STATEMENT OF
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OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
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Mr. Chairman and Members of the Subcommittee:

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

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

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

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

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

The Need for Confidentiality

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

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

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

Conversely, the Institute for Healthcare Improvement (IHI) has found that all employee reporting programs (voluntary and mandatory) result in substantial underreporting.[4] Several studies have shown that computer monitoring strategies have identified many times more potential adverse events than were reported through employee reporting mechanisms.[5,6,7] The IHI's "Trigger Tools" are also used to identify adverse events and detect safety problems.[8,9,10,11] Moreover, not having specific facility and patient information has caused frustration when VA Central Office and oversight bodies have requested Veterans Health Administration (VHA) data regarding adverse events. Facility patient safety managers have also had to create secondary, duplicative systems in order to capture the patient information needed for effective reviews and reports.

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

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[2] Institute of Medicine, "To Err is Human: Building a Safer Health System", November 1999
[3] The Joint Commission, "2008 Comprehensive Accreditation Manual for Hospitals: The Official Handbook," PI-1.
[4] Institute for Healthcare Improvement, "Introduction to Trigger Tools for Identifying Adverse Events," Available at: http://www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/Tools/IntrotoTriggerToolsforIdentifyingAEs.htm, Accessed: August 25, 2010.
[5] David W. Bates, MD, MSc, et al., "Detecting Adverse Events Using Information Technology," *J Am Med Inform Assoc*, Vol. 10, No. 2, March–April 2003, pp. 115–128.
[6] M. K. Szekendi, et al., "Active surveillance using electronic triggers to detect adverse events in hospitalized patients," *Qual Saf Health Care*, Vol. 15, June 2006, pp. 184–190.
[7] C. W. Johnson, "How will we get the data and what will we do with it then? Issues in the reporting of adverse healthcare events," *Qual Saf Health Care*, Vol. 12, December 2003, p. ii64.
[8]Rozich JD, Haraden CR, Resar RK. Adverse drug event trigger tool: A practical methodology for measuring medication related harm. Quality and Safety in Health Care. 2003 Jun;12(3):194-200.
[9] Sharek PJ, Horbar JD, Mason W, et al. Adverse events in the neonatal intensive care unit: Development, testing, and findings of an NICU-focused trigger tool to identify harm in North American NICUs. Pediatrics. 2006 Oct;118(4):1332-1340.
[10] Griffin FA, Classen DC. Detection of adverse events in surgical patients using the Trigger Tool approach. Quality and Safety in Health Care. 2008 Aug;17(4):253-258.
[11] Classen DC, Lloyd RC, Provost L, Griffin FA, Resar R. Development and evaluation of the Institute for Healthcare Improvement Global Trigger Tool. Journal of Patient Safety. 2008 Sep;4(3):169-177.

The Need for Transparency: Health Care

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

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

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

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

Notably, VA at that time opposed the bill as written as too prescriptive in its requirements, and stated that much of the information required by H.R. 1448 is available through other avenues, such as The Joint Commission's (previously known as the Joint Commission on Accreditation for Healthcare Organizations) website that provides standardized comparative data in a form that has been tested for consumer understandability and usefulness.

S. 1427 (111th) and H.R. 1448 (110th), both sought to provide easily accessible reports published in acceptable lay terms on the quality of VA's medical centers that include quality-measures data that allow for an assessment of health care effectiveness, safety, timeliness, efficiency, patient-centeredness, and equity. In contrast, the bill now before the Subcommittee would simply make publicly available redacted versions of VA's medical quality-assurance

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[12] Department of Veterans Affairs. "Patient Centered Medical Home Model Concept Paper," March 15, 2010. Available at: http://www1.va.gov/PrimaryCare/docs/pcmh_ConceptPaper.doc; Accessed: August 26, 2010.
[13] http://www.patientsafety.gov/patients.html#intro; Accessed: August 26, 2010.
[14] Cross, Gerald M, Acting Under Secretary for Health, Department of Veterans Affairs. Statement to the Senate, Committee on Veterans Affairs. "Hearing on Pending Legislation," Hearing, October 21, 2009. Available at: http://www.veterans.senate.gov/hearings.cfm?action=release.display&release_id=faa07041-78f1-45c7-93f1-fff7b5a6f978; Accessed: August 26, 2010.

records. It is uncertain whether making such documents available on VA's website would meet the needs of veterans and their families to make informed decisions.

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

The Need for Transparency: Disability Compensation

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

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

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

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

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

not fully developed because those claims do not contain quality assurance records to validate the injuries claimed.

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

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

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

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

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

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

This measure would require VA to identify a qualified nursing or medical school to develop a literature review and evidence-based guidelines for recovery coordination, establish a

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

consensus conference, and develop training modules for care coordination. The bill would authorize $1.2 million for that effort. Also, the bill would authorize $500,000 for training 45 recovery coordinators by the designated nursing or medical school, and would authorize $1.2 million for the development, validation and piloting of technology tools and software that is compatible with VA and Department of Defense (DoD) systems for recovery coordination.

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

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

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

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

A September 16, 2008, report to Congress on the development of a comprehensive policy for DoD and VA on the care, management, and transition of recovering service members addresses the maximum number of recovering service members whose cases may be assigned to a recovery care coordinator as required by the Wounded Warrior Act. It states that the appropriate workload or case ratio for FRCs is not known. These are new positions for which there are no comparable data or ratios. Currently, all FRCs are tracking time utilization. New

cases are distributed based on existing caseloads. In the near future, the FRCP will implement acuity based measures to more precisely balance caseloads. [17]

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

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

FRCP Education, Training, and Technology Tools

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

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

[17] Report to Congress on the Comprehensive Policy Improvements to the Care, Management and Transition of Recovering Service Members (NDAA Section 1611 and 1615), September 16, 2008. Available at: http://prhome.defense.gov/WWCTP/docs/09-16-08_1900_Final_Report_to_Congress_-_1611_and_1615.pdf Accessed: September 2, 2010.

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

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

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

Also, the bill seems ambiguous in both the purpose and intended uses of the care coordination software and the language in Section 2(c)(1)(A), which would require the VA to enter into relationship with a subcontractor. Further, we urge the Subcommittee to include a public reporting requirement summarizing the results of the software pilot program. Finally, we recommend technical changes to the language, since the program to which it refers is the Federal Recovery Coordination, not *Coordinator*, Program.

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

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

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

Although DAV has no specific resolution calling for an Injured and Amputee Bill of Rights, DAV fully supports VA's Amputee System of care. DAV, as part of the *Independent Budget*, strongly supports full implementation of the VA amputation system of care program and encourages Congress to provide adequate resources for the staffing and training of this important program. The *Independent Budget* recommends that VA expeditiously implement the proposed system providing proper staffing levels and training to ensure VA provides superior health services for aging and newly injured veterans who need these unique services. Also, the VISN prosthetics representatives should maintain and disseminate objectives, policies, guidelines, and

regulations on all issues of interpretation of prosthetics policies, including administration and oversight of VHA's Prosthetics and Orthotics Laboratories. The overall goals of this bill appear to be in line with these stated recommendations and objectives; therefore, we have no objection of the passage of this measure.

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

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

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

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

Mr. Chairman, this bill would restore some bargaining rights for clinical care employees of the VHA that were eroded by the former Administration. The bill would amend subsections (b) and (d) of section 7422 of title 38, United States Code, by striking "compensation" both places it appears and inserting "basic rates of pay" in its place. The intent of the bill would be to authorize employee representatives of recognized bargaining units to bargain with VHA management over matters of employee compensation other than rates of basic pay.

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

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

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

H.R. 5641– Heroes at Home Act

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

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

New partnerships between Home Based Primary Care (HBPC) and the MFHs and CRCs have allowed veterans to live independently in the community, as a preferred means to receive family-style living with room, board, and personal care. Under the MFH Program, the administrative costs for VHA are less than $10 per day, and the cost of Home Based Primary Care, medications and supplies averages less than $50 per day. Understandably, VA perceives

this program as a cost-effective alternative to nursing home placement, and it is gaining popularity as evidenced by the program's expansion.

DAV is pleased with VA's innovation by offering the MFH program as part of its long-term care program. Notably, patient participation in this program, while voluntary, yields very high satisfaction ratings from veterans. But because MHF operates under the CRC authority, participating veterans must pay the MFH caregiver approximately $1,500 to $4,000 per month for room and board, 24-hour supervision, assistance with medications, and whatever personal care may be needed.[19] Even veterans who are otherwise entitled to nursing home care fully paid for by VA under the Veterans Millennium Health Care and Benefits Act (Millennium Act)[20] or under VA's policy on nursing home eligibility[21], must pay to live independently in a CRC or MFH. According to VA, MFH is appropriate for certain veterans whose conditions warrant a nursing home level of care but who prefer a non-institutional setting. In other words, were it not for MFH, veterans who meet the nursing home level of care standards would qualify for VA paid care to receive it. In addition, veterans who do not have the resources to pay the MFH caregiver are not able to avail themselves of this benefit.

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

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

In a special article written for the State of the Art Planning Committee by Kenneth Shay, DDS, MS, Director of VA Geriatric Programs, and James F. Burris, MD, Chief Consultant for VA Geriatrics and Extended Care, they note there are three fundamental building blocks of long-term care for chronically ill elders. They are personal care, housing, and chronic disease care. Meaningful goals for long-term care relate to maintaining and improving function and quality of

[19] 38 U.S.C. § 1730(a)(3).
[20] P.L. 106-117, 113 Stat. 1545 (1999) required that through December 31, 2003, VA provide nursing home care to those veterans with a service-connected disability rated at 70 percent or greater,4 those requiring nursing home care because of a condition related to their military service who do not have a service-connected disability rating of 70 percent or greater, and those who were admitted to VA nursing homes on or before the effective date of the act. Subsequent law extended these provisions.
[21] VA's policy on nursing home eligibility required that VISNs provide nursing home care to veterans with 60 percent service-connected disability ratings who are also classified as unemployable or Permanent and Total Disabled.
[22] U.S. Department of Veterans Affairs. Patient Care Services. *Geriatrics and Extended Care Strategic Plan*. Washington DC, December 24, 2008.

life while maximizing safety and autonomy. Because these goals are not always compatible, there need to be tradeoffs and ranked priorities. In addition, they cite the most-rapid growth in non-VA extended care options has been in "assisted living," a loosely defined and minimally regulated set of residential and care services that VA does not have statutory authority to provide or pay for. Yet suitably supportive housing is a key component of non-institutional long-term care, so VA has sought to implement alternative, creative solutions to facilitate disabled veterans' access to supportive living options without the agency actually paying the costs of room and board.[23]

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

Clearly, VA's MFH program should be realigned under a more appropriate statutory authority. Public Law 106-117 authorized an Assisted Living Pilot Program (ALPP) carried out in VA's VISN 20. Conducted from January 29, 2003, through June 23, 2004, and involving 634 veterans who were placed in assisted living facilities, the pilot project yielded an overall assessment report submitted to Congress stating, "the ALPP could fill an important niche in the continuum of long-term-care services at a time when VA is facing a steep increase in the number of chronically ill elderly who will need increasing amounts of long-term care."[24] Unfortunately, VA's transmittal letter that conveyed the ALPP report to Congress stated that VA was not seeking authority at that time to provide assisted living services, because VA considered assisted living to be primarily a housing function.

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

Current estimates show more than 900,000 Americans live in approximately 39,500 assisted living residences in the United States.[25] The 2009 MetLife survey put the average cost of assisted living providing 10 or more services at $41,628 annually in 2009, but found that private room nursing home rates average $79,935 per year, and semi-private room rates average

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

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

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

$72,270 per year.[26] In fiscal year (FY) 2009, VA spent over $5.2 billion—about 12 percent of its total health care spending—to provide for veterans' long-term care needs. Nearly 82 percent ($4.2 billion) of VA's total long-term care spending in FY 2009 was for nursing home care. For FY 2011, VA expects to spend over $6.8 billion—over 13 percent of its total health care budget—to provide for veterans' long-term care needs. Over 78 percent ($5.4 billion) of VA's total long-term care spending in FY 2011 will be for nursing home care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DAV supports the intention of this bill in particular ensuring the availability of information at readily accessible locations. We urge the Subcommittee to include contact information of congressionally chartered Veterans Service Organizations (VSO) that can provide free counseling and assistance to veterans and their dependents in pursuing claims for compensation of service-connected conditions. We are concerned however, with the administrative burden on VA employees orally being required to ask each veteran who visits a VA facility if the veteran would like to receive information when the total number outpatient care encounters in FY 2009 was 92,892,834.[28] While we support the good intentions of this bill, this notification requirement may prove impossible to implement.

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

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

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

Mr. Chairman, there is a great need for specific emphasis on the needs of homeless women veterans, homeless veterans with children, and homeless veterans suffering from serious mental illness. We have greater numbers of women veterans coming to VA with post-deployment mental health needs due to combat exposure, which puts them at higher risk for becoming homeless. Likewise, many homeless veterans with minor children have been unable

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

to avail themselves of VA's excellent programs because no support for their children is available in VA programs. It is clear this measure will provide comprehensive services to this vulnerable population including homeless veterans who are frail elderly, terminally ill, or suffering from serious mental illness.

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

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

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

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