

*Statement
of*

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Mr. Chairman and members of the Subcommittee, I am pleased to be here today to discuss the progress, challenges, and future direction of health care in the Department of Veterans Affairs (VA).

Since 1995, we have dramatically transformed the VA health care system. We have moved from an inpatient model of care characterized by limited facilities often far from patients' homes to an outpatient model with more than 350 additional sites of care. While we still provide comprehensive specialty care, we now also emphasize the coordination of care through the universal assignment of primary care providers and teams. We emphasize disease prevention and early intervention, allowing veterans to avoid illnesses and complications and allowing us to avoid the added costs of their treatment. As a result of these strategies, VA today is able to provide higher quality care to more than 500,000 additional veterans with 25,000 fewer employees than it did just six years ago. Moreover, since 1997, VHA has reduced the cost per patient by 24 percent.

The key goal that underlies VA's transformation and continues to drive our strategies for the future is a quest for health care value. We have defined value as quality divided by cost. While we do not yet have a perfect system to measure either quality or cost, we have made significant progress in measuring both. We have defined and developed measures across four domains of quality (technical quality, access, patient satisfaction, and functional status) and

continue to improve our measurement of cost. The quality and cost measures are directly translated into our value framework and the “six for 2006” goals.

Before I detail our progress and current strategies toward the “six for 2006,” I would like to comment on some of the overarching themes and strategies that pertain to most or all of the 2006 goals. The following issues are important areas of concentration for us and will directly impact our success in achieving our key goals. They are workforce development, information technology, performance measurement, quality and capacity in our special emphasis programs, enhancement of our academic missions of teaching and research, the Veterans Health Initiative, rationalization and modernization of our facilities (CARES), distribution of funding (VERA), and continuous self assessment using the Baldrige process.

Workforce Development. VA’s health care workforce is the key to achieving all of our goals. We must recruit, retain, and develop the best staff if we are to continue to improve. Recently, we have noted shortages of nurses and pharmacists in some parts of the country and the projected shortages in these and other professions are alarming. Increasingly, we have difficulty matching private sector pay levels in such critical areas as physician specialists and computer experts. We also must continuously invest in the education of our workforce to allow them to keep pace with changing patient needs and rapid changes in health care technology. Last year, I established a taskforce to recommend a comprehensive set of actions to address these and other workforce issues. The recommendations of this taskforce are currently under review.

Information technology. Information technology is at the heart of most changes in VHA. We use technology to process clinical and administrative information, to automate previously manual processes, to deliver care across distances, to train staff, and to conduct research. Examples of the use of technology include the computerized patient record, a cost accounting and

analysis system (DSS), consolidated mail out pharmacy (CMOP), simulated patient training in surgery and anesthesia, gamma-knife radiation therapy, advanced neuro-imaging, bar-coding to aid in the accuracy of medication administration, tele-health, and many others.

Two key principles in the development of our computerized medical record are that it is owned by the veteran and that it must be compatible with emerging and established standards such that a veteran can take his/her electronic record to or bring it from any other health care service provider. If a veteran chooses VA to maintain the health record, we must preserve its integrity and security and use it only for the benefit of the veteran or society – and only with his/her permission. We call our initiative for a veteran-controlled health data repository and associated functionalities "HealtheVet."

Performance measurement. The performance measurement system used in VA has played a key role in the transformation of the system and will continue to be a key strategy in the continued evolution of the system. Each year, approximately twenty key measures are selected for emphasis and become the significant component of a performance contract between network directors or chief officers and the Under Secretary for Health. Some of the detailed results are presented below. The power of the system is derived from the focus on defining the most important goals for the year, the development of measures to chart progress toward those goals, the open feedback about the progress (or lack of progress) toward those goals and the necessity that administrators must team with front line staff to make the outcomes for patients change.

Quality and capacity in special emphasis programs. Since 1996, we have moved from inpatient care to outpatient models in medicine, surgery, and mental health. The numbers of patients seen with serious mental illness, for homelessness, or suffering with PTSD have increased. The number of patients with substance abuse treated has decreased, especially between FY 1999 and FY 2000. We are working to understand the reasons for this drop and to assure

access to substance abuse programs in our clinics as well as in our larger facilities. To this end, I plan to establish a National Mental Health Improvement Program (NMHIP). This program will be modeled after a number of well-established VA data-driven improvement programs, such as the Continuous Improvement in Cardiac Surgery Program (CICSP), the National Surgical Quality Improvement Program (NSQIP), the VA Diabetes Program, the Pharmacy Benefits Management Program (PBM), and the Spinal Cord Injury/Dysfunction National Program. This new program will use validated data collection, expert analysis, and active intervention by an oversight team to continuously improve the access, outcomes, and function of patients in need of our mental health programs. These programs include those for patients who are Seriously Chronically Mentally Ill, or who suffer from Post Traumatic Stress Disorder, Substance Abuse, or Homelessness. This program will draw upon existing resources in our Health Services Research and Development Service (HSR&D) including existing initiatives in our Quality Enhancement Research Initiative (QUERI) and our Mental Health Strategic Health Care Group (MHSHG) including the Northeast Program Evaluation Center (NEPEC).

The number of patients treated for spinal cord injury and dysfunction, blind rehabilitation, and traumatic brain injury has increased over the 1996 baseline. Fortunately, the number of patients needing amputation has decreased due to our aggressive management of vascular disease and diabetes.

Academic missions. The academic missions of research and health professions education are part of our “six for 2006” goal to “build healthy communities.” However, they are also a critical strategy to deliver high quality and efficient care. These missions allow us to attract the very best and brightest clinical staff and enable us to be early adopters of new advances in medical knowledge and practice. We must challenge our academic staff to turn their creative talent loose on the development of new care delivery models that can simultaneously address quality, convenience, research, and education. We will engage them in that quest.

Veterans Health Initiative. The Veterans Health Initiative was established in September 1999 to recognize the connection between certain health effects and military service, prepare health care providers to better serve veteran patients, and to provide a data base for further study. The development for this initiative began with the Military Service History project, which involved a pocket card for medical residents. This card details the important components of a military service history, summarizes some of the health risks associated with various periods of service, addresses more generic health issues of concern to all veterans, and specifies Web sites containing references relevant to the issues.

The components of the initiative will be a provider education program leading to certification in veterans' health; a comprehensive military history that will be coded in a registry and be available for education, outcomes analysis, and research; a database for any veteran to register his military history and to automatically receive updated and relevant information on issues of concern to him/her (only as requested); and a Web site where any veteran or health care provider can access the latest scientific evidence on the health effects of military service.

Aligning capital assets to veterans' needs. CARES (Capital Asset Realignment for Enhanced Services) will affect every network in VHA. We have embarked on a significant new planning process with the goal of enhancing health care services to veterans by realigning capital assets. The CARES process starts with the objective assessment of veterans' current and future health care needs within each network and proceeds with the identification of service delivery options to meet those needs and the strategic realignment of capital assets and related resources to better serve the needs of veterans. Through CARES, networks will develop plans for enhanced services that are based upon objective criteria and analysis, cost-effectiveness and may include capital asset restructuring. These plans will take into account future directions in

health care delivery, demographic projections, physical plant capacity, community health care capacity and workforce requirements. Network capital asset realignment proposals will be evaluated and ranked by VHA using a structured decision methodology. All savings generated through implementation of CARES will be reinvested in meeting veterans' health care needs.

Resource allocation. To date, no ideal system to allocate resources in health care has been devised. Fee for service plans lead to overuse of procedures and high costs while managed care plans are criticized for restriction of choice of provider and of access to specialty care. VA uses a risk adjusted, capitated model called VERA (Veterans Equitable Resource Allocation) to allocate resources among VHA's 22 networks. Distribution within each network is based on a set of principles, but in the absence of an ideal system, we have not mandated a single method for all networks. Ideally, VERA would be simple, fair, and promote quality of care. We do not believe that any models have been able to drive quality, therefore, we keep the allocation system simple and work hard to measure the quality of care provided.

VERA has undergone extensive scrutiny since VHA implemented it in 1997. The effectiveness of VERA has been assessed by PricewaterhouseCoopers and by two GAO reviews. All three studies viewed VERA in positive terms. PricewaterhouseCoopers reported that VERA, which allocates resources based on objective measures of need, is ahead of other budget allocation systems, which typically depend on historical allocations with periodic adjustments.

We reviewed the recommendations from PricewaterhouseCoopers and GAO and implemented many of them. For FY 2001, the following VERA policy changes or refinements were approved for the network budget allocations:

- VERA Basic and Complex patient classes and criteria were developed for hepatitis C patients.
- The Complex Care projection methodology was adjusted to delete the veteran population factor in favor of historical utilization.

- Research support funds were passed through VERA directly to each VA medical center.
- VHA changed the workload factor for computing the labor index that weights Basic and Complex Care workload consistent with recent costs.
- The three-year phase-in of Non-Recurring Maintenance (NRM) based fully on patient care workload and the cost of construction was completed.

We are currently examining several additional areas of possible refinements to VERA for implementation in FY 2002 or later, but no conclusions have been made yet. These areas include patient classifications, priority 7 veterans and market share, the cost impact of treating patients above age 75, the existing geographic price adjustment formula to include contracted salary rates and energy expenditures, and the use of risk adjustment models to account for differences in age and disease burden in the population served. We remain committed to the evaluation of all reasonable explanations for variance in the model.

Baldrige and the future. VHA will apply for the President's Quality Award in the fall of 2001 and for the Malcolm Baldrige National Quality Award in May of 2002. We do not undertake these processes for the awards themselves, although we aim to win. Rather, we seek the experience, the outside feedback, and the development of skills in critical self-assessment. We have been struck by the economic success of previous award winners and by their achievements in service quality. We believe that we can identify gaps in our systems and can improve the integration of all we do. The Baldrige criteria will provide a structured and integrated framework for many of the processes we perform today. In the end, sober self-assessment is a skill that should benefit any organization.

Within the last year we have updated VHA's strategic framework to reflect six organizational goals that closely match our six domains of health care value.

I will now review our progress and plans for achieving these goals, which are known as the “six for 2006.”

Put Quality First until First in Quality. A major force in the transformation of the VA health care system was the implementation of the Performance Measurement System. This system was initiated to meet challenges of improving health care quality, patient satisfaction, and economic efficiencies. The foundation of the Performance Measurement System is broad, statistically reliable, ongoing measurement of performance objectives. As a result of this system, VHA is increasingly able to measure and report on quality. Moreover, the ability to measure allows us to identify areas for improvement.

VHA’s quality is not merely good -- in many areas it surpasses government targets and private sector performance. VHA’s record regarding post-operative morbidity and mortality is as good as or better than that found in any published study of non-VA surgical programs. Our immunization rates for pneumococcal pneumonia and for influenza far exceed the goals established for the U.S. population. Our breast and cervical cancer screening rates are also well above the national average performance in these areas. VA patients receive life-saving aspirin and beta-blocker administration after heart attacks 96 percent of the time, whereas Medicare patients receive this therapy in only 68 percent of cases.

VHA recognized that the use of evidence-based, clinical practice guidelines would have an appreciable impact on patient care and initiated development of National Clinical Practice Guidelines in 1995. Guidelines were established for many high volume, high risk diseases. A joint effort between VA and DoD has led to the development of more than a dozen clinical practice guidelines intended to assure quality and continuity of care.

VHA’s strides in quality and its leadership in health care quality management were specifically cited at the recent Institute of Medicine briefing accompanying the publication of their report, “Crossing the Quality Chasm.” To further our efforts in quality improvement, we will continue to use and update our

extensive quality and performance measurement tools. For example, the expanded Prevention Index and the Chronic Disease Care Index, which now encompasses the clinical practice guidelines, were recently revised on the basis of the current medical literature and expert opinion.

In 1998, VA launched the Quality Enhancement Research Initiative (QUERI). The QUERI mission is to translate research discoveries and innovations into better patient care and systems improvements. It is founded on the principle that practice needs determine the research agenda, and research results determine interventions that improve the quality of patient care. The Institute of Medicine, in its report "Crossing the Quality Chasm," specifically noted QUERI as a model for translating the best research evidence into the best patient care.

VHA has also been recognized as a leader in efforts to prevent health care errors and improve patient safety. Improved patient safety requires reporting systems to identify and understand adverse events and close calls and the design and deployment of systems that reduce such vulnerabilities. VHA has introduced a mandatory reporting system for adverse events and close calls that is coupled with rigorous root cause analysis. This system has been operational for over a year and has resulted in a 900-fold increase in close calls reported. Close call analysis is the preferable way to learn of system vulnerabilities, because they can be identified without patient injury.

VA also believes that health care will discover additional vulnerabilities by instituting a separate, voluntary, and anonymous reporting system. To that end, VA formed an agreement with NASA to develop a Patient Safety Reporting System (PSRS) patterned after one that has been used successfully in aviation. The system's guiding principles are voluntary participation, confidentiality protection, and non-punitive reporting. It is designed to be a complementary external system to our current internal reporting system. VA's National Center for Patient Safety and NASA have been working on the design and development of this system. Pilot testing will begin this year with the entire system on line by the beginning of FY2002.

The discovery of system weaknesses must be followed by system redesign. Examples of system improvements include: national implementation of Bar Code Medication Administration (BCMA) that improves the accuracy of medication administration, extensive deployment of computerized order entry that eliminates handwriting and other common errors, the removal of bulk medications from nursing wards to minimize mixing errors, and working through an interactive fix of a design flaw in a temporary transvenous pacemaker with the manufacturer.

Provide Easy Access to Medical Knowledge, Expertise, and Care.

Traditionally, access to care has addressed issues of travel times, waiting times, and insurance. This goal includes those issues as well as access to knowledge via the telephone or Internet and access to the knowledge of specialists where appropriate.

As VA has shifted from an inpatient-focused system to one that is outpatient-based, we have extended care to 350 additional sites, for a total of more than 1,300. Approximately, 100 additional community-based outpatient clinics have received congressional approval and are slated to be phased in over the next several months. Telephone triage and advice programs have been implemented at all hospitals, and health education is available on the Internet. Last year, VA did more than 350,000 consultations via telemedicine (the patient or a diagnostic image and the provider were connected via voice and usually video). Telemedicine and home-care teleconsultation initiatives have also been implemented for spinal cord injury patients. In 1998 and 1999, the Vet Center program implemented the Vet Center-Linked Primary Care project. Telemedicine is used in 20 Vet Centers to promote access to primary care for high-risk, underserved veterans in locations closer to their respective communities.

Applying for VA health care has never been easier. We have eliminated almost three-fourths of the health care-related forms we once required. Veterans can now obtain applications for enrollment and medical care over the Internet.

Veterans may send the forms electronically to the VA health care facilities they have selected or they can print out the completed forms and mail them.

Eligibility reform and community clinics have enhanced access but in some areas demand has preceded recruitment resulting in extended waiting times for appointments. VHA is committed to providing timely care to the veterans enrolled in our health care system. We have recently developed a data system and performance expectations with regard to waiting times for primary care and specialist consultation. We believe that our performance goals for waiting times, commonly known as “30-30-20,” are industry leading and fully support patient expectations for timely access to care. Our strategic goal is to provide 90 percent of new primary care and specialty care visits within 30 days, and see 90 percent of patients within 20 minutes of their scheduled appointment time. Of course, patients with emergencies or urgent needs are seen as quickly as is medically appropriate. VHA is now working with the Institute for Healthcare Improvement (IHI) on a major initiative that will focus on the rapid spread of the most successful actions underway within each VISN to achieve the “30-30-20” performance goals. VHA has already seen system-wide improvements in average clinic waiting times between the start in April 2000 to December 2000.

While the early progress on waiting times is encouraging, we have more to do in the broader field of access. We must eliminate barriers to care which result from such things as poverty, race, gender, geography, language, age, and bias. We will evolve strategies to provide care to vulnerable populations including the homeless, the mentally ill, the aged, and those infected by the Hepatitis C virus. We also have developed a body of knowledge about veterans’ health issues that we will make available to any veteran or any health care provider.

VHA has been faced with access issues in extended and long term care. VA has expanded programs targeted for the elderly, including Geriatric Evaluation and Management (GEM) Programs, home-based primary care initiatives, and pilot programs in long-term care and assisted living as authorized by the Veterans Millennium Health care and Benefits Act, Public Law 106-117.

Enhance, Preserve, and Restore Patient Function. The restoration of function (rehabilitation) is the cornerstone of VA's health care mission. VA has nationally recognized programs for the rehabilitation of veterans who are blind, suffering from brain dysfunction, afflicted with spinal cord injuries, or who are amputees. Notable progress is being made in the development of outcome measures that evaluate functional improvements in each of these special programs.

Amputation rates in VA are lower than age-matched private sector populations and continue to decrease. Activities are underway to further integrate all of VA's low vision and blind programs to improve the continuity of care. A recent report comparing VA spinal cord care with that in the U. S. private sector and in Sweden concluded that the totality of VA's benefits package is unmatched. VA provided far greater continuity and breadth of care than did the private sector. Life-long, integrated, and comprehensive care for spinal cord patients is provided in VA and Sweden, but not in other venues. The Traumatic Brain Injury (TBI) Network of Care provides case-managed, comprehensive, specialized rehabilitation spanning the period from discharge from the acute surgical treatment unit until permanent living arrangements can be made. A significant number of these patients are referred to VA facilities from the military. Nine research centers of excellence conduct studies emphasizing wheelchair design and technology, brain rehabilitation, spinal cord injury and multiple sclerosis, early detection of hearing loss, orientation techniques for blind persons, and amputation prevention and joint replacement.

VA also provides comprehensive mental health services across a continuum of care, from intensive inpatient mental health units for acutely ill persons to residential care settings, outpatient clinics, Day Hospital, and Day Treatment programs. The number of veterans receiving mental health care in the VA health care system has steadily increased since 1996. VHA will continue to monitor care and work with networks to improve and maintain both the capacity and the quality of care for all veterans with serious mental illness. Recent initiatives have been undertaken to increase mental health treatment in community-based outpatient clinics, increase use of assistive community

treatment for the most seriously mentally ill veterans, and increased use of opiate substitution clinics in major urban centers. It is also worth noting that VA is the only federal agency that provides substantial hands-on assistance directly to homeless veterans and has the largest network of homeless assistance programs in the country.

The primary objective of all special programs is to provide the best possible care and achieve the maximum independence for patients by restoring lost function or decreasing the impact of their disabilities. We will continue to enhance our programs in rehabilitation, sharpening our focus on improved functional capacity for veterans who suffer from spinal cord injury, blindness, amputations, brain dysfunction, and mental illness. To improve the integration of activities and to assure VA has adequate capacity to meet the specialized health care needs of veterans, VHA has created a position in headquarters to serve as the coordinator for special disability programs and has designated a clinical coordinator in each VISN to work with individual facilities and headquarters offices to monitor capacity and maintain specialized services.

Exceed Patients' Expectations. VA created the National Customer Feedback Center (now the National Performance Data Feedback Center, or NPDFC) in 1993 to measure and improve patient satisfaction with care and to allow comparison with other health care systems. Annual inpatient and outpatient patient satisfaction surveys based on the Picker instrument were developed using focus groups of patients and their families. Patient service standards were also developed, and specialty surveys, such as long-term care, have been added over the years. Beginning in FY 2001, VHA's new Performance Analysis Center for Excellence (PACE) will refine and expand the data feedback, satisfaction surveying, and other objectives accomplished by the NPDFC. PACE will use clinical literature and VA data to identify new clinically and operationally important performance improvement opportunities, aligning activities with the strategic objectives of VHA's "6 for 2006."

The overall customer satisfaction scores from VHA's inpatient and outpatient surveys have remained relatively flat for the last several years, with approximately 65 percent of patients rating VA's services as "very good" and "excellent." However, when we consider the significant structural and programmatic realignments the VA health care system has undergone in the last six years, it is gratifying that veterans continue to show a high level of satisfaction and confidence in VA health care. Nonetheless, we believe that a more focused approach will have a strong impact on improving our performance. Therefore, in FY 2001 VHA will begin to focus on three key areas of patient satisfaction: patient education, visit coordination, and pharmacy services. These are areas in which our surveys indicate that we have the greatest opportunity and need for improvement. In addition, we will further focus the system on the patient by emphasizing the goal of ensuring that veterans participate fully in decisions affecting their health care and understand those decisions completely.

The American Customer Satisfaction Index (ACSI) provides an independent assessment to be used with VA's own data. This Index, a cross-industry/government measure of customer satisfaction released December 22, 2000 asked questions about veterans' overall satisfaction with their experiences in a recent visit to a VA medical center. Overall, VA's customer satisfaction index was 78 on a 100-point scale, seven points above the customer satisfaction score of 71 given by the general public for all sectors of business, and eight points above the score for private hospitals. Customer service, perceived in terms of courtesy and professionalism, was the highest of VA's three measurement areas, an average score of 87. ACSI considers scores above 80 to be "high." On questions about patients' likely return to VA medical centers and willingness to say positive things about VA, VA scored an 88.

Maximize Resource Use to Benefit Veterans. Since 1997, VHA has reduced the cost of care per veteran treated by 24 percent. But while a reduction in costs is a significant accomplishment, it does not, by itself, assure that we are obtaining or providing the best health care value for the dollars we spend.

Therefore, we have developed a VALUE index that includes both cost and other domains of value such as quality, access, and satisfaction in order to express meaningful outcomes for VHA's resource investments. Unlike a simple cost measure that can lead to false impressions of efficiency, the VALUE measure demonstrates a balanced perspective of cost efficiency along with desired outcomes. The measure portrays the desired outcomes that VHA purchases with its budgeted resources by establishing a value relationship of Quality-Access-Satisfaction to dollars (QAS/cost). The use of the QAS/Cost VALUE measure will establish an understandable value relationship of outcomes to dollars.

We must also expand our partnerships with federal, state, local, and private entities to minimize redundancy in programs and services and to leverage our buying power. Through multiple partnerships, VA will be in a position to manage its services in such a way as to enhance the quality and coordination of care provided to veterans.

Build Healthy Communities. Veterans can only reach their maximum health potential if they live in healthy communities and healthy environments. We will continue our work in detecting emerging pathogens, in the immunization of large populations, and in the understanding of the long-term effects of toxic agents on health. Our research and educational roles will continue to benefit veterans and non-veterans alike. Our pioneering work in patient safety has the potential to improve health care for all. We will work with community partners to combat homelessness and to coordinate care for veterans. VA's influence on the nation's health goes well beyond its primary mission of providing care for veterans.

We will continue our efforts to integrate our research and educational roles with our rapidly changing care delivery system. VA's research program, the recipient of three Nobel Prizes and a plethora of other awards, concentrates on health care concerns that are prevalent among veterans. VA fosters multidisciplinary research, pilot studies, and research training for teams of

investigators unraveling questions concerning such health issues as cancer, multiple sclerosis, Hepatitis C, kidney disease, depression, stroke, Alzheimer's disease, heart attack, lung disease, bone disease, Parkinson's disease, diabetes, gastrointestinal disorders, and wound healing. VA's research program also pursues research at the interface of health care systems, patients, and health care outcomes. The priorities have expanded to include access to health care, managed care strategies, the effect of facility integrations, changes in clinical services organization with line management, and ethnic, cultural, and gender issues as they relate to health services use. Many VA research studies have been used within and outside VA to assess new technologies, explore strategies for improving health outcomes, and evaluate the cost-effectiveness of services and therapies.

VA's research program will continue its decidedly clinical focus as a unique national asset. To this end, VA Research intends to lead the nation in multi-site clinical trials, rehabilitation research and development, and health services research and development. The majority of research allocations will continue to be devoted to health services research and research with potential clinical applications. Lastly, VA's research program, through the high quality of its research offerings, will attract and retain highly trained clinician researchers who will continue to enhance the VA's patient care mission.

VA's training mission is accomplished through academic affiliations with many of the nations' medical schools and other schools in health sciences, an important and unique characteristic of the VA health care system. VA remains the nation's largest provider of graduate medical education. Affiliations with 107 of the nation's 125 medical schools provide the context for training that annually affects over one-third of the nation's medical resident trainees, including half the nation's third and fourth year medical students. In addition, over 54,000 associated health trainees in nursing, psychology, pharmacy, and over 40 other disciplines receive part or all of their clinical training in VA facilities. We currently fund approximately 9,000 positions in graduate medical education. As residents rotate through these positions, they are exposed to the best evidence-based

medical practices in the country. They take this knowledge with them as they complete their training and begin their careers in the care of veterans and non-veterans. VA can claim it has trained, at least in part, more than half of the nation's practicing physicians.

VA's academic affiliations are robust and provide vigorous opportunities for providing the best approaches for continuous improvement of health care for veterans while contributing to strengthened academic medical institutions throughout the country. We must work hard to keep them healthy.

In providing medical contingency backup for the Department of Defense, VA supports DoD's medical system during wartime. VA also assists the Public Health Service, The Federal Emergency Management Agency (FEMA) and the National Disaster Medical System (NDMS) in providing emergency care to victims of natural and other disasters. Under Presidential Decision Directive 62 (Combating Terrorism), VA works with the Department of Health and Human Services to procure stockpiles of antidote and other necessary pharmaceuticals, and to train medical personnel in NDMS hospitals for responding to the health consequences of the use of weapons of mass destruction. VA is uniquely positioned to do this training since it represents a large portion of the Nation's medical capability and has facilities located throughout the country. I cannot stress too much the importance of VA's role in emergency preparedness and response, and I will work to ensure that VA remains able to meet its obligations.

In summary, Mr. Chairman, VHA has chosen goals that would challenge any organization. Our organization has undertaken a profound transformation and should be justifiably proud of its accomplishments. However, we must continue to change and adapt as changes in information technology, biotechnology, health care financing, and public accountability impact all health care systems. Additional gains in health care value are possible if we are able to manage health information more effectively, improve care coordination and communications with our patients, eliminate variability in care and change our infrastructure as needed to meet current needs. As we look to the future of VA

health care, we are very optimistic that VA will meet the challenges it faces and will be viewed as a model health system for its many accomplishments.