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NOMINATION OF JONATHAN B. PERLIN TO BE UNDER SECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

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THURSDAY, APRIL 7, 2005

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WITNESS

NOMINATION OF JONATHAN B. PERLIN TO BE UNDER SECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS

THURSDAY, APRIL 7, 2005

UNITED STATES SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10:04 a.m., in room SR–418, Russell Senate Office Building, Hon. Larry E. Craig presiding.

Present: Senators Craig, Burr, Thune, Isakson, Akaka, Jeffords, Murray, and Salazar.

OPENING STATEMENT OF HON. LARRY E. CRAIG, CHAIRMAN, U.S. SENATOR FROM IDAHO

Chairman CRAIG. The Senate Committee on Veterans' Affairs will be in order. Good morning, ladies and gentlemen, and welcome to this hearing. And a very special good morning to you, Dr. Perlin.

Dr. PERLIN. Good morning.

Chairman CRAIG. We are pleased to have you before the Committee. It is our pleasure this morning to take the testimony of Dr. Jonathan B. Perlin.

As everyone in this room likely knows, the President has nominated Dr. Perlin to serve as VA's Under Secretary for Health. This is an exceedingly important position. The Under Secretary, in effect, serves as CEO of the VA's entire health care system, the largest integrated health care system in the United States. Dr. Perlin, this is a big, big, big job.

Now that I have impressed you with that—but I didn't need to because you already know—I must tell you that I believe you are up to the challenge. Before I proceed, let me offer to the Committee a brief summary of Dr. Perlin's extraordinary background, and probably this is going to get repeated by our colleague John Thune a bit.

But as you know, Dr. Perlin now serves as VA's Acting Under Secretary for Health. Prior to taking that assignment, he served as Deputy Under Secretary of Health from 2002 to 2004 while also serving as VA's Chief Research and Development Officer. And from 1999 to 2002, he was VA's Chief Quality and Performance Officer.

Before taking on these important jobs at VA Headquarters, Dr. Perlin served from 1997 to 1999 as Medical Director of the Medical College of Virginia. Prior to that, he had been, among other things, an Adjutant Professor of Medicine at the Medical School and, most

importantly, a practicing physician at VA's Medical Center in Richmond, Virginia.

Dr. Perlin's academic background is truly impressive. He holds the following degrees: a Bachelor's degree from the University of Virginia in Interdisciplinary Studies, a Ph.D. in Pharmacology and Toxicology from the Medical College of Virginia, an M.D. from the Medical College of Virginia, and finally, a Master's degree in Health Administration from Virginia Commonwealth University.

Dr. Perlin has received so many grants and awards that I am not going to list them. But clearly, he is recognized for his professionalism and through his training and background has arrived at these levels.

I also note that Dr. Perlin is married to a physician and that several of his family members are with us today. I hope you will take the opportunity, Doctor, when it is appropriate, to introduce them.

Before I swear Dr. Perlin in, let me turn to my colleagues here for any opening comments they would like to make. And then I will ask you to take the oath, as is customary here in the Senate for confirmation hearings of our Executive Branch personnel, and then we will hear testimony from you.

But first, let me turn to the Ranking Member of this Committee, Danny Akaka.

Senator Akaka.

STATEMENT OF HON. DANIEL K. AKAKA, RANKING MEMBER, U.S. SENATOR FROM HAWAII

Senator AKAKA. Thank you very much, Mr. Chairman. I am delighted to be here with you and working with you on this Veterans' Affairs Committee.

I want to add my welcome to Dr. Jonathan Perlin. And not only to you, but to your family, too. I want to say aloha and welcome to Dr. Donna, wife of Dr. Perlin, and also Benjamin, his son. And his sister, Sarah is not here because she had to take a field trip at school.

Chairman CRAIG. He is missing a Spanish test.

[Laughter.]

Senator AKAKA. But we are delighted to have you, and we have the reason why Dr. Perlin, our witness today is here, and that is his parents, Dr. Perlin and his mother, who are here with him. And we welcome you, too.

Looking at the first row, I see a friend for many, many years in Hawaii and thereafter, General Mick Kicklighter. And I want to say welcome to you, too, and all others here from VA and friends of VA.

Today's confirmation hearing is enormously important, as was mentioned by the Chairman. The VA medical system, as he said, is the largest health care system in this country and one of the largest in the world. And the quality of service is known as being very good.

It is a program with many strengths. And having said that, it is also a program with many weaknesses. One major weakness is that it lacks the resources that it needs to provide medical care for all our Nation's veterans who would like to obtain care there.

The VA Under Secretary for Health is one of the most important public servants. And I am reiterating that. The next Under Secretary will guide the VA medical system at a time when so many new veterans will be turning to VA for help. The next Under Secretary will assume his duties in a tough financial climate. The funding squeeze means that some will push proposals to curtail benefits and to put limits on who can access these benefits.

The President has his ideas and his solutions to make room for returning servicemembers. And from what I see, part of the President's solution is to literally force other veterans out of the system. This is short-sighted, as the proposed cuts for care will surely affect Iraq and Afghanistan veterans.

I urge you now, Dr. Perlin, if you are confirmed—and I have no question that you will be—you must look for ways to uphold the promises we made to all of our troops. We in Congress and the millions of veterans across this country will accept no less. We want to do the best we can for them.

In the coming year, I will be dedicating my efforts to maintaining access to a high-quality health care system for all veterans, whether they are new veterans returning from the war or older veterans in need of good nursing home care. Our goal is to keep what has made VA great while strengthening it in such areas as long-term care and mental health.

VA needs a leader who is strong enough to offer his own ideas but be able to delegate authority to others. And I am glad we had the chance to talk together on some of these issues yesterday. One purpose of this confirmation hearing is to convey our concerns about maintaining a viable VA medical system and give to Dr. Perlin the opportunity to let us know how he plans to meet those challenges.

Dr. Perlin, I appreciate your responses to my pre-hearing questions, and I ask, Mr. Chairman, that the questions and Dr. Perlin's answers be entered into the record.

Thank you very much.

Chairman CRAIG. Without objection, they will become a part of the record.

[Pre-hearing questions from Sen. Akaka for Dr. Perlin follow:]

RESPONSE TO WRITTEN PRE-HEARING QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO DR. JONATHAN B. PERLIN, NOMINEE TO BE UNDER SECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. Perlin, if confirmed, your term would run until 2008. Please describe your vision for the VA health care system by that year. Specifically describe the mix of services that you believe enrolled veterans will receive, the makeup of staff providing these services, and a description of the VA facilities involved.

Answer: My goal for the year 2008 is to ensure excellent, safe, effective and compassionate health care for veterans who have chosen VA for their health care needs. I expect that we will make better use of advanced technologies that exist today, such as our electronic health records system, and new technologies that may be better developed by then, such as remote physiological monitoring systems, to help care for veterans in their homes. I also hope that accelerating our research programs will enable us to better help our patients' rehabilitation, physical and mental health needs.

2. The Committee notes with concern the numerous positions that are currently vacant in VHA, including the heads of mental health, a number of professional services, and other key positions, including your own position of Deputy Under Sec-

retary, should you be Confirmed. What are your plans and priorities to address these vacancies?

Answer: I have absolute confidence in the abilities of Dr. Michael Kussman to continue to discharge the responsibilities of Deputy Under Secretary. He has been serving diligently on an acting basis, and VA would be fortunate to have the benefit of his leadership as the permanent Deputy Under Secretary.

Our Department has also been aggressively recruiting for the positions of Chief Research and Development Officer. I have elevated the position of Chief of Chief Consultant for the Mental Health Strategic Health Care Group to Deputy Chief of Patient Care Services for Mental Health Care, and recruitment is currently underway for this position. Another critical role is Chief Consultant for the Emergency Management Strategic Health Care Group. I can report that we are in the advanced stages of all of these recruiting efforts, and that we have very promising candidates for each position.

3. The Fiscal Year 2006 (FY06) budget request contains a proposal to enact an increase in prescription drug co-payments from $7 to $15 for "middle-income" veterans and an annual enrollment fee of $250 for "middle-income" veterans. Given VA's assumption that the proposals will suppress demand and that veterans will, in fact, leave the VA health care system, what is your view of these fees? Additionally, VA intends to continue its ban on so-called "middle-income" or Priority 8 veterans. How do you feel about explicitly excluding certain veterans from the system?

Answer: VA has proposed cost sharing policies for Priority 7 and 8 enrollees as a means of balancing veteran demand and available resources. If the $250 enrollment fee is not adopted, another means to balance available resources must be found.

In a perfect world without resource constraints, VHA would welcome all veterans to have access to our care. While I wish that there were no resource constraints, that is not the case. VA must make sure that it never falls short in meeting those with greatest need, including Service Connected, Special Needs, Financially Challenged and New Combat Veterans.

4. I am deeply concerned about VA's present approach to caring for veterans suffering from PTSD and other mental health disorders.

A. Please describe the priority that you believe VA should place on providing care to veterans with PTSD, and how you would ensure that priority is manifested in budget requests and programmatic planning.

Answer: I place the highest priority on Mental Health Care and share your interest in assuring accessible, excellent, and caring Post Traumatic Stress Disorder (PTSD) treatment. I believe that our Department needs to place an extremely high priority on providing care to veterans with PTSD. This fiscal year we have allocated $100 million to implement initiatives contained in the Department's Mental Health Strategic Plan. The President's fiscal year 06 budget proposes to supplement this with an additional $100 million. These initiatives will benefit not only veterans with PTSD, but all veterans receiving mental health care from VHA. In addition, this week we are announcing that we will add 50 additional veterans of the Global War on Terrorism to our Readjustment Counseling Service, to provide outreach and services to fellow service members returning from Iraq and Afghanistan.

B. From your experience as Acting Under Secretary, what is your assessment of the unmet treatment needs among veterans with PTSD? Where do you see the most room for VA to improve?

Answer: I believe that we are meeting the needs of veterans with PTSD. To improve our service to these veterans, however, we must improve the availability of services to some veterans, especially those living in rural areas; and we must also do additional research to ascertain and treat possible co-morbidities facing those with a PTSD diagnosis. I have identified improving access to specialty mental health services and substance abuse treatment as two critical priorities for fiscal year 05 and fiscal year 06, in accordance with our Mental Health Strategic Plan.

C. Based on your experience as Acting Under Secretary and your time as VHA's Chief Quality and Performance Officer, please give your assessment of the Readjustment Counseling Service and the relationship to VA medical centers. Also, please describe the relationship today between the mental health departments at VA Medical Centers and the Vet Centers.

Answer: Our Vet Centers offer a safe haven to veterans to explore and discuss adjustment reactions they may be having, and appropriate referrals to ensure that those who require additional help receive it expeditiously. I particularly appreciate Dr. Al Batres' initiative to create better data interfaces between Vet Centers and VA medical centers, so that we can improve the clinical interface between the two organizations.

5. As you know, in 1997, VA implemented the Veterans Equitable Resource Allocation (VERA) methodology to manage how funds are provided throughout the system.

A. Given the tremendous fiscal pressure faced by certain networks, are you still satisfied that this system is a fair way to allocate funds?

Answer: VERA as a methodology has been reviewed three times by the RAND corporation and found to be a fair and equitable way for VHA to distribute resources. Given these findings by an impartial outside organization, I am satisfied that VERA is, in fact, a fair way to allocate funding.

B. In your view, does VERA sufficiently allow VA managers to sustain programs for high cost patients and patients in need of specialized services?

Answer: We have recently eliminated several disincentives to VISNs to provide care for patients in need of specialized services under the VERA systems; one involving blinded veterans, and the other involving veterans seeking certain mental health treatment. We will continue to search out such disincentives, and remove them as they become known.

6. As you may know, I am deeply concerned about issues relating to long-term care services and delivery in VA.

A. Based on estimates, the number of veterans age 85 and older will dramatically increase—from 154,000 in 1990 to 1.3 million in 2010. If confirmed, what changes would you seek to implement to allow VHA to respond to the impact of this looming change? How do you reconcile the current budget proposal and its vision of the future of VA long-term care with the projected increase in demand for these services?

Answer: The statistics you mention are for all veterans, not the number of veterans above 85 VA expects to see in 2010. I believe that with our current budget proposals, we will be able to meet the long-term care needs of World War II veterans. Our goal is to provide long-term care in the least restrictive setting that is compatible with a veteran's medical condition and personal circumstances, and we are moving aggressively to meet that goal.

B. The budget proposal for FY06 includes a number of changes to both State and VA nursing homes. What is your view of the proposed changes to the State Veterans Home program? Do you believe these changes could jeopardize the future of these homes if needed funding is no longer available?

Answer: State homes provide an important complement to our long-term care program. They are an incredible resource for veterans, and VA fully supports their continuance. To insure fairness and consistency, VA proposed similar eligibility criteria across all institutional long-term care venues. VA would continue to expand access to non-institutional long-term care with an emphasis on community-based and in-home care. This approach allows veterans to receive needed services in the comfort of their own homes and is much more closely aligned with progressive community care standards.

C. It is widely acknowledged within the health care industry that long-term care is moving out of the institutional realm and more into the non-institutional realm, as most patients prefer to stay in their own homes or in a similar setting. In 2003, GAO found that VA's non-institutional capacity was inconsistent and inadequate system-wide. What is your view of where VA is on implementing GAO's recommendations in this area, and what further steps would you envision taking to bring VA's capacity up to more appropriate levels?

Answer: In its report, GAO made some very good points. We acknowledge the shortfalls they highlighted, and are moving aggressively to close the gaps in the non-institutional care services we provide. The average daily census in all of our non-institutional services combined grew by 27 percent in Fiscal Year 2004, and our target for fiscal year 2005 is an additional 18 percent growth. To meet these targets, we are expanding our non-institutional care programs. We recently approved our 100th Home-Based Primary Care program, an increase of almost 25 percent in less than 2 years. Home Hospice programs have increased by 50 percent in the last year. Care Coordination programs, which use telehealth and disease management technologies to support veterans, are expected to double by the end of this fiscal year. We have also introduced a performance measure for VISN Directors to increase the census in the non-institutional long-term care programs in their networks, and we are committed to further expand our non-institutional care capacity to meet veterans health care needs.

D. In 1999, Congress made sweeping changes to VA's long-term care programs. A major facet of this legislation was a mandatory bed census requirement for institutional long-term care services. Part of the FY06 budget submission also proposed the elimination of the census requirement. What is your view of this proposal, and of the future of VA institutional long-term care services, particularly while non-institutional capacity is nowhere near adequate?

Answer: I believe that we need to define bed requirements by need and not by legislation. As a clinician, I have often had to discuss long-term care decisions with families who felt that institutional care was what their loved one needed. After explaining alternatives to them, they frequently determined that non-institutional care was much more in the interests of their loved ones and themselves. There will always be a need for institutional long-term care capacity, but our aggressive efforts to provide additional alternatives should provide the capacity we will require to adequately serve our older veteran population.

7. The relationship between VA medical centers and medical schools has endured for more than 50 years. I am concerned that this relationship may not be functioning at an optimal level today as compared with that of decades past.

A. If you are confirmed, what are the strengths and weaknesses of VA's current relations with American medical schools?

Answer: I believe that the relationship between our medical centers and our affiliates could be better, and I look forward, as Under Secretary, to building a new framework for productive, synergistic, and equitable interaction.

B. With respect to any weaknesses you identify, what are your top goals for strengthening VA's relations with schools of medicine?

Answer: Our medical school affiliation agreements, in general, were formulated sixty years ago, at the close of World War II. It is time, in my opinion, to create a new series of agreements-ones that hopefully will remain in place for the next sixty years. To do this, I would like to form a committee of senior VA employees and medical school deans to discuss the framework for new agreements.

8. In recent years, VA seems to have operated under the premise that it may not have been receiving its "fair share" of benefits from its affiliations, and that action has been necessary to shift the balance of power toward VA. To what foundational issues do you attribute any such imbalance?

Answer: VA has, as our primary reason for existence, the responsibility to provide world-class care to the veterans it is our privilege to serve. Medical schools are responsible for educating new generations of clinicians. There is occasional tension between us; however, to say that VHA has not received our "fair share" from these agreements would be misleading. To the extent that problems have occurred, I believe it is due to the fact that we are still working on principles arrived at 60 years ago, at the end of World War II, and that it is time for us to discuss, as equals, what our partnership should look like in the future.

9. One prominent State university recently considered ending a longstanding medical affiliation with VA but thankfully did not do so. As the Under Secretary for Health, how would you propose to address any problematic or frictional affiliations to ensure veterans continue to receive the benefits of affiliation?

Answer: I propose creating a committee of senior VA employees and medical school deans to discuss how we will continue our partnership for many years into the future.

10. It has been reported to me that you recently convened a meeting with representatives of the Association of American Medical Colleges (AAMC) to discuss affiliation relations. Please provide the Committee with a summary of these discussions with AAMC and any conclusions you may have reached, or plan you may be formulating, based on that meeting.

Answer: There was no meeting to discuss affiliation relations with AAMC. However, I do meet regularly with AAMC's VA Liaison Committee as well as the Council of Deans to discuss our relationship. The recurrent themes of these meetings related to some of the tensions arising from IG audits of part-time physician time and attendance and concerns about the new sole-source clinical service contract process.

11. How will you encourage the non-veteran health care system to better understand the VA health care system?

Answer: One of the most effective means of communicating our successes to the public is through positive media. Recently, The Globe and Mail, a Canadian newspaper published an article that carried the headline, "U.S. veterans' health care healed itself: So can our Medicare system". It went on to say, "The U.S. Veterans Health Administration is, by any measure, a remarkable success story, a tale of revitalization the likes of which is rarely seen." In January 2005 the Washington Monthly magazine stated, "Today's troops are headed into the country's best healthcare system—the VA." Additionally, the Institute for Healthcare Improvement (IHI) consistently cites the VA as the gold standard for patient safety. I do believe we need to do a better job of explaining the importance of serving veterans to the many clinicians who receive all or part of their training from our Department. I also believe we must share our many innovations, including the Electronic Health Record, with others in health care. I am particularly excited about the partnership with the Department of Health and Human Services to make a version of our electronic

health record (known for this purpose as VistA-Office EHR) available, especially to rural and underserved areas.

12. There has been a push, mostly from within VA, to encourage more cooperation and sharing agreements between VA and the Department of Defense (DoD).

A. What areas do you see as having the most potential for new sharing arrangements?

Answer: Clinical activities when there are complementary needs have the greatest potential for new sharing agreements. In addition, we have the goal, which I support, of having at lest 80 percent of our facilities become TRICARE Network providers, and each VISN has performance measures to support continued sharing between the Departments. There are over 250 separate sharing activities currently; they range from shared specialty services, to shared capital equipment (e.g., MRI & CT), to joint purchasing, to shared personnel management. At a national level, the joint procurement activities that have been so successful in pharmacy are beginning to be recapitulated in the area of medical-surgical supplies and capital equipment acquisition; I believe that is an extremely promising area of work.

B. What would you do to bring DoD to the table to bring about more sharing successes?

Answer: VA and DoD already collaborate on several levels. Our framework consists of the Joint Executive Council (JEC), the Health Executive Council (HEC), the Joint Strategic Planning Committee and the Construction Planning Committee, and is composed of senior leaders of both Departments. Our two Departments approved an initial Joint Strategic Plan in 2003 and this year, we have updated the plan to include specific performance metrics; a more strategic planning horizonl and a commitment to link JSP goals and objectives to Department strategic plans. I believe that we are on the verge of many sharing successes, and that the framework is currently in place to accomplish this.

C. I commend VA's establishment of a permanent office to address the needs of returning service members. While many strides have been made to ensure a seamless transition from active duty to veteran status, more must be done to ease this integration into the VA system and reintegration into society. What is your view of the work that remains in this area, and how would you seek to accomplish a truly seamless transition? What are your plans to combat the cultural issues that accompany the transition to veteran status?

Answer: Veterans Health Administration must honor our returning heroes and their families by providing them with care that is compassionate and dignified; and by coordinating every possible service and support activity that may help improve their functioning, and restore them to their rightful place in our society. VA has embraced the opportunity to serve these heroes by reinventing existing programs, creating outreach initiatives, enhancing specialized clinical care, and collaborating with our DoD partners to share access to health records.

Our medical centers will do their best heal the wounds of combat veterans, and our vet centers will support their readjustment efforts. We have an opportunity to define VA, and VHA, for a new generation of veterans, and we will make the most of that opportunity.

13. The Administration's FY06 budget request relies heavily on co-payments from veterans and collections from third-party insurance. VA is estimating $2.1 billion in collections for fiscal year 2006, assuming the enactment of the policy proposals included in the budget request.

A. What changes to the MCCF program do you envision to improve third-party collections?

Answer: Recently, we have automated a number of critical revenue processes which have dramatically improved collections. These include electronic insurance identification; electronic claims generation capabilities; electronic receipt of third party insurance remittance advices and associated payments; a lockbox to automatically apply payments from veterans to co-payment charges; an electronic remittance advice to accurately identify deductible/coinsurance amounts that Medicare supplemental insurers calculate to determine reimbursement to VA; and electronic documentation templates. In the future, we will improve our collections by creating consolidated patient accounting centers (CPAC's), which are designed to gain economies of scale by regionally consolidating key business functions; and to implement an industry proven Patient Financial Services System (PFSS) that will yield dramatic improvements in both the timeliness and quality of claims and collections.

B. VA cannot charge a co-payment that is more than the cost of medication. To justify the proposed $15 prescription co-payment, VA included a myriad of administrative costs. Do you feel that this charge is appropriate for over-the-counter medications such as aspirins, vitamins, and cough syrup?

Answer: VHA does not have the business processes and computer programs in place to implement a "tiered" co-pay for pharmaceuticals. That is something we may be able to implement in the future. In the meantime, the existing co-pay structure is a reasonable approach.

C. If confirmed, would you recommend that the $15 co-payment amount be increased in the future?

Answer: One of the ways in which VA balances veteran demand and available resources is through cost-sharing policies such as the existing co-payment of $7 for a 30-day supply of medications. I believe that this balance should continue to be looked at in the future and co-payments adjusted thoughtfully.

D. What is your view of contracting out portions of the MCCF collection effort? Recently, companies that employ electronic appeals software, among other innovations, have revolutionized the way funds that are owed to VA can be recovered. Will you continue to pursue the use of these alternative methods for collections?

Answer: Absolutely. We will continue to pursue all available means to improve our revenue cycle performance success.

14. Do you believe that the VistA system is still able to meet the clinical and administrative needs of VHA?

Answer: VHA has used our pioneering VistA electronic health record systems for more than a decade. It provides an integrated record covering all aspects of patient care and treatment, and maintains records on five million eligible veterans who have chosen to receive their health care from our Department. We are proud to lead the health care industry in the use of information technology, and fully believe that there is no better or more comprehensive health care software in the world.

While there is no better system today for supporting clinical needs, VistA must be improved in its ability to support administrative needs. The "rehosting" efforts will allow VistA functions to become the next generation "HealtheVet" system, which will allow easier programming, and support better administrative data and appropriate data sharing (especially, the ability to incorporate electronic health data from DoD, as those data come online).

15. What are your views on CoreFLS and how VA managed this large-scale contract?

Answer: VistA works for VHA because end users (clinicians) were engaged in its development process. I believe that CoreFLS did not work for VA because the end State was not well defined, and the end users were not adequately involved in the process. Absence of "business owner" participation doomed the computerized medical record recently installed in Cedars-Sinai. The relationship of business owner engagement and success is well-recognized.

16. The Committee understands that several clinics have stopped seeing new patients because of fiscal constraints. Please provide detail on any such changes in any of the networks, including overall guidance VA Headquarters is providing on this issue.

Answer: VA has guidelines for Community Based Outpatient Clinics (CBOCs) to assure productivity, high quality, and access. Our guidelines to ensure quality care at CBOCs include setting a ceiling of 1,200 patients per primary care provider, and insuring that proper support resources are provided in sufficient quantity, such as examination rooms. This helps us to provide timely and high quality care to veterans at our CBOCs. CBOCs are an integral part of our strategy of insuring that care for veterans is provided in the most appropriate environment, and has reduced hospital use by providing care in outpatient clinics. In the last 4 years, we have increased the number of CBOCs by 91. The CARES decision called for the development of 156 new CBOCs, pending the availability of financial resources and the validation of their need with the most current data available. I believe that they are a vital part of VHA's future ability to care for veterans. Some CBOCs are contracted on a "capitated" basis—that is, the contractor is paid a flat rate for each patient. When a contract has achieved its budgeted level, VHA may limit new enrollment.

17. A couple of years ago, Committee staff found grave inconsistencies in access to mental health services at clinics within the VA health care system. How do you plan to improve the availability of mental health services at CBOCs across the country? Please also describe the management of these clinics, for example, the process you use to evaluate and renew contracts for CBOC providers.

Answer: VHA's goal in mental health is to support the six goals of the President's New Freedom Commission for transforming Mental Health Care in America. The plan provides special attention to the needs of seriously mentally ill veterans and veterans with PTSD. My highest priority in this area is to increase access to behavioral health services, and to reduce disparity to such access. Today, 71 percent of our CBOCs provide direct access to Mental Health services, and all of our CBOCs are able to refer cases to our medical centers.

CBOC contracts are typically awarded for 1 year with an option for four 1-year renewal. Before any contract renewal, facilities review contract terms and conduct analyses regarding in house capabilities and cost benefit. The results may support a decision to renew the contract or cancel. At contract expiration, an analysis is done to determine their own internal capabilities and the benefits of continuing to use contracts. If a contract model is recommended, a new open solicitation is issued. The care provided to patients at contract CBOCs must meet the same quality standards as care provided in VA facilities.

18. Non-physician providers are critical to the VA health care system. Please describe what you see as the future role within VA for non-physician providers, such as physician assistants and advanced nurse practitioners.

Answer: Non-physician providers are critical, not only to VHA, but to the entire health care system. VA will continue to be a leader in providing opportunities for physician assistants and nurse practitioners. We have been approached by professional organizations to serve as a model not only for collaborative practice, but also for collaborative practice education, and we will do so. Collaborative practice, involving non-physician providers is seen as the model for successful future health care.

19. Last year, Congress passed legislation that completely restructured the physician and dentist pay structure. This was done mainly in response to the fact that VA was forced to enter into high dollar scarce medical contracts for the provision of certain specialty services at facilities where VA could not recruit full-time doctors in those areas. Please describe any other recruitment and retention problems involving health care personnel you have encountered within the VA health care system.

A. Do you think the changes that have been made to the pay structure will help solve the problems VA has been facing?

Answer: The new legislation for physician and dentist pay is effective January 2006. VA is working aggressively and is confident policies and procedures will be in place to take full advantage of opportunities included in this legislation. The new pay structure will allow us to create pay ranges designed to recruit and retain the many different specialties and assignments in our VA system. We can also use the new pay flexibilities to parallel community standards and attract scarce specialty resources.

B. What more would you suggest needs to be done to respond to these difficulties?

Answer: Continuing recruitment and retention problems involving our health care personnel include the following:

a. The need for expanded authority under Title 38 to hire additional positions that are critical to the support of our health care professionals. These include Nursing Assistants, Medical Clerks, Medical Technicians, Health Technicians and Food Service Workers.

b. The ability to hire a limited number of annuitants without an offset to their retirement. VA loses these incredible resources to our competitors when they retire. VA could reduce costs by being able to utilize these fully trained and seasoned staff to bridge between vacancies, extended absences, etc. Staff would feel more valuable and have a better transition into their retirement.

20. VA recently issued new procedures to address reported flaws and begin strengthening your timekeeping system. Please describe to the Committee the State of implementation of the new timekeeping system for part-time VA physicians.

Answer: The part-time physician time and attendance pilot eliminates core hours for those part time physicians on adjustable work hours. Each physician signs an agreement for the number of hours they will work during the year. They will be paid in equal amounts each pay period. The hours they actually work will be negotiated with their supervisors prior to each pay period based on VA needs. At the end of their agreement, reconciliation will take place for those hours that were worked in excess or below the agreement.

The physician time and attendance policy was manually piloted from October 2004 through January 2005. In January 2005, the Alpha test on these new procedures was initiated and concluded at the end of March when the next phase was implemented.

The beta testing for the electronic time will be completed April 8, 2004. The national release of this new Electronic Time and Attendance (ETA) software to support the time and attendance for part time physicians for adjustable work hours will be April 27, 2005. All facilities have 30-days to load the software into their systems. The policy supporting the new software is targeted for release for mid-May. In addition a draft of this new directive and handbook is in final review with a targeted date of mid-May 2005.

21. Dr. Perlin, you once served as a part-time VA physician while practicing at the Medical College of Virginia, its academic health center, and the McGuire VA Medical Center in Richmond.

A. What are your personal reflections on practicing in a mixed environment, in particular in reference to apportioning and accounting for your professional time in VA versus your attending responsibilities at the other facility, as well as for any teaching or research responsibilities you may have had, whether at the University or at VA?

Answer: Like most of my colleagues, I worked 60-plus hour weeks as an attending physician when I was in Richmond. I had scheduled times when I was at VA, scheduled times when I was at MCV, and scheduled times when I discharged my teaching responsibilities. There were times when I had "ward attending physician" duties at VA, and during those periods, I spent 30 consecutive days caring for VA inpatients. My other responsibilities were adjusted accordingly. I regularly juggled my responsibilities as a physician; a teacher; and a researcher; but I always understood that whatever I did revolved around my most important mission: to provide the best possible care I could to the patients I was responsible for.

B. Assuming you were currently practicing in the MCV-VA McGuire environment, how would the new approach to part-time timekeeping affect your working conditions of a joint faculty member, a department head, or staff physician?

Answer: The new timekeeping concept that VHA is currently developing and will be implementing provides a much more rational basis for the distribution of a physician's time than the old Core Hours doctrine, which often required physicians to be present when they were not needed; and caused them not to be present when they were needed in order to be technically compliant with the regulations.

C. Did your personal experience in Richmond help inform VHA's new policies on part-time physician timekeeping; and if so, in what manner?

Answer: Yes, it did, by instilling in me the firm belief that there had to be a better, and more rational, way to manage my time and that of others.

D. You recently wrote the deans of the 107 medical schools with which VA is affiliated on the topic of part-time physician's time-and-attendance matter. Please provide the Committee the content of that letter and explain your approach to the schools, your assessment of whether your effort was successful, and any further steps you intend to take in this regard.

Answer: In short, my letter expressed the concept that improper supervision put three lives at risk, not one-the patient, the trainee, and the trainee's supervisor. I used that concept to explain to the deans why we needed to change our existing system. I was quite surprised that the only letters I received in response were letters of thanks, agreeing that not only did the existing system fail our patients, but also the ethical responsibilities we had to ensure the proper training of medical school students.

22. The Inspector General reviewed VHA's policies in contracting for specialty services in the affiliated environment. VHA has been criticized for often relying on sole source methods to procure clinical services, often from practitioners associated with VA-affiliated schools of medicine and their academic health centers. The IG has specifically recommended using competition to gain VHA a better business advantage in obtaining scarce and highly specialized health care practitioners to care for veterans. What views do you hold on these matters of contracting policy, and what are your plans as Under Secretary to manage such specialty contracting?

Answer: While we should always strive for competition to get the best business propositions for veterans in our contracting activities, sole source procurements of clinical services from VA affiliates often offer value and extend our capability to work with outstanding health care residents and fellows. Fellows are clinicians who could practice independently in particular specialties, but are continuing in additional training for periods of one to 7 years. Consequently, they are highly skilled in advanced practice in medical areas like interventional cardiology, interventional radiology and the surgical subspecialties, like cardio-thoracic or neurosurgery.

I am concerned that limiting our ability to do sole source contracting will keep us from obtaining highly skilled residents and fellows as well as top notch faculty. This will make it impossible for VA to serve veterans properly because of the overall loss of productivity from the imminent absence of fellows and residents because a low-bid procurement effectively severed supervisory faculty from their appointed roles and required residents and fellows to go elsewhere for appropriate supervision. In implementing the IG's recommendations, we will have to weigh all factors including this one.

23. Your immediate predecessor informed the Committee that VHA intended to address high-cost contract specialty services partly by reforming VA physician compensation policy. In response, Congress enacted Public Law 108–445, which gives VA wide latitude to establish market-sensitive physician compensation rates, along with a significantly higher salary cap, and new incentives for performance pay.

A. What is the status of implementation of the reform in VA's physician compensation system?

Answer: The legislation provided for an effective date of January 8, 2006. In order to assure VHA has policy and procedure in place, we have convened a core work group to oversee the myriad of details and consultation required to effectively implement this legislation. Currently, the policy and procedures are in their final draft. General Counsel will be responding to this policy by April 21, 2005. We have purchased available pay publications and finalizing the appointment of Executive and Steering Committees. Our timeline of events provides for having recommended pay ranges to the Secretary for consideration by September 2005. We must publicize the approved pay ranges for 60 days in the Federal Register. VHA expects to conduct training to the field during the 60 day notice period, and be ready to effect the new pay system on January 8, 2006. The policy also requires that all physicians and dentists have their initial review completed by the appropriate Physician and Dentist Pay Compensation Panel by no later than May 14, 2006.

B. What are your views on the potential of the new compensation authority to influence VA's performance in attracting new specialty physicians to full-time VA employment?

Answer: The new legislation provides broad authority to address pay comparability in a number of ways, including geographic needs, individual expertise, scarce specialties and the ability to recruit physicians and dentists for complex assignments.

VHA views this new pay system as a significant enhancement to our ability to attract new specialty physician to full time employment.

24. In the past, VA has had increasing difficulty recruiting and retaining an adequate number of high quality nurses. Please describe what you see as the current role of nurses in the VA health care system, and how that might change, if at all, over the next 20 years.

Answer: America's veterans deserve the best treatment our Nation can provide. Nurses are central to our mission to provide them with safe, high quality and compassionate care. I believe that VHA has done an outstanding job of recruiting many of the best nurses our nation's nursing schools provide, and of retaining a cadre of experienced and competent nurses. In the next 20 years, VHA will need to maintain and expand our nursing staffs as the number of veterans increase. We must, as the National Commission on VA Nursing explained, actively address those factors known to affect the retention of nurses: leadership, professional development; work environment; respect and recognition; and fair compensation. We must also develop and test technology and actively embrace research leading to the creation of new nursing roles that complement innovations in health care. Among the actions we must take, or have taken, are making the facility nurse executives members of the executive body at VISNs and facilities; engaging experts to evaluate and redesign nursing work processes; more aggressively recruiting for the best and brightest nursing school graduates; and creating new affiliations with schools for advanced degree nurses, baccalaureate nurses, and also with associate degree programs.

25. As you are in a unique position to know, the VA research and development program not only makes a major contribution to our national effort to combat disease, but also serves to maintain a high quality of care for veterans through its impact on physician recruitment and retention.

A. Fiscal growth in this program, however, has slowed to nearly a flat line, and average award amounts have also declined. During the first 4-year term of this President, only minimal increases in the research account were proposed in budgets. Sadly, Congress has acted only marginally to change that trend, as opposed to what has been done for the National Institutes of Health and other Federal research activities. The flat budgetary environment in VA research has a consequence in delaying funding for, or preventing altogether, good research proposals from being funded. VA's average "pay line" for awards to principal investigators is reportedly down to a scant 15 percent of submitted proposals. Five years ago, it was double that level.

i) Can you explain why the pay line has dropped out of proportion to the overall funding available for VA research, and provide the reasons average award amounts have declined?

Answer: Paylines have dropped though not necessarily in a manner disproportionate to overall funding for VA research. Only about 20 percent of the current Research and Development (R&D) budget is available for new awards in an average year because of recurring and out-year commitments for grants, centers and career development awards. The VA Office of Research and Development (ORD) is transitioning to shorter durations of awards and conducting competitive reviews of all centers to assure that a higher percentage of funding is available annually for

new awards. The goal is to achieve a workable balance among the competing needs for research and continue to fund new projects at a comparable rate as has happened previously.

ii) Given our concerns about the status of VA's affiliations, our new policy on part-time physicians and the stringent reviews of scarce medical specialist contracting, what are your concerns as Under Secretary, if confirmed, about the present financial condition of VA research?

Answer: A successful and vibrant research program is critical to the health of affiliations with our academic partners. The VA Office of Research and Development (ORD) presently supports nearly 3000 clinician investigators, many of whom forgo higher salaries available in other settings because they value participation in VA research. Not only do these investigators make important contributions to advancing medical knowledge and improving health care for veterans, they also provide outstanding, direct medical care to veterans and serve as the educators for the next generation of health care providers.

For nearly 50 years, the close and mutually beneficial relationship between VA medical centers and their academic affiliates has enhanced patient care, teaching and research. Almost uniformly, part-time VA physicians have more than fulfilled their commitments in terms of time and effort devoted to VA. It has always been essential for clinicians to be flexible in responding to the complex and changing demands of patient care, research and teaching. Recent efforts to impose more rigid constraints on clinicians' scheduling threatens to undermine that flexibility, and undermines their ability to fulfill those commitments.

iii) What are your views on the importance of VA research compared to funding for services?

Answer: Research is an integral part of providing exceptional health care to veterans. The VA Research program is unique among Federal research entities. Rather than funding investigators or programs that are divorced from clinical care or that are outside of the department, institute, or agency, VA's research program is intramural. Only VA investigators are funded to conduct research. The clinicians who are most familiar with the health care needs of the veteran population are also the scientists who submit research proposals, manage the projects, and publish the results. In fact, more than 80 percent of VA's researchers are physicians, nurses, and other professionals who provide patient care. This unique combination of clinician-researcher provides the direct connection to clinical care and the health care needs of veterans. VA is committed to evidence-based medical care and VA's research program is committed to providing the evidence for the best practice of medical care.

iv) What can be done to combat the chronic under-funding of the VA research program?

Answer: The VA Office of Research and Development (ORD) continues to make significant contributions to the health care of veterans, and the program enjoys the full support of the Department. As priorities for VA change and as new scientific developments emerge, VA ORD must continue to review research priorities in relation to the evolving needs of veteran patients.

It is also important for VA ORD to closely manage and leverage its resources. To assure adequate funding is available each year for new projects, especially to meet newly identified veteran-centric needs, VA is transitioning to shorter durations of awards and conducting competitive reviews of all research centers.

VA ORD is strengthening its partnerships within VHA, other Federal agencies, as well as academic affiliates and the non-profit sector to leverage the funding as efficiently as possible.

v) How do you think VA should allocate its limited research funds among the general areas of basic, applied clinical, and health services research.

Answer: As an intramural program, the VA Office of Research and Development (ORD) has a clear responsibility to assure that sponsored research addresses the needs of veterans who seek care from VA. The quality of the research and relevance to the veteran population remain the determining factors in deciding what studies to fund. Rather than focus on numerical percentage allocation of research funds for each Service, the goal is to be sure that the funded projects meet stringent standards for scientific rigor and match the current needs of veterans. Priorities change as needs change.

Examples of VA's efforts to allocate according to the needs of veterans, rather than an apportionment among Services, are the recent solicitations for proposals involving deployment health including rehabilitation and prosthetics, mental health, and poly trauma projects.

B. One of VA's hallmarks is the sheltering of "bench to bedside" research. VA clinical practitioners and physician-scholars serve as principal investigators in VA- and NIH-funded research projects. They have the ability and the means to apply results

of their own and colleagues' research in the clinical arm of the institution that husbands both activities. This unique setting has served VA well as a powerful recruitment and retention incentive, while elevating the standard of care to veterans.

i) Recognizing that designating time for clinician investigators to conduct research and providing them with adequate infrastructure are continuing problems in VA, would you support addressing this by administering investigator salaries and facilities operation costs centrally, in a manner similar to that used by NIB, to ensure that VA-funded investigators have adequate time and resources to conduct research?

Answer: In all parts of the health care sector, including VA, pressures to increase clinical productivity have risen. In some cases, this has eroded time available for clinicians to perform research. Because the VA research program is exclusively intramural, it has permitted a different approach to funding investigator time than used by other granting agencies such as NIH. Provision of salary support to investigators through the VERA research allocation is intended to enable clinician investigators to balance clinical and research responsibilities and to provide flexibility. This issue is being addressed by the VHA National Leadership Board, Health Systems Committee and a task force has recently been approved to describe how VERA research funds are being utilized and to outline a set of best practices. At the present, we believe this approach is preferable to transferring VERA research funds to the research appropriation.

ii) Do you believe the falling payline, pressures on the affiliations, the part-time physician timekeeping controversy, and the flat budget, not only for research itself but in the medical care programs in general, affect the attractiveness of VA as a place of employment for physicians, research scientists, and other professionals? What are your views on addressing these matters, to reverse any such negative effects? (Two Questions Combined)

Answer: I agree that participation in VA research is a significant incentive for high quality medical professionals to join the VA system. The reasons for this are many and remain strong recruitment and retention tools. VA maintains a climate of scientific inquiry and rigor that continues to attract the highest caliber physicians.

Within the broad range of research from the very basic as well as applied research, VA highly values research that specifically addresses medical issues that are most relevant to the veteran population. In many such areas, VA is widely regarded as an international leader, including research related to rehabilitation, mental health and post-traumatic stress disorder, and health services delivery. VA also emphasizes research that capitalizes on its unique strengths, such as the integrated delivery system and the electronic medical record. The VA Cooperative Studies Program, for example, is internationally recognized for conducting the highest quality, multi-center studies that address clinically important topics that are difficult, if not impossible, to perform in other settings.

C. As VHA's former Acting Chief Research and Development Officer what, in your view, should be the goals of VA's research program over the next 4 years?

Answer: It is crucial that VA's research must focus on veterans: the aging population, the increasing numbers of women, and the emerging needs of veterans of our most current deployments. We must be sure that the research program from basic to applied science addresses rehabilitation, mental health, and deployment issues.

I support the merit review process. We must maintain the highest standards of scientific rigor. To have a program respected in the scientific community, VA must also support a strong research oversight program. Accountability and assurances that our research programs meet and exceed all legal requirements, standards, and practice guidelines must be an ongoing task.

High standards for and implementation of practices for human subject protection, biosafety, and biosecurity are hallmarks of an excellent research program, and I will expect nothing else for VA's research program. It is also important to improve our relationships with entities like the National Institutes of Health and Department of Defense. I am pleased with the partnerships developing in the area of rehabilitation research. But we can do more.

Not only must we maintain our successful research programs, but we must also continue to forge new initiatives. Health Services research facilitates and expedites improving the system through more effective and efficient care delivery. As a health care system with arguably the finest electronic health record in the world, we have exciting opportunities to use it as a platform for groundbreaking work. For example, we are presently exploring exciting opportunities to established a research program in genomic medicine that has the potential not only advance scientific discoveries in this area but also to provide objective improvements in the health care of veterans in areas such as improved medication prescribing and avoidance of adverse drug effects.

26. What does your experience tell you with regard to women veterans' access to VA health care services? What changes, if any, would you propose in this area if confirmed as Under Secretary?

Answer: Between 1990 and 2000, the women veteran population increased by 33.3 percent. Today, women represent approximately 7 percent of the total veteran population, and by the year 2010, they will be well over 10 percent, as they now make up 14 percent of the active duty military. VA has designed services and programs to be responsive to the gender-specific needs of women veterans. VA offers comprehensive healthcare services for women including: counseling for sexual trauma; Pap smears, mammography and general reproductive health care; and full-time Women Veterans Coordinators at most VA medical centers. Providing gender-specific, age-appropriate health care is our most important responsibility to women veterans. It should be noted that we already set the benchmark for care in the United States in such areas as breast and cervical cancer screening. As Under Secretary, I would propose additional research in the areas of general women's health and in issues related to military service, such as Military Sexual Trauma.

27. Please provide me with the status of recommendations for VA made by the President's New Freedom Commission on Mental Health. Specifically, I am interested in knowing more about how VA will abide by Recommendation 2.3, which calls for the alignment of relevant Federal Programs, including VA, to improve access and accountability for mental health services.

Answer: VHA developed a Comprehensive Strategic Mental Health Plan in accordance with the President's New Freedom Commission on Mental Health. VHA has identified goals and strategies to align mental health commensurate with the President's goal. One such area is to "improve access and accountability for mental health services".

VHA has multiple initiatives which are in progress with other Federal agencies to reach this goal. VA has established a partnership with SAMSHA to coordinate policy and planning. A formal VA/DOD council develops clinical practice guidelines which all clinicians use to ensure all clients receive evidence based care. Coordination with DOD is allowing VA to improve access for Operation Enduring Freedom and Operation Iraqi Freedom to have a Seamless Transition into VA services. Additional housing for homeless veterans is made accessible through the partnership with HUD. Prevention of homeless, unemployment, and mental health support is addressed through Partnerships with the Department of Labor. VA has developed Work Restorative services that promote entrepreneurship to expand Compensated Work Therapy for veterans who have lost work skills. Contracts are developed with state, local, and community partners.

28. In October of last year, Congress passed the Federal Workforce Flexibility Act. This bill, among other things, enhanced vacation time and other benefits for the purposes of making the Federal Government a more competitive employer. What is the current status of the implementation of these changes, particularly to the vacation time for Senior Executives and the compensation for official travel during off-duty hours?

Answer: The new leave provisions for SES were implemented immediately after the Act's passage on October 30, 2004.

The Office of Personnel Management (OPM) issued regulations regarding the compensatory time off for travel provisions on January 27, 2005. A draft VA policy to implement the regulations is currently under review by the Administrations and Staff Offices. Other provisions of the Act dealing with enhanced recruitment and retention incentives will be implemented once OPM issues regulations. VHA will, of course, comply with OPM regulations and the implementing VA policy.

Chairman CRAIG. Senator Isakson, any opening comment?

STATEMENT OF HON. JOHNNY ISAKSON, U.S. SENATOR FROM GEORGIA

Senator ISAKSON. Thank you, Mr. Chairman. And welcome to Dr. Perlin and his family. It was a pleasure to meet all of you, and it is a great day.

And I told Dr. Perlin back in the Chairman's office that unfortunately for Dr. Perlin, last night I was home by 8:00, and I had my briefing book. And I said, "well, I am going to get prepared." For me, I have never seen a more impressive resume. And I look for-

ward to hearing your testimony and what you have to say here today.

So I will only make one set of remarks. I married into a career Navy family. My father-in-law is 91, a retired Navy Commander. Both of my brothers-in-law are retired Navy. And at Christmas, Thanksgiving, and frequently on e-mail, VA health care is something I hear a lot about.

The VA has done a lot of wonderful things, and there are a lot of challenges ahead, as Mr. Akaka has said, with regard to long-term care and with regard to nursing home care, which we will certainly discuss later on. But I am confident, from having heard about you and read about you, that your commitment to excellence and the most often used word in your resume, which is the word "quality," will serve our veterans well in the years to come.

I welcome you here today.

Chairman CRAIG. Senator Jeffords.

STATEMENT OF HON. JAMES M. JEFFORDS,
U.S. SENATOR FROM VERMONT

Senator JEFFORDS. Thank you, Mr. Chairman, for holding this hearing so that we can have an opportunity to discuss the important issues of VA health with Dr. Perlin.

I am pleased that last month, under the leadership of the Chairman, funding was added to the Senate version of the bill of the VA health care. While I would have preferred a bigger addition, it is still better than the President's budget.

Dr. Perlin, you are going to have a tough job. New veterans are streaming home from Iraq, many with very tough wounds. And yet the VA budget hasn't risen sufficiently to cover inflation. I don't envy your task in keeping American promises to our veterans in the budget that you are given.

And I am glad that you bring with this job the experience of having acted as head of the VA health for the past year. That experience should prove invaluable, and I look forward to discussing the important issues with you.

Thank you.

Chairman CRAIG. Senator Salazar, you have just arrived. Do you have any opening comments before we turn to Dr. Perlin's introduction?

Senator SALAZAR. I have an opening comment, but I will just submit it for the record and look forward to asking the doctor some questions.

Chairman CRAIG. Fine enough.

[The prepared statement of Senator Salazar follows:]

PREPARED STATEMENT OF HON. KEN SALAZAR,
U.S. SENATOR FROM COLORADO

Thank you, Mr. Chairman, Senator Akaka. Thank you, Dr. Perlin, for coming here this morning. I know that you have appeared at many hearings over the years in your duties with the VA, but this one is special. This one is about you.

Today, we will have the chance to review the record of an experienced administrator.

I am entering this hearing with the sincere hope that Dr. Perlin is willing and able to make the major reforms that are needed at the VA. And with a message that the Members of this Committee will be watching.

Over the next few years, VHA will face one of the hardest periods in its history. Costs are expected to continue to rise and demand on the system will increase. The VA is bringing in thousands of seriously injured veterans from Iraq and Afghanistan. The VHA will be tested. It will not have the resources to meet demand. Dr. Perlin will have the choice whether or not to continue the VA's trend toward rationing care.

Right now, thousands of veterans are being turned away from the VA. Since January 2003, when the VA suspended enrollment of new Priority 8 veterans, 192,000 veterans across the country and 2,000 Coloradoans have sought VA care and been turned away. The Administration's new budget hopes to kick 1.1 million more veterans out of the system next year with draconian cuts in service and increased fees. 130,000 of these veterans have no other form of health coverage.

This cold-hearted approach is the worst way to go. Before we leave 130,000 veterans without any health care, we need to exhaust every other option.

The VHA collects less than half of its claims on third party private insurers, costing the VHA billions a year. Why? A recent Inspector General report found that the VHA may be paying excessive prices on major construction projects valued at $133.6 million. Why? Another OIG report showed that the VHA has done little to comply with Federal energy savings standards, costing the agency as much as $12 million a year. Why?

These problems are the administrative bread and butter of the VA. I hope it will be Dr. Perlin's priority to squeeze every last dollar of waste out of the system, before we continue squeezing veterans out into the cold.

Thank you Dr. Perlin. I look forward to your testimony.

Chairman CRAIG. Now let me turn to our colleague John Thune for the introduction of the nominee.

STATEMENT OF HON. JOHN THUNE, A U.S. SENATOR FROM SOUTH DAKOTA

Senator THUNE. Thank you, Mr. Chairman, Senator Akaka, and Members of the Committee.

I, too, want to echo what has already been said and welcome Dr. Perlin and his family here this morning. I have been extremely impressed in my discussions with him by his knowledge, his experience, his vision for the future of the system.

He has, as many of you have already noted, a very difficult job when it comes to administering a program with a finite amount of resources and budget. But he has a record, I think, of proving to be very innovative, very creative, and I look forward to working with him in the days ahead.

I have the honor, Mr. Chairman, to introduce to you and my fellow Committee Members the President's nominee for the position of Under Secretary for Health for the Department of Veterans Affairs, Dr. Jonathan B. Perlin.

Dr. Perlin is supremely qualified to fill the position for which he has been nominated. For the past year, he has led the Veterans Health Administration as its Acting Under Secretary for Health, serving as acting chief executive officer for our Nation's largest integrated health care system.

Before that, he served as Deputy Under Secretary for Health from July 2002 to April 2004, and from December 2003 to July 2004, Dr. Perlin simultaneously served as VHA's Acting Chief Research and Development Officer, directing a $1.8 billion research program specializing in basic, clinical, rehabilitation, and health services research.

Between 1999 and 2002, Dr. Perlin was VHA's Chief Quality and Performance Officer. In that role, he supported quality improvement and performance management throughout the veterans

health system. As a result of his efforts, VA is one of two Federal agencies we in the Congress have commended for managing for results not once, but twice.

VHA's Quality and Performance Program has also been specifically recognized by both the Innovations in American Government and the RIT/USA Today Quality Cup programs.

His VA experience also includes appointments at Richmond, Virginia, VA Medical Center, where he saw patients and led in the development and implementation of a group practice system. He was also the first chief of the center's Telemedicine Section, developing an interstate network for providing clinical consultations to improve care to veterans.

Dr. Perlin's background includes expertise in health care, quality management, health information technologies, medical education, and health services research. Prior to joining VHA, he served as Medical Director for Quality Improvement at the Medical College of Virginia Hospitals, part of the Virginia Commonwealth University Health System.

At VCU, he helped establish the Health Services Research Fellowship in the Division of Quality Health Care, Department of Internal Medicine, and was Associate Director of the Internal Medicine Residency Training Program. He is broadly published and maintains an academic appointment as Adjunct Associate Professor of Medicine and Health Administration at Virginia Commonwealth University.

A Fellow of the American College of Physicians, Dr. Perlin has a Master's Degree of Science in Health Administration. He received his Ph.D. in Pharmacology and Toxicology, performing research in molecular neurobiology, along with his M.D. as part of the Medical Scientist Training Program at Virginia Commonwealth University's Medical College of Virginia campus.

He is clearly among the best and the brightest of this generation of public servants, and we are fortunate that he has chosen to dedicate his career to serving America's veterans.

I thank the Committee for considering his nomination. I look forward to a speedy confirmation process, and I would simply again add, Mr. Chairman, that I have just been extremely impressed by this gentleman's understanding of technology. I am very interested in telemedicine, very interested in applying technology to the health care world. He is very much at the forefront of that.

I think he is a great nominee, and I hope that this Committee will work quickly and that the Senate will confirm him so that he can continue the great work that he is doing.

Thank you, Mr. Chairman, and I yield to Dr. Perlin.

Chairman CRAIG. John, thank you very much.

Doctor, would you please rise? Dr. Perlin, do you solemnly swear or affirm that the testimony you are about to give the Committee at this hearing shall be the truth, the whole truth, and nothing but the truth, so help you God?

Dr. PERLIN. I do.

Chairman CRAIG. Please be seated, and you may proceed.

TESTIMONY OF JONATHAN B. PERLIN, M.D., PH.D., MSHA, FACP, NOMINEE TO BE UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS

Dr. PERLIN. Chairman Craig, Ranking Member Akaka, Members of the Committee, and staff, thank you very much for the opportunity to sit before you this morning.

Senator Thune, thank you so very much for that kind and generous introduction.

Before I begin my statement, I would like also to note that my wife, Donna; my son, Benjamin; my parents, Dr. and Mrs. Seymour Perlin; are here with me today. Their love and their support has made it possible for me to devote my unwavering focus to veterans health issues in the past few years. Without their help, I could not possibly have qualified for the office for which I have the honor of your consideration.

I would also like to note that no one does this job alone. I am very fortunate to be joined by colleagues that I know the Committee also regards in the highest esteem. I am joined this morning by General Mick Kicklighter, VA chief of staff, whose stalwart leadership sets an example for the entire department.

It is also my pleasure to recognize that I am joined today by Dr. Michael Kussman, Brigadier General Michael Kussman, Retired, our Deputy Under Secretary for Health, Acting, and Ms. Laura Miller, our Deputy Under Secretary for Operations and Management.

I am also pleased this morning to note and thank my colleagues from the veterans service organization community without whose support as well we would not do nearly the job in serving the needs of veterans.

Mr. Chairman, when I was a medical school student, I had the privilege of receiving part of my training at a VA medical center. My time at VA was my favorite part of my entire medical school experience. I had the privilege of taking care of some of the last Buffalo soldiers and World War I doughboys, along with veterans of World War II, Korea, and Vietnam.

I especially enjoyed talking to those older veterans about their connection to American history and, almost invariably, to witness the humble selflessness they displayed when they spoke of what they did in service to our Nation. Sometimes their stories were sad or tragic. Sometimes they were humorous, sometimes incredibly heroic, but always filled with passion and with a patriotism and pride I had never encountered before.

Years later, when given the opportunity, I gratefully returned to VA. I returned for the opportunity to serve America's heroes and to help our Nation meaningfully and tangibly express our gratitude to the men and women of all generations who successfully defended our freedom while in uniform.

Since I came back to VA Central Office in 1999 to lead VA's Performance Measurement and Quality Management Program, I have proudly been a part of the singular transformation of the Veterans Health Administration into an organization that the *Washington Monthly* recently said produces the "best health care anywhere." There are many reasons for this transformation.

VHA's performance measurement system enables us to hold ourselves accountable for providing the best care for veterans. A recent RAND study focusing on our care demonstrated to the Nation and the world that it is possible to measurably and rapidly improve health care quality and that specific improvement initiatives are the right way to do so.

Placing significant emphasis on performance measurement is not an academic exercise. It improves real outcomes for real veterans.

Our revolutionary electronic health record provides better, safer, and more consistent care to veterans by harnessing information technology to serve the clinical care needs of America's veterans.

And our pathbreaking research program has given us the first effective therapies for tuberculosis; better fitting, lighter artificial limbs; the implantable cardiac pacemaker; the CT, the MRI; and even the nicotine patch.

Today, VA researchers, focusing on veterans' needs, are on the verge of dozens of new discoveries and developments—like the artificial retina—that will improve care, restore function, and enhance the health and well-being of veterans and all of the world's citizens.

And last, but by no means least, we are reinventing existing programs, enthusiastically creating outreach initiatives, enhancing specialized clinical care, and collaborating with our Department of Defense partners to better serve our newest generation of returning heroes. It is VHA's highest priority to ensure their seamless transition back to our society, and we are making significant progress in this area.

Just this week, for example, we announced that we will be hiring 50 additional Operation Iraqi Freedom and Operation Enduring Freedom veterans to provide timely outreach services to other veterans returning from Afghanistan and Iraq. They will join the 50 other veterans previously hired by the department for the same purpose.

But for all of our successes in the last 10 years, I know that the past is but prologue to the present and to the future. We have the incredible opportunity today to move VA health care from intervention to prevention, to be able to predict outcomes with near-certainty even before treatment is begun, and to truly provide our patients with the kind of high performance, high value, high quality, safe, patient-centered health care that will enable us to fully meet President Lincoln's great goal to care for those who shall have borne the battle and for their families.

Mr. Chairman, General Omar Bradley wrote in his memoirs about his experiences as administrator of the Department of Veterans Affairs. He said that, "Nothing I have done in my life gave me more satisfaction than the knowledge that I had done my utmost to ease veterans' way when they come home."

In every VA role that I have had—as medical student, house officer, young staff member, and certainly now—I have understood General Bradley's sentiment, and I appreciate the privilege that I have been given to serve America's veterans.

I am humbled that the President has nominated me to lead the Veterans Health Administration for the next 4 years. And I promise you, and I promise America, that I, too, will do my utmost to

ease the way for today's veterans and their families—those who are already home and those who are still fighting overseas.

If confirmed, I will work with you and all Members of this Congress to build a safe, effective, and compassionate health care system that will fully meet the needs of the men and women it is VHA's honor and privilege to serve.

Thank you.

[The prepared statement of Dr. Perlin follows:]

PREPARED STATEMENT OF DR. JONATHAN B. PERLIN, ACTING UNDER SECRETARY OF HEALTH, DEPARTMENT OF VETERANS AFFAIRS

Chairman Craig, Ranking Member Akaka, Members of the Committee and its staff. Good morning.

Before I begin my statement, may I mention that my wife Donna, my son Benjamin, and my parents, Dr. and Mrs. Seymour Perlin, are all here with me today. Their love and support has made it possible for me to devote my unwavering focus to veterans' health issues in the past few years. Without their help, I could not possibly have qualified for the office for which I have the honor of your consideration.

Mr. Chairman, when I was a medical school student, I had the privilege of receiving part of my training at a VA medical center. My time at VA was my favorite part of the entire medical school experience. I had the privilege of taking care of some of the last Buffalo Soldiers and World War I doughboys—along with veterans of World War II, Korea and Vietnam.

I especially enjoyed talking to these older veterans about their connection to American history, and almost invariably to witness the humble selflessness they displayed when they spoke of what they did in service to our Nation. Sometimes their stories were sad or tragic; sometimes they were humorous; sometimes incredibly heroic; but they were always filled with passion, and with a patriotism and pride I had never encountered before.

Years later, when given the opportunity, I gratefully returned to VA. I returned for the opportunity to serve America's heroes, and to help our Nation meaningfully and tangibly express our gratitude to the men and women of all generations who successfully defended our freedom while in uniform.

Since I came back to VA Central Office in 1999, to lead VA's performance measurement and quality management program, I have proudly been a part of the singular transformation of the Veterans Health Administration into an organization the *Washington Monthly* recently said produces the "best care anywhere."

There are many reasons for this transformation.

VHA's performance measurement system enables us to hold ourselves accountable for providing the best care for veterans. A recent RAND study focusing on our care demonstrated to the Nation and the world that it is possible to measurably and rapidly improve health care quality—and that specific improvement initiatives are the right way to do so. Placing significant emphasis on performance measurement is not an academic exercise—it improves real outcomes for real veterans.

Our revolutionary Electronic Health Record system provides better, safer and more consistent care to veterans by harnessing information technology to serve the clinical care needs of America's veterans;

Our path-breaking research program has given us the first effective therapies for tuberculosis; Better fitting, lighter artificial limbs; The implantable cardiac pacemaker; The CT scanner and MRI machine; And the nicotine patch.

Today, VA researchers, focusing on veterans' needs, are on the verge of dozens of new discoveries and developments—like the artificial retina—that will improve care, restore function, and enhance the health and well being of veterans and all the world's citizens;

And, last but by no means least, we are reinventing existing programs, enthusiastically creating outreach initiatives, enhancing specialized clinical care, and collaborating with our Department of Defense partners to better serve our newest generation of returning heroes. It is VHA's highest priority to ensure their seamless transition back to our society, and we are making significant progress in this area.

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And to truly provide our patients with the kind of high performance, high value, high quality, safe, patient-centered health care that will enable us to fully meet President Lincoln's great goal to care for those who shall have borne the battle and for their families.

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If confirmed, I will work with you and all Members of this Congress to build a safe, effective, compassionate health care system that will fully meet the needs of the men and women it is VHA's privilege, and honor, to serve.

Thank you.

QUESTIONAIRE FOR PRESIDENTIAL NOMINEE

PART I: ALL THE INFORMATION IN THIS PART WILL BE MADE PUBLIC.

1. Name: Jonathan Brian Perlin.
2. Present Address: 205 Serenade Court, Millersville, MD 21108.
3. Position to which nominated: Under Secretary for Health, Department of Veterans Affairs.
4. Date of nomination: 2/18/2005.
5. Date of birth: February 25, 1961.
6. Place of birth: New York, NY.
7. Marital Status: Married.
8. Full name of spouse: Donna Jablonski Perlin.
9. Names and ages of children: Benjamin Alexander—June 3, 1994 (Age 10); Sarah Elizabeth, January 13, 1998 (Age 7).
10: Education: Institution, dates attended, degrees received, dates of degree; University of Virginia, Charlottesville, VA; 1979–1984; BA/Interdisciplinary Honors; BA 1985 Medical College of Virginia, Richmond, VA; 1986–1992; MD/PhD (Pharmacology & Toxicology); PhD, 1991-MD, 1992; Medical College of Virginia/Virginia Commonwealth University, Richmond, VA; 1995–1997; Master of Science Health Administration Executive Program; MSHA 1997.
11. Honors and awards: List below all scholarships, fellowships, honorary degrees, military medals, honorary society memberships, and any other special recognitions for outstanding service or achievement.

- Medical Scientist (MD/PhD) Training Program, Medical College of Virginia,1986–1992
- Alpha Omega Alpha, Medical Honor Society, 1993
- Innovations in Government Semifinalist, (VA Performance Measurement Program)
- Council for Excellence in Government, Kennedy School, Harvard, 2000
- RIT USA Today Quality Cup Semifinalist, (VA Performance Measurement Program), 2001
- Fellow, American College of Physicians, 2001
- Commendation "For Service Following 9–11", Department of Veterans Affairs, 2002
- Richard A. Kern Award for Federal Medicine, AMSUS (Association of Military Surgeons of the United States), 2003
- Frank Brown Berry Federal Medicine Finalist, U.S. Medicine Institute, 2004

• Vision Award, Improving Chronic Illness Care. MacColl Institute/Group Health, 2004

12. Memberships: List below all memberships and offices held in professional, fraternal, business, scholarly, civic, charitable, and other organizations for the last 5 years and any other prior memberships or offices you consider relevant:

American Medical Association—Inactive Member 1986–present
American College of Physician Executives—Inactive Member 1997–present
Alpha Omega Alpha Honor Medical Society—Member 1993–present
Medical College of Virginia Alumni Association—Member 1992–present
American College of Physicians—Fellow 1993–present
Association of Military Surgeons of the United States (AMSUS)
2nd Vice-President—4/04–11/04
1st Vice-President & President-elect—11/04–present

13. Employment record: List below all employment (except military service) since your twenty-first birthday, including the title or description of job, name of employer, location of work, and inclusive dates of employment.

1983–85: Laboratory Technician, University of Virginia, Charlottesville, VA
1986–92: Medical Scientist (MD/PhD) Training Program, Medical College of Virginia, Richmond, VA
1992–95: Medical Resident, Medical College of Virginia, Richmond, VA
1995–96: Chief Medical Resident/Instructor in Medicine, Medical College of Virginia, Richmond, VA
1996–97: Group Practice Chief (and Chief of Telemedicine Section), Medicine Service, Hunter Holmes McGuire VA Medical Center, Richmond, VA
1997–99: Medical Director, Quality Improvement, Medical College of Virginia Hospitals
1997–99: Director, Continuing Internal Medicine Education, Associate Director, Internal Medicine Residency Training Program, Associate Director, Health Services Research Fellowship Program, Department of Internal Medicine, Virginia Commonwealth, University, Richmond, VA
1999–02: Chief Quality & Performance Officer, Veterans Health Administration, Washington, DC
7/02–4/04: Deputy Under Secretary for Health, Department of Veterans Affairs, Washington, DC
4/04–Present: Acting Under Secretary for Health, Department of Veterans Affairs, Washington, DC

14. Military service: List below all military service (including reserve components and National Guard or Air National Guard), with inclusive dates of service, rank, permanent duty stations and units of assignment, titles, descriptions of assignments, and type of discharge.

N/A

15. Government record: List any advisory, consultative, honorary, or other part-time service or positions with Federal, State, or local governments other than those listed above.

1999: Consultant to Commonwealth of Virginia on Telemedicine and Telehealth Infrastructure. (Work performed through Division of Quality Healthcare, Department of Internal Medicine, Virginia Commonwealth University)

16. Published writings: List the titles, publishers, and dates of books, articles, reports, or other published materials you have written.

Please see attached CV pages 45–52. (Includes more than 80 peer-reviewed journal articles, book chapters, abstracts, and manuscripts published or in press)

17. Political affiliations and activities: (a) List all memberships and offices held in and financial contributions and services rendered to any political party or election committee during the last 10 years.

N/A

(b) List all elective public offices for which you have been a candidate and the month and year of each election involved.

N/A

18. Future employment relationships:

(a) State whether you will sever all connections with your present employer, business firm, association, or organization if you are confirmed by the Senate.

N/A: I am currently a Federal employee of the Department of Veterans Affairs (VA). VA would be my prospective employer, if confirmed.

(b) State whether you have any plans after completing Government service to resume employment, affiliation, or practice with your previous employer, business firm, association, or organization.

I would be likely to continue service with the Department of Veterans Affairs (or another Federal Agency) after Government Service as VA Under Secretary for Health.

(c) What commitments, if any, have been made to you for employment after you leave Federal service?

None.

(d) (If appointed for a term of specified duration) Do you intend to serve the full term for which you have been appointed?

Yes.

(e) (If appointed for an indefinite period) Do you intend to serve until the next Presidential election?

Term of appointment is for four (4) years.

19. Potential conflicts of interest:

(a) Describe any financial arrangements, deferred compensation agreements, or other continuing financial, business, or professional dealings which you have with business associates, clients, or customers who will be affected by policies which you will influence in the position to which you have been nominated.

None.

(b) List any investments, obligations, liabilities, or other financial relationships which constitute potential conflicts of interest with the position to which you have been nominated.

None.

(c) Describe any business relationship, dealing, or financial transaction which you have had during the last 5 years, whether for yourself, on behalf of a client, or acting as an agent, that constitutes a potential conflict of interest with the position to which you have been nominated.

None.

(d) Describe any lobbying activity during the past 10 years in which you have engaged for the purpose of directly or indirectly influencing the passage, defeat; or modification of any Federal legislation or for the purpose of affecting the administration and execution of Federal law or policy.

N/A

(e) Explain how you will resolve any potential conflict of interest that may be disclosed by your responses to the above items. (Please provide a copy of any trust or other agreements involved.)

N/A

20. Testifying before the Congress:

(a) Do you agree to appear and testify before any duly constituted committee of the Congress upon the request of such committee?

Yes.

(b) Do you agree to provide such information as is requested by such a committee?

Yes.

POST-HEARING QUESTIONS FROM SENATOR DANIEL K. AKAKA FOR JONATHAN B. PERLIN, M.D., PH.D., NOMINEE TO BE UNDER SECRETARY FOR HEALTH

Question 1. Networks are living under tough fiscal constraints. While many have deficits, I understand that to date, none have asked for supplemental funds. What is the reason for this?

Response: You are correct that networks and facilities are being challenged by continued patient demand growth. However, most are gaining the efficiencies or taking the management actions required to operate within their allocated funding levels while continuing to maintain the highest quality of care for those they serve. To date, only one network has requested an adjustment to its funding level this fiscal year. The need for that adjustment is currently being analyzed by our Finance Committee and VHA Office of Finance staff who will present a recommendation to me very soon. One other network has been provided some additional funding due to management and quality issues at a specific facility found to need immediate attention.

Question 2. In your capacity as Acting Under Secretary for Health, you were responsible for the oversight of VA's Research and Development program. What do you plan to do to improve oversight of this vital segment of the Veterans Health Administration?

Response: I expect to announce the appointment of a permanent Chief Research and Development Officer (CRADO) very soon. I will work directly with the CRADO

to assure that the research portfolio maintains its focus on veterancentric issues and that the VA research program continues to be regarded as one of the best scientific programs in the world. I have worked closely with the interim leadership to strengthen the Office of Research and Development, and I expect to maintain the same close relationship with the new leadership.

We have continued to improve our human subjects protection program. To date, all chairs and members of Institutional Review Boards that oversee VA research have received special training. An aggressive accreditation is underway and on schedule. Presently half of all IRBs have received accreditation from the National Committee on Quality Assurance - more than double the number of all other accreditations in the country. We have completed training for all board members for VA Nonprofit Corporations that support research and education. The Nonprofit Oversight Board, which I chair, is creating an aggressive, new oversight program. I support a strong, yet reasonable, financial conflict of interest policy. A handbook is currently in final review, and I will monitor the progress of implementation and support the ORD leadership in taking appropriate action if conflicts of interest are identified. We must continue to make progress in establishing and maintaining high standards for biosafety and biosecurity to protect employees and volunteers. I am pleased that a new biosafety program is being implemented, and I expect to have continuing discussions with ORD leadership about continuous improvement in these areas.

The Office of Research Oversight (ORO) serves as the primary VHA office in advising me on all matters of research compliance and assurance for human subjects protections, animal welfare, research safety and security, and research misconduct. ORO promotes and enhances the responsible conduct of research in these areas in conformance with laws, regulations, and policies. This office reports directly to me and briefs me routinely and about any particular matters of concern in research compliance. ORO manages its program of oversight through a variety of mechanisms, which include the provision of assistance to VHA's research community on how to prevent and correct research noncompliance. ORO carries out "for cause" onsite reviews and has recently launched a program to carry out routine site visits to review compliance in each of the areas of research it oversees. In addition, ORO has taken the lead in security/safety inspections for BSL-3 laboratories in the last 2 years. ORO also has begun quality assurance approach to help VHA facilities improve compliance activities.

I should add, that no amount of oversight is effective or worthwhile unless the quality of our science and our investigators is the highest possible. I will insist that the projects conducted by VA investigators meet the highest standards of integrity and scientific rigor and that the independence of our highly respected merit review process is maintained. I am committed to and will work to protect this process.

Question 3. I am pleased that VA has directed appropriate attention to the issue of returning service members, and the logistics of integrating them into the VA system and back into society as seamlessly as possible. However, it has been difficult to get a real assessment of what the current conflicts will mean for VA health care in terms of both costs and new patient workload. Current data indicate that VHA will see double the amount of new patients from Operations Iraqi and Enduring Freedom. What are your thoughts on how VA will be able to absorb this influx, and whether additional funding is necessary?

Response: I am confident that our FY 2005 budget and our FY 2006 budget request provide sufficient resources and capacity to address all their health care needs. Meeting the comprehensive health care needs of returning OIF and OEF veterans who choose to come to VA is one of the Department's highest priorities.

Our latest data show that we have seen nearly 63,000 veterans of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). In this context, we must bear in mind that OEF veterans may have been seen by VA beginning in FY 2002, and OIF veterans beginning in FY 2003. Therefore, the 63,000 number does not represent the workload of a single fiscal year. Nonetheless, simply for the sake of comparison, that number is approximately 1.5 percent of the 4.2 million unique patients we have seen thus far in FY 2005 (as of January 31, 2005). Thus, the number we have seen to date has been a very small percentage of our overall workload.

OIF and OEF veterans have sought VA health care for a wide-variety of physical and psychological problems. The most common health problems have been musculoskeletal ailments (principally joint and back disorders) and diseases of the digestive system, with teeth and gum problems predominating. No particular health problem stands out among these veterans at present. The medical issues we have seen to date are those we would expect to see in young, active, military populations. However, we will continue to monitor the health status of recent OIF and OEF veterans to ensure that VA aligns its health care programs to meet their needs.

Question 4. The Administration has made it clear that VA should predominantly serve service-connected and indigent veterans. What is your view of this policy, and do you believe that the system can survive seeing only that population?

Response: VA has an obligation to meet the health care needs of all enrolled veterans in a timely manner and provide all the same high-quality health care. We will continue to do that so long as I am Under Secretary for Health.

In a perfect world without resource constraints, we would welcome all veterans to have access to our care. However, in a time of fiscal constraint, we must make sure that it never falls short in meeting those with greatest need, including veterans with service-connected disabilities, veterans whose incomes and other resources are the most limited, veterans with special needs, and new combat veterans. Therefore, we have found it necessary to make difficult decisions and have proposed cost-sharing policies for Priority 7 and 8 enrollees as a means of balancing veteran demand and available resources.

We believe that these policies are modest in their scope, and their impact limited. We are currently projecting the loss of 1.1 million enrollees and 213,000 unique patients if these policies are implemented. However, even given these two proposals, we are projecting 6.8 million enrollees and 5.2 million unique patients for FY 2006. Moreover, Priority 7 and 8 enrollees who have no other health care options are expected to remain in the VA health care system.

Question 5. Have you had a chance to discuss the need for an annual enrollment decision with the newly confirmed Secretary, Jim Nicholson? When do you anticipate Secretary Nicholson making this decision, and what has your role been in the decision-making process?

Response: There have been no formal discussions with the Secretary about the FY 2006 enrollment decision. At this time we are in the initial stages of collecting and analyzing FY 2006 enrollment and budget projections. We expect the Secretary to make his decision toward the end of the current fiscal year. My role is essentially two-fold. First, I oversee and provide direction to the staff of the Veterans Health Administration (VHA) who are responsible with formulating the data on the basis of which VHA's formal recommendations will be made to the Secretary. Second, I advise the Secretary and explain VHA's recommendations based on our final data analysis.

Question 6. There have been a number of reports and articles that have come out recently citing VA as one of the nation's leaders in quality of health care. It has been broadly acknowledged that VA has made great strides in the past decade and has become the model for large-scale health care delivery. How do you intend to get the word out to service members and veterans alike about VA's new status as a top-notch health care system?

Response: VHA understands that our responsibility is to provide information on the services we provide to veterans and their families; members of Congress; veterans service organizations; state and community leaders, and others. We do seek positive publicity for our organization and its accomplishments to insure that eligible veterans have a favorable impression of the care we provide so that they will seek the care they may need; to support our recruitment efforts; and to foster professional respect for our clinicians and other employees. Every VHA hospital has at least one collateral duty or full time Public Affairs Officer; every network has a Public Affairs Office; and four Central Office FTEE are dedicated to the Office of Communications Management within the Office of Communications. All work closely with VA's senior communications organization, the Office of Public and Intergovernmental Affairs to identify publicity opportunities, develop new publicity vehicles, and insure the Department speaks with one voice. As your question notes, a number of news media outlets have recently cited VHA as a leader in quality health care; many of those stories were generated by the efforts of VACO and facility Public Affairs Officers. We expect to continue our level of effort in this area in the future; hopefully with continued good results.

Question 7. As you know, GAO issued a report in February of this year that questioned VA's capability to treat veterans with Post-Traumatic Stress Disorder. You were quoted in one article as "taking exception" to GAO's findings. GAO's biggest issue was that VA has lagged in implementation of the Advisory Committee on PTSD's recommendations. What has been done since this report was released to move closer to the goals that GAO found were unmet? When will the Committee receive the Mental Health Strategic Plan?

Response: I specifically referred to the narrow focus of the GAO report and my concern that a conclusion could be misinterpreted and leave the impression that globally, VA was providing sub-standard care for veterans with PTSD simply because there was incomplete implementation of the PTSD Committee's recommendations. This impression is entirely erroneous.

That said, however, I have met with the members of the Special Committee, and we have agreed upon a plan of action that embodies the spirit and intent of the Advisory Committee recommendations. The Co-Chairs of the Special Committee have expressed their support for VA's implementation of the Committee's recommendations, and are now working in concert with VHA officials health to achieve the goals identified by the Special Committee. The Committee chairs are in agreement that all of the goals have been incorporated into VA's Mental Health Strategic Plan (MHSP).

VA continues to expand resources to improve the care for PTSD patients. For example:

• In response to Public Law 108–170, VA has approved $5 million per year for three years to establish new PTSD programs, and an additional $5 million per year for three years for new OIF/OEF programs.

• VA is developing a plan to add new PTSD Clinical Teams (PCTs) throughout the nation in areas of shortage.

• VA and DOD held a joint strategic planning meeting in March 2005 to coordinate ways to bridge the gaps for soldiers needing PTSD and other mental health care when they are separated from active duty.

On October 1, 2004, VA provided copies of the draft MHSP to the Veterans' Affairs Committees of the House and Senate. On November 18, 2005, the Secretary approved the MHSP, subject to integration of its initiatives with the FY 2005 and FY 2006 budgets. The integration process is nearly complete. It is my hope that we will be able to provide the Committee a copy of the final Mental Health Strategic Plan in the near future.

Question 8. How will you meet the nursing home care needs of veterans with serious mental illnesses, who typically cannot obtain that type of care in community nursing homes or state veterans' homes?

Response: We will continue to emphasize the provision of a spectrum of institutional and non-institutional geriatric and extended care services to all enrolled veterans, including those with serious mental illness. However, in a time of constrained resources, we are proposing to restrict the provision of long-term maintenance nursing home care to our highest mission priority, serviceconnected disabled veterans and those with special needs not generally met in the community, such as traumatic brain injury or ventilator dependency. Patients with serious chronic mental illness have also been identified as one of the special populations for whom VA would provide long-term maintenance nursing home care. We are projecting that there will be adequate capacity to care for these patients now and in the future.

Question 9. Constituents of mine have raised the issue that fee basis care is no longer being provided to veterans living on Molokai. Please provide me with a status of the fee basis program on the island.

Response: My staff has confirmed with the Acting Director of the Pacific islands Healthcare System that this is not true. There is a uniform fee basis policy for all the neighbor islands, and there has been no change in policy for Molokai. The Acting Director and his staff are not aware of any specific veteran complaint on this issue, but would be happy to review and respond to any that may come to light.

Answer: I propose creating a committee of senior VA employees and medical school deans to discuss how we will continue our partnership for many years into the future.

Question 10. It has been reported to me that you recently convened a meeting with representatives of the Association of American Medical Colleges (AAMC) to discuss affiliation relations. Please provide the Committee with a summary of these discussions with AAMC and any conclusions you may have reached, or plan you may be formulating, based on that meeting.

Answer: There was no meeting to discuss affiliation relations with AAMC. However, I do meet regularly with AAMC's VA Liaison Committee as well as the Council of Deans to discuss our relationship. The recurrent themes of these meetings related to some of the tensions arising from IG audits of part-time physician time and attendance and concerns about the new sole-source clinical service contract process.

Question 11. How will you encourage the non-veteran health care system to better understand the VA health care system?

Answer: One of the most effective means of communicating our successes to the public is through positive media. Recently, The Globe and Mail, a Canadian newspaper published an article that carried the headline, "U.S. veterans' health care healed itself: So can our Medicare system". It went on to say, "The U.S. Veterans Health Administration is, by any measure, a remarkable success story, a tale of revitalization the likes of which is rarely seen." In January 2005 the Washington Monthly magazine stated, "Today's troops are headed into the country's best healthcare system—the VA." Additionally, the Institute for Healthcare Improvement (IHI)

consistently cites the VA as the gold standard for patient safety. I do believe we need to do a better job of explaining the importance of serving veterans to the many clinicians who receive all or part of their training from our Department. I also believe we must share our many innovations, including the Electronic Health Record, with others in health care. I am particularly excited about the partnership with the Department of Health and Human Services to make a version of our electronic health record (known for this purpose as VistA-Office EHR) available, especially to rural and underserved areas.

Question 12. There has been a push, mostly from within VA, to encourage more cooperation and sharing agreements between VA and the Department of Defense (DOD).

A. What areas do you see as having the most potential for new sharing arrangements?

Answer: Clinical activities when there are complementary needs have the greatest potential for new sharing agreements. In addition, we have the goal, which I support, of having at lest 80 percent of our facilities become TRICARE Network providers, and each VISN has performance measures to support continued sharing between the Departments. There are over 250 separate sharing activities currently; they range from shared specialty services, to shared capital equipment (e.g., MRI & CT), to joint purchasing, to shared personnel management. At a national level, the joint procurement activities that have been so successful in pharmacy are beginning to be recapitulated in the area of medical-surgical supplies and capital equipment acquisition; I believe that is an extremely promising area of work.

B. What would you do to bring DOD to the table to bring about more sharing successes?

Answer: VA and DOD already collaborate on several levels. Our framework consists of the Joint Executive Council (JEC), the Health Executive Council (HEC), the Joint Strategic Planning Committee and the Construction Planning Committee, and is composed of senior leaders of both Departments. Our two Departments approved an initial Joint Strategic Plan in 2003 and this year, we have updated the plan to include specific performance metrics; a more strategic planning horizonl and a commitment to link JSP goals and objectives to Department strategic plans. I believe that we are on the verge of many sharing successes, and that the framework is currently in place to accomplish this.

C. I commend VA's establishment of a permanent office to address the needs of returning servicemembers. While many strides have been made to ensure a seamless transition from active duty to veteran status, more must be done to ease this integration into the VA system and reintegration into society. What is your view of the work that remains in this area, and how would you seek to accomplish a truly seamless transition? What are your plans to combat the cultural issues that accompany the transition to veteran status?

Answer: Veterans Health Administration must honor our returning heroes and their families by providing them with care that is compassionate and dignified; and by coordinating every possible service and support activity that may help improve their functioning, and restore them to their rightful place in our society. VA has embraced the opportunity to serve these heroes by reinventing existing programs, creating outreach initiatives, enhancing specialized clinical care, and collaborating with our DOD partners to share access to health records.

Our medical centers will do their best heal the wounds of combat veterans, and our vet centers will support their readjustment efforts. We have an opportunity to define VA, and VHA, for a new generation of veterans, and we will make the most of that opportunity.

Question 13. The Administration's FY06 budget request relies heavily on co-payments from veterans and collections from third-party insurance. VA is estimating $2.1 billion in collections for fiscal year 2006, assuming the enactment of the policy proposals included in the budget request.

A. What changes to the MCCF program do you envision to improve third-party collections?

Answer: Recently, we have automated a number of critical revenue processes which have dramatically improved collections. These include electronic insurance identification; electronic claims generation capabilities; electronic receipt of third party insurance remittance advices and associated payments; a lockbox to automatically apply payments from veterans to co-payment charges; an electronic remittance advice to accurately identify deductible/coinsurance amounts that Medicare supplemental insurers calculate to determine reimbursement to VA; and electronic documentation templates. In the future, we will improve our collections by creating consolidated patient accounting centers (CPAC's), which are designed to gain economies of scale by regionally consolidating key business functions; and to implement an in-

dustry proven Patient Financial Services System (PFSS) that will yield dramatic improvements in both the timeliness and quality of claims and collections.

B. VA cannot charge a co-payment that is more than the cost of medication. To justify the proposed $15 prescription co-payment, VA included a myriad of administrative costs. Do you feel that this charge is appropriate for over-the-counter medications such as aspirins, vitamins, and cough syrup?

Answer: VHA does not have the business processes and computer programs in place to implement a "tiered" co-pay for pharmaceuticals. That is something we may be able to implement in the future. In the meantime, the existing co-pay structure is a reasonable approach.

C. If confirmed, would you recommend that the $15 co-payment amount be increased in the future?

Answer: One of the ways in which VA balances veteran demand and available resources is through cost-sharing policies such as the existing co-payment of $7 for a 30-day supply of medications. I believe that this balance should continue to be looked at in the future and co-payments adjusted thoughtfully.

D. What is your view of contracting out portions of the MCCF collection effort? Recently, companies that employ electronic appeals software, among other innovations, have revolutionized the way funds that are owed to VA can be recovered. Will you continue to pursue the use of these alternative methods for collections?

Answer: Absolutely. We will continue to pursue all available means to improve our revenue cycle performance success.

Question 14. Do you believe that the VistA system is still able to meet the clinical and administrative needs of VHA?

Answer: VHA has used our pioneering VistA electronic health record systems for more than a decade. It provides an integrated record covering all aspects of patient care and treatment, and maintains records on five million eligible veterans who have chosen to receive their health care from our Department. We are proud to lead the health care industry in the use of information technology, and fully believe that there is no better or more comprehensive health care software in the world.

While there is no better system today for supporting clinical needs, VistA must be improved in its ability to support administrative needs. The "rehosting" efforts will allow VistA functions to become the next generation "HealtheVet" system, which will allow easier programming, and support better administrative data and appropriate data sharing (especially, the ability to incorporate electronic health data from DOD, as those data come online).

Question 15. What are your views on CoreFLS and how VA managed this large-scale contract?

Answer: VistA works for VHA because end users (clinicians) were engaged in its development process. I believe that CoreFLS did not work for VA because the end State was not well defined, and the end users were not adequately involved in the process. Absence of "business owner" participation doomed the computerized medical record recently installed in Cedars-Sinai. The relationship of business owner engagement and success is well-recognized.

Question 16. The Committee understands that several clinics have stopped seeing new patients because of fiscal constraints. Please provide detail on any such changes in any of the networks, including overall guidance VA Headquarters is providing on this issue.

Answer: VA has guidelines for Community Based Outpatient Clinics (CBOCs) to assure productivity, high quality, and access. Our guidelines to ensure quality care at CBOCs include setting a ceiling of 1,200 patients per primary care provider, and insuring that proper support resources are provided in sufficient quantity, such as examination rooms. This helps us to provide timely and high quality care to veterans at our CBOCs. CBOCs are an integral part of our strategy of insuring that care for veterans is provided in the most appropriate environment, and has reduced hospital use by providing care in outpatient clinics. In the last 4 years, we have increased the number of CBOCs by 91. The CARES decision called for the development of 156 new CBOCs, pending the availability of financial resources and the validation of their need with the most current data available. I believe that they are a vital part of VHA's future ability to care for veterans. Some CBOCs are contracted on a "capitated" basis—that is, the contractor is paid a flat rate for each patient. When a contract has achieved its budgeted level, VHA may limit new enrollment.

Question 17. A couple of years ago, Committee staff found grave inconsistencies in access to mental health services at clinics within the VA health care system. How do you plan to improve the availability of mental health services at CBOCs across the country? Please also describe the management of these clinics, for example, the process you use to evaluate and renew contracts for CBOC providers.

Answer: VHA's goal in mental health is to support the six goals of the President's New Freedom Commission for transforming Mental Health Care in America. The plan provides special attention to the needs of seriously mentally ill veterans and veterans with PTSD. My highest priority in this area is to increase access to behavioral health services, and to reduce disparity to such access. Today, 71 percent of our CBOCs provide direct access to Mental Health services, and all of our CBOCs are able to refer cases to our medical centers.

CBOC contracts are typically awarded for 1 year with an option for four 1-year renewal. Before any contract renewal, facilities review contract terms and conduct analyses regarding in house capabilities and cost benefit. The results may support a decision to renew the contract or cancel. At contract expiration, an analysis is done to determine their own internal capabilities and the benefits of continuing to use contracts. If a contract model is recommended, a new open solicitation is issued. The care provided to patients at contract CBOCs must meet the same quality standards as care provided in VA facilities.

Question 18. Non-physician providers are critical to the VA health care system. Please describe what you see as the future role within VA for non-physician providers, such as physician assistants and advanced nurse practitioners.

Answer: Non-physician providers are critical, not only to VHA, but to the entire health care system. VA will continue to be a leader in providing opportunities for physician assistants and nurse practitioners. We have been approached by professional organizations to serve as a model not only for collaborative practice, but also for collaborative practice education, and we will do so. Collaborative practice, involving non-physician providers is seen as the model for successful future health care.

Question 19. Last year, Congress passed legislation that completely restructured the physician and dentist pay structure. This was done mainly in response to the fact that VA was forced to enter into high dollar scarce medical contracts for the provision of certain specialty services at facilities where VA could not recruit full-time doctors in those areas. Please describe any other recruitment and retention problems involving health care personnel you have encountered within the VA health care system.

A. Do you think the changes that have been made to the pay structure will help solve the problems VA has been facing?

Answer: The new legislation for physician and dentist pay is effective January 2006. VA is working aggressively and is confident policies and procedures will be in place to take full advantage of opportunities included in this legislation. The new pay structure will allow us to create pay ranges designed to recruit and retain the many different specialties and assignments in our VA system. We can also use the new pay flexibilities to parallel community standards and attract scarce specialty resources.

B. What more would you suggest needs to be done to respond to these difficulties?

Answer: Continuing recruitment and retention problems involving our health care personnel include the following:

a. The need for expanded authority under Title 38 to hire additional positions that are critical to the support of our health care professionals. These include Nursing Assistants, Medical Clerks, Medical Technicians, Health Technicians and Food Service Workers.

b. The ability to hire a limited number of annuitants without an offset to their retirement. VA loses these incredible resources to our competitors when they retire. VA could reduce costs by being able to utilize these fully trained and seasoned staff to bridge between vacancies, extended absences, etc. Staff would feel more valuable and have a better transition into their retirement.

Question 20. VA recently issued new procedures to address reported flaws and begin strengthening your timekeeping system. Please describe to the Committee the state of implementation of the new timekeeping system for part-time VA physicians.

Answer: The part-time physician time and attendance pilot eliminates core hours for those part time physicians on adjustable work hours. Each physician signs an agreement for the number of hours they will work during the year. They will be paid in equal amounts each pay period. The hours they actually work will be negotiated with their supervisors prior to each pay period based on VA needs. At the end of their agreement, reconciliation will take place for those hours that were worked in excess or below the agreement.

The physician time and attendance policy was manually piloted from October 2004 through January 2005. In January 2005, the Alpha test on these new procedures was initiated and concluded at the end of March when the next phase was implemented.

The beta testing for the electronic time will be completed April 8, 2004. The national release of this new Electronic Time and Attendance (ETA) software to support

the time and attendance for part time physicians for adjustable work hours will be April 27, 2005. All facilities have 30-days to load the software into their systems. The policy supporting the new software is targeted for release for mid-May. In addition a draft of this new directive and handbook is in final review with a targeted date of mid-May 2005.

Question 21. Dr. Perlin, you once served as a part-time VA physician while practicing at the Medical College of Virginia, its academic health center, and the McGuire VA Medical Center in Richmond.

A. What are your personal reflections on practicing in a mixed environment, in particular in reference to apportioning and accounting for your professional time in VA versus your attending responsibilities at the other facility, as well as for any teaching or research responsibilities you may have had, whether at the University or at VA?

Answer: Like most of my colleagues, I worked 60-plus hour weeks as an attending physician when I was in Richmond. I had scheduled times when I was at VA, scheduled times when I was at MCV, and scheduled times when I discharged my teaching responsibilities. There were times when I had "ward attending physician" duties at VA, and during those periods, I spent 30 consecutive days caring for VA inpatients. My other responsibilities were adjusted accordingly. I regularly juggled my responsibilities as a physician; a teacher; and a researcher; but I always understood that whatever I did revolved around my most important mission: to provide the best possible care I could to the patients I was responsible for.

B. Assuming you were currently practicing in the MCV-VA McGuire environment, how would the new approach to part-time timekeeping affect your working conditions of a joint faculty member, a department head, or staff physician?

Answer: The new timekeeping concept that VHA is currently developing and will be implementing provides a much more rational basis for the distribution of a physician's time than the old Core Hours doctrine, which often required physicians to be present when they were not needed; and caused them not to be present when they were needed in order to be technically compliant with the regulations.

C. Did your personal experience in Richmond help inform VHA's new policies on part-time physician timekeeping; and if so, in what manner?

Answer: Yes, it did, by instilling in me the firm belief that there had to be a better, and more rational, way to manage my time and that of others.

D. You recently wrote the deans of the 107 medical schools with which VA is affiliated on the topic of part-time physician's time-and-attendance matter. Please provide the Committee the content of that letter and explain your approach to the schools, your assessment of whether your effort was successful, and any further steps you intend to take in this regard.

Answer: In short, my letter expressed the concept that improper supervision put three lives at risk, not one-the patient, the trainee, and the trainee's supervisor. I used that concept to explain to the deans why we needed to change our existing system. I was quite surprised that the only letters I received in response were letters of thanks, agreeing that not only did the existing system fail our patients, but also the ethical responsibilities we had to ensure the proper training of medical school students.

Question 22. The Inspector General reviewed VHA's policies in contracting for specialty services in the affiliated environment. VHA has been criticized for often relying on sole source methods to procure clinical services, often from practitioners associated with VA-affiliated schools of medicine and their academic health centers. The IG has specifically recommended using competition to gain VHA a better business advantage in obtaining scarce and highly specialized health care practitioners to care for veterans. What views do you hold on these matters of contracting policy, and what are your plans as Under Secretary to manage such specialty contracting?

Answer: While we should always strive for competition to get the best business propositions for veterans in our contracting activities, sole source procurements of clinical services from VA affiliates often offer value and extend our capability to work with outstanding health care residents and fellows. Fellows are clinicians who could practice independently in particular specialties, but are continuing in additional training for periods of one to 7 years. Consequently, they are highly skilled in advanced practice in medical areas like interventional cardiology, interventional radiology and the surgical subspecialties, like cardio-thoracic or neurosurgery.

I am concerned that limiting our ability to do sole source contracting will keep us from obtaining highly skilled residents and fellows as well as top notch faculty. This will make it impossible for VA to serve veterans properly because of the overall loss of productivity from the imminent absence of fellows and residents because a low-bid procurement effectively severed supervisory faculty from their appointed roles and required residents and fellows to go elsewhere for appropriate supervision.

In implementing the IG's recommendations, we will have to weigh all factors including this one.

Question 23. Your immediate predecessor informed the Committee that VHA intended to address high-cost contract specialty services partly by reforming VA physician compensation policy. In response, Congress enacted Public Law 108–445, which gives VA wide latitude to establish market-sensitive physician compensation rates, along with a significantly higher salary cap, and new incentives for performance pay.

A. What is the status of implementation of the reform in VA's physician compensation system?

Answer: The legislation provided for an effective date of January 8, 2006. In order to assure VHA has policy and procedure in place, we have convened a core work group to oversee the myriad of details and consultation required to effectively implement this legislation. Currently, the policy and procedures are in their final draft. General Counsel will be responding to this policy by April 21, 2005. We have purchased available pay publications and finalizing the appointment of Executive and Steering Committees. Our timeline of events provides for having recommended pay ranges to the Secretary for consideration by September 2005. We must publicize the approved pay ranges for 60 days in the Federal Register. VHA expects to conduct training to the field during the 60 day notice period, and be ready to effect the new pay system on January 8, 2006. The policy also requires that all physicians and dentists have their initial review completed by the appropriate Physician and Dentist Pay Compensation Panel by no later than May 14, 2006.

B. What are your views on the potential of the new compensation authority to influence VA's performance in attracting new specialty physicians to full-time VA employment?

Answer: The new legislation provides broad authority to address pay comparability in a number of ways, including geographic needs, individual expertise, scarce specialties and the ability to recruit physicians and dentists for complex assignments.

VHA views this new pay system as a significant enhancement to our ability to attract new specialty physician to full time employment.

Question 24. In the past, VA has had increasing difficulty recruiting and retaining an adequate number of high quality nurses. Please describe what you see as the current role of nurses in the VA health care system, and how that might change, if at all, over the next 20 years.

Answer: America's veterans deserve the best treatment our Nation can provide. Nurses are central to our mission to provide them with safe, high quality and compassionate care. I believe that VHA has done an outstanding job of recruiting many of the best nurses our nation's nursing schools provide, and of retaining a cadre of experienced and competent nurses. In the next 20 years, VHA will need to maintain and expand our nursing staffs as the number of veterans increase. We must, as the National Commission on VA Nursing explained, actively address those factors known to affect the retention of nurses: leadership, professional development; work environment; respect and recognition; and fair compensation. We must also develop and test technology and actively embrace research leading to the creation of new nursing roles that complement innovations in health care. Among the actions we must take, or have taken, are making the facility nurse executives members of the executive body at VISNs and facilities; engaging experts to evaluate and redesign nursing work processes; more aggressively recruiting for the best and brightest nursing school graduates; and creating new affiliations with schools for advanced degree nurses, baccalaureate nurses, and also with associate degree programs.

Question 25. As you are in a unique position to know, the VA research and development program not only makes a major contribution to our national effort to combat disease, but also serves to maintain a high quality of care for veterans through its impact on physician recruitment and retention.

A. Fiscal growth in this program, however, has slowed to nearly a flat line, and average award amounts have also declined. During the first 4-year term of this President, only minimal increases in the research account were proposed in budgets. Sadly, Congress has acted only marginally to change that trend, as opposed to what has been done for the National Institutes of Health and other Federal research activities. The flat budgetary environment in VA research has a consequence in delaying funding for, or preventing altogether, good research proposals from being funded. VA's average "pay line" for awards to principal investigators is reportedly down to a scant 15 percent of submitted proposals. Five years ago, it was double that level.

i) Can you explain why the pay line has dropped out of proportion to the overall funding available for VA research, and provide the reasons average award amounts have declined?

Answer: Paylines have dropped though not necessarily in a manner disproportionate to overall funding for VA research. Only about 20 percent of the current Research and Development (R&D) budget is available for new awards in an average year because of recurring and out-year commitments for grants, centers and career development awards. The VA Office of Research and Development (ORD) is transitioning to shorter durations of awards and conducting competitive reviews of all centers to assure that a higher percentage of funding is available annually for new awards. The goal is to achieve a workable balance among the competing needs for research and continue to fund new projects at a comparable rate as has happened previously.

ii) Given our concerns about the status of VA's affiliations, our new policy on part-time physicians and the stringent reviews of scarce medical specialist contracting, what are your concerns as Under Secretary, if confirmed, about the present financial condition of VA research?

Answer: A successful and vibrant research program is critical to the health of affiliations with our academic partners. The VA Office of Research and Development (ORD) presently supports nearly 3000 clinician investigators, many of whom forgo higher salaries available in other settings because they value participation in VA research. Not only do these investigators make important contributions to advancing medical knowledge and improving health care for veterans, they also provide outstanding, direct medical care to veterans and serve as the educators for the next generation of health care providers.

For nearly 50 years, the close and mutually beneficial relationship between VA medical centers and their academic affiliates has enhanced patient care, teaching and research. Almost uniformly, part-time VA physicians have more than fulfilled their commitments in terms of time and effort devoted to VA. It has always been essential for clinicians to be flexible in responding to the complex and changing demands of patient care, research and teaching. Recent efforts to impose more rigid constraints on clinicians' scheduling threatens to undermine that flexibility, and undermines their ability to fulfill those commitments.

iii) What are your views on the importance of VA research compared to funding for services?

Answer: Research is an integral part of providing exceptional health care to veterans. The VA Research program is unique among Federal research entities. Rather than funding investigators or programs that are divorced from clinical care or that are outside of the department, institute, or agency, VA's research program is intramural. Only VA investigators are funded to conduct research. The clinicians who are most familiar with the health care needs of the veteran population are also the scientists who submit research proposals, manage the projects, and publish the results. In fact, more than 80 percent of VA's researchers are physicians, nurses, and other professionals who provide patient care. This unique combination of clinician-researcher provides the direct connection to clinical care and the health care needs of veterans. VA is committed to evidence-based medical care and VA's research program is committed to providing the evidence for the best practice of medical care.

iv) What can be done to combat the chronic under-funding of the VA research program?

Answer: The VA Office of Research and Development (ORD) continues to make significant contributions to the health care of veterans, and the program enjoys the full support of the Department. As priorities for VA change and as new scientific developments emerge, VA ORD must continue to review research priorities in relation to the evolving needs of veteran patients.

It is also important for VA ORD to closely manage and leverage its resources. To assure adequate funding is available each year for new projects, especially to meet newly identified veteran-centric needs, VA is transitioning to shorter durations of awards and conducting competitive reviews of all research centers.

VA ORD is strengthening its partnerships within VHA, other Federal agencies, as well as academic affiliates and the non-profit sector to leverage the funding as efficiently as possible.

v) How do you think VA should allocate its limited research funds among the general areas of basic, applied clinical, and health services research.

Answer: As an intramural program, the VA Office of Research and Development (ORD) has a clear responsibility to assure that sponsored research addresses the needs of veterans who seek care from VA. The quality of the research and relevance to the veteran population remain the determining factors in deciding what studies to fund. Rather than focus on numerical percentage allocation of research funds for

each Service, the goal is to be sure that the funded projects meet stringent standards for scientific rigor and match the current needs of veterans. Priorities change as needs change.

Examples of VA's efforts to allocate according to the needs of veterans, rather than an apportionment among Services, are the recent solicitations for proposals involving deployment health including rehabilitation and prosthetics, mental health, and poly trauma projects.

B. One of VA's hallmarks is the sheltering of "bench to bedside" research. VA clinical practitioners and physician-scholars serve as principal investigators in VA- and NIH-funded research projects. They have the ability and the means to apply results of their own and colleagues' research in the clinical arm of the institution that husbands both activities. This unique setting has served VA well as a powerful recruitment and retention incentive, while elevating the standard of care to veterans.

i) Recognizing that designating time for clinician investigators to conduct research and providing them with adequate infrastructure are continuing problems in VA, would you support addressing this by administering investigator salaries and facilities operation costs centrally, in a manner similar to that used by NIB, to ensure that VA-funded investigators have adequate time and resources to conduct research?

Answer: In all parts of the health care sector, including VA, pressures to increase clinical productivity have risen. In some cases, this has eroded time available for clinicians to perform research. Because the VA research program is exclusively intramural, it has permitted a different approach to funding investigator time than used by other granting agencies such as NIH. Provision of salary support to investigators through the VERA research allocation is intended to enable clinician investigators to balance clinical and research responsibilities and to provide flexibility. This issue is being addressed by the VHA National Leadership Board, Health Systems Committee and a task force has recently been approved to describe how VERA research funds are being utilized and to outline a set of best practices. At the present, we believe this approach is preferable to transferring VERA research funds to the research appropriation.

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POST-HEARING QUESTIONS FROM SENATOR ARLEN SPECTER FOR JONATHAN B. PERLIN, M.D., PH.D., NOMINEE TO BE UNDER SECRETARY FOR HEALTH

Question 1. In view of the fact that diabetes is the third largest bill for the VA and that 1.1 million veterans have been stricken with diabetes, what is the VA system doing in the area of preventative care for diabetes patients? What is the VA system doing to curb diabetic ulcerations resulting from improper footwear? Has the VA looked at the economic advantages of centrally ordering diabetic shoes? Is the VA using the latest technology in developing its diabetic shoes? If so, what is it? Walter Reed, Bethesda Naval Hospital, and the NIH are using the latest technology in their diabetic shoes. Has the VA consulted with them?

Response: Clinical problems associated with the diabetic foot have been a concern of VHA for a number of years. VA sets the standard for overall health status monitoring of patients with diabetes, providing near-universal preventive care through blood glucose monitoring and follow-up. VA podiatric care for veterans with diabetes is provided by highly competent professionals with access to the latest technology and techniques, thanks to a vibrant academic partnership with schools of podiatric medicine.

Proper prescriptions, appropriate footwear and prevention are the keystones to quality foot care. VA purchases shoes, whether from national contracts or individual orders, only from companies that use the most advanced materials for shock absorption, accommodation, and fit. New technologies for taking images of the foot in order to fabricate orthotics or inserts for shoes are in use at many VA podiatry services. VA is currently reviewing and evaluating the option of a national contract for the purchase of both therapeutic shoes (including depth shoes) and custom molded shoes. These factors—quality, cost, and access to the latest technologies—will be used from an evidence-based perspective for the standards and criteria which will be used to evaluate shoe manufacturers.

Question 2. Israel has expertise in handling veterans' issues due to its requirement that all Israelis serve in its military. They have dealt with a number of the same issues that confront our veterans returning home from Iraq and Afghanistan. I know that Israel is interested in working with us to collectively work to address these issues. Would you consider forming a working group including members of the Veterans Health Administration and officials, clinicians, and researchers of the Israeli Ministry of Defense for a collaborative research effort in various areas including post-traumatic stress disorder, virtual reality rehabilitation for motor recovery and ambulatory training for veterans with prosthetic limbs, robotic rehabilitation trials for neurological impaired and for veterans with limb loss, and other issues confronting both the United States and Israel?

Response: VA recognizes the importance of conducting cutting edge research that advances knowledge about the problems affecting veterans returning home from Iraq and Afghanistan. For example, in FY 2004 VA spent over $5 million for 34 projects related to diagnosis and management of PTSD, including virtual reality therapy. VA is funding additional studies in FY 2005, several of which are being conducted in collaboration with the Department of Defense.

VA's Office of Research and Development collaborates with many entities regularly on scientifically meritorious research focused on the high priority health care needs of veterans. These collaborations are always accomplished through VA's intramural program after careful review of scientific merit, clinical relevance, ethics, and investigator productivity. Unlike agencies such as the National Institutes of Health, VA does not have statutory authority to make research grants to colleges and universities, cities, states, or any other non-VA entity. Rather, VA's research funding is available only to those researchers who are primarily employed by VA.

To initiate a collaborative project, an investigator affiliated with a VA medical facility would need to submit a formal research proposal and provide information about any proposed partnerships. Then, either a standing committee chartered under the Federal Advisory Committee Act (FACA) or a special non-FACA panel

with appropriate scientific and research expertise would review the proposal for scientific merit, clinical relevance, ethics, and other administrative issues such as budget and investigator productivity. Each proposal receives a priority score based on a number of factors including significance (e.g., plausibility, originality, possibility of results); approach (e.g., valid study design, state-of-the-art methodology, proper study subjects, appropriate analysis of data)" feasibility (suitable background of investigators and facility resources), and ethical and safety issues.

VA would be happy to review proposals for collaborative projects with Israel if the research proposal meets the statutory and regulatory authorities for VA's research program.

POST-HEARING QUESTIONS FROM SENATOR JOHN D. ROCKEFELLER IV FOR JONATHAN B. PERLIN, M.D., PH.D., NOMINEE TO BE UNDER SECRETARY FOR HEALTH

Question 1. In January of 2003, your predecessor Dr. Roswell testified before Congress that, in a typical year, VA requires a 13 or 14 percent annual increase in funding to care for veterans seeking VA medical care. Do you agree with his assessment? If not, why not?

Response: The President's 2006 budget request includes budgetary resources of $30.7 billion (including $750 million for construction and $2.6 billion in collections) (includes proposed policies) for the medical care program, an increase of 2.5 percent over the enacted level for 2005 to meet actuarially projected demand for health care services. If the policies proposed with the budget are accepted and implemented, the resources requested will be sufficient.

Question 2. In March of 2005, the Congressional Budget Office (CBO) examined the potential budgetary implications of meeting the demands of veterans' health care through the year 2025, assuming that the per capita health care costs would grow by 6.1 percent in 2006 in nominal terms and fall to 4.2 percent in 2025. Do you believe that VA will be able to sustain its current health care system for current and future veterans using CBO's health care costs projections?

Response: Forecasting resource needs 20 years into the future is very risky at best and pure speculation at worst. In the past, however, both the President and Congress have ensured that sufficient resources were made available to provide the high quality of care that VA has become renowned for. Based upon historical precedent, therefore, I strongly believe and am confident that both future Presidents and Congress will continue to work together to ensure that our nation's veterans receive the appropriate level of health care.

Question 3. With the current enrollment decision restricting the enrollment of Priority Group 8 veterans, do you believe Veterans Health Administration has the critical mass of patients it needs to provide a full continuum of high quality medical care now and in the future?

Response: Yes. The VHA health care demand model, which is produced by a private sector health care actuarial firm, provides VA with the data needed to assess the concept of critical mass. For any enrollment policy scenario, the actuarial model can project future veteran enrollment and health care service utilization for over 50 health care services.

Because the actuarial model projects that enrollment in Priorities 1–7 will grow from 5.51 million in FY 2004 to 5.99 million in FY 2015, the suspension of enrollment in Priority 8 is expected to cause only a small decrease in total enrollment and veteran patients by FY 201115. In FY 2004, 4.54 million veterans used VA health care, and 4.47 million are projected to be patients in FY 2015. (These projections do not assume the implementation of the $250 annual enrollment fee proposed in the FY 2006 Budget.)

Question 4. What are your thoughts on providing direct spending (mandatory funding) for Priority Groups 1–6?

Response: At present, VA is considering H.R. 515, a "mandatory" funding bill recently introduced by Congressman Evans. We have recently completed our analysis of this legislation and are in the process of preparation of a formal response. The Administration has in the past opposed such legislation, as articulated, for example, by the Deputy Secretary in his testimony before the Senate Veterans' Affairs Committee on June 22, 2004.

Question 5. What is the rate of enrollment into VA medical care of veterans from Afghanistan and Iraq, including National Guard and Reserves?

Response: On the basis of the latest roster of veterans from Operation Iraqi Freedom and Operation Enduring Freedom, we have identified approximately 289,600

veterans. Of these, approximately 63,000 (22 percent) have sought health care in VA. Active duty veterans accounted for 27,800 of these patients, and Reserve/National Guard members have accounted for 35,200.

Question 6. How has the funding and the staffing for Vet Centers changed since 2001 to provide for the veterans from Afghanistan and Iraq, including National Guard and Reserves?

Response: The Vet Center program operating budget for FY 2001 was $76.7 million. This amount covered the cost of 206 community-based Vet Centers and 943 staff. The budget for FY 2005 is $89.3 million. In February 2004 I authorized a Vet Center program staff augmentation to enhance the program's capacity to provide outreach to the new veterans returning from combat operations in OEF and OIF. Specifically, the Vet Centers have hired and trained a cadre of 50 new outreach workers from among the ranks of recently separated OEF and OIF veterans at targeted Vet Centers. These 50 new staff members were hired on a three-year temporary basis. In March 2005, based upon the demonstrated success of the Global War on Terrorism (GWOT) veteran outreach initiative to locate and inform new returning veterans, I authorized the Vet Centers to hire an additional 50 GWOT veterans to further enhance the program's outreach capacity. Additionally we are in the process of converting the initial 50 GWOT veteran outreach counselors to career status. The latter action will increase the Vet Center program's annual recurring budget by $2.5 million. Also, in November 2004, I approved a plan to establish a new 5-person Vet Center in Nashville, TN. This will increase the number of Vet Centers to 207 system-wide, and increase the program's recurring base by $393,000 annually.

Question 7. The significant number of service members sustaining limb amputation has spurred DOD's progress in prosthetics and rehabilitation. What advances has VA made to ensure that it is in the forefront amputee healthcare, prosthetic design, and postprosthetic amputee rehabilitation?

Response: a. VA has no more important mission today than to restore the maximum amount of functioning possible to those men and women who have returned from combat with injuries or illnesses. To ensure that these heroes receive the state-of-the-art care they are entitled to, here are some of the most recent initiatives we have undertaken. A collaborative effort with Prosthetic and Sensory Aids Service (PSAS), Physical Medicine and Rehabilitation Service (PM&RS) and Rehabilitation Research and Development (RR&D) has been initiated to develop and implement a system of care within the VA for our older veteran amputees and new amputees transitioning from DoD to VHA. This workgroup has identified four levels of care to provide prosthetic, rehabilitative and research care for the amputee patient.

b. Four Polytrauma Centers have been named to provide total healthcare to VHA patients and to Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) soldiers returning with numerous and complex injuries and conditions. They will serve as Level II sites in the Amputation System of Care. Level II facilities will provide a high level of expert care, a full range of clinical and ancillary resources, and serve as a resource to other facilities within their network. Criteria for Level II sites include the presence of a Commission on Accreditation of Rehabilitation Facilities (CARF)accredited inpatient rehabilitation unit, an accredited Prosthetic/Orthotic Lab, surgical expertise in the area of polytrauma, and access to telerehabilitation technology. The facility will coordinate the care and level of services required to meet the needs of the amputee population and assure that patients have access to the same high level of care across the network. Level II facilities will enter information into a clinical database and manage outcomes of polytrauma within their respective VISNs. They will be responsible for implementing care that transitions individuals back into their home community.

Site visits to the prosthetic/orthotic laboratory of the four polytrauma centers are being conducted to assess the functional level and current resources. In addition to these four Polytrauma Centers, PSAS and PM&RS are developing a plan to have at least an additional 17 Level II Centers, located throughout the 21 Veterans Integrated Service Networks (VISN). Level II facilities will be located at tertiary care facilities and have a full range of professional staff and services to care for the needs of the amputee patient.

c. VHA Handbook 1173.3, Amputee Clinic Teams and Artificial Limbs was updated in June 2004, to include current VA procedures for administering amputee clinic teams and providing artificial limbs to veteran beneficiaries.

d. VHA Prosthetic and Orthotic (P&O) Laboratories have been mandated to become accredited (VHA Directive 2004-020; Accreditation of VA Prosthetic and Orthotic Laboratories dated May 17, 2004). There are currently 35 P&O Laboratories accredited by the American Board of Certification (ABC) or the Board of Certification for Orthotists and Prosthetists (BOC).

e. Certification of Staff—VHA is committed to having at least one certified practitioner located in each of its P&O Laboratories. There are currently 104 certified practitioners that have achieved certification from ABC and BOC.

f. Many of our Prosthetists and Orthotists have attended recent programs at Walter Reed Army Medical Center, at Orlando, Florida. VHA Prosthetists and Orthotists were exposed to new and emerging technologies at these conferences. Additionally, manufacturers are being scheduled to provide in-house training to VHA Prosthetists and Orthotists on new and emerging technologies.

g. When new and emerging technology is available through Prosthetic and Orthotic manufacturers, our VHA veteran patients and OEF/OIF patients are provided with these advanced designs and components.

h. Computerized Aided Design/Computer Aided Manufacture (CAD/CAM) technology has been employed in the majority of VHA P&O Laboratories since the mid 1990s. This technology enables Prosthetists/Orthotists to design and manufacture custom prosthetic and orthotic appliances by computer technology.

i. Approval for a new Prosthetic/Orthotic Residency Program marks the first National residency program for Prosthetic and Orthotic students in VHA. Having a Prosthetic/Orthotic Residency Program will enable VHA to train and potentially recruit these students once they have successfully achieved their degrees and certification.

Question 8. What will be your process to evaluate the need and future at the Clarksburg VA Medical Center for its inpatient psychiatric unit. This is a priority for veterans in NorthCentral West Virginia, and I would like to be apprised on your decision making process at every step.

Response: A conceptual Behavioral Health Care Model was submitted by the Clarksburg VA Medical Center (VAMC) to the Network Director, VISN 4, on February 7, 2005. Under this model, a small inpatient care unit would continue to provide acute psychiatric care for patients. To complement this care, Clarksburg proposes creating subacute beds, a partial hospitalization program, and other new components of mental health care not currently available at Clarksburg. The primary focus is on the provision of behavioral health services through a continuum of care, while enhancing quality, access, and cost effectiveness.

In follow-up discussions between Network and VA Medical Center staff, the conceptual model was well received and accepted. Clarksburg VAMC has submitted an implementation plan detailing the transition from the existing model of care to the proposed model. The proposed model complies with the goals of the President's New Freedom Commission on Mental Health. In April 2005, Network staff will conduct a site visit at Clarksburg to further discuss and refine the implementation plan. The viability of this approach will be monitored through the balance of FY 2005.

POST-HEARING QUESTIONS FROM SENATOR LINDSEY GRAHAM FOR JONATHAN B. PERLIN, M.D., PH.D., NOMINEE TO BE UNDER SECRETARY FOR HEALTH

Question 1. The Veterans Affairs (VA) Inspector General has just completed an audit of physician timekeeping at Charleston VA, which included many of the MUSC physician faculty who work part time in the VA and Medical University hospitals. I am pleased that the audit was highly successful, again demonstrating the ability to have physicians involved jointly with VA and the MUSC affiliate. For many scarce specialties in medicine (liver doctors, cancer specialists), surgery, psychiatry, and others, VA can not afford to recruit and hire its own full time specialists, due to the higher salaries available in the private sector.

It is common practice for part-time VA physicians (faculty from the university) to work more hours caring for VA patients within any pay period than the time listed as their assigned core hours. The Dean at MUSC and other schools have suggested that VA consider a more flexible policy of "time-banking" which would give the physicians credit for their after hours off duty coverage, weekend and holiday work (currently they get no credit or recognition or pay for this activity). If properly documented and tracked, a flexible time bank could be used also to offset minor shortfalls in the attendance a physician might have during official duty hours because of emergencies or competing priorities at the medical school.

What is your opinion of such a remedy to this nationwide timekeeping problem?

Response: VA has introduced significant improvements to our policy on timekeeping for part-time physicians. The revised system, currently undergoing phased implementation, eliminates core hours for part time physicians on adjustable work hours. Each physician signs an agreement for the number of hours they will

work during the year. They will be paid in equal amounts each pay period. The hours they actually work will be negotiated with their supervisors prior to each pay period, based on VA's needs. At the end of their agreement, reconciliation will take place for those hours that were worked in excess of or below the agreement.

This physician time and attendance policy was piloted from October 2004 through January 2005. In January 2005, the Alpha test on these new procedures was initiated and concluded at the end of March when the Beta phase was implemented.

The Beta testing for the electronic time will be completed by the end of April 2005. The national release of new Electronic Time and Attendance (ETA) software to support the time and attendance for part time physicians for adjustable work hours will also be the end of April 2005. All facilities will have 30 days to load the software into their systems. A policy supporting the new software is targeted for release for mid-May. A draft directive and handbook addressing timekeeping for part-time physicians is in final review with a targeted date of mid-May 2005.

Question 2. It has been suggested that The Medical University of South Carolina (MUSC) and the Charleston VA Medical Clinic could collaborate to build new, modern, state-of-the-art hospital facilities that can be shared, reducing the building costs to both partners. MUSC has already begun its Phase 1 expansion, building a new specialty hospital across the street from the Charleston VAMC. In addition, The Medical University has initiated a Phase 2 planning effort that could include the Veterans Administration and help provide the VA with an avenue to replace its aging facility.

a. What is your opinion of such joint ventures between the VA and affiliated University Medical Centers?

Response: In general, the close relationships between VAMCs and affiliated university medical centers provide excellent opportunities to explore potential joint ventures. Any joint venture would have to meet the needs of both partners. In the case of MUSCs proposal, the financial terms were not feasible, nor was a replacement hospital for Charleston deemed necessary. There was an agreement for an enhanced use lease of Doughty Street property that allowed MUSC to move ahead with their own construction plans while bringing lease income to VA. Discussions continue with MUSC on other sharing opportunities, such as support/ancillary services, expensive technologies, scarce medical specialty services, steam generation, and joint parking solutions.

b. Are you supportive of such collaborative strategies that rely on the VA's enhanced use authority?

Response: Yes. One of the needs identified through the CARES process was VHA's plan for management of its property and other capital assets, much of which is not currently fully utilized. The Enhanced Use Lease authority provides an opportunity for VHA to engage in joint venture relationships for use of these assets.

c. What advice would you give the local VA and MUSC leadership in Charleston to facilitate their sharing/collaborating?

Response: My expectation is that the Charleston VAMC and MUSC will continue their constructive, mutually beneficial relationship. Future opportunities for cooperation should be fully explored and implemented when they will both benefit our mutual patient populations and make good business sense.

POST-HEARING QUESTIONS FROM SENATOR KEN SALAZAR FOR JONATHAN B. PERLIN, M.D., PH.D., NOMINEE TO BE UNDER SECRETARY FOR HEALTH

MENTAL HEALTH AND LONG-TERM CARE

Question 1. In the report of VA's CARES decisions published in May 2004, the Secretary indicated that VA would develop appropriate forecasting models and strategic plans for mental health and long-term care services. That was more than a year ago, but we haven't seen any plans.

a. What is the status of these reports and what is causing the delays?

Response: The model modifications for Mental Health involved extensive discussions with clinical experts and our actuarial consultant and have been completed. The strategic planning guidance which will utilize this data is going through VHA concurrence and will be released to our field planners in the near future. Strategic plans will be submitted to the Under Secretary for Health by the end of July 2005.

The Long Term Care model projections while completed is influenced by the changes in policy included in the FY2006 budget submission and we are awaiting final appropriation action before it is released.

b. How will you ensure that VA makes progress in eliminating current geographic inequities in veterans' access to mental health services, especially for those in rural areas?

Response: The prime outreach initiative for reaching veterans who live in areas not served by VA medical centers has been the creation of 680 community based outpatient clinics (CBOCs) throughout the country. Seventy-two of those CBOCs are in rural (7–99 civilians per square mile) or highly rural counties (1–6 civilians per square mile).

Accountability for delivery of mental health services rests with the VISN Directors. Performance contracts that specific outcome measures to achieve the desired mental health goals.

The VHA budget for the remaining FY 2005 and FY 2006 includes additional funding for VISNs that have a gap in their mental health services in CBOCs on the order of $24 million. This funding is centrally directed and targeted to areas of greatest need.

VHA is providing $9 million additional funding to provide more telemental health services to CBOCs and rural communities this next fiscal year so that specialty mental services, such as treatment for post-traumatic stress disorders, can be made available even in remote areas.

VHA has provided better access to our mental health intensive case management services by expanding the number of teams from 49 to 78 since FY 2000. Two additional teams are planned for this year and $4.5 million will be used to fund additional programs in FY 2006.

In order to fill other gaps in mental health services, in FY 2006, VHA will fund:

- $29 million for continued expansion of PTSD services and OIF/OEF mental health services;
- $10 million for augmentation and expansion of homeless domiciliaries plus $4 million for staffing augmentation and outreach for other homeless initiatives; and
- $20 million for continued expansion of substance abuse services.

As I'm sure you're aware, I have allocated $100 million additional funds for the expansion of mental health services in FY 2005 and an additional $100 million in funds in FY 2006. This funding is evidence of VHA's commitment to mental health services—and that commitment must be further appreciated given the context of the current budgetary constraints.

For the first time the Department has developed a Mental Health Strategic Plan that acts as a long term road map to guide the expansion of MH services throughout VHA. The plan is monitored for compliance by the Deputy Under Secretary for Health and the Deputy Under Secretary for Health for Operations and Management to assure that implementation is progressing. VHA is committed to meeting the mental health needs of veterans throughout the country, including rural areas.

c. Will VA evaluate the location of its mental health services to ensure that acute inpatient psychiatric services are collocated with other acute inpatient services when possible and that domiciliary and residential rehabilitation services are located as close as possible to the areas where veterans who use those services reside?

Response: A forecasting model to project the demand for acute inpatient psychiatric services has been developed. The model takes current utilization of acute inpatient psychiatric services as well as projected enrollees into account to determine future demand for services.

In addition to the forecasting model, VHA's Mental Health Strategic Plan has identified integration of medical and mental health care as a major theme. This integration of medical and mental health care for veterans is considered essential and forms the basis for development of a national plan for consistent provision of a full complement of care and supportive services in order to effectively treat veterans with mental illnesses.

Thus, while collocation of acute inpatient psychiatric services with other acute inpatient services is not specifically addressed in either the projection model or the Mental Health Strategic Plan, it is VHA's intention to assure that veterans with mental illness have access ito the full range of medical and mental health services including acute inpatient psychiatry and other acute inpatient services when necessary.

With regard to the location of domiciliary and residential rehabilitation services, again a forecasting model has been developed to project the need for these kinds of services. Use of this model identified gaps in residential rehabilitation services for homeless veterans in VISNs 5, 6, 7, 8, 9, 11, 16, 17, 19, and 22. Based on gap analysis, VHA issued a Request for Proposals (RFP) to invite these VISNs to apply for specialized funding for 3 years to activate Domiciliary Residential Rehabilitation and Treatment Programs (DRRTPs) for homeless veterans. Based on final review and approval of the applications submitted under this RFP VHA expects to provide

funding for 7 new DRRTPs this year (FY 2005). VHA also expects to make additional funding available for additional new DRRTPs in FY 2006.

d. How do you propose to meet the nursing home care needs of veterans with serious mental illnesses, who typically can not obtain that care in community nursing homes or State veterans' homes?

Response: We will continue to emphasize the provision of a spectrum of institutional and non-institutional geriatric and extended care services to all enrolled veterans, including those with serious mental illness. However, in a time of constrained resources, we are proposing to restrict the provision of long-term maintenance nursing home care to our highest mission priority, service-connected disabled veterans (Priority groups 'I - 3) and those with special needs not generally met in the community, such as traumatic brain injury or ventilator dependency. Patients with serious chronic mental illness have also been identified as one of the special populations for whom VA will provide long-term maintenance nursing home care. We are projecting that there will be adequate capacity to care for these patients now and in the future.

e. There is some controversy about how VA should balance short-term nursing care needs (such as post-acute care) with long-term nursing home care needs. What do you think VA's policy should be on this issue?

Response: Our policy is articulated in the FY 2006 budget submission. VA will provide short-term care for all who need it; long-term care will be limited to Priority Groups 1–3 and those with special needs, as cited above.

f. VA's increasing emphasis on non institutional long-term care services is encouraging for veterans who prefer to stay at home rather than enter a nursing home. Based on GAO's work, however, VA's estimate of how many veterans receive these services appears to be overstated. What steps will you take to ensure that VA provides a more accurate measure of workload for home-based primary care?

Response: VA's measure of access to care is "Days of Enrollment", a standard and accurate measure that is also utilized by the Centers for Medicare and Medicaid Services. VA does not concur with GAO that this measure overstates access. VA currently tracks three measures of access: days of enrollment, unique veterans served, and number of visits (GAO's preferred measure). We believe that these measures in combination provide us an accurate picture of workload and utilization.

POST-HEARING QUESTIONS FROM SENATOR JOHN ENSIGN FOR JONATHAN B. PERLIN, M.D., PH.D., NOMINEE TO BE UNDER SECRETARY FOR HEALTH

Question 1. Dr. Perlin, I understand there were some comments by members of the House of Representatives regarding the status of the future Las Vegas Veterans Hospital. Those comments alluded to the fact that the hospital was not a "done deal" and caused much concern amongst the Veterans community in Nevada. Please elaborate on your understanding of the status of the Las Vegas Veterans Administration Hospital?

Response: I am pleased to advise that $199 million in construction funding for a comprehensive 90 bed medical center in Las Vegas is included in VA's budget for FY 2006. Funding for a 120 bed VA nursing home will be considered for the FY 2007 budget, and the facility is currently scheduled to open in FY 2010. The total cost of the comprehensive medical center and long term care facility is $286 million. Construction of the project will begin in 2007. A project architectural design contract has been awarded to a joint venture between RTKL Associates, Inc. in Washington, DC and JMA Architecture Studios in Las Vegas, NV. A schematic design for the facility is currently under development.

VA is also planning to lease a minimum of four Community Based Outpatient Clinics throughout the Las Vegas Metropolitan Area to meet approximately 50% of primary care needs of Las Vegas area veterans. This will allow many veterans the opportunity to continue to receive their primary care close to their home.

The Las Vegas Metropolitan Area is one of the fastest growing in the nation. VA is committed to meeting the growing healthcare demands of Nevada's veterans.

Question 2. Dr. Perlin, rural healthcare is a vital importance to the veterans of northern Nevada. Those who live in Elko must travel to Salt Lake City, a drive of more than 5 hours, to get some of their healthcare needs met. I know that Elko failed to meet the CARES Commission population standard of 7,000, but isn't there something that the VA can do to address this situation?

Response: The VA Rocky Mountain Network (VISN 19) and the VA Salt Lake City Health Care System understand that Elko County, Nevada is an underserved area for VA health care. It is also located a significant distance from the nearest VA

Medical Center in Salt Lake City. VISN 19 plans to first address the need for three priority Community Based Outpatient Clinic (CBOC) sites that were contained in the Secretary's May 2004 CARES Decision (Lewiston, Montana; Cut Bank, Montana; and Salt lake City, Utah). The VISN planned to activate those three priority CBOCs in FY 2005. However, resources are not available to activate those clinics in 2005, and they may not be available in FY 2006. After the CARES priority CBOCs are activated, then VISN 19 will address plans for developing CBOCs in other underserved areas, such as Elko.

Question 3. Dr. Perlin, John Bright is currently the Acting Director of the VA Southern Nevada Healthcare System. Every Veterans' organization in my state is anxious to change the "acting" to "permanent." What is the status of this appointment?

Response: The Secretary recently approved the appointment of Mr. Bright into this permanent position. However, because Mr. Bright will be a new member of the Senior Executive Service, his proposed appointment had to be sent to the Office of Personnel Management (OPM) for final approval. VA anticipates hearing from OPM in the very near future. At that time, VA will notify your office and, following that notification and Mr. Bright's formal notification, will announce Mr. Bright's appointment to all our stakeholders in Southern Nevada.

Chairman CRAIG. Well, Doctor, thank you for your opening statement and the thoughts involved and, I believe, the sincere compassion expressed by that statement.

We are going to move to 5-minute rounds for questioning from myself and our colleagues as it relates to your service.

You assumed the role of Acting Under Secretary of Health in April of 2004. So you have had 1 year's experience on the job. Beyond your testimony, what have you learned during this acting status? What experience have you had that is going to obviously give you a leg up as the permanent Under Secretary of Health in this situation?

Dr. PERLIN. Mr. Chairman, during the past year as Acting Under Secretary, almost a year to the day yesterday, I have learned a tremendous amount. Your description of the enormity of the job is precise and accurate.

The responsibilities of our first mission of providing world-class health care for veterans are themselves enormous, but we have three other missions as well in statute: research to improve the health and well-being of veterans, an academic mission to provide services for veterans and to, in fact, meet the needs of the country, and to provide back-up to our partners in Department of Defense. I have learned the enormity of that mission.

I have also learned it is an incredible privilege, and I also learned that no one does this job alone. Working with the Secretary and the Deputy Secretary, with Congress, with veterans service organizations, academic partners, public and private sector, and receiving support from my family are all part of what is necessary to bring to this job to make sure that we provide the highest level of quality for veterans.

I have realized that we have a highly motivated workforce. I think the stories that we have all heard after the hurricanes of selfless sacrifice, the ability to deploy within 24 hours to support veterans and, in fact, the country are really quite remarkable and demonstrates the commitment of those who work in VA to veterans.

And I have learned, perhaps most importantly, that it is possible, despite the size of the organization, to make change. I believe we shared with you "12-for-12" strategic priorities, and in some abso-

lutely critical areas, such as moving forward and seamless transition, we have been able to make real progress in easing the new veterans' transition from active duty, or from reserve service, into VA.

Chairman CRAIG. Twelve goals for 12 months I think is what you called it, when you released that set of goals as you became the Acting Under Secretary of Health. Share with the Committee briefly, if you would, the 12 "for" 12 plan, what it was intended to accomplish, what it has accomplished, and frankly, what it has not. Where were the shortfalls or where are the shortfalls, as you see them, through that 12 and 12?

Dr. PERLIN. Well, thank you, Mr. Chairman.

The 12-for-12 was a 12-month action plan for improving care and service and effectiveness and efficiency throughout VA. It was really divided into four major components. One was mission improvement, and the most critical area, clearly, was seamless transition.

The other areas included clinical practice improvement. We had clinical process improvement in mental health care, in long-term care, and in acute care services specifically, and business process improvement. Improvement in our managerial efficiency so that we could serve more veterans with the resources that we are entrusted with and also serve as a vehicle for further strategic planning.

As I mentioned, the most critical was "seamless transition." And with the able leadership of Dr. Michael Kussman, we have established a permanent Seamless Transition office, and the first time ever, there are VHA social workers in military treatment facilities not only here in Washington at National Naval Hospital, and Walter Reed, but at Brook, Madigan, Eisenhower, Darnell, Evans, and 250 points of contact throughout the country.

We have facilitated our tighter relationship with VBA and with our colleagues in VBA. Last year, over 7,200 briefings have been done to literally hundreds of thousands of troops throughout the world, including at Landstuhl and on troop transport ships back to the United States.

I have mentioned some of the successes, but in every story, there is still work to do. And this is, indeed, a journey. It is not a work that is completed. We have further work to do, as you know, in terms of really tightening that relationship, especially around information with our partners in the Department of Defense.

There have been steps forward. In fact, just last month, Department of Defense placed four uniformed personnel at our major polytrauma centers. But there is further work to do in that regard. And we know that we have further work to do in terms of improving our business processes so that we can make sure that every last resource serves the veteran.

Chairman CRAIG. Thank you.

Let me turn to my colleague, Senator Akaka.

Danny.

Senator AKAKA. Thank you very much, Mr. Chairman.

Dr. Perlin, you have such outstanding credentials and experiences working in the Department of Veterans Affairs health care system. And because of the chat we had, which I consider very good, there was a strong understanding of who you are and what you want to be.

At the outset, I want to ask, as Under Secretary, would you be willing to fight for the health care that veterans are entitled to even when opposed by OMB or even the White House?

Dr. PERLIN. Sir, I believe that my job requires that I join the Secretary as the veterans' advocate within the Department of Veterans Affairs. That our job is to provide information that is accurate and supportive of telling the story of what services are required for the veterans it is our privilege to serve.

Senator AKAKA. In answers to my pre-hearing questions, you mentioned—and as we talked about—better technology to be one of your main goals. Please discuss this further and tell me more about your vision for the future of VA health care. Particularly, what will your other priorities be, and how you will lead VHA and work with the various networks and the costs of implementing these initiatives?

Dr. PERLIN. Well, thank you, sir, for the question.

First, in terms of some of the technologies, let me just note that many of these technologies build from the incredible electronic health record that VA has. This electronic health record allows us to be far more efficient.

The President's Information Technology Advisory Committee noted for the country, that in the United States, 1-in-7 hospitalizations occurs because previous records were not available, and 1-in-5 lab tests are repeated. That doesn't happen in VA, because every last one of our hospitals and clinics are computerized, and so we have that information.

So for the cost of $78 per patient per year, roughly akin to not repeating one lab test, we can provide safe, excellent care. That information is transportable. It is transportable across the country. So the ability to serve particularly rural veterans by placing devices for communication—communication not just in words or in text, but with device that connect to a telephone, such as for a heart failure patient, instead of having to come to the clinic, who can stand on a digital electronic scale and send the information of his or her weight back to the team at the clinic or hospital means that not only can we keep that patient from having to drive to the clinic. But in fact, rather than waiting for the patient to become ill and show up in the emergency room with fluid overload, we can actually use that technology to know that he or she is getting into trouble and call them, perhaps change their medication, or even go out to visit them.

So my vision for the future is that we use these technologies particularly to help those veterans who may not be rural, but are also isolated by virtue of extreme age or frailty or chronic illness or even mental illness and support them in the comfort of their community and the comfort of their families.

So I believe those technologies are absolutely critical for helping us transcend some of those boundaries.

Senator AKAKA. And as far as priorities are concerned, yesterday you mentioned the 50 Vet Center Outreach positions that you are adding. Can you tell us more?

Dr. PERLIN. Yes. Thank you, Senator.

I appreciate the discussion that we had, the opportunity for discussion at the hearing recently on seamless transition. And we had

a very positive discussion about the effect of 50 OEF/OIF (Operation Iraqi Freedom, and Operation Enduring Freedom) counselors, veterans themselves who would provide outreach to other servicemembers returning home.

And following that discussion with this Committee, we have expedited, (in fact, just on March 30th), signed a directive to hire 50 additional counselors for outreach to veterans. But with the permission of the Chairman, I would like to submit for the record an announcement that came out just yesterday, identifying these new positions and these new individuals.

Chairman CRAIG. We will make that a part of the record.

[The announcement follows:]

DEPARTMENT OF VETERANS AFFAIRS,
OFFICE OF PUBLIC AFFAIRS,
MEDIA RELATIONS,
Washington, DC 20420

VA TO HIRE 50 NEW OIF/OEF OUTREACH COUNSELORS

Washington—The Department of Veterans Affairs will hire 50 veterans of Operations Iraqi and Enduring Freedom (OIF/OEF) to provide outreach services to veterans returning from Afghanistan and Iraq. They will join 50 other OIF/ OEF outreach counselors already hired by VA.

"How we care for our returning combat veterans will define VA for decades," said Secretary of Veterans Affairs Jim Nicholson.

The outreach counselors will brief servicemen and women leaving the military about VA benefits and services available to them and their family members. They will also encourage new veterans to use their local Vet Center as a point of entry to VA and its services.

"We believe that our outreach to veterans is most effective when the message is carried by their comrades," said Dr. Jonathan B. Perlin, VA's Acting Under Secretary for Health.

Outreach counselors visit military installations, coordinate with military family assistance centers and conduct one-on-one interviews with returning veterans and their families.

The new outreach counselors will be located in the 206 Vet Centers operated by VA throughout the country, especially near military out processing stations. They will be hired for a 3-year period.

Vet Centers have been VA's first line of contact for troops returning from combat for every war since Vietnam. For 26 years, counselors have provided services for the psychological and social readjustment needs of combat veterans, and prevented possible development of more chronic and delayed forms of war-related trauma.

Vet Center employees have seen more than 16,000 of the 244,000 combat veterans VA estimates have left the service since the start of the Global War on Terrorism.

People wishing to receive e-mail from VA with the latest news releases and updated fact sheets can subscribe at the following Internet address: *http://www.va.gov/opa/pressrel/opalist—listserv.cfm*

Dr. PERLIN. Thank you, sir.

Senator AKAKA. Yes, and I just want to close by saying we are looking forward to your coming on board, and you will have to fill many now vacant positions. And we look forward to seeing these slots filled in the near future.

Thank you very much, Mr. Chairman.

Chairman CRAIG. Senator Akaka, thank you.

Senator Isakson.

Senator ISAKSON. Thank you, Mr. Chairman.

One observation, Dr. Perlin. Senator Jeffords and I are on the Health, Education, Labor, and Pension Committee and have had, I think, three hearings already regarding the FDA. And I just wanted to make the observation that the VA, from everything I

have gleaned from those hearings, is leading the United States of America in information technology and information management for patients, for pharmaceuticals, and for care.

And in reading your resume, I know you made a major presentation last year on what VA has done and what it can be as a foundation for the country. So I want to commend you, and the others at the VA deserve credit because I do think that harnessing information technology in health care can have more to do with lowering medical errors, improving prevention than any single thing that we can do. And the VA has been a leader in that. And I commend you on that.

Dr. PERLIN. Thank you, sir.

Senator ISAKSON. Second, I saw where you gave a presentation entitled, "No One Grows Old Saying, 'Gee, I Hope I End Up In A Nursing Home.'" And I have never seen a better title or a more prophetic statement.

We obviously are confronted with great challenges in terms of nursing homes, and looking at the VA stats, we have got over 40,000 veterans in institutional care. And we have got a number of them in non-institutional, but assisted care.

What I wanted to ask you, are there any, beyond telehealth and some of the other home respite programs, are there any incentives for caregiver benefits or caregiver incentives so that some veterans can be supported by the VA, but not be institutionalized?

Dr. PERLIN. Well, thank you, Senator, and thank you as well for the very close reading of the resumè.

It is imperative that we find ways to support veterans in their communities. I came to that statement after many conversations with my own patients who, in fact, particularly the World War II generation, are fiercely independent, but sometimes just having a little trouble. And that is the person who really doesn't need to be in the nursing home. That is the person who with some of the technologies, such as the digital scale for the heart failure patient that I just mentioned, can be supported in their home.

And your question about that, how can we work toward supporting the caregiver and not just the patient, is absolutely critically important because, as you know, if we institutionalize that patient, we may not only prevent that patient from aging successfully in his or her community, but even aging in the context of a spousal relationship of 50 or 60 years duration.

And a new program that VA is developing to complement the electronic health record is something called "My Healthe Vet," and it is the patient's portal to their health record. And it is really a support system, not just for the patient, but the patient's caregivers, be it a spouse or a child who might be helping to support that patient.

I think your other comment, this is important for the country, is absolutely accurate. Data from the Organization for Economic Cooperation and Development would suggest that the cost of institutional care in European countries with aging curve ahead of our own, the costs for one individual in their eighth decade, is equivalent to per capita gross domestic product.

So even if we didn't feel morally that it is the right thing to do as a country, we will have to confront these sorts of economic deci-

sions. So we are very appreciative of the ability to work with the Senate and with Congress to develop these new technologies, to provide a service for veterans and caregivers, but also I think something that may provide a greater service to the country as well.

Senator ISAKSON. Last month, I had the occasion to visit Landstuhl Regional Medical Center in Ramstein, Germany, where our wounded veterans from Iraq and from Afghanistan are coming, and one thing made a tremendous impression on me. With the new technology in body armor, the new technology in protection for eyes, and the new technologies that we are using in terms of delivering intensive care almost on the battlefield with our intervention teams, many, many veterans are being saved today from injuries in combat, and we are going to have more unique types of surviving veterans and their injuries.

Is the VA focusing—and are maybe some of these 50 you are bringing in—designed to help focus on the care that is going to be needed that is going to be so unique to the Iraqi conflict?

Dr. PERLIN. Senator, your question is right on target. If you survive a forward injury to a combat surgical hospital, or "CSH", you have a 98.3 percent chance of survival back to the States. But those improvised explosive devices, in the context of body armor, may leave someone with an injury that leads to amputation or blindness or hearing loss, spinal cord injury, traumatic brain injury, or all of the above in conjunction with the psychological trauma.

Those 50 outreach counselors help all veterans, but with the VA social workers that are at military treatment facilities, through video teleconferences with our VA medical centers, we are working closely with DOD to meet the needs of this newest generation and the newest injuries, physical and emotional, providing mental health services as well as aggressive rehabilitation.

It starts with the same sort of intention as restoring a professional athlete back to competitive play level.

Senator ISAKSON. Thank you very much, Doctor.

Thank you, Mr. Chairman.

Chairman CRAIG. Thank you, Senator.

Now let me turn to Senator Jeffords.

Jim.

Senator JEFFORDS. The Administration has proposed that a fee be charged of all new enrollees and the cost of prescription drugs increased for veterans. Thankfully, the Senate has spoken against these changes. But the fact that they are in the President's budget proposals indicates the depth of the problem confronting the VA.

It seems to me that given the expected level of funding, you are going to have to make some very difficult choices between cutting services to veterans or reducing the pool of veterans who will be served by the VA. What criteria will you use to make these decisions, and what do you think the core mission of the VA is?

Dr. PERLIN. Senator Jeffords, the policy proposals we understood very clearly from this Committee, the Senate that a number of them have not been well received. And we recognize that we have a tight budget going into this year.

But we presented a budget which, as a package, allowed us to project the ability to provide care to that entire population of veterans. That was a package, and we appreciate Chairman Craig's subsequent consideration of VA in light of some of the sentiment about the policy proposals.

I believe, and I think we have heard from the President and from the Secretary, that our first mission is to those who are most vulnerable. Those individuals who have illness or injury as a result of service, those service-connected veterans. Those with catastrophic disabilities, those who have statutorily defined catastrophic disabilities. Those individuals who are financially challenged, and critically now, those individuals who are returning from combat.

We need to make sure that those who are most vulnerable receive, first and foremost, the attention of VA. And I think I would be remiss to speculate before the decision is actually formed. It would be a hypothetical. But of course, Congress provided the Secretary with a prioritization, and any decisions that the Secretary might consider—again, absolutely hypothetical—would have to follow the guidance provided to us by Congress.

Senator JEFFORDS. What do you think is the core mission of the VA?

Dr. PERLIN. I think the core mission is really so eloquently stated in Lincoln's words, "To care for those who shall have borne the battle, and for his widow and for his orphan." And I think that the first mission is to those who are most vulnerable.

Senator JEFFORDS. What is our obligation to the veterans that fall outside of that core mission?

Dr. PERLIN. Well, this is an ongoing dialog. It is a public dialog about how far VA resources will extend in terms of serving veterans. In this country, there are 25 million veterans today. But the core mission are those individuals who have vulnerabilities as a result of their service, especially combat service.

Senator JEFFORDS. With respect to mental health, it has been estimated that about a third of the servicemembers returning from Iraq have some mental health problems. Members of the National Guard and Reserves are less likely to live near military installations and, therefore, will be turning to the VA in a large number to receive their health care.

I would assume that most VA rural health facilities, particularly the CBOCs, do not have mental health specialists on their staff. Yet the number of people depending on the VA for specialized mental health is likely to skyrocket. Research shows that early intervention and treatment can prevent the onset of more serious diagnosis, PTSD.

How does the VA propose to meet these increasing needs?

Dr. PERLIN. Sir, we have no higher mission than serving the needs of our returning combat personnel. In fact, 248,000 individuals have separated from service in OIF and OEF, and of those, about 50,000 have come to VHA, about 16,000, to a readjustment counseling center. And in fact, out of the 248,000, about 3 percent have been either diagnosed with, or are being evaluated for, PTSD.

A far larger number of individuals will have adjustment reactions, and one would view that as part of the normal continuum of

normal experience. It is when the symptoms are persistent that post traumatic stress disorder as a diagnosis would be entertained.

But even beyond the mission of meeting the mental health needs of these returning service personnel in 2005, we have, one, developed a new mental health strategic plan and, two, have added $100 million directly to mental health support to increase access, particularly in rural areas, and other areas where there have been disparities, to specialty mental health care services.

All CBOCs—Community-Based Outpatient Clinics—with over 1,500 patients have direct onsite mental health care. And all CBOCs have referral mechanisms for specialty mental health care. There are 144 PTSD programs in the fiscal year 2006 budget. The $100 million, which this Committee supported, being added to the $2.2 billion for direct specialty mental health services, will help to add 627 new personnel to support the needs of not only new servicemembers, but all veterans with PTSD, with mental illness, with substance use disorders, to extend outreach, and reduce disparity, and improve service.

Senator JEFFORDS. Several years ago, I introduced legislation to implement Medicare subvention, allowing the VA to be reimbursed by Medicare for care given to Medicare-eligible vets. Very serious negotiations ensued between the VA and the HHS.

It seems that we were close to making this happen, but time ran out before it was finished. And we have not gotten back to that issue since. What is your position on VA subvention, and do you see a role for closer cooperation between Medicare and the VA?

Dr. PERLIN. Senator, let me give you my personal views on this. It is my understanding that when eligibility reform was drafted, and was being considered, Medicare subvention or the ability for VA to collect for Medicare services from Medicare, that was part of the framing of how eligibility reform would work.

I know there has not been much discussion of this recently, and I know there have been some concerns in terms of the relationship to the Medicare Trust Fund. I would observe there is a recent study by Gary Nugent and Ann Hendricks in *"Medical Care"* that suggests that VA's care is 18 to 22 percent more efficient. And so, if that were to occur, it would be a good value.

A discussion that this body has had recently was something called VA Plus Choice or a VA Advantage program, which was a plan to develop a partnership with the Department of Health and Human Services, Medicare program specifically, to allow Medicare beneficiaries to exercise their Medicare benefit for services in VA. That program would require further legislative support.

But the discussions are ongoing, and I do agree with your premise that VA, the Department of Health and Human Services, and the Medicare program specifically, should work more closely in coordinating Federal health care supports.

Senator JEFFORDS. Well, thank you. And I would appreciate it if we could be in touch on the progress there. Thank you very much.

Chairman CRAIG. Jim, thank you.

Let us turn to Senator Salazar.

Ken.

Senator SALAZAR. Thank you, Mr. Chairman, and thank you again for your leadership of this Committee and for standing up for veterans.

Dr. Perlin, congratulations to you, and congratulations as well to your wonderful family. It is always good to see families here in support of the great honor that you are being bestowed on to serve our country. So congratulations to each member of your family, including your young son.

Let me ask first a parochial question, and that is with respect to Fitzsimmons and the effort to construct a new hospital for veterans at Fitzsimmons, can you please give me a quick update?

Do you share the Secretary's commitment on the construction of that hospital? And you know by now that it obviously is a major priority of Senator Allard and mine and the rest of the delegation. And give me a quick update on where we are on Fitzsimmons.

Dr. PERLIN. Well, Senator Salazar, first, thank you for your kind remarks. And thank you for your support of a replacement hospital in Denver.

I absolutely share the Secretary's enthusiasm. As you know, I combined my trip to the Association of Military Surgeons of the United States, AMSUS, in Denver with a trip to the Fitzsimmons campus to see how we could get back on track. And since that time, in November of last year, there has been a great deal of progress.

As you know, the Secretary's team has been working on this, and in fact, I recently had a conversation with the Surgeon General of the Air Force, Peach Taylor, and he continues to express his commitment to the sharing that is such an important part of this concept.

Further, there are obvious benefits by being a part of that campus: For example, the ability for us to share services, specialty services, capital intensive equipment, and the ability to partner, of course, with our Federal colleagues.

The limiting factor has been really determining a suitable piece of land, and I know we started initially with the idea of seeking 40 acres. A minimum footprint to allow for good spinal cord injury access and good nursing home access at ground level is about 28 acres or so. And I appreciate anything that you might do to assist us in coming to the ability to get started on what we believe should occur.

Senator SALAZAR. I appreciate those comments, and I very much look forward to working with you on that very important project for the West.

Second, let me ask you about rural health care and your views on how we might be able to help make sure that veterans who live far away from where we offer services are, in fact, served. And I have heard some of your testimony and read some of your remarks concerning telemedicine and other ways in which we would outreach to those veterans who live in remote communities.

For me, it is a personal issue when I go up into places like northwest Colorado and recognize that many of our veterans who live in those communities up there have to go back and forth 200 miles to Grand Junction to receive any kind of service. And there are many of us on this Committee, as well as my colleagues in the Senate, who have wanted to move forward and trying to make sure

that we are making much more of an effort in the creation of rural outpatient health care clinics that would serve our veterans.

I would like your thoughts generally on how we serve our veterans who are located in these remote areas of rural America, both generally and specifically with respect to the construction and creation of some of these outlying facilities.

Dr. PERLIN. Well, thank you for that question. It takes me right back to Chairman Craig's first question, what did I learn during this past year? I learned it is a very large country, and some areas of the country are really intensely isolated. And I appreciated that in Washington State and in Colorado as well.

When we framed the CARES review, we built into that some criteria to try to make care more accessible. We framed that we wanted primary care not farther than 60 minutes, recognizing that 60 minutes may be a few blocks in New York City or quite a few miles in the West. Ninety minutes to regular hospital care and 2 hours or the community standard to tertiary care.

We have made a tremendous amount of progress. And I think that the way we have proceeded actually demonstrates that the approach has been not only more effective, but more efficient. We have made a lot of progress by building these outpatient clinics that have allowed us to move to model of health promotion and disease prevention.

In fact, over the last 9 years, we have gone from less than 200 outpatient clinics to now, including the clinics that are actually onsite at facilities of medical centers, to 871. And that is about 704 as of today, that are offsite. They really do provide that access.

But no matter how many clinics we ultimately have, we will never be everywhere that veterans are. This is, as I learned, a huge country with many remote areas. And to augment that, the use of technologies are critically important. We have not only the capacity for telehealth but last year, did nearly 500,000 patient visits using telehealth technologies. Not only things like heart failure, but also telemental health—the ability to check in on patients with mental illness—that were very well received.

Those technologies allowed us to actually provide services in some areas that we have not traditionally had access, like Indian nations.

Senator SALAZAR. If I may, Dr. Perlin, because I see my time is up here on this question? I understand the use of new technology to make sure that we are doing the very best that we can.

In terms of the creation of additional facilities, I recognize the progress that the VA has made over the last several years. In terms of additional outpatient health care facilities, other than those that are currently authorized under the CARES process, what is your view? I mean, I think I heard somewhere that the statistic was that we currently are working on a list of 150 additional ones. But the question—and frankly in my State, both in northeast and northwest Colorado—we don't have a facility that would actually be within that list of 150.

And so, I am wondering what additional efforts you might have in mind with respect to those additional facilities that might be needed in Washington or Idaho or anywhere else in the country?

Dr. PERLIN. Sir, in short, the 156 that you refer to were those that were prioritized in the Secretary's CARES process. Beyond that, we review the needs locally, and it is really an operational decision within each network. And the ability to bring on new CBOCs is directly related to the resources that are available to support not only the capital development of the new clinic, but also the operation of that clinic.

So we try to balance the needs and the degree to which there is a veteran population and come to something that really supports veterans. In absence of that, we look to technologies and relationships with local hospitals and practices to try to find accessible support.

Senator SALAZAR. Let me just say that I very much look forward to working with you, Dr. Perlin, as we do outreach and make sure we are providing health care to our veterans who live in those far out communities.

Dr. PERLIN. Thank you.

Senator SALAZAR. Thank you, Mr. Chairman.

Chairman CRAIG. Thank you, Senator.

Now let me turn to Senator Patty Murray, from the State of Washington.

Patty.

Senator MURRAY. Thank you very much, Mr. Chairman.

And I want to join you and Senator Akaka and our colleagues in welcoming Acting Under Secretary Perlin before the Committee. Just let me say for the record that I think he has done a tremendous job during his tenure at the VA, and I really am impressed with his ability and his passion to serve our veterans. And I thank you very much for your service to this country.

We had a chance to meet yesterday and talk about a few issues. And obviously, the Walla Walla facility is one that is very important to me. It covers a three-State area, including Chairman Craig's, and serves 65,000 veterans.

We had a chance to talk about the fact that the CARES Commission was mistaken in their thinking that they should close that facility. They rejected that, and now we are working with the Committee to really put in place a facility that reduces the VA's pressure to maintain the 84 acres and the historic buildings as well as serve the veterans. And I appreciate your commitment to working with us to make sure that that is accomplished in a good way for everybody, and I just wanted to say that publicly.

Dr. PERLIN. Thank you.

Senator MURRAY. My first question really regards the CBOCs that we talked about as well yesterday. We have two areas in our State that, as Senator Salazar was just talking about, are very remote, that have been promised CBOCs. One in Wenatchee, where people actually have to go over a mountain pass to get care at a VA today, and one in the North Walkum area, where people have to travel more than 100 miles in a difficult area as well to receive care at the VA.

Both of these facilities have been promised, but we now understand that they are in jeopardy because of finances. And I wanted to ask you for the record this morning, I know that cost of establishing those is estimated at about $5 million. Can you tell me

what we need to do to make sure that these two essential facilities become a reality and when they might be available for veterans in these areas?

Dr. PERLIN. First, Senator, thank you very much for your kind words and the comments on Walla Walla, because the local access panels and further study really are intended to make sure that we have a good community partnership in finding ways to support veterans and the communities in the best fashion. I thank you for your support of that.

With respect to the clinics, after our discussion yesterday, I went back and reviewed VISN 20 and Washington State in particular and noted that in the CARES decision that north central Washington, Bellingham, and Centralia were the three that were prioritized there. And our goal is to balance those prioritized clinics and the needs of veterans in particular areas.

But as I mentioned to Senator Salazar, the ability to develop new clinics to augment the nearly 900 that we have now, 871 to be precise, is directly tied to resources. And capital construction of the clinics, unlike a major capital project, is part of the operational balance. And so, we will bring on those clinics as budget permits.

Senator MURRAY. Well, you have talked about the lack of resources several times now, and I know firsthand it is real. Washington State is home to six military installations, and many veterans choose to stay in Washington when they leave service. And in addition, the vast reach of the VISN 20 includes four States—Washington, Oregon, Idaho, and Alaska.

The number of soldiers from the Northwest serving on duty in Iraq and Afghanistan today is going to place a real burden on our budget when they return. VISN 20 is projected to be the fastest-growing network. Again, this year, they expect an 8 percent increase in enrollment, including a 5 percent increase in Category A veterans.

We know that the hiring freeze has been technically lifted, but according to our network director, he does not have a budget to hire. Attrition rates, he has told me, have slowed to a point that he is using his capital budget to pay for salaries and mandatory costs. He says he is not replacing equipment or upgrading facilities, and at this rate, he is only going to be able to hire one person to replace the five that leave.

Dr. Perlin, you have talked about lack of resources to accomplish all the things we do. Yet what I keep hearing here is that there is some kind of $500 million reserve in the VA's budget. Can you clear that up for me?

Why are we not using that $500 million? Is it phantom? Is it real? And why aren't we using it, when clearly CBOCs and other facilities are so essential to providing services for not only today's vets, but for those soldiers who are returning to us?

Dr. PERLIN. Thank you, Senator.

You know, the acquisition of capital equipment is balanced over the year. In terms of your network, for instance, you noted very high demands. If funds are spent right, they are really titrated to make sure that we don't end up not able to provide the services. We balance the capital equipment purchases with that.

There is not a $500 million phantom reserve that exists for any sorts of additional activities.

Senator MURRAY. Is there a $500 million reserve?

Dr. PERLIN. No.

Senator MURRAY. There is no $500 million reserve?

Dr. PERLIN. I don't know where that might have been suggested, but there is no $500 million reserve that is sitting there for future projects.

Let me be clear that there are CARES funds, the capital constructions funds—a different pot—that are not able to be converted. The 2006 budget calls for $750 million in capital construction, but that is a separate appropriation line that cannot be operationalized for other purposes.

But there is no—within operational dollars—$500 million reserve.

Senator MURRAY. OK. Well, Mr. Chairman, as you know, I am very, very concerned about the lack of dollars that we have for our veterans, particularly those who are returning. That is why I am talking, hopefully, with you and others about putting some additional money into the supplemental.

Because I believe that we have an obligation to these soldiers as part of the cost of war, and I am deeply concerned that we will not have the facilities available as they return.

Thank you very much.

Chairman CRAIG. Patty, thank you very much.

Let us turn to Senator Burr.

Richard.

Senator BURR. Thank you, Mr. Chairman.

Dr. Perlin, welcome. And as well, welcome to your family.

You should really be commended because I think you have brought a level of progress to health care at the veterans clinics through the integration of technology that has directly affected the quality of care. And I think that goes overlooked.

But I would also take this opportunity to share with my colleagues that many of the things that we do in telemedicine, many of the technological uses to deliver medicine today at the Veterans Administration, we still don't pay for in Medicare reimbursements. So some of the advances that we highlight and that we hear from veterans, the things that make their quality of life better, that make access to health care easier, we don't do that across the whole population.

And I think that is something that we need to sit down and look at long and hard, because if it works for them, why are we not doing it for the largest piece of health care that we have got in this country? And I think we have got a lot of progress that we can make.

On the question of technology, the VA plans to move to remote monitoring of diabetics in the veteran population. I commend you for that because I think we all understand that the ability in real time to watch the health of an individual is better, that our ability to regulate the insulin need is better in the remote case, and consequently, quality of care and the long-term effects of diabetes are reduced.

But the reality is that we have a segment of the population of veterans that are at an age that e-mail is not something that they do daily. Working the remote on the TV or programming the clock on the VCR is challenging. And relying on this remote monitoring as their only source of diabetes control will be a difficult transition. Share with me, if you will, how we are going to handle both of these worlds.

Dr. PERLIN. Thank you, Senator, for your comments and also thank you very much for the opportunity to discuss some of these technologies as they may apply more broadly to our country.

Diabetes is a great example because in our population, obesity is really becoming an epidemic. Surgeon General Carmona asked what the number-one public health threat was. The answer, to everyone's surprise, obesity and, as a consequence, diabetes. 7.3 percent of the American population has diabetes, and in VA, it is nearly 20 percent. And we learned from Surgeon General Carmona that 54 percent of today's military are overweight or obese. So diabetes is a huge issue in VA.

The goal with the new technology is actually to make it easier. Some of these new blood glucose self-monitoring meters, or glucometers, can be plugged right into the phone and just automatically push one button to send blood sugar readings to the patients care team. So I can tell you as a doctor, I have never had a patient with diabetes ever bring me a successfully completed log book. And the ability to actually check your sugar and just put it up to the phone, push one button, actually works pretty well.

In public libraries, I have noticed that there are two populations. There are young children using the Internet and there are older adults using the Internet, primarily for health questions. And that has actually been validated in the scientific literature. But I am pleased to be able to share with you that VA actually was recently noted in the Annals of Internal Medicine as the benchmark in the country for diabetes care.

And you are right. Some of these technologies may not work for certain individuals, but the ability to tailor it to the needs of each and every veteran, be it with new technologies or be it with high touch, low tech, is really how VA needs to be able to serve to be successful in achieving the highest levels of diabetes care.

Senator BURR. I appreciate it because I think what you said is the VA is not going into this blindly, saying it is this way or no way.

Dr. PERLIN. You bet.

Senator BURR. You will adapt it. Thank you.

Currently, the VA has targeted the construction of nine community-based outpatient clinics in North Carolina. We know the realities of the 2006 budget and how tight it is, and Senator Murray expressed the concern over our ability to service the entire population of needs that are out there.

Share with me, if you can—it is of great interest, and I would expect each one of us to talk about projects in our given States. It is particularly alarming to me because we are the State with the fastest-growing veterans population in the country. And I think you and I probably both agree that is not a trend that is going to

change in the next decade. Will you be able to fulfill that type of goal of nine new clinics?

Dr. PERLIN. Senator, thank you for the question.

North Carolina does have the fastest growth rate that I am aware of. Clearly, the ability to bring on clinics is dependent on the budget.

But part of serving veterans is not just building new clinics, it is using the resources that we have more efficiently to reach the veterans and use the facilities and resources that we do have in any situation, be it a new building, be it modernizing a building, be it new equipment. We make choices. All of us make choices, and our choices, we hope, are those that will serve the veterans best.

And in North Carolina, we are working aggressively with a program called Advanced Clinic Access to try to make sure that our clinics and our physicians and nurses and pharmacists are all as efficient as possible so that the access is as good as possible for veterans, even in fast-growing States like North Carolina.

Senator BURR. Last question, Mr. Chairman, if I can? I am sure you have been asked this. We will continue to ask it until we probably do the budget. Do you believe that the Veterans Health Administration will be able to accomplish its mission of providing health care to our Nation's veterans with the proposed 2006 budget?

Dr. PERLIN. The budget as proposed, with all the policies and the value of those policies, would work. If certain policies are not enacted, I think the Secretary would have to reconsider how we make adjustments to make sure that we do our job of meeting the mission.

Senator BURR. Thank you, Dr. Perlin.

Mr. Chairman, I encourage all of our colleagues to quickly move this nomination. Thank you.

Chairman CRAIG. Richard, thank you.

Doctor, I think you have heard a common theme of concern amongst all of us, and that is, of course, adequate resources to accomplish your mission, to sustain the quality of health care that we have built inside your system that you administer and will continue to.

I had three marvelous young soldiers in my office today. One has lost all of his eyesight in Iraq. One has lost two legs. The other one has lost one leg. And they are in transition and doing remarkably well. In fact, those who had lost their limbs had taken a leave from skiing to be in my office today to lobby me about some new approaches for transitional funding and insurance for them and their families as their colleagues and buddies go through similar experiences.

I thought at the time—I looked at one young man walking out of my office with a tremendous stride, but he had a prosthesis underneath that pant leg. You couldn't see it. You could hardly tell it. It appeared to be seamless, but if he hadn't had those long pants on, it would have been obvious.

I think that is the thing that concerns me the most in our search for seamlessness. Sometimes Government looks whole when you look at the suit. But when you start taking off the suit, all of a sud-

den you find that there are pieces under there that don't really fit or don't communicate or aren't coordinated.

And we have held several hearings. We will continue to pursue this very aggressively and openly, those relationships between DOD and veterans and Social Security, for that matter, for certain needs and others.

In that, resource coordination is going to be tremendously valuable. My guess is there will never be enough resource. But having said that, I will continue to pursue with you something that the Senator from Vermont talked about, Medicare subvention—an opportunity, a resource. If it works, if we can make it work. It is obviously moving dollars from one pot to another pot. It is Federal dollars, but still, at the same time, it is a potential resource.

I had a fascinating visit last night with the chief executive of TriCare West. And the work they are doing, they talked about the potential opportunity to have a relationship with the Veterans Administration for their particular clients as it relates to veterans, and that is something that I will pursue with them and ultimately with you.

Again, how do you create seamlessness in relationships, and how do you blend resources where oftentimes there is tremendous rigidity to do so for institutional bias or because of the law? And we will search those out over time as they become obvious to us and as we can work with you to do so.

I know that one of the fears I always heard with Medicare subvention was, well, gee, if Medicare starts paying, then Congress will back off from their obligation to the Veterans Administration. I don't sense that. And if we do it right, as you have said, there is an efficiency in the quality of care now being delivered by veterans health care that might actually save a few dollars here and there. And that is a tremendously positive approach.

We know the efficiencies and prescriptions and pharmaceuticals that have, as a result of doing it right, getting it down, repeating it on a daily basis, scope, size, magnitude, and therefore, savings as a result. Those are all very positive accomplishments.

So my guess is this will not be your last journey to Capitol Hill. We will anticipate your presence here as needed, as you have promised, and I know you will deliver on. And when you can't come to see us, I will come see you, as I am sure others of our colleagues will.

There isn't one person in this room or one Member of the U.S. Senate that is not fully Committed to the service and the effective relationships that need to be developed for the benefit of our veterans.

Do either of my colleagues have further questions that they would want to ask?

Senator Salazar.

Senator SALAZAR. Mr. Chairman, I have just one more question if you will let me.

Chairman CRAIG. Please proceed.

Senator SALAZAR. In my State of Colorado—I am sure this is the same reality in other States—there are concerns about State nursing homes. In my State, the President's proposed budget essentially would have required the closing of most of our State veterans nurs-

ing homes. And because of the work of the Senate and the budget resolution, I think it was $410 million that were added to help with some of these services.

My question to you, Dr. Perlin, is how do you foresee moving forward with respect to these nursing homes that would have been so affected by the President's proposals?

Dr. PERLIN. Thank you, Senator, for that question. And first, let me note that I appreciate the sentiment of this Committee on that proposal. And I had the privilege of meeting recently with the State directors of Veterans Affairs. I met with the directors of the nursing homes, and what I want to reaffirm, what I want to assure, is that VA absolutely supports the State Veterans Homes. They are an invaluable resource for an aging population. They do a phenomenal service, and they do provide that service very efficiently.

So I foresee working with those State Homes more progressively to make sure that we can together meet the needs of veterans who will benefit from those services.

Senator SALAZAR. Thank you, Mr. Chairman. And I have no further questions.

Chairman CRAIG. Senator, thank you very much.

Again, Dr. Perlin, thank you for being with us this morning. As my colleague Senator Akaka said, we will move as quickly and as expeditiously as we possibly can to change your status from acting to official.

Dr. PERLIN. Thank you, sir.

Chairman CRAIG. The Committee record will remain open for a short period of time for any additional questions that might want to be asked, at least through the balance of the day. And of course, I am confident that you will respond quickly to those.

Again, thank you very much, and the hearing will stand adjourned.

[Whereupon, at 11:18 a.m., the hearing adjourned.]

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