Federal Health Matters

VSOs Describe Health Care Goals to Congress

Providing prompt and sufficient funding for VA health care, enabling the DoD and VA to share health information, and supporting the caregivers of disabled veterans were among the top health care goals described by representatives of veterans service organizations (VSOs) who testified before Congress in February and March.

The VSOs were invited to share their legislative priorities at joint meetings of the House and Senate VA Committees held on February 24, March 5, March 12, and March 18. Speakers included representatives of American Veterans (AMVETS), Blinded Veterans Association (BVA), Disabled American Veterans (DAV), Fleet Reserve Association (FRA), Iraq and Afghanistan Veterans of America (IAVA), Jewish War Veterans of the USA (JWV), Non Commissioned Officers Association of the United States of America (NCOA), Paralyzed Veterans of America (PVA), The Retired Enlisted Association (REA), Veterans of Foreign Wars (VFW), and Wounded Warrior Project (WWP).

Throughout the hearings, the most frequently mentioned goal was the passage of the Veterans Health Care Budget Reform and Transparency Act (VHCBRTA) of 2009 (S. 423/H.R. 1016). This proposed legislation, introduced in both houses on February 12, would authorize Congress to make appropriations for VA health care one year before the start of each fiscal year. Several speakers noted that, for 19 of the past 22 fiscal years, Congress did not fund VA health care until the fiscal year was already underway. Ira Novoselsky, national commander of JWV, said that such lateness leads to "disruption of services, research, capital construction, and access to VA services." Advance funding, in contrast, would allow the VA to "aggressively recruit doctors and nurses," according to Glen M. Gardner, Jr., commander-in-chief of VFW.

Several speakers also expressed support for removing veterans' health care funding from the discretionary budget and making it mandatory. Discretionary funding forces VSOs to "fight each year to ensure that Congress provides adequate funding," said Patrick Campbell, chief legislative counsel of IAVA. Eight organizations represented at the hearings belong to the Partnership for Veterans Health Care Budget Reform, which strongly supports both VHCBRTA and mandatory funding.

The hearings included many references to the need for the DoD and the VA to share health records electronically—a goal that the departments hope to achieve by September 30, 2009. Joseph L. Barnes, national executive director of FRA; Charlie L. Flowers, national president of REA; and Novoselsky added that the DoD and the VA should establish a permanent, jointly staffed agency to oversee interdepartmental collaborations.

Some speakers argued that the VA should do more to train and support caregivers of disabled veterans. Dawn Halfaker, vice president of the board of directors for WWP, said the VA should provide such caregivers with group counseling, a 24-hour hotline for urgent assistance, 30 days of respite care per year, health care coverage, and a monthly allowance on par with the cost of contracting for similar home care through local agencies. The VA also should eliminate copayments for some catastrophically disabled veterans, according to Norman Jones, Jr., national president of BVA, and Randy L. Pleva, Sr., national president of PVA.

Concerns about the quality of care available to female veterans and the access to care available to rural veterans came up repeatedly during the hearings. Campbell called for the VA to reduce variability and ensure consistency of services provided by its women's health clinics. He also suggested establishing "a pilot program that creates a network of drivers" to support rural veterans who lack transportation to VA hospitals. Garner and H. Gene Overstreet, president of NCOA, added that limited contract care could help bring VA services to remote areas.

Mental health issues also were discussed by several speakers. John Chad Hapner, national commander of AMVETS, said that "a systematic postdeployment survey with targeted questions" could help to detect mental health problems.

Endoscopic Equipment Errors Leave Veterans at Risk

In March, the Miami VA Medical Center (MVAMC) in Miami, FL announced that it had failed to disinfect some endoscopic equipment properly and, thus, had exposed thousands of patients to a minimal risk of hepatitis or HIV infection. This discovery was the third of its kind to emerge in the VA in recent months, and a VA spokesperson said on March 27 that the department is conducting an internal, system-wide evaluation of endoscopic equipment use.

The first problem emerged on December 1, 2008 at the Alvin C.

York Campus of the VA Tennessee Valley Healthcare System (VATVHS) in Murfreesboro, TN. There, an incorrect valve was found in an irrigation tube used during a colonoscopy, and another tube may not have been changed properly between procedures. In addition, the Augusta VA Medical Center (AVAMC) in Augusta, GA was found to have conducted ear, nose, and throat examinations with improperly reprocessed endoscopic equipment. In response, the VA issued a memo on February 4 directing all of its medical centers to conduct an intensive program of endoscopic equipment training and review. The MVAMC's discovery of improperly disinfected endoscopes emerged from this program.

After each of these incidents, the VA informed patients who may have been affected and offered them free blood testing. Letters were sent to about 6,400 patients who had colonoscopies at the VATVHS between April 23, 2003 and December 1, 2008; about 1,100 patients who underwent ear, nose, and throat procedures at the AVAMC between January and November 2008; and more than 3,200 patients who had colonoscopies at the MVAMC between May 2004 and March 2009.

The VA said on March 25 that 10 VATVHS patients and six AVAMC patients had tested positive for infection thus far. Of the VATVHS patients, six had tested positive for hepatitis C infection and four had tested positive for hepatitis B infection. Results for the AVAMC patients were still being evaluated. A VA spokesperson emphasized that the patients may have contracted these infections from sources other than the endoscopic equipment. According to a March 26 article in *The New York Times*, Anthony Kalloo, MD, chief of gastroenterology and hepatology at Johns Hopkins University School of Medicine in Baltimore, MD, identified the risk of cross-contamination from the MVAMC's equipment to be about one in 1.8 million.

In addition to its system-wide review, the VA has sent a five-member team of physicians and administrators to investigate what went wrong at the MVAMC. Both Rep. Steve Buyer (R-IN) and Sen. John F. Kerry (D-MA) have asked VA Inspector General George J. Opfer to investigate the endoscopic equipment issue, and Buyer has further requested that the House VA Committee address the issue in an oversight hearing. ●