Strictly Speaking

U.S. Department of Veterans Affairs **March 2000 No. 55**

Office of Public Affairs **(202) 273-5730**

VA 2001 BUDGET PROPOSAL

STATEMENT OF THE HONORABLE TOGO D. WEST, JR.
SECRETARY OF VETERANS AFFAIRS
BEFORE THE HOUSE COMMITTEE ON VETERANS' AFFAIRS
February 17, 2000

Mr. Chairman and members of the Committee, good morning. I am pleased to present the President's 2001 budget request for the Department of Veterans Affairs (VA). The President's budget for 2001 uses a fiscally responsible approach to balancing the budget. Utilizing realistic and responsible funding levels, it puts our Nation on a path to eliminate the national debt in the year 2013, making our Nation debt free for the first time since 1835.

The President's request for VA reflects the largest discretionary dollar increase ever proposed for veterans' programs. It demonstrates his continued commitment to those who served our country with honor. Our budget proposes significant increases for each of VA's three administrations and all of our staff functions. These resources will allow us to continue to improve our ability to provide the highest quality service to our Nation's veterans—service they have earned through their sacrifices for America.

We are requesting approximately $48 billion, which includes $22 billion for discretionary programs, without collections, and $26 billion for entitlements. Our request for discretionary programs is $1.5 billion more than last year's enacted funding level. This request, along with additional resources agreed to by Congress and the Administration in 2000, reflects a two-year total increase of more than $3.1 billion, or 16.4 percent.

Our veterans are entitled to the best health care America can provide. In the past few years, we have transformed the hospitals run by VA to provide greater access for better care to more veterans. And with the funding in our Fiscal Year 2001 budget, we will continue this improvement.

The budget provides $20.9 billion, including $608 million in medical collection transfers, to provide medical care to eligible veterans. This represents a $1.4 billion increase over last year's level. VA plans to open 63 new outpatient clinics and treat 100,000 more patients in 2001 than in 2000, a 2.6 percent increase. This patient level is 24 percent above the 1997 baseline, which exceeds our goal of a 20 percent increase.

We are focusing our resources on improving veterans' access to VA health care and the services we provide them through newly established service standards and access goals. These are:

- New patients are to receive an initial or non-urgent appointment with their primary care or other appropriate provider within 30 days.
- Patients will receive a non-urgent specialty appointment within 30 days when referred by a VA practitioner.
- Patients will be seen within 20 minutes of their scheduled appointment.

Restructuring efforts made possible through the use of buyout authority will allow us to redirect an additional 1,500 full-time equivalent (FTE) employees to meeting these goals. Altogether, more than 2,200 employees will be dedicated to improving access and services. These FTE, along with planned management savings and an additional funding request of $77 million, will provide a total resource commitment of $400 million in this area in 2001.

To enhance VA's leadership role in patient safety management, we plan to spend $137 million to monitor and oversee safety issues and to comprehensively train all VA staff on a recurring basis.

We are also requesting an increase of $145 million to treat veterans with Hepatitis C. In addition, our budget would fully fund the $548 million needed to implement provisions in the Millennium Act dealing with specialized mental health services, emergency care, and extended care services—rather than depend on new collection authority generating $350 million. Consequently, this amount of collections will be returned to the Treasury.

Enhancing VA's patient safety management and reporting system will also improve the quality of care we provide veterans. It has been reported in medical literature that as many as 180,000 deaths occur in the United States each year due to errors in medical care, many of which are preventable. It will take dramatic action from every health-care provider, not only VA, to improve in this area.

VA has not only recognized the problem, but also recognized that it is the greatest opportunity we have had in a very long time to make dramatic improvements in the way health care is provided in our country.

We have acknowledged that it is impossible to correct or prevent errors without first accepting that they exist.

We are taking a systematic approach to solving the problem of patient safety, and to the way we deliver health care, to identify problems and develop solutions.

We have launched the National Patient Safety Partnership, an organization that has brought together Federal and private sector experts to join forces to address this problem.

We have recognized that change will require a team effort at every level of our organization, and we are committed to making that effort.

VA has led the Nation in identifying problems that result in medical errors. Our budget will enable VA to continue its world leadership in patient safety initiatives — benefiting not only veterans, but all Americans.

Our oversight of patient safety will be addressed through comprehensive monitoring at the national and local levels. We will be redirecting an additional 190 FTE toward patient safety enhancements, which means 500 FTE will be dedicated to this effort. Significant training, highlighted by a national center for patient safety, a quality scholars program, and 20 hours of biannual training for all full-time staff, will keep VA at the forefront of this important area.

In addition to basic clinical components funded through medical care, the 2001 budget request provides considerable support for the education and training of health professionals, and for VA's research programs.

In addition, we will increase the number of unique patients treated to 3.9 million, continue to enhance the quality of our care, and improve customer satisfaction.

Among our most important new initiatives are those designed to provide long-term care for veterans. These initiatives are linked to the provisions of the Millennium Act. The $350 million increase for these initiatives included in this budget will enhance home and community-based care programs for older veterans. It will also cover out-of-system emergency care for certain veterans.

VA is committed to formulating and implementing a well-designed pilot of VA-Medicare subvention. Currently, the Department of Defense is operating a three-year subvention demonstration in six sites, scheduled to end in December 2000, and the demonstration results may offer a useful lesson for us. We look forward to working with you again to pass a VA subvention model that does not jeopardize the Medicare Trust Funds or VA's ability to provide top-quality medical care to high-priority veterans.

We propose a legislative initiative to combine the Health Care Services Improvement Fund and the Extended Care Revolving Fund with the Medical Care Collections Fund (MCCF) to improve administrative efficiencies. This legislative proposal also allows 50 percent of medical collections to be returned to the Treasury as they are received until a level of $350 million is achieved. Returning collections in this amount will recoup Millennium Act funding appropriated in medical care, while maintaining an incentive to collect all government debt.

To continue VA's identification and treatment of Hepatitis C for veterans, we request an additional $145 million, which will increase the total funding level to combat this disease to $340 million. Also provided is funding to meet anticipated increases for pharmaceutical and prosthetic costs.

We continue to support a two-year spending availability of $900 million, less than five percent of our resources—excluding those funds set aside due to the deferred spending of medical equipment funds required by law. This proposal will provide VA with maximum flexibility regarding spending decisions and will promote cost-effective decision-making.

For Medical and Prosthetic Research, a total of $321 million and 2,883 FTE will support more than 1,942 high-priority research projects to enhance the quality of health care our veterans are provided. This level of funding will allow VA to continue our significant research in the areas of Gulf War veterans' illnesses, diabetes, Parkinson's disease, spinal cord injury, cancer, prostate disease, depression, environmental hazards, and women's issues, as well as rehabilitation and Health Services Research and Development field programs.

No other federally-supported clinical or research entity has initiated or completed such critical and ambitious research activities on behalf of America's veterans as VA. The Department expects the amount of non-appropriated research funding we receive from the private and public sectors to total an additional $497 million.

The Balanced Budget Act of 1997 and the Millennium Act allow VA to retain collections from third parties, copayments, per diems, and certain other sources. These collections are deposited in the MCCF and are available for transfer to the Medical Care appropriation. The funds remain available to VA until they are expended. For 2001, VA estimates more than $958 million will be collected, of which VA will retain $608 million.

In part, we will be able to do this by implementing reasonable charges to certain veterans for inpatient and outpatient procedures. In addition, we are in the process of ensuring that our collection documentation meets the requirements of the Health Care Financing Administration. We are also looking to improve our ability to collect funds from private-sector organizations. Additional Tricare payments from the Department of Defense, and increased copayments by veterans as provided for in the Millennium Act, are assumed in the collection estimate.

For the Medical Administration and Miscellaneous Operating Expenses, or MAMOE activity, we are requesting $64.8 million in appropriations and expect $7.2 million in reimbursements to support 584 FTE in 2001. This level of staffing will strengthen the functions, especially in the areas of quality assurance and performance management, needed to oversee VA's efforts.

Our veterans are entitled to have their claims for benefits processed correctly and in a timely manner. This budget will fund initiatives to process claims and education benefits in an electronic environment—allowing those who process claims to have complete and easy access to the information they need.

For benefits administration, the budget provides $999 million. The request reflects an increase of $109 million over the operating level enacted in 2000 and a one-time adjustment of $30 million from the Readjustment Benefit Account to ensure that all Vocational Rehabilitation and Employment administrative costs are funded from General Operating Expenses. Excluding this technical adjustment, this is a 13 percent increase.

These additional resources will ensure that veterans' compensation, pension, vocational rehabilitation and employment, education, and housing benefits will continue to be delivered while we move forward with our reengineering efforts. To help us process disability claims more efficiently, provide quality-enhancing initiatives, and continue our succession planning efforts, 586 FTE will be added to compensation processing.

VA's benefits programs are a tangible expression of the Nation's obligations to its veterans. For 2001, the Administration is requesting $22.8 billion to support compensation payments to 2.3 million veterans, 301,000 survivors and 864 children of Vietnam veterans who were born with spina bifida, and to support pension payments to 363,000 veterans and 253,000 survivors.

We propose to provide a cost-of-living adjustment (COLA) based on the change in the Consumer Price Index, to all compensation beneficiaries, including spouses and children receiving dependency and indemnity compensation. The percentage of the COLA is currently estimated at 2.5 percent, which is the same percentage that will be provided, under current law, to veterans' pension and Social Security recipients. The increase would be effective December 1, 2000, and would cost an estimated $345 million during 2001.

If Congress approves, VA will pay full disability compensation to veterans of Filipino forces residing in the United States who currently receive benefits at half the level that U.S. veterans receive. The cost of this legislation is estimated to be $25 million over five years.

The Administration is also proposing repeal of a provision in the Balanced Budget Act of 1997 which would preclude the government from making its October 2000 VA benefit payments on Friday, September 29, 2000, and instead require that they be delayed until Monday, October 2 (in fiscal year 2001). Under the law which would otherwise apply, when the first of the month falls on a weekend, payments are to be made on the Friday immediately preceding it.

In order to enhance educational opportunities for veterans and eligible dependents and provide various special assistance programs for disabled veterans, an appropriation of $1.6 billion is being requested for the Readjustment Benefits program.

Education benefits will be provided for about 480,000 trainees in 2001, including 309,000 training under the Montgomery GI Bill. This request includes funds for the annual Consumer Price Index adjustment, which is estimated to be 2.7 percent effective October 1, 2000, for education programs.

The heart of VBA's strategy for improved customer service is measurable success. This budget builds on critical indicators that have been instrumental in past performance. VBA is positioning itself to improve dramatically the delivery of benefits and services.

Mr. Chairman, as we all know, VA is not completing work on claims for compensation and pension benefits in as timely a manner as we would like. This is a difficult problem not easily or quickly resolved. More veterans are receiving disability compensation today than at any time in the history of the United States and, despite a declining veteran population, VA has an ever-increasing compensation workload.

Veterans are filing claims today for more issues or conditions than at any time in our history. The complexity of these claims has also increased dramatically. The level of effort required to evaluate a claim for benefits today is significantly greater than just eight years ago. This is because of both the increased complexity of today's claims and expanded procedural requirements occasioned by judicial review of our decisions. VA has embarked on an aggressive program to hire veterans service representatives who, when fully trained in these intricate procedures, will ensure veterans get the right decision on their claim the first time.

By the end of 2001, we expect to have 1,000 more employees to work on adjudicating claims than we had last year. Significant strides have been made in implementing our case management approach to customer service and in improving the information technology infrastructure that supports veterans' claims processing. For example, two years ago, a veteran would get a busy signal more than half the time he or she called our nationwide toll-free number; today, the percent of blocked calls is 5 percent.

The problems facing VA in overcoming its claims processing backlog were long in making and are systemic in nature. All of us are dissatisfied with the rate of our progress, but there is no "quick fix" to this problem. To do what is needed will take time, but we have put in place a foundation for success and are requesting a budget through which these goals will be achievable.

Our vision for VBA emphasizes accurate and timely claims decisions, along with a high level of customer service and satisfaction. To reach those goals, VBA's 2001 budget request is $999 million and 11,824 FTE. This represents an increase of $109 million and 287 FTE above the 2000 level, plus a one-time adjustment of $30 million from the Readjustment Benefit Account for Vocational Rehabilitation and Employment administrative costs.

By combining this increase in the number of employees with positions available due to efficiencies in other areas, VBA will be able to increase its number of personnel in claims processing and associated initiatives by 586. This will result in a 20 percent increase in adjudication staffing since 1999.

This budget continues to include funding for a pilot project, *Virtual VBA,* which will allow VA to process veterans' claims in an electronic environment, eventually eliminating the now paper-intensive and time-consuming manual claims process. When fully implemented, it will provide for complete access to information by anyone with access to the new system.

In addition to the electronic claims processing pilot project and increased FTE, VBA seeks funding in the amount of $31.1 million for a number of other C&P initiatives including:

- The expansion of our Systematic Technical Accuracy Review (STAR) Program in order to obtain current and diagnostic information about the accuracy of the work being produced at field stations.

- The Systematic Individual Performance Assessment (SIPA), a new initiative designed to complement the on-going STAR program, which will bring performance assessment and accountability to the journey-level employee. This will help keep fraud from occurring and will improve oversight of individual decision-making accountability.

- Training and Performance Support Systems (TPSS), an ongoing multi-year training initiative for employees working in the area of compensation and pension. The effectiveness of this training has been established and it substantially improves the accuracy of the work of those who complete it.

- Initiatives to assist in replacing our antiquated payment system and provide various improvements to existing technology used in this environment.

Funding is included for the enhancement of education activities intended to improve stakeholder and customer satisfaction. Building upon the EDI/EFT initiative, funding is included for The Education Expert System (TEES), an umbrella project that will expand our achievements in the area of electronic data exchange and funds transfer, and will make changes to the application used by schools to transmit enrollment information to VA.

This budget contains several initiatives designed to provide much needed improvements in service and accountability to VA's housing program. Included is funding to redesign our Loan Service and Claims processes in order to automate routine activities. Funds are also provided for an ongoing effort to consolidate guaranteed loan servicing at the nine Regional Loan Centers. Other projects include providing a redesign of the Construction and Valuation system; continuing the consolidation of the mortgage loan accounting functions to one centralized location; and enhancing the Lockbox Funding Fee system and a system to provide on-line determinations of eligibility for loan guaranty benefits.

Funding has also been included to support several areas of service that the Vocational Rehabilitation and Employment program has sought to strengthen. These initiatives are designed to improve communications, emphasize outreach, increase access, improve case management, and emphasize the program's central goal of finding appropriate employment for our veterans.

Mr. Chairman, issues regarding the Department's responsibility to procure for claimants the evidence necessary to establish their eligibility for disability and death benefits are also of concern to many. What responsibility do claimants, and those advocating on their behalf, have to first demonstrate their claims are plausible before significant Government resources are devoted to the claims' further development? Should the Department's obligation be the same regardless of a claim's plausibility, or should VA resources be devoted to those claims most likely to prove meritorious? The answers will directly affect our ability to award benefits in a timely manner to deserving claimants.

On December 2, 1999, we published for public comment a notice of proposed rulemaking concerning well-grounded claims and VA's duty to assist claimants. Consistent with currently controlling judicial precedents, the regulations we have proposed would include important exceptions to a general rule that claimants must present plausible claims before the Department's duty to assist arises.

First, under the proposed rule, there are certain types of assistance VA would provide without regard to whether a plausible claim had been submitted. VA would routinely procure service medical records in claims for service-connected disability or death benefits, and would obtain records of any VA medical treatment identified by a claimant.

Further, if VA determines a claim is not "well grounded," which is the legal term denoting plausibility, a claimant would be notified of the types of evidence they would need to present to make it so. In addition, our proposal exempts certain claimants from the well-grounded-claim requirement: those whose claims are filed within a year after service separation and certain specific categories of others, such as the terminally ill and those unable to afford medical treatment, for whom the burden of producing evidence may be especially onerous.

Within the dictates of current law, we have attempted to strike an appropriate balance between the obligations of claimants for Federal funds and their claims representatives and those of the Government they honorably served.

We are hopeful that, with input from veterans and their representatives, we can develop a final rule that will be both acceptable to veterans and administratively feasible. Should Congress judge the outcome of this rulemaking unacceptable and contemplate shifting more of the evidentiary burden onto the Department, we ask only that consideration be given to the resource and performance issues, which would necessarily accompany such a change in law.

Our veterans deserve a dignified and respectful final resting place. The final resting places we provide for them—our Nation's VA cemeteries—are national shrines and must be maintained in a way that does honor to the men and women who are buried there.

The budget requests $110 million, $13 million more than the 2000 enacted level, for the operation of the National Cemetery Administration (NCA). This 13 percent increase will reinforce our national shrine commitment by beginning an extensive renovation of the grounds, gravesites and grave markers at cemeteries where the most need exists.

New national cemeteries at Albany, NY; Chicago, IL; Dallas/Ft. Worth, TX; and Cleveland, OH will be fully operational in 2001. We will begin master planning on sites in Atlanta, GA; Detroit, MI; Miami, FL; and Sacramento, CA.

One of VA's strategic goals is to assure that national cemeteries are shrines dedicated to preserving our Nation's history, nurturing patriotism, and honoring the service and sacrifice veterans have made. In order to achieve this objective, it is necessary for NCA to address some deferred-maintenance needs. Improvements in the appearance of burial grounds and historic structures will be accomplished with an additional $5 million requested in this budget.

VA estimates that the annual number of veteran deaths will peak in the year 2008 before beginning to decrease. Consequently, NCA's workload is projected to rise during that period. NCA is preparing for this increase by planning for the construction of new national cemeteries, extending the service life of existing cemeteries, and encouraging states to build state veterans cemeteries.

This budget includes funding and FTE to address increasing interment and maintenance workload at the national cemeteries, including the high rates of increase in interments during the first years of operation at the new cemeteries just completed. The budget also includes planning funds in the Construction, Major Projects appropriation to continue the development of additional new national cemeteries.

VA is asking for $226.5 million for the Office of the Secretary, six Assistant Secretaries, Board of Veterans' Appeals, Board of Contract Appeals and General Counsel. This request, along with $4.4 million associated with credit reform funding, will provide us a total resource level of $230.9 million.

Compared to last year's appropriation, the 2001 request is $20.3 million higher. The budget authority, along with $53 million in anticipated reimbursements, will provide for total obligations of $280 million in 2001. FTE will decrease by 93 in 2001 from the 2000 current estimate of 2,528.

We are requesting $45.9 million in funding for the Board of Veterans' Appeals for 2001. The Board's marked improvement in timeliness in making decisions on veterans claims, its increase in productivity, and its reduction of the appeals backlog from 1995 through 1999 have exceeded our most optimistic expectations.

The budget request will give us the opportunity to continue to decrease the amount of time it takes to process veterans' appeals. BVA and VBA have adopted a joint performance indicator that is a system-wide measure of how long it takes to resolve an appeal made by a veteran. In 2001, we project it will take an average of 650 days. In 1999, it took an average of 745 days.

We are requesting $56.6 million for the Office of the General Counsel. This would include $47.6 million in budget authority, and an additional $9.0 million funded through reimbursements under the MCCF, the Credit Reform statute, and other reimbursable authorities. This level of funding is essential if the office is to continue to meet the increasing demand for legal services required by VA's three administrations, and if it is to keep pace with its representational responsibilities at the Court of Appeals for Veterans Claims (CAVC).

Increased funding for the Office of the General Counsel will also permit us to address rising demands for representation of the Department in workplace disputes.

For the Office of Information and Technology (OI&T), we are requesting $30.9 million in total obligations and 195 FTE, including $22.3 million in budget authority (156 FTE) and reimbursements of $8.6 million (39 FTE). These resources would enable OI&T to continue to support information technology policy, program assistance, VA capital planning, the nationwide telecommunications network, the VACO campus office automation platform and local network, and other efforts. The Austin Automation Center is separately supported by VA's Franchise Fund.

VA successfully began the Year 2000 without any significant Y2K incidents. VA benefits were paid on time and our health-care facilities remained open throughout the date rollover. Having met the challenge of Y2K, our next priority is information security.

In early 1999, VA initiated a Department response to the General Accounting Office (GAO) and Inspector General recommendations on the need for a strengthened VA information security program. A Department-wide working group created a security plan for investment of $83.3 million from 2000-2005 with funding to be redirected from completed Year 2000 efforts.

The plan, which GAO commended, is a comprehensive approach to managing risk through continuous risk assessment, incident response processing, policy development, workforce education, virus protection, intrusion detection, and strong centralized management and oversight. Immediate undertakings have resulted in the establishment of a national Critical Incident Response Capability system, which tracks security incidents; the initiation of a Department-wide assessment of risk; piloting of Web-based workforce security awareness training; and the issuance of strengthened security policies for high-risk areas.

For 2001, the Office of Financial Management (OFM) is requesting $30.9 million in total obligation authority and an average employment of 229. This request includes $29.1 million in budget authority and $1.8 million in reimbursable authority. These resources will allow us to continue our current level of operations and sustain efforts on critical initiatives underway. Reimbursements will fund financial operation and program reviews, and will allow us to provide assistance in financial policy development and oversight.

The requested budget authority also includes $2.6 million toward implementation efforts of a new integrated VA core Financial and Logistics System to replace the current financial management system and its interfaces. OFM will coordinate the Department's investment in this area. In 2001, the total investment of approximately $57 million will fund specific tasks for the acquisition (Phase III) and the prototyping and implementation (Phase IV) phases of the project.

We are requesting $13.9 million and 65 FTE to support the activities of the Office of Planning and Analysis (OP&A). With these resources, OP&A will continue to facilitate the Department's strategic planning process; provide actuarial and analytical support to VA program offices; conduct statutorily required program evaluations; coordinate corporate management improvement activities; and support the development, analysis, and review of issues affecting veterans' programs.

Funding increases for 2001 will support expanded analyses and reports of data collected in the National Survey of Veterans, which will be conducted in 2000. Additional funding will be used to enhance data development and actuarial services so that VA program offices and others will have available more sophisticated demographic and socio-economic information about veterans. This will improve our service delivery planning.

Increased funding will also support a continuous environmental scan process, including stakeholder consultation sessions and focus group meetings, and an ambitious schedule of program evaluations mandated by Title 38 and the Government Performance and Results Act.

The Office of Human Resources and Administration (HR&A) is requesting $82.8 million in total obligation authority and an average employment of 579 FTE. The requested budget authority for HR&A is $51.4 million.

Included are requests for additional resources to carry out several initiatives, such as developing and implementing strategies to prevent discrimination complaints; developing a Departmental workforce succession planning and decision system; conducting the Department's next One VA organizational assessment; conducting VA's next Human Resources conference; and maintaining and testing the Department's Continuity of Operations Plan for assuring essential emergency services.

The total figure for HR&A reimbursements is $31.4 million. This includes $27.8 million and 260 FTE for the Office of Resolution Management (ORM) and $3 million to complete development of the department's HR LINK$ personnel payroll system. In 2001, the Department is again requesting that the operations of ORM and Office of Employment Discrimination Complaint Adjudication (OEDCA), located in the Office of the Secretary, be funded through reimbursements from its customers.

In summary, a total appropriation of $1.062 billion is requested for General Operating Expenses (GOE): $835 million for VBA and $226.5 million for General Administration in 2001. This funding level, combined with $168 million of administrative costs associated with VA's credit programs, funded in the loan program accounts under credit reform provisions; $9.8 million in reimbursements from the compensation and pensions account for costs associated with the implementation of the Omnibus Budget Reconciliation Act of 1990 as amended; $36.5 million from insurance funds' excess revenues; and other reimbursable authority, will provide $1.359 billion to support operations in the GOE account.

Our Franchise Fund completed its third year of operations on September 30, 1999. The six lines of business, our Enterprise Centers, are proving to be very successful. Sales to federal entities have dramatically increased since our initial year of operations in 1997, from $59.1 million to $97.3 million. The 1998 financial statements of the

Fund were audited by a private sector CPA firm. The audit resulted in an unqualified, or clean, opinion. On October 1, 2000, the Shared Services Center (SSC), which will support the implementation and operation of the HR LINK$ personnel payroll system, will join VA's Enterprise Centers.

The 2001 request for the Office of the Inspector General (OIG) contains total resources slightly over $49 million. The request includes direct budget authority of $46.5 million and planned reimbursements of $2.6 million, which supports average staffing levels of 369 and 24 positions, respectively.

This funding provides OIG with an increase of $1 million for nine positions. The request will assist OIG in expanding oversight in the quality of health-care services rendered our veterans, identifying internal control vulnerabilities in benefit payment processes, and detecting fraud through extensive review and analysis of VA databases and matching initiatives.

We are requesting new budget authority of $309 million for the Department's construction programs. Our request provides funding for two major construction projects and another $10 million for an effort to assess our medical infrastructure needs for the future. A 10 percent increase above last year's requested level is included for minor construction and the grant programs for state veterans' nursing homes and cemeteries.

We are requesting new budget authority totaling $62 million for the major construction program. The major construction request includes funding for a seismic corrections project at Palo Alto, CA and a gravesite development project at Ft. Logan National Cemetery in Colorado. An additional $10 million is requested in planning funds to continue the Capital Asset Realignment for Enhanced Services (CARES) studies. Congress initially provided $10 million to begin these market-based assessments of health-care requirements and capital needs in 2000. The 2001 request also includes planning funds to continue the development of four new national cemeteries, to be located near Atlanta, GA; Detroit, MI; Miami, FL; and Sacramento, CA.

Additionally, we are requesting new budget authority totaling $162 million for VA's minor construction program. The request will be used to make improvements throughout the Nation to our medical centers' ambulatory care settings, patient environment, and aging infrastructure. Funds have also been requested for nursing home care, clinical improvements, correction of code deficiencies in existing facilities, and the elimination of fire and safety deficiencies at our facilities.

Funds requested in the minor construction budget will also support VBA and staff office construction requirements, and gravesite development and improvements at existing national cemeteries. In addition, as a result of the expanded authority provided by the Millennium Act, minor construction funds may be used to make capital contribution payments for enhanced-use lease projects such as the new regional office building at Milwaukee, Wisconsin.

The 2001 request of $60 million for the Grants for the Construction of State Extended Care Facilities will provide funding to assist states in establishing new nursing homes and domiciliaries or renovating existing facilities. The 2001 request of $25 million for the Grants for the Construction of State Veterans Cemeteries will provide funding to assist states in establishing, expanding, or improving state veterans cemeteries.

Mr. Chairman, for 224 years, America's men and women in uniform have brought a record of security and peace to the North American continent that is unmatched in the history of the world.

I believe this budget meets the needs of the Nation's veterans and lives up to the commitment we have to them.

I want to thank the members and staffs for your continued interest in our Department's needs. I look forward to continuing to work with you on behalf of our Nation's veterans and their families.

I also want to thank the veterans service organizations for the vigorous efforts they have made on behalf of veterans during the appropriations process, and I look forward to continuing to work with them on these issues in the future.

Thank you for your time, and your consideration.

REHABILITATION RESEARCH – NO REASON TO HOLD BACK

CHRISTOPHER REEVE
VA REHABILITATION RESEARCH AND DEVELOPMENT CONFERENCE
CRYSTAL CITY, VIRGINIA
February 21, 2000

Dr. Mindy Aisen, M.D., Director of VA Rehabilitation Research and Development Service, introduces guest speaker Christopher Reeve:

We are presenting you with a plaque, and I'd like to read it to everybody. The Department of Veterans' Affairs Rehabilitation Research and Development Service extends its sincere appreciation to Christopher Reeve in honor of his personal commitment to research on behalf of persons with disabilities.

The Christopher Reeve Paralysis Foundation and its predecessor, the Christopher Reeve Foundation, have successfully challenged the community of scientists studying spinal cord injury to push the field into the future, offering the possibility of true hope, not just for better care but for a cure. As a leader with vision, an articulate thinker, and a tireless advocate, Christopher Reeve has advanced the field of spinal cord injury research and serves as an inspiration not just to others with a disability but to us all.

***Mr. Reeve*:** Well, thank you very much, everybody, and Dr. Aisen. It's always interesting to me -- if I receive a plaque -- and it's happened a couple of times -- to hear such nice things about you while you're still alive. It's a nice surprise. They usually will talk about you after you're gone, but to hear such words of praise now, it's really meaningful.

I'm very glad to be sitting here talking to the choir that already is singing the right song. So many times I have to speak to groups who basically have an adversarial position to what I'm talking about and to what all of you believe. The whole VA system today is a model of what research can and must be. And when I look down the list of accomplishments of various centers and how proactive it is, I just rejoice.

I think my involvement in research and in rehabilitation came in June of 1995 when I arrived at Kessler in New Jersey, one of the best rehab facilities in the country. I was given a spinal cord manual, and of course I was not particularly interested in studying it, because there were things in it I'd rather not know about.

But the first thing I noticed is that it was written in 1990, and it makes no reference whatsoever to people with an injury above C4, and the real reason for that is

because most of them didn't live or if they did live, the idea was nothing could be done for them. Well, that was really the thing that made me really angry, and anger can fuel progress and change if you don't let it get the better of you.

It's very difficult to be marginalized; to say, well, up to this point, people with an injury above C4 simply just didn't live or weren't even worth dealing with. And there was one terrible case of a woman who was a C2, a vent-dependent quadriplegic who was at home. She had 24-hour a day nursing care, but the nurses came from an agency, so many of them would come basically not knowing the patient, just showing up to meet the insurance requirements.

One particular nurse came to do the night shift, and she's somebody who had, unfortunately, a drinking problem. The patient, the woman, was in bed asleep. The nurse was downstairs, and the patient had a pop-off -- the ventilator hose came off. The alarm sounded on the vent. There was a monitor system downstairs, but the nurse had basically passed out cold and did not respond to the alarm, and the patient suffocated and died.

Believe or not, the defense's argument in terms of trying to reduce the settlement was to say she had no quality of life anyway. And this information came to me, and I volunteered to testify at the trial. And they settled out of court the next day.

So, I think the very idea that a defense attorney could go to sleep at night knowing that he was going to go into court and use that defense -- sure, every defendant is entitled to the best defense, but at some point your conscience has got to have a heart.

I think the answer is kind of like building the transcontinental railway, and that is let's say all the great brains, all the researchers on every condition involving the central nervous system -- the brain, the spinal cord -- they start researching on the West and head East. Patients have to start in the East and head West, and their job, our job, is to be in the best possible physical shape so that when we meet in Utah or wherever, halfway across the country, assuming that the tracks actually do meet and we drive in that golden spike, there is going to be the connection that will allow the patient to have a complete life and the best possible life. That really is the symbol for the achievement that has to be made -- researchers and rehab specialists moving towards each other in a new way.

So, just to briefly take you through my own story, when I was first injured, I could only move my jaw. And gradually I could move my head. And first I was told that I was a C2 Complete. This was a completely erroneous diagnosis, because it turns out I have complete sensation all the way to the bottom of my spine, and that means a lot. I also have the ventral side of my spinal cord — the side that controls movement is completely in tact — so that I just have a 25-millimeter lesion on the dorsal side at C2 and that secondary damage did not go below C3. These are all very encouraging signs, and that helps give me the motivation to go to work to improve all that.

And I was told, to begin with, that I would never be able to breathe on my own. And for the first year or so it was true. And then I just decided I can't -- I just can't — accept that. Now, you need C4 innervation to breathe, but what happened was I started when I was at Kessler, just before I left, and much to my surprise I was able that first day to breathe for about four minutes. I used my neck; I used my shoulders; I used everything just to try to suck that air in.

Well, let's fast-forward now to nearly five years since the accident. Now, I'm working with two specialists from the University of Florida at Gainesville, and believe it or not, they believe that I now have enough C4 innervation that without having to go away to an institution and stay there for months and months and months, only trying to breathe and having no life, that I can use their training method, which is absolutely state-of-the-art, and if I keep going the way I'm progressing now, I'll be off the vent sometime later next year.

And that is simply because I, frankly, was unwilling to accept the idea of staying chained to this hose. They have such a progressive attitude that once they realized I had ascended to the point where I have C4 innervation, they just volunteered. They just contacted me and decided to help.

In another case two years ago, I had two blood clots behind my knee, and they were right in the same spot, one right after the other. And, of course, that's the side I have feeling on, which made it pretty painful, pretty unpleasant. I was put on Cumadin, and the blood clots eventually dissolved, but I was told that the vein would harden, and there would never be adequate circulation there again.

But by using FES (electrical) stimulation, by riding an exercise bicycle, by standing on a tilt table, by doing treadmill walking therapy, the next time I went back for a doppler and an ultrasound in that area, the blood flow was back to normal. I have completely normal circulation and no pain behind the knee.

And then the best thing to ever happen was I was introduced to Dr. Reggie Etherton at UCLA. He has pioneered treadmill walking therapy for spinal cord patients. The idea is that the brain really does not provide a lot of information to the legs in order to walk. In other words, it doesn't require heavy, heavy thinking to walk. He believes that there is energy and memory stored in the spinal cord that can be used.

He had never worked with a patient with my level of injury, but I guess just to humor me he let me try. Well, I was put into a parachute harness, pulled up onto the treadmill, and immediately passed out, simply because I had never gotten up that quickly before. So, I said, "No, no, no, no, no, let's go again." And this time they pulled me up and started the treadmill right away, and I was fine. And all the assistants needed to do was to plant my feet so I didn't twist an ankle.

But the very first time, I walked. It was documented both by video and also by computer. So, I have a tape at home of this little green guy walking along, and there's definitely a bounce to his step, and it looks like he could skip any minute for joy. And that was me, first time.

Once again there's evidence of somebody saying, "All right, we've never tried it with somebody at this level before, but why not? Why not see where it could go?" And that is the attitude that we have to have. Forget the limitation, throw away the handbook, and go and see what can be done.

I was very fortunate, because when I came back, Dr. Aisen set a program where I could go once a week and use the treadmill. It's not ideally suited for spinal cord patients, because you really need a system of bungee cords, and that's not available; in fact, the machine is in a tiny, cramped little room when it should be out in the middle of the floor and used for outpatients as well as stroke and spinal cord patients in the hospital.

But I want to tell you what it did for me. It reduced a bad case I had of heterotrophic ossification (HO) in both hips; completely eliminated it on the left side, and reduced it by 75 percent on the right side. And then a bone scan was done, because as you know, one of the things a spinal cord victim has to fear the most is osteoporosis which will eventually make it impossible to stand. So this bone scan was done. First, they took a core group sample of ten individuals of my general description, in terms of age, height, weight, et cetera. They did a bone scan on them, and they all scored 100 percent. And then, after I had been training for quite some time at Berg, they did a bone scan on me, and I scored 120 percent. And this is clearly because of the work on the treadmill.

Also, in terms of getting rid of HO and keeping the bone density strong, you get a cardiovascular workout and, clearly, getting the patient up and moving is one of the most important things you can do, and it's a crime that it's not available for everybody.

This is where insurance comes in. When I went home from Kessler, it was agreed that a physical therapist would come to the house twice a week, but the insurance company would only pay for him to do work down to my shoulders, because, at the time, I could only move my shoulders. And I said, "What, at 75 bucks a pop the guy is going to come over and move my shoulders? My staff could do that." I mean, shoulder shrugs? I'm not going to pay for that. So, he was a very nice guy, but we got rid of him immediately.

We went on to do our own program and, fortunately, a couple of my aides are physical therapists who have been in school for physical therapy. And we put a whole program together which, as I said, involves FES, the tilt table, the treadmill, the bike, and also diet, all of these things.

My goal, psychologically, I think is similar to most patients. Whether or not you believe your recovery is going to come is sort of like personally my relationship with God. I'm not sure I believe in God, but I'm going to behave as though he's watching. And I think that that's the same thing you should do with physical therapy. In other words, there's not going to be a magic bullet, but all the ingredients, I firmly believe, are there.

That's why I love the excitement about the (Superbowl) ad. Researchers were asked, "Is this irresponsible?" And they said, "No, it's a motivating vision." And you'll notice in newspapers or TV commentary, there's not one doctor, not one scientist, not one researcher has come out and made an accusation or said anything negative about the ad. Unfortunately, what happened is that because it played during the Superbowl, everybody was talking at their Superbowl parties and probably missed the beginning dialogue which makes it absolutely clear this is sometime in the future. Could be 2007, 2010, who knows?

But the scientists say now it's not a question of if, but when. So, if the patient knows that, and we do know that — and with the work that's being done by the VA system all across the country, it seems to me you all understand that — it's not about preparing a patient just to go home and accept his condition.

Rehabilitative therapy right now is about preparing for a new age, a new future, and anything is possible. And if it doesn't happen, what's the worst? You have a much healthier patient. So, there's a win-win situation there. If it doesn't work out, if all the therapies that are being worked on now run into problems or don't work in humans, I'm still going to be one very healthy patient. I'm going to live a long and productive and active life at the C2 level where even five years ago I wasn't supposed to be alive.

It really is a testament -- see, I just love competition. When I find out there's nothing in the book about me because C2s don't live and their life isn't worth anything, boy, that really gets me going. And that's what you need, you need a fire. The patient needs to be ignited, and thanks to the research that you guys are doing, you're giving real hope to people; yes, for looking for the cure, but meanwhile lighting a fire saying, "Don't sit on your butt. Don't just accept being the way you are, but challenge yourself physically as far as you can go, because you're going to be happier, healthier, more productive, and there may be big surprises along the way."

For example, my breathing. If I hadn't tried, I never would have known. Now I'm at the point where I expect I'm going to get off this hose while still living my life, directing, being with my family, running a foundation, doing all of that and getting off the hose by end of next year. That was considered impossible, but it was also impossible to put a man on the moon. It was also impossible to cure polio. It was also impossible to cure diphtheria, cholera, TB, and AIDS.

In 1984, the government spent zero dollars on AIDS research, because AIDS was thought to be a death sentence, and the virus was far too complicated to deal with. Today, the government spends annually $1.8 billion a year on research, and people who would have been dead four or five years ago now have the virus virtually undetectable in their bloodstream, and they're living normal lives.

That was something thought impossible until we put money and talent together and aimed it toward a problem. We fix it, and what we have here with all the diseases, Alzheimer's, MS, Parkinson's, we simply have problems that need the money and the talent to address them, and we'll conquer them; there's no doubt about it. There really are no limitations at all.

I just am very glad to come down here today to congratulate a group that is dedicated to that principle that there's no reason to hold us back. Yes, the problems are difficult, but with real dedication and with enough funding from the public and private sectors, we'll beat these things, we'll beat these problems. And millions of people around the world will have you to thank for it. Thanks very much.

VA RESEARCH DAY

REMARKS BY DR. JOHN FEUSSNER
VA CHIEF RESEARCH AND DEVELOPMENT OFFICER
SYRACUSE, NY, VA MEDICAL CENTER
December 16, 1999

I would like to welcome Congressman Walsh who is attending this VA Research Day. We do appreciate your willingness to take the time personally to celebrate the outstanding achievements of the physicians and scientists here in Syracuse.

With the U.S. health-care enterprise in a remarkable state of flux, the complexity of the traditional mission of VA – that is, patient care, education and research—has increased. This turn of events is characterized by rapid change which, in turn, heightens our own concerns and anxieties. But this is not just difficult for us! This is equally difficult for our partners, academic health centers like this one here, who are our partners in achieving excellence, realizing discovery and creating innovation.

As scientists, health-care professionals, local and national leaders, we must continue to embrace the challenge of our increasingly complex mission and the derived tasks.

The VA health-care system is unique in the U.S., if only because it is a national health system. Because VA research focuses on health problems common and relevant to veterans, a natural synergy can be forged among the clinical care, management and research components of the VA.

Recently, the VA research program has made remarkable contributions to health care in the U.S. VA investigators competed successfully for research space on the Russian Space Station Mir and the space shuttle launch of Neurolab.

This research has direct applications for diminishing kidney toxicity of commonly used antibiotics, nerve cell regeneration, and tissue, and even organ engineering. In these experiments, we focused on discovering the genetic signals that direct cells to structure themselves as organs, not merely to grow as a tissue mono-layer.

I believe that we will look back on these seminal experiments in 20 or 30 years and marvel at the breakthroughs VA investigators made, and the remarkably effective collaboration between two federal agencies, VA and NASA. In the future, we will grow new organs from your own cells. We will create a new standard for tissue and organ transplantation, or should I say, replacement!

Recall that it has been about 25 years since the pioneering research on organ transplantation—done by a VA physician—resulted in the first liver transplant done by VA. This former research innovation is no longer just for researchers. Today it is a part of patient care. And today it saves lives!

The VA recently completed research on the use of the hormone erythropoietin, which improves anemia in patients with kidney failure. We showed how we can use this treatment more cost-effectively. The VA is now collaborating with the Health Care Finance Administration to see if we can help Medicare save hundreds of millions of dollars annually on this one medication. In this case again, all Americans stand to benefit from this VA research.

Our national surgical quality improvement program has improved the quality of surgical care in a VA hospital while decreasing hospital length of stay. In a recent editorial in the surgical literature entitled "The Future is Now," two leading academic surgeons challenged the private sector to emulate VA quality improvement methods. They lamented the fact that the private sector may not be able to catch up with the VA quality improvement effort for another decade. And this VA national surgical quality improvement program has been ongoing since 1992!

Closer to home, right here, several recent research products and discoveries have had, or will have, a major impact on health care not only in VA but throughout the country. In my opinion, Congressman Walsh should be mightily proud of the research effort here in Syracuse. This VA research program, and the one at the university, is not merely first class, this VA research enterprise is world class. And that statement is not just rhetoric!

I am personally familiar with the excellent work of Dr. Bill Boden. Bill is no stranger to this issue of translating research results to improved patient care. Bill is one physician scientist who has succeeded, and continues to succeed, in defining best practices for such key medical problems as heart disease.

I do believe that Dr. Boden's work on Vanquish, a national VA cooperative study, has been the only time recently that a VA investigator made the nightly news on all four major networks simultaneously. Why? Because he challenged conventional wisdom, then brought the best science to bear in studying treatment strategies for the hospital care of patients with certain kinds of heart attacks.

Remember my allusion to world class research? Bill's success doing clinical trials internationally stimulated the VA research office to engage the MRC's in Canada and the UK to establish a formal international research collaboration, which we successfully launched last summer.

I am also familiar with the path-breaking work of Dr. Peter Strick. Recently, Dr. Strick and his colleagues, Dr. Donna Hoffman and Dr. Kakei from Tokyo, discovered new information about the language of the motor cortex, a region of the brain that helps control muscle movement throughout the body.

Dr. Strick made the amazing discovery that the motor cortex has its own language. To use Dr. Strick's own words, "Researchers need to decipher this language before they can develop prosthetics that communicate with the brain. It is similar to a programmer's need to understand the correct computer language in order to develop functional software."

Dr. Strick's work, published just this September in the journal Science, is the first study to document the existence of both types of neurons in the motor cortex. And who will benefit from this line of investigation? Veterans, to be sure! But also other Americans who suffer with stroke, Parkinson's disease and spinal cord injuries.

And it is not only we in VA who recognize the excellence of Dr. Strick's discoveries. He has been selected as a fellow in the prestigious American Association for the Advance of Science.

And there is so much more here. Excellent surgeons fully engaged in the research enterprise like Dr. Michael Sobel studying blood clotting, Dr. Gabriel Hass evaluating tumors of the kidney and prostate, and Dr. Dennis Krauss also studying prostate disorders. And I could easily go on further.

Just reviewing the interests and work of these several investigators, it should be clear that the spectrum of VA research extends from basic discovery to application of research results to improved quality of patient care.

These investigators are representative of many other scientists and physician investigators who provide evidence for why, and how, the VA's commitment to research pays dividends measurable as improved patient care. Their research, their work, the work of their colleagues, and your support provide justification for our investment in the VA research program.

In my opinion, this day exemplifies our commitment to our shared health-care values: excellence in patient care, education, and medical research. It is a privilege for me to share this day with you. You are fortunate to have such effective leadership here, and such dedicated physicians and scientists, such persistent and committed administrators.

Reflecting the words of Charles Dickens about "Christmas Yet to Come," I anxiously await your achievements yet to come.

Congratulations on this outstanding day, and your outstanding work.

VA Patient Safety Program

Statement of Thomas L. Garthwaite, M.D. VA Acting Under Secretary for Health Before the Committee on Veterans' Affairs and the Committee On Appropriations, Subcommittee on Labor, HHS, Education and Related Agencies

January 25, 2000

I am pleased to appear before you to discuss VA's ongoing activities and initiatives to ensure the safety of patients who receive care from VA. In December 1999, the Institute of Medicine (IOM) released a report "To Err is Human: Building a Safer Health System." The report reviewed existing studies and concluded that as many as 98,000 preventable deaths occur each year in United States' health care due to error. The IOM recommended creating a new National Center for Patient Safety that would focus on research and policy related to errors in health care, improved error reporting systems, improved analysis/feedback methods, performance standards for health-care organizations and individuals, and other specific governmental actions. Importantly, they cautioned that the focus must be on creating a culture of safety that will require improving systems, not assigning blame.

VA interpreted the IOM report as a validation of our commitment to improving patient safety in our healthcare system. All of the IOM recommendations applicable to VA have either been in place or were in the process of being implemented prior to the release of the report. While VA has had quality and safety related activities ongoing for many years, it was in 1997 that our formal patient safety program was launched. Leaders in the field of patient safety and medical error outside VA have participated in the design of our system and recognize VA as a pioneer in these efforts.

During 1997, VA intensified its already extensive efforts in quality improvement by launching a major initiative on patient safety. We recognized that programs to improve quality and safety in healthcare often share purpose and corrective actions. However, we believed that patient safety required a new and different approach. We set out to create a new culture of safety in which our employees detect and tell us about unsafe situations and systems as part of their daily work. Once we know about unsafe situations and systems, we are committed to design and implement new systems and processes that diminish the chance of error.

Highlights of Patient Safety Activities at VA: 1997-Present

VA recognized that patient safety is not a VA-specific issue, therefore we asked other health-care organizations to join us in an effort to understand the issues and to
act for patient safety. As a result, the National Patient Safety Partnership (NPSP), a public-private consortium of organizations with a shared interest and commitment to patient safety improvement, was formed in 1997. The charter members, in addition to VA, included the American Medical Association, the American Hospital Association, the American Nurses Association, the Joint Commission on Accreditation of Healthcare Organizations, the Association of American Medical Colleges, the Institute for Healthcare Improvement, and the National Patient Safety Foundation at the AMA. Five additional organizations have subsequently joined the charter members in the Partnership: the Department of Defense - Health Affairs, National Institute for Occupational Safety and Health, the Food and Drug Administration, Agency for Healthcare Quality and Research, and the Health Care Financing Administration. This group addresses high impact issues that are of importance to a broad cross section of the health care industry. An example of the Partnership's activity was the establishment of a clearinghouse for information related to the effect of Y2K computer issues on medical devices. The NPSP also called public and industry attention to preventable adverse drug events and promulgated simple actions that patients, providers, purchasers and organizations could take to minimize their chance of an adverse drug event. The partnership serves as a model of what a private-public collaboration can do to improve patient safety.

In 1998, VA created the National Center for Patient Safety (NCPS) to lead and integrate the patient safety efforts for VA. As the IOM report advises, VA created this center as a commitment to patient safety as a corporate priority with a direct reporting relationship to the Under Secretary for Health. The NCPS employs human-factors engineering and safety system approaches in its activities. The first task for the Center was to devise systems to capture, analyze and fix weaknesses in our systems that affect patient safety.

We sought to design reporting systems that would identify adverse events that might be preventable now or in the future. In addition, we sought systems to identify and analyze situations or events that would have resulted in an adverse event if not for either luck or the quick action of a health-care provider – we call such events "close calls." We believe that "close calls" provide the best opportunity to learn and institute preventive strategies, as they will unmask most system weaknesses before a patient is injured and avoid the liability issues implicit in investigations of injury. This emphasis on "close calls" has been employed by organizations outside of health care with great success.

VA consulted with experts (Expert Advisory Panel for Patient Safety System Design), obtaining advice to enhance the design of VA's reporting systems. These experts in the safety field included Dr. Charles Billings, one of the founders of the Aviation Safety Reporting System, as well as other experts from NASA and the academic community. They advised us that an ideal reporting system a) must be non-punitive, voluntary, confidential and de-identified; b) must make extensive use of narratives; c) should have interdisciplinary review teams; and d) most importantly, must focus on identifying vulnerabilities rather than attempting to define rates of error. VA has used these principles to design the patient safety reporting systems we have in use or in development.

Based on the expert advice and on lessons learned from our first generation mandatory adverse event reporting, the NCPS has developed a comprehensive adverse event, close call analysis and corrective action program which includes an end-to-end handling of event reports. This system not only allows for the determination of the root causes, but also captures the corrective actions as well as the concurrence and support of local management for implementation. The system includes a number of innovations such as algorithms and computer aided analysis to determine the root cause of adverse events and close calls. The Joint Commission on Accreditation of Healthcare Organizations and the American Hospital Association are currently evaluating parts of the system for use.

The improved event reporting system is being pilot tested in VA's VISN 8. Extensive training is used as the new system is introduced to assure full understanding of the search for the root cause and redesign of the system. To date, response from the pilot site is positive. The quality managers and clinicians using the system believe that the new methods analysis of error will make a significant difference in the care of veterans.

A complementary, de-identified voluntary reporting system is in the process of being implemented. It is patterned after the highly successful Aviation Reporting System that NASA operates on behalf of the FAA. It will be external to VA and will allow employees and patients to report unsafe occurrences without fear of administrative or other action being taken against them.

Based on lessons learned, VA has promulgated specific procedures and policies aimed at reducing risk of error. These include such things as restricting access to concentrated potassium chloride on patient care units, use of barcode technology for patient identification and blood transfusions in operating rooms, and for verification procedures prior to injection of radio-labeled blood products. Based on the observation of a VA nurse of rental car return procedures, VA developed a system for using wireless bar coding to improve medication administration. That system was piloted at the Topeka VA Medical Center and will be in all VA hospitals by June of this year. At least two-thirds of medication errors can be prevented with this system.

In 1999, VA established four Patient Safety Centers of Inquiry. These Centers conduct research on critical patient safety challenges. Activities at the Centers of Inquiry range from fall prevention and operating room simulators to understanding the role of poor communication in patient safety. The Center in Palo Alto, which is affiliated with Stanford University, is a recognized leader in the area of simulation and has been featured prominently in the media.. Their simulated operating room allows surgeons and anesthesiologists to train and do research without endangering a patient. VA expects to create additional simulation facilities to train its physicians and other healthcare professionals. One simulator with appropriate staff could train about 600 anesthesiologists and residents-in-training per year. This means that virtually all VA anesthesiologists/anesthetists can be trained in a year on clinical situations that could not be simulated safely in patients. As a result of analyzing common variations during simulated operations, the center has developed a checklist card of facts that should be kept close at hand. These checklist cards will be attached to all anesthesia machines across VA.

VA is partnering with the Institute for Healthcare Improvement to build learning collaboratives aimed at reducing medication errors, a major issue identified in the Institute of Medicine report. IHI collaboratives will affect several hundred VHA personnel each year. Other IHI collaboratives have resulted in measurable improvements and similar results are anticipated with medication errors.

Another key VA strategy to reduce medical errors involves the development of a new curriculum on safety. VA is moving forward with plans to provide education and training relevant to patient safety not only to those already in practice but also at the medical, nursing, and health professional school level. This will be the first time an extensive safety curriculum will be developed and broadly implemented. VA is particularly well situated to lead the educational effort due to the extensive role it plays in the education of health-care professionals in the United States. (VA is affiliated with 105 medical schools and up to one-half of all physicians train in a VA facility during medical school or residency.) Additionally, we have instituted a performance goal and measure to provide VA employees 20 hours of training on patient safety this year.

VA instituted a Patient Safety Improvement Awards Program to focus interest on and reward innovations in identifying and fixing system weaknesses. Not only does this produce ideas for patient safety improvements that might otherwise go unnoticed but it further reinforces the importance that VA places on patient safety activities.

In 1995, VA instituted a Performance Measurement System that uses objective measures of patient outcomes to set goals and reward achievement. Since 1998, VA has incorporated a performance goal and measure for its executives for accomplishment in patient safety activities. Last year, each network had to implement three patient safety initiatives to be fully successful and six initiatives to be outstanding.

Other performance goals and measures assess the use of Clinical Practice Guidelines. By holding entire medical centers and geographic networks responsible for measured outcomes, we are able to institute reminder systems and redundancies that lead to dramatic improvements in performance. For example, patients who receive medications known as "beta-blockers" following a heart attack are 43 percent less likely to die in the subsequent two years and are rehospitalized for heart ailments 22 percent less often. A goal of providing this therapy to 80 percent of eligible patients has been set in the private sector, and recent medical literature reports rates of use as low as only 21 percent in some settings. In the VA, over 94 percent of heart-attack patients receive this life-saving medication.

Another example of the power of using systems rather than relying on individual adherence to clinical guidelines is in immunization. It is estimated that 50% of elderly Americans and other high-risk individuals have not received the pneumococcal pneumonia vaccine despite its demonstrated ability to minimize death and hospitalization. VA's emphasis on preventive health care has led to achieving pneumonia vaccination rates that exceed standards set for HMOs by almost 20 percent and nearly double published community rates. Similar accomplishments have been achieved in providing annual influenza vaccinations.

We believe that patient safety can only be achieved by working towards a "culture of safety." Patient safety improvement requires a new mindset that recognizes that real solutions require an understanding of the "hidden" opportunities behind the more obvious errors. Unfortunately, systems thinking is not historically rooted in medicine. On the contrary, the field of medicine has typically ascribed errors to individuals and embraced the name-blame-shame-and-train approach to error reduction. Such an approach by its very nature forecloses the opportunity to find systems solutions to problems. Other industries such as aviation have recognized the failings of this approach and over many years have succeeded in transitioning from a similar blame and faultfinding approach to a system-based approach that seeks the root causes of errors. VA realized how pivotal culture is to improving safety and in 1998, conducted a culture survey of a sample of employees. Of interest, the shame of making an error was a more powerful inhibitor of reporting than was fear of punishment. Employees readily forgave mistakes in others but were intolerant of their own. We plan to survey culture broadly in VA for several years to track the progress of our efforts.

VA created a database of adverse events and asked our Medical Inspector to review it. The report has been widely, yet often inaccurately, quoted or critiqued in the media. The database was created to discover common and important adverse events in order to focus our efforts in patient system redesign. Commonly, the media assumed that all the adverse events (and deaths) were due to error. They were not. Neither the report nor the database cataloged which adverse events were preventable with today's state of knowledge and therefore could be characterized as errors. For example, most of the adverse events were falls, suicides and parasuicidal events (attempted suicides, suicide gestures), or medication errors. It is not possible with today's knowledge to

operate a national system of nursing homes and acute-care hospitals treating the elderly and chronically ill without a number of falls. Yet, we know that it is important to look for common factors to allow us to reduce the frequency of falls in the future. Similarly, psychiatrists have tried unsuccessfully to predict which patients will commit suicide. By looking at our data we hope to be able to predict high-risk patients in the future and therefore be able to prevent suicides. We have already learned that men with a recent diagnosis of cancer, who live alone and who own a gun, are more likely to commit suicide. We hope to study the use of additional interventions in this subgroup of patients at high risk of suicide.

Conclusion

With no successful models in large health-care systems to guide us, VA turned to other high risk, high performance industries to learn principles for safety. We have borrowed both methods and people from safety-conscious settings such as aviation and space travel and from underutilized disciplines like human factors engineering. These efforts have already produced significant improvements in VA, and we believe will do the same in all healthcare settings.

We would prefer that all of health care had begun to address the issue of patient safety long ago. For too long, the emphasis has been on holding individuals accountable and hoping that well-intended and well-educated professionals wouldn't make human mistakes. As the IOM aptly states in the title of its report: "To err is human." We are pleased to be on the leading edge as health care takes a systems approach to patient safety. We are anxious to discover new ways to make VA and all health care safer. We appreciate your support of these efforts and intend to keep you fully informed of our progress.

READJUSTMENT COUNSELING SERVICE
20TH ANNIVERSARY

HONORABLE HERSHEL GOBER
DEPUTY SECRETARY OF VETERANS AFFAIRS
READJUSTMENT COUNSELING SERVICE CONFERENCE
RENO, NEVADA
February 9, 2000

Thank you very much for that kind introduction. And thank you all for that warm welcome. I bring you greetings from President Clinton. It's good to see all of you again. You all look so well.

I was back in Arkansas in mid-January to participate in one of our Millennium Standdowns and to address a state conference of the American Legion. That was a thrill. Everybody in the audience was someone that I knew. And I can't tell you how many came up to me and said something like, "Hershel, you really look well." That was nice, but it reminded me that there are five stages of life – Infancy; Childhood; Adolescence; Adulthood; and "My you're looking well these days."

Then there is the story of two old veterans driving along. Bill was driving and Frank was the passenger. As they came to an intersection Frank looked up just in time see the light was red, but Bill drove right on through. Frank didn't say anything because his eyes were not as good as they used to be and he thought he could be wrong. But, as they came to another intersection he looked up again. It sure seemed the light was red, but Bill drove right through that intersection. Frank kept quiet but he also kept his eye on the road. When the next intersection came up, he watched the light carefully. Sure enough, it was red and Bill drove right through. Frank said, "Doggone it, Bill. You have run through red lights at the last three intersections. You could have gotten us killed." Bill turned to Frank with a surprised look on his face and said. "My gosh! Am I driving?"

During the twenty years that the Readjustment Counseling Service (RCS) has been in existence, I'm sure there were times you turned to one another and asked, "Who is driving this thing?" I want you to know that there were many times that <u>you</u> were driving the program while everyone else was looking for red lights, detours, U-turns, and go slow signs.

There are thousands of veterans who are grateful that you kept your eyes on the road, drove toward a destination many others couldn't or wouldn't see, and helped veterans all along the way. I want to thank you all for that dedication.

Before 1994

It's important to look back to see where we have come from and where we are. In 1993, I traveled to a Vet Center in Beckley, West Virginia. All our Vet Centers in those days operated on what I call the quota system. We were numbers driven. How many veterans can we see today? How many more can we see next month? The quota kept going up! The emphasis was on quantity - not necessarily on quality of service and high levels of clinical care. Employee morale was low and veterans coming for help were affected by that attitude. Most of you in RCS felt you were held in low regard at the Headquarters level, even that the program would be sold out so other programs could be enhanced. In a few words, although individually you were all working harder, it seemed to many of you that:

your efforts were ignored or diminished; the quality of care for veterans were not the standards that you wanted them to be; and survival of a program mandated by law was in jeopardy.

I am proud of the turn around that has occurred during this administration. In 1995, we recognized that VA health care needed to be:

Customer Driven; Community based; Outside the Hospital; Accountable; and veteran and family user friendly.

RCS always viewed this as a model that fit the needs of the veterans it was created to serve. To my way of thinking, our Vet Centers were the community based, customer driven, provider of services outside the hospital setting that was ready, willing and able to be accountable for its work.

Combat veterans are finding their way to the 206 Vet Centers around the nation in ever-increasing numbers. But, now they find a service where quality of care is more important than numbers of veterans seen. They are finding vet centers staffed with highly motivated people where morale is much higher than before.

Each year some 180,000 veterans are referred from Vet Centers to Medical Centers or Community Based Outpatient Clinics for health care services. Some 50 to 55-thousand of these veterans are new to VA's health-care system. They get their services exclusively at Vet Centers. Vet Centers are prime providers of veterans to expand our patient base. That is good because we want to expand our health care services to every veteran who earned and needs health care.

Since Readjustment Counseling Service was established in 1979 there always has been a requirement to extend the life of the program from time to time. In 1996, Congress opened the Vet Centers to all combat veterans. How long will we need RCS and the vet centers is a question I'm sure you are asked from time to time. My answer is as long as there is a combat veteran who experienced trauma or as long as there is a sexually traumatized veteran — there will be a need for Vet Centers.

These past seven years have been among the most rewarding of my professional career. When you look at the big picture for VA, you see that we are treating more veterans in more places than ever before. And you find that more veterans and their families are satisfied with the care they are receiving. Just two days ago (Monday, February 7, 2000), President Clinton sent to Congress his budget request for Fiscal Year 2001. It contains the largest increase in discretionary spending for veterans ever proposed by any President — $1.5 billion.

I can tell you that we have worked hard to craft this budget and to get the President's willing and enthusiastic support for this level of increase. As we push for passage of this budget bill, you can be sure my voice will be heard in support of the outstanding work you and all the 942 staff members in the 206 Vet Centers provide to veterans. You are right there where you are needed – in the locations where the veterans who need your specialized and understanding care can reach you without hassle. And that is the way it should be. As long as veterans need a way to find access to quality re-adjustment services — provided in a caring manner that will help them and their families achieve a successful post-war adjustment – there must be Vet Centers.

Thank you for all that you have done and for all the veterans you have helped. You have created a model of service that all our health-care services can do well to emulate.

God Bless our veterans. God Bless all of you and your families.

RESEARCH ON GULF WAR VETERANS' ILLNESSES

STATEMENT OF JOHN R. FEUSSNER, M.D.

VA CHIEF RESEARCH AND DEVELOPMENT OFFICER

BEFORE THE NATIONAL SECURITY, VETERANS AFFAIRS, AND

INTERNATIONAL RELATIONS SUBCOMMITTEE

HOUSE COMMITTEE ON GOVERNMENT REFORM

February 2, 2000

Mr. Chairman and members of the Subcommittee, thank you for this opportunity to discuss the status of the current and projected federal research program on Gulf War veterans' illnesses. I serve as the Department of Veterans Affairs' (VA) Chief Research and Development Officer and the Chairperson of the Research Working Group (RWG) of the Persian Gulf Veterans Coordinating Board (PGVCB).

In your invitation to this hearing, you indicated that the purpose of the hearing was to examine the pending report of the General Accounting Office (GAO): "Gulf War Illnesses: Management Actions Needed to Answer Basic Questions." Indeed, VA commented on the draft report last summer; until today we have not seen the final report. Nevertheless, as I update your Subcommittee on our research concerning Gulf War veterans' illnesses, I have attempted to incorporate appropriate references and sensitivity to the GAO's work. While we did not agree with everything the draft report contained six months ago, we do agree that we should continue reviewing these matters as we develop future plans and studies.

Mr. Chairman, the primary charge to the RWG is to assess the state and direction of research; identify gaps in factual knowledge and conceptual understanding; identify testable hypotheses; identify potential new research approaches; review research concepts as they are developed; collect and disseminate scientifically peer-reviewed research information; and ensure that appropriate peer review and oversight are applied to research conducted and sponsored by the federal government.

An important function of the RWG is programmatic review of, and recommendation to, funding agencies on research proposals that have been competitively and scientifically reviewed. The RWG continues to work diligently to foster the highest standards of competition and scientific review for all research on Gulf War veterans' illnesses.

As an operational policy, the RWG works through the line management authority each department maintains over its intramural scientists, extramural research program managers, and budgets.

By drawing together the three Departments (Defense, Health and Human Services, Veterans Affairs), the RWG has been able to develop an overall research strategy, serve as a common forum for researchers to present ideas and findings, and collectively respond to emerging research issues and problems.

The RWG has guided the federal research portfolio using a number of different sources of input. These sources include results from ongoing research; various expert panels and oversight committees, such as the Institute of Medicine (IOM), the National Institutes of Health (NIH); the Senate Veterans' Affairs Committee Special Investigations Unit; several Congressional committees including this Subcommittee; the Presidential Advisory Committee on Gulf War Veterans' Illnesses; independent scientists; and Gulf War veterans themselves. The RWG has used advice and information from these sources in developing and implementing a research strategy embodied in "A Working Plan for Research on Persian Gulf Veterans' Illnesses." This strategy was first released in August 1995 and revised in November 1996. These documents resulted in twenty-one research objectives. The RWG is currently developing summary updates of these research objectives, work which should be finalized prior to the end of this fiscal year. This plan is responsive to the draft recommendation of GAO; that we publish an assessment of progress on the 1995-96 research objectives stated in the working plan.

Mr. Chairman, other notable activities and accomplishments of the RWG include:

- Production and dissemination of annual reports to Congress on progress and results of federal research activities;

- Secondary programmatic review of research proposals submitted to funding agencies;

- Presentations by federal and non-federal researchers before the RWG;

- Organization of annual meetings for federally-funded researchers;

- Organization of an international symposium in conjunction with the Society of Toxicology on the health effects of low-level exposure to chemical warfare nerve agents;

- Development of a strategy for research on the health effects of exposure to low levels of chemical warfare nerve agents;
- Follow-up investigation of preliminary reports of positive experimental serological tests for leishmaniasis; and

- Development of treatment trials for Gulf War veterans.

To date, the federal government is projecting cumulative expenditures of $159 million for Gulf War research from FY 1994 through FY 2000. There are over 150 projects at various stages of completion in the research portfolio on these veterans' illnesses. In the past two years alone, 30 projects have been added to this portfolio. Research projects have been funded in the categories of basic research, and applied research such as clinical epidemiology and population-based epidemiologic research. Thus far, the overall emphasis of research has been in the areas of the brain and nervous system and in symptoms and general health of Gulf War veterans. After these, the greatest research emphasis is on diagnosis. To date, 47 federally funded projects have been completed, resulting in a total of 98 peer-reviewed publications in the scientific literature. There are currently a total of 116 principal investigators, including 25 from DoD, 38 from VA, 4 from HHS, 32 who are university-affiliated, 5 non-U. S. counterparts, and 12 from non-government organizations other than universities. All projects and their categories are described in complete detail in the "Annual Report to Congress" for 1998. The next annual report will include research updates through calendar year 1999. We believe that this kind of collaboration within the federal medical and research communities is consistent with that which was recommended in the GAO's draft report.

Other highlights of the ongoing research efforts on Gulf War veterans' illnesses include the following:

In early 1997, VA and DoD tasked the Medical Follow-up Agency (MFUA) of the Institute of Medicine to undertake a feasibility study on the potential to do follow-up of individuals at Aberdeen Proving Ground to examine for potential long-term health effects of exposure to chemical warfare nerve agents. This work is focusing on MFUA's access to cohorts of veterans exposed at Aberdeen as a part of their research on the health effects of low-level exposure to nerve agents dating back to the 1950s. The MFUA completed the pilot study in 1998 and determined that the full study could be completed. DoD funded the MFUA (#DoD-93) to proceed with the full-scale study, which is currently underway.

Shortly after the June 1996 announcement of the events at Khamisiyah, Iraq, the RWG recommended that DoD fund three scientifically-meritorious projects in the areas of (1) dosimetry research on exposure to sulfur mustard that will enable quantitative determinations of sulfur mustard exposure at short and long-term intervals; (2) research on the toxicokinetics of the nerve agent VX in three species of animals. The results of this research will facilitate animal to human extrapolation of observed effects in animals resulting from controlled low-level nerve agent exposure; and (3) research on the role of genetic expression of cholinesterases in protecting against anticholinesterase nerve agents. Each of these is described in more detail in the "Annual Report to Congress on Federally Sponsored Research on Gulf War Veterans' Illnesses" (Projects DoD-49 through 51). We expect that these studies will be completed this year.

The DoD published a four-part broad agency announcement (BAA) to amplify research on low-level chemical warfare nerve agent effects, as well as research on the health effects of other exposures including insecticides, the nerve agent prophylaxis pyridostigmine bromide (PB), and stress. The BAA resulted in funding recommendations for 12 new projects, valued at approximately $12 million, and covering such exposures as Sarin, PB, insecticides, psychological and heat stress, alone and in various combinations.

As part of the BAA, the scientific community was asked for proposals for a feasibility study on the conduct of epidemiological research on the possible health outcomes among troops potentially exposed to Sarin at Khamisiyah, Iraq in March 1991. Unfortunately, there was no response from the scientific community to this request. The DoD subsequently asked MFUA to develop a protocol for conducting such a study. MFUA designed a protocol that was peer-reviewed by a panel of experts assembled by the American Institute of Biological Sciences. The proposal was deemed meritorious by an independent scientific peer-review panel and the RWG recommended to DoD that this project be funded. This project (#DoD-69) is anticipated to be completed this year.

Although issues around the potential health impacts on our troops of potential low-level exposures to nerve agents are very important to us, there are other exposures and health outcomes of concern as well. For example, musculoskeletal conditions among Gulf War veterans are clearly evident based on the frequency of these conditions among veterans reporting to the VA and DoD registries, and on results of a number of research studies, including CDC's study of Iowa Gulf War veterans. The federal government sponsors a significant amount of research to clarify the pathophysiology and clinical significance of musculoskeletal conditions in Gulf War veterans.

Because of the importance of ensuring appropriate and effective treatment for Gulf War veterans' illnesses, my office formed a planning group and charged it with developing a Program Announcement (a type of invitation for applications) requesting proposals within the VA system, or in collaboration with DoD, for multi-center trials for candidate treatments of clearly defined medical syndromes or illnesses among subgroups of Gulf War veterans. This Program Announcement was issued in January 1998.

As a result of epidemiological findings to date, subgroups of ill Gulf War veterans have been identified for whom trials of potential treatment are appropriate. In the spring of 1998, the VA Cooperative Studies Program initiated planning for two treatment trials, subsequently known as the "ABT" (antibiotic treatment) and "EBT" (exercise-behavioral therapy) trials. Both trials underwent thorough scientific review and were approved for funding only after rigorous external review provided by the Cooperative Studies Evaluation Committee. Patient characteristics for entry into both trials are similar. All veterans who served in the Gulf between August 1990 and August 1991 are eligible for the studies. Patients are considered to have Gulf War Veterans' Illnesses

(GWVI) if they have at least two of three symptoms (fatigue, musculoskeletal pain, neurocognitive dysfunction) that began after August 1990 and that have lasted for more than six months up to the present.

The ABT trial seeks to study 450 Gulf War veterans at 28 sites throughout the U.S. The study initiated patient accession in May of 1999. The primary hypothesis of the study is that antibiotic treatment directed against mycoplasma species will improve functional status of patients with GWVI who are tested as mycoplasma positive at baseline. The total cost of this treatment trial is approximately $13 million. The trial will be completed about one year from now. Preliminary demographic information indicates that 15% of the study participants are women, nearly 20% represent minority groups, 37% have attained an educational level of college or higher, and about 70% are employed. Nearly 85% of patients currently enrolled in the study exhibit all three symptoms of fatigue, pain, and neurocognitive difficulties. Recruitment of Gulf War veterans into the antibiotic trial is proceeding ahead of schedule.

The EBT trial seeks to study 1,356 Gulf War veterans at 20 sites throughout the U.S. The study initiated patient accessions in April of 1999. The primary hypotheses of the study is that both aerobic exercise and cognitive behavioral therapy (CBT) will significantly improve physical function in veterans with GWVI, and that the combination of CBT and exercise will be more beneficial than either treatment would be alone. The cost of this treatment trial is approximately $9.3 million. The trial will be completed on or about December 2001. Thus far, nearly 500 veterans have joined the study.

Both VA and DoD have undertaken new initiatives that are focused on the neurobiology of stress and stress-related disorders. In addition, other new research efforts include:

- A total of 14 new projects were initiated in FY 1998/99 as part of the 1997 DoD BAA request for proposals for studies of post conflict illnesses that extend beyond the Persian Gulf War. These studies will address aspects of the wartime experience that create a confluence of cognitive, emotional, and physical factors to produce chronic, non-specific symptoms and physiological outcomes.

- A total of nine new projects were funded in July 1998 as a result of VA and DoD's request for intramural proposals valued at $5 million for research on the neurobiology of stress. Expected completion dates for these studies range from the year 2000 through 2002.

Mr. Chairman, I will now provide you with an update of the VA National Survey of Persian Gulf Veterans authorized by Public Law 103-446.

As you may recall, the National Survey is designed to determine the prevalence of symptoms and illnesses among a national random sampling of Gulf War veterans. The Survey is being conducted in three phases. Phase I was a population-based mail

survey of the health of 30,000 randomly selected veterans from the Gulf War era (15,000 Gulf War veterans and 15,000 non-Gulf War veterans, males and females). The data collection phase is complete and analysis of the data continues. Phase II consisted of a telephone interview of 2,000 non-respondents from Phase I (1,000 from each group) to determine if there are any response differences between respondents and non-respondents. Phase II is complete. In Phase III, 2,000 of the veterans who responded to the postal survey and underwent a telephone interview will be invited, along with their family members, to participate in a comprehensive physical examination protocol. These examinations are being conducted at 16 VA medical centers and involve specialized examinations including neurological, rheumatological, psychological, and pulmonological evaluations. When the National Survey is complete we will have a much clearer picture of the prevalence of symptoms and illnesses among Gulf War veterans.

The VA's Office of Research and Development awarded funds for Phase III of the National Health Survey of Persian Gulf Veterans in November 1998. Currently, 16 sites are participating in these physical examinations. A subcommittee of the Cooperative Studies Evaluation Committee (CSEC, a federally chartered advisory committee) scientifically reviewed the protocol for Phase III and recommended funding. This study is scheduled to examine approximately 2,000 veterans, plus 3,000 of their spouses and children. To date, over 1,000 veterans have joined this observational study, and another 1,230 spouses and children have been examined. The study will cost approximately $12 million and will complete patient recruitment in May of 2001.

The medical evaluations in Phase III are designed to determine:

- Whether Gulf War veterans have an increased prevalence of the following conditions frequently reported in the literature, compared to a control group of non-deployed veterans: Chronic Fatigue Syndrome (CFS); Fibromyalgia (FM); neurologic abnormalities, including peripheral neuropathy and cognitive dysfunction; post-traumatic stress disorder (PTSD); and measures of general health status.
- Whether the specific medical conditions of arthritis, dermatitis, hypertension, bronchitis, and asthma that have been reported as more frequent among Gulf War veterans compared to non-deployed veterans are of greater prevalence among deployed Gulf War veterans upon objective clinical examination.

- Whether the prevalence of any of these conditions is greater among the spouses of Gulf War veterans than among spouses of non-deployed veterans.

- Whether the prevalence of medical conditions and major birth defects found on a pediatric physical examination in the children conceived after the war is greater for Gulf War veterans than for non-deployed veterans.

Mr. Chairman, one of the GAO draft report's recommendations addressed the need to compile data on Gulf War veterans, track their health problems and map the

care they receive. We believe that our work in implementing the survey required under Pub. L. 103-446 is responsive to the intent of GAO's draft recommendation.

This research program, as well as research outside of the government, has yielded important new information. Some of the highlights of recent research findings include:

- Ongoing analysis from the Iowa epidemiologic study of Gulf War veterans using standard measures of health status indicate that nearly 90% of Gulf War veterans reported their health status as "good" to "excellent," while the remainder rate their health status as "poor" to "fair." Interim analysis of this population-based cohort of Gulf veterans also indicates that a minority of them (14%) experienced a significant decline in their health status. Declines were noted in physical functioning and social functioning, while mental health scales showed improvement.

- Population-based epidemiological studies are showing that Gulf War veterans self-report more symptoms and exposures than non-deployed veterans of the same era. Ongoing and newly-funded projects are directed toward determining whether a causal connection may exist.

- Based on VA and DoD mortality studies there does not appear to be more deaths from disease-related causes among Gulf veterans when compared to non-deployed veterans of the same era. VA plans to continue following the mortality trends of these veterans.

- A study of military hospitalizations has shown that, at least among active duty personnel, the rate of hospitalizations of Gulf War veterans did not exceed that of their non-deployed counterparts. This suggests that Gulf War veterans, who remain on active duty, are not experiencing more illnesses of an acuity or severity that would lead to hospitalization. To account for potential bias from restricting this study to military hospitals, the investigators are extending their study to include civilian health care facilities.

- A sub-study of the hospitalization study shows that infants of Gulf War veterans have not experienced a greater prevalence of birth defects compared to the infants of non-deployed era veterans. A more focused examination of the rare birth defect known as Goldenhar Syndrome also failed to find any difference in prevalence in infants of Gulf War veterans compared to non-deployed era veterans. Further studies of birth outcomes continue to explore this concern.

- The Baltimore VAMC Depleted Uranium Program team recently published results showing elevated urine uranium excretion by soldiers who had been wounded by uranium shrapnel. The Baltimore VAMC has an ongoing medical surveillance program that is following a cohort of 33 U.S. soldiers wounded while on or in vehicles struck by depleted uranium penetrators during the Gulf War. The presence of

retained shrapnel was identified by x-ray. Urine uranium concentrations were measured. The presence of uranium in the urine can be used to determine the rate at which embedded depleted uranium fragments are releasing biologically active uranium ions. Importantly, there is no evidence of a relationship between urine uranium excretion and kidney function. While we have seen no definitive evidence of adverse clinical outcomes associated with uranium exposure, these veterans will remain under continuing medical surveillance.

- Recent research studies have provided important information on the interactions of neurotoxins and other exposures. One study indicates that exercise stress can increase the penetration of pyridostigmine (PB) across the blood-brain barrier in mice suggesting the possibility that PB could cause a central nervous system effect. Another published study, however, suggests that PB does not cross the blood-brain barrier in guinea pigs exposed to extreme heat stress. These inconsistent results with different stressors, in different rodent species, suggest that any extrapolation of such results to humans would be premature. Still another research project has reported on the effects of two weeks' exposure to low doses of PB on the neuromuscular junction. Although ultra-structural examination of the nerve terminal showed degeneration after two weeks of exposure, the effects were reversed following cessation of exposure. The RWG will continue its research on the toxicology of such interactions.

- Neurobehavioral studies of Gulf War veterans and control populations suggest that some Gulf War veterans have brain function abnormalities in such areas as memory, cognition, and motor control. The current RWG research portfolio includes seven studies using methods of sophisticated brain imaging such as conventional and functional magnetic resonance imaging (fMRI), magnetic resonance spectroscopy, and "SPECT" imaging. In addition, four studies are currently under contract review.

- A study conducted at the National Cancer Institute examined blood samples drawn from deployed veterans who went to the Gulf immediately after the end of hostilities. Blood samples were collected in Germany and in the Gulf and tested for a marker of exposure to polycyclic aromatic hydrocarbons (PAH) (a carcinogenic product of partial combustion of petroleum products). The researchers found more markers for PAH exposure in the samples taken in Germany than in the Gulf.

- Recently, Gulf War veterans have voiced concerns about a possible association between amyotrophic lateral sclerosis (ALS) and service in the war. Although there is no clear indication of an excess rate of ALS among Gulf veterans, the available data could represent an underestimate of the actual rate. Furthermore, preliminary data suggested that the age distribution of cases of ALS in Gulf veterans appeared to be younger than the age distribution of cases of ALS in the general U.S. population. Accordingly, VA is leading a research effort to identify all cases of ALS, or other motor-neuron diseases, occurring among Gulf War veterans. VA is collaborating

with DoD, CDC, and various university disease experts to determine the veterans' health status and to describe their exposures to potential causal and risk factors for ALS, based on clinical examinations at VA or non-VA centers of excellence in neurologic diseases. This initial case-finding effort will take approximately one year and will provide the most definitive information about the rate of ALS among Gulf veterans, and the age distribution of the diagnosed patients.

As the federal research program continues to provide more results, we will substantially increase our understanding of Gulf War veterans' illnesses, which will enhance our ability to diagnose and treat them. In addition, this newly gained knowledge will enhance prevention of, and intervention in, illnesses in participants of future deployments.

Mr. Chairman, thank you again for permitting me this opportunity to summarize our work so that, using science, we may better understand the health problems of Gulf War veterans. You have my assurance that we will continue this effort to resolve or ameliorate health problems in this population to the greatest extent possible.

Mr. Chairman, I will conclude my testimony here and am happy to answer any questions you or other Committee members may have.

The Honorable Eligah D. Clark
Chairman, Board of Veterans' Appeals
VA Central Office
African American History Month Program

February 2, 2000

As I look out over the audience, I see, and to my great pleasure, that there are quite a few people from the Board of Veterans' Appeals here. I would like to inform you up front, that this was not mandatory.

Having heard that introduction from Mr. Brickhouse, I was reminded of a situation which occurred on April 3, 1968. Dr. Martin Luther King, Jr. was preparing to give the very last sermon of his life. He had just been introduced by his close friend, Dr. Ralph David Abernathy, who had gone on about his accomplishments and things of that nature. When Dr. King rose to speak, he said something to the effect that, I was sitting here listening to that magnificent introduction by my friend and I could not help but wonder who he was talking about. And this is the kind of impression I got from hearing my friend, Mr. Brickhouse, at his introduction of me. I very much appreciate the things that he said, but even more so, I appreciate the privilege and the honor that it is for me to be here to make the opening remarks to kick off this 75th Observance of African-American History Month.

By being placed in this position, this gives me a wide field in which to deal. The theme for this year provides such a fertile field for exploring the ideas behind and the ideas that support the concept of African-American History month. Having provided such a wide and fertile field of exploration, it places one at a disadvantage as to where to begin. Because I recognize I have a very short time to share with you some of my views.

You don't begin in 1620 when a shipload of slaves arrived on these shores, because our legacy began long before then. You cannot begin in West Africa, where so many men and their children were torn from the land of their birth. You cannot begin in the middle passage from which only the strong survived, and you cannot begin on January 1, 1863, when the Emancipation Proclamation took effect, giving millions of African-American slaves the expectation, the prospect, the hope of facing the rising sun of a new day begun. So where do you begin? It is difficult to find a point of beginning,

because the legacy of African-Americans precedes the memory of mankind and the ending of the African-American legacy will surpass the imagination of human kind. So where do we begin?

One school of thought is that you begin planning for tomorrow by remembering your yesterdays. This school of thought is grounded in the concept that those who do not remember our history are condemned to repeat it. This concept has a certain and comfortable assurance about it. But the value of this principle to its heritage, lies in the ability to distinguish between remembering history and relying upon history. We remember our history, we remember our legacy, because it gives us a certain appreciation of our identity. It gives us an understanding of our common cultural experience and it validates our place in the spectrum of human experience. But we do not rely upon it. We cannot rely upon it. Whether we are beginning a new millennium, a new year, or a new day, we must look forward to new challenges. The challenges that we will face in the 21st century are in some ways completely unpredictable, and in other ways they are as foreseeable as yesterday's news.

I would like to briefly mention to you a discipline, which has gained a certain degree of acceptance and perhaps even notoriety lately, it is called the discipline of futurology. Some of you may be familiar with it. Futurologists study trends, they study effects and they study changes in certain other societal phenomena. As a result of these studies, they have made certain projections about future occurrences. Some of you might remember Alvin Toffler, a few years ago Alvin Toffler wrote a trilogy of books based on the theme of Futurology. The first and perhaps most well-known, is called *Future Shock*. He also wrote two other books that are part of the trilogy, one called the *Third Wave* and one called *Power Shift*. But even before then, some of you may remember George Orwell, he wrote a book titled *1984*. A lot of people perceived this as vision of the future. The perception I got from reading those books might be at odds with the perceptions of others. One of the things I noticed about these futurology predictions is that in a broad sense, there is a certain degree of reliable accuracy. But in a narrower sense, a more detailed sense as the saying goes "the devil is in the details."

With this in mind, I will attempt to share with you about the speculations about which I perceived as challenges the African-American must face in the 21st century. In a general sense, these challenges are the same as those we have faced throughout our history. The details of course, are totally unpredictable, generally unforeseeable and for the most part unimaginable. Barring some gigantic societal upheaval, there are three challenges that I believe we can expect to face in the 21st century. The first challenge which I see our society facing is the challenges of education. There is a saying that "education makes people easy to lead but difficult to drive. Easy to govern but impossible to enslave." I see education in the 21st century as our greatest challenge but also one of our best hopes.

The challenge we face is to motivate the next generation of African-Americans to accept, to understand and to appreciate the value of a sound, a thorough and a comprehensive education. By a sound education I mean an education that is grounded in the value of democracy and equal opportunities which serve as the foundation of this nation. By a thorough education I mean an education based on an objective, measurable but unbiased opportunity. An unbiased standard of achievement, not just a social promotion based on birthdays. By a comprehensive education, I mean an education that stresses the substance of society's values not just its superficial form. Such an education would teach the next generation the value of hard work and public service, not just the valuation of consumer goods.

The second challenge I see for the 21st century is the challenge of economics. This is a challenge which has defeated our people for many generations. This is a challenge which we must recognize, we must face and we must overcome. The challenge of the 21st century will be to educate more African-Americans to understand that getting rich or to use the street term , "getting paid," is not the same as acquiring wealth. Accumulating consumer goods whose value depreciates before you get home is not acquiring wealth. Wearing name brand clothes while paying rent on someone else's tax shelter is not acquiring wealth. Winning the lottery and blowing it on a new car and a Caribbean vacation is not reaping the maximum benefits of this capitalistic society into which many of our people have poured their blood, their sweat and their lives.

The next generation must understand that wealth involves transferring assets from one generation to the next and building upon those assets. We cannot do that with Eddie Bauer jackets. We cannot do that with Giorgio Armani suits. We cannot do that with our Jaquar-XJ6. These may be expressions of wealth, they might even be means to acquiring wealth, but they are not manifestations of wealth. We must teach our children that wealth lies in acquiring assets that make your money work for you, so that you will not have to work for your money. This does not mean that you must have a large quantity of money to acquire real estate or invest in the stock market. What it means is that you must exercise discipline over the money that you do have. You must exercise the same strict discipline over your money as you would if you were the trustee over someone's trust account.

When I think of people running up a large credit card debit and paying off the minimum amount each month, the picture that come to my mind is that of the sharecropper. Because no matter how hard you work and how big your crop, at the end of the year you still owe the plantation owner more than you made. This is the way it is with our consumer goods and credit cards. If someone chooses to do this, they have a right to make that choice. But, it should be a choice. It should be a knowing and intelligence choice, recognizing that there exists a viable alternative. This is an economic challenge that we must face and overcome in the 21st century. Perhaps we should consider the title of Brooke Stephen's book and the underlying principle, *Wealth Happens—One Day at a Time*.

The third challenge, which I would like to briefly share my views on, is the challenge of excellence. I see this as more a challenge of self-discipline and an acknowledgement of our own ordinariness. This is because it is an extraordinary person who can achieve excellence without exercising self-discipline. It was Theodore Martin who said, "Excellence in any art or profession is attained only by hard and persistent work." We must impress upon the next generation of African-Americans that the pursuit of excellence, in even the most menial job is a noble and dignified achievement. A great man once said, and I am sure you will recognize his words, "If a man is called to be a street sweeper he should sweep streets even as Michelangelo painted, or Beethoven composed music, or Shakespeare wrote poetry. He should sweep streets so well that all the host of heaven and earth will pause to say here lived a great street sweeper who did his job well." Those are the words of Dr. Martin Luther King, Jr. Our challenge is to teach our children to embrace the nobility, the dignity, the inherent worth of whatever they choose to do.

This challenge is made more difficult by countervailing messages with which we are constantly bombarded by the most effective teacher of past few generations. This society's excessive admiration, adulation and adoration of athletes, celebrities and entertainers. For the person whose chosen profession is to shape and mold the minds of the next generation is paid less per year than a basketball player is paid per dribble. It is a real challenge for our children to distinguish the worth of the profession from the pay of the person. This is a challenge that we must help them face and we must help them overcome.

You may ask how do these challenges of the 21st century differ from other challenges? For the great part they don't. These challenges have been the same for many generations, and they will continue. But as I said, if the substance remains the same, "the devil is in the details." It is the constantly changing nature of society which provides the details of the challenges. The educational demands are constantly changing, because the economics of the society are being driven by changes which require achieving and manifesting excellence in different ways.

Ask yourself when was the last time you heard Stevie Wonder play "Fingertips." It was probably about 1965. Yet, he still makes beautiful music and he is successful in a volatile and ever changing profession. Why? Because he has a good education in the basics of his profession. He understood and exploited the economics of his profession and he achieved excellence through hard and persistent work. By that standard, Stevie Wonder represents the quintessential post-modern professional.

The legacy of the African-American people is often characterized as a struggle to achieve freedom. Freedom from chattel slavery, freedom from political disenfranchise-

ment, freedom from educational deprivation. It can be claimed that these struggles have been won, but there is one struggle that is still being fought. We are still struggling to free our minds from the industrial age slavery of accumulating material goods to the information age freedom of acquiring wealth and human dignity.

In addressing this issue, in August of 1963, Dr. King said, "We must forever conduct our struggle on the high plane of dignity and discipline." I am very pleased and privileged to have had the opportunity to share with you some of my views and to kick off the observance of African-American History Month. I leave you with one more challenge to consider. As you go about from day to day, you are often called upon to make hard moral choices, try to work into that equation an inquiry which I think should be the guiding principal for all of us throughout the 21st century. Ask yourself, "Will this be my legacy? Will this be my legacy?"