market pay, and similar concerns. This would seem to allow VA managers to undermine Congressional intent from law passed in recent years to ensure that nurse and physician pay are competitive with the private sector and to ensure nurse work schedules are competitive with local markets.

Interestingly, given the VA's interpretation of current laws, these specific health care professionals are not afforded the same rights as employees who they work side-by-side with every day. For instance, Licensed Practicing Nurses (LPN) and Nursing Assistants (NA) can challenge pay and scheduling policies, while RN's cannot. This simply makes no sense to us.

H.R. 4463, the "Veterans Health Care Quality Improvement Act"

PVA supports H.R. 4463, the "Veterans Health Care Quality Improvement Act." We certainly appreciate the underlying intent of this bill which is to ensure that the health care provided by the VA is the very best available. Section 2 of the legislation defines standards that must be met for physicians to practice in the VA. It requires the disclosure of certain information pertaining to the past performance of a physician and requires the Director of each Veterans Integrated Service Network (VISN) to investigate any past disciplinary or medical incompetence issues of physicians to be hired.

We would like to draw attention to one particular provision in Section 2 that we believe could be problematic. Specifically, the legislation calls for a physician to be licensed to practice in the state in which the medical facility he or she is currently working in is located. We believe that this may be an unreasonable expectation and may make it more difficult for the VA to hire physicians, particularly in specialized care fields. This provision addresses a problem that we do not think actually exists. When hiring doctors, or any health care professionals, a VA facility should properly investigate and scrutinize the professional history of that individual. Whether or not a doctor is licensed in a state has no bearing on whether or not the VA is properly vetting individuals to be hired. Moreover, we would hate to see a situation created where a VA facility is unable to hire a critical physician who provides care in one of VA's specialized services simply because he or she does not have an in-state license, particular if that doctor is otherwise qualified.

PVA supports Section 3 of H.R. 4463 that requires the Under Secretary for Health to designate a national quality assurance officer and a quality assurance officer for each VISN. This establishes a quality-assurance program for the health care system and provides a method for VA health care workers to report incidents of inconsistency. We believe that one of the keys to high quality health care services is an affective quality assurance program. This program could be beneficial for improving accountability within the health care system.

We likewise support Section 4 of the legislation that offers incentives to attract physicians to work in the VA health care system. It also encourages the VA to recruit part time physicians from local medical schools. PVA has expressed concern in the past that the VA is struggling to attract high quality physicians, particularly to specialized services like spinal cord injury care, blind rehabilitation, and mental health.

H.R. 5888

H.R. 5888 will expand eligibility for emergency medical care at the VA for some veterans. Currently, veterans who have a secondary insurance provider that pays a portion of medical expenses in the event of an emergency do not have the balance of their medical expenses covered by the VA. This proposed legislation will eliminate that situation. It will prevent the VA from denying payment for emergency service at non-VA hospitals when a veteran is partially covered by the secondary insurance. PVA supports this legislation.

H.R. 6114, the "SUNSET Act"

H.R. 6114 repeals the requirement that HIV testing can be done only with the signature consent of the individual. This provision will allow the VA to be compliant with Centers for Disease Control (CDC) guidelines for HIV testing. PVA has no specific position on this legislation.

H.R. 6122, the "Veterans Pain Care Act"

PVA supports H.R. 6122, the "Veterans Pain Care Act." This legislation would require the VA to develop and implement a comprehensive policy for managing pain care for veterans enrolled in the VA health care system. PVA believes that comprehensive pain care is not consistently provided across the entire system. We have seen firsthand the benefits of pain care programs as each VA facility that supports a spinal cord injury (SCI) unit also maintains a pain care program. Veterans with spinal cord injury know all too well the impact that pain, including phantom pain, can have on their daily life. The pain care programs that SCI veterans have access to have greatly enhanced their rehabilitation and improved their quality of life.

The one caution we would offer is an expectation that every facility in the VA should have a pain care program. While we understand this would be the most preferred outcome, we are not sure this would be reasonable. We see no reason why pain care and management cannot be handled in some fashion similar to the hub-and-spoke model used by the VA to provide certain types of specialized care, including spinal cord injury care. However, this suggestion does not mean that the VA cannot have a comprehensive, system-wide policy for pain care.

Mr. Chairman and members of the Subcommittee, PVA would once again like to thank you for the opportunity to provide our views on this important legislation. We look forward to working with you to continue to improve the health care services available to veterans.

Thank you again. We would be happy to answer any questions that you might have.

Statement of Dennis M. Cullinan, Director, National Legislative Service, Veterans of Foreign Wars of the United States

MR. CHAIRMAN AND MEMBERS OF THIS SUBCOMMITTEE:

First under discussion today is **H.R. 4089**, addressing VA employee's collective bargaining rights. Specifically, it repeals specified exceptions to rights of certain Department of Veterans Affairs (VA) employees to engage in collective bargaining. It further requires a final decision of the VA with respect to the review of an adverse personnel action against a VA employee to be issued not later than 60 days after such action has been appealed. Subjects such decision to judicial review in the appropriate U.S. District Court or, if the decision is made by a labor arbitrator, in the U.S. Court of Appeals for the Federal Circuit. The VFW has no position on this legislation.

Next under review is **H.R. 4463**, entitled the "Veterans Health Care Quality Improvement Act." This bill directs the Secretary of Veterans Affairs to prescribe standards for appointment and practice as a physician within the Veterans Health Administration (VHA) of the Department of Veterans Affairs (VA). This bill requires: (1) applicants to provide certain information, including each lawsuit, civil ac-

tion, or other claim against the individual for medical malpractice or negligence, and their results; (2) each appointee to disclose any judgments against the individual for medical malpractice or negligence and any payments made; and (3) physicians already employed within the VHA to disclose such information. It also prohibits a new appointment without: (1) approval of the regional director of the Veterans Integrated Services Network (Network) in which the individual will serve; (2) board certification in the specialties in which the individual will practice; and (3) a license to practice medicine in that state.

It requires: (1) the VHA's Under Secretary of Health to designate a national Quality Assurance Officer for the VHA quality assurance program; (2) each Network regional director to appoint a quality assurance officer; and (3) the director of each VHA medical facility to appoint a quality assurance officer.

The bill directs the Secretary to review VA policies for maintaining health care quality and patient safety at VA medical facilities.

Additionally the Secretary, in order to recruit and retain VHA physicians in hard-to-fill positions, must: (1) repay certain educational loans for individuals who agree to serve for at least three years as a VHA physician; (2) reimburse tuition for medical students who agree to serve as a VHA physician after such education; and (3) enroll in the Federal Employees Health Benefits Program an individual who agrees to serve as a VHA physician for at least five days per month. Encourages the Secretary to undertake additional incentives to encourage individuals to serve or practice as VHA physicians.

The VFW supports this legislation to both ensure higher quality VA health care and the enforcement of stringent, uniform professional standards throughout the system. This bill also addresses the recruitment and retention of health care professionals in hard to fill specialty areas, something we view as being vital. We would, however, voice our concern regarding section (2)(g) requiring VA doctors to be licensed within each state where they practice. VA, similar to the DoD health care, is a federal system where such an approach would be neither appropriate nor practical. We are very concerned that this approach would result in severely limiting mobility within the system to the detriment of veteran patients. For example a particular cardiologist working at the Buffalo, NY VAMC whose services were at once urgently needed at the Cleveland, OH VAMC could be prevented from acting under this section. We believe that the other safe-guards and the much enhanced vetting process established by this bill will well meet the need for the enforcement of stricter professional standards.

We would voice our strong support for **H.R. 5888**, to expand veteran eligibility for reimbursement by the Secretary of Veterans Affairs for emergency treatment furnished in a non-Department facility. This bill would correct a unjust anomaly under law where by a veteran with health insurance that covers a portion of an emergency medical procedure at a non-VA facility will be saddled with the remaining cost whereby a veteran with no health insurance is left debt free under the same circumstances. Not only is this a gross inequity penalizing, for example, veterans who must carry insurance to provide for their families, it is also a perverse disincentive for veterans in general to carry any medical insurance at all. We urge this bill's swift enactment.

The VFW also lends its support to **H.R. 6114**, the "Simplifying and Updating National Standards to Encourage Testing of the Human Immunodeficiency Virus of 2008" or "SUNSET Act of 2008." It is our view that the instant statute is outdated in requiring VA to provide a veteran with pre-test counseling and to obtain the veteran's written informed consent prior to testing the veteran for HIV infection. This impedes VA's ability to identify positive cases that should be addressed with medical intervention as early as possible. As a result, many infected patients unknowingly suffer very serious medical complications that could have been prevented as well as spreading the virus to their partners. HIV no longer carries the stigma that was attached to it when this statute was enacted and testing for HIV infection in routine clinical settings no longer merits extra measures VA is now required of by law. Again, we support this bill.

The VFW supports **H.R. 6122**, the "Veterans Pain Care Act of 2008." This bill directs the Secretary of Veterans Affairs to develop and implement a comprehensive policy on the management of pain experienced by veterans enrolled for health care services provided by the Department of Veterans Affairs. Pain management is an essential component of modern medical care as well as being absolutely key in assuring the best possible quality of life. Given the pain associated with the terrible traumatic injuries suffered by our men and women in uniform fighting in places like Iraq and Afghanistan, this issue is particularly compelling. We also appreciate and value the inclusion of the VSO's in the consultative process with the Secretary in periodically reviewing and revising VA's pain management policy.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions that you or any member of your Subcommittee may have.

MATERIAL SUBMITTED FOR THE RECORD

DEPARTMENT OF VETERANS AFFAIRS
 Veterans Health Administration
 Washington DC 20420

IL 10-2005-017
 In Reply Refer To: 13

September 2, 2005

UNDER SECRETARY FOR HEALTH'S INFORMATION LETTER**NEED FOR ROUTINE HUMAN IMMUNODEFICIENCY
 VIRUS (HIV) RISK ASSESSMENT AND TESTING**

1. This Information Letter provides information regarding the importance of offering every veteran under the care of the Department of Veterans Affairs (VA) the opportunity to have a voluntary test for Human Immunodeficiency Virus (HIV) and to periodically discuss and evaluate HIV risk with a knowledgeable VA health care professional.
2. **Background**
 - a. Advances in medical treatment over the past decade have resulted in most HIV-infected individuals living long lives free of opportunistic infections and other complications of the Acquired Immune Deficiency Syndrome (AIDS).
 - b. Despite advances in HIV therapy, patients who are diagnosed only when they become severely immunosuppressed may still experience otherwise preventable morbidity and mortality as a result of delayed diagnosis. Research in VA settings has confirmed that there are missed opportunities for timely diagnosis and treatment of HIV infection.
 1. In a blinded seroprevalence study at six VA sites, funded by the VA Quality Enhancement Research Initiative (QUERI), previously undetected HIV infection was present in 0–1.7 percent of inpatients and 0.3–2.9 percent of outpatients (see subpar. 4a).
 2. In another VA QUERI research study of four facilities between 1995 and 2000, fewer than half of patients with known risk factors documented in the medical record had been HIV tested. (see subpar. 4b).
 3. From research conducted as part of the National Institutes of Health-funded Veterans Aging Cohort study, 50 percent of newly HIV diagnosed patients in VA between 1998 and 2002 had CD4 lymphocyte counts of less than 200 cells per cubic millimeter (indicating advanced levels of immune suppression) at the time of diagnosis, and 48 percent of these suffered an AIDS-related complication during the first year after diagnosis. These patients had, on average, 3.7 years of VA care before diagnosis, indicating that there were missed opportunities to make diagnoses at a stage when HIV treatment could have prevented many of the complications experienced by these patients (see subpar. 4c).
 4. Among VA patients with known hepatitis C infection, approximately two-thirds have never been tested for HIV despite the significant overlap in epidemiology and risk factors (data from VA Hepatitis C Case Registry).
 - c. The Centers for Disease Control and Prevention (CDC) estimates that approximately 40,000 new HIV infections occur every year in the United States (U.S.) and that many of these are the result of sexual or drug use contact with individuals who are unaware of their own HIV infection. Knowledge of one's HIV infection status can be a powerful motivator to encourage behavior change that decreases risk of infection to others. The CDC has recommended that HIV risk assessment and testing become a part of routine medical care (see subpar. 4d).
 - d. Two recently published independent cost-effectiveness studies concluded that routine HIV screening, even in low prevalence populations, should be cost effective based on avoided clinical complications resulting from decreased transmission (see subpar. 4e and subpar. 4f).
 - e. The U.S. Preventive Services Task Force (USPSTF) recently issued guidelines including a strong recommendation that clinicians screen for HIV in all adolescents and adults at increased risk for HIV infection (see subpar. 4g).
 - f. HIV testing in VA is governed by Federal statutes and regulations that require signature consent and pre-and post-test counseling for HIV testing.

Within these parameters, considerable opportunities exist to make HIV testing more routine and accessible.

3. **Recommendations.** Given the great opportunity to prevent morbidity and mortality, to benefit the health of veterans and non-veteran communities, and to make effective use of VA health care resources, all VA facilities and health care providers need to develop and adopt strategies to decrease the number of veterans who are unaware of their HIV infection status. Traditional risk-identification strategies may be ineffective, and systems designed many years ago to carefully control HIV counseling and testing may no longer be necessary or desirable. Some or all of the following strategies may be useful:
 - a. Encourage all providers in primary care, mental health, and substance use treatment settings to routinely engage patients in discussions of HIV risk and to offer testing to all veterans who are at risk for HIV, to women veterans who are pregnant or are considering pregnancy, and to any veteran who wishes to be tested. **NOTE:** For a detailed discussion of HIV transmission and risk, refer to the VA HIV Prevention Handbook (<http://vaww.vhaco.va.gov/aidservice/prevention/handbook.htm>). For additional information on HIV testing in VA, refer to the Frequently Asked Questions document on the Web site of VA's Public Health Strategic Health Care Group (<http://vaww.vhaco.va.gov/aidservice/consent/testingFAQ.htm>).
 - b. Make voluntary HIV testing a routine part of the initial assessment in care settings where the prevalence of HIV risk is expected to be high, such as viral hepatitis (B&C) clinics, substance use treatment programs, sites where sexually transmitted diseases are treated, and programs for homeless veterans. Implementation of routine, voluntary HIV testing in settings where expected HIV prevalence is lower, such as primary care clinics, is likely to be cost effective as well (see subpar. 4b and subpar. 4c).
 - c. Work with facility and Veterans Integrated Services Network (VISN) laboratory leadership to implement rapid testing technologies in settings where the logistics of a veteran returning for test results and post-test counseling creates an obstacle for HIV testing.
 - d. Incorporate Registered Nurses and other non-physician medical professionals who are familiar with VA HIV testing policies and procedures in the process of discussing HIV risk assessment and testing.
 - e. Allow patients to request testing without requiring a detailed risk assessment.
 - f. Conduct reviews of recent HIV diagnoses to identify opportunities missed for earlier diagnosis.

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Under Secretary for Health

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Committee on Veterans' Affairs
 Subcommittee on Health
 Washington, DC.
 August 27, 2008

Honorable James B. Peake, M.D.
 Secretary
 U.S. Department of Veterans Affairs
 810 Vermont Avenue, NW
 Washington, DC 20420

Dear Secretary Peake:

On Thursday, June 5, 2008, Dr. Gerald M. Cross, Principal Deputy Under Secretary for Health, Veterans Health Administration, testified before the Subcommittee on Health on H.R. 4089, H.R. 4463, and H.R. 5888, H.R. 6114, and H.R. 6122.

As a followup to the hearing, I request that Dr. Cross respond to the following questions in written form for the record:

1. What collective bargaining rights does current law provide for title 38 employees?
2. At the Subcommittee's May 22, 2008 hearing on Human Resources Challenges within the Department of Veterans Affairs (VA), the Nurses Association of Veterans Affairs (NOVA) expressed concern for patient safety if matters relating to "direct patient care" and "clinical competence" were included in collective bargaining rights. In your view, are these valid concerns? If so, why?
3. The Secretary is held responsible for the quality of care provided to veterans. What impact would transferring the Secretary's authority for direct patient care and clinical competency determinations to a non-clinical third party who is not accountable have on veterans' health care?
4. Under title 5, employee compensation cannot be subject to collective bargaining. Would H.R. 4089 allow unions to bargain over the amount of a title 38 employee's compensation? What other exceptions are available to collective bargaining under title 5 that would be authorized under title 38, and what effect would these provisions have on our veterans?
5. Proponents of H.R. 4089 believe that VA's policy regarding collective bargaining rights negatively affects recruitment and retention. In your view, is this a valid concern? Please explain. What other factors affect VA's ability to recruit and retain health care professionals?
6. What benefits are available to title 38 employees that may not be available in the private sector, and/or under title 5 authorities?
7. Would H.R. 4089 have an impact on VA's peer review system? Please explain.
8. In the Office of Inspector General (IG) January 28, 2008 report, *Quality of Care Issues, VA Medical Center, Marion, Illinois*, the IG recommended the Under Secretary for Health explore the feasibility of implementing a process to independently identify all State licenses for VA physicians. Please provide the Subcommittee an update on the status of this and other patient safety and quality management recommendations from this report.
9. Gaps were found in both the 2004 and 2006 GAO reviews of credentialing and privileging at VA medical facilities. What steps has VA taken to ensure that each medical provider is fully credentialed and privileged?
10. What can be done to improve VA's system to verify the qualifications of physicians currently employed with the VA?
11. At a minimum of every two years, VA physicians are required to resubmit their applications for clinical privileges, and a physician who fails to disclose the requested information on license termination or surrender for cause may be terminated. How many VA physicians have been terminated for failure to disclose this required information?
12. How does VA's current application process protect patient safety? How can this process be improved to further protect patient safety?

The attention to these questions by the witnesses is much appreciated, and I request that they be returned to the Subcommittee on Health no later than close of business, 5:00 p.m., Friday, September 26, 2008.

Sincerely,

Jeff Miller
 Ranking Republican Member

Questions for the Record
Hon. Jeff Miller, Ranking Republican Member
Subcommittee on Health, House Committee on Veterans' Affairs
June 5, 2008
H.R. 4089, H.R. 4463, and H.R. 5888, H.R. 6114 and H.R. 6122

Question 1: What collective bargaining rights does current law provide for title 38 employees?

Response: Current law allows title 38 employees the right to bargain and grieve anything title 5 employees may grieve with the following exceptions: (1) professional conduct and competence issues; (2) peer review; or (3) the establishment, determination, or adjustment of employee compensation under title 38.

Question 2: At the Subcommittee's May 22, 2008 hearing on Human Resources Challenges within the Department of Veterans Affairs (VA), the Nurses Organization of Veterans Affairs (NOVA) expressed concern for patient safety if matters relating to "direct patient care" and "clinical competence" were included in collective bargaining rights. In your view, are these valid concerns? If so, why?

Response: VA concurs with NOVA's concerns related to the impact on patient safety that would result from a direct supervisor's lack of authority to determine whether or not an employee is clinically competent and the ability to take immediate action to ensure patient safety. Clinical competence of a professional nurse should only be determined by another member of the nursing profession. VA nursing executives are responsible for determining the clinical competence of their registered nurses, and are accountable for taking action (with input from nurse managers and nursing education staff) to ensure appropriate care is being delivered to veterans. In addition, the decision to initiate new clinical services, programs, training or service hours must remain the sole prerogative of the VA medical center (VAMC) senior leadership. To involve national or local bargaining units may result in delays in necessary clinical actions.

Question 3: The Secretary is held responsible for the quality of care provided to veterans. What impact would transferring the Secretary's authority for direct patient care and clinical competency to a non-clinical third party who is not accountable have on veteran's health care?

Response: Transferring the Secretary's authority for direct patient care and clinical competency to a non-clinical third party who is not accountable for veteran's health care, as proposed by H.R. 4089, would seriously compromise the Secretary's ability to meet the statutory responsibility for assuring the quality and safety of care provided to veterans. It would transfer determinations about direct patient care and the clinical competency of Veterans Health Administration (VHA) clinicians to independent third-party labor arbitrators. There is no assurance that these arbitrators would have any medical training or experience in clinical management; and they are not accountable for the quality and safety of care provided to veterans.

Question 4: Under title 5, employee compensation cannot be subject to collective bargaining. Would H.R. 4089 allow unions to bargain over the amount of title 38 employee's compensation? What other exceptions are available to collective bargaining under title 5 that would be authorized under title 38, and what effect would these provisions have on our veterans?

Response: H.R. 4089 would allow unions to bargain over the amount of title 38 employees' compensation. It would also allow title 38 employees to bargain over certain aspects of employee discipline which are governed by Federal regulations for title 5 employees. The potential for collective bargaining over title 38 discretionary compensation would not only be at odds with the norm within the Federal government, it would also create an undesirable precedent for Federal pay generally. Such significant changes in VA's collective bargaining obligations could adversely impact VA's budget and management rights and would also skew the current balance maintained between providing beneficial working conditions for title 38 professionals and meeting patient care needs. In addition it could lead to increased arbitration costs for VA.

Question 5: Proponents of H.R. 4089 believe that VA's policy regarding collective bargaining rights negatively affects recruitment and retention. In your view, is this a valid concern? Please explain. What other factors affect VA's ability to recruit and retain health care professionals?

Response: VA has no data to support the contentions made by the American Federation of Government Employees (AFGE) that recruitment and retention of our professional health care employees is negatively impacted by collective bargaining rights, nor has AFGE provided any evidence to support this contention.

VA has no more trouble filling positions than private hospitals, and turnover is similar or lower; therefore, we do not agree that bargaining rights are a determining

factor. VA experiences the same challenges filling positions that private sector hospitals face; job opportunities for health care providers exceed the number of qualified candidates in many occupations and an inequity in geographical distribution of health care workers particularly increases recruitment challenges in rural areas.

VA's generous benefits packages and title 38 pay systems, such as the physician and dentist pay system and the nurse locality pay system, have made VA more competitive and improved our ability to recruit and retain health care professionals.

Question 6: What benefits are available to title 38 employees that may not be available in the private sector, and/or under title 5 authorities?

Response: VA employees under title 38 and the title 38 hybrid systems enjoy the same robust benefits—health, life insurance and retirement benefits package—offered to all Federal government employees. Pure title 38 employees receive 5 weeks per year of paid vacation from the date of appointment as a Federal employee. This exceeds the title 5 benefit for vacation time. Title 38 employees are able to carry over the highest rates of annual leave (685 hours) year to year, which is greater than most private sector employers allow. All Federal employees may carry over sick leave with no limit.

Congress has established pay systems for title 38 employees that are more flexible than the General Schedule, which covers title 5 employees. The nurse locality pay systems allow each VHA facility to establish pay and specialty schedules for nurses based on surveys of the pay practices of other employers in the area. This allows each facility to structure its pay schedules to be more competitive. The physician and dentist pay system allows VA to establish national pay ranges for various specialties after consulting national pay surveys. Local facilities can then set individual pay for each physician and dentist based on local market conditions and the individual's qualifications and credentials. VHA facilities can also offer special pay in the range of \$10,000 to \$25,000 for nurse executives. This flexibility has made it possible for facilities to be more competitive in recruiting and retaining highly qualified individuals in these critical positions. The Office of Personnel Management has delegated authority to VA that allows VHA facilities to establish special salary rates for title 38 and hybrid title 38 occupations when necessary to keep the local pay rates competitive in its marketplace. This authority is generally not available to other agencies for title 5 positions.

Additionally, VA health care providers' malpractice liability is covered by the Federal Torts Claims Act and employees cannot be individually sued for actions extending from "conscientious" performance of their Federal duties.

Another advantage to Federal employment under both the title 38 and title 38 hybrid personnel systems is a level of job security during uncertain times that does not necessarily apply to health care workers in the private sector.

Title 38 and hybrid title 38 employees are eligible for special advancement for achievement awards for their outside professional accomplishments, self-development and for taking external leadership roles in the advancement of their occupations. These awards, consisting of a one to five step pay increase, depend on the specific professional accomplishment. These awards are not available to title 5 employees. Title 38 employees may receive premium pay based on their actual rate of pay rather than the capped GS-10 rate for title 5 employees. Additionally, title 38 nurses have their unused sick leave counted in the calculation of their retirement benefits (not to determine eligibility for retirement).

Question 7: Would H.R. 4089 have an impact on VA's peer review system? Please explain.

Response: H.R. 4089 would subject peer review processes and decisions to compromise and/or reversal through collective bargaining and negotiated grievance procedures. VHA uses peer review in a number of ways. Professional standards boards evaluate the qualifications and credentials of title 38 employees and make recommendations for appointments and advancements. Compensation panels perform peer reviews to recommend compensation for physicians and dentists based on the providers' individual credentials and specialty assignments. Peer review is also used to evaluate questions related to patient care and providers' clinical competency in a number of situations, through the Disciplinary Appeals Boards to which providers may appeal disciplinary actions that involve patient care or clinical competency issues.

The purpose of these peer review processes is to ensure that decisions about patient care and clinical competence issues are made by qualified clinicians rather than by laypersons (judges, arbitrators, union officials) that lack the clinical training and expertise necessary to make such decisions.

Subjecting the peer review processes and decisions to collective bargaining would severely limit the effectiveness of the peer review processes. It would transfer cur-

rent VHA clinicians' peer review and the clinical competency of VHA clinicians to independent third-party labor arbitrators.

Question 8: In the Office of Inspector General (IG) January 28, 2008 report, *Quality of Care Issues, VA Medical Center, Marion Illinois*, the IG recommended the Under Secretary for Health explore the feasibility of implementing a process to independently identify all State licenses for VA physicians. Please provide the Subcommittee an update on the status of this and other patient safety and quality management recommendations from this report.

Response: In July 2008, VHA implemented an automated query to the Federation of State Medical Boards (FSMB) to identify all current and previously held physician State medical licenses. VHA worked on developing this process with FSMB and is the first health care system in the United States to use this assessment tool. As of July 2008, the automated query is complete and is being used.

Question 9: Gaps were found in both the 2004 and 2006 GAO reviews of credentialing and privileging at VA medical facilities. What steps has VA taken to ensure that each medical provider is fully credentialed and privileged?

Response: VHA Directive 2006-067, *Credentialing of Health Care Professionals*, was issued on December 22, 2006, to address the Government Accountability Office (GAO) recommendations in the March 31, 2004 report *VA Health Care: Improved Screening of Practitioners Would Reduce Risk to Veterans* (GAO-04-566). The GAO report contained four recommendations: 1) require facility officials to contact State licensing boards and national certifying organizations to include all State licenses and national certificates held by applicants and employed practitioners, 2) expand the query of the Healthcare Integrity and Protection Data Bank (HIPDB) to include all licensed practitioners that VA intends to hire and periodically query this database for continued employment, 3) require fingerprint checks for all health care practitioners who were previously exempted from background investigations and who have direct patient care access, and 4) require fingerprint checks for all health care practitioners who were previously exempted from background investigations and who have direct patient care access. GAO considers all but one recommendation contained in this report implemented. Recommendation to expand the query of the HIPDB to include all licensed practitioners that VA intends to hire and periodically query this database for continued employment was partially implemented. VA directs all of its medical facilities to query the HIPDB for all applicants prior to employment and most volunteers prior to being given an assignment. VA's requirement to query the HIPDB for all applicants and new volunteers goes beyond GAO's recommendation to query on those applicants who are licensed. VA has not begun to query HIPDB on a periodic basis for continued employment as recommended. As of July 2008, VA is continuing to work on processes and procedures to allow this screening to occur automatically and expand it to include other VA databases.

VHA Directive 2006-067, *Credentialing of Health Care Professionals*, was issued on December 22, 2006, to address the Government Accountability Office (GAO) recommendations in the March 31, 2004 report *VA Health Care: Improved Screening of Practitioners Would Reduce Risk to Veterans* (GAO-04-566).

GAO issued a report on May 25, 2006, *VA Health Care: Steps Taken to Improve Practitioner Screening, but Facility Compliance with Screening Requirements Is Poor* (GAO-06-544) containing two recommendations. GAO recommended that VA standardize a method for documenting facility officials' review of fingerprint-only background investigation results and decisions regarding suitability to work in VA medical facilities. GAO considers this recommendation implemented by the issuance of VA directive and handbook 0710 on May 18, 2007. GAO's second recommendation that VA expand the Office of Human Resource Management oversight program to include a review of VA facilities' compliance with screening requirements for all types of salaried and non-salaried health care practitioners is considered partially implemented. VA's Office of the Medical Inspector has developed a compliance assessment tool which it will pilot test at the Baltimore VA medical center, then refine the tool and use it at eight other medical centers. VA's Office of Human Resources Management will continue to review facility compliance with VA's personnel screening requirements as part of its on-site HR inspections.

Question 10: What can be done to improve VA's system to verify the qualifications of physicians currently employed with the VA?

Response: Listed below are recent enhancements made to improve VA's credentialing process.

- At the time of initial or re-appointment processing, all VHA clinicians now sign a revised release of information form allowing the agency to request not only public information, but also information regarding any open/pending allegations/charges from State Licensing Boards.

- More than 3,200 senior medical staff leaders have completed focused training on roles and responsibilities of medical staff leaders and the use of provider-specific performance profiles.
- VHA has worked with the FSMB to develop an automated system to identify all current and previously held physician State medical licenses. This system was implemented in July 2008. When used in combination with the revised practitioner Release of Information, VHA has become the first health system in the United States to use a comprehensive assessment of all State Licensing Board actions regardless of the State of completion.

Additional enhancements to our credentialing and privileging systems and policies are being implemented. This includes mandatory participation in the National Practitioner Data Bank-Health Integrity and Protection Data Banks proactive disclosure service (tentatively slated for November 2008), and developing guidance and templates to document local facility current privileging processes and the data/materials used for confirmation of competency (slated for release October 2008).

Question 11: At a minimum of every two years, VA physicians are required to resubmit their application for clinical privileges, and a physician who fails to disclose the requested information on license termination or surrender for cause may be terminated. How many VA physicians have been terminated for failure to disclose this required information?

Response: VHA's Office of Quality and Performance is aware of one practitioner being removed due to failure to fully disclose all information concerning credentials. These cases are managed locally, so it is possible that others have been terminated without being reported to the national level.

Question 12: How does VA's current application process protect patient safety? How can this process be improved to further protect patient safety?

Response: In support of quality, effective, and safe patient care, our application process includes primary-source verification of:

- education;
- training;
- all licenses ever held;
- confirmation of active, current, unrestricted licensure;
- references who can attest to current competency;
- experience related to requested privileges;
- status of privileges held at other institutions;
- documentation of all actions (licensing, malpractice, clinical practice reviews);
- National Practitioner Data Bank (NPDB) query;
- Federation of State Medical Boards (FSMB) query (results list all States where licenses have been held); and
- FSMB Disciplinary Alert Service (ongoing monitoring of any actions against any State license).

For confirmation of competency, focused professional practice evaluations (FPPE) are conducted for all practitioners initially granted privileges at any facility or granted a new privilege for the first time. These reviews may include chart review, monitoring clinical practice patterns, simulation, proctoring, external peer review, or discussion with other individuals involved in the care of each patient. Results of FPPE and ongoing monitoring of performance allow the facility to identify and address, in a timely manner, practice patterns that impact quality of care and patient.

Additionally, all facilities have been requested by the Deputy Under Secretary for Health for Operations and Management to review all privileges performed at their facilities, confirm adequacy of resources for all facility privileges, and confirm current competence for practitioners who have been granted privileges.

The review of each practitioner's current competence is documented by the service chief in the provider profile. This documentation includes the information that was used as evidence of current competence and any monitoring and/or followup that is required. This information is fully evaluated and documented by the facility's Medical Staff Executive Committee.

Updated VHA Handbook 1100.19 (pending publication) also clarifies practitioner-specific information to be compiled in the provider profile and evaluated as part of the facility's ongoing monitoring, as well as for the reappraisal and privileging process.