

Congressional Hearings

May 6, 2003

VA Homeless Assistance Programs

Review by House Veterans Affairs Committee (HVAC), Subcommittee on Health, 334 Cannon House Office Building (Cannon) at 1:00 p.m.

May 7, 2003

VA Medical Care Collection Fund

Review by HVAC, Subcommittee on Oversight and Investigations, 334 Cannon at 2:00 p.m.

May 8, 2003

Alleged fraud, waste, abuse and mismanagement in VA programs.

Review by HVAC, Subcommittee on Health, 334 Cannon at 10:00 a.m.



**Message from the Chief Consultant,
Proposed Office of Care Coordination,**
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Making Home the Preferred Place of Care for Patients

VHA is embarking on a nationwide roll out of a new model of care delivery which seeks to make the home the preferred place of care, when appropriate.

Some 30,000 to 60,000 veteran patients may initially benefit from this care coordination program that will help manage many chronic diseases. These include diabetes, congestive heart failure, wound care, Alzheimer's and Parkinson's disease and multiple sclerosis.

Most importantly, this program will help to maintain independence in patients with many chronic diseases, help them live longer in their own homes, and prevent or delay long-term institutional care

Over the last five years, the use of information technology has transformed the way VHA provides care for patients. The computerized patient record makes patients' information available to providers at the point of care. Gone is the frustration for patients of having to keep repeating the same basic information such as address, date of birth, symptoms and medications at every stage of the care delivery process. Moreover, charts are no longer missing; and medication errors have been drastically reduced.

Other advances in information technology are further transforming the convenience of care delivery by electronically connecting patients, in their homes or in assisted living facilities, to computer chat rooms for PTSD support.

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VA Actions on Severe Acute Respiratory Syndrome (SARS)

VA is taking steps to protect staff and patients from and keep them informed about severe acute respiratory syndrome, or SARS, a serious illness characterized by fever and respiratory symptoms that may progress to a fatal form of pneumonia.

Reporting: A Directive is being issued requiring facilities to report initial and follow-up information on SARS cases to their VISN office, which will forward the information to the Office of Public Health and Environmental Hazards (13). As of April 18, 7 suspected SARS cases in VA had been reported.

Supplies: Respiratory isolation rooms with negative air pressure should be used for suspected SARS patients where possible. Health care workers should employ personal protective equipment appropriate for standard, contact, and airborne precautions, including eye protection. Airborne precautions require use of a NIOSH-certified N-95 respirator; higher-level protection may be considered for aerosol-generating procedures.

Information and training: A VA SARS web site has been established, and is updated almost daily, at <http://www.publichealth.va.gov/SARS> with links to the lead Federal agency, the Centers for Disease Control and Prevention (CDC) at <http://www.cdc.gov/>, to the World Health Organization, and to the medical literature. VA has developed and placed on its web site SARS information for clinicians, as well as for employees, patients, and visitors.

Guidance: VA is following CDC guidance on triage and evaluation of suspected SARS patients, management of exposure to SARS in health care institutions, and SARS infection control practices.



CARES is taking steps to assure that VA is able to meet its emergency management responsibilities support for the Department of Defense (DoD) if backup care is needed.

Networks must include these goals in deciding where their hospitals and clinics are placed, and their size and scope.

"I support, respect and honor our DoD mission," said Under Secretary for Health Robert Roswell. "But the critical thing is not surge capacity with regard to beds, it's staffing. I have asked all of our directors to identify ways to bring back retirees, to increase use of part-time nurses, and to reemploy nurses who are in non-nursing roles.

"Holding on to facilities with the idea that they create surge bed capacity is not the answer. Excess buildings are not the core component of any response to a national emergency.

"Let me assure you, this is something the CARES team and I take very seriously."

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Making Home the Preferred Place of Care for Patients

Monitoring devices for chronic diseases, with video conferencing for consultation advice, are available for patients to remotely monitor their vital signs.

VHA's health care delivery is being transformed by the marriage of these new technologies and trained health professionals who coordinate care for patients. As a result, patients show greater than 90 percent satisfaction with such care. They need fewer hospital admissions and outpatient visits and less medication.

The new Office of Care Coordination is being developed within VHA's Office of Patient Care Services. It will support the national care coordination roll out, provide e-health information to patients and contribute to the patient held record, My Health-e-Vet. The new office will work collaboratively with VHA and network groups to bring care to the patient where, when and how they need it.

VHA Re-emphasizes Coronary Care Guidance to Staff and Patients

VHA medical care staff members are now being reminded to advise all patients to:

- ?? Be acutely aware of signs and symptoms of a heart attack
- ?? Immediately call 911 when heart attack symptoms appear
- ?? Tell the responding ambulance driver to proceed immediately to the nearest hospital emergency room, even if it is not at a VA facility

VA would pay for costs of the ambulance and for the subsequent coronary care for eligible veterans, according to VA officials.

VA Study Compares Cardiac Care Data of VA and Medicare Patients

A VA sponsored study by Harvard Medical School and PriceWaterhouseCooper compared mortality data for VA and Medicare patients who suffered heart attacks in 1997-1999. While a higher mortality rate was found among VA patients at the 30-day, 1, 2 and 3-year points, neither the study team nor VA know the reasons for the differences.

However, the study team noted a possible relationship between the higher mortality rate and two other findings: veterans were less likely than Medicare patients to undergo invasive procedures such as coronary angiography, angioplasty and surgery; and veterans traveled twice as far for critical cardiac care than Medicare patients: 30 miles versus 15 miles.

VA is reviewing the study to determine why fewer invasive interventions were performed, and how to either shorten travel times for veterans or encourage them to seek closer private care in emergencies. VA is committed to a thorough analysis of the study findings and to developing plans to correct any deficiencies in the quality of its cardiac care.

Both VA and the study team acknowledge that they do not fully understand the outcomes of the study.

The study team used basic administrative data to reach its conclusions, but a more thorough look at related clinical and socioeconomic data will be required to better comprehend the findings of the study and the VA cardiac care program.

Whether the burden of disease in the veteran population is greater than in the Medicare population, and the most important underlying factor determining morbidity and mortality, can only be determined by a more complete clinical review of patient records.