LEGISLATIVE HEARING ON H.R. 1490, 'VETERANS' PRIVACY ACT;' H.R. 1792, 'INFECTIOUS DISEASE REPORTING ACT;' AND H.R. 1804, 'FOREIGN TRAVEL ACCOUNTABILITY ACT'

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

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Wednesday, June 19, 2013

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
Washington, D.C.

The Subcommittee met, pursuant to notice, at 1:30 p.m., in Room 334, Cannon House Office Building, Hon. Mike Coffman [Chairman of the Subcommittee] presiding.

Present: Representatives Coffman, Roe, Huelskamp, Benishek, Walorski, Kirkpatrick, and O'Rourke.

Also Present: Representative Miller.

OPENING STATEMENT OF CHAIRMAN COFFMAN

Mr. COFFMAN. Good afternoon. This hearing will come to order.

I want to welcome everyone to today's legislative hearing on H.R. 1490, the Veterans' Privacy Act; H.R. 1792, the Infectious Disease Reporting Act; and H.R. 1804, the Foreign Travel Accountability Act.

The three bills we will consider today are the result of investigations conducted by this Subcommittee in the course of its oversight duties that have reported poor judgment and mismanagement by the Department of Veterans Affairs.

These bills are intended to heighten the protections for our veterans at VA medical centers and prevent the recurrence of problems identified in the investigations.

H.R. 1490, the Veterans' Privacy Act, was introduced by the Chairman of the Full Committee, Representative Jeff Miller. The bill directs the secretary of Veterans Affairs to prescribe regulations to ensure that in the absence of informed consent by the patient or their legal representative and any visual recording can only be conducted under limited circumstances such as under a court order.

In April, I introduced H.R. 1792, the Infectious Disease Reporting Act. Based on investigations conducted by this Subcommittee as well as a hearing in February, it is clear that VA needs to be held to the same standard for infectious disease reporting as its health care counterparts in each state.

The Infectious Disease Reporting Act will require VA facilities nationwide to comply with state infectious disease reporting requirements. Once reported to the state, this data will be reported

to the Centers for Disease Control and Prevention and used to monitor public health.

Each state faces its own unique challenges regarding infectious diseases and the Infectious Disease Reporting Act takes this into account.

It is baffling to me that the University of Pittsburgh Medical Center Hospital which sits just a few hundred feet from the Pittsburgh VA Medical Center is required to report infectious diseases while the VA hospital is not.

The news reports from Pittsburgh this last weekend detailing the extent of the Legionella problem and that it dates as far back as 2007 underscore the need for this legislation.

The fact that VA provided information to reporters that this Subcommittee has been requesting since January is unacceptable. This lack of transparency looks like an attempt to evade legislative oversight and makes me wonder whether there is more to the story than what VA has chosen to reveal.

The need for the Infectious Disease Reporting Act is reflected not just in the Legionella Disease outbreak in Pittsburgh, just last month, almost 20 veterans tested positive for hepatitis A or B after a VA hospital in Buffalo admitted to reusing insulin pins on patients.

Time and again, we have heard from VA that they are industry leaders in various areas, but infectious disease reporting, VA does not even compete.

Our final bill today is H.R. 1804, the Foreign Travel Accountability Act, which was introduced by Congressman Tim Huelskamp, a Member of this Subcommittee. This bill directs the secretary to submit to Congress semi-annual reports on foreign travel. The reports will include among other things the purpose of each trip, the destination, and the total cost to the department.

In January, after VA told him the State Department may have records on VA foreign travel, Chairman Miller sent a request to the State Department for more information.

Just last week, he received the State Department's two cents reply which referred him back to VA. This ridiculous finger pointing clearly exhibits the need for this legislation.

It is important that taxpayer dollars appropriated to VA are properly spent on providing the care and benefits our veterans have earned, not sending VA employees abroad on taxpayer subsidized vacations that do little to improve the care veterans receive.

I appreciate everyone's participation in today's hearing and now yield to the Ranking Member for her opening statement.

[THE PREPARED STATEMENT OF CHAIRMAN COFFMAN APPEARS IN THE APPENDIX]

OPENING STATEMENT OF HON. ANN KIRKPATRICK

Mrs. KIRKPATRICK. Thank you, Mr. Chairman.

Today we meet to hear testimony on H.R. 1490, the Veterans' Privacy Act; H.R. 1792, the Infectious Disease Reporting Act; and H.R. 1804, the Foreign Travel Accountability Act.

H.R. 1490 seeks to ensure that any visual recording made in a VA health care facility is done so with the express permission of the veteran.

H.R. 1792 requires the VA to report any instance of infectious disease within medical facilities to the appropriate state entity.

And the third bill, H.R. 1804, requires that foreign travel of VA employees on official business be reported to Congress.

As the Subcommittee on Oversight and Investigations, it is our primary duty to provide oversight of all VA programs and facilities to ensure they are run effectively, efficiently, and lawfully.

Our mutual goal is to deliver the best possible services and protect eligible veterans and their dependents when they are in VA facilities receiving services.

It is my hope through the oversight process not only to point out weaknesses in areas needing attention, but also to back the VA up in its mission to care for veterans.

As times change and new challenges arise, we must work hard to provide VA with the tools it needs to be successful and meet those challenges.

I look forward to the witness testimony today to examine how the changes embodied in each of the bills can help veterans.

I thank the witnesses for being here and for answering our questions, and I thank the others who are here today for your interest.

I yield back, Mr. Chairman.

Mr. COFFMAN. Thank you, Ranking Member Kirkpatrick.

We will now hear from our first panel of witnesses. At the dais, I am honored to have our Chairman, Jeff Miller, to discuss H.R. 1490, the Veterans' Privacy Act.

Next we will hear from the Honorable Tim Huelskamp from Kansas, who will also be speaking from the dais, who is sponsoring H.R. 1804.

Thank you both for joining us here today. Your complete written statements will be made part of the hearing record.

Chairman Miller, you are now recognized for five minutes.

STATEMENT OF HON. JEFF MILLER

Mr. MILLER. Thank you very much, Mr. Chairman.

Members, it is a pleasure to be here with you again. And you may know some of the details of what I am about to tell you, but others of you may not.

Last June, a video camera disguised as a smoke detector was installed in the room of a brain damaged veteran at the James Haley VA Medical Center in Tampa. When the veteran's family discovered the camera, they were understandably upset.

When asked about the camera, VA officials first denied that the camera existed. Then they, in fact, admitted that the smoke detector was, in fact, a camera. Further when asked if the camera was recording, VA said, no, it was only there to monitor the patient.

And only after inquiries by the media and this Committee did VA come clean and admit that the camera was, in fact, recording what was going on in the patient's room. Ultimately, VA yielded to the pressure and removed the camera.

When I learned about these events, needless to say, I was shocked at VA's apparent disregard for the privacy rights of its vet-

eran patients. VA failed to provide any justification for covertly recording this patient in his private room.

In light of this incident, I asked VA under what legal authority did they place the camera in the patient's room. And VA's legal opinion was that the hidden camera did not, in fact, violate law and that they were looking at developing a national policy to address the issue of video surveillance of its patients.

I have recently been told by VA that they do not intend to have this policy in place before September 2013. This is a year after, well over a year after I found out that the incident actually occurred.

So in order to protect the privacy rights of veterans who receive medical care from VA hospitals, I have introduced what I call the Veterans' Privacy Act.

This bill directs the VA to prescribe regulations to ensure that any visual recording made of a patient during the course of their care by VA is carried out only with the full and informed consent of the patient or when appropriate that patient's representative.

Now the bill does contain some important exceptions. The secretary would be authorized to waive notice and consent for recordings upon determination by a physician or a psychologist that the recording is medically necessary or pursuant to a court order or when the recording would occur in a public setting where a person would not have a reasonable expectation of privacy such as in a waiting room or in a hallway.

I look forward to working with Committee Members, our veteran service organization partners, the VA, and other stakeholders on this bill because protecting the privacy rights of patients while they are receiving care in VA must be among one of our constant priorities.

I appreciate Chairman Coffman for holding this hearing today. Your hard work and leadership on the Subcommittee of Oversight and Investigation is greatly appreciated by me, the Ranking Member, and other Members of this Committee. And I appreciate the opportunity to be here with all of you today and I yield back my time.

[THE PREPARED STATEMENT OF HON. JEFF MILLER APPEARS IN THE APPENDIX]

Mr. COFFMAN. Chairman Miller, thank you so much for your testimony.

Congressman Huelskamp, you are recognized for five minutes.

STATEMENT OF TIM HUELSKAMP

Mr. HUELSKAMP. Thank you, Mr. Chairman.

It is a pleasure to be here with you today and the other Members of our Subcommittee on Oversight and Investigations. I also appreciate representatives from our VSO partners and other interested stakeholders to discuss H.R. 1804, the Foreign Travel Accountability Act.

The bill is very simple and very straightforward and would direct the secretary of the VA to submit the House and Senate Veterans' Affairs Committees a semi-annual report on all foreign travel made during the previous 180-day period.

Each report will be required to include the purpose of the travel, destination, name and title of each employee traveling, along with the duration and the total cost including transportation, lodging, and a multitude of other associated costs.

I believe providing Congress information about foreign travel by VA employees is not an unreasonable requirement. In fact, I think receipt of this information is critical to making certain we do our job properly here, Mr. Chairman, in providing proper oversight of the VA's expenditure of taxpayer dollars.

I look forward to working hand in hand with other Committee Members, our VSO partners, and other stakeholders including the department on this bill as it is discussed this afternoon. I take our responsibility of oversight very seriously as stewards of not only taxpayer dollars but as stewards and advocates for veterans. I think this is a very critical bill.

And, again, thank you for holding this hearing and I look forward to any questions you might have. And with that, I yield back.

Mr. COFFMAN. Thank you, Mr. Huelskamp.

Without objection, in the interest of time, there are no questions for the first panel. Any Members wishing to ask questions of the first panel may submit them for the record. Without objection, so ordered.

On behalf of the Subcommittee, I thank you both for your testimony. You are now excused except for Mr. Huelskamp.

I now invite our second panel to the witness table. First we will hear from Dr. Robert L. Jesse, Principal Director Under Secretary for Health for the Department of Veterans Affairs.

Accompanying Dr. Jesse is Ms. Jane Clare Joyner, Deputy Assistant General Counsel for the Department of Veterans Affairs.

Dr. Jesse, your complete written statement will be made part of the hearing record and you are now recognized for five minutes.

STATEMENT OF ROBERT L. JESSE, PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY JANE CLARE JOYNER, DEPUTY ASSISTANT GENERAL COUNSEL, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. JESSE. Thank you, sir.

Good afternoon, Chairman Coffman, Ranking Member Kirkpatrick, and Members of the Subcommittee and Chairman Miller.

I am pleased to provide the department's views on each of the bills on today's agenda. Thank you for the opportunity to do so.

And as you mentioned, today joining me is Deputy Assistant General Counsel Jane Clare Joyner.

Chairman Coffman, we do appreciate your continued efforts and those of this Subcommittee to support and improve veterans' health care.

VA recognizes the importance of addressing the underlying issues related to each of these bills and looks forward to continued opportunities to work with you and the Members of the Subcommittee and Congress to enhance the impact that each of the bills will have on our ability to provide quality health care for our Nation's veterans.

I will address a few key points for each bill today and a more detailed explanation is in that written testimony.

To be very clear up front, we do support the intent of each of these bills and we will be committed to working with you to craft the best solution to meet those intents.

I will start with H.R. 1490, the Veterans' Privacy Act. The bill concerns video recording of veterans and procedures and is intended to ensure that such recordings are made only with the full and informed consent of the patient and his or her representative.

VA supports the intent of H.R. 1490, too, but believes that the bill could be improved so that it does not have unintended consequences that might impair our ability to provide state-of-the-art health care that is increasingly dependent on technologies that connect patients and providers.

Toward that end, we would recommend clarification of the term video recording and despite the three important exemptions carved out by the bill, the current definition still may have some ambiguity and as such could be open to interpretation.

Such ambiguity could adversely impact patient care. For example, the term video recording could include certain x-rays, MRIs, and other clinical imaging studies such as catheterization, that under a strict interpretation could be seen in a way that could prevent such images from being sent remotely via secure channels for remote reading.

VA has made great strides in our use of telehealth modalities to connect providers to patients and to other providers in ways that improve care across distance and time and we believe clarification is needed to ensure that we do not stall the deployment or utilization of such technologies through unintended interpretations of the current language in the bill.

We believe the wording in the bill could actually in some respects have the effect of lowering the current standard of care in that it would allow a doctor or psychologist to conduct imaging without the patient's consent if they deemed it medically necessary. And we are certain that this is not the intent of this legislation.

So we fully agree with the intent and will work closely with you to ensure that the language is as precise and correct as possible.

The second bill on the agenda, 1792, the Infectious Disease Reporting Act, would require VA to report certain infectious diseases that occur in VA medical facilities as defined by each state and according to the laws of the state where the facility is located.

The legislation authorizes states to file civil actions against VA and for payment of penalties. VA absolutely supports that its facilities report infectious diseases to external health authorities in a manner comparable to reporting done by non-VA health care facilities.

VA understands the reporting of selected infectious diseases has been widely accepted as mutually advantageous to both health care providers and to the recipients of the information.

Public reporting of designated infectious diseases is necessary to inform local, state, and Federal health authorities about the current state of public health and about emerging threats.

And, therefore, VA is committed to expanding and making more consistent its reporting to the appropriate state and local authorities in a more standardized basis for all reported diseases.

We believe we can create the assurances and transparency that will result in reliable, consistent, and timely compliance with these requirements. We believe this effort would be more effective than requiring VA, which is a national health care provider, to follow specific state law.

And that would require a significant amount of administrative burden. But if the Committee determines it prefers this approach of individual state mandates, we do have some technical suggestions on H.R. 1792, which are outlined in the written testimony.

H.R. 1804, the Foreign Travel Accountability Act, establishes a requirement for a semi-annual report of covered foreign travel. VA does not object to the idea of providing information to Congress and the taxpayers regarding these expenditures.

However, VA does recommend that H.R. 1804 be amended as drafted. The requirements would be burdensome, especially in light of improvements made by VA on the amount it spent on foreign travel.

We have exercised considerable restraint with regards to all travel and to be specific, this has resulted in a 40 percent decline in the use of medical funding for foreign travel from fiscal year 2011 to fiscal year 2012. Twenty-five percent of this is for covering out of U.S. operations like the clinic in the Philippines.

So speaking for VHA, we have worked hard to ensure that all travel both domestic and foreign is both essential and appropriately managed through the Federal travel system which captures all the information needed to manage employee travel in a transactional manner.

Thank you for the opportunity to testify before the Committee and I would be pleased to respond to your questions or the Members may have at this time.

[THE PREPARED STATEMENT OF ROBERT L. JESSE APPEARS IN THE APPENDIX]

Mr. COFFMAN. All right. Dr. Jesse, your testimony suggests VA encourages voluntary adherence to state mandated processes.

If VA is prepared to accept the administrative burden associated with voluntary adherence, why is it prepared to accept the burden of mandated adherence to state reporting requirements?

Dr. JESSE. I am sorry. I am not sure I understood.

Mr. COFFMAN. Well, I think that is written. I am sorry.

Dr. JESSE. Can I answer what I think you are asking?

Mr. COFFMAN. Well, okay. So, yeah, go ahead.

Dr. JESSE. Okay. So I think VA does not have a problem with reporting to states. And, in fact, the history is actually of us coming to you to ask for a legislative relief to allow that to happen.

Mr. COFFMAN. Uh-huh.

Dr. JESSE. Recent examples, as you would remember, are the reporting to the state prescribing counsels that engages VA in the monitoring particularly of opiate prescriptions and before that to report to the state cancer registries.

And so there are privacy rights built into the Title 38 legislation that all have to be considered and, I think, readdressed to do this.

So whether we do it, you know, through legislation or whether we do it voluntarily, the burden is only that each state is different and making sure that we do that in a state-by-state way creates just—it is complex, but we will do it. We have done it in the past. We have proven that we are committed to doing so.

Mr. COFFMAN. So you are not opposed to it?

Dr. JESSE. No, no, no.

Mr. COFFMAN. Okay.

Dr. JESSE. Not at all.

Mr. COFFMAN. Just wanted to make sure.

Okay. Then let's see. Dr. Jesse, in your testimony, VA states that H.R. 1792 would, quote, create administrative burdens by requiring compliance with many different state laws. I just think you answered that, so let's skip that one.

Ms. Joyner, VA has indicated that it has a legal basis for covert visual recording in patient rooms.

Can you please describe the department's purported legal authority in this regard?

Ms. JOYNER. Well, I think any analysis would have to start with the Fourth Amendment, you know, the unlawful search and seizure. We would look at the case law which talks about the need for a particular search, the scope of the search, the manner in which a search would take place, and then, of course, the place of the search.

I think if, my recommendation, if a facility wanted to do a covert observation would also be to talk to the assistant U.S. attorney just to discuss what was planned as well.

Mr. COFFMAN. Okay. Mr. Miller.

Mr. MILLER. So it begs the question in the Tampa facility, was that procedure followed?

Ms. JOYNER. I am not sure. I can find that out for you and give it for the record.

Mr. MILLER. Okay, because it has been a year. And I would hope that since this apparently is the only incident of its type that has occurred within the system that—and, again, we want to work—I do want to work with VA to solve this problem because obviously they felt there was a need. And I understand what the director says the need was.

And so if you would take that for the record, I would appreciate it.

Mr. COFFMAN. Ranking Member Kirkpatrick.

Mrs. KIRKPATRICK. Thank you.

Doctor, does HIPAA have an exemption for public health reporting where health staff is able to identify a person affected by a disease?

Dr. JESSE. I am not absolutely positive about HIPAA, though I do know that we can report the—I think the legislation that gets in the way is not HIPAA. It is ours. It is the 5701 and 1733 part of Title 38. I hope I said that correctly.

But I am not sure that HIPAA does because these are requirements for managing patients and generally one has a business re-

lationship. There is a memorandum of understanding between the facilities and the state health departments that exist.

And, in fact, those state health departments then, it is the authority and that is MOUs with the state health authorities that the CDC comes in under when they come in as part of an investigation.

So I am not sure that HIPAA is the issue here, but you could probably answer that better.

Ms. JOYNER. As we said in the testimony, the real stumbling block is Title 38 and it is similar to the changes that Congress made with regard to, as Dr. Jesse said, the state prescription monitoring programs. So it is 5701 and it is 7332 of Title 38. And so changes to that would make the process of reporting easier.

Mrs. KIRKPATRICK. Well, Doctor, I have a concern. In your written testimony, you say there is a possibility that in reporting infectious diseases that personal information could be released. And so I just want to pursue that with you.

How could that happen?

Dr. JESSE. So I think the context of that was and one of the reasons why we were so fastidious back on the reporting to the state cancer registries, because it turned out that some of those registries were, in fact, releasing patient level information and patients, VA patients, veterans, were being contacted by outside entities saying we understand you have cancer and we would like to help you. And that release as it turned out was coming somehow through the state authority. So we need, in terms of protecting our patients, we need to make very certain that when we release data to outside entities that there are clear agreements about how that data will be managed and kept private and protected.

Mrs. KIRKPATRICK. So that is going to require an MOU with all of these different agencies?

Dr. JESSE. Yeah. Generally it requires an MOU and with very specific statements about how data get handled, yes.

Mrs. KIRKPATRICK. My other concern is the number of reports the VA has to make to Congress.

Do you know how many of those reports are mandatory?

Dr. JESSE. I have no idea.

Mrs. KIRKPATRICK. Do you have any idea about the cost of that reporting?

Dr. JESSE. I do not know about the cost, but I do know it requires extensive resources at times in order to compile information, particularly when that information is not retrievable out of an existing data set.

So when we have to do things manually it takes an incredible amount of time and an incredible amount of person hours to do that. And it just depends on how big the request is.

Mrs. KIRKPATRICK. Can you get back to me with that information?

Dr. JESSE. I can try, certainly, yeah.

Mrs. KIRKPATRICK. And also because now you are under the state reporting plan and the District of Columbia. So you have 51 reports you have to prepare.

And are you advocating then for just one central reporting place so that you do not have to do all 51 states and the District of Columbia?

Dr. JESSE. Yeah, that is a great question. I actually asked that myself because it would be easier for us. The CDC annually puts out a list of reportable diseases and to my mind, it would seemingly be more straightforward to report directly to the CDC.

But the answer that I got, and our infectious disease and public health people all agree with this, is that the public health knowledge base needs to be at the local level as quickly as possible.

And so that is why it has been established that that reporting comes through local and state authorities and then rolls up to the CDC rather than going straight to the CDC and then going back down.

It would be easier for us if we had an annual list from CDC of what needs to be reported and can report directly to them. The concern from the public health folk including ours is that bypassing the local authorities may actually create an asymmetry of information at their level where they need it most.

Mrs. KIRKPATRICK. Okay. Thank you, Doctor.

I yield back.

Mr. COFFMAN. Mr. Huelskamp.

Mr. HUELSKAMP. Thank you, Mr. Chairman.

I want to follow-up on a couple items. Dr. Jesse, you mentioned the incidents where cancer patients had been solicited by outside companies.

Were you able to determine exactly where they had received that information with certitude?

Dr. JESSE. I do not remember the precise details, but we did know it had come through a release from one of the state boards. Now, whether that was voluntary or accidental, I do not know. But it certainly redoubled our efforts to get the appropriate legislative relief to allow that to happen.

Mr. HUELSKAMP. Okay. I appreciate that. And as you recall, the Committee had a hearing, I believe two weeks ago, about the VA database and 20 million veterans and personal medical information that was potentially hacked and many details of follow-up on that.

One question I had at that hearing which did not get answered, and I do not know if I submitted it, was the follow-up that apparently the department provides credit monitoring services for those they believe whose information had been hacked.

Do you know and can you provide, and I am sure you can, how many folks that you provided and identified that needed that service?

Dr. JESSE. The hacking that you are referring to, I do not know about because, frankly, I cannot say that we know who was.

When we have a breach of information and we have had, as you know, you get monthly reports on these, we do provide credit monitoring to people who we believe that their information, particularly Social Security numbers, have been compromised.

And I am sure we can tell you that. That is a matter of record because I think we report that to you on a monthly basis. But I do not know any incidents from the recent hearing and the talk about being hacked. I just do not know.

Mr. HUELSKAMP. Yeah. And you might. It was in quite a few of the local newspapers and made reference to that and state sponsored actors in the database and information that was encrypted

on the way out. And so, yeah, I would like to see what numbers of those you have identified as potentially having that problem.

The second question would be, you do note in your testimony that H.R. 1792 would, quote, create administrative burdens by requiring compliance with many different state laws. As I understand it, every private facility has to meet these requirements.

Are you saying the VA should be exempt from these requirements when private facilities are not? I do not understand.

Dr. JESSE. And I think that actually comes back to the Ranking Member's question. Would the reporting on a national level through one central authority be easier and more straightforward.

From a national level, we have to look across 50 states and the District of Columbia and maybe even some out of U.S. areas of operation, Puerto Rico, Virgin Islands, Philippines, for instances. And all of those states have themselves individual regulations and methods of reporting.

Now, the facilities in those states will know them and in many cases are already complying with those state regulations. It is difficult to manage on our perspective because we have got to get these up-feeds from every individual facility.

And one of the challenges is, well, is that remember the structure of the VA in terms of particularly the regional, the VA medical centers that do the more complex things often pull from multiple states.

So in VISN 6 which is Virginia, West Virginia, and North Carolina, the patient seen in Richmond would be coming from other states on a regular basis.

And then, you know, how does that information then get back to the state where the patient resides? And in that case, so I have asked this question, and apparently that is something that the state health authorities would do on a point-to-point basis.

But then it becomes kind of out of our hands. And so that from a single national reporting perspective, there may be some sense of that. But, again, I am told that reporting locally is probably the most important thing and then entrusting the states when they know the state of residence is different than the state of diagnosis to get that information back.

Mr. HUELSKAMP. Yeah. I appreciate that difficulty and I think it is becoming clear as we look at some of the proposed regulations. HHS for the President's health care plan, that would require, I believe, the VA to provide information to the national database and this hub. And then that is part of that.

You are going to have to provide that for the hub already; is that correct?

Dr. JESSE. We are going to provide it through these hubs, yes.

Mr. HUELSKAMP. Yeah. Okay.

Dr. JESSE. So it is, yeah, it is——

Mr. HUELSKAMP. How far along are you? Are you ready to implement that by January 1st as required under the law or not?

Dr. JESSE. Well, I cannot say for certain, but I would sure hope so.

Mr. HUELSKAMP. Yeah. Well, the law is pretty clear.

Dr. JESSE. Yeah.

Mr. HUELSKAMP. There is no hope so. That is a requirement.

One other thing, for your superiors, I have 23 outstanding questions from early September that are basic budget data and they have yet to answer those questions.

And it is pretty hard to hear you mention a monthly report that you are providing information, when I have outstanding questions submitted through the Committee that you all have refused to answer, Dr. Jesse, so you might ask your superiors in the budget division about that.

Dr. JESSE. I will do that.

Mr. HUELSKAMP. I yield back.

Mr. COFFMAN. Thank you, Mr. Huelskamp.

Mr. O'Rourke.

Mr. O'ROURKE. Thank you, Mr. Chairman.

On the subject of infectious disease reporting——

Dr. JESSE. Yes, sir.

Mr. O'ROURKE. —for the veteran in the community that I represent in El Paso, Texas, if he wants to find out about a potential outbreak, for example, in the VA clinic in El Paso or one of the regional hospitals that serve that population there, how would he go about doing that? How is that information made available to the public and to the veterans that we serve?

Dr. JESSE. So that question can be asked of the local facility. And every VA facility has an infection control nurse who has a tie to the national infectious disease program.

But it is the job of that person to keep track of all of the infections, both the ones, as you might guess, coming through the emergency department like flus because these get reported up as well as hospital acquired infections which, as I am sure you know, this health care system, the entire country is working hard to eliminate.

But that information is available at the facility and then when reported, when the reportable diseases go out, that can be received, gotten from the local health authorities as well, who will know by hospital, who that is.

I am presuming that they release it by facility, but they do know it for the community. But the VA information is transparent. In fact, we report our hospital acquired infections through a Web site run by HHS called Hospitals Compare.

And the problem with that is that that data set, the HHS data set is about 18 to 24 months in lags. So VA has a mirror site which is called VA Hospitals Compare where we report our data currently and both are publicly facing Web sites.

And we also have a Web site called ASPIRE and ASPIRE is named because we do not report how we are doing relative to other people. We report how we are doing relative to what the expected outcome, our expectations of the outcome should be.

So, for instance, we do not believe it is sufficient to be in the top ten percent of people with hospital acquired infections. We believe they should be zero and our reporting and how it appears in ASPIRE looks at that.

So those are publicly facing Web sites. You can drill down to every facility and they are available as well.

Mr. O'ROURKE. Great. And just to be clear, I think you have touched on this, but what is the lag time between an outbreak and when that is reported on these publicly facing Web sites?

Dr. JESSE. So the publicly reported go up monthly, I believe. It may be quarterly, but I believe it is monthly.

But when you say an outbreak, when incidents—and so in public health terms, it is the difference between incidents and prevalence meaning incidents is each individual event. And those should be reported as they occur. And then the prevalence is essentially what is there at the time. And so you are looking at two different things and need to be a little bit cautious of what you are looking at.

So an outbreak would imply a cluster of incidents in a period of time as opposed to events that occur over a longer period of time where you are aggregating them.

Mr. O'ROURKE. Okay. And then I do not have the specific information that Chairman Miller was referring to in terms of covert surveillance within VA facilities, but wanted to know if you or Ms. Joyner could describe a scenario in which that would be appropriate. And I guess I am mostly interested in being able to be responsive to veterans that I represent.

Would that ever take place in the examination room where I think someone could arguably have an expectation of privacy?

Dr. JESSE. So the broad answer is it should not. Now, there was a time when the Joint Commission, I believe, and this does no longer exist, but there was a standard that said patients that were being monitored, meaning EKG monitoring in ICUs, should be in direct line of sight of the nursing station. And if not, they had to have video cameras to look at them.

That no longer exists, but the Joint Commission does have a standard that says if you are recording a patient, the patient has to be aware of it and signed consent on that.

I cannot think of an incident where we would do covert surveillance as any matter of routine.

Mr. O'ROURKE. Or without a warrant——

Dr. JESSE. Without a warrant, yeah.

Mr. O'ROURKE. —in a place where——

Dr. JESSE. As I said——

Mr. O'ROURKE. —someone has a reasonable expectation?

Dr. JESSE. Yeah. I just cannot come up with an instance where we would want to do that.

So an interesting thing is we do now have essentially a tele-ICU. And what happens in these is there is a control station that has physicians, intensivists, and nurses literally one state covering—one place can cover a broad geographic area.

And all of those patients who are being remotely monitored, there is a camera in those rooms, actually a very high-fidelity camera that allows the physician in the remote site literally almost to do a physical exam.

Mr. O'ROURKE. But not covert?

Dr. JESSE. But it is not covert. And people who are in those systems, they are well aware that this is an ICU space that is monitored by a tele-ICU operation, markedly improves patient safety.

It is a great force multiplier for high-level intensivist care in places where we simply do not always have that standard. But it

is not covert. Your question about covert, I just cannot imagine something that would not require a warrant.

Mr. O'ROURKE. Okay. Thank you.

Thank you, Mr. Chair.

Mr. COFFMAN. Dr. Benishek.

Mr. BENISHEK. Thank you, Mr. Chairman.

Ms. Joyner, the VA raised a legal objection to the waiver of sovereign immunity in the bill because it would subject VA to the same civil penalties that would be imposed against other medical facilities in the state for failing to report.

Why is that an unreasonable request?

Ms. JOYNER. I think it probably came down to the use of fiscal monies to be spending it to that rather than directly to patient care.

Mr. BENISHEK. Well, it is just that it seems to me that sometimes there is, you know, noncompliance and we are just trying to think of a compliance motivator, I guess——

Ms. JOYNER. Uh-huh.

Mr. BENISHEK. —because I know in my experience it seems sometimes that things do not just get done. I know Dr. Jesse and I have had conversations in the past about, you know, the response to IG reports——

Ms. JOYNER. Uh-huh.

Mr. BENISHEK. —that do not get done, you know, and you agree with that report. And they say they are going to do it and it never happens. And nobody seems to be responsible. Those are the kind of issues I think that are in the legislation trying to fix that.

Dr. Jesse, do you have a comment on that?

Dr. JESSE. Other than what Ms. Joyner said, I guess the one question is, does that binding authority that the state health authorities, the local health authorities have over the non-VA hospitals. Is it used often and does it have an effect?

Mr. BENISHEK. Yeah. I mean, everybody wants the money to be used for patient care. I mean, even the state facility, you know, that would be fine. I think it is a method of compliance. I do not know exactly a better way of inducing compliance with regulations or the IG requests that we have seen in the past, but trying to figure out a way of doing that.

Dr. JESSE. The attention of this Committee is a pretty good way to get——

Mr. BENISHEK. Well, I know, but just need to work in the sense of the issue that we brought up before with, you know, the doctor plan within the VA, the IG report. You know, there was 30 years of no plan with eight IG reports, you know, asking for a plan. So I still have not seen, you know, that plan. But I guess that is the best answer that I can get here today.

Let me ask you another question. Can you explain what information is contained in the data submitted to the e-government travel service system? What kind of data is there?

Dr. JESSE. So in what is called fed travel or the electronic Federal travel system, the first thing that has to go in there is actually, I guess the equivalent of a travel order, so who is the traveler and where are they going and why. And then all of the travel arrangements get made through that.

So you can see who flew where, what the cost of the flights were. It is in there. I do not think it captures hotels. Well, it captures it in terms of cost because when the travelers submit their travel reimbursements, all the receipts get in, get photocopied, get forwarded and sent somewhere. They are sent in.

So you actually have a line-by-line accounting of the cost of the trip and you have in there at the higher order of where the trip was to and for what purpose and who was the traveler.

Mr. BENISHEK. And is that filled out by the traveler then or the supervisor or——

Dr. JESSE. So it has to be approved by a supervisor. Somebody has the approving authority for each person who travels who is the supervisory function. And then the reports are filed on return of the trip. And they then get reviewed.

So if I travel and then that gets submitted, it comes back and says it is under review. When it gets signed off, it will then close it out. And then any out-of-pocket expenses that I had would then get reimbursed. So until that is signed off, it does not get reimbursed.

So, you know, we have worked very hard in VHA to ensure that fed traveler is used on a consistent basis for both domestic and foreign travel. And that way the information is captured as part of the transaction, as part of doing the work, and does not require somebody to go back, pull paperwork, review things, and, frankly, have the opportunity to miss a lot.

So having it done through this way we think is important. One way or the other, it is important.

Mr. BENISHEK. All right. Thank you. My time is up.

Mr. COFFMAN. Mr. O'Rourke, do you have any further questions for this panel?

Mr. O'ROURKE. No questions.

Mr. COFFMAN. Very well. Thank you all for your testimony. And then the panel is dismissed.

And we are going to have to recess for votes. Thank you.

[Recess.]

Mr. COFFMAN. I now welcome our third panel and final panel to the witness table. On this panel, we will hear from Dr. Timothy Jones, Epidemiologist for the State of Tennessee and President of the Council of State and Territorial Epidemiologists; Mr. Nick McCormick, Legislative Associate for the Iraq and Afghanistan Veterans of America; and Dr. Paul Etkind, if I am saying that right, Etkind, Senior Director of Infectious Diseases, National Association of County and City Health Officials.

All of your complete written statements will be made part of the hearing record.

Dr. Jones, you are now recognized for five minutes.

STATEMENTS OF TIMOTHY F. JONES, TENNESSEE STATE EPIDEMIOLOGIST, PRESIDENT, COUNCIL OF STATE AND TERRITORIAL EPIDEMIOLOGISTS; NICK MCCORMICK, LEGISLATIVE ASSOCIATE, IRAQ AND AFGHANISTAN VETERANS OF AMERICA; PAUL ETKIND, SENIOR DIRECTOR OF INFECTIOUS DISEASES, NATIONAL ASSOCIATION OF COUNTY AND CITY HEALTH OFFICIALS

STATEMENT OF TIMOTHY F. JONES

Dr. JONES. Good afternoon, Mr. Chairman, Ms. Kirkpatrick, and Members of the Subcommittee.

As you have heard, I am Tim Jones, the State Epidemiologist in Tennessee and I represent the Council for State and Territorial Epidemiologists for CSTE.

CSTE represents more than 1,100 members of the epidemiology and surveillance workforce and health departments who work on the front lines of public health to investigate and control communicable diseases.

I am pleased to offer this testimony on your legislation to strengthen infectious disease reporting by the U.S. Department of Veterans Affairs.

A hundred and thirty-five years of infectious disease reporting in the U.S. has culminated in the national diseases surveillance system that we use today. This surveillance system gives public health officials powerful capabilities to monitor the spread of diseases across the United States.

As the voice of our Nation's epidemiologists, CSTE is responsible for defining which diseases and conditions are reportable in states and which will be voluntarily reported to CDC.

Effective public health surveillance begins with the local and state health departments. Mandatory disease reporting of individual patients is thus governed by state and local laws.

A critical step in the ability to respond appropriately to outbreaks and other threats is the prompt notification of public health authorities on diseases posing a potential risk to our communities.

Virtually all health care providers in all states are required to report communicable diseases to their local health authorities for additional investigation.

Unfortunately, VA health care facilities do not always follow these rules which has led to some substantial problems that have been averted were this not the case.

The outbreak of Legionnaires' Disease associated with a VA hospital in Pennsylvania highlighted the importance of a prompt and thorough response to disease control. Unfortunately, it was not an isolated incident.

I have personal experience with other examples of sub-optimal coordination of disease reporting with VA institutions. I have been involved in investigations of known outbreaks in which the state health department's participation in a foodborne outbreak in a VA hospital was abruptly curtailed because of concerns about jurisdictional authorities.

Lack of tuberculosis reporting has hampered control efforts outside a VA hospital. Failure to report an infection control lapse in

a VA hospital made it very challenging for us to respond to inquiries from the community.

We have learned indirectly and unofficially through personal acquaintances of a dramatic cluster of illnesses associated with preparation of medications in a health care institution and it unfortunately resulted in several cases of blindness that may have been prevented with mandated reporting to public health authorities.

To be clear, I do not mean to imply that I think that any of these examples reflect purposeful avoidance of responsibilities. To the contrary, I know that in many of these situations, well-meaning VA staff were as frustrated as we were about the effective variable interpretations of the applicability of state health laws in these Federal institutions.

CSTE has reviewed the current versions of the VA reporting bills and we are heartily supportive of your efforts. Federal legislation will enhance VA reporting to the national surveillance system and, thus, is in the best interest of public health.

We feel strongly that it is best to craft legislation in such a way that mandates VA hospitals comply with state laws which will ensure that they remain on equal footing with all health care facilities as these rules evolve over time.

We believe that if VA facilities comply, many outbreaks will be detected, investigated, and stopped earlier than they may be otherwise.

In addition, no patient of any health care institutions is a resident of an encapsulated universe. Patients, staff, and families are active members of the communities surrounding those facilities and their inevitable interactions have important public health implications both inside and outside of those facilities.

It is impossible to separate a health care facility from its community. Public health law must acknowledge this and facilitate and require VA health care facilities to follow the same laws that govern all other institutions in our states and which protect the health of us all.

Thank you for the opportunity to testify today, and I am happy to address your questions.

[THE PREPARED STATEMENT OF TIMOTHY F. JONES APPEARS IN THE APPENDIX]

Mr. COFFMAN. Mr. McCormick, you have five minutes to deliver your remarks.

STATEMENT OF NICK MCCORMICK

Mr. MCCORMICK. Thank you. Mr. Chairman, Ranking Member Kirkpatrick, thank you for holding this important meeting this afternoon.

On behalf of Iraq and Afghanistan Veterans of America, I would extend our gratitude for being given the opportunity to share with you our views and recommendations regarding these important pieces of legislation.

IAVA is the Nation's first and largest non-profit, nonpartisan organization for veterans of the wars of Iraq and Afghanistan and their supporters. Founded in 2004, our mission is important, but simple, to improve the lives of veterans and their families.

With a steadily growing base of over 200,000 members and supporters, we strive to help create a society that honors and supports veterans of all generations.

IAVA believes that effective oversight of veteran issues is integral to the successful implementation of policy and to delivery of services that affect the lives of America's veteran population.

The men and women who volunteered to serve in our Nation's military enter into a unique agreement of trust with their government. This trust mandates persistent oversight of and when necessary deliberate investigation into the agencies and mechanisms charged with delivery of services to this unique population.

IAVA is, therefore, pleased to lend its support and endorsement of these three pieces of legislation pending before the Committee.

Regarding H.R. 1490, IAVA supports the Veterans' Privacy Act which would ensure that any visual recording made of a patient during the course of care through VA is conducted only with the consent of that patient or in appropriate cases a representative of the patient.

There are undoubtedly certain circumstances that may warrant the installation of monitoring devices in patient rooms for the safety of both patients and staff or to monitor patients' behavioral activity just as heart and respiration monitors are often needed to monitor a patient's physiological activity.

However, IAVA believes that veterans and/or their family members who are receiving medical treatment at VA facilities or their representatives should be notified of the facility administration's intent in consultation with the medical professionals directly involved in delivering care to place cameras and/or other monitoring equipment in a patient's room and no such action should be undertaken without the express consent of the patient or their representative.

Regarding H.R. 1792, IAVA also supports the Infectious Disease Reporting Act which would direct the secretary of Veterans Affairs to report each case of reportable infectious disease that occurs at a medical facility of the VA to the appropriate state entity as well as the accrediting organization of such facility.

Had this bill been law at the time of the outbreak of Legionnaires' Disease at the O'Hare and Oakland campuses of the VA Pittsburgh Healthcare System in 2011 and 2012, the number of infected people could potentially have been far lower.

Indeed, the CDC's after action report on this incident indicated that poor communication and procedural missteps in the VA Pittsburgh system were just as much to blame for the outbreak as the bacteria itself.

Our veterans have been taught the ability to communicate effectively as one of the most essential characteristics of good leadership and is necessary to mission success.

IAVA fully supports the Infectious Disease Reporting Act because it represents the kind of common sense communication policy that American veterans deserve with regard to their health care.

And, finally, regarding H.R. 1804, IAVA also supports the Foreign Travel Accountability Act which would direct the secretary of Veterans Affairs to report semi-annually to the Congressional Veterans' Committees on official foreign travel made by VA employees.

These individuals are on the front lines of assisting American veterans and their family members with health care issues, educational benefits, and disability claims, and IAVA commends these employees for their work.

However, according to VA reports produced to this Committee, VA employees have taken over 1,300 trips for unspecified or unacceptably vague purposes.

From the Internal Revenue Service to the General Services Administration, government spending scandals have become much too common in occurrence.

The responsibility of the VA to support the Nation's veterans necessitates the VA be held to the highest ethical standards with regard to the management of public funds. Many of America's veterans and their families are experiencing great financial hardship while waiting for the disability claim to be processed and many of them are waiting while they struggle to cope with the physical, emotional, and mental scars of war.

IAVA supports the Foreign Travel Accountability Act because our veteran members understand better than most that every penny counts and every penny should be accounted for.

Mr. Chairman, we at IAVA again appreciate the opportunity to offer our views on these important pieces of legislation and we look forward to continuing to work with each of you, your staff, and the Subcommittee to improve the lives of veterans and their families.

Thank you again for your time and consideration.

[THE PREPARED STATEMENT OF NICK MCCORMICK APPEARS IN THE APPENDIX]

Mr. COFFMAN. Thank you, Mr. McCormick.

Now, did you serve in Iraq or Afghanistan or——

Mr. MCCORMICK. I served in Iraq, Mr. Chairman, in 2008.

Mr. COFFMAN. With what branch of service?

Mr. MCCORMICK. The U.S. Army, sir.

Mr. COFFMAN. Thank you for your service.

Dr. Etkind, you have five minutes. Thank you.

STATEMENT OF PAUL ETKIND

Dr. ETKIND. Thank you for this opportunity to speak with you today.

My name is Paul Etkind. I am Senior Director of Infectious Diseases at the National Association of County and City Health Officials or NACCHO and a former epidemiologist for the Massachusetts Health Department as well as for the City of Nashua, New Hampshire.

NACCHO is a membership organization comprised of the Nation's 2,800 local health departments. The city, county, metropolitan district, and tribal departments work every day to ensure the safety of the water we drink, the food we eat, the air we breathe, and to protect every resident from disease and disaster.

Chairman Coffman, NACCHO and local health departments across the country recognize and appreciate your leadership on this issue of disease reporting to Federal, state, and local health authorities.

NACCHO is pleased that the Subcommittee is considering the Infectious Disease Reporting Act or H.R. 1792. The bill directs the secretary of Veterans Affairs to report each case of reportable infectious diseases that occurs at a medical facility of the Department of Veterans Affairs or the VA to the appropriate state entity as well as to the accrediting organization of such facility.

The bill is an important step to ensuring coordination between state and local health departments and the VA health care facilities located within their jurisdictions.

NACCHO believes it is critical for disease surveillance, identifying disease outbreaks, and recognizing disease trends in a community that reportable disease notices go to the health department of the county or the community where the person with this diagnosed disease or condition resides.

Each state has its own legal mandates for what is reported and to whom, but there is a robust system of notification and referral between the states and between the states and their local health departments.

Even if a VA facility is a regional reference institution that draws patients from different states and locales, this notification and referral system will assure that the right locale will be rapidly informed and prevention follow-up will be instituted.

Although there are variances in the reporting conventions between some states, often the first responders to a notice of a reportable disease is at the local health department.

The impact of prevention and control activities which are the result of case investigations are enhanced when cases are reported earlier.

The VA is one of the largest medical care systems in our Nation. Their facilities are an important part of the health care provider network in our Nation's communities and are, therefore, important to public health surveillance as well as to disease prevention activities.

In December 2012, NACCHO wrote the VA urging they reaffirm the importance of achieving timely and complete reporting of reportable diseases and conditions from all its health care facilities.

Local health departments around the country have varying relationships with these facilities. Whether a VA reports notifiable disease to the health department should not be dependent upon individual relationships. Rather, it should be established as a system-wide expectation.

Unfortunately, health care associated infections such as those that occurred at the Pittsburgh VA are far too common. Since 2001, more than 150,000 patients have been potentially exposed to hepatitis B, hepatitis C, and HIV due to unsafe medical practices in American health care facilities.

We believe this legislation is an important step to ensuring that possible health care associated infections are reported and investigated as early as possible.

The bill calls for penalties for non-reporting. In practice, penalties are rarely assessed for cases that are not reported. This puts the health department and the physician or medical facility into an adversarial position which most health departments prefer not to

do since it may negatively affect future dealings between those entities.

NACCHO recommends the VA health facility be subject to the same penalties as a medical facility not owned by the Federal Government. It keeps the option of a financial penalty open, but opens the institution up for other penalties which or remediation strategies which some states may have on their books.

The bill has the added importance of facilitating the formal entrance of a large medical care facility or system into the Nation's public health surveillance and care system. NACCHO has no doubt that this will be positive for disease prevention and will provide a formal mechanism for developing relationships between the VA at all levels and public health authorities at all levels.

This will not only help with disease prevention and control, but these relationships are the bedrock of responding to and mitigating the effects of any kind of emergency that a community, a state, or our Nation might encounter.

Chairman Coffman and Ranking Member Kirkpatrick, thank you again for your attention to this important public health issue. NACCHO looks forward to continuing to work with you to address this issue as the legislation moves forward.

If you have questions about this statement, please do not hesitate to contact me whether it is here or you have my email as well as my phone number. Thank you so much.

[THE PREPARED STATEMENT OF PAUL ETKIND APPEARS IN THE APPENDIX]

Mr. COFFMAN. Thank you all for your testimony.

Dr. Etkind, your organization, NACCHO, I just want to clarify this, it recommends amending the bill to require reporting diagnosed cases of infection rather than merely those occurring at a VA medical facility?

Dr. ETKIND. That is right. We believe that the cases should be reported as they are diagnosed. If they are occurring at a medical center, it could be somebody who comes in with that or it may not be a new infection. I think the clarity is greater if it is when the diagnosis is made. Then it is considered to be a new case.

Mr. COFFMAN. Is this because of the time sensitive nature in terms of public health of being able to respond as a——

Dr. ETKIND. The sooner we know post diagnosis, then the more effective we can be in terms of preventing other cases whether they are community-based or helping the institution to prevent further cases.

Mr. COFFMAN. Okay. Dr. Jones, in your testimony, you mentioned your involvement in outbreaks at VA hospitals in which a state's health department participation was abruptly curtailed due to concerns about jurisdictional authorities.

Can you elaborate on this a little further?

Dr. JONES. Yeah. That was an unfortunate example. We knew that there was a gastroenteritis foodborne outbreak in a VA hospital. It was reported to us. We had developed a questionnaire. We had a team there that had had their briefing sitting around the table in the facility and were just starting to go down the hall to interview patients when someone came in, whispered into the ear

of the infection control nurse, and he said I am sorry, you are going to have to leave.

And it was some invisible person's interpretation that all of a sudden the state did not have jurisdiction there.

Mr. COFFMAN. Okay. Do you think under current law, were they right, though? Did the state have jurisdiction?

Dr. JONES. No. I mean, the VA's testimony——

Mr. COFFMAN. Okay.

Dr. JONES. —says that VA does not have to comply.

Mr. COFFMAN. Right.

Dr. JONES. I think there is a lot of crossed wires in terms of interpreting whether or not facilities have to comply depending on the institution.

Mr. COFFMAN. Okay. Mr. McCormick, what are your thoughts on VA's recommendation that employee foreign travel paid for by non-Federal sources be excluded from the foreign travel accountability ban?

Mr. MCCORMICK. I am sorry. Can you clarify that again, Mr. Chairman?

Mr. COFFMAN. I am assuming that by non, let's see, by non-Federal sources, so I suspect that that would be, say, a non-profit organization, I would assume that was involved in promoting something that the VA had an interest on internationally. And so they attended a conference that was underwritten by another entity that was not taxpayer funded.

Would you feel that that should fall under the accountability requirements as well?

Mr. MCCORMICK. I think, you know, full accountability is a good thing, Mr. Chairman. You know, in the military, 100 percent accountability is expected of every servicemember, and I think to hold those same standards and apply them to members of the VA is something that, you know, we would be supportive of.

Mr. COFFMAN. Okay. Ranking Member Kirkpatrick.

Mrs. KIRKPATRICK. Thank you, Mr. Chairman.

Dr. Etkind, how many VA facilities currently report infectious diseases?

Dr. ETKIND. I could not tell you that. I am sorry. Again, there is no systematic collection of that information. It is all based on the, frankly, the personal relationships between the health authorities in those communities and the authorities within the VA.

Mrs. KIRKPATRICK. Is there a standardized policy or system for reporting infectious diseases within the VA?

Dr. ETKIND. My understanding is that there is an urging that reporting be done, but there is no mandate.

Mrs. KIRKPATRICK. Here is my concern. You said that where there is mandatory reporting, it is rarely enforced. And so if we are requiring mandatory reporting by the VA and it is not enforced, then we really have not made any progress here.

Dr. ETKIND. No, I would respectfully disagree. I think that we try to stay away from the mandate. If there is a problem, the typical response from local health departments and, frankly, in my own history has been to go and you discuss it. You find out where the disconnect is and you try to remediate it.

Just is there a misunderstanding about some law? Is there a misunderstanding about regulations or procedures? And most often a professional conversation between authorities is sufficient for making sure that everybody is on the same page.

Mrs. KIRKPATRICK. I represent a large rural district in Arizona and a lot of the veterans go to a private practice physician or a community health center or maybe a regional hospital that is not part of the VA system.

Do you think this bill adequately covers those veterans who get treatment outside of the VA system?

Mr. MCCORMICK. I think that the private sector is clearly subject to the reporting laws of those states, Arizona in particular. So I do not fear that they are missed somehow.

If there are cases that occur and it is discovered that they had not been reported and perhaps we would have known about them much sooner where we could have interrupted possibly secondary transmission, at that point that is when you visit the doctor and you talk about what happened and figure out where the disconnect is.

Mrs. KIRKPATRICK. Dr. Jones, moving to you, one of our first hearings was about the Legionnaire outbreak. And you said in your testimony that you thought better coordination could have prevented some of the deaths and some of the cases that broke out.

Can you describe for me in a little more detail what kind of coordination you see could have been in place at the VA to prevent those deaths?

Dr. JONES. I think in general, I mean, we in public health are used to investigating outbreaks quickly and thoroughly. And it is really important that that be done promptly. I mean, the whole point is to stop it before it spreads.

I was not in that particular VA, but we had an instance where, you know, a VA called us and said we have had four patients with TB in the last two months. We think we have had a problem. And, oh, by the way, three of them are dead.

You know, how many people did they expose in the previous two months while we did not know about them? And that is the kind of thing where I think in cooperation with the VA, you know, they are taking good care of patients, but we can help them do that tracing outside the VA in the community and prevent those kind of exposures if we hear about them promptly.

Mrs. KIRKPATRICK. How quickly should they have been reported?

Dr. JONES. It depends on the disease, but basically for most things by the next business day. There are some things like meningitis where we want to get called at three a.m. on a Sunday because we have got to go to the school and find the other kids that were exposed and give them antibiotics. But in general, within a day or so.

Mrs. KIRKPATRICK. Is it your opinion that the VA has a system in place right now for reporting infectious diseases that is adequate?

Dr. JONES. I think the system is not the problem at all. It is just following the law. But, you know, the VA has an incredibly advanced sophisticated medical record system and I think it would be resource free for them.

I mean, my understanding is someone could sit in Washington and hit a button at eight p.m. every night and report to states. So I think it would be a very easy thing to implement.

Mrs. KIRKPATRICK. Wouldn't it also be easy to implement that reporting to the CDC?

Dr. JONES. Yes. In general, the CDC does not like to collect personal identifiers. And they are really not the ones that contact patients individually and do the ground work. So, you know, collecting national data, yes, that would be easy. But I think it should not go through CDC and down to states because we do not have time to wait for that.

Mrs. KIRKPATRICK. Okay. Thank you, Doctor.

I yield back.

Mr. COFFMAN. Dr. Jones, can you talk a little about how different parts of the country face different challenges when it comes to infectious diseases?

Dr. JONES. Yes. We heard a little bit earlier about the fact that different states require different diseases to be reported. In essence, you know, 99 percent of those lists are identical across the country. There are very rare exceptions.

I mean, valley fever in central California, vibrio in coastal states where they have oysters. But those are small exceptions. Never have I heard a complaint from a private or non-profit hospital about administrative burden in terms of different rules in different places. I mean, it is essentially a nonissue because the states are so similar.

Mr. COFFMAN. Okay. Dr. Etkind, in your testimony, you state, quote, whether a VA reports notifiable diseases to the health department should not be dependent upon individual relationships.

Can you talk about instances where the lack of personal relationships negatively impacted patients?

Dr. ETKIND. I think whenever there is a delay in reporting and ultimately when the problem gets to be so great that you say, hey, we need to bring in other people, at that point you are kind of far down the process and you have lost opportunities to reduce the risk of people for further transmission.

Mr. COFFMAN. And, Mr. McCormick, have VA's actions of placing a covert camera in a veteran's room without consent and the Legionnaires' Disease outbreak in Pittsburgh had any effect on veterans' trust in VA?

Mr. MCCORMICK. Mr. Chairman, I would certainly say it does obviously given the number of issues that my organization has raised over the last few months and few years with respect to the VA.

Instances like these lead us to think that the VA's head-in not in the game, so to speak, or their efforts at rectifying the problems that veterans face are misguided or, you know, present us with a lot of problems that remain to be solved. And the path they choose on these issues is very troubling.

So I would say, yes, the credibility definitely takes a hit when these sorts of things are in the news and so forth.

Mr. COFFMAN. Thank you.

Ranking Member Kirkpatrick.

Mrs. KIRKPATRICK. Mr. McCormick, you were testifying about the Foreign Travel Accountability Act. In the act, we require a report to Congress semi-annually.

Do you think that it would be better to have it just once a year rather than twice a year? I would just like your opinion about that.

Mr. MCCORMICK. Simply in terms of numbers, Ranking Member Kirkpatrick, basically I think semi-annually is better. Just it, you know, cultivates sharper recordkeeping. And given the tight budgets here in D.C. today and so forth, I think it keeps individuals on their toes as far as the money that they are charged with handling, administering, and so forth. So I think semi-annually is far better.

Mrs. KIRKPATRICK. My last question is for anybody on the panel who can answer it. Doesn't HIPAA prevent the surveillance of a patient in a hospital including the VA system?

Dr. JONES. Not at all. There is an exception for public health to receive personally identifiable information and that is really the whole point. You know, if someone has got TB, got HIV, whatever it happens to be, we need to know who they are, what their address is to be able to go and find them, find their community members and their families and do something about it.

Public health has an impeccable record in terms of confidentiality, particularly in communicable diseases. I am not aware of any breaches. And then any time that we share that information when it is not needed, we eliminate any personal identifiers. None go to CDC. None are ever public.

Mrs. KIRKPATRICK. Okay. So you are satisfied that is not happening?

Dr. JONES. Absolutely.

Mrs. KIRKPATRICK. Okay. Thank you, panel. Thank you very much.

And thank you, Mr. Chairman. I yield back.

Mr. COFFMAN. Thank you, Ranking Member Kirkpatrick.

And I just want to say how important I think that this reporting is down at the state and local level from a public health standpoint because you are the ones that are on the front lines of dealing with infectious diseases.

And I think it would be highly inappropriate, I think it is highly inappropriate for the VA not to report to you because your communities are impacted, could be impacted or are impacted by the spread of infectious diseases when they go beyond the boundaries of the VA system which is likely in infectious diseases.

And, Mr. McCormick, I think you addressed the issue of non-Federal travel. And I just want to state how important that is because I think that they should have to disclose if they are not traveling on the taxpayers' dime who, in fact, is funding that and is there a conflict of interest involved in that.

And so I think it is just important to have a full accounting of that.

And with that, the meeting is adjourned. Thank you very much.

[Whereupon, at 3:31 p.m., the Subcommittee was adjourned.]

APPENDIX

Prepared Statement of Hon. Mike Coffman, Chairman

Good afternoon. This hearing will come to order.

I want to welcome everyone to today's legislative hearing on:

- H.R. 1490, The Veterans' Privacy Act;
- H.R. 1792, The Infectious Disease Reporting Act; and
- H.R. 1804, The Foreign Travel Accountability Act.

The three bills we will consider today are the result of investigations conducted by this Subcommittee in the course of its oversight duties that have revealed poor judgment and mismanagement by the Department of Veterans Affairs.

These bills are intended to heighten the protections for our veterans at VA medical centers and prevent the recurrence of problems identified in the investigations.

H.R. 1490, the Veterans' Privacy Act, was introduced by the Chairman of the Full Committee, Representative Jeff Miller. The bill directs the Secretary of Veterans Affairs to prescribe regulations to ensure that, in the absence of informed consent by the patient or their legal representative, any visual recording can only be conducted under limited circumstances such as under court order.

In April, I introduced H.R. 1792, the Infectious Disease Reporting Act. Based on investigations conducted by this Subcommittee, as well as a hearing in February it is clear that VA needs to be held to the same standard for infectious disease reporting as its health care counterparts in each state.

The Infectious Disease Reporting Act will require VA facilities nationwide to comply with state infectious disease reporting requirements. Once reported to the state, this data will be reported to the Centers for Disease Control and Prevention and used to monitor public health. Each state faces its own unique challenges regarding infectious diseases and the Infectious Disease Reporting Act takes this into account. It is baffling to me that the University of Pittsburgh Medical Center Hospital, which sits just a few hundred feet from the Pittsburgh VA medical center, is required to report infectious diseases while the VA hospital is not.

The news reports from Pittsburgh this past weekend detailing the extent of the Legionella problem and that it dates as far back as 2007 underscore the need for this legislation. The fact that VA provided information to reporters that this Subcommittee has been requesting since January is unacceptable. This lack of transparency looks like an attempt to evade legislative oversight and makes me wonder whether there is more to this story than what VA has chosen to reveal.

The need for the infectious disease reporting act is reflected not just in the Legionnaires' Disease outbreak in Pittsburgh. Just last month almost twenty veterans tested positive for hepatitis A or B after a VA hospital in Buffalo admitted to reusing insulin pens on patients.

Time and again we have heard from VA that they are industry leaders in various areas, but in infectious disease reporting, VA doesn't even compete.

Our final bill today is H.R. 1804, the Foreign Travel Accountability Act, which was introduced by Congressman Tim Huelskamp, a Member of this Subcommittee. This bill directs the Secretary to submit to Congress semi-annual reports on foreign travel. The reports will include, among other things, the purpose each trip, the destination, the total cost to the Department.

In January, after VA told him the State Department may have records on VA foreign travel, Chairman Miller sent a request to the State Department for more information. Just last week he received the State Department's two sentence reply which referred him back to VA. This ridiculous finger pointing clearly exhibits the need for this legislation.

It is important that taxpayer dollars appropriated to VA are properly spent on providing the care and benefits our veterans have earned. Not sending VA employees abroad on taxpayer subsidized vacations that do little to improve the care veterans receive.

I appreciate everyone's participation in today's hearing and now yield to the Ranking Member for her opening statement.

Prepared Statement of Hon. Jackie Walorski

Mr. Chairman and Ranking Member, it's an honor to serve on this Committee.

I thank you for holding this legislative hearing to advance pending legislation which will improve oversight of certain VA programs and practices. This will ultimately result in strengthening the quality of care for our veterans.

I also want to thank the veteran service organizations testifying today and those in attendance. Your resolve to bring attention to inefficiencies and significant shortcomings within the VA has not gone unnoticed. Because of you, this Committee has committed itself to ensuring the VA continually improves the services you have earned.

Through hearings this Committee has held and through the work of countless individuals seeking to better the VA, a number of critical issues have arisen which must be addressed. The legislation my colleagues have brought before us today addresses many of the concerns raised by veterans and the oversight work of this Committee.

Outside of the headquarters of the VA, there exist the words of President Abraham Lincoln, "To care for him who shall have borne the battle and for his widow, and his orphan."[1] The VA must not waiver in its obligation to our Nation's veterans.

I look forward to working with my colleagues and our panelists on this legislation before us.

Thank you.

Prepared Statement of Hon. Jeff Miller

Thank you, Chairman Coffman.

It is a pleasure to be here today with you, to discuss my bill, the Veterans' Privacy Act.

Last June, a video camera disguised as a smoke detector was installed in the room of a brain damaged veteran at the James A. Haley VA Medical Center in Tampa, Florida. When the veteran's family discovered the camera, they were understandably upset.

When asked about the camera, VA officials first denied the existence of the camera, then later admitted that the "smoke detector" was actually a video camera. When further asked if the camera was recording, VA told the family that the camera was not recording, but only monitoring the patient.

Only after inquiries by the media and this Committee did VA come clean and admit that the camera was recording. Ultimately, VA yielded to the pressure and removed the camera from the patient's room. When I learned about these events, I was shocked at VA's disregard for the privacy rights of its veteran patients.

VA failed to provide any justification for covertly recording this patient in his room. In light of this incident, I asked VA for what it believed was its legal authority to place a camera in a patient's room without consent. VA's legal opinion was that the hidden camera did not violate the law, and further represented that it was developing a national policy to address the issue of video surveillance of patients.

I have recently been told that VA did not expect to have the policy finalized before September 2013, more than a year after these events occurred, and a year after I was first told that a policy was forthcoming.

Therefore, in order to protect the privacy rights of veterans who receive medical care from VA hospitals, I have introduced the Veterans' Privacy Act. My bill directs VA to prescribe regulations to ensure that any visual recording made of a patient during the course of care by VA is carried out only with the full and informed consent of that patient or, in appropriate cases, their representative.

The bill contains important exceptions. The Secretary would be authorized to waive notice and consent where:

1) Upon determination by a physician or psychologist that the recording is medically necessary, or

[1] U.S. Department of Veterans Affairs, "The Origina of the VA Motto: Lincoln's Second Inaugural Address." *http://www.va.gov/opa/publications/celebrate/vamotto.pdf.*

2) Pursuant to a court order, or

3) When the recording would occur in a public setting where a person would not have a reasonable expectation of privacy, such as a waiting room or hallway.

I look forward to working with Committee Members, our VSO partners, VA, and other stakeholders on this bill, because protecting the privacy of patients while receiving care in VA must be among our constant priorities.

Thank you once again, Chairman Coffman, for holding this hearing today and for your hard work and leadership of the Subcommittee on Oversight & Investigations. I appreciate the opportunity to be with you all today. With that, I yield back.

Prepared Statement of Robert L. Jesse, M.D., Ph.D.

Good afternoon Chairman Coffman, Ranking Member Kirkpatrick, and Members of the Subcommittee. Thank you for inviting me here today to present our views on several bills that would affect Department of Veterans Affairs (VA) health programs and services. Joining me today is Jane Clare Joyner, Deputy Assistant General Counsel. Because of the time afforded for preparation of testimony, we do not yet have cleared costs for these bills.

H.R. 1490 Veterans Privacy Act.

H.R. 1490 would amend VA's informed consent statute to establish a new subsection concerning visual recording of Veterans made when VA is providing care under title 38, United States Code. The bill would require the Secretary to promulgate regulations establishing procedures to ensure that a visual recording of a patient receiving such care is made only with the full and informed consent of the patient or, in appropriate cases, the patient's representative. The bill would allow the VA to waive the informed consent requirement under three circumstances: pursuant to a determination by a physician or psychologist that such recording is medically necessary; pursuant to a warrant or order of a court of competent jurisdiction; or in a public setting where a person would not have a reasonable expectation to privacy. The term "visual recording" would be defined to mean the recording or transmission of images or video.

VA supports the intent of the bill but we recommend some clarification to ensure the best interests of patients are supported. We are concerned that the definition of "visual recording" is ambiguous and open to interpretation, which could adversely impact patient care. For example, the "transmission of images" could encompass still photographs or images, such as x-rays that are then digitized or scanned, as well as cine images that are now routine in catheterization laboratories and Magnetic Resonance Imaging (MRI). In VA, such images are commonly sent to a physician via secured email for reading. These concerns could be corrected by revising subsection (b)(3) to state that the term "visual recording" means the recording or transmission of images or video, excluding medical imaging such as those images produced by radiographic procedures, nuclear medicine, endoscopy, ultrasound, etc., and images, video and other clinical materials transmitted for the purposes of telehealth. For example, in FY2012, 9 percent of Veterans received elements of their care via telehealth.

We recommend this change to the definition, in part, because as written, H.R. 1490 would allow a physician or psychologist to conduct a medical imaging procedure, such as an X-ray, Computed Tomography (CT) scan, MRI scan, or ultrasound on a patient without the patient's consent if the physician or psychologist deemed the procedure to be medically necessary. This exception is not consistent with ethical standards for informed consent for treatments and procedures. Competent patients have the right to make autonomous decisions about the medical interventions that clinicians propose to perform on them. H.R. 1490 would, as currently written, lower the standard for patient consent and autonomous decision- making. We assume this is not the intent of the drafters.

H.R. 1792 Infectious Disease Reporting Act.

H.R. 1792 would amend VA's quality assurance statute, 38 U.S.C. §7311, to require VA to report certain infectious diseases that occur in VA medical facilities. The bill would define a "reportable infectious disease" as a disease that the State, in which the facility is located, requires to be reported. VA would be required to report such diseases to an appropriate entity in accordance with State law. Similarly, the bill would require reporting to the accrediting organization of the facility. The bill states that if VA fails to make a required report in accordance with State law, VA must pay the State an amount equal to the penalty paid by non-Federal facili-

ties that fail to make such reports. The bill would waive sovereign immunity and authorize States to file civil actions against VA to recover any amounts due for failure to make required reports in accordance with State law. Such suits would be filed in U.S. district court for the district in which the medical facility is located. The reporting requirement would take effect 60 days after the date of enactment.

VA supports, in general, the provision of information to outside entities on infectious diseases. The Centers for Disease Control and Prevention (CDC) depends on communicable disease surveillance to carry out analysis and form national recommendations. Reporting of selected infectious diseases has been widely accepted as mutually advantageous to both health care providers and the recipients of the information. CDC advises States and Territories as they formulate their individual requirements for health reporting. While no VA entity is currently required to participate in these State-mandated reporting processes, VA Medical Centers have been encouraged to participate in the process; over the years VA and VHA have provided guidance through Handbooks and Directives on how to achieve this participation while assuring compliance with existing Federal laws that protect privacy and confidentiality.

VA would like to discuss with the Committee ideas to provide more standardization and consistency in its practices to fulfill the aims of the bill, which we believe can be achieved without new mandates in legislation that raise legal complications, as well as create administrative burdens by requiring compliance with many different State laws.

Most States do espouse a general framework of "accepted" reportable disease as agreed to by the Council on State and Territorial Epidemiologists; many of these are similar to, if not identical to, those recommended by CDC. However, while CDC has some basic elements of data which it evaluates relative to communicable diseases, many States have reporting requirements that included numerous data elements beyond those which contributes to the disparity in reporting requirements from State to State.

We look forward to discussing with the Committee VA's current practices and ideas to expand on what VA is now doing.

While we submit that a voluntary approach is our preferred course of action, we also offer below suggested changes to the bill should Congress choose to move forward with a mandated approach.

First, the bill would amend VA's quality assurance statute, 38 U.S.C. §7311. This type of reporting requirement is not appropriate as part of VA's Quality Assurance (QA) program because names and personal identifiers cannot generally be disclosed from QA records. Thus, we recommend the legislation not be drafted as an amendment to 38 U.S.C. §7311. We are available to provide technical assistance to the Subcommittee to address this concern.

Second, in light of the reporting requirements, it may be necessary to amend two VA statutes protecting the confidentiality of Veterans records: 38 U.S.C. §5701 and §7332. Unless amended, these provisions may hinder, or even prohibit, disclosure of necessary information.

Third, the bill requires reporting of "a reportable infectious disease that occurs at a medical facility of the Department of Veterans Affairs in accordance with the laws of the State in which the facility is located." Each State defines reportable infectious diseases for its purposes. However, precisely which infectious diseases should be reported by VA is not clear. Specifically, the phrase "occurs at a medical facility" in section 2 is ambiguous. It is not clear whether this means that VA should report all State-defined reportable infectious diseases, all health care facility-associated infectious diseases (such as central line-associated bloodstream infections, catheter-associated urinary tract infections, and ventilator–associated pneumonia), or only those health care facility-associated infectious diseases that are part of the State-defined reportable infectious diseases. Further, it is not clear what would be required if, for example, a patient who resides in Nevada, develops a reportable infection while being cared for at a VA hospital in California, where State law may differ.

Fourth, we believe that requiring the reporting of each case of a reportable infectious disease to the *accrediting organization* of each facility would be inappropriate, unnecessary, and burdensome. The Joint Commission, which is currently the accrediting organization for all Veterans Health Administration facilities, does not typically receive systematically-collected health outcomes data on infectious conditions, and it is not clear how such data would inform the accreditation process. In the normal course of their reviews of VA health care facilities, The Joint Commission, as well as other oversight entities, would be able to verify reporting to States once the legislation is enacted.

Finally, we are also concerned about the administrative burden associated with waiving sovereign immunity to allow States to fine VA for failure to report in accordance with State law and to file civil action against VA to recover such fines. We are opposed to this provision of the statute, and believe these features are not necessary to achieve the intent of the bill. We are glad to make ourselves available to provide technical assistance to the Subcommittee to address these concerns.

H.R. 1804 Foreign Travel Accountability Act.

H.R. 1804 would amend title 38, United States Code by adding a new section 518 to establish a requirement for semiannual reporting of "covered foreign travel" made during the 180 days preceding the report. The bill would require VA to report the details of each instance of covered foreign travel, including the purpose, destination, name, and title of each traveling employee, as well as the final costs of all covered foreign travel made during the period covered by the report. The bill would provide that reports required by section 518 include all of the above information regardless of whether the information duplicates the quarterly report to Congress on conference expenses under section 517 of title 38, United States Code. The bill would define "covered foreign travel" to include any official travel made by a VA employee, including one stationed in a foreign country, to a location outside of the United States or Washington, D.C., any U.S. territory, commonwealth or possession, Indian lands, or U.S. territorial waters.

VA has no objection to providing Congress with useful information for its oversight responsibilities, but we recommend the bill be amended so the data required by the semiannual reports is consistent with the data available from the E–Gov Travel Service (ETS) system, which is currently FedTraveler.com. We believe these data will meet the general purpose of this legislation. Using ETS data will ensure an efficient and accurate report. As currently outlined in the bill, the report would require data that are not available in ETS. For example, expenses or reimbursements related to operating and maintaining a car, including the cost of fuel and mileage are generally not available in ETS. Rather, privately-owned vehicle costs would only be reimbursed based on mileage. Operating and maintenance costs would not be reimbursed. Costs for rental vehicles, if authorized, would be identified on the travel report, but operating and maintenance costs would not be reimbursed or known. Operating and maintenance costs for Government vehicles would be difficult to separate out for each travel episode. Similarly, computer rental fees, rental of hall auditoriums or meeting spaces, and entertainment appear to fall under the category of acquisition expenses associated with a conference. As such they would not be associated with a particular traveler, nor would such costs be reflected in the ETS.

VA recommends the bill be amended to exclude any employee foreign travel where a non-Federal source reimburses the Government for all costs. Section 1353 of title 31, United States Code, authorizes agencies to accept gifts of travel in support of official travel from non-Federal sources. Agencies are required to report the acceptance of such travel gifts on a semi-annual basis to the Office of Government Ethics (OGE). Because the bill appears to be concerned with reporting the costs of VA employee foreign travel, such purpose would not be served by including no-cost travel which VA already reports on a semi-annual basis to OGE.

Finally, VA requests clarification as to the timeframe covered by each report. Our understanding is that the initial report due June 30, 2014, would cover the first half of Fiscal Year (FY) 2014, October 1, 2013 through March 31, 2014, and that the report due December 31, 2014, would cover the second half of FY 2014, April 1, 2014 through September 30, 2014. Similarly, we understand that the required reports would be based on approved and completed expense vouchers, so that travel for which an expense voucher is pending but not approved at the end of the reporting period would be included in the subsequent period. VA would be glad to meet with the Committee to provide technical assistance on this legislation.

Mr. Chairman, this concludes my statement. Thank you for the opportunity to appear before you today. I would be pleased to respond to questions you or the other Members may have.

Prepared Statement of Timothy F. Jones, M.D.

Mr. Chairman and Members of the Subcommittee——

The Council of State and Territorial Epidemiologists (CSTE) welcomes the opportunity to provide the House Committee on Veterans' Affairs, Subcommittee on Oversight and Investigations this written statement for the record on legislation to en-

hance infectious disease reporting by the U.S. Department of Veterans Affairs (VA) including, H.R. 1490, H.R. 1792, and H.R. 1804. CSTE represents more than 1,100 members comprised of the epidemiology and surveillance workforce in federal, state, and local health departments. We work on the front lines of public health, investigating and controlling communicable diseases nationwide. [1]

A critical step in the ability to respond appropriately to outbreaks and other threats is the prompt notification of public health authorities on diseases posing a potential risk to our communities. Virtually all health care providers, in all states, are required to report communicable diseases to their local health authorities for additional investigation. Unfortunately, VA health care facilities are exceptions to this rule, which has led to some substantial problems that may have been averted were this not the case. The legislation introduced to hold VA health care facilities to the same standards as other health care providers will help address this problem, and CSTE heartily supports these efforts.

Disease Surveillance Rooted in Effective Federalism [2]

The long-standing history of infectious disease reporting in the United States serves as an example of effective federalism that has been refined over 135 years. Beginning in 1878, Congress authorized the U.S. Marine Hospital Service (forerunner of the Public Health Service or PHS) to collect reports from U.S. consuls overseas about local occurrences of diseases such as cholera, smallpox, plague, and yellow fever. This information was used to institute quarantine measures to prevent introducing or spreading these diseases in the United States. In 1879, Congress funded the collection and publishing of reports of these notifiable diseases and in 1893 expanded the authority for weekly reporting and publishing of these cases to include data from states and municipal authorities.

To improve the uniformity of the data, Congress in 1902 directed the Surgeon General to provide specific forms to be used for collecting and compiling these data and for publishing reports at the national level. In 1903, the PHS convened the first annual conference of state and territorial health officers to begin implementation of the congressional act, thus marking the dawn of national surveillance for communicable, infectious diseases of public health importance. By 1928, all states, the District of Columbia, Hawaii, and Puerto Rico were participants in the national reporting of 29 specified diseases.

In 1950, a new federal agency, then named the Centers for Disease Control (now the Centers for Disease Control and Prevention or CDC), recognized the importance of state input in reporting communicable diseases, and asked the Association of State and Territorial Health Officials (ASTHO)—the national nonprofit organization representing U.S. public health agencies and their employees—to convene state epidemiologists and charge them with the responsibility of deciding which diseases should be reported nationally. A conference of state and territorial epidemiologists generated a fully documented list of nationally notifiable diseases. Ten years later, CDC assumed responsibility for collecting data on these nationally notifiable diseases and began publishing the *Morbidity and Mortality Weekly Report* (MMWR) with data reported by state health departments. [3]

Today, these data are the foundation of the National Notifiable Diseases Surveillance System (NNDSS), a multifaceted public health disease surveillance system that gives public health officials powerful capabilities to monitor the occurrence and spread of diseases. Fifty-seven jurisdictions contribute to the NNDSS: the 50 states, New York City, the District of Columbia, and 5 territories including Guam, Commonwealth of Northern Mariana Islands, American Samoa, U.S. Virgin Islands and Puerto Rico. As the voice of these state, territorial, and local epidemiologists, CSTE maintains responsibility for defining and recommending which diseases and conditions are reportable within states and localities, and which of these diseases and conditions will be voluntarily reported to CDC. In collaboration with CDC, CSTE

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[1] Epidemiologists are best known for detecting, monitoring, controlling, and preventing infectious disease outbreaks. Perhaps less known, but equally important, is epidemiologists' work to monitor chronic disease, injuries, and environmental health threats; identify factors that put individuals at greater health risk; implement prevention strategies; and prepare for and respond to natural disasters.

[2] "A Brief History of the National Notifiable Disease Surveillance System," Centers for Disease Control and Prevention. Available at *http://wwwn.cdc.gov/nndss/script/history.aspx,* accessed May 30, 2013.

[3] Based on weekly reports to CDC by state health departments, the *MMWR* series is CDC's primary vehicle for scientific publication of timely, reliable, authoritative, accurate, objective, and useful public health information and recommendations. *MMWR* readership predominantly consists of physicians, nurses, public health practitioners, epidemiologists and other scientists, researchers, educators, and laboratorians.

works to determine changes to the list of nationally notifiable conditions and to enhance processes and procedures of the NNDSS.

Disease Reporting Governed by State, Local Laws and Rules

Effective public health surveillance begins with the local- and state-health departments. Mandatory disease reporting of individual patients and corresponding health records with personal identifying information is thus governed by state and local laws and rules, which vary by jurisdiction. These data provide the direction and scope of many state and local health department activities, from detecting individual cases and controlling outbreaks to implementing prevention and intervention activities. Because of the Health Information Portability and Accountability Act (HIPAA) exemptions for public health reporting, health department staff is able to identify persons affected by the diseases of concern to investigate and institute control measures to prevent further spread of disease. State health departments support national public health surveillance by voluntarily sharing their notifiable disease reports using *de-identified* data with CDC.

Health Care Providers Are Critical Partners in Surveillance

State and local public health departments are reliant on their partners in the health care community—those who interact directly with patients—to obtain case reports on many infectious and non-infectious diseases. While public health reporting laws and rules differ by locale, they are similar in that these health care providers—including physicians, laboratories, and other providers of care—are required to report legally notifiable diseases to their jurisdiction's public health authorities when they reasonably suspect a patient of having a disease or condition of concern. Once reported, assigning residence (by state, county, etc.), de-duplicating reports, and other reconciliations are responsibilities of the public health agency.

Health care facilities, including acute care hospitals, long-term care facilities, and outpatient facilities generally also fall under mandated reporting requirements. In practice, physicians often assume that the acute care hospital infection control staff will initiate a report to the public health agency on a patient for whom the physician is caring. Notably, for health care facility reporting mandates, a specific individual responsible for reporting is not named in the law or rule, but rather it is expected that the *facility shall report.* Other individuals or entities may also be mandated to report events of potential public health concern. For example, in many places school principals or restaurant owners must report when outbreaks occur that may be associated with their establishments (e.g. influenza-like illness, foodborne disease).

Failure of an individual or entity to report is frequently a crime and potentially punishable as a misdemeanor offense with imprisonment, de-licensing, or fines. In practice, however, criminal penalties are exceedingly rarely used; compliance is encouraged by continuing education and public health relationships with health care providers.

Public Health Agencies Collect, Investigate Disease Reports

The public health agency to which disease reports are sent depends on the jurisdiction, but is generally the state or local health department where the disease is diagnosed. In most cases, medical providers and health care facilities report directly to the local or county health department where they are located, or in the absence of local health departments, directly to the state. Large, multistate laboratories usually send electronic lab reports to the state health department where the patient or ordering facility is located. All states have mechanisms to share reports with other jurisdictions as appropriate, depending on where a disease was contracted or treated, and where and how measures to investigate and control them must be implemented.

Generally, state and local health departments are responsible for investigating these communicable diseases reports, and responding appropriately. Depending on the situation, such responsibilities may involve compiling of data for routine reporting, or investigating outbreaks or emergent events which require an immediate and vigorous response to protect the public's health. Rapid access to information is critical to accurately and promptly investigating such reports.

Consistent and Complete Disease Reporting Necessary to Protect Public Health

State and local laws and rules require reporting of a list of diseases and conditions designated as notifiable by CSTE and CDC. Jurisdictions may make minor changes to the list of reportable diseases to fit local or regional needs, such as the addition of "Valley Fever," which is caused by a fungus (*Coccidioidomycosis*) that is endemic only to the Southwest region of the United States.

The goal of public health reporting is to detect, investigate and prevent diseases and conditions that pose a potential threat to others in the local, state, regional, national or even international communities. Many examples of this are well-known. A report of a case of tuberculosis leads to provision of treatment for the patient to render them no longer infectious, identification and notification of close contacts for evaluation and treatment, and occasionally quarantine or other public health measures as necessary to prevent additional spread of disease. Persons with sexually transmitted diseases are promptly treated, and their close contacts are identified and treated to prevent further spread. Persons who have had close contact with a patient with meningococcal meningitis are traced and urgently treated to prevent them from contracting disease. Clusters of illness associated with restaurants are investigated immediately in order to ensure that conditions at the implicated establishment are corrected immediately or it is closed until that is accomplished. Foodborne disease outbreaks often lead to traceback of foods, with recalls of many thousands of pounds of product, preventing potential illness over very large areas of distribution. Other prominent recent examples include a nationwide outbreak of fungal meningitis, in which identification and recall of a contaminated pharmaceutical product prevented potentially hundreds of additional deaths.

It is not at all uncommon for public health agencies to receive several reports of illness from various sources, which to an individual clinician or institution may appear isolated or sporadic, but which in aggregate signify an important cluster or outbreak. This is an example of the critical importance of all health care providers and facilities consistently and promptly reporting diseases to their local authorities.

While many cases of reportable diseases are "sporadic," or unrelated to others and require little additional follow-up, some extent of public health investigation is necessary to ensure that they are not a sign of a potentially more widespread situation requiring interventions to mitigate additional spread. Unfortunately, it is not uncommon for public health investigations to identify causes of disease involving such things as widely disseminated food products, contaminated medications, malfunctioning equipment, unsafe food-handling or manufacturing processes, intentionally perpetrated acts, or unsafe environmental conditions to which the public may be exposed (sometimes including, unfortunately, health care facilities). In the large majority of cases, persons or establishments potentially involved in an outbreak are extremely cooperative with public health authorities in working toward identifying and eliminating the sources of health threats. Rarely, however, concerns such as legal culpability, economic sequelae, or adverse publicity can hinder investigations and response. Uniform adherence to legal reporting requirements is essential to ensure that there are no such barriers to protecting the public's health and safety.

Public health authorities work closely with private and institutional health care providers in this capacity. Confidentiality is rigorously protected by public health laws at all times. Authorities make every effort not to interfere with personal physician-patient relationships and individual treatment decisions, but rather work to provide additional services and resources which a physician or institution would not otherwise have available. This can include performing investigations in the broader community, coordination with other public health and regulatory agencies, provision of services otherwise inaccessible to high-risk populations, public information management, and occasionally use of public health legal authorities to overcome barriers to appropriate disease control.

Breakdowns in VA Reporting Necessitate New Legislation

A recent VA Office of the Inspector General report regarding an outbreak of Legionnaire's Disease associated with a VA hospital in Pennsylvania highlighted the importance of a prompt and thorough response to disease control.[4] In that instance, improved coordination with state and local public health authorities might have helped prevent infections and deaths associated with the outbreak. But unfortunately, the Pennsylvania Legionnaire's case is not an isolated incident. There are other examples of suboptimal coordination of disease reporting with VA institutions and state and local public health agencies.

I have been involved in investigations of known outbreaks in VA hospitals in which the state health department's participation was rather abruptly curtailed due to concerns about jurisdictional authorities. Lack of prompt notification of cases of tuberculosis has hampered control efforts outside the institution in which the person was housed. Lack of information regarding communication with large numbers of persons potentially exposed to infection control lapses within a health care facility

[4] *Healthcare Inspection: Legionnaire's Disease at the VA Pittsburg Healthcare System, Pittsburg, PA.* Department of Veterans Affairs Office of Inspector General, Office of Healthcare Inspections. April 23, 2013.

have made it challenging to respond to public inquiries from many of those persons once they were back out in our communities. We once learned of a dramatic cluster of illnesses (one resulting in several cases of blindness) associated with preparation of medications in a health care institution, only indirectly when notified unofficially by personal acquaintances.

These examples do not reflect malintent, dereliction of duties, or purposeful avoidance of responsibilities, per se. To the contrary, in many of these situations, well-meaning VA staff were equally frustrated about the effect of variable interpretations of the applicability of state public health requirements in these federal institutions. Over many years, efforts to address such barriers have been quite variable, often appearing to depend highly on particular individual interpretations of regulations and policies.

CSTE subject matter experts have reviewed the current versions of the VA reporting bills and in principle, are very supportive of these efforts. CSTE believes that federal legislation will enhance VA reporting to the NNDSS, and thus is in the best interest of public health. CSTE feels strongly that the best way to craft legislation that will ensure that VA health care facilities will be on a level playing field with other reporting health care facilities is to mandate that VA facilities comply with jurisdictional, i.e., state and local reporting laws, rules, and procedures. Referring federal requirements to these laws, rules, and procedures will ensure VA facilities remain on equal footing with private health care facilities as these rules evolve over time. Similarly, requiring that VA adhere to existing standards will enhance, rather than reinvent, the already effective NNDSS; requiring the VA to diverge from existing standards could place an unnecessary administrative burden on the system.

CSTE experts have reviewed many scenarios, including the Pennsylvania VA Legionnaires outbreak, and believe that if VA facilities comply with jurisdictional reporting laws, many facility-based outbreaks will be detected, investigated, and stopped earlier than they may be otherwise. In addition, no patient of any health care institution is a resident of an encapsulated universe. Patients, staff, and families are active members of the communities surrounding those facilities, and their inevitable interactions have important public health implications both inside and outside those buildings. It is impossible to separate a health care facility from its community, and vice versa. Public health law must acknowledge this, and facilitate and require VA health care facilities to follow the same laws that govern all other institutions in our states, which protect the health of us all.

CSTE appreciates the opportunity to submit this statement for the record and looks forward to working with the Subcommittee as it seeks to strengthen public health law in the interest of our nation's veterans and citizens. If you have questions about this statement, please do not hesitate to contact me at *Tim.F.Jones@tn.gov* or (615) 532–1408. You may also contact CSTE's Executive Director, Dr. Jeffrey Engel, at *JEngel@cste.org* or (770) 458–3811.

Prepared Statement of Nick McCormick

Bill #	Bill Name	Sponsor	Position
H.R. 1490	Veteran's Privacy Act	Miller	Support.
H.R. 1792	Infectious Disease Reporting Act	Coffman	Support.
H.R. 1804	Foreign Travel Accountability Act	Huelskamp	Support.

Chairman Coffman, Ranking Member Kirkpatrick, and Distinguished Members of the Subcommittee:

On behalf of Iraq and Afghanistan Veterans of America (IAVA), I would like to extend our gratitude for beinggiven the opportunity to share with you our views and recommendations regarding these important pieces of legislation.

IAVA is the nation's first and largest nonprofit, nonpartisan organization for veterans of the wars in Iraq and Afghanistan and their supporters. Founded in 2004, our mission is important but simple – to improve the lives of Iraq and Afghanistan veterans and their families. With a steadily growing base of over 200,000 members and supporters, we strive to help create a society that honors and supports veterans of all generations.

IAVA believes that effective oversight of veteran issues is integral to the successful implementation of policy and to the delivery of services that affect the lives of

America's veteran population. The men and women who volunteer to serve in our nation's military enter into a unique agreement of trust with their government. This trust mandates persistent oversight of and, when necessary, deliberate investigation into the agencies and mechanisms charged with delivery of services to this unique population.

H.R. 1490

IAVA supports H.R. 1490, the Veterans' Privacy Act, which would ensure that any visual recording made of a patient during the course of care through the Department of Veterans Affairs (VA) is conducted only with the consent of that patient or, in appropriate cases, a representative of the patient.There are, undoubtedly, certain circumstances that may warrant the installation of monitoring devices in patient rooms for the safety of both patients and staff or to monitor a patient's behavioral activity, just as heart and respiration monitors are often needed to monitor a patient's physiological activity. However, IAVA believes that veterans and/or their family members who are receiving medical treatment at VA facilities, or their representatives, should be notified of the facility administration's intent – in consultation with the medical professionals directly involved in delivering care – to place cameras and other monitoring equipment in a patient's room, and no such action should be undertaken without the expressed consent of the patient or their representative.

H.R. 1792

IAVA supports H.R. 1792, the Infectious Disease Reporting Act, which would direct the Secretary of Veterans Affairs to report each case of reportable infectious disease (a disease that a state requires to be reported) that occurs at a medical facility of the VA to the appropriate state entity, as well as to the accrediting organization of such facility.

In 2011–12, 32 people were infected with Legionnaires' disease in the Pittsburgh area. It was later determined that the source of at least 5, and potentially up to 21 of these infections was contaminated water at the O'Hara and Oakland campuses of the VA Pittsburgh Healthcare System. Had this bill been law at the time of this outbreak, the number of infected people could potentially have been far lower. Indeed, the CDC's after-action-report on this incident indicated that poor communication and procedural missteps in the VA Pittsburgh system were just as much to blame for the outbreak as the Legionella bacteria itself.

Our veterans have been taught that the ability to communicate effectively is one of the most essential characteristics of good leadership and is integral to mission success. IAVA fully supports the Infectious Disease Reporting Act because it represents the kind of common-sense communication policy that American veterans deserve with regard to their healthcare.

H.R.1804

IAVA supports H.R. 1804, the Foreign Travel Accountability Act, which would direct the Secretary of Veterans Affairs to report semiannually to the congressional veterans committees on official foreign travel made by VA employees.VA employees are at the frontlines of assisting American veterans and their family members with healthcare issues, educational benefits, and disability claims, and IAVA commends these employees for their work. However, according to VA reports provided to this committee, VA employees have taken over 1,300 trips for unspecified or unacceptably vague purposes. From the Internal Revenue Serviceto the General Services Administration, government spending scandals have become much too common an occurrence.

The responsibility of the VA to support the nation's veterans necessitates that the VA be held to the highest ethical standards with regard to the management of public funds. Many of America's veterans and their families are experiencing great financial hardship while waiting for their disability claims to be processed, and many of them are waiting while they struggle to cope with the physical, emotional, and mental scars of war. IAVA supports the Foreign Travel Accountability Act because our veteran members understand better than most that every penny counts, and every penny should be accounted for.

Mr. Chairman, we at IAVA again appreciate the opportunity to offer our views on these important pieces of legislation, and we look forward to continuing to work with each of you, your staff, and the Subcommittee to improve the lives of veterans and their families. Thank you for your time and attention.

Prepared Statement of Paul Etkind DrPH, MPH

Chairman Coffman, Ranking Member Kirkpatrick and members of the Subcommittee, the National Association of County and City Health Official (NACCHO) appreciates the opportunity to submit testimony for the legislative hearing on H.R. 1490 "Veterans' Privacy Act;" H.R. 1792, "Infectious Disease Reporting Act;" and H.R. 1804, "Foreign Travel Accountability Act." NACCHO is a membership organization comprised of the nation's 2,800 local health departments. These city, county, metropolitan, district, and tribal departments work every day to ensure the safety of the water we drink, the food we eat, and the air we breathe, and to protect every resident from disease and disaster.

NACCHO and local health departments across the country recognize and appreciate the Chairman Coffman's leadership on the issue of disease reporting to federal, state, and local health authorities.

NACCHO is pleased that the Subcommittee is considering the Infectious Disease Reporting Act (H.R. 1792). The bill directs the Secretary of Veterans Affairs to report each case of reportable infectious disease that occurs at a medical facility of the Department of Veterans Affairs (VA) to the appropriate state entity, as well as to the accrediting organization of such facility. The bill is an important step to ensuring coordination between state and local health departments and the VA health care facilities located in their jurisdictions.

NACCHO believes it is critical for disease surveillance, identifying disease outbreaks, and recognizing disease trends in a community that reportable disease notices go to the health department of the county or community where the person with this diagnosed disease or condition resides. Each state has its own legal mandates for what is reported and to whom, but there is a robust system of notification and referral between the states and between the states and their local health departments. Even if a VA facility is a regional reference institution drawing patients from different states and locales, this notification and referral system assures that the right locale will be rapidly informed and prevention follow-up will be instituted.

Although there may be minor differences between reportable disease lists between some of the states, a standard list of reportable diseases and conditions would most closely look like the list issued by the Centers for Disease Control and Prevention ("CDC") through its National Notifiable Disease Surveillance System (NNDSS). The list can be accessed at *http://wwwn.cdc.gov/nndss/document/nndss—event—code—list—July—28—final.pdf.*

Although there may be variances in the reporting conventions between some states, often the first responders to a notice of a reportable disease is the local health department. The impact of prevention and control activities, which are the result of case investigations, is enhanced when cases are reported earlier. The VA is one of the largest medical care systems in our nation. Their facilities are an important part of the healthcare provider network in our nation's communities, and are therefore important to public health surveillance activities as well as disease prevention activities.

It is important to note that the legionellosis at the Pittsburgh VA has resulted in a VA/Allegheny County Advisory Group reviewing the policies relevant to legionella prevention and control. Similarly, the VA in St. Louis and the city health department collaborated in notifying 1,800 patients who may have been exposed to Hepatitis B, Hepatitis C and HIV because of a breakdown in dental equipment sterilization procedures in 2009–2010. Further, the Danville (IL) VA recently instituted a policy of restricting visitors from the community because 6 patients began exhibiting flu-like symptoms. These prevention activities recognize the connections between the institution and the community. Both need to be engaged for their activities to have the desired impact.

Timely disease surveillance is critical to preventing infectious disease morbidity and mortality. Incomplete reporting, lack of consistent national standards, and a lack of timely reporting have created significant barriers to appropriate and effective disease-specific control measures since delays between the onset of illness and receipt of disease notification can allow for additional transmission to occur and additional people to become ill, thereby facilitating further spread of infection.

In December 2012, NACCHO wrote the VA urging they reaffirm the importance of achieving timely and complete reporting of reportable diseases and conditions from all of its health care facilities. Local health departments around the country have varying relationships with these facilities. Whether a VA reports notifiable disease to the health department should not be dependent upon individual relationships; rather, it should be established as a system-wide expectation.

In addition to reporting communicable diseases, NACCHO urges amending the legislation to include timely and complete reporting of other conditions such as cancer, genetic diseases and birth defects, and vital records such as births and deaths. Many states also have some chronic diseases and occupational injuries/conditions included in their reportable disease list.

Unfortunately, healthcare-associated infections (HAIs), such as those that occurred at the Pittsburgh VA facility are far too common. Since 2001, more than 150,000 patients have been potentially exposed to hepatitis B and C viruses and HIV due to unsafe medical practices in American healthcare facilities. One of the most recent examples, and one of the highest profile outbreaks, occurred last year when the CDC and state and local health departments notified nearly 14,000 patients of their possible exposure during a multistate outbreak of fungal meningitis and other infections.

At any given time, about one in every 20 hospitalized patients has an HAI, while over one million HAIs occur across health care every year. Hospital-acquired HAIs alone are responsible for $28 billion to $33 billion in potentially preventable health care expenditures annually. Scientific evidence has shown that certain types of HAIs can be drastically reduced to save lives and avoid excess costs.

The federal government has made progress in recent years to reduce HAIs and has developed a *National Action Plan to Prevent Health Care-Associated Infections.* While the Department of Veterans Administration participates on the federal steering committee, we believe there is more to be done. We believe this legislation is an important first step to ensuring possible HAI's are reported and investigated as early as possible.

Most, if not all, states require that diseases be reported by the diagnosing physician, or the institution in which the diagnosis was made. NACCHO recommends that the bill reflect reporting a case *diagnosed* rather than *occurring* at a medical facility. A case that occurs at a healthcare facility would only capture someone who became ill while in the care of the medical facility.

The bill calls for penalties for non-reporting. In practice, penalties are rarely assessed for cases that are not reported. That puts the health department and the physician/medical facility into an adversarial position, which most health departments prefer not to do since it may negatively affect future dealings between the entities. NACCHO recommends that the VA health facility be subject to the same penalties as a medical facility not owned by the federal government. That keeps the option of a financial penalty but opens the institution up for other possible penalties which some states may have on their books.

This bill will have the added importance of being a pilot, or test, of having a large federal medical care system formally entering the nation's public health surveillance and care system. NACCHO has no doubt that the results will be positive for disease prevention and will provide a formal mechanism for developing relationships between the VA at all levels with public health authorities at all levels. This will not only help with disease prevention and control, but these relationships are the bedrock of responding to and mitigating the effects of any kind of emergency that a community, state or nation might encounter.

The relationships built with the help of emergency preparedness funding between public health, medical care, emergency response, and public safety officials in the first decade of this century played a huge part in the successful response to the H1N1 influenza pandemic. How much will our emergency response system, and national security, be improved if other large federal medical care systems were to be formally joined to the public health and private medical care sectors? The National Institutes of Health has several large care facilities, one of which only recently had an outbreak of a resistant bacterium that was difficult to control. The same threat exists in the Department of Defense, with its hospitals and clinics on bases across the nation. Armed forces personnel are not restricted to these bases: they live, shop and enjoy the recreational facilities of the surrounding communities. There are a myriad of opportunities for infectious diseases to pass between the bases and their surrounding communities. Another setting at risk is the federal prison system, with its numerous clinics and hospitals. Employees do not live on prison grounds. They move back and forth between the prisons and their respective neighboring communities, creating the same opportunities for pathogens to similarly move between institutions and communities. I would ask that you consider the even broader, and positive, implications of this bill.

NACCHO appreciates the opportunity to submit testimony and thanks the Subcommittee for their attention to this important public health issue. NACCHO looks forward to continuing to work with the Subcommittee as the legislation moves forward. If there are questions about this statement, please contact me at *petkind@naccho.org* or (202) 507–4260.

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