LEGISLATIVE HEARING ON H.R. 183; H.R. 2527; H.R. 2661; H.R. 2974; H.R. 3180; H.R. 3387; H.R. 3831; H.R. 4198; AND, DRAFT LEGISLATION TO AUTHORIZE MAJOR MEDICAL FACILITY PROJECTS FOR THE DEPARTMENT OF VETERANS AFFAIRS FOR FISCAL YEAR 2014 AND FOR OTHER PURPOSES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

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

ONE HUNDRED THIRTEENTH CONGRESS

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Thursday, March 27, 2014

STATEMENT FOR THE RECORD

LEGISLATIVE HEARING ON H.R. 183; H.R. 2527; H.R. 2661; H.R. 2974; H.R. 3180; H.R. 3387; H.R. 3831; H.R. 4198; AND, DRAFT LEGISLATION TO AUTHORIZE MAJOR MEDICAL FACILITY PROJECTS FOR THE DEPARTMENT OF VETERANS AFFAIRS FOR FISCAL YEAR 2014 AND FOR OTHER PURPOSES

Thursday, March 27, 2014

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

The subcommittee met, pursuant to notice, at 9:03 a.m., in Room 334, Cannon House Office Building, Hon. Dan Benishek [chairman of the subcommittee] presiding.

Present: Representatives Benishek, Roe, Denham, Walorski, Brownley, Negrete-McLeod, Kuster, and Titus.

OPENING STATEMENT OF CHAIRMAN DAN BENISHEK

Mr. BENISHEK. The subcommittee will come to order. Before we begin I would like to ask unanimous consent from my friends and colleagues and members of the full committee to sit on the dais and participate in today's proceedings. Without objection, so ordered.

Good morning. And thank you all for joining us today to discuss pending legislation regarding the health care benefits and services provided to our nation's veterans through the Department of Veterans Affairs. The ten bills we will discuss today are H.R. 183, the Veterans Dog Training Therapy Act; H.R. 2527, to provide veterans with counseling and treatment for sexual trauma that occurred during inactive duty training; H.R. 2661, the Veterans Access to Timely Medical Appointments Act; H.R. 2974, to provide beneficiary travel eligibility for veterans seeking treatment or care for military sexual trauma; H.R. 3387, the Classified Veterans Access to Care Act; H.R. 3508, to clarify the qualifications of VA hearing aid specialists; H.R. 3180, to provide an exception to the requirement that the federal government recover a portion of the value or certain projects; H.R. 3881, the Veterans Dialysis Pilot Program Review Act; H.R. 4198, the Appropriate Care for Disabled Veterans Act; and draft legislation to authorize VA major medical facility projects for fiscal year 2014.

By and large these ten bills aim to address two of this subcommittee's highest priorities: ensuring that our veterans have access to the care that they need, and two, ensuring that VA is held accountable when that care fails to meet the high standards that

it should. Some of these bills, such as H.R. 2527 and H.R. 2974, which aim to resolve gaps in care for veterans who have experienced military sexual trauma, address issues that have been raised through subcommittee oversight. Others, such as H.R. 2661, H.R. 2508, and H.R. 3831, which concern lengthy patient waiting times, access to care for hearing impaired veterans, and ongoing issues with the provision of dialysis care, address issues that were raised through external stakeholder reviews by the VA Inspector General and the Government Accountability Office. Still others, such as H.R. 183 and H.R. 4198, which concern the need for innovative treatment options for veterans with Post Traumatic Stress Disorder and the need to ensure that VA maintains adequate capacity to provide for the unique health care needs of disabled veterans, address issues that were raised by our veteran constituents and veterans service organizations. One other, the draft legislation to authorize VA major medical facility projects for fiscal year 2014 and of note authorize the construction of a new bed tower at the James A. Haley Veterans' Hospital in Tampa, Florida, is the department's own legislative request.

I would note that VA's fiscal year 2015 budget submission includes five additional lease authorization requests that are not included in the draft bill we will discuss this morning. While I recognize the value of those five lease authorization requests, which would certainly be included in future VA major medical facility lease authorization packages moving through the committee, I thought it was important to thoroughly analyze and receive stakeholder views on the department's fiscal year 2014 request.

As you may know, last Fall the House passed H.R. 3521, the Department of Veterans Affairs Major Medical Facility Lease Authorization Act of 2013, which would authorize 27 VA major medical facility leases requested by the department in the fiscal year 2014 budget submission. It is my sincere hope that H.R. 3521 will be passed through the Senate and quickly signed into law.

I would like to express my gratitude to my colleagues who have sponsored the legislation on our agenda today and who are joining us this morning to discuss their proposals. I would also like to thank our witnesses from the Disabled Veterans of America, the Paralyzed Veterans of America, and the Veterans of Foreign Wars, as well as the witness from VA for their leadership and advocacy on behalf of our veterans and for being here today to offer their views.

It is critical that we have thorough understanding of the benefits and consequences of each of these bills before moving forward in the legislative process. And as such I look forward to a detailed and comprehensive conversation. With that, I now yield to Ranking Member Brownley for any opening statement she may have.

[THE PREPARED STATEMENT OF DAN BENISHEK APPEARS IN THE APPENDIX]

OPENING STATEMENT OF JULIA BROWNLEY, RANKING MEMBER

Ms. BROWNLEY. Thank you, Mr. Chairman. As you said the purpose of today's hearing will be to explore the policy implications of nine bills and one draft piece of legislation before us today which covers a wide range of topics that would expand and enhance VA's health ca reprograms and services.

I am glad this committee is considering Representative Walorski's legislation, H.R. 2974, which I have proudly cosponsored. I believe there is a lot of work to be done for our veterans that are victims of military sexual trauma and providing travel benefits to those veterans is a good start. I look forward to hearing the views from our panelists and appreciate the hard work that I know their testimony will demonstrate. While I am disappointed in the department for not furnishing views on three of the bills I do understand that sometimes there are extenuating circumstances that preclude them from submitting their views in a timely manner. I hope the VA will be able to at least comment on some of the provisions. As you know, Mr. Chairman, we hold these legislative hearings to ensure that the committee is as fully informed as possible and we rely on this input to make intelligent and well-educated decisions on whether to advance a bill from this subcommittee.

I look forward to a frank and open discussion on the very topics that are presented before us today. And thank you again, Mr. Chairman. And I yield back.

Mr. BENISHEK. Thank you, Ms. Brownley. Joining us on the first panel today, and hopefully a few more members will show, are Representative Michael Grimm from New York; Representative and committee member Dina Titus from Nevada; Representative and committee member Jackie Walorski from Indiana; Representative Sean Duffy from Wisconsin; Representative Marcy Kaptur from Ohio; Representative Kyrsten Sinema from Arizona; Representative and committee member David Roe from Tennessee; and Representative and committee member Jeff Denham from California.

It is an honor to have you all here this morning. I look forward to hearing your testimony. Mr. Grimm, may we begin with you?

Mr. GRIMM. Yes, Chairman.

Mr. BENISHEK. Please proceed with your testimony.

STATEMENT OF HON. MICHAEL GRIMM

Mr. GRIMM. Thank you very much, Chairman. I appreciate it. Both Chairman Benishek and Ranking Member Brownley, thank you for allowing me to testify today on H.R. 183, the Veterans Dog Training Therapy Act. This is a bill I introduced along with my friend the ranking member of the House Veterans' Affairs Committee, Congressman Michaud, in the last Congress and again this Congress.

As a Marine combat veteran, it is a unique honor for me to address this committee. Having seen firsthand both the physical and mental wounds of War that the members of our nation's military are faced with I have a very special appreciation for the important work this committee does every single day. Today millions of Iraq and Afghanistan veterans have returned home to the challenge of

a stagnant economy, high unemployment, and for many the long road to recovery for the mental and physical wounds sustained during their service. During my time in Congress I have had the honor to meet with a number of our nation's veterans who are now faced with the challenges of coping with PTSD and physical disabilities resulting from their service in combat. Their stories are not for the weak of heart and are truly moving.

It was these personal accounts of recover, both physical and mental, and the important role therapy and service dogs played in that process, that inspired this legislation. The Veterans Dog Training Therapy Act would require the Department of Veterans Affairs to conduct a five-year pilot program in at least three, but not more than five, VA medical centers assessing the effectiveness of addressing post-deployment mental health and PTSD through the therapeutic medium of training service dogs for veterans with disabilities. These trained service dogs are then given to physically disabled veterans to help them with their daily activities. Simply put, this program treats veterans suffering from PTSD while at the same time aiding those suffering from physical disabilities.

When I originally introduced this legislation in the 112th Congress both the House Veterans' Affairs Committee and the full House of Representatives passed it with overwhelming bipartisan support. Additionally, with high veteran suicide rats and more servicemen and women returning from deployment being diagnosed with PTSD, this bill meets a crucial need for additional treatment methods. I believe that by caring for our nation's veterans suffering from the hidden wounds of PTSD while at the same time providing assistance dogs for those with physical disabilities we create a win-win for everyone which I believe is a goal we can all be proud to accomplish.

Working in conjunction with a number of veterans service organizations I have drafted updated language which mirrors changes made to this legislation in the 112th Congress. And I hope to work with the committee during mark up of H.R. 183 to ensure this program provides our nation's veterans with the highest quality care for both PTSD and physical disabilities while maintaining my commitment to fiscal responsibility.

Again, I would like to thank the committee for holding today's hearing and I look forward to working with you to ensure that this program is included in your continuing efforts to guarantee that our nation's heroes have the best possible programs for treating PTSD and providing disability assistance. Thank you, and I yield back.

[THE PREPARED STATEMENT OF MICHAEL GRIMM APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you very much for your testimony, Mr. Grimm. Let me yield five minutes to Ms. Walorski for her statement. Thank you.

STATEMENT OF HON. JACKIE WALORSKI

Mrs. WALORSKI. Good morning. Chairman Benishek, thank you, Ranking Member Brownley, and members of the committee, thank you for the opportunity to discuss H.R. 2974, a bill making victims

of military sexual trauma eligible for Department of Veterans Affairs beneficiary travel benefits. According to the VA, one in five women and one in 100 men screen positive for military sexual trauma, or MST.

The VA provides counseling, care, and services to veterans and certain other servicemembers who may not have veteran status but who experienced MST while serving on active duty or active duty for training. VHA policy states, "veterans and eligible individuals who report experiences of MST but were deemed ineligible for other VA health care benefits or enrollment may be provided MST-related care only. This benefit extends to Reservists and members of the National Guard who were activated to full-time duty status in the armed forces. Veterans and eligible individuals who received an other than honorable discharge may be able to receive free MST-related care with Veterans Benefits Administration regional office approval."

Every VA medical center offers evidence-based therapy for conditions related to MST and has providers who know how to treat the downstream effects of MST. Nationwide there are almost two dozen programs that offer specialized treatment in both residential and in patient settings. All health care for treatment for mental and physical health conditions related to MST, including medications, is provided free of charge. Fee basis is available when it is not appropriate to provide counseling in a VA facility, when VA facilities are geographically inaccessible or when VA facilities are unable to provide care in a timely manner.

Overall while VA has taken the appropriate steps to provide counseling services for victims of MST, these services need to be more accessible. MST-related care must be provided in a setting that is therapeutically appropriate and takes into account the circumstances related in the need for such care. A supportive environment is essential for recovery. VA policy states that any veteran with MST must receive clinically appropriate care regardless of the location.

Veterans being treated for conditions associated with MST are often admitted to programs outside their Veteran Integrated Service Network. VA health care in general, especially for women, has been characterized as fragmented. Patients with special needs who are unable to access the services they need from their local providers are referred elsewhere and oftentimes have to travel long distances to receive such services. According to a 2012 VA Inspector General report, obtaining authorization for travel funding was frequently cited as a major problem for both patients and staff.

The beneficiary travel policy indicates that only certain categories of veterans are eligible for travel benefits and payment is only authorized to the closest facility providing a comparable service. The current beneficiary travel policy contradicts VA's MST policy, which states that patients with MST should be referred to programs that are clinically indicated regardless of geographic location. A veteran should never have to choose to skip treatment for conditions related to MST due to distance or lack of transportation.

I applaud VA's commitment to an effective program that provides counseling and treatment to men and women in need of help in overcoming the physical and psychological stress associated with

MST. However, VA is not doing enough to help veterans access these important resources and services. Survivors of MST should not feel re-traumatized and helpless because of geographic barriers to treatment. Representative Kuster and I introduced H.R. 2974 to make victims of MST eligible for VA beneficiary travel benefits. By better aligning the beneficiary travel policy with VA's current policy for responding to veterans who have experienced MST, H.R. 2974 ensures appropriate services are more readily available to meet the treatment needs of our nation's veterans.

I am grateful to work with Representative Kuster and the committee in addressing this critical issue for the survivors of military sexual trauma and I again thank you for this opportunity to speak today.

[THE PREPARED STATEMENT OF JACKIE WALORSKI APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you very much for your testimony and for the legislation. Dr. Roe, are you ready? Well, some members may be late in joining us. But I think as long as we are all here I would ask a couple of questions of the people that are here with us this morning. So I will yield myself five minutes to begin that.

Mr. Grimm, there is a statement from VA in their written testimony I would like you to respond to. It says, "The VA does not support the specific provisions of H.R. 183 because the bill focuses on the training of the dog as opposed to what we believe is the goal of the legislation, which is finding better ways to improve the health of this veteran population." Can you respond to that?

Mr. GRIMM. Certainly. Thank you, Chairman. Simply put, they completely miss the mark. It is actually the veteran that may have Post Traumatic Stress that is actually training the dog. It is the actual training that is the therapy itself. Often veterans come back and they have had so much responsibility, literally life and death responsibility for multiple tours, years at a time. And they come back and they feel very minimized. They do not have that sense of responsibility. Many of them cannot find work. They are having trouble fitting in. And they feel that everyone is looking at them differently. And for, and I cannot tell you how it happens because it is almost magical. It seems almost as if it is miraculous. But what we have noticed is when these veterans tend to this animal, to this dog, to train them, one it gives them that sense of responsibility back again, that they are doing something that is important. And the way these animals just seem to know how to act around these veterans is simply amazing.

So it gives them a sense of purpose. And when they know that the dog, if they succeed and the dog is fully trained that then that dog is going to be given to a fellow veterans with physical disabilities, it is a veteran helping another veteran. That is what is happening here. So it is, whether the dog actually gets trained fully or not is almost irrelevant. If the dog gets fully trained, great. We pass that dog on, it gets certified, and goes to another veteran. But if not what we are finding is many times the veteran, just that sense of being needed is a big step in the process of being healed. And sometimes they even just want to take the dog home and it becomes a pet. Either way, and that is why the actual training of

the dog is very secondary. It is that sense of purpose given to that veteran. That is the actual therapy itself. So I think the Veterans Administration in this case is just completely missing the mark. I yield back.

Mr. BENISHEK. Well I certainly know that we just did a field hearing in California. And that, they have veterans who are working with horses. I am not a horse person. But, they found the same thing, in that either the animal seems to be able to provide a measure of confidence to patients with Post Traumatic Stress Disorder. And I think, there is a lot of opportunity for this sort of alternative methods of treatment. Because we should be really casting a wide net to try to find what can help many of our veterans. So I applaud your efforts here.

Let me—oh, are you waiting to talk now? Oh, okay. Well one other question for you, Mr. Grimm. Would you be willing to consider amendments to H.R. 183 that would allow VA to be flexible in the housing and training off campus, as the VFW suggested?

Mr. GRIMM. Chairman, absolutely. In fact I have proactively been working in conjunction with several VSOs on this issue and intend to suggest modified language to the committee based on a number of recommendations that we have already received. So there are VSOs that are doing this in Palo Alto and other places that have gotten it pretty much down to a science and we are willing to incorporate all of those things. So we think that absolutely.

Mr. BENISHEK. Thank you. I will yield to Ms. Brownley for questions.

Ms. BROWNLEY. Thank you, Mr. Chairman. I am not sure that I have a question but I did want to make a remark with regards to Ms. Sinema's bill and thank you for bringing this bill forward. And suicide and suicide prevention is one of the number one goals of this committee. And as you know and the committee knows and the audience knows that, you know, 22 suicides a day in our country by our veterans and that is completely unacceptable. And I know that your legislation unfortunately will not save Daniel's life but hopefully it will save someone else's life. And I know today even on the Mall the Iraq and Afghanistan Veterans of America, whose number one priority is suicide prevention, is having a big occasion out on the Mall and will be raising flags, thousands of flags in honor of our veterans who have committed suicide and who have served our country so honorably. So I just wanted to thank you for bringing this legislation forward and this seems like a very, very simple fix that is part of the VA's policy in some sense and a very simple fix to potentially save future lives. So thank you very much for bringing it forward.

Mr. BENISHEK. Thank you very much. Mr. Duffy.

STATEMENT OF HON. SEAN DUFFY

Mr. DUFFY. Good morning and thank you, Chairman Benishek and Ranking Member Brownley for holding today's very important hearing and for allowing me to testify on my bill 3508. I worked on this along with Congressman Tim Walz from Minnesota and I appreciate all his work and efforts to make sure this is a bipartisan proposal. This is a proposal that will address the times and backlogs that our veterans have to receive services from the VA.

Currently you have the VA that hires doctors of audiology, which is wonderful. When our veterans receive services the services are wonderful. The problem is there is long wait times and backlogs before they are actually able to get in and see the doctors. Oftentimes a veteran who needs an initial exam or a hearing test will wait two weeks to one year for that initial appointment with the audiologist. And then their hearing aids are ordered, it is two weeks to one year before they actually get the hearing aid itself. And then once they get the hearing aid they have to go back to the VA where it is an appointment time of six weeks to six months before they get that appointment. And then if you have to have your hearing aid tweaked or adjusted, it is another wait time of six weeks to six months.

This is unacceptable. When you have our younger veterans who are coming home from War and our aging veterans who have had hearing loss issues, you cannot hear. And they are waiting weeks if not months before they can get into the VA. It is creating real problems and I think a disservice to our veterans.

This came to my attention, one of my constituents, Roger, he is a Vietnam Vet. He is 70 years old. He had a hearing aid, the hearing aid went out on him. And so he called the VA to get an appointment to go get a new hearing aid and they told him it would take six months before he got an appointment. Six months! He cannot hear. This is unacceptable. So he went to his local hearing aid specialist, bought a new hearing aid out of pocket and paid $5,000 for it. Now Roger could afford that. It was a significant dent to him. But a lot of our veterans cannot afford to pay $5,000 to get service on their own when they actually could get service from the VA.

So what we are doing in this bill is asking that we allow the VA to hire hearing aid specialists. For the complex issues of hearing loss and hearing issues we still have the audiologists. But we will have hearing aid specialists who can do some of the more minor functions in regard to hearing loss like dispensing, repairing, adjusting, and fitting the aids. So we can eliminate that backlog and get our veterans seen right away. So not only will the VA be allowed to hire hearing aid specialists, not required, not mandated, but allowed if they see fit to hire hearing aid specialists, we will also allow the VA to contract with hearing aid specialists around our rural communities.

I know, Chairman Benishek, you and I share district lines. We do not come from the most populated districts in the country. We live in rural America. And you hear stories about our veterans and the length of travel time they have to go to the VA clinics. If we allow the VA to actually contract with hearing aid specialists in their community, far less disruption for our veterans to just have the simple pleasure of hearing provided to them and services provided to them from the VA. So I hope the committee will consider our bipartisan proposal and I think it goes a long way to making sure we are doing justice by way of the men and women who have so honorably served our country. I yield back.

[THE PREPARED STATEMENT OF SEAN DUFFY APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you very much, Mr. Duffy. Now I will call on Representative Sinema.

STATEMENT OF HON. KYRSTEN SINEMA

Ms. SINEMA. Thank you, Chairman Benishek and Ranking Member Brownley, for holding today's hearing, and thank you to my colleagues who have introduced important bills that improve the quality of care available to veterans, especially Congresswoman Walorski's legislation to make travel assistance available for veterans seeking care for military sexual trauma.

I am here to discuss H.R. 3387, the Classified Veterans Access to Care Act, and thank you, Chairman Benishek, for cosponsoring this bill. The Classified Veterans Access to Care Act ensures that veterans with classified experiences can access appropriate mental health services at the Department of Veterans Affairs.

I am working on this issue because last year a veteran in my district, Daniel Somers, failed to receive the mental health care he needed and tragically committed suicide. No veteran or family should have to go through the tragedy that the Somers family experienced. Daniel Somers was an Army veteran of two tours in Iraq. He served on Task Force Lightning, an intelligence unit. He ran over 400 combat missions as a machine gunner in the turret of a HUMVEE. Part of his role required him to interrogate dozens of terror suspects and his work was deemed classified.

Like many veterans, Daniel was haunted by the War when he returned home. He suffered from flashbacks, nightmares, depression, and additional symptoms of Post Traumatic Stress Disorder made worse by a Traumatic Brain Injury. Daniel needed help and he and his family asked for help. Unfortunately the VA enrolled Daniel in group therapy sessions, which Daniel could not attend for fear of disclosing classified information. Despite requests for individuals counseling, or some other reasonable accommodation to allow Daniel to receive appropriate care for his PTSD, the VA delayed providing Daniel with appropriate support and care. Like many, Daniel's isolation got worse when he returned to civilian life. He tried to provide for his family but he was unable to work due to his disability. He struggled with the VA bureaucracy. His disability appeal had been pending for over two years in the system without resolution and he did not get the help he needed in time.

On June 10, 2013, Daniel wrote a letter to his family. It begins, "I am sorry that it has come to this. The fact is for as long as I can remember my motivation for getting up everyday has been so that you would not have to bury me. As things have continued to get worse it has become clear that this alone is not a sufficient reason to carry on. The fact is, I am not getting better. I am not going to get better. And I will most certainly deteriorate further as time goes on. From a logical standpoint it is better to simply end things quickly and let any repercussions from that play out in the short term than to drag things out in the long term."

He goes on to say, "I am left with basically nothing. Too trapped in a War to be at peace, too damaged to be at War. Abandoned by those who would take the easy route, and a liability to those who stick it out and thus deserve better. So you see, not only am I bet-

ter dead but the world is better off without me in it. This is what brought me to my actual final mission."

Daniel's parents, Howard and Jean, were devastated by the loss of their son. But they bravely shared Daniel's story and created a mission of their own. Their mission is to ensure that Daniel's story brings to light America's deadliest War: the 22 veterans that we lose everyday to suicide. My office worked with Howard and Jean to develop this Act so that veterans can seek and receive comprehensive mental health care from the VA regardless of the classified nature of their military experiences. Our bill directs the Secretary of the VA to establish standards and procedures to ensure that a veteran who participated in a classified mission or served in a sensitive unit may access mental health care in a manner that fully accommodates the veteran's obligation to not improperly disclose classified information. It also directs the Secretary to disseminate guidance to employees of the Veterans Health Administration, including mental health professionals, on such standards and procedures on how to best engage veterans during the course of mental health treatment with respect to classified information. And finally, the bill directs the Secretary to allow veterans with classified experiences to self-identify so they can quickly receive care in an appropriate setting.

Our legislation is supported by the Retired Enlisted Association, the Association of the United States Navy, and the Iraq and Afghanistan Veterans of America. As the IAVA states in its letter of support, these reforms to mental health treatment are necessary to provide safe and inclusive care for all veterans. I look forward to continuing to work with the committee to ensure that no veteran feels trapped, like my constituent Daniel did, and that all veterans have access to appropriate mental health care.

Again, thank you, Chairman Benishek and Ranking Member Brownley, for including the Classified Veterans Access to Care Act in today's hearing. Thank you.

[THE PREPARED STATEMENT OF KYRSTEN SINEMA APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you very much for your compelling testimony. Ms. Titus. Are you ready to go ahead?

STATEMENT OF HON. DINA TITUS

Ms. TITUS. I am, Mr. Chairman. Thank you for your indulgence. I apologize. I am introducing H.R. 2527. I certainly appreciate your and the ranking member's including this in the hearing today.

This is bipartisan legislation that addresses an unacceptable gap in current law that effectively leaves certain victims of sexual assault without support and treatment that they need and deserve. Members of the National Guard and other Reserve components of the armed services who have fought bravely for our country, and many have completed multiple tours in Iraq and Afghanistan, certainly that is true of the National Guard in Nevada. Since September 11th, more than 50,000 Guardsmen and Guardswomen have been called to service both at home and abroad.

Now we all recognize the great importance of the National Guard and other Reserve components and we thank them for their incred-

ible service. Members of the National Guard and other Reserve components who are unfortunate victims of sexual assault while they are on active duty are like members of other armed forces. They are provided with all the services and resources they need to recover and heal physically and emotionally. This treatment is provided by the VA for free for as long as it is needed and this is the very least that we can do. These benefits, however, are not offered to members of the National Guard or other Reserve components who experience sexual assault while they are on active training missions. For example, members of the Guard are required to participate in training missions one weekend a month and two weeks a year. This oversight is simply unacceptable and it leaves many who have served our country so well without any assistance or support during a very devastating time if they are such victims.

The National Guard Military Sexual Trauma Parity Act would fix this omission and clarify that all victims of sexual trauma in the National Guard or the other Reserve components would have access to the resources and services they need whether they are on active duty or they are in a required training mission. We should make it a priority to change the culture of the military and put an end to the acts of sexual trauma that exist within our military and that we have heard so much about lately. But until we do that, however, we have to provide victims of this kind of trauma with the care that they need. And certainly that would include not just the active military but also our National Guard in these other times.

So I want to thank many of the VSO organizations for their support, the VA is supportive of this, and I thank the subcommittee for including this important legislation. And I yield back.

[THE PREPARED STATEMENT OF DINA TITUS APPEARS IN THE APPENDIX]

Mr. BENISHEK. I yield five minutes to Dr. Roe to present his testimony.

STATEMENT OF HON. DAVID P. ROE

Dr. ROE. Thank you, Mr. Chairman. And it is my pleasure to present H.R. 3831, the Veterans Dialysis Pilot Program Review Act, to my colleagues on the subcommittee. This bill would prevent the Veterans Health Administration from rolling out a new in house dialysis centers until an independent review of the VHA dialysis pilot program has been completed.

In 2009 the Secretary of Veterans Affairs launched a VHA dialysis pilot program creating four test sites at outpatient VA clinics to see if quality dialysis treatment could be delivered to veterans in house at a lower cost than contracting the care out to commercial dialysis treatment centers. In 2012 a GAO report, which I ask to be inserted into the record——

Mr. BENISHEK. So ordered.

Dr. ROE. Thank you. Shows that early implementation of the dialysis pilot program has shown many weakness, including erroneous cost estimation practices and cost savings calculations. The Department of Veterans Affairs, however, is moving to expand the in house dialysis program nationally before review of the pilot pro-

gram has been performed. In fact, VA is still contracting for an independent analysis of how well it is working.

H.R. 3831 would simply direct the Secretary of Veterans Affairs to halt the establishment of any new VA dialysis clinics until each of the four original pilot sites has been operating for two years, an independent analysis of the sites is conducted, and a full report has been submitted to Congress. The intent of this bill is to ensure that we have found out if this pilot program is in the best interests of veterans and taxpayers before the VA rolls out the program nationally.

And let me say this briefly. This does not prevent the four senators from continuing exactly what they are doing, and it does nothing to veterans receiving care that they are now from the private sector. It is just to see if the program works before we roll out another program at the VA. How many times have we seen this? We do not, we start a program, do not even analyze it, and then we are explaining and trying to figure out why it does not work. That is all we are doing, is just asking to do exactly what the VA said it would do which is to analyze the program before they expand it. That is all this is.

And anecdotally, Mr. Grimm, I completely agree with what you are doing and I wholeheartedly support. I have seen veterans at home, I have met veterans and talked to them, it is really amazing to see what these animals can do. So I am very supportive of your bill. I yield back.

Mr. BENISHEK. Thank you. Ms. Walorski, do you have any questions you would like to ask?

Mrs. WALORSKI. Thank you, Mr. Chairman. I just have a couple of comments. To Representative Grimm, I applaud your efforts as well. I was just at Walter Reed's Research and Development Facility just a couple of weeks ago and saw a whole new program they are laying out with actually a whole breed of labs that they are using for pet therapy. And they have even taken it a step farther, which I think is phenomenal, because the therapy is for the veteran. And they are actually now allowing the veteran to name their therapy dog the name of their buddy that was left behind that was killed. And it is powerful. And pet therapy is a powerful tool. And just seeing the families there and the veterans that were involved in the training was incredible, and we have seen it in our district as well.

And then also to Representative Sinema, I just, I applaud your efforts on that bill. I think, I am appalled by what we hear sometimes what seems to be everyday in this committee about how our veterans are treated. And this issue of suicide, I would agree with Ranking Member Brownley, is one of our top issues on this committee and this subcommittee. And I had a situation in my district where we had a Vietnam Vet that was not dealing with a classified issue necessarily but was certainly dealing with extreme depression, mental health issues based on chronic pain from the effects of Agent Orange. And we did everything we could and then some and it just was not enough. And they sent him home over Christmas and we got a call from his wife that he committed suicide. And it was one of the most distressing things I have dealt with being in Congress. It just, it is a sad, sad reality. And we have to do bet-

ter. We just have to completely do better for the sake of our veterans in this country. And I yield back the rest of my time. Thank you, Mr. Chairman.

[THE PREPARED STATEMENT OF DAVID ROE APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thanks, Ms. Walorski. Ms. Kuster.

Ms. KUSTER. Thank you, Chairman Benishek, and thank you Ranking Member Brownley. And I just want to speak on a couple of bills but I want to make a comment about our members, our colleagues coming forward with these bills and this committee being one of the few places that we can make bipartisan progress. So I just want to speak to the bill that I had the opportunity to be original cosponsor with Representative Walorski, and commend your work on military sexual trauma generally and specifically making sure that our veterans, both men and women, get the treatment that they need and have the funds for travel that they need.

I also want to comment my colleague Representative Sinema for giving Daniel's live a legacy and meaning. And I think for all of us we each have our individual stories in our districts, but I have had the opportunity to meet Daniel's family with you and just to know that he, his life will have a purpose if we can do everything that we can on this committee and convince our colleagues that this is a priority issue for our country.

And lastly to my colleague Representative Titus, I do a lot with the National Guard in New Hampshire and we have also had a very high level of participation in these conflicts, and I think it is critically important to include the National Guard. I have been having a series of round tables with our veterans and our VSOs and our National Guard on the issue of military sexual assault. And I completely agree with you that we need to eradicate this problem from our military, but in the meantime we need to be doing everything we can on this committee to make sure that people get the treatment that they need in a timely way.

So I have no questions, just comments. Just thank you for your leadership and thank you, Representative Brownley, for your leadership on this committee. Thank you.

Mr. BENISHEK. Thank you, Ms. Kuster. Ms. Negrete-McLeod? Do you have any questions? Ms. Titus, do you have any questions?

Well I think we can excuse the first panel. Thank you very much for your testimony today and for taking the effort to put through these good efforts to improve services to our veterans. Thank you very much for your time.

We will proceed with the next panel. Mr. Denham may still arrive to present his bill and if he does we will give him some time to present his case.

Will now welcome the second panel to the witness table. Joining us on the second panel is Ms. Joy Ilem, Deputy National Legislative Director from the Disabled American Veterans; Ms. Alethea Predeoux, the Associate Director of Health Analysis for the Paralyzed Veterans of America; and Aleksandr Morosky, the Senior Legislative Associate for the Veterans of Foreign Wars. Thank you for being here this morning and for your hard work and advocacy

on behalf of our veterans. I appreciate your being here to present your views and we will begin with Ms. Ilem.

STATEMENT OF JOY J. ILEM

Ms. ILEM. Thank you, Mr. Chairman and members of the subcommittee. We appreciate your inviting DAV to testify at this legislative hearing. My comments will be focused primarily on the bills DAV supports but DAV's written testimony submitted for the record discusses our position on each measure in detail.

H.R. 2527 seeks to expand eligibility for counseling and treatment for conditions related to military sexual trauma, or MST. Current law authorizes VA to provide such services for those who served on active duty, or active duty for training. H.R. 2527 would amend the statute to include veterans in the Reserve components of the armed forces during inactive duty for training as well so that they too will become eligible for this type of care. Based on DAV Resolution No. 125 we are pleased to support this measure and urge its enactment.

H.R. 2974 seeks to provide eligibility for beneficiary travel reimbursement to veterans receiving care in one VA facility but based on a clinical determination they need to access a specialized MST program or treatment only available at another VA facility. According to the Inspector General, as noted, patients and VA mental health staff have indicated they are often challenged to obtain authorization for VA funded patient transportation to these specialized centers. DAV Resolution No. 125 calls on VA to ensure all MST survivors have access to the specialized treatment programs and services they need to fully recover. Therefore DAV supports this legislation but we also recommend the subcommittee review the VA's beneficiary travel policy as it relates to other groups of veterans' access to VA specialized care as well.

H.R. 2661, the Veterans Access to Timely Medical Appointments Act, would direct VA to establish a national standardized scheduling policy to improve timely access to care. While the intent of this bill is laudable and we appreciate the sponsors' efforts, DAV believes the overriding component to solve many of VA's access challenges is a lack of an effective automated scheduling system. While the bill seeks to rectify many of the existing problems identified by GAO, enactment of this bill would not address what we consider the core issue. Specifically the implementation of a modernized scheduling system so that VA could begin to be based on reliable data, begin to assess demand versus capacity as well as determine associated staffing needs and resources more accurately. While DAV supports the intent of the legislation based on our Resolution No. 204, we urge the subcommittee to work with the bill's sponsor and VA to fully address the underlying issues related to this problem and determine how the intent of this measure could be best achieved.

H.R. 3387 seeks to ensure that standards and procedures are in place for VA clinicians to provide mental health treatment to veterans who served in a classified military mission. We agree that guidance on how to best engage such veterans during the course of mental health treatment is critical to ensuring the veteran is able to access appropriate care and services without having to dis-

close sensitive information. DAV Resolution No. 193 supports program improvement and enhanced resources for VA mental health programs and we believe this bill is consistent with the purposes of our resolution. Therefore DAV offers its support of this measure.

H.R. 4198 seeks to reinstate the requirement for an annual report to Congress on the capacity of VA to provide specialized treatment and rehabilitative needs of disabled veterans. Although we have no specific resolution calling to reinstate the report we do acknowledge the importance of having data that accurately reflects available capacity for these important services. However, due to the changes in health care delivery since the requirement of the original report we recommend amendments to the bill that would track capacity in discrete bed intensive units along the lines of the intent of the bill yet also obtain relevant information on VA program capacities that are no longer bed intensive, such as specialty outpatient mental health services, substance use disorder treatment services, and long term services and supports, among others. DAV asks the committee to consider approving the bill in its current form with the understanding that at a future legislative meeting of the committee an amendment would be offered by the bill's sponsor incorporating the changes we hope to achieve cooperatively.

My final comments are related to the draft bill to authorize major VA medical facility projects for fiscal year 2014. DAV strongly supports this draft measure on the basis of DAV Resolutions No. 28 and 188.

Mr. Chairman and members of the subcommittee, thank you for considering the views of DAV today and I am happy to respond to any questions you may have related to these proposals or in any of DAV's testimony. Thank you.

[THE PREPARED STATEMENT OF JOY ILEM APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you very much for your testimony. Ms. Predeoux, you may begin.

STATEMENT OF ALETHEA PREDEOUX

Ms. PREDEOUX. Thank you. Chairman Benishek, Ranking Member Brownley, and members of the subcommittee, Paralyzed Veterans of America, PVA, would like to thank you for the opportunity to present our views on the health care legislation being considered by the subcommittee. These important bills will help ensure that veterans have access to quality and timely health care services through the Department of Veterans Affairs.

We are particularly pleased that H.R. 4198, which is a legislative priority for PVA, is among the legislation being reviewed today. My remarks will focus on only a few bills as PVA's full statement as been submitted to the subcommittee.

H.R. 2661, the Veterans Access to Timely Medical Appointments Act, proposes to establish a standardized scheduling policy for veterans enrolled in VA health care. This scheduling policy would mandate that VA schedule all primary care appointments within seven days of the date requested by the veteran or the health care provider on behalf of the veteran, and require specialty care medical appointments to be scheduled within 14 days of the date requested by the veteran or physician. Timely access to quality care

is vital to VA's core mission of providing primary care and specialized services to veterans. PVA is concerned with how to determine the best standardized policy for scheduling primary and speciality care appointments. Measuring patient access and demand is an extremely complex tasks. Despite VA's stated goals of providing primary care appointments within seven days of a veteran's requested date and 14 days for specialty care, wait times continue to exist. Legislating these goals as standardized policy for scheduling VA medical appointments has the potential to lead to unintended outcomes that could force VA into contracting for care with private providers too frequently. We encourage the VA and Congress to determine if VA has adequate resources to develop, implement, and support a patient scheduling system that will address issues involving wait time measures, sufficient staffing levels, and patient demand.

PVA supports H.R. 2974, a bill to amend Title 38 to provide for eligibility for beneficiary travel for veterans seeking treatment or care for military sexual trauma in specialized outpatient and residential programs. Recognizing that the burden of cost associated with travel for health care services can lead to veterans foregoing much needed medical attention for many years, PVA has advocated for expanding beneficiary travel eligibility for specialized groups of veterans such as catastrophically disabled and severely injured ill and wounded veterans. PVA believes that veterans seeking treatment for MST should be eligible for beneficiary travel and sufficient resources should be provided for the costs associated with expanding this program.

Lastly, PVA strongly supports H.R. 4198, the Appropriate Care for Disabled Veterans Act. This legislation proposes to amend Title 38 to reinstate the requirement for an annual report on the capacity of the VA to provide specialized treatment and rehabilitative needs for disabled veterans. Many of the VA's specialized systems of care and rehabilitative programs have established policies on the staffing requirements and number of beds that must be available to maintain capacity and provide high quality care. When VA facilities do not adhere to these staffing policies and requirements veterans suffer with prolonged wait times for medical appointments, or in the case of PVA members having to limit their care to an SCI clinic despite the need to receive more comprehensive care from an SCI hospital. Requiring the VA to provide Congress with an annual capacity report to be audited by the Office of the Inspector General would give VA leadership and Congress an accurate depiction of VA's ability to provide quality care and services to disabled veterans. This is particularly important for measuring access and bed capacity of VA's specialized services for blinded veterans, veterans with spinal cord injury or disorder, and veterans who have sustained severe traumatic brain injury. PVA also urges the subcommittee to not only reinstate the reporting requirement but also update the language in Title 38 to most accurately reflect specialized services within VA for VA long term care, mental health, and substance use disorders.

We thank the subcommittee for recognizing VA's capacity to provide specialized services as a priority in VA health care deliver and look forward to working with our VSO partners and this sub-

committee to update this report so that it reflects useful information that will improve care delivery for all veterans receiving services through VA's specialized programs.

Again, I thank you for the opportunity to submit our views on the bills being reviewed today and I am happy to answer any questions.

[THE PREPARED STATEMENT OF ALETHEA PREDEOUX APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you very much for your testimony. Mr. Morosky, could you proceed?

STATEMENT OF ALEKSANDR MOROSKY

Mr. MOROSKY. Chairman Benishek, Ranking Member Brownley, and members of the subcommittee, on behalf of the Veterans of Foreign Wars of the United States and our auxiliaries I want to thank you for the opportunity to present VFW's stance on legislation pending before this subcommittee. The bills we are discussing today are aimed at improving the quality of veterans health care and we thank you for bringing them forward.

(The Veterans Dog Training Therapy Act)—The VFW recognizes the potential value of canine therapy and would not be opposed to a pilot program to treat veterans with PTSD by teaching them to train service dogs. We do however have two suggestions that we believe would strengthen this bill. First, we suggest the bill be amended to allow VA to carry out the pilot program in partnership with existing community resources. Second, we recommend the bill be amended to allow VA the flexibility to house the dogs at off site locations when necessary. With these changes, VFW fully supports this bill.

(H.R. 2527)—The VFW supports this legislation which would authorize VA to provide counseling and treatment to servicemembers who experience MST during inactive duty training. The VFW strongly believes that members of the Reserve component who experience MST during weekend drills or other inactive duty deserve the same MST related services as those who experience sexual trauma while activated.

(The Veterans Access to Timely Medical Appointments Act)—Although the VFW strongly supports the intent of this legislation to reduce appointment wait times for veterans we do not support the statutory mandate of VA's seven-day primary care and 14-day specialty care appointment wait time goals. The VFW is primarily concerned that this legislation would force VA to overutilize purchased care. VA's new purchase care model, PC3, is still being implemented. Its effectiveness is still unknown and it may not be the best option for many veterans. The VFW wants to see PC3 as a secondary option to direct care, as it was intended. To solve this problem of long wait times VA must implement its plans for appointment scheduling, physician staffing, and purchased care, and VFW urges continued congressional oversight to ensure that those things happen.

(H.R. 2974)—The VFW strongly supports this legislation. Under current VA policy all MST victims are eligible for residential rehab treatment programs and facilities that do not have those programs have been directed to refer veterans to those that do. Not all MST

victims, however, meet the current criteria for beneficiary travel reimbursement. This legislation would fix that problem, fully aligning VA travel policy with MST treatment policy.

(H.R. 3508)—This legislation would authorize VA to hire hearing specialists as full-time employees at department facilities to provide hearing health services alongside audiologists and hearing health technicians. Although we appreciate this bill's intent to increase hearing health access, the VFW believes that VA has the ability to address that issue under its current hiring authority. We strongly believe that VA must improve timeliness in issuing and repairing hearing aids. But adding a new class of provider whose scope of practice overlaps that of existing employees does not get to the root of the problem. To fully address the issue VA must determine proper staffing levels of audiologists and hearing health technicians necessary to provide timely care and increase the number of those employees accordingly.

(H.R. 3180)—The VFW supports this legislation which would allow state veterans homes that receive residential care contracts or grants from VA to also contract with VA under the health care for Homeless Veterans Supported Housing Program. As long as there are homeless veterans who need them, beds in state veterans homes should not remain empty simply due to the unintended consequences of a federal regulation.

(Classified Veterans Access to Care Act)—The VFW supports this legislation which would require VA to develop standards to provide care for veterans who participate in sensitive missions in a way that does not require them to improperly disclose classified information. The VFW believes that this requirement is reasonable and would ensure that veterans feel that they can access the mental health services they need without violating any non-disclosure responsibilities they may have.

(The Veterans Dialysis Pilot Program Review Act)—The VFW supports this legislation. A May, 2012 GAO report found that VA was planning to expand the dialysis pilot despite not having developed adequate performance measures to evaluate the existing locations. The purpose of any pilot program should be to assess its strengths and weaknesses on a small scale before deciding whether or not it should be expanded.

(The Appropriate Care for Disabled Veterans Act)—The VFW supports this legislation which would reinstate the requirement for VA to submit an annual report to Congress on its capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans. The VFW believes that current accurate data on VA capacity will greatly assist Congress in conducting oversight on veterans access to care.

(The draft bill to authorize major medical facility projects)—It is critical that VA is provided with the authority to enter into the 27 major medical leases. Many of these leases have been awaiting authorization for nearly two years. These facilities provide direct medical care in the community where veterans live and VA must enter into these new leases to serve their needs. The VFW supports the provision expanding VA's enhanced use lease authority, but VA must make every effort to lease these unused or underutilized

properties for projects that directly support veterans and their families before considering other leasing projects.

Mr. Chairman, this concludes my testimony and I look forward to any questions you or other members of the committee may have.

[THE PREPARED STATEMENT OF ALEKSANDR MOROSKY APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you very much, Mr. Morosky, for your testimony. I will begin by yielding myself five minutes for some questions. The question I had was about the appointment schedule there or the timely access. Are there any provisions of that legislation that you do support? I think, Mr. Morosky, you were the most critical of that legislation.

Ms. ILEM. I think for DAV, I mean, we support the intent, wanting to have timely access. I think we did have some concern about legislating the seven-day and the 14-day requirements. But I think for DAV the biggest thing was that to really achieve these goals we felt that the core of the problem is the scheduling package that is 30 years old and VA has testified on that a number of times. So to achieve that things and correct the deficiencies that I think they really want to get at, I think that is the most important thing for us, that would be included. But, you know, there are, I think the overall intent, to improve access, we do not have a problem with.

Mr. BENISHEK. All right, great. Go ahead, Mr. Predeoux, do you have a response?

Ms. PREDEOUX. Just to piggyback off what Ms. Ilem just said. We agree with the intent. Our concern would just be making sure that the VA has adequate tools to ensure that the standards that are set are standards that are reasonable and positively impact patient care deliver within the VA.

Mr. BENISHEK. Mr. Morosky, do you have any?

Mr. MOROSKY. And Mr. Chairman, we also support the intent. It is mainly the seven- and 14-day requirement that we do not support. You know, wait times result is another way of saying access. And VA's plan for access right now is to develop its appointment scheduling policy so that the wait times are accurate and representative. They are not accurate and representative right now. So to put a day number on it when they are not accurately reporting what the wait times are may be a bit too soon. It is also their physician staffing plans that they are instituting across specialty care, that is part of access. It is hard to have access if you do not have enough providers. And third, they are just finishing rolling out their PC3 program. And so all those things put together are going to equal access and we certainly support the greatest level of access. And we support the intent of this bill, which is to provide that.

Mr. BENISHEK. Right. Right. Well we brought up this PC3 program, I have my own particular concerns about how that is going to work. Because I am not sure what the level of payment they are going to provide to providers and if people are actually going to sign up now. Talking to the VA myself on several occasions, they seem to think that it is all going to go hunky-dory. But I do not know if that is actually going to be the case, you know what I mean? Because I have not seen any actual numbers of how many people have actually signed up. So I am just so hesitant. And I un-

derstand your concern about mandating in statute, a date and a time. But I do not see, all the time that I have talked to VA and they say, "well, we are going to have it done." And then it never actually happens. And we keep, bypassing deadlines and that. It is very frustrating to me.

Let me switch topics a little bit. There was some concern about H.R. 183, the Veterans Dog Training Therapy Act. The statement for the record from the Wounded Warrior Project equated H.R. 183 with a directed research program and states that decisions to fund research initiatives, however appealing as they may appear, should be based on peer review evaluation process. Do you agree that the pilot program that would be mandated by H.R. 183 amounts to directed research? Does anyone have a comment on that?

Ms. PREDEOUX. I was not able to read the statement from the Wounded Warriors. But as far as research, I can only imagine that they are likening it to the fact that the VA, this is not a traditional program in the area of mental health. And along the lines of the comments that you made earlier from the first panel, PVA supports this as an alternative, non-traditional method for mental health care and dog therapy training. I am not sure, we will definitely have benefits from it and it could be considered research in some respects. But I am not sure I agree with the statement that it is directed research.

Mr. BENISHEK. Mr. Morosky, I think the Veterans of Foreign Wars in their written statement expressed concerns regarding the potential use of, or kenneling service dogs at a VA medical center could lead to some problems. Would you be supportive of an amendments to H.R. 183 that would allow VA flexibility to house and train service dogs off campus?

Mr. MOROSKY. Yes, we would. That along with allowing them to go into community partnerships, like the Palo Alto VA Medical Facility does with I believe it is called the Bergen Canine Institute. We feel that has been very beneficial. It has led to positive patient and provider responses. So with those two things we would be supportive of this legislation.

Mr. BENISHEK. I think you heard that Mr. Grimm was, willing to do that sort of thing. So I hope that you all can get together and figure that out.

Mr. MOROSKY. Yes, sir. We will.

Mr. BENISHEK. I am out of time, thank you. Ms. Walorski, do you have any questions for the panel? Or Ms. Brownley, sorry.

Ms. BROWNLEY. Thank you, Mr. Chairman. You have asked a lot of the questions that I was going to ask. But I think I will go back again to H.R. 2661, and I concur that I agree with the intent of the bill. I think I just wanted to ask, I hear what the concerns are with regards to, you know, strict standards and possibly encouraging some data manipulation and we would not get the, you know, the accurate data that we all are looking for which is a very small wait time and not a long one. Do you think that that is still happening, that we have not done enough oversight to correct it? I think that we do need an automated system. We are not there yet. But I mean, do you see this happening across the country in terms of not providing accurate information?

Ms. ILEM. I think there has been, you know, continued concern because of the limitations of the current IT system that is in place, of what VA can actually do. I think the parts of the bill that talk about making sure people are trained properly and know the procedures and the policies is critical, I mean, that is absolute. But without a system that is nuanced for what they are really trying to capture today, I think everybody, at the end of the day everybody wants to just be sure we know are people waiting? They want to be sensitive in certain areas if there is a backlog in a certain area for certain procedures so that they can then transfer resources into that area and the proper amount of staff. We do not want to see VA just having to, you know, send people out of the system unless it is absolutely necessary because they cannot get a timely appointment. But to be more sensitive through this, you know, through that type of a scheduling package that they can really see do we have a wait list? Do we have a, and we have not seen that. I mean, it has just been very, you know, they have goals, they want to see people as quickly as possible. And you know, but if you cannot meet those goals then what happens? So I think, you know, the goal is to see is it a lack of resources? Is it a lack of management issues? You know, what is the problem in this particular area that we cannot get people seen in a timely manner?

Ms. BROWNLEY. Thank you. Anybody else have a comment on that? Or I think——

Mr. MOROSKY. We mentioned the past sort of data misrepresentation in our testimony as well. We hope that the VA is not still doing that. We feel like they are trying to be more open and honest and transparent about it. But we would not want to impose such a strict standard on them that it sort of almost encourages not necessarily data manipulation but as we all know there are different ways to present data and you can present data in a way that is more favorable to yourself or that is maybe more apples to apples that everybody can understand. We just want to make sure that they are being as transparent as possible without the undue constraints of unreasonable standards.

Ms. BROWNLEY. Thank you. I did not have a chance to tell Representative Grimm how much I support his bill. The VA will state that, you know, training of dogs is sort of outside of their purview. I am just wondering from your perspective whether you agree, disagree with the VA's perspective on it?

Ms. ILEM. I would just note that, you know, VA seems to have been more open in the past couple of years to the complementary and alternative medicine and treatment options for veterans and certainly that is what we are hearing. I mean, especially with service animals. You know, we have heard such great feedback from so many veterans saying, you know, this helped me get off, you know, so much medication. I really, you know, I have this connection with my service animal. It has allowed me to get out and do things that, you know, I was not able to do. So and we have also heard about, you know, the therapeutic training, aspects of training an animal. So I mean, if they are going to do it it would be nice to see if they can see what, you know, some outcomes of that would be for veterans. I mean, certainly we are hearing positive feedback based on the program up in Palo Alto. So we would hope that, and I see the

problems that VA would, or challenges they would face with having, as the bill is currently written. But I think the amendments that have been suggested would be appropriate.

Ms. BROWNLEY. Thank you. And just, well, I might have run out of time but I will yield back.

Mr. BENISHEK. Thank you. Ms. Negrete-McLeod, do you have any questions? In that case, we will excuse the second panel. Thank you very much for your input. We may have some written questions which we hope you will answer for us. So thank you very much for your testimony.

At this time I will recognize the gentleman from California Mr. Denham to present his legislation.

STATEMENT OF HON. JEFF DENHAM

Mr. DENHAM. Thank you, Chairman Benishek, Ranking Member Brownley, and thank you to the panel as supporters of H.R. 4198, the Appropriate Care for Disabled Veterans Act. This legislation has the support of the Paralyzed Veterans of America, Veterans of Foreign Wars, and the Disabled American Veterans, and I look forward to working with each of those groups as this bill moves forward.

Mr. Chairman, as you know the number of disabled veterans has been increasing at an alarming rate. The number of severely disabled veterans is increasing even at a quicker rate. These severely disabled veterans are suffering from a range of issues from spinal cord injury, dysfunction, blindness, Traumatic Brain Injury, or mental health disorders. Many require prosthetic or orthotic and sensory aids and all need specialized care in their communities.

It is the responsibility of this committee to ensure that the VA is meeting the mission requirement. To ensure that the veterans had the care they needed Congress mandated in the beginning of 1996 that the VA maintain its capacity for the specialized treatment and rehabilitative needs of disabled veterans based on a number of specific measurements. For spinal cord injuries in particular this capacity was to be measured by the number of staffed beds and the number of full-time employees available to provide care. The VA was also required to report this information to Congress after it was reviewed by the VA's Office of the Inspector General. Unfortunately this report requirement has lapsed and consequently so has the VA's adherence to the capacity standards required by Congress. As an example, Paralyzed Veterans of America's testimony explains how issues involving VA's capacity such as staffing directly impacts daily bed censuses and thus creates access issues for veterans who need comprehensive care.

With this bill we have the opportunity to restore and modernize that reporting requirement so that this committee and our partners in the VSO community maintain a thorough understanding of the VA's ability to provide specialized care across the Veterans Health Administration system. To that end I welcome the testimony that we just heard. The American people have provided extraordinary resources to the Department of Veterans Affairs. It is our job to provide oversight of those resources. We cannot provide the oversight necessary without accurate information.

Mr. Chairman, thank you for letting me speak out of order.

[THE PREPARED STATEMENT OF JEFF DENHAM APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you very much, Mr. Denham. At this point I will call up the third panel then. Joining us from the Department of Veterans Affairs is Dr. Madhulka Agarwal, Deputy Under Secretary for Health for Policy and Services. She is accompanied by Mr. Philip Matkovsky, the Assistant Deputy Under Secretary for Health for Operations and Management, and Renée Szybala, the Acting Assistant General Counsel. Thank you all for being here this morning. Dr. Agarwal, please proceed.

STATEMENT OF MADHULKA AGARWAL, M.D., M.P.H., DEPUTY UNDER SECRETARY FOR HEALTH FOR POLICY AND SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY PHILIP MATKOVSKY, ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH FOR OPERATIONS AND MANAGEMENT, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND RENEE L. SZYBALA, ACTING ASSISTANT GENERAL COUNSEL, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF MADHULKA AGARWAL

Dr. AGARWAL. Good morning, Chairman Benishek, Ranking Member Brownley, and members of the subcommittee. We appreciate your continued efforts to support and improve veterans health care. Thank you for the opportunity to address the bills on today's agenda and to discuss the impact of these bills on VHA's health care operations. Joining me today are Mr. Philip Matkovsky, Assistant Deputy Under Secretary for Health for Operations and Management, and Ms. Renee Szybala, Acting Assistant General Counsel.

I want to thank the subcommittee for the opportunity to testify concerning the bills we support, starting with H.R. 2527. We fully support affording the same crucial benefits to our National Guard and Reservists as others who have suffered the indignity of military sexual trauma. VA is poised to begin delivering services to the population as soon as this bill is enacted.

Let me also assure the subcommittee that while we do not yet have prepared views on H.R. 2974, our evaluation of the bill is being done within the context of recognizing the importance of this issue for these veterans. Likewise although in draft form the major medical facilities projects bill would authorize critically needed operations and we support it as well.

With respect to the other bills on the agenda I want to state at the outset that we support the intent behind many of the provisions in these bills but have valid concerns that have been highlighted in our testimony, and we ask the subcommittee to reconsider them.

H.R. 183 requires a five-year pilot to evaluate using service dog training programs to address post-deployment mental health and PTSD symptoms and produce specially trained service dogs for veterans. VA is fully committed to effective and proven treatment modalities as well as to alternative therapies, especially for veterans suffering from mental health disorders including PTSD. However,

VA does not support H.R. 183 as written. This Bill contains a high number of requirements related to selection and training of the proposed service dogs. The bill requires a specialized and rigorous training methodology for these service dogs which exceeds the competence and expertise in VHA.

We have concerns about H.R. 2661. This bill seeks to identify specific standards with respect to appointment scheduling and access to VA services. VA is fully supportive of systems and organizational processes that promote a culture of excellence and accountability. However, H.R. 2661 does not provide the critical flexibility that is needed to manage clinical acuity, resources, and patient preferences for appointment scheduling. VA looks forward to continuing our ongoing and active engagement with the subcommittee and other members in this very important area.

Another bill which we cannot support as written is H.R. 3508. This bill seeks to clarify qualifications for hearing aid specialists within the department. We believe the clinical expertise that is already provided in the department by our audiology health technicians working under the supervision of our professional audiologists can provide the necessary services that this bill seeks to require. Should VA need to leverage the capabilities of hearing aid specialists the Secretary already has the legal authority to appoint such individuals.

H.R. 3831 would prohibit VA from expanding the free standing dialysis pilot programs and prohibit the creation of any new dialysis capability provided by VA. VA plans to brief our congressional committees on the results of the dialysis pilot program before establishing any new free standing dialysis center. However, restricting our ability to create needed capacity in our super CBOCs or in our replacement hospitals, or the new medical centers that are planned to be activated soon would negatively impact our ability to deliver services to veterans who need dialysis at these sites.

Finally we do not believe that H.R. 3180 as drafted has application in the current contracting environment for state homes. We also have concerns about the potential impact on our residential settings.

In the time allotted to prepare for this hearing we were not able to complete our views and testimony on the remaining two bills. Thank you for the opportunity testify before you today. My colleagues and I will be pleased to respond to questions that you have, or other members may have for us. Thank you.

[THE PREPARED STATEMENT OF MADHULKA AGARWAL APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you for your testimony, Dr. Agarwal. I will yield myself five minutes for questions. I hope that you will submit answers or some comments on the other legislation that you say you have not had time to do that——

Dr. AGARWAL. Yes sir, we will.

Mr. BENISHEK [continuing]. In the near future. So I would appreciate that. I understand Mr. Duffy's reason for his legislation about the audiology component. Have you done any studies about, his concern with waiting, waiting 6 months to get care and the timeline? Are you trying to hire more audiologists? What is the story with that whole problem?

Dr. AGARWAL. So thank you again for an opportunity to clarify certain issues related to the wait times, both for the hearing aids that would be delivered to our veteran patients as well as to be able to see an audiologist in the clinic. We have taken actions on both fronts. So let me just describe what had happened about the hearing aid delivery to our veteran patients that had gone in for repairs. There had been vacancies in the Denver Acquisition Logistics Center for a long period of time, which has been rectified. And the delivery times for those repairs are back to our standards.

As for the hearing services wait times in the audiology clinics, various actions have been taken. First of all the number of audiologists and support staff have been increased. The number of sites of care where we provide audiology services has also been increased. We are increasingly providing teleaudiology services, the sites, if I can recall correctly, are going up from 25 sites to up to 71 sites by the end of this year largely in the rural communities. We are also looking to provide these hearing services with non-VA services, the fee care contracts, as well as we are looking at the overall systems we design of the hearing services, to see how we can manage our demand and capacity better.

Mr. BENISHEK. It is my understanding that hearing loss and tinnitus is one of the largest claims for medical disability among returning veterans now. It definitely needs a ramp up. I appreciate what you said here. I did not quite analyze it in my brain as fast as you said it, the implications of all that. We would like to look at that a little bit better but I appreciate that.

My other question is about the dialysis pilot program that Dr. Roe's talked about. I still do not understand. He, as I understand it, he thinks that we should analyze the results of the pilot program before moving along to, building more centers. I am sort of familiar with dialysis and that most dialysis in the country now is done through, local dialysis centers. And it just seems to me that supporting that access is better than VA having another access point in the same community, as there already may be services. So I am just a little concerned about that duplication there. Am I incorrect in that assumption? Because people who are getting dialysis now are getting dialysis now, it is just they are getting paid by different sources. I was in a situation where in my local area there were two dialysis centers, one at VA and one at the other community hospital. So that did not make much sense having two different dialysis centers. And I just seem to think that, VA supporting a local dialysis center person makes a little more sense than having another one in VA. Can you give me your thoughts on that?

Dr. AGARWAL. Sure. So sir, currently VA overall provides dialysis to 17,000 veteran patients. Of that, only 20 percent of it is done in house in our medical centers.

Mr. BENISHEK. Right.

Dr. AGARWAL. We have 65 facilities that offer dialysis service in the, as you probably have noted, in our medical centers. Not everyone provides it.

Mr. BENISHEK. Right.

Dr. AGARWAL. The other 80 percent is of course non-VA care through different contracts.

Mr. BENISHEK. Right.

Dr. AGARWAL. The pilot that we were referencing earlier was started in 2010 and the intention here is to look at four aspects. First of all is the quality of care, the access to care, veteran satisfaction, as well if they are cost effective. So that component of the pilot, sir, we will be completing that evaluation because there was a certain delay in two of those centers, in the next couple of years and we will submit the evaluation to Congress before we will proceed with expanding any free standing units.

However, we have certain medical centers that are going to be activated this year, Orlando being one example. And they have ten regular dialysis stations and one isolation. There is a super CBOC in Green Bay, Wisconsin that also has, it has been planned to have several regular dialysis stations there as well as a couple of replacement hospitals. So with this bill it would restrict our ability to expand on what has been planned for quite some time during the construction phase.

Mr. BENISHEK. All right, thank you. I am out of time. Ms. Brownley, do you have any questions for the panel?

Ms. BROWNLEY. Just quickly, thank you, Mr. Chair. I wanted the panel to just if they could briefly comment on H.R. 3387, which is Representative Sinema's bill on Classified Veterans Access to Care Act. And I do not think that you commented on it in your testimony. And just if you could share your sort of initial response or feelings towards the bill? And do you recognize it as a problem? I would imagine hopefully there are not too many cases across the country where suicide was the ultimate outcome, but I would imagine that there are quite a few people who were in classified positions who may not have access to the appropriate mental health care. So if you could just comment I would appreciate it.

Dr. AGARWAL. So Ranking Member Brownley, thank you for that question. It was a very compelling testimony and I have heard of this case of Mr. Somers before. And I will sort of personally say that, you know, the fact that we need to provide services in the context of what information the veterans can provide to us. So that is the first goal. Our strategic goal, which is to be proactive to offer personalized and patient drive services I think also is in line with this legislation. But it has got to be done, within that context, that if someone is not ready for group therapy, then we need to offer the kind of services that sort of fit their needs and no one else's. So I do not know if I am on the right track. But clearly I think the intent is going to be well supported. And if we need to provide more education and guidance to our clinicians, we will do so.

Ms. BROWNLEY. Thank you. And I also wanted to ask briefly on your draft bill, I think part of the bill, the draft legislation to authorize the major medical facilities projects includes in Section 4 amendments that modify the definition of the medical facility. If you could comment on that? And if you could also explain how some of these amendments will assist the VA in their construction of medical facilities and why the need for the transfer authority that you have requested.

Dr. AGARWAL. I am going to ask my colleague Philip Matkovsky to answer that.

Ms. BROWNLEY. Thank you.

Mr. MATKOVSKY. Some of them are sort of technical adjustments in Section 4, and then there is an element which allows us to use certain funds in design. In the current practice we have been, you know, seeking appropriation of funds off a prospectus and the Secretary has instituted something that is called the Construction Review Council. Mr. Hagstrom is our, sort of presides over our construction portfolio. And we have adjusted the practice so that we are going to a 35 percent design which gives us a much more accurate picture of the scope of the project prior to requesting appropriation of funds. But in order to accomplish that we need to be able to sort of redirect certain funds to get to the 35 percent design.

I think it is a good idea. It is a little bit hard to have a perfectly accurate estimate on something that is a few-page prospectus. Having 35 percent designs gives us a much more valid estimate to bring to this committee for authorization of funds.

Ms. BROWNLEY. Can you comment on some of the technical adjustments?

Mr. MATKOVSKY. In a couple of cases here we are looking at definition for a major medical facility lease as it relates to some of the lease issues that we have had. But some of them I will have to take for the record as I am not terribly proficient on them. Sorry.

Ms. BROWNLEY. Thank you. I will yield back.

Mr. BENISHEK. Thanks, Ms. Brownley. Mr. Denham, five minutes for questions.

Mr. DENHAM. Thank you, Mr. Chair. Dr. Agarwal, do you support the legislation that I proposed here, H.R. 4198?

Dr. AGARWAL. This is 3180, sir.

Mr. DENHAM. 4198.

Dr. AGARWAL. 4198. Okay. This is the capacity?

Mr. DENHAM. Reporting requirements.

Dr. AGARWAL. So we have to provide you the formal views of the department. But as a concept I will tell you that the capacity report as I have seen it from 2008 provided detailed information on the availability of beds, as well as services for many of our program areas, spinal cord injury rehabilitation, mental health, and so on. So in general I think it is very important to know what the capacity is. So in that of course we agree that, you know, it should be supported. However, health care delivery has also evolved over time and there are many services that were provided way back in 1996 have sort of changed their scope. So I think it is going to be important to make sure that the metrics for each of these programs is appropriate.

Mr. DENHAM. So is that an excuse on why the reporting is not being done today? Because they have changed?

Dr. AGARWAL. Sir, I would not say that this——

Mr. DENHAM. So how long does it take you to support a bill? To get authorization back from the agency?

Dr. AGARWAL. Sir, I am going to defer it to my right.

Ms. SZYBALA. We just got too many bills.

Mr. DENHAM. Too many bills? Yes, we have too many committee hearings, too fast.

Ms. SZYBALA. I understand.

Mr. DENHAM. And even though we only get your testimony the night before we still find time to prepare questions and be prepared

for the committee hearing. This bill has been in print for over two weeks. So we would expect a response, I think, that our disabled veterans would expect a response. How do you respond to the testimony of the PVA which states that staffing vacancies are creating access issues for severely disabled veterans?

Dr. AGARWAL. Sir, that is something that we take very seriously. We have regular meetings with PVA on those reports and PVA also does oversight of our facilities very closely.

Mr. DENHAM. So do you think the VA is meeting its requirement, its capacity requirements for the specialized care?

Dr. AGARWAL. So generically I believe that we are. But if there are certainly instances where we are not then we would love to find those out and we will be having those discussions with PVA.

Mr. DENHAM. Well, that is fantastic. We would love to find that out, too, which is why we want that 1996 reporting requirement back to Congress. That is an important reporting requirement that we feel that Congress not only should mandate but we ought to actually get that information so we know whether you are doing your job.

Dr. AGARWAL. Sir, as I previously stated we certainly support the intent. But I think we need to also have the appropriate metrics.

Mr. DENHAM. And when can you provide what those metrics would be back to this committee?

Ms. SZYBALA. I do not know——

Mr. DENHAM. I do not know is not a good answer for us to take back to our constituents.

Ms. SZYBALA. I do understand that. But health care has evolved so that beds is not a metric now for everything. We do telehealth. We have CBOCs——

Mr. DENHAM. I understand. But the question here is there is a reporting requirement. Congress is going to continue to mandate that reporting requirement. If you are telling us that there needs to be new metrics in place, we would ask what do you think those metrics should be? And I do not know is not a good answer.

Ms. SZYBALA. Well, I understand. I mean I think we provide technical assistance when asked to feed into that——

Mr. DENHAM. Okay. So if you are telling us that new metrics needs to be in place, how long will it take you to come back to this committee with what those new metrics are?

Ms. SZYBALA. I cannot give you a date. I cannot.

Mr. DENHAM. Can you give us an estimation?

Ms. SZYBALA. I really, I think that is ill-advised. It is too many facets of VA get involved. And it is hard to control. So all I can say——

Mr. DENHAM. Telling a disabled veteran that has come back from serving in our military that they may have to wait because we do not know is not an acceptable answer. So this committee will be providing a list of questions so that we can get back those answers in writing on what those metrics should, what the timeline would be, and what the reporting requirements will be.

Ms. SZYBALA. And we will get it all to you as fast as we can.

Mr. DENHAM. Thank you. I yield back.

Mr. BENISHEK. Dr. Agarwal, the subcommittee will be submitting additional questions for the record. I would appreciate your assist-

ance in ensuring an expedient response to these inquiries. If there are no further questions, then the third panel is excused. I ask unanimous consent that all members have five legislative days to revise and extend their remarks and include extraneous material. Without objection, so ordered.

I would like to thank again all of our witnesses and the audience members for joining us this morning. The hearing is now adjourned.

[Whereupon, at 10:34 a.m., the subcommittee was adjourned.]

APPENDIX

PREPARED STATEMENT OF CHAIRMAN DAN BENISHEK

Good morning and thank you all for joining us today to discuss pending legislation regarding the health care benefits and services provided to our nation's veterans through the Department of Veterans Affairs (VA).

The ten bills we will discuss this morning are:

H.R. 183, the Veterans Dog Training Therapy Act;

H.R. 2527, to provide veterans with counseling and treatment for sexual trauma that occurred during inactive duty training;

H.R. 2661, the Veterans Access to Timely Medical Appointments Act;

H.R. 2974, to provide beneficiary travel eligibility for veterans seeking treatment or care for military sexual trauma;

H.R. 3387, the Classified Veterans Access to Care Act;

H.R. 3508, to clarify the qualifications of VA hearing aid specialists;

H.R. 3180, to provide an exception to the requirement that the Federal Government recover a portion of the value of certain projects;

H.R. 3831, the Veterans Dialysis Pilot Program Review Act;

H.R. 4198, the Appropriate Care for Disabled Veterans Act; and,

Draft legislation, to authorize VA major medical facility projects for fiscal year 2014.

By and large, these ten bills aim to address two of this Subcommittee's highest priorities: (1) Ensuring that our veterans have access to the care that they need; and, (2) ensuring that VA is held accountable when that care fails to meet the high standards that it should.

Some of these bills—such as H.R. 2527 and H.R. 2974, which aim to resolve gaps in care for veterans who have experienced military sexual trauma—address issues that have been raised through Subcommittee oversight.

Others—such as H.R. 2661, H.R. 3508, and H.R. 3831, which concern lengthy patient waiting times, access to care for hearing-impaired veterans, and ongoing issues with the provision of dialysis care—address issues that were raised through external stakeholder reviews by the VA Inspector General and the Government Accountability Office.

Still others—such as H.R. 183 and H.R. 4198, which concern the need for innovative treatment options for veterans with post-traumatic stress disorder and the need to ensure that VA maintains adequate capacity to provide for the unique health care needs of disabled veterans—address issues that were raised by our veteran constituents and veterans service organizations.

One other—the draft legislation to authorize VA major medical facility projects for fiscal year (FY) 2014 and, of note, authorize the construction of a new bed tower at the James A. Haley Veterans' Hospital in Tampa, Florida—is the Department's own legislative request.

I would note that VA's FY 2015 budget submission includes five additional lease authorization requests that are not included in the draft bill we will discuss this morning.

While I recognize the value of those five lease authorization requests—which would certainly be included in future VA major medical facility lease authorization packages moving through the Committee—I felt it was important to thoroughly analyze and receive stakeholder views on the Department's FY 2014 request.

As you may know, last fall the House passed H.R. 3521, the Department of Veterans Affairs Major Medical Facility Lease Authorization Act of 2013, which would authorize 27 VA major medical facility leases requested by the Department in the FY 2014 budget submission.

It is my sincere hope that H.R. 3521 will be passed through the Senate and quickly signed into law.

I would like to express my gratitude to my colleagues who have sponsored the legislation on our agenda today and who are joining us this morning to discuss their proposals.

I would also like to thank our witnesses from the Disabled Veterans of America, the Paralyzed Veterans of America, and the Veterans of Foreign Wars, as well as the witnesses from the VA for their leadership and advocacy on behalf of our veterans and for being here today to offer their views.

It is critical that we have a thorough understanding of the benefits and consequences of each of these bills before moving forward in the legislative process and, as such, I look forward to a detailed and comprehensive conversation.

PREPARED STATEMENT OF HON. MICHAEL G. GRIMM

Chairman Benishek, Ranking Member Brownley, thank you for allowing me to testify today on H.R. 183, the "Veterans Dog Training Therapy Act," a bill I introduced along with my friend the Ranking Member of the House Veterans Affairs Committee, Congressman Michaud. As a Marine Combat Veteran of Operation Desert Storm it is a unique honor for me to address this committee. Having seen firsthand both the physical and mental wounds of war that the members of our nation's military are faced with, I have a special appreciation for the important work this committee does every day.

Today, millions of Iraq and Afghanistan Veterans have returned home to the challenge of a stagnant economy, high unemployment rate, and, for many, the long road to recovery from the mental and physical wounds sustained during their service.

During my time in Congress I have had the honor to meet with a number of our nation's veterans who are now faced with the challenges of coping with PTSD and physical disabilities resulting from their service in Iraq and Afghanistan. Their stories are not for the weak of heart and are truly moving. It was these personal accounts of recovery, both physical and mental, and the important role therapy and service dogs played in that process, that inspired this legislation.

The Veterans Dog Training Therapy Act would require the Department of Veterans Affairs to conduct a five-year pilot program in at least three but not more than five VA medical centers assessing the effectiveness of addressing post-deployment mental health and PTSD through the therapeutic medium of training service dogs for veterans with disabilities. These trained service dogs are then given to physically disabled veterans to help them with their daily activities. Simply put, this program treats veterans suffering from PTSD while at the same time aiding those suffering from physical disabilities. When I originally introduced this legislation in the 112th Congress both the House Veterans Affairs Committee and the full House of Representatives passed it with overwhelming bipartisan support.

Additionally, with high veteran suicide rates and more servicemen and women returning from deployment being diagnosed with PTSD, this bill meets a crucial need for additional treatment methods. I believe that by caring for our nation's veterans suffering from the hidden wounds of PTSD while at the same time providing assistance dogs to those with physical disabilities we create a win-win for everyone, which I believe is a goal we can all be proud to accomplish.

Working in conjunction with a number of Veteran Service Organizations, I have drafted updated language which mirrors changes made to this legislation in the 112th Congress, and I hope to work with the committee during markup of H.R. 183 to ensure this program provides our nations veterans with the highest quality care for both PTSD and physical disabilities, while maintaining my commitment to fiscal responsibility.

Again, I would like to thank the committee for holding today's hearing and I look forward to working with you to ensure that this program is included in your continuing efforts to guarantee that our nation's heroes have the best possible programs for treating PTSD and providing disability assistance.

PREPARED STATEMENT OF HON. DINA TITUS

Chairman Benishek, Ranking Member Brownley, fellow members of the Committee.

Thank you for including my bill H.R. 2527, the National Guard Military Sexual Trauma Parity Act on today's agenda. This bipartisan legislation addresses an unacceptable gap in current law that effectively leaves certain victims of sexual assault without the support and treatment that they need.

Members of the National Guard and other reserve components of the armed services have fought bravely for our country, many completing multiple tours of duty in Iraq and Afghanistan. Since September 11th, more than 50,000 Guardsmen and Guardswomen have been called to service, both at home and abroad.

We recognize the great importance of the National Guard and other reserve components, and thank them for their service. Members of the National Guard or other reserve components who are the unfortunate victims of sexual assault while on active duty are, like members of the other armed forces, provided all the resources and services they need to recover and heal, physically and emotionally. This treatment is provided by the VA for free for as long as is needed. This is the very least that we can do.

These benefits, however, are not offered to members of the National Guard or other reserve components who experience sexual assault while on inactive training missions. For example, Members of the Guard are required to participate in training missions one weekend a month and two weeks a year. This oversight is simply unacceptable, and leaves so many who have served our country without assistance or support during a devastating time.

The National Guard Military Sexual Trauma Parity Act would fix this omission and clarify that all victims of sexual trauma in the National Guard or other reserve components have access to the resources and services they need whether they are on active duty or on a required training mission.

We must make it a priority to change the culture of the military and put an end to acts of sexual trauma within our armed services. Until we do, however, we must provide victims with the care that they need and deserve.

I want to thank many of the Veteran Service Organizations for their support and appreciate that this subcommittee will consider this important legislation creating parity for the brave men and women in the National Guard and other reserve components.

PREPARED STATEMENT OF HON. JACKIE WALORSKI

Good morning, Chairman Benishek, Ranking Member Brownley, and members of the Committee. Thank you for the opportunity to discuss H.R. 2974, a bill making victims of military sexual trauma (MST) eligible for Department of Veterans Affairs (VA) beneficiary travel benefits.

According to the Department of Veterans Affairs, 1 in 5 women, and 1 in 100 men screen positive for military sexual trauma (MST).[1] The VA provides counseling, care, and services to veterans and certain other servicemembers who may not have veteran status, but who experienced MST while serving on active duty or active duty for training.[2] VHA policy[3] states that "veterans and eligible individuals who report experiences of MST, but who are deemed ineligible for other VA health care benefits or enrollment, may be provided MST-related care only. This benefit extends to Reservists and members of the National Guard who were activated to full-time duty status in the Armed Forces. Veterans and eligible individuals who received an 'other than honorable' discharge may be able to receive free MST-related care with the Veterans Benefits Administration Regional Office approval".

Every VA Medical Center (VAMC) offers evidence-based therapy for conditions related to MST, and has providers knowledgeable about treatment for the aftereffects of MST.[4] Nationwide there are almost two dozen programs that offer specialized treatment in residential or inpatient settings. All health care for treatment of mental and physical health conditions related to MST, including medications, is provided free of charge. Fee basis is available when it is clinically inadvisable to provide counseling in a VA facility, when VA facilities are geographically inaccessible, or when VA facilities are unable to provide care in a timely manner.[5] Overall, while VA has taken the appropriate steps to provide counseling services for victims of MST, these services need to be more accessible.

MST-related care must be provided in a setting that is therapeutically appropriate, taking into account the circumstances that resulted in the need for such care. A supportive environment is essential for recovery. Thus, VA policy states that any veteran with MST must receive clinically appropriate care regardless of location. Veterans being treated for conditions associated with MST are often admitted to programs outside their Veterans Integrated Service Network. VA health care in general, especially for women, has been characterized as fragmented.[6] Patients with

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[1] Department of Veterans Affairs, National Center for PTSD, Military Sexual Trauma Fact Sheet, September 2013 *http://www.mentalhealth.va.gov/docs/mst-general-factsheet.pdf.*

[2] U.S. Code, Title 38, Section 1720D, 1992.

[3] VHA Directive 2010–033, Military Sexual Trauma (MST) Programming, July 14, 2010.

[4] McCutcheon, SJ and Pavao, J; Military Sexual Trauma Support Team, VA Office of Mental Health Services, National Training Summit on WomenVeterans; "Resources for Military Sexual Trauma (MST) Survivors," PowerPoint, 2011.

[5] Department of Veterans Affairs Office of Inspector General. health care Inspection Report No. 12–03399–54, Inpatient and Residential Programs For Female Veterans with Mental Health Conditions Related to Military Sexual Trauma, December 5, 2012. Retrieved from *http://www.va.gov/oig/pubs/VAOIG-12-03399-54.pdf.*

[6] Washington DL, Yano, EM, Simon B, and Sun S. 2006. To Use or Not to Use: What Influences Why Women Veterans Choose VA Health Care. J Gen Intern Med, 21(Suppl 3): S11–S18.

special [7] needs who are unable to access the services they need from their local providers are referred elsewhere, and oftentimes have to travel long distances to receive such services. According to a 2012 VA Inspector General report, obtaining authorization for travel funding was frequently cited as a major problem for both patients and staff. [8] The beneficiary travel policy indicates that only certain categories of veterans are eligible for travel benefits, and payment is only authorized to the closest facility providing a comparable service. [9]

The current beneficiary travel policy contradicts VA's MST policy, which states that patients with MST should be referred to programs that are clinically indicated regardless of geographic location. A veteran should never have to choose to skip treatment for conditions related to MST due to distance or a lack of transportation.

I applaud VA's commitment to an effective program that provides counseling and treatment to men and women in need of help in overcoming the physical and psychological stress associated with MST. However, VA is not doing enough to help veterans access these important resources and services. Survivors of MST should not feel re-traumatized and helpless because of geographic barriers to treatment.

Representative Kuster and I introduced H.R. 2974 to make victims of MST eligible for VA beneficiary travel benefits. By better aligning the beneficiary travel policy with VA's current policy for responding to veterans who have experienced MST, H.R. 2974 ensures appropriate services are more readily available to meet the treatment needs of our nation's veterans. I am grateful to work with Representative Kuster and the committee in addressing this critical issue for the survivors of military sexual trauma. I thank you again for this opportunity to speak today.

PREPARED STATEMENT OF HON. SEAN DUFFY

Good morning. Thank you, Chairman Benishek and Ranking Member Brownley for holding this hearing today. I appreciate the opportunity to testify on behalf of H.R. 3508, legislation I introduced to help address the long wait times and lack of access our Veterans are facing in regard to hearing health.

Our aging and younger veterans returning from the battlefield are seeking help from the VA for hearing loss more than any other disability facing them today. The demand for audiology services is growing at nearly 10% per year. Because of this increased demand, the VA can't keep up.

Veterans across the US are being forced to wait weeks or even months for an appointment, Veterans like my constituent Roger from Marshfield. Roger is 70 years old and a Veteran of the Vietnam War. He suffers from hearing loss, and when he sought help from the VA, he was told he could not get an appointment for six months. Unfortunately, Roger couldn't wait that long, so he went to his local hearing aid specialist—and he was seen that day. Roger was willing to pay out of pocket for his hearing aids because six months was just too long to wait.

This situation is because today the VA is only allowed to use Doctors of Audiology to provide hearing services to Veterans. While audiology doctors are a great resource for the VA and provide adequate service for Veterans, there are not enough to keep up with the demand and needs of people like Roger.

Hearing aid specialists have gone through a 1–2 year apprenticeship training period, have completed a comprehensive written exam, and are certified by the state to fit and sell hearing aids. They are very qualified to support the specialized services of Audiology doctors by fitting, adjusting, and making minor repairs to hearing aids, helping to relieve the current burden Audiologists have of performing all hearing services for the VA. With the provisions of my bill in place, VA Audiologists can turn their attention to specialized cases and complex conditions, and people like Roger won't be waiting six months for hearing aids.

A recent Office of Inspector General report supported these findings: 42 percent of Veterans waited more than 30 days from the time the medical facility received the hearing aids to the time they were mailed back to the Veteran and blames the delay in repairs on staff vacancies and an increase in workload. My bill would also

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[7] Bean-Mayberry B, Chang CC, McNeil M, Hayes P, Scholle SH. 2004. Comprehensive care for women veterans: indicators of dual use of VA and non-VA providers. J Am Med Womens Assoc, 59(3): 192–7.

[8] Department of Veterans Affairs Office of Inspector General. health care Inspection Report No. 12–03399–54, Inpatient and Residential Programs For Female Veterans with Mental Health Conditions Related to Military Sexual Trauma, December 5, 2012. Retrieved from *http://www.va.gov/oig/pubs/VAOIG-12-03399-54.pdf.*

[9] VHA Handbook 1601B.05, Beneficiary Travel, July 23, 2010.

allow the VA to fill those staff vacancies with specialists certified for adjusting and repairing hearing aids.

H.R. 3508 has the support of the Iraq and Afghanistan Veterans of America, the International Hearing Society, VetsFirst, Blinded Veterans Association, and American Veterans.

As Americans, we can never repay our debt to Veterans like Roger, but Congress can pass common-sense measures like H.R. 3508 to help make their lives back home a little easier. I urge the Committee to pass my legislation quickly and appreciate your support today.

I yield back the balance of my time.

PREPARED STATEMENT OF HON. MARCY KAPTUR

Chairman Benishek, Ranking Member Brownley, and Members of the Subcommittee, I appreciate the Subcommittee's consideration today of H.R. 3180, and thank you for the opportunity to submit testimony on this important legislation.

This bill takes a critical step to address a most unfortunate epidemic of homelessness among our veterans. The U.S. Department of Housing and Urban Development estimates that nearly 60,000 veterans are homeless on any given night, including more than 12,000 veterans of our most recent military involvements. Moreover, about 1.4 million veterans are considered at risk of homelessness.

In a prosperous nation such as ours, this is simply unacceptable. These men and women who did so much in service to our nation deserve better. The U.S. Department of Veterans Affairs does provide critical services for our homeless veterans and indeed, all who served. Still, many slip through the cracks.

H.R. 3180 would provide help to ensure that number is lower. This legislation is intended to remove the barriers faced by State Veterans Homes in running homeless veterans programs. Many State Homes operate with continued vacancies—beds that could be filled by homeless veterans. Unfortunately, federal requirements can hinder these efforts.

By providing an exemption for State Homes that receive a contract or grant from VA for residential care programs, including homeless veterans programs, we remove disincentives to State Homes to offer homelessness services.

This provision places no requirements on VA to award special treatment in grants and contracts. Nor does it take away from the base services of State Homes in favor of homelessness programs. It simply puts State Homes on a level playing field with other groups providing homeless veterans programs.

As we wind down our military involvements overseas, we face a renewed need to provide the services our veterans have earned. We should be doing everything we can to ensure these services are provided efficiently and effectively. Especially in the tight fiscal constraints we currently face, we must ensure that we are not wasting precious resources. H.R. 3180 takes an important step in that direction and I urge continued favorable consideration of the bill.

Thank you again Mr. Chairman and Members of the Subcommittee.

PREPARED STATEMENT OF HON. KYRSTEN SINEMA

Thank you Chairman Benishek and Ranking Member Brownley for holding this legislative hearing.

Thank you to my colleagues who introduced important bills to improve the quality of care available to veterans, especially Congresswoman Walorski's legislation, H.R. 2974, to make travel assistance available for veterans seeking care for military sexual trauma.

I am here to discuss H.R. 3387, the Classified Veterans Access to Care Act—thank you Chairman Benishek for helping me to introduce this bipartisan bill.

The Classified Veterans Access to Care Act ensures that veterans with classified experiences can access appropriate mental health services at the Department of Veterans Affairs.

I am working on this issue because last year a military family in my district—the family of Daniel Somers—was devastated when Daniel failed to receive the care he needed and committed suicide.

No veteran or family should go through the same tragedy that the Somers family experienced.

Daniel Somers was an Army veteran of two tours in Iraq. He served on Task Force Lightning, an intelligence unit. He ran over 400 combat missions as a machine gunner in the turret of a Humvee. Part of his role required him to interrogate dozens of terrorist suspects, and his work was deemed classified.

Like many veterans, Daniel was haunted by the war when he returned. He suffered from flashbacks, nightmares, depression, and additional symptoms of Post-Traumatic Stress Disorder, made worse by a traumatic brain injury. Daniel needed help. He and his family asked for help the best way they knew how.

Unfortunately, the VA enrolled Daniel in group therapy sessions, which Daniel would not attend for fear of disclosing classified information. Despite requests for individualized counseling, or some other reasonable accommodation to allow Daniel to fully share what gave him nightmares, VA delayed providing Daniel with appropriate support and care.

Like many, Daniel's isolation got worse when he transitioned to civilian life. He tried to provide for his family, but he was unable to work due to his disability. Daniel struggled with the VA bureaucracy; his disability appeal had been pending for over two years in the system without any resolution. Daniel didn't get the help he needed in time.

On June 10, 2013, Daniel wrote a letter to his family. It begins:

I am sorry that it has come to this.

The fact is, for as long as I can remember my motivation for getting up every day has been so that you would not have to bury me. As things have continued to get worse, it has become clear that this alone is not a sufficient reason to carry on. The fact is, I am not getting better, I am not going to get better, and I will most certainly deteriorate further as time goes on. From a logical standpoint, it is better to simply end things quickly and let any repercussions from that play out in the short term than to drag things out into the long term.

He goes on to say:

I am left with basically nothing. Too trapped in a war to be at peace, too damaged to be at war. Abandoned by those who would take the easy route, and a liability to those who stick it out—and thus deserve better. So you see, not only am I better off dead, but the world is better without me in it.

This is what brought me to my actual final mission.

Daniel's parents, Howard and Jean, were devastated by the loss of their son, but they bravely shared Daniel's story and created a mission of their own. Their mission is to ensure that Daniel's story brings to light America's deadliest war—the 22 veterans that we lose every day to suicide.

My office worked closely with Howard and Jean to develop the Classified Veterans Access to Care Act so that veterans know they can seek and receive comprehensive mental health care from the VA, regardless of the classified nature of their military experiences.

Our bill directs the Secretary of the VA to establish standards and procedures to ensure that a veteran who participated in a classified mission or served in a sensitive unit may access mental health care in a manner that fully accommodates the veteran's obligation to not improperly disclose classified information.

It also directs the Secretary to disseminate guidance to employees of the Veterans Health Administration, including mental health professionals, on such standards and procedures and on how to best engage such veterans during the course of mental health treatment with respect to classified information.

Finally, the bill directs the Secretary to allow veterans with classified experiences to self-identify so they can quickly receive care in an appropriate setting.

Our legislation is supported by the Retired Enlisted Association, the Association of the United States Navy, and the Iraq and Afghanistan Veterans of America.

As the Iraq and Afghanistan Veterans of America states in its letter of support, "these reforms to mental health treatment are necessary to provide safe and inclusive care for all veterans."

I look forward to continuing to work with the Committee to ensure that no veteran feels trapped like Daniel and that all our veterans have access to the necessary mental health care they need and deserve.

By working together, and using the strength that the Somers family shows every day, we can end the scourge of veteran suicide, and ensure that veterans and their families have the care they need and deserve.

Again, thank you Chairman Benishek and Ranking Member Brownley for including H.R. 3387, the Classified Veterans Access to Care Act in today's hearing. I welcome any questions you may have.

PREPARED STATEMENT OF HON. PHIL ROE, MD

Mr. Chairman, it is my pleasure to present H.R. 3831, the Veterans Dialysis Pilot Program Review Act, to my colleagues on this subcommittee. This bill would prevent the Veterans Health Administration (VHA) from rolling out new in-house dialyses centers until an independent review of the VHA Dialysis Pilot Program has been completed.

In 2009, the Secretary of Veterans Affairs launched the VHA Dialysis Pilot Program, creating four test sites at outpatient VA clinics to see if quality dialysis treatment could be delivered to veterans in house at a lower cost than contracting care out to commercial dialysis treatment centers. A 2012 GAO report, which I ask to be inserted into the record, shows that the early implementation of the Dialysis Pilot Program has shown many weaknesses, including erroneous cost estimation practices and cost savings calculations. The Department of Veterans Affairs (VA), however, is moving to expand the in-house dialysis program nationally—before a review of the pilot has been performed. In fact, VA is still contracting for an independent analysis of how well it is working.

H.R. 3831 would simply direct the Secretary of Veterans Affairs to halt the establishment of any new VA dialysis clinics until each of the four original pilot sites has been operating for two years, an independent analysis of the sites is conducted, and a full report has been submitted to Congress. The intent of this bill is to ensure that we find out if this pilot program is in the best interest of veterans and taxpayers before the VA rolls out the program nationally.

I would like to thank the witnesses for coming before us today and I look forward to their testimony.

PREPARED STATEMENT OF HON. JEFF DENHAM

Chairman Benishek, Ranking Member Brownley,

Thank you for the opportunity to testify today on behalf of my legislation, H.R. 4198, the Appropriate Care for Disabled Veterans Act. I am pleased that this legislation has the support of the Paralyzed Veterans of America, Veterans of Foreign Wars and Disabled American Veterans and look forward to working with these groups further as we move this important bill through the legislative process.

Mr. Chairman, as you know, the number of disabled veterans has been increasing at an alarming rate. The number of severely disabled veterans is increasing even more quickly. These severely disabled veterans are suffering from a range of issues—spinal cord injury/dysfunction (SCI/D); blindness; traumatic brain injury (TBI); or mental health disorders. Many require prosthetic, orthotic and sensory aids, and all need specialized care in their communities. It is the responsibility of this committee to ensure that the VA is meeting that mission requirement.

To ensure that veterans had the care they needed, Congress mandated, beginning in 1996, that the VA maintain its capacity for the specialized treatment and rehabilitative needs of disabled veterans based on a number of specific measurements. For spinal cord injuries in particular, this capacity was to be measured by the number of staffed beds and the number of full-time employee equivalents available to provide care. The VA was also required to report this information to Congress after it was reviewed by the VA's Office of the Inspector General.

Unfortunately this reporting requirement has lapsed and consequently so has the VA's adherence to the capacity standards required by Congress. As an example, Paralyzed Veterans of America's testimony explains how issues involving VA's capacity such as staffing directly impacts daily bed censuses and thus, creates access issues for veterans who need comprehensive care.

With this bill, we have the opportunity to restore and modernize that reporting requirement so that this committee and our partners in the VSO community maintain a thorough understanding of the VA's ability to provide specialized care across the Veterans Health Administration system.

To that end I welcome the testimony provided today by Disabled American Veterans which points out how substantial changes in the way the VA provides care in such areas as substance abuse disorders, long-term nursing care and prosthetics require new capacity measurements not based on standards set in 1996.

The American people have provided extraordinary resources to the Department of Veterans Affairs. It is our job to provide oversight of those resources. We cannot provide the oversight necessary without accurate information.

Chairman Benishek, Ranking Member Brownley, thank you again for the opportunity to speak on behalf of this legislation.

PREPARED STATEMENT OF JOY J. ILEM

Chairman Benishek, Ranking Member Brownley and Members of the Subcommittee:

On behalf of the DAV and our 1.2 million members, all of whom are wartime wounded, injured and ill veterans, I am pleased to present our views on legislative measures that are the focus of the Subcommittee today, and of DAV and our members.

H.R. 183, the Veterans Dog Training Therapy Act

This bill would require the Secretary of Veterans Affairs to conduct a 5-year pilot program to assess the effectiveness of a therapeutic medium of service dog training and handling in addressing post-deployment mental health and post-traumatic stress disorder (PTSD) symptoms in veterans.

The pilot program would be carried out in three to five Department of Veterans Affairs (VA) medical centers with available resources to educate veterans with certain mental health conditions, in the art and science of service dog training and handling. The bill would require a facility to offer wheelchair accessibility, dedicated indoor space for grooming and training dogs; a classroom or lecture space for education; office space for staff; storage for training equipment; periodic use of other areas to train the dogs with wheelchair users; outdoor exercise and toileting space; and, transportation for weekly field trips to train the dogs in other environments.

The pilot program would be administered through VA's Recreation Therapy Service led by a certified recreation therapist with sufficient experience to administer and oversee the pilot program. The measure also would require that, when the selection of dogs was made, a deference would be given to dogs from animal shelters or foster homes with compatible temperaments to serve as service dogs, and with health clearances. Each service dog in training would live at the pilot program site or in a volunteer foster home in close proximity to the training site during the period of training.

Veterans with post-deployment mental health conditions, including PTSD, would be able to volunteer to participate in the pilot if the Secretary determined adequate resources were available and those selected could participate in conjunction with VA's compensated work therapy program. Under the bill, the Secretary would also give veterans preference in the hiring of certified service dog trainers to those who had successfully completed therapy for PTSD or other residential treatment.

The goal of the pilot would be to maximize the therapeutic benefits to veterans participating in the program and to ultimately provide well-trained service dogs to veterans with certain disabilities. The stated purpose of the pilot program would be to determine how effectively trained dogs would assist veterans in reducing mental health stigma; improve emotional stability and patience; reintegrate into civilian society; and, make other positive changes that aid veterans' quality of life and recovery. The bill would require VA to study and document such efficacy, and to provide a series of reports to Congress.

Although DAV has no specific resolution approved by our membership relating to service dogs that would authorize DAV to formally support this measure, we recognize that trained service animals can play an important role in maintaining functionality and promoting veterans' recovery, maximum independence and improved quality of life. We recognize this pilot program could be of benefit to veterans suffering from post-deployment mental health struggles, including PTSD. We understand a similar program that operates at the Palo Alto VA Medical Center has been beneficial for veterans—and specifically in improving symptoms associated with post-deployment mental health problems, including PTSD. DAV is supportive of non-traditional therapies and expanded treatment options for veterans. For these reasons we have no objection to this bill.

H.R. 2527, To Provide Veterans With Counseling and Treatment for Sexual Trauma That Occurred During Inactive Duty Training

Unfortunately, the sexual assault and harassment scourge continues in the active military services, and often results in lingering emotional or chronic psychological symptoms or conditions in victims of these attacks. Currently, Title 38, United States Code, section 1720D authorizes VA to provide priority counseling and specialized treatment for eligible veterans who have experienced military sexual trauma (MST), but this eligibility is limited to only those who served on active duty or active duty for training.

This measure would amend Section 1720D to include veterans serving in the reserve components of the armed forces during inactive duty for training so that they, too, will be eligible for VA counseling services for conditions related to sexual trauma that occurred during their training.

DAV Resolution 125 calls on VA to ensure that all military sexual trauma survivors gain access to the VA specialized treatment programs and services they need to fully recover from sexual trauma that occurred during their military service. Therefore, DAV is pleased to support H.R. 2527 and urges its enactment.

H.R. 2661, the Veterans Access to Timely Medical Appointments Act

This bill would direct the Secretary of Veterans Affairs to establish a standardized scheduling policy for veterans enrolled in the VA health care system. This measure would propose to improve veterans' timely access to health care in the VA based on an external finding of unreliable waiting time data, lack of local adherence to national scheduling policy, and ineffective oversight by VA on the scheduling process itself.

If enacted, the bill would require VA to implement recent Government Accountability Office (GAO) recommendations (GAO–13–130, *http://www.gao.gov/assets/660/651076.pdf*) to improve the reliability and accuracy of appointment waiting time measures; ensure VA medical centers (VAMC) consistently observe and adhere to official VA scheduling policy; require VAMCs to allocate staffing resources based on actual scheduling needs; and, ensure that VAMCs provide oversight of, and implement best practices to improve, veterans' telephone access to care. The bill would also require VA to make a series of reports to Congress on its efforts to improve scheduling under the mandates of this bill.

DAV has testified on numerous occasions before this Committee on the topic of timely access in general, and of a variety of individual VA health care scheduling challenges, such as those in outpatient primary care, in mental health, in prosthetics and sensory aids and in other specialized services. While policies made at VA's Central Office seek to standardize a set of goals and actions across all VA facilities and programs, such as for timely access, or access-to-care standards, the mechanisms by which these policies are implemented locally may vary over time for a variety of reasons.

We also note that VA's national waiting time policies have been changed over the years, and were re-defined and re-interpreted as they encountered conflicts with realities on the ground. For example, about 20 years ago, to respond to criticisms about long waiting times, particularly for specialty services, VA established its "30/30/20" goal. For outpatient care, patients were to receive initial, non-urgent appointments with their primary care or other appropriate providers within 30 days of requesting visits; receive specialty care appointments within 30 days when referred by primary care providers; and, be seen by providers within 20 minutes of scheduled appointments. In 2000, to replace paper waiting lists, changes were made to VHA's automated scheduling module, measuring actual waiting times versus VA's 30-day standard. Over time, VA has used several different waiting time measures defining and refining which patients would be included in waiting time analysis, which outpatient and specialty clinic services would be counted in waiting time calculations, and when waiting times started and ended. VA's access goals changed again in 2010 when VA began measuring performance for all outpatients based on a new 14-day waiting time benchmark. All these shifts and amendments have encountered challenges when they were implemented locally.

While the intent of the bill is laudable and we appreciate the sponsor's interest in this ongoing challenge at VA, DAV believes the overriding critical component to solving many of VA's access challenges, unaddressed and lingering for several years now, is lack of an effective, sensitive and contemporary automated VA health care scheduling system.

VA's outpatient clinic scheduling module is a core component of the Veterans Health Information Systems and Technology Architecture (VistA), a landmark multi-functional computerized patient records system, first deployed 30 years ago. The system has been modified many times since, and now performs multiple interrelated functions affecting patients, clinicians and other VA resources. The VistA scheduling module captures data which enables VA to measure, manage and improve access, quality and efficiency of care, and monitors operating and capital resources used in providing care. However, as has been continually reported and observed by GAO, "the VistA scheduling system is outdated and inefficient, which hinders the timely scheduling of medical appointments." (See GAO–13–130, page 24.) We believe when a new scheduling system is eventually installed, VA could reasonably begin to assess demand versus capacity, as well as determine associated staffing needs and resources more accurately for management and oversight purposes.

Measuring capacity, patient access and demand is a complex issue. DAV believes that progress toward successful implementation of VA's timely access policy must be assessed to ascertain what is or is not being achieved and why. Valid and reliable

information is crucial because it helps shape decisions and actions at various levels to ensure compliance with policy directives, reaching intermediate performance indicators or benchmarks, and achieving long-term policy goals and objectives. Many of these important objectives are hampered because of weaknesses and failures of VA's current IT scheduling infrastructure. Furthermore, trying to standardize waiting times may result in VA having to contract for services if staffing levels and appropriate resources are not identified to resolve excessive waiting times.

While DAV supports the intent of this legislation based on our Resolution No. 204, which calls on VA and Congress to ensure timely access to quality VA services, to identify and correct the related underlying data, scheduling and reporting problems that exist, and to provide sufficient resources and staff to achieve this goal, we believe this bill may bring an opposite effect. Despite its good intentions, enactment of this bill would not address these issues, and may only further complicate VA's ongoing quest to meet its own national access standards. Like the author of this bill, we want veterans to gain and keep access to timely care in VA. Therefore, we urge the Subcommittee to work with VA to fully address the core issues to determine how the intent of this measure could be best achieved.

H.R. 2974, To Provide for the Eligibility for Beneficiary Travel for Veterans Seeking Treatment or Care For Military Sexual Trauma in Specialized Outpatient or Residential Programs at Facilities of the Department of Veterans Affairs

This bill would amend Title 38, United States Code, section 111, to provide veterans new eligibility for VA beneficiary travel reimbursement if they need to travel to specialized outpatient or residential programs at VA facilities for treatment of mental health conditions related to sexual trauma that occurred during their military service.

The Sexual Assault Prevention and Response Office (SAPRO) in the Department of Defense (DoD) reports that over 3,000 sexual assaults are acknowledged each year across the military branches. However, SAPRO estimates 87 percent of these assaults actually go unreported—meaning that as many as 26,000 sexual assaults are likely to occur in DoD each year. The VA provides specialized residential and outpatient counseling programs and evidence-based treatments to military sexual trauma (MST) survivors, and notes that nearly 800,000 MST-related patient encounters take place annually.

According to VA's Office of the Inspector General (VAOIG) Report No. 12–03399–54, Inpatient and Residential Programs for Female Veterans with Mental Health Conditions Related to Military Sexual Trauma, VA facility and mental health services staff interviewed by the VAOIG consistently indicated difficulties obtaining VA authorization for patient transportation funding to VA's specialized centers for MST. We believe these difficulties arise from conflicting VA authorities and policies. Specifically, VHA Directive 2010–033, Military Sexual Trauma (MST) Programming, establishes policy that veterans and eligible individuals must have access to VA residential or inpatient programs able to provide specialized MST-related mental health care. However, access to such care is affected for veterans eligible and not eligible for beneficiary travel benefits.

In the case of a veteran who is eligible for beneficiary travel benefits under current statutory authority,[1] applying VHA Directive 2010–033 requires clearer guidance on inter-facility referrals for care, consistent implementation of current policy, and oversight.

Clearer guidance to VA facilities from VA Central Office is needed to help determine which VA facility would be responsible for paying beneficiary travel benefits when more than one VA facility is involved in a veteran's care, or when treating VA facilities are located in different Veterans Integrated Service Networks (VISN). This lack of guidance for beneficiary travel affects all types of care including for MST-related conditions. Ostensibly, the memorandum of understanding on inter-facility referrals required in VHA Directive 2010–033, should address this problem.

Consistent implementation and oversight is required when mileage reimbursement is calculated to the nearest VA facility. The VAOIG report indicates that reimbursement is only authorized to the VA facility "where the care or services could be provided." This interpretation is not wholly accurate.

[1] Traveling for treatment or care: 1) for a service-connected disability; 2) for any disability of a veteran rated 30 percent or more for a service-connected disability; 3) for a scheduled compensation and pension examination; 4) of a veteran receiving pension under 38 U.S.C. §1521, and; 5) a veteran whose annual income (as determined under 38 U.S.C. §1503) does not exceed the maximum annual rate of pension under 38 U.S.C. §1521 (as adjusted under 38 U.S.C. §5312) if the veteran was eligible for pension.

Title 38, Code of Federal Regulations, section 70.30(b)(1) and VHA Handbook 1601B.05 state that reimbursement for beneficiary travel to an eligible beneficiary "[i]s limited to travel from a beneficiary's residence to the nearest VA facility where the care or services could be provided and from such VA facility to the beneficiary's residence." However, the Handbook also indicates that the nearest appropriate VA facility is subject to a clinician's determination. The "nearest appropriate VA facility" means the particular VA facility that a VA provider determines is capable of providing the treatment or service required. Thus, if a VA clinician indicates a veteran who is eligible for beneficiary travel requires specialized treatment for MST at a VA facility located in a different VISN, current policy states the amount of beneficiary travel payment or reimbursement shall be calculated from the veteran's residence to the distant facility, not the home VA facility.

In the case of a veteran who is not eligible for beneficiary travel under current statutory authority, we believe successfully achieving the intentions of VHA Directive 2010–033 regarding access to specialized MST-related residential or inpatient MST-related care would require enactment of H.R. 2974.

As you may be aware, DAV called for enactment of a similar measure in testifying before the Senate Veterans' Affairs Committee on October 30, 2013, regarding a draft bill, the Survivors of Military Sexual Assault and Domestic Abuse Act of 2013. Thus, in accordance with DAV Resolution No. 125, which calls for supporting legislation to change beneficiary travel policies to meet the specialized clinical needs of veterans receiving MST-related treatment, DAV supports H.R. 2974. However, DAV also testified on May 21, 2013, before this Subcommittee on a related bill that proposed to amend Section 111 by expanding eligibility for beneficiary travel reimbursement benefits to another select group of veterans. That bill, H.R. 1284, would have given new eligibility for VA beneficiary travel reimbursement to veterans needing specialized care for vision impairment, for spinal cord injury or disorder, or for double or other multiple amputations. In that testimony, we urged this Subcommittee, as we do now, to consider a more equitable approach to beneficiary travel eligibility.

Specifically, in addition to a handful of specialized MST residential programs targeted by H.R. 2974, VA operates 24 spinal cord injury/dysfunction rehabilitation centers, 13 blind rehabilitation centers, 7 geriatric research, education and clinical centers, 7 mental illness research, education and clinical centers, 3 war-related illness and injury study centers, and a number of other clinical centers of excellence. Access to these centers is important for veterans with conditions connected to the expertise of these centers.

In DAV's view, the developing care delivery model for MST-related specialized treatment is similar to the concentrations of other specialized VA clinical services that often require patients to travel long distances to gain access to these services. Without VA's support for their transportation costs to reach these centers, some veterans encounter challenging barriers to care and do not benefit from the higher quality care and outcomes intended by VA and Congress in establishing and operating these centers of excellence. This problem should be addressed through the legislative process.

H.R. 3180, To Include Contracts and Grants for Residential Care for Veterans in the Exception to the Requirement That the Federal Government Recover a Portion of the Value of Certain Projects

H.R. 3180 was introduced with the intention of allowing some state veterans homes to compete for existing grants to support the operation of homeless veterans programs using a portion of excess bed capacity in state home domiciliaries. The bill would amend Title 38, United States Code, to authorize a state veterans home to receive contracts or grants from VA for any residential care program, including a homeless veterans program, without being subjected to required federal recapture of prior VA construction grants to the home for the building of those beds. Under current statute, state veterans homes receive federal support, including both per diem payments for veterans' care and construction grants, to operate only three authorized programs: skilled nursing care, adult day health care, and domiciliary care. Under current law, were a state home to use facilities previously granted by VA to operate any other type of program, the federal government would seek to recapture a proportionate value of the construction grant funds that had been provided over the prior 20 years.

The legislation as currently drafted, however, does not specifically reference either domiciliaries or homeless veterans programs, nor would it assure the intended outcome. The bill's current language would create a broad exception to the recapture provision that could be applied to any residential care program for veterans, and its enactment could raise the potential for other unintended consequences. Based on

DAV Resolution 165, DAV supports the intention of H.R. 3180—to use existing excess capacity to help homeless veterans—but recommends that the Subcommittee work with VA, state homes and veterans service organizations to craft more targeted and effective legislative language to achieve the goal of this bill.

H.R. 3387, the Classified Veterans Access to Care Act

This bill would seek to amend Title 38, United States Code, to improve mental health treatment provided by the VA to veterans who served in classified military missions. If enacted, this bill would provide accommodation to certain veterans in VA mental health care treatment to not improperly disclose classified information in cases in which they served in "sensitive military assignments" or "sensitive units." The bill would define both of these terms, as well as the term "classified information." The bill would require VA to establish standards and procedures to carry out its purposes.

Given the unique nature of this relatively small group of veterans who have been deployed in classified missions or worked in sensitive units while serving, we would hope VA already acknowledges, especially in its mental health treatment programs, the need to be respectful of these veterans' particular circumstances and personal military histories.

Many of VA's treatment programs are provided in group therapy settings. A veteran who served in a classified mission may well not be comfortable discussing that personal history in the presence of a group, and we hope that VA already has established procedures in place to make arrangements for individual counseling or therapy sessions in such cases. We understand this to already be the case in VA's readjustment counseling Vet Centers. We also understand that service members with security clearances receive training about disclosure and restrictions on classified information.

We understand from VA that generally, active duty personnel are able to discuss their experiences without revealing classified information to counselors and therapists, and should be able to engage in treatment irrespective of whether their health care providers possess comparable levels (or any) security clearance. In our review of this issue, we have discovered that even in prolonged exposure-based therapy for PTSD, it is not the case that every detail of an event or experience must be shared by a veteran with a provider in order for treatment to be effective. It is reasonable to believe that VA mental health providers and Vet Center counselors respect and work within the limits of the information that veterans can share and within the confines of any confidentiality requirements and security clearance levels that may be involved.

A reasonable approach would be to inform active duty personnel (and certain veterans) seeking mental health services in VA about all the limits of confidentiality, to include the fact that the care provider may not possess a security clearance. We note that mental health providers working in the DoD routinely inform their patients about the limits of confidentiality, but not security clearance limitations. Nevertheless, VA mental health practitioners and counselors could be at times impeded in aiding particular individuals because they may believe they are effectively "gagged," and thus unable to describe in therapy certain military events or activities sheltered from disclosure that might be, or could become, keys to improved treatment. For example, in prolonged exposure therapy, reliving a traumatic event or incident repetitively has proven to be an effective treatment to reduce or control symptoms of post-traumatic stress disorder. In these cases, a talented, experienced practitioner should be able to use other techniques, such as cognitive behavioral therapy, to enable a service member or veteran to deal with his or her individual challenges, without disclosing classified information.

While it may be technically unnecessary, enactment of this bill could reinforce a sense that these particular veterans' prior military duties should not become a bar to their receiving effective VA mental health services following their discharges, or be a reason to avoid seeking treatment. Thus, we believe enactment could make a positive contribution to care, or help persuade some veterans to actually seek VA mental health services who had not previously done so because of the nature or duties of their prior sensitive or classified military assignments.

While DAV has not received a resolution from our membership concerning mental health services for veterans who once worked in classified or sensitive military activities, we did receive Resolution No. 193, at our most recent national convention, that supports "enhanced [VA] resources for VA mental health programs to achieve readjustment of new war veterans and continued effective mental health care for all enrolled veterans needing such services." We believe this bill is consistent with the purposes of our resolution; therefore, DAV offers its support of this measure.

H.R. 3508, To Clarify the Qualifications of Hearing Aid Specialists of the Veterans Health Administration of the Department of Veterans Affairs

If enacted, this bill would authorize the appointment of hearing aid specialists in the Veterans Health Administration (VHA). The bill would specify that such individuals hold associate degrees in hearing instrument sciences, or the equivalent, from colleges or universities approved by the Secretary, or have successfully completed approved hearing aid specialist apprenticeship programs. Individuals eligible for appointment would need to be licensed by a state as a hearing aid specialist, or its equivalent.

The Secretary would also be required to submit an annual report on timely access to hearing health services to include staffing levels and average waiting times for patients seeking appointments, a description of how the Secretary measured performance related to appointments and care in hearing health, and information on contracting policies with respect to providing hearing health services in non-VA facilities. Not later than 180 days after enactment of this bill, the Secretary would be required to update and reissue the VHA handbook, "VHA Audiology and Speech-Language Pathology Services," to reflect these new requirements.

On February 20, 2014, the VA's Office of the Inspector General (VAOIG) issued a report and findings of its audit of VA hearing aid services (VAOIG 12–02910–80). The purpose of the audit was to evaluate the effectiveness of VA's administration of hearing aid orders. According to the report, VA is not issuing hearing aids to veterans in a timely manner or meeting its own five-day goal to complete repair services of hearing aids issued previously. Specifically, VHA issued 30 percent of its hearing aids to veterans more than 30 days from the estimated date the facility received hearing aids from vendors. Audiology staff attributed the delays to inadequate staffing levels and the large number of veterans requiring compensation and pension examinations, which they reported take priority over other types of clinic appointments. The VAOIG further noted that with the veteran population aging, demand for hearing aid services has increased from 596,000 in FY 2011 to over 665,000 in FY 2012. Also, the VAOIG estimated that about 19,500 sealed packages of hearing aids were awaiting repairs at VA's Denver Acquisition and Logistics Center and that 17–24 days were being consumed by the center to complete the repair services, exceeding VA's five-day timeliness standard for such services.

The VAOIG recommended VA develop a plan to implement productivity standards and staffing plans for audiology clinics as well as to determine appropriate staffing levels for its repair laboratory, and to establish controls to track and monitor received hearing aids pending repair. The VA Under Secretary for Health concurred with the audit recommendations and submitted corrective action plans. We understand these actions have been initiated and look forward to VA's report.

DAV has no specific resolution from our membership related to the employment of hearing aid specialists within VA. However, the findings of the VAOIG report cited demonstrate that VA is now struggling to meet timely access for the delivery of hearing aids and for completing necessary repairs on malfunctioning ones. Because hearing loss (including tinnitus) is the most prevalent service-connected disability for veterans, and the demand for audiology services and hearing aid repairs and adjustments continues to rise, having qualified hearing aid specialists available for basic services (within their scope of practice, for necessary repairs and cleaning) may significantly reduce the waiting times found by VAOIG. We do, however, defer to VA to ensure that hearing aid specialists would meet VA's quality standards, through their certified scope of practice, and could contribute in reducing the backlog of hearing aid repairs and delivery of hearing aids to veterans. If this can be verified by VA we have no objection to passage of this measure.

H.R. 3831, the Veterans Dialysis Pilot Program Review Act of 2014

This measure would require the Secretary to undertake an independent analysis of the existing dialysis program implemented by the VA and provide a report to Congress on the review prior to expanding the existing dialysis pilot program at VAMCs in Durham and Fayetteville, North Carolina; Philadelphia, Pennsylvania; and Cleveland, Ohio, or creating any new dialysis capability.

VA estimates show that in FY 2011, approximately 35,000 veterans enrolled in the VA health care system were diagnosed with end-stage renal disease (ESRD), reflecting a higher prevalence of this condition in the VA population than in the general U.S. population. (Comparison of outcomes for veterans receiving dialysis care from VA and non-VA providers, Wang et al., BMC Health Services Research 2013, 13:26.) VA initiated several studies of this population based on the rapidly rising cost of VA-financed hemodialysis treatment in non-VA facilities and the high rates of morbidity and mortality of veteran patients with ESRD. (Comparing VA and pri-

vate sector health care costs for end-stage renal disease, Hynes et al., Medical care 2012, 50(2):161–170.)

ESRD patients are one of the most resource-intensive population cohorts in the VA health care system. The reality of hemodialysis is often overwhelming to these patients. Kidney failure is a life-altering disease that has a significant impact on a veteran's overall physical and mental health, lifestyle, and livelihood. A veteran diagnosed with ESRD who needs dialysis typically requires three outpatient treatments per week, each requiring about four hours, to be repeated for the remainder of his or her life, absent kidney transplant.

In a May 2012 report, the GAO evaluated VA's dialysis pilot. GAO reported VA had not fully developed performance measures for assessing the dialysis pilot locations, even though the Department had already begun planning an expansion of the pilot to additional sites. Further, GAO concluded that such an expansion "should not occur until after VA has defined clear performance measures for the existing pilot locations and evaluated their success."

DAV has no approved, specific resolution on this issue, and therefore takes no formal position on this bill. We do, however, offer some concerns that we ask the Subcommittee to consider.

While Congress has been focused on the accuracy of VA's data, analysis, and plan of action to address the growing demand for dialysis therapies depicted in recent Committee reports (House Appropriations Report 112–094, page 41, May 31, 2011 and House Appropriations Reports 112–491, pages 39–40, May 23, 2012), DAV is concerned that enactment of this measure would, at least through July 2015, restrict VA's capacity to provide life-sustaining dialysis treatment through fee-basis dialysis, except for those under sharing or other negotiated agreements.

We note for the Subcommittee that VA testified on October 30, 2013, before the Senate Veterans' Affairs Committee, and indicated that requiring continuation of the four initial pilot sites without change beyond these activities for at least the next two years would prohibit activation of any additional free-standing VA dialysis centers until at least 2015. The VA also testified that a restriction of this type had the potential to ". . . adversely impact VA's efforts to optimize Veterans' dialysis care." Given the brittle nature of these veterans' health problems and their very high morbidity and mortality rates due to this fatal disease, in our judgment new projects that the VA is currently working to activate should continue without interruption or further delay, and certainly should go forward without regard to the fate of these four pilot programs. Further, DAV would be deeply concerned if this bill were to halt or restrict VA from continuing to provide dialysis care to veterans within the system itself, or through private providers under contract.

Discussions surrounding the dialysis pilot of the Department's purchased and provided dialysis therapy appear generally to be centered on cost. We find insufficient emphasis on the veteran patient; therefore, we appreciate this legislation's inclusion of non-cost factors such as access to care, quality of care, and veteran satisfaction in the bill's provisions related to independent analysis of the VA dialysis pilot program.

As one of four Independent Budget veterans service organizations (IBVSOs), we note that coordinating care among the veteran, dialysis clinic, VA nephrologists, and VA facilities and physicians, is essential to improving clinical outcomes and reducing the total costs of care. The benefits of an integrated, collaborative approach for this population have been proven in several Centers for Medicare and Medicaid Services demonstration projects and within private-sector programs sponsored by health plans and the dialysis community. Such programs implement specific interventions that are known to avoid unnecessary hospitalizations, which, when they occur for these patients, frequently cost more than the total cost of dialysis treatments. These interventions include a focus on behavioral modification and various motivational techniques. The potential return on investment in better clinical outcomes, higher quality of life, and lower costs could be substantial for VA and veteran patients if integrated care coordination were emphasized.

We understand that some community dialysis providers are piloting the integrated care management concept among their veteran population cohorts. The IBVSOs believe that VA should also provide integrated care management in this pilot program that can test and demonstrate the value of such an approach to VA and the veterans it serves.

H.R. 4198, the Appropriate Care for Disabled Veterans Act

H.R. 4198 would amend Title 38, United States Code, to reinstate the requirement for an annual report to Congress on the capacity of the VA to provide for specialized treatment and rehabilitative needs of disabled veterans. The renewed report would emphasize a special—but not exclusive—focus on maintenance of programs

of care for spinal cord injury/dysfunction (SCI/D); blindness; traumatic brain injury (TBI); prosthetic, orthotic and sensory aids; and mental health.

We have received no national resolution approved by our membership to support reinstatement of this previous reporting requirement; however, we wish to offer some thoughts to the Subcommittee for its consideration in determining how to manage this proposal.

Section 1706, Title 38, United States Code, was formulated by the Committee in the mid-1990's and was first authorized in Public Law 104–262. The section was subsequently revised in three additional acts, the last of which was Public Law 109–461, an act that extended the reporting requirement through 2008. The capacity report has been suspended since that time, but other provisions of section 1706 are still applicable to VA.

Several elements in the report that H.R. 4198 would reauthorize rely on the year 1996 (the year of enactment of Public Law 104–262) as the benchmark year for VA capacity comparisons and reporting going forward. Given changes in the veteran patient population, their health care needs, and the manner in which health care is delivered today, we believe reinstating the existing comparison year of 1996 for a number of important programs would not produce information useful for Congressional oversight, for review by members of our community of veterans service organizations, and for others with interest in VA capacity.

Due to the nature and severity of veterans' contemporary war injuries from Iraq and Afghanistan, and the consequent massive investment in new and innovative prosthetics made by both VA and the Department of Defense since 2002, VA's prosthetic and sensory aids program is now more innovative, extensive and expensive today than in 1996. Thus, 1996 would not be an appropriate benchmark in our view. In this light a more effective date for comparative reporting purposes in the prosthetics program might be 2001 or, perhaps even 2010, so that Congress could more closely gauge how VA capacity to provide these specialized services may be changing annually during a more meaningful interval.

Importantly, in no small part because of this Committee's advocacy and the benevolence of Congressional appropriators, VA mental health programs including those for substance-use disorder, have been reformed, revised and expanded to such an extent that they barely resemble those of nearly twenty years ago. In staffing alone, since 2002, VA has added over 20,000 mental health personnel to its employment rolls. VA already reports to Congress in its annual budget submissions estimated total expenditures on mental health, but reporting of detailed subsets is not currently required. We believe more detail on mental health program capacity should be made available.

As an example of the need for public reporting, we note that substance-use disorder bed units were prevalent in VA and elsewhere in 1996 when the expired reporting requirement was first established, but they are much rarer now. In fact over the past decade and more, VA has severely curtailed inpatient residential substance-use disorder programs. Most of these programs are now conducted on an outpatient basis. The expired language of section 1706 assumes inpatient substance-use programs are still prevalent today. Also, VA maintains a number of detoxification beds for acute substance-use disorder intake cases, but we have experienced challenges in determining the number and location of these beds since no publicly available inventory of them is maintained by VA.

In another evolution in VA, traditional long-term, skilled nursing care (historically a bed-intensive program) has given way to VA's establishment of an array of institutional and non-institutional long-term services and supports. The expired language is silent on VA long-term services and supports capacity, but as an important and growing component of VA's clinical care mission, we believe it should be included. DAV is supportive of the VA's initiative to rebalance its long-term services and supports portfolio to care for veterans closer to where they live by increasing access to and creating new and innovative home and community-based services. However, variation in availability and accessibility of VA long-term services and supports across the 21 VA health care networks has been critiqued in multiple reports by the GAO. These reports collectively could offer insights into how a capacity report might be structured.

In certain discrete bed units (such as VA SCI/D centers, designated TBI rehabilitation units, and residential blind rehabilitation centers, for example), year-to-year comparative bed capacities by unit, and full-time employee equivalents assigned to each such unit (as well as the distribution of those staff by health profession, compared to VA's "objective standards of job performance," as also prescribed by section 1706), could provide a meaningful yardstick to ascertain VA's true capacity to care for and rehabilitate veterans in these particular specialized bed-based units. Given the bill sponsor's coordination with Paralyzed Veterans of America in crafting this

bill, DAV would support amendments to this bill that would require VA to report to Congress on discrete bed-intensive rehabilitation programs along the parameters of the expired section. As described in this testimony, for other VA specialized health care programs we believe a more nuanced report to gauge capacity taking into account the changes that have occurred in these programs would be more beneficial for oversight and monitoring purposes.

Representatives of DAV and other veterans organizations recently have discussed these concerns and needs with the bill's sponsor, and have offered our assistance in crafting a possible substitute amendment that would accomplish our goal of reinstating a capacity-reporting statute that would track capacity resources in discrete bed-intensive units along the lines of the intent of this bill, yet also would provide Congress information on VA capacities that are not bed-intensive or bed-relevant as described above.

Taking into account these concerns, DAV asks the Subcommittee to consider approving the bill in its current form, with the understanding that at a future legislative meeting of the Committee an amendment in the nature of a substitute will be offered by the bill's sponsor, incorporating the agreed-on changes that we hope to achieve in a collaborative fashion.

Draft Bill, To Authorize Major Medical Facility Projects for the Department of Veterans Affairs for Fiscal Year 2014

Sections 1, 2, and 3 of this bill would authorize, or amend a prior authorization of, 27 major medical facility leases, primarily outpatient clinic facilities, in fiscal year 2014, and would authorize appropriations of $236.6 million, an amount sufficient for VA to execute these leases. These are the same leases that are included in H.R. 3521, a bill passed by the House in 2013, and that are also embedded in S. 1982, now pending before the Senate.

DAV strongly supports these sections on the basis that these new or expanded community-based clinics and other leased facilities would improve access to convenient VA primary and specialty outpatient care, and provide other positive health outcomes that support veterans, consistent with DAV Resolution No. 028. We urge the Committee to advance these provisions, and to deal as well with the ongoing stalemate between the Office of Management and Budget and the Congressional Budget Office on an acceptable method of treating the long-term costs of these facilities under the Budget Control and Impoundment Act of 1974, as amended.

Section 4 of the bill would broaden the statutory definition of VA "medical facility" in Title 38, United States Code, section 8101(3), by adding the term "or as otherwise authorized by law" that conveys jurisdiction of a capital entity to the VA Secretary. This section of the bill also would amend the definition of "major medical facility project" to exclude shared federal facilities constructed, altered or acquired, so long as the cost of VA's share did not exceed $10 million; the section would apply this same logic to federally shared major medical facility leases when VA's share did not exceed $1 million in annual rental costs. We have no objection to this change in definition that would provide VA additional flexibility to establish VA health care facilities in the future with other federal health partners.

This section of the bill would create a new section 8111A in Title 38, United States Code, to authorize the Secretary to enter into agreements with other federal agencies to plan, design and construct shared federal medical facilities for the stated purpose of improving access, quality and cost effectiveness of health care provided by VA to veterans, and by other federal agencies to their respective beneficiaries. The authorization would also empower the Secretary to transfer funds to another federal agency for these purposes, so long as such transfer did not exceed the applicable existing thresholds in Title 38, United States Code, for major medical facilities or major medical facility leases ($10 million, and $1 million, respectively). The Secretary would also be authorized to receive funds from other federal agencies for these same purposes, for VA construction or leases of shared federal facilities.

We understand that VA has been stymied in the past in cooperating with the DoD on shared facilities projects due to lack of clear statutory authority within VA to do so. This language, if enacted, would provide VA this specific authority. Our only concern is that this policy be applied to shared VA–DoD facilities and not become the basis for shared activities with numerous other potential federal health agencies with missions unrelated to the care of veterans and military beneficiaries. With that understanding DAV offers no objection to this language.

Section 5 of the bill would amend VA's existing authority for enhanced-use leases by liberalizing the purposes of such leases to two clear options: enhance the use of the property concerned; or, provide supported housing for homeless veterans. Because the enhanced-use lease authority has been moribund since Congress last amended it, now adding general language that would enhance the use of unneeded

VA structures, in a complementary manner, in addition to their use for homeless veterans (the only approved use under current law) might stimulate new lease activity. VA anticipates this more flexible language will generate receipt of new funds from leaseholders of unused VA structures producing no income now. On that basis, DAV would not object to enactment of this section.

Sections 6 and 7 of the bill would modify a prior act of Congress that authorized a major medical facility construction project at the Tampa, Florida VAMC, in effect authorizing a new bed tower at that facility in the amount of $231.5 million, in lieu of upgrades of the existing tower previously authorized by law in 2008. It is our understanding from VA that a determination has been made that constructing a new tower in lieu of renovating the existing one would be a more cost-effective use of these funds. Section 7 also would restrict the use of certain funds in carrying out the Tampa project. DAV takes no position on this section, but makes no objection to this proposed change.

In summary, we would offer no objection to the Committee's approval of this bill in its current form.

Mr. Chairman and Members of the Subcommittee, thank you for inviting DAV to testify before the Subcommittee on these legislative proposals. I stand ready to respond to any questions you wish to ask that are related to these proposals, DAV's positions on them, or other matters related to this testimony.

PREPARED STATEMENT OF ALETHEA PREDEOUX

Chairman Benishek, Ranking Member Brownley, and members of the Subcommittee, Paralyzed Veterans of American (PVA) would like to thank you for the opportunity to present our views on the health care legislation being considered by the Subcommittee. These important bills will help ensure that veterans have access to quality and timely health care services through the Department of Veterans Affairs (VA). We are particularly pleased that H.R. 4198, which is a legislative priority of PVA, is among the legislation being reviewed today.

H.R. 183, the "Veterans Dog Training Therapy Act"

PVA does not have an official position on H.R. 183, the "Veterans Dog Training Therapy Act." If enacted, this legislation would direct the VA to conduct a pilot program on dog training therapy for veterans. PVA recognizes that dog training has been successfully used as a beneficial form of therapy for veterans dealing with Post-Traumatic Stress Disorder (PTSD) and other mental health issues. A model program for this service was created in 2008 at the Palo Alto VA Medical Center in conjunction with the Assistance Dog Program. This program, maintained by the Recreational Therapy Service at the Palo Alto VA medical center, was designed to create a therapeutic environment for veterans with post-deployment mental health issues and symptoms of PTSD to address their mental health needs.

In these programs, veterans training service dogs is believed to help address symptoms associated with post-deployment mental health issues and PTSD in a number of ways. Specifically, veterans participating in these programs demonstrated improved emotional regulation, sleep patterns, and a sense of personal safety. They also experienced reduced levels of anxiety and social isolation. Further, veterans' participation in these programs has enabled them to actively instill or reestablish a sense of purpose and meaning while providing an opportunity to help fellow veterans reintegrate back into the community. PVA does not oppose dog training therapy as a non-traditional form of mental health care. However, if this legislation is enacted as written, it would differ from the existing program at the Palo Alto VA medical center in that the VA would be fully responsible for all aspects of caring for the dogs and the training program. PVA does not believe that VA has the resources needed for such an undertaking.

H.R. 2527

PVA strongly supports H.R. 2527, which proposes to amend Title 38 United States Code to provide veterans with counseling and treatment for military sexual trauma (MST) that occurred during inactive duty training. As discussed in the FY 2015 Independent Budget, currently members of the National Guard or Reserves who experienced sexual trauma during drill training do not have access to VA counseling and treatment for sexual trauma. If a veteran is injured while in drill status, including transit to or from drill training, all such injuries are considered service-connected. The unfortunate instance of sexual trauma should not be treated differently. To deny veterans who serve in the reserve components of the military VA MST-re-

lated care for sexual trauma experienced during inactive duty training is not only inequitable, but detrimental to veterans' health and well-being.

H.R. 2661, the "Veterans Access to Timely Medical Appointments Act"

The "Veterans Access to Timely Medical Appointments Act," proposes to establish a standardized scheduling policy for veterans enrolled in the VA health care system. This scheduling policy would mandate that VA schedule all primary care appointments within seven days of the date requested by the veteran or the health care provider on behalf of the veteran, and require specialty care medical appointments to be scheduled within 14 days of the date requested by the veteran or physician.

Timely access to quality care is vital to VA's core mission of providing primary care and specialized services to veterans. Therefore, PVA believes that the VA must develop reasonable standards for scheduling medical appointments, and have a system that allows VA leadership to assess and evaluate scheduling practices as well as veterans' access to care. It is for this reason that we are pleased that H.R. 2661 addresses the Government Accountability Office's four main recommendations from its March 14, 2013, testimony before the Subcommittee on Oversight and Investigations, "VA Health Care: Appointment Scheduling Oversight and Wait Time Measures Need Improvement." The four recommendations were as follows:

- Improve the reliability of [VA] medical appointment wait time measures.
- Ensure VA medical centers consistently implement VHA's scheduling policy.
- Require VA medical centers to allocate staffing resources based on scheduling needs.
- Ensure VA medical centers provide oversight of telephone access and implement best practices to improve telephone access for clinical care.

Nonetheless, PVA is concerned with how to determine the best standardized policy for scheduling primary and specialty care appointments. Measuring patient access and demand is an extremely complex task. Despite the VA's stated goals of providing primary care appointments within seven days of a veterans' requested date, and 14 days for primary care, wait times continue to exist and fall outside of these seven and 14 day goals, and the definition of a veterans "desired" or requested appointment date varies across VA's national system of care.

Legislating these goals as standardized policy for scheduling VA medical appointments has the potential to lead to unintended outcomes that could force VA into contracting for care with private providers too frequently. PVA urges the Subcommittee to work with VA leadership to make access to VA care timelier. We encourage the VA and Congress to determine if VA has adequate resources to develop, implement, and support a patient scheduling system that will address issues involving wait time measures, sufficient staffing levels, and patient demand.

H.R. 2974

PVA supports H.R. 2974, a bill to amend Title 38 United States Code to provide for eligibility for beneficiary travel for veterans seeking treatment or care for MST in specialized outpatient or residential programs at VA facilities. For many years, PVA has advocated for expanding beneficiary travel eligibility to specialized groups of veterans, such as catastrophically disabled, and severely injured, ill, and wounded veterans, recognizing that the burden of costs associated with travel for health care services can lead to veterans forgoing much needed medical attention. In fact, PVA testified before the Subcommittee last year in support of H.R. 1284, legislation to expand VA beneficiary travel benefits to catastrophically disabled veterans. It is for these reasons PVA believes that VA should extend the beneficiary travel benefit to veterans seeking treatment for MST, and Congress must ensure that sufficient resources will be provided for the costs associated with expanding eligibility of the beneficiary travel program.

Additionally, it is often the case that veterans who have experienced sexual trauma related to their military service receive care from specialized programs such as specialized outpatient or residential programs outside of their nearest VA medical center or their Veteran Integrated Service Networks. When this is the case, the veteran is not eligible for beneficiary travel because current policy only allows for travel reimbursement benefits from the veteran's home to the nearest VA facility providing the services rendered. The VA's policy for beneficiary travel benefits should coincide with VA MST policy that veterans who have experienced MST should be referred to treatment that is clinically indicated regardless of geographic location. [1]

H.R. 3508

[1] "The FY 2015 Independent Budget," *www.independentbudget.org*.

PVA does not have an official position on H.R. 3508, legislation that proposes to amend Title 38 United States Code to clarify the qualifications of hearing aid specialists of the Veterans Health Administration of the VA.

H.R. 3180

PVA does not have an official position on H.R. 3180, legislation that proposes to amend Title 38 United States Code to include contracts and grants for residential care for veterans as an exception to the requirement that the federal government recover a portion of the value of certain projects.

H.R. 3387, the "Classified Veterans Access to Care Act"

PVA supports H.R. 3387, the "Classified Veterans Access to Care Act," which proposes to improve the mental health treatment provided by the VA to veterans who served on a classified mission. It is PVA's position that all VA mental health care should meet the specific, individual need of the veteran seeking medical services on a consistent basis. The VA should also ensure that veterans seeking mental health services have access to care options provided in appropriate settings. This is particularly important for veterans who served on classified missions. This particular cohort of veterans should not be compromised by inappropriate care settings that force them to choose between their duty not to improperly disclose classified information and their need to get much needed help. If this legislation is enacted, the VA should make a concerted effort to inform veterans of the option to self identify as a "covered" veteran to help provide immediate mental health care, and alleviate any concerns regarding veterans' military service records not indicating that they participated on classified missions.

H.R. 3831, the "Veterans Dialysis Pilot Program Review Act of 2014"

PVA generally supports H.R. 3831, the "Veterans Dialysis Pilot Program Review Act of 2014." If enacted this legislation would require VA to review the dialysis pilot program and submit a report to Congress before expanding the program. Gathering and analyzing data to make the most informed decisions is always best when such choices involve veterans' health care. For this reason, PVA supports the provisions of this bill that require independent analysis of the pilot and a VA report that includes cost comparisons and non-cost factors such as access to care and quality of care provided to veterans. PVA believes that the dialysis pilot should be completed and comprehensive analysis should be conducted to determine the best, most cost-efficient, way to provide veterans with timely, quality access to dialysis care.

On October 30, 2013, the VA testified at the Senate Committee on Veterans Affairs' hearing on health and benefits legislation that requiring implementation of each of the four initial pilot sites for at least two years would prohibit activation of any free-standing dialysis centers until 2015. The VA further testified that such a restriction has the potential to " . . . adversely impact VA's efforts to optimize Veterans' dialysis care." Keeping the well-being and health care needs of veterans first, projects involving dialysis centers that the VA is currently working to activate should continue to completion without interruption. Additionally, PVA does not support provisions of this bill that would prevent VA from continuing, establishing, or providing dialysis care for veterans within the VA or with outside providers.

H.R. 4198, the "Appropriate Care for Disabled Veterans Act"

PVA strongly supports H.R. 4198, a bill to amend Title 38 United States Code, to reinstate the requirement for an annual report on the capacity of the VA to provide for specialized treatment and rehabilitative needs of disabled veterans. Since 1996, the VA has been required to collect and maintain specific information and data that is a reflection of its capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans. Initially, the VA was also required to compile this data into a report for Congress on an annual basis. Unfortunately, this reporting requirement expired in April of 2008.

H.R. 4198 would reinstate the annual reporting requirement, mandating that the VA provide an annual report to Congress that includes information such as utilization rates, staffing, and facility bed censuses. Requiring the VA to compile such data into the form of a report to share with Congress annually will lead to more accountability within the VA, help ensure more efficient allocation of VA resources, particularly in the area of staffing, and improve veterans' access to care in VA's specialized systems of care. Ultimately, the VA's capacity to provide specialized care and rehabilitative treatment for disabled veterans is directly correlated to its ability to provide veterans with timely, quality health care services.

Within the VA's Spinal Cord Injury and Dysfunction (SCI/D) system of care, access to timely care is critical to the health and well-being of this population of veterans. Many of the VA's specialized systems of care and rehabilitative programs

have established policies on the staffing requirements and number of beds that must be available to maintain capacity and provide high quality care. When VA facilities do not adhere to these staffing policies and requirements, veterans suffer with prolonged wait times for medical appointments, or in the case of PVA members, having to limit their care to an SCI/D clinic, despite the need to receive more comprehensive care from an SCI/D hospital. There have been instances within VA's SCI/D system of care when staffing positions have gone vacant for long periods at a time, and as a result, the facility's bed capacity is decreased, decreasing veterans' access to care. Requiring the VA to provide Congress with an annual capacity report, to be audited by the VA Office of Inspector General, will allow VA leadership and Congress to have an accurate depiction of VA's ability to provide quality care and services to disabled veterans—blinded veterans, veterans with spinal cord injury/disorder, and veterans who have sustained a traumatic brain injury—as it relates to access and bed capacity of VA specialized services and rehabilitative programs.

Recognizing that not all VA specialized services and rehabilitative programs for disabled veterans require inpatient care, the current language of Title 38 United States Code, Section 1706, does not fully allow for accurate evaluation of VA's current capacity to provide many specialized and rehabilitative health care services that cannot be sufficiently measured using a bed census. PVA urges the Subcommittee to not only reinstate the reporting requirement, but also update the language in Title 38 to most accurately reflect the current specialized services within the VA, especially in the areas of VA long-term care, mental health care and substance use disorders.

We thank the Subcommittee for recognizing VA's capacity to provide specialized services as a priority in VA health care delivery and look forward to working with our VSO partners and the Subcommittee to update this report so that it reflects useful information that will improve care delivery for all veterans receiving services through VA specialized systems of care.

Draft Legislation to Authorize Major Medical Facility Projects for the Department of Veterans Affairs for Fiscal Year 2014 and for Other Purposes

PVA generally supports the draft legislation to authorize major medical facility projects for the VA for fiscal year 2014. PVA fully supports provisions of this bill that authorize fiscal year 2014 major medical facility leases. Authorization of funding for these facilities is critical to the VA maintaining its ability to provide health care services. We urge Congress to continue to work towards the most viable solution for dealing with the long-term costs of VA facilities given the Congressional Budget Office's current scoring methodology for facility leases.

Of particular importance to PVA is section 4 of this legislation which includes amendments to modify the definition of a medical facility and to authorize VA to plan, design, construct, or lease joint VA and federal use medical facilities. PVA is aware that while there are not many instances where VA shares federal medical facilities, such arrangements do exist. However, we have concerns regarding shared federal medical facility projects and leases as it has the potential to result in situations that diminish VA's unique mission of providing solely for veterans' medical health care needs. Sharing medical facilities with federal agencies has the potential to dilute not only VA's mission but the quality of care delivered to veterans. This is particularly the case when considering shared facilities with federal agencies that are not accustomed to building health care services around patients that are veterans and military service members like VA and the Department of Defense.

This concludes my statement. PVA would like to thank the Subcommittee for allowing us to testify on these important issues involving veterans' health care services from the VA. We look forward to working with both the Subcommittee and the VA to improve veterans' access to care and the quality of services provided through the VA.

Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 2013

National Council on Disability—Contract for Services—$35,000.

Fiscal Year 2012

No federal grants or contracts received.

Fiscal Year 2011

Court of Appeals for Veterans Claims, Administered by the Legal Services Corporation—National Veterans Legal Services Program—$262,787.

Alethea Predeoux, Senior Associate Director for Health Legislation, PVA

Alethea joined Paralyzed Veterans of America in 2007 and works in PVA's national office in Washington, DC. As a member of PVA's Government Relations staff, Alethea is responsible for monitoring and analyzing policy within the Department of Veterans Affairs (VA) to determine how such policies impact the health care of disabled veterans, particularly veterans with Spinal Cord Injury/Dysfunction (SCI). Alethea also covers issues involving women veterans, VA human resources, prosthetics, and mental health. Alethea's professional experience is in the area of legislative affairs and government policy.

In addition to her policy work, Alethea also manages the production of The Independent Budget, a comprehensive budget and policy document produced by veterans for veterans.

Alethea earned a Master's Degree in Public Policy from George Mason University and completed her undergraduate studies in Political Science at Spelman College.

PREPARED STATEMENT OF ALEKS MOROSKY

Chairman Benishek, Ranking Member Brownley and members of the Subcommittee, on behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and our Auxiliaries, I want to thank you for the opportunity to present the VFW's stance on legislation pending before this Subcommittee. Your hard work and dedication to improving the quality of veterans' health care positively impacts the lives of all those who have served in our nation's military. The bills we are discussing today are aimed at continuing that progress and we thank the Committee for bringing them forward.

H.R. 183, Veterans Dog Training Therapy Act

This legislation would require the Department of Veterans Affairs (VA) to establish a pilot program at three to five facilities to assess the effectiveness of treating veterans for post-traumatic stress disorder (PTSD) by instructing them in the art of service dog training. The Palo Alto VA Medical Center (VAMC) has been operating a similar program since 2008 in partnership with the Bergin University of Canine Studies, known as Paws for Purple Hearts, which resulted in positive feedback from veterans and staff.

The VFW recognizes the potential value of canine therapy and would not be opposed to a limited pilot program for the purpose of collecting data to determine its effectiveness in treating veterans for PTSD. We do, however, have suggestions that we believe would strengthen H.R. 183, which we hope the subcommittee would consider, should this bill be advanced to markup.

VA has been directed by Executive Order to establish community mental health partnerships, and numerous organizations around the country have expertise in the field of service dog training. We believe that the collaboration with the Bergin University of Canine Studies has benefitted the Paws for Purple Hearts program, and similar relationships should be encouraged going forward. For this reason, we suggest that the bill be amended to allow VA to carry out the pilot program at the selected sites in partnership with existing community resources.

We also believe that it may not always be appropriate to kennel dogs on the grounds of VA medical facilities. The VFW is concerned that noise, sanitation, and available space could present problems for VA facilities tasked with the primary mission of delivering health care to veterans. We recommend the bill be amended to allow VA the flexibility to house and train the dogs at off-site locations when necessary. With the above changes, the VFW would fully support this legislation.

H.R. 2527, To Amend Title 38, United States Code to Provide Veterans With Counseling and Treatment for Sexual Trauma That Occurred During Inactive Duty Training

The VFW supports this legislation which would authorize VA to provide counseling and treatment to service members who experience military sexual trauma (MST) during inactive duty training. VA policy states that veterans are entitled to treatment for all physical and mental health conditions determined by a VA provider to be related to MST, without the need for service connection or other enrollment qualifications. Current law, however, narrowly defines MST as having occurred while the service member was on active duty or active duty for training status. This means that many veterans who experienced MST on inactive duty but while still in uniform, cannot receive the care they need.

VA is aware of this loophole and included proposals to expand eligibility for MST treatment to those who experienced MST during inactive duty in their FY 2014 and

FY 2015 budget requests. The VFW agrees that members of the Reserve Component who experience sexual trauma during weekend drills or other inactive duty should be entitled to the same MST-related services as those who experience sexual trauma while activated, and we encourage the subcommittee to move quickly on this critical legislation.

H.R. 2661, Veterans Access to Timely Medical Appointments Act

This legislation would codify the 2012 VA goal of completing all primary care appointments within seven days of the desired date and all specialty care appointments within fourteen days of the desired date. Additionally, it would require VA to comply with several recommendations of a March 2012 Government Accountability Office (GAO) report including: eliminating scheduler error, providing reliable appointment wait time data, standardizing the scheduling policy across all Veterans Integrated Service Networks (VISNs) and VAMCs, restricting the scheduling system to those who have been properly trained, improving veterans' phone access, and routine assessments. Although the VFW strongly supports the recommendations of GAO and the intent of this legislation to reduce appointment wait times for veterans, we do not support a statutory mandate of VA's appointment wait time goals at this time.

In the past, VA has tried to enforce scheduling policies and wait time standards without proper training of staff and using flawed tracking programs. GAO found that this often led to data manipulation by staff in an effort to falsely create the appearance of short wait times. We are concerned that codifying the VA wait time goals would apply so much pressure that it would encourage further data manipulation in order to comply with the law. Transparency and honest self-assessment will be necessary to truly reduce the wait times experienced by veterans.

Complicating the well-known deficiencies in VA appointment scheduling is the fact that VA is still in the process of establishing productivity standards to determine appropriate physician staffing levels at its facilities. Simply put, it is impossible to achieve the greatest level of access if too few providers are available to meet the demand for care. Accurate appointment scheduling and proper physician staffing must both be achieved in order to solve the problem of long appointment wait times.

The VFW is also concerned that this legislation would force VA to over-utilize purchased care in order to meet its mandates. VA's new purchased care model, Patient-Centered Community Care (PC3), is still being implemented. Its effectiveness is still unknown, and it may not be the best option for many veterans. The VFW wants to see PC3 succeed, but as a secondary option to direct care, as it was intended, not as VA's only option to comply with the law. Suddenly sending large numbers of veterans out of VA for care would not solve the appointment wait time problem at VA facilities, only camouflaging it.

VA should be given the opportunity to implement its plans for appointment scheduling, physician staffing, and purchased care before its self-imposed wait time goals are written into law. Furthermore, VA should not be discouraged from setting ambitious goals in the future out of fear that their announcement will be quickly followed by statutory mandates. In order to solve the problem of long appointment wait times, the VFW urges continued congressional oversight to ensure that VA complies with GAO and VA Office of the Inspector General (OIG) recommendations.

H.R. 2794, To Amend Title 38, United States Code to Provide for the Eligibility for Beneficiary Travel for Veterans Seeking Treatment or Care for Military Sexual Trauma in Specialized Outpatient or Residential Programs at Facilities of the Department of Veterans Affairs, and for Other Purposes

The VFW supports this legislation which would extend beneficiary travel benefits to veterans seeking care at VA facilities for conditions associated with MST. VA currently provides care for all physical and mental health conditions determined by a VA provider to be related to MST, without the need for service connection. This care is provided with no copay charges and without any income eligibility requirements. Qualifying veterans are eligible for residential rehabilitation treatment programs, and facilities that do not have those programs have been directed to refer veterans to those that do in order to guarantee access. This means that some veterans have to travel significant distances to receive MST care.

VA travel benefits are currently available to veterans who have a service-connected (SC) rating of 30 percent or more, are traveling for treatment of a SC condition, are eligible for pension, or are traveling for a scheduled compensation and pension examination. Not all veterans eligible for MST care are included in one of those categories. As a result, many MST victims may have to forgo the care they need and deserve, simply because they cannot afford the costs of traveling to facilities that are able to provide that care.

OIG identified this as a problem in a December 2012 report, stating that VHA beneficiary travel policies are not properly aligned with MST policy. They recommended that the travel policy be reviewed. As of now the travel policy has not changed. This legislation would fix the problem by adding veterans who are receiving MST treatment to the list of eligible travel beneficiaries.

H.R. 3508, To Amend Title 38, United States Code, to Clarify the Qualifications of Hearing Aid Specialists of the Veterans Health Administration of the Department of Veterans Affairs, and for Other Purposes

This legislation would authorize VA to hire hearing aid specialists as full time employees at department facilities to provide hearing health services alongside audiologists and hearing health technicians. Hearing aid specialists would assume the responsibilities of performing in-house repairs, currently performed by technicians, and fitting and dispensing hearing aids, currently performed by audiologists. Although we appreciate this bill's intent to increase hearing health access and reduce wait times for hearing aids and repairs, the VFW believes that VA has the ability to address these issues under its current hiring authority.

The VFW strongly believes that VA must improve timeliness in issuing and repairing hearing aids. A February 20, 2014 OIG report revealed that 30 percent of veterans are waiting longer than 30 days to receive new hearing aids, and repairs take an average of 17 to 24 days to complete, far exceeding the VA 5-day timeliness goal for those services. According to the report, the long wait times can be attributed to a steadily increasing work load, which will likely continue to increase as the veteran population grows older. This problem is compounded by the fact that many audiology clinics are not fully staffed. Additionally, OIG found that the Denver Acquisition and Logistics Center (DALC), which performs major hearing aid repairs for VAMCs nationwide, lacks an adequate tracking system for the devices it receives.

To address these problems, OIG recommended that VA develop and implement productivity standards to determine proper staffing levels in audiology clinics and establish tracking controls for the hearing aids received by the DALC. VA concurred with these recommendations and will include audiology in its implementation plan for productivity standards. In our opinion, this is the correct course of action. The VFW believes that adding a new class of provider whose scope of practice overlaps that of existing employees does not get to the root of the problem. To fully address the issue, VA must determine the proper staffing levels of audiologists and hearing health technicians necessary to meet timeliness standards and increase the number of those employees accordingly.

H.R. 3180, To Amend Title 38, United States Code, to Include Contracts and Grants for Residential Care for Veterans in the Exception to the Requirement That the Federal Government Recover a Portion of the Value of Certain Projects

The VFW supports this legislation which would allow state veterans homes that receive residential care contracts or grants from VA to also contract with VA under the Health Care for Homeless Veterans (HCHV) supported housing program. Since state veterans homes receive VA funding for other programs, the recapture clause of section 8136 of Title 38 prohibits them from receiving HCHV funds. Only those state veterans homes that also run outpatient VA clinics are currently exempted from the recapture clause. This means that many state veterans homes with empty beds are unable to offer them to homeless veterans in their communities. Similarly exempting them from the recapture clause would solve this problem.

The Secretary's ambitious five-year plan to end homelessness among veterans includes six strategic pillars. The sixth pillar is community partnerships, which certainly must include state veterans homes. The VFW strongly supports the Secretary's five-year plan and believes that state veterans homes should be utilized to the fullest extent possible to ensure its success. As long as there are homeless veterans who need them, beds in state veterans homes should not remain empty simply due to the unintended consequences of a federal regulation.

H.R. 3387, Classified Veterans Access to Care Act

The VFW supports this legislation which would require VA to develop standards and disseminate guidance to ensure that veterans who participated in sensitive missions or were assigned to sensitive units are able to access mental health services in a way that does not require them to improperly disclose classified information.

We are aware that this legislation was inspired by the case of Daniel Somers, a veteran of sensitive missions in Iraq, who felt that he was unable to participate in the group therapy sessions offered to him at the Phoenix VAMC, believing that he would be required to share classified information with other group members. Trag-

ically, Daniel Somers took his own life last year. The VFW has been in contact with his parents, who strongly believe that had their son been offered individual therapy from the beginning due to the nature of his service, his suicide may have been prevented. The VFW believes that requiring VA to develop standards for those who served on sensitive missions is reasonable and would ensure that veterans feel that they can access the services they need without violating any nondisclosure responsibilities they may have.

H.R. 3831, Veterans Dialysis Pilot Program Review Act of 2014

The VFW supports this legislation which would prohibit VA from expanding the dialysis pilot program until the program has operated at each initial facility for at least two years, an independent analysis has been conducted at each facility, and a report is submitted to Congress.

A May 2012 GAO report found that VA was planning to expand the pilot, despite not having developed adequate performance measures to evaluate the existing locations. While the GAO report focused primarily on cost, the VFW is pleased that the report required by this legislation would also examine non-cost factors such as access, quality of care, and veteran satisfaction.

The purpose of any pilot program should be to assess its strengths and weaknesses on a small scale in order to decide whether or not it should be expanded. If and when it is instituted on a large scale, it should be done based on a detailed analysis and lessons learned from the pilot. Therefore, we believe it is both reasonable and prudent to require VA to submit a detailed report on the dialysis pilot program before it is allowed to expand.

H.R. 4198, Appropriate Care for Disabled Veterans Act

The VFW supports this legislation which would reinstate the requirement for VA to submit an annual report to Congress on its capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans. This requirement expired in 2008 and since that time, it has become apparent that the capacity of VA specialty care has been inadequate to meet veteran demand. The VFW believes that current accurate data on VA capacity will greatly assist Congress in conducting oversight on veterans' access to care.

Since the report was first mandated in 1996, many changes have been made in the way VA provides specialty care. We look forward to working with the subcommittee and our Independent Budget Veterans Service Organization (IBVSO) partners to identify any necessary updates to the original reporting requirements to ensure future reports are relevant and actionable.

Draft Bill, To Authorize Major Medical Facility Projects for the Department of Veterans Affairs for Fiscal Year 2014

This legislation provides VA the authority to enter into 27 major facility leases, allows VA to construct or lease joint VA/Federal use medical facilities, expands VA's Enhanced-Use Lease (EUL) authority, and modifies the authority to build a major medical facility project in Tampa, Florida.

Sections 1, 2 and 3 provide authorization for VA major facility leases. It is critical that VA is provided the authority to enter into the 27 major medical leases. Many of these leases have been awaiting authorization for nearly two years. Most of these facilities are Community-Based Outpatient Clinics (CBOC) that have provided direct medical care in the communities where veterans live. However, since the current leases have expired and there is a need to expand capacity or change the physical location of the CBOCs to better serve the needs of veterans, VA must enter into new leases.

Congress had failed to authorize these leases because of the Congressional Budget Office's revised scoring model, which now requires VA to account for the full lease amount in the first year of the lease. Congress must find a workable solution to allow VA to continue its major capital leasing projects. Failing to pass this authorization into law will create greater access and timeliness issues for veterans and in the end cost VA more as they begin reimbursing veterans for travel to distant medical centers or pay for fee-based care in the community. The VFW fully supports these provisions and their quick passage.

Section 4 amends VA's current medical facility construction and leasing authority to allow VA to enter into joint acquisitions and leases with other Federal agencies. Currently, when VA sees the value in co-locating a medical or research facility with another agency, either VA or the other agency must already own the property and grant the other agency a portion of the property through an acquisition by exchange. By amending the current authority, VA will be able to reduce construction and/or lease costs by acquiring, planning and building facilities jointly. The VFW sees the value in this authority and we fully support this provision.

Section 5 amends VA's authority to enter into EULs. In 2012, VA was forced to modify its EUL authority, greatly reducing its ability to lease out its unused or underutilized properties. This authority will greatly widen VA's lease options, thereby producing revenue and reducing the number of unused or underutilized properties in VA's inventory. The VFW understands that when VA property is unused or underutilized, VA still incurs significant costs to maintain it, ultimately squandering resources that could be better used serving veterans. This is why the VFW supports the idea of expanding VA's leasing authority, but we must also point out that VA must make every effort to lease these unused or underutilized properties for projects that directly support veterans and their families before considering other leasing projects.

Sections 6 and 7 authorize modification and the appropriations for the major medical project in Tampa, Florida. VA has requested that a previously authorized upgrade to the medical facility bed tower be reauthorized as a new bed tower at the Tampa, Florida medical center. The VFW supports this modification.

Mr. Chairman, this concludes my testimony and I look forward to any questions you and the members of this Subcommittee may have.

Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, VFW has not received any federal grants in Fiscal Year 2013, nor has it received any federal grants in the two previous Fiscal Years.

PREPARED STATEMENT OF MADHULIKA AGARWAL, M.D., M.P.H.

Good Morning Chairman Benishek, Ranking Member Brownley, and Members of the Subcommittee. Thank you for inviting me here today to present our views on ten bills that would affect Department of Veterans Affairs (VA) health programs and services. Joining me today is Mr. Philip Matkovsky, Assistant Deputy Under Secretary for Health for Operations and Management and Ms. Reneé L. Szybala, Acting Assistant General Counsel.

We do not yet have cleared views on H.R. 3387, H.R. 4198, and H.R. 2974. Also, we do not yet have estimated costs associated with implementing several of the bills. We will forward these views and any estimated costs to you as soon as they are available.

H.R. 183, Veterans Dog Training Therapy Act

H.R. 183 would require the Secretary, within 120 days of enactment, to commence a pilot program for a 5-year period to assess the effectiveness of using service dog training programs to address post-deployment mental health and post-traumatic stress disorder (PTSD) symptoms and produce specially-trained service dogs for Veterans. The bill would require the Secretary to conduct the pilot program at a minimum of three and not more than five VA medical centers.

The bill also includes provisions concerning the service dogs themselves and the personnel assigned to the program. The bill requires VA to ensure that each service dog in training have adequate temperament and health clearances. Dogs in animal shelters or foster homes are not to be overlooked as candidates. The Secretary must also ensure that each service dog in training is taught all essential commands and behaviors required of service dogs. The bill would require each pilot program site to have certified service dog training instructors with preference given to Veterans who have graduated from a residential treatment program and are adequately certified in service dog training.

VA supports the identification of effective treatment modalities to address PTSD and other post-deployment mental health symptoms; however, VA does not support the specific provisions in H.R. 183 because the bill focuses on the training of the dog as opposed to what we believe is the goal of this legislation, which is finding better ways to improve the health of this Veteran population by exploring the efficacy and effectiveness of certain treatments, specifically Animal Assisted Therapy or Animal Facilitated Therapy, that will prepare dogs to become service dogs for Veterans.

The restrictions that would be imposed by H.R. 183 regarding the criteria for the selection of dogs and the qualifications required of the trainers pose significant challenges to the goal of this legislation. Provisions requiring medical centers to ensure appropriate areas for the "art and science" of service dog training are focused on ensuring the quality of the rigorous training regimen required to produce well-trained service dogs as opposed to the therapeutic activities that Animal Assisted

Therapy or Animal Facilitated Therapy may provide if appropriately administered as a component of a comprehensive mental health treatment program. This specialized and rigorous training regimen for the service dogs falls outside the purview and mission of VA health care and well beyond the scope of corporate expertise. These same concerns are extended to provisions related to the design of the pilot, such as the acceptance of animals from shelters, educating participants about service dog training methodologies, practical hands-on training and grooming of service dogs, ensuring mastery of all essential commands, and residency requirements for dogs.

The VA Palo Alto Health Care System (Menlo Park Division), in collaboration with Bergin University of Canine Studies, established the Palo Alto Service Dog Training Program in July 2008. The Palo Alto program is not an example of VA independently and internally training or producing service dogs for Veterans. The dogs involved in the Palo Alto program were trained to become service dogs by an external organization, accredited by Assistance Dogs International, over an extended period of time and subject to standards as adopted and applied by that organization. The Palo Alto program, using VA facilities for the therapy portion but relying completely on the external organization's dog training program, focuses on basic obedience (e.g., commands such as "sit," "stay," and "heel") and public access skills (sensitizing dogs to different environments) to prepare the dogs to become service dogs for disabled persons because VA does not have the expertise, experience, or resources to develop independent training criteria or otherwise train or produce safe, high-quality service dogs for Veterans. Such training is highly specialized and includes the training of the Veteran who is to receive the service dog.

Cost estimates for this bill were not available at the time of the hearing.

H.R. 2527, To Provide Veterans With Counseling and Treatment for Sexual Trauma That Occurred During Inactive Duty Training

H.R. 2527 would amend 38 United States Code (U.S.C.) 1720D to extend VA's counseling and care benefits for treatment of sexual trauma to Veterans who experienced sexual trauma while serving on inactive duty for training. Current authority covers only sexual trauma that a Veteran experienced while serving on active duty or active duty for training.

H.R. 2527 would also define the term "Veteran," with respect to inactive duty training described in section 1720D(a)(1), as amended by the bill, to include an individual who is not eligible for VA health care benefits (under 38 U.S.C. chapter 17), and who, while serving in the reserve components of the Armed Forces, performed such inactive duty training but did not serve on active duty.

VA supports this bill as it would close a gap in eligibility for military sexual trauma-related counseling and care. The current gap in eligibility arises when sexual trauma occurs during weekend drill trainings for members of the National Guard or Reserves. Weekend drill trainings are inactive duty training. Unless a Veteran who experienced sexual trauma while serving on inactive duty for training is eligible to enroll in VA's health care system and receive needed care under VA's medical benefits package, VA lacks current authority to treat the Veteran for conditions resulting from that trauma.

VA anticipates this bill will require minimal additional funding.

H.R. 2661, The Veterans Access to Timely Medical Appointments Act

H.R. 2661 would require the Secretary, not later than 180 days after enactment, to implement a standardized policy to ensure that enrolled Veterans are able to schedule primary care appointments within 7 days, and specialty care appointments within 14 days, of the date such appointment is requested by the Veteran or the Veteran's provider. In addition, the Secretary would be required to ensure the policy is not subject to interpretation or prone to scheduling errors and is able to provide the Secretary with reliable data regarding the length of time Veterans wait for appointments. The bill would also require VHA, in carrying out the policy, to use uniform procedures and to issue detailed guidance to Directors of Veterans Integrated Service Networks (VISN) to ensure consistent implementation at each VA medical center (VAMC) and other related VA facilities. The Secretary would be required to ensure that only VA employees, who have completed required training, are allowed to schedule medical appointments and that annual performance reports of each VISN's performance under the policy are made public.

H.R. 2661 would also require the Secretary, not later than 180 days after enactment and each 180-day period thereafter, to assess the resources of each VISN to determine the ability of the VISN to meet its scheduling requirements. To ensure that each VISN meets the scheduling requirements of its enrollees, the Secretary would be authorized to reprogram funds and to allocate or transfer staff and other

resources within VHA and the VISN; however, Congress would need to be notified of any such reprogramming.

The bill would further require the Secretary to direct each VAMC to provide oversight of telephone access and to implement the best practices outlined in VHA's Telephone Improvement Guide including, at a minimum, practices to ensure calls are answered in a timely manner and that patients' messages are returned with a call within 24 hours. Each VAMC's call center would also need to be properly staffed to meet the demands of its patient-population.

Finally, H.R. 2661 would require VA's Office of Inspector General, in consultation with Veterans Service Organizations, to submit a detailed annual report to Congress on VA's progress in implementing the requirements of the bill.

VA does not support H.R. 2661. VA continues to make progress in the reliability of measuring and reporting waiting times. This process is heavily dependent on the software, technology and business processes available at the time. Mandating the timeframe within which a patient must receive an appointment is ill-advised because the process of scheduling is multi-factorial, and flexibility is required to ensure that scheduling occurs in a manner that is in line with clinical operating standards, which can evolve over time. This also extends to clinical contacts made by telephone. We also are uncertain of the basis for the inflexible timetables that would be mandated by H.R. 2661. We would be interested in discussing this issue with the Committee, including the need for flexibility while ensuring Veterans receive access to high-quality health care.

VA believes the telephone-related elements of the bill state valuable principles but could conflict with our ongoing efforts. The practices outlined in the Telephone Improvement Guide are currently being tested at both the VISN and facility level. In addition, three VISNs are investigating the use of specific communication models to assess the most effective approach by which to provide Veterans with responsive, available telephone service. It may be that these models will prove more efficient and preferable to what is used now or even to what would be required by H.R. 2661. Similar to scheduling procedures and other clinical operational matters, we believe codifying in law the details of how VA communicates with our patients is ill-advised. Once in statute, such terms could well end up preventing VA from identifying and using newer and more effective mechanisms and procedures that better align with clinical operational and clinical practice standards.

VA is unable to estimate the cost of this bill.

H.R. 2974, To Provide Beneficiary Travel Eligibility for Veterans Seeking Treatment or Care for Military Sexual Trauma

H.R. 2974 would amend 38 U.S.C. 111(b)(1) to ensure beneficiary travel eligibility for Veterans whose travel to a specialized outpatient or residential program at a VA facility for treatment or care for military sexual trauma. The bill would define the term "military sexual trauma" in 38 U.S.C. 111 to mean "psychological trauma, which in the judgment of a Department mental health professional, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty or active duty for training;" and the bill would define the term "sexual harassment" to mean "repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character." The amendments made by this legislation would apply with respect to travel occurring after enactment.

VA is currently reviewing this bill and will provide a position upon completion of this review. As a technical matter, we note that the bill purports to add a new subsection (g) to section 111 of Title 38 U.S.C. We believe the drafters intended to add a new subsection (h) to section 111 instead, as the bill makes no mention of striking the current subsection (g) in section 111.

Cost estimates for this bill were not available at the time of the hearing.

H.R. 3180, To Provide an Exception to the Requirement That the Federal Government Recover a Portion of the Value of Certain Projects

H.R. 3180 would authorize VA to contract with, or award a grant to, a state for residential care for Veterans in a state home without triggering the recapture of the state home construction grants previously awarded to the state for that home. The term "residential care" is not defined in Title 38 U.S.C. For purposes of the community residential care program, the term "community residential care" is defined in 38 CFR § 17.62 to mean "the monitoring, supervision, and assistance, in accordance with a statement of needed care, of the daily living activities of referred Veterans in an approved home in the community by the facility's provider." However, VA cannot provide grants or contracts for such care under that program. See 38 U.S.C. § 1730(b)(3). Nevertheless, under another authority, 38 U.S.C. § 1720(g), VA may con-

tract with appropriate entities to provide specialized residential care and rehabilitation services to an Operation Enduring Freedom (OEF) or Operation Iraqi Freedom (OIF) Veteran, who VA determines suffers from a traumatic brain injury, has an accumulation of deficits in activities of daily living and instrumental activities of daily living, and because of these deficits, would otherwise require admission to a nursing home even though such care would generally exceed the Veteran's nursing needs. If H.R. 3180 is enacted, VA could contract with states to provide residential care in a state home under section 1720(g) without triggering the recapture of a grant.

VA does not support enactment of this bill because it would authorize VA to contract with state homes without triggering the recapture of the state home construction grants previously awarded to the state for that home for care for which they currently receive VA per diem payments under the VA State Home Grant Program. State Veterans homes can provide any combination of three levels of care: nursing home, domiciliary, and adult day health care without being subject to the recapture of any VA construction grant. Domiciliary care is essentially specialized residential care that VA may contract for under 38 U.S.C. § 1720(g). State Veterans homes that provide domiciliary care should thus be capable of providing specialized residential care and rehabilitation services for OEF/OIF Veterans who suffer from a traumatic brain injury.

There are no current requests from states for state Veterans homes to provide residential care under VA contract or grant. Thus, VA cannot predict future costs that would be associated with this bill.

H.R. 3508, To Clarify the Qualifications of VA Hearing Aid Specialists

H.R. 3508 would amend 38 U.S.C. 7401(3) to include hearing aid specialists among personnel who may be appointed by VA as the Secretary may find necessary for the health care of Veterans. The bill would also amend 38 U.S.C. 7402(b) to specify qualifications for hearing aid specialists, including requiring the individual "hold an associate's degree in hearing instrument sciences, or its equivalent, from a college or university approved by the Secretary, or have successfully completed a hearing aid specialist apprenticeship program approved by the Secretary," and "be licensed as a hearing aid specialist, or its equivalent, in a State." Hearing aid specialists who do not meet these requirements would still be eligible for appointment to a hearing aid specialist position if, during the 2 years prior to enactment of the bill, the individual "held an unrevoked, unsuspended hearing aid license, or its equivalent, in a State," and "worked as a licensed hearing aid specialist in a State."

In addition, H.R. 3508 would require VA, no later than 1 year after enactment and each year thereafter, to report to Congress on timely access to hearing health services and contracting policies with respect to providing hearing health services in non-VA facilities. VA would be required to include in the report VHA staffing levels of audiologists, health technicians in audiology, and hearing aid specialists; a description of performance measures with respect to appointments and care related to hearing health; average wait times for specified appointments; percentages of patients whose wait times fell within specified time frames; the number of patients referred to non-VA audiologists for initial hearing health diagnosis appointments and to non-VA hearing aid specialists for follow-up hearing health care; and VHA policies regarding referral to non-VA hearing aid specialists and how such policies will be applied under the Patient-Centered Community Care initiative.

Finally, H.R. 3508 would require VA, no later than 180 days after enactment, to update and reissue VHA Handbook 1170.02, VHA Audiology and Speech-Language Pathology Services, to reflect the requirements of this bill.

VA values the current contribution being made by hearing aid or instrument specialists to hearing loss treatment and evaluation services, however, VA does not believe this bill is necessary as the Secretary already has existing authority under 38 U.S.C. § 7401(3) to appoint such specialists if deemed necessary to support the recruitment and retention needs of the Department. In addition, the Secretary already has authority under 38 U.S.C. § 7402(b) to establish qualification standards for health care occupations, including establishing technical qualifications for hearing aid specialists. VA believes this bill's language unduly restricts the Secretary's latitude to establish qualification standards under this authority, and that existing procedures for establishing qualifications standards under title 5 series 640 or hybrid Title 38 are sufficient.

Also, VA is concerned that the lack of standardized educational or professional health licensure requirements could fragment hearing health care services and limit delivery of comprehensive hearing health care under the language in H.R. 3508.

A highly trained workforce is required to deliver comprehensive services and coordinate care in the VA health care system, given VA's mission to provide com-

prehensive patient-centered health care. Utilizing occupations that are limited in training and scope for comprehensive hearing health services under the proposed legislation would fragment the current high-quality health care delivery system, especially because Veterans frequently exhibit hearing loss in combination with other co-morbidities.

VA audiologists are doctoral-level professionals trained to diagnose and treat hearing loss, acoustic trauma and ear injuries, tinnitus, auditory processing disorders, and patients with vestibular complaints. VA provides comprehensive hearing health care services and employs both audiologists and audiology health care technicians who deliver care coordinated within the Patient Aligned Care Team (PACT). VA can appoint hearing aid specialists as audiology health technicians in job series 640 (health technicians) under title 5. VA currently employs 318 audiology health technicians (also commonly known as audiology assistants) who function under the supervision of audiologists. Some of these audiology health technicians are licensed as hearing aid specialists, although they are hired as health technicians whether or not they are licensed as hearing aid specialists.

Audiology health technicians, currently employed in audiology clinics as valued members of the audiology team and working under the direction of audiologists, have a broader scope of practice than the typical hearing aid specialist. VA developed this job series and associated core competencies for health technicians to provide efficient support services and assist audiologists in the provision of comprehensive hearing care. Examples of the scope of services include cerumen management, aural rehabilitation, hearing conservation and prevention of noise-induced hearing loss, tinnitus management, hearing aids and other amplification technologies including implantable auditory devices, and management of Veterans' hearing health care with other health care disciplines in the context of their overarching patient-centered needs.

The VA audiology health technician has duties and responsibilities beyond those allowed by state law for hearing aid specialists. The hearing instrument specialist occupation has no consistent professional education requirements and no standardized internships resulting in highly-variable skill sets. In 33 states, only a high school education is required for hearing instrument specialist licensure. Nine states have no educational requirement and eight states require an associate's degree. As a result, based on hybrid Title 38 grade-related education requirements, hearing instrument specialists are likely to be hired at low grades making less money working for VA than they would earn working in the retail business community where they are licensed to sell hearing aids. Hearing instrument specialists are licensed to sell hearing aids and are regulated primarily for their hearing aid sales roles. The license does not require professional education, clinical training, or experiential health care apprenticeships, and the licensure qualifications have not changed in many years. They are not part of any health care teams in the military, the academic or medical/professional school environment, or the hospital environment. Substituting the VA audiology health technician with a hearing instrument specialist would fragment hearing health care services and limit delivery of comprehensive hearing health care.

Finally, with respect to the treatment of "certain current specialists" in section 1(b) of the bill, we note that VHA does not appoint hearing aid specialists, and none are actively practicing in VHA as hearing aid specialists. Some audiology assistants (health technicians) are licensed as hearing aid specialists and may use these skills in performing their duties, but they were hired as health technicians and function under the scope of practice defined in their position description.

Cost estimates for this bill were not available at the time of the hearing.

H.R. 3831, The Veterans Dialysis Pilot Program Review Act

If enacted, H.R. 3831 would prohibit VA from expanding VA's dialysis pilot program or creating any new dialysis capability provided by VA in any facility other than the four participating free-standing dialysis facilities until three requirements have been met: VA has implemented the pilot program at each facility for at least 2 years; VA has provided for an independent analysis of the pilot program at each facility; and VA has submitted a report to Congress. The required report must include the results of the independent analysis and a comparison of both cost and non-cost factors (such as access to care, quality of care, and Veteran satisfaction) concerning the dialysis pilot program, and must address any recommendations from the Government Accountability Office with respect to the pilot. The bill would also require the Secretary to fully utilize VA dialysis resources in existence at the time this bill is enacted, including utilization of any community dialysis provider with whom the Secretary has entered into a contract or agreement for the provision of such care.

VA fully supports using the results of our ongoing dialysis pilot program to inform the expansion of dialysis care by VA. However, VA is concerned that enactment of this bill in its current form would delay activating additional VA free-standing dialysis centers, which could adversely impact VA's efforts to optimize Veterans' dialysis care. This bill would have the effect of preventing VA from creating any new dialysis capacity until July 2015 because one of the pilot facilities (Cleveland, Ohio) did not activate until July 2013. Delaying expansion would also adversely impact VA's ability to realize potential cost savings associated with free-standing dialysis centers.

VA has already developed an evaluation plan to assess performance of each pilot. Additionally, VA has contracted with the University of Michigan-Kidney Epidemiology and Cost Center (UM–KECC) to conduct an independent analysis of the pilot facilities. In fiscal year 2013, UM–KECC produced five clinical quality and four cost reports analyzing the performance of the Raleigh and Fayetteville, North Carolina pilots. UM–KECC will be producing these reports for all four pilot sites in fiscal year 2014.

VA is ready to work with the Committee to ensure the Committee is briefed on the results of the pilot program before establishing any new free-standing dialysis centers.

Cost estimates for this bill were not available at the time of the hearing.

Draft Bill To Authorize Major Medical Facility Projects for the Department of Veterans Affairs for Fiscal Year 2014 and for Other Purposes

The draft bill represents the Administration's request for its fiscal year 2014 construction program and includes other measures useful for VA. It authorizes numerous individual medical leases proposed by VA, including those proposed in its fiscal year 2013 budget, and includes provisions aimed at facilitating more streamlined planning, construction, and leasing for joint VA/Federal-use medical facilities. The bill would also enhance VA's Enhanced-Use Lease authority and authorize major construction funds for VHA facilities in Tampa, Florida. Mr. Chairman, we appreciate your inclusion of this Administration request on the agenda today.

Conclusion

Mr. Chairman, this concludes my statement. Thank you for the opportunity to appear before you today. I am ready to respond to questions you or the other Members of the Subcommittee may have.

FOR THE RECORD

House Committee on Veterans' Affairs, Subcommittee on Health
Hearing on Pending Health Care Legislation
March 27, 2014
Rep. Kevin McCarthy

Chairman Benishek, Ranking Member Brownley and Members of the Subcommittee

Thank you for allowing me to testify on legislation I introduced, H.R. 2661, the Veterans Access to Timely Medical Appointments Act. This bill is based on the Government Accountability Office (GAO) audit on the Veterans Health Administration's (VHA) scheduling of timely medical appointments, as well as a Veterans Affairs Oversight and Investigation Subcommittee hearing on the audit's findings. After disappointing responses from leadership at the Department of Veterans Affairs (VA), I decided to take legislative action to implement the GAO's recommendations to improve the wait times our veterans face to receive care.

Chairman Miller and I led 28 other members in requesting the GAO to conduct this audit on the VHA regarding its scheduling of medical appointments because I was receiving numerous complaints from veterans in my district who were waiting months for crucial medical appointments at either the local VA clinic in Bakersfield or at the VA Medical Center in Los Angeles. This audit was released over a year ago and to this day, the complaints of poor service from the VA to schedule timely medical appointments is still one of the most frequent by veterans in my district. I would also note that according to the GAO's website, none of its recommendations have yet to be implemented by the VA.

H.R. 2661 would legislatively implement the GAO's recommendations and aid the VA in developing a better scheduling policy so veterans can have timely access to needed care. Specifically, it addresses the GAO-identified factors contributing to unreliability of appointment wait times by mandating the VA to improve their

medical appointment scheduling policy within 180 days of the bill's enactment. The bill requires the VA to schedule primary care appointments within seven days and specialty care appointments within fourteen days—goals used internally by VA supervisors and identified within the GAO report. It also addresses the allocation of scheduling resources to meet the demands of veterans, and to ensure timely medical appointments by improving the VA's telephone access and responsiveness. GAO found that the VA's positive wait time reports are far greater than veterans actually experience. This is due to a number of reasons, including unreliable data input by VA employees, the VA not requiring stricter adherence to scheduling policy, and a lack of over sight on the scheduling process as a whole.

The VA's 2015 Budget request does not sufficiently address the wait times new veterans face when scheduling medical appointments and receiving care. It only marginally decrease times and provides no accountability measures. We have tens of thousands of new veterans who served in Iraq and Afghanistan who can't get appointments in a timely fashion. The VA's recent Performance Accountability Report says that 41% of new primary care appointments are scheduled within 14 days of the creation date, and 40% of new specialty care appointments are within 14 days of the creation date. This means that over 60% of these veterans aren't getting appointments within two weeks. It concerns me that the budget submission only marginally increases scheduling goals to 51% and 45% respectively, and reveals a lack of urgency within the VA to ensure funding reduces wait times. Why should veterans and Congress tolerate such low targets?

There have also been recent news stories on a supposed whistleblower who alleges that the VA's Greater Los Angeles Medical Center, which serves the health care needs of my constituents, "administratively closed" about 40,000 appointments in order to reduce the medical appointment backlog to make its numbers look better. According to Dr. Petzel—who spoke briefly about this issue during a Subcommittee on Health Oversight Hearing last month—no patients were denied care and there was no attempt to destroy records in this instance. With an ongoing investigation, I was surprised by this testimony. That is why Chairman Benishek and I requested an independent investigation of these allegations, for which we are still waiting on the results. Regardless, it is still not clear to me that the needs of these 40,000 veterans were adequately met by the Department. This highlights the troubled scheduling system within the VA and that it is not meeting the needs of our nation's veterans.

I am confident that H.R. 2661 will help the VA better meet the needs of the veterans it serves with timely access to medical appointments by creating a cohesive and unified scheduling policy that is both reliable and predictable. After a decade of war, it is our responsibility as Members of Congress to ensure that the department created to serve the men and women returning home and discharged of their military service have access to the care they need. I look forward to continuing to work with Chairman Miller, this committee, the Veterans Service Organizations, and my constituents to see that we solve the problems within the VA and help create a better system to serve our veterans.

AMERICAN ACADEMY OF OTOLARYNGOLOGY—HEAD AND NECK SURGERY

The American Academy of Otolaryngology—Head and Neck Surgery (AAO–HNS) thanks the Subcommittee for the opportunity to submit a statement for the record regarding H.R. 3508, a bill to amend Title 38, United States Code, to clarify the qualifications of hearing aid specialists of the Veterans Health Administration of the Department of Veterans Affairs, and for other purposes.

The AAO–HNS, with approximately 12,000 members nationwide, is the medical specialty society for physicians dedicated to the care of patients with disorders of the ears, nose, throat (ENT), and related structures of the head and neck. Our members are specifically trained to provide hearing-impaired patients with a full medical evaluation, diagnosis, and treatment for their hearing disorders. Given the specialization of our members, the AAO–HNS closely monitors various pieces of legislation pertaining to the delivery of hearing health care services, including H.R. 3508.

The AAO–HNS strongly supports the development and utilization of VA programs designed to broaden veterans' access to quality hearing health care services, and recognizes that in some areas, current VA programs are failing to meet the needs of the veteran population. However, while the AAO–HNS does not officially oppose H.R. 3508 at this point in the legislative process, we believe current Congressional action to advance the bill is premature and may represent an unnecessary legislative approach to address process failures within the VA.

It is our understanding that the purpose of H.R. 3508 is to mitigate an ongoing issue within the VA regarding long wait times for hearing aids and hearing health care services for veterans in general. While this is a laudable goal, we are concerned that the bill, spearheaded by the national association representing hearing aid dispensers, would have unintended consequences. We find it necessary to register our concerns for the record so the members of this Subcommittee are fully advised of its potential impact.

Timing of Legislation

Hearing-related issues, including hearing loss and tinnitus, are among the most common injuries within our nation's population of active and retired service men and women. The proliferation of these types of injuries among veterans presents a serious challenge for the VA. In fact, the AAO–HNS believes that the VA should explore all appropriate means necessary to ensure the delivery of high-quality hearing health care services.

However, efforts to expand access to care must be balanced and include assurances that veterans are being cared for by the most qualified and appropriate hearing health care professionals. Hearing loss and tinnitus, particularly within the veteran population, are complex health issues, and therefore require a more comprehensive approach in regards to treatment.

While the AAO–HNS contends that the underlying intent of H.R. 3508 to ensure robust hearing-health related services are available to veterans is commendable, we are concerned that the course of action outlined in the bill attempts to legislatively correct what should, at least initially, be viewed as a "process" issue within the VA.

Following a February 2014 audit of the VA's hearing health services, the VA Office of Inspector General (OIG) released a report outlining existing problem areas within the VA system. Specifically, the report recognized that inadequate staffing, coupled with inefficient operations/processes, at a major VA hearing aid center in Denver, CO (where a large percentage of hearing aids are repaired), accounted for much of the issue relating to long wait times. Based on the report's findings, the OIG recommended that the VA focus its immediate efforts on developing a plan for implementing more consistent/cohesive standards for audiology and hearing care centers in general.

Given the OIG report and its recommendations for improving existing processes within the VA, the AAO–HNS contends that it is premature to pursue a legislative remedy for issues that may potentially be resolved via internal process changes.

Inclusion of Hearing Aid Specialists in OIG Report

As stated, the AAO–HNS believes the VA should have the opportunity to conduct and implement a plan related to the productivity standards and staffing for audiology clinics, as recommended by the recent OIG audit, prior to passage of any legislation related to the provision of hearing health care services by the VA. We maintain that one of the main tenets of H.R. 3508—to allow hearing aid specialists the ability to directly contract with the VA—is duplicative to the current statutory authority of the VA. In fact, 38 U.S.C. 7401 allows the Secretary to appoint "such other classes of health care occupations as the Secretary considers necessary for the recruitment and retention needs of the Department." Given that hearing aid specialists in some locations are already being contracted with by the VA to provide limited hearing health services, the Secretary should take hearing aid specialists in consideration when developing care plans and remedies as it implements the recommendations set forth in the OIG report.

Additional Considerations/Concerns Relating to H.R. 3508

If after the implementation of the OIG's recommendations, legislation is still deemed necessary, the AAO–HNS looks forward to working with the bill's sponsors and this Subcommittee to address the below concerns with the current draft of H.R. 3508.

- Inclusion of hearing aid specialists in 38 USC 7402(b) as a new paragraph (14) rather than inclusion in the existing "catch-all" paragraph (14) with other health care professionals with comparable training [see Section (1)(a)(2)].
- Inclusion in Section (1)(c)(3)(B) of the bill the provisions of certain services by hearing aid specialists as described in Section (1)(c)(2)(C). Most notably, disability rating evaluations, primary hearing aid evaluations, and ordering of hearing aids are beyond the existing state laws governing the appropriate scope of practice of hearing aid dispensers.
- Inclusion of Section (1)(d) requiring the Secretary to "update and re-issue" the handbook entitled "VHA Audiology and Speech Language Pathology" based upon the findings of the bill's required report. The AAO–HNS is concerned with this par-

ticular provision, especially without a requirement for stakeholder and Congressional input, given the VA's unilateral revisions set forth in a recently updated version of its nursing handbook.

In conclusion, the AAO–HNS appreciates the opportunity to comment on this critical issue and to work with all interested (and impacted) parties to ensure our nation's veterans have timely access to and receive the highest quality hearing health care services. However, for the reasons set forth above, we respectfully urge the Subcommittee to not advance H.R. 3508 at this time and await the implementation of the OIG's recommendations.

Thank you for your consideration. To receive additional information, please contact Megan Marcinko, AAO–HNS Senior Manager for Congressional & Political Affairs, at *mmarcinko@entnet.org* or 703–535–3796.

DEPARTMENT OF VETERANS AFFAIRS OFFICE OF THE INSPECTOR GENERAL

March 25, 2014

The Hon. Dan Benishek, MD, Chairman
Subcommittee on Health, Committee on Veterans' Affairs,
United States House of Representatives,
Washington, DC 20515

Dear Mr. Chairman:

This is in response to your March 20, 2014, request for the views of the Office of Inspector General on legislation the Subcommittee will be considering on March 27, 2014. Specifically, we are concerned about the requirements for the Office of Inspector General (OIG) contained in Section 3(d) of H.R. 2661, The Veterans Access to Timely Medical Appointments Act, which would require the OIG to submit an annual report on the Secretary's progress in implementing the requirements contained in the bill. We are concerned about the following issues:

• Consultation with veteran service organizations (VSOs)—The bill requires the OIG to consult with Veteran Service Organizations (VSOs) as we prepare the report. The OIG's independence is key to producing reports that are a fair and balanced review of VA programs and operations. We believe that a statutory requirement to consult with and ostensibly gain the consensus of VSOs, or any other stakeholders, in the course of an OIG review can impinge on our independent authority to plan the scope and methodology of our work, and sets a troubling precedent.

• Annual Report—The OIG has a finite capacity to conduct and complete timely and relevant assessments of VA programs and operations. With an already substantial number of mandatory audits such as FISMA and the Consolidated Financial Statements, the addition of another annual reporting requirement on waiting times limits our flexibility to plan other oversight projects on current or emerging areas of concern on VA programs. Since 2001, the OIG has issued eight reports [1] dealing with inaccurate waiting times. While we fully expect to follow up on this important issue as the need arises in the future, we do not believe an annual requirement in statute is necessary. Furthermore, an annual reporting requirement may not allow sufficient time to measure the effectiveness of actions taken by VA to implement recommended corrective actions from the OIG's prior year reports.

We would also like to comment on H.R. 2974, "To amend Title 38, United States Code, to provide for the eligibility for beneficiary travel for veterans seeking treatment or care for military sexual trauma in specialized outpatient or residential programs at facilities of the Department of Veterans Affairs, and for other purposes," which would address a recommendation we made in our report, health care Inspection—Inpatient and Residential Programs for Female Veterans with Mental Health Conditions Related to Military Sexual Trauma. This legislation would allow VA to pay for travel for veterans being treated for mental health issues related to military

[1] Review of Veterans' Access to Mental Health Care (April 23, 2012); Veterans Health Administration Review of Alleged Use of Unauthorized Wait Lists at the Portland VA Medical Center (August 17, 2010); Review of Alleged Manipulation of Waiting Times, North Florida/South Georgia Veterans Health System (December 4, 2008); Audit of Veterans Health Administration's Efforts to Reduce Unused Outpatient Appointments (December 4, 2008); Audit of Alleged Manipulation of Waiting Times in Veterans Integrated Service Network 3 (May 19, 2008); Audit of the Veterans Health Administration's Outpatient Waiting Times (September 10, 2007); Audit of the Veterans Health Administration's Outpatient Scheduling Procedures (July 7, 2005); Audit of the Availability of health care Services in the Florida/Puerto Rico Veterans Integrated Service Network (VISN) 8 (August 13, 2001).

sexual trauma at any VA facility regardless of the location. We support this legislation.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

Richard J. Griffin, Acting Inspector General

INTERNATIONAL HEARING SOCIETY

Chairman Benishek, Ranking Member Brownley, and esteemed Members of the Subcommittee:

International Hearing Society thanks you for the opportunity to comment on H.R. 3508. IHS stands in full support of the bill, which would create a new provider class for hearing aid specialists within the Department of Veterans Affairs (VA), thereby enabling the VA to hire hearing aid specialists to help deliver hearing aid services to Veterans. The bill would also require the VA to report annually to Congress on appointment wait times and the utilization of providers for hearing-related services, which would make the VA's efforts to address the backlog more transparent and provide much needed data to inform Congress about Veterans' experiences in accessing hearing aid services through the VA.

The International Hearing Society, founded in 1951, is a professional membership organization that represents hearing aid specialists, dispensing audiologists, and dispensing physicians, including the approximately 9,000 hearing aid specialists who practice in the United States. IHS promotes and maintains the highest possible standards for its members in the best interests of the hearing-impaired population they serve by conducting programs in competency accreditation, testing, education and training, and encourages continued growth and education for its members through advanced certification programs.

The VA has seen a dramatic rise in the demand for audiology services in the last five years. According to the VA there were 1,617,377 outpatient audiology visits [1] in 2012, up 36% from 2009.[2] The number of hearing aids ordered per year has also dramatically increased with more than 665,000 ordered over the 12-month period ending in September 2012,[3] up from 475,945 in FY 2009,[4] or an increase of 39% in four years. With tinnitus and hearing loss being the two most prevalent service-connected disabilities for veterans receiving federal compensation, the demand will continue to rise. And despite audiologist-hiring following a similar growth track with a 34% increase in staffing between 2009 and 2013, the high demand and subsequent backlog continue to affect the VA's ability to deliver timely and high-quality hearing health care.

IHS and its membership have a great deal of respect for VA audiologists. They provide a wide variety of critical services to our Veterans, including compensation and pension exams (over 157,247 performed in 2012 for 151,934 Veterans), programming and providing support for cochlear implant implantation and use, vestibular (balance) disorder services, tinnitus services, hearing conservation, hearing aid services, and advanced hearing testing. VA audiologists are also responsible for training and supervising audiology health technicians.

The high demands on VA audiologists' time and expertise means that the VA is not currently able to meet all Veterans' needs for hearing health care services. To that point, in February 2014, the VA Inspector General released a report, "Audit of VA Hearing Aid Services" that found that "during the 6-month period ending September 2012, VHA issued 30 percent of its hearing aids to veterans more than 30 days from the estimated date the facility received the hearing aids from its vendors." The audit also found that deliveries of repaired hearing aids to Veterans were subject to delay partially due to "inadequate staffing to meet an increased workload, due in part to the large number of veterans requiring C&P audiology examinations."

In a practical sense, as a result of the backlog and delays, many Veterans are experiencing long wait times for appointments, shortened appointments, and limited follow-up care and counseling. And hearing aid specialists are observing an increase

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[1] 2013 Presentation to the Joint Defense Veterans Audiology Conference, "Update on the VA Audiology Program", Lucille B. Beck, PhD

[2] 2010 Presentation to the Joint Defense Veterans Audiology Conference, "21st Century Approach to VA Audiology Care", Lucille B. Beck, PhD

[3] VA Office of Inspector General report "Audit of VA's Hearing Aid Services," February 20, 2014

[4] 2010 Presentation to the Joint Defense Veterans Audiology Conference, "21st Century Approach to VA Audiology Care", Lucille B. Beck, PhD

in the number of Veterans who seek care in their private offices as well. These Veterans request hearing aid specialists' help with hearing aid adjustments and repairs, oftentimes because they do not want to wait for the next available VA appointment, which may be months away, or because the distance to the closest VA facility that offers audiology services is too far to travel. We also have many Veterans who choose to purchase hearing aids at their own expense through a private hearing aid specialist, rather than using the benefits they've earned and are entitled to, because they want to work with someone local who they trust.

Considering the safety risks involved as well as the impact untreated hearing loss can have on one's personal relationships and mental well-being, the VA needs an immediate solution to deal with the backlog and get Veterans the help they need. We also know that our working-age Veterans are anxious to contribute to society through employment, and properly fit and adjusted hearing aids are necessary for their success in obtaining and maintaining a job.

H.R. 3508 provides the VA a much needed solution by creating a new provider class for hearing aid specialists to work within the VA. Hearing aid specialists can help the VA hearing health care team by providing hearing aid evaluations; hearing aid fittings and orientation; hearing aid verification and clinical outcome measurements; customary after care services, including repairs, reprogramming and modification; and the making of ear impressions for ear molds—just as they are currently authorized to do in the VA's fee-for-service contract network.

By adding hearing aid specialists to the audiology-led team to perform these specialized hearing aid services independently, audiologists will be able to focus on Veterans with complex medical and audiological conditions, as well as perform the disability evaluations, testing, and treatment services for which audiologists are uniquely qualified to provide—thereby creating efficiencies within the system and supporting the team-based approach. Adoption of the hearing aid specialist job classification at this juncture will also be advantageous given the fact that VA Audiology and Speech Pathology Service management will be developing staff and productivity standards as a result of the Inspector General's audit and recommendations,[5] and would be able to consider the use of hearing aid specialists as they develop their model.

Also, by virtue of the report language in H.R. 3508, which would shine a light on the VA's utilization of hearing aid specialists in its contract network, it is our hope that the VA would take better advantage of this willing and able provider type to help address the need for hearing aid services.

Hearing Aid Specialist Qualifications

Hearing aid specialists are regulated professionals in all 50 states and in the non-VA market, hearing aid specialists perform hearing tests and dispense 50% of hearing aids to the public. They are licensed/registered to perform hearing evaluations, screen for the Food and Drug Administration (FDA) "Red Flags" indicating a possible medical condition requiring physician intervention, determine candidacy for hearing aids, provide hearing aid recommendation and selection, perform hearing aid fittings and adjustments, perform fitting verification and hearing aid repairs, take ear impressions for ear molds, and provide counseling and aural rehabilitation.

Training for the profession is predominantly done through an apprenticeship model, which works very well given the hands-on and technical skill involved. And while licensure requirements vary from state to state, in addition to the apprenticeship experience, candidates generally must hold a minimum of a high school diploma, or they must hold an associates degree in hearing instrument sciences. Based on an industry study, we know that the actual level of schooling of a hearing aid specialist on average is an associates degree or higher. In nearly every state, candidates must pass both written and practical examinations, and in many states a distance learning course in hearing instrument sciences is required or recommended.

Hearing aid specialists are already recognized by several Federal agencies to perform hearing health care services. The Standard Occupational Classification (SOC) identifies hearing aid specialists within the health care Practitioners and Technical Occupations category (29–2092), and the Federal Employee Health Benefit program and Office of Policy and Management support the use of hearing aid specialists for hearing aid and related services. And while Medicare does not cover hearing testing for the purpose of recommending hearing aids (a policy that applies to all dispensing practitioners), hearing aid specialists provide hearing testing, hearing aids, and related services for state Medicaid programs around the country. Further, many insur-

[5] VA Office of Inspector General report "Audit of VA's Hearing Aid Services," February 20, 2014

ance companies contract with hearing aid specialists to provide hearing tests and hearing aid services for their beneficiaries.

Finally, evidence shows that there is no comparable difference in the quality and outcomes of hearing aid services based on site of service or type of provider. A well-respected industry study found that instead the best determinant of patient satisfaction is whether the provider used best practices like fit verification, making adjustments beyond the manufacturer's initial settings, providing counseling, and selecting the appropriate device for one's loss and manual dexterity.[6]

VA Strategies To Address Demand

To address the demand for audiology and hearing aid services, the VA has been relying on the use of teleaudiology, audiology health technicians, and contract audiologists outside the VA setting. While IHS applauds the VA for its efforts to better serve the needs of Veterans, each of these strategies has its limitations. Though teleaudiology can make audiological services more available in remote settings, the cost of staffing and facilities are needlessly high, especially given that hearing aid specialists have fully-equipped offices, oftentimes operate in rural settings, and perform home and nursing home visits. Audiology health technicians have a very limited scope of duties, which does not include hearing aid tests or the fitting and dispensing of hearing aids, and must be supervised by audiologists. Finally, increased reliance solely on contract audiologists may also limit access as there are not enough audiologists to fill the current and future need for hearing care services. In order to fill the need, the field needs an additional 23,000 audiologists by 2030; however only about 600 are entering the profession annually.[7]

As the federal government seeks to become more efficient and cost-effective, we urge the Subcommittee to pass H.R. 3508, which will round out the VA hearing health care team to mirror the private-market model, and increase Veterans' access to care, improve overall quality, and reduce cost. Now is the time to embrace hearing aid specialists to help meet the hearing health care needs of our Veterans, which will only continue to rise in the coming years.

Thank you for your consideration and for your service to our Veterans. With questions, please contact government affairs director Alissa Parady at 571–212–8596 or *aparady@ihsinfo.org.*

International Hearing Society, 6880 Middlebelt Rd., Ste. 4 Livonia, MI 48154, Phone: (734) 522–7200 Fax: (734) 522–0200, Web site: *www.ihsinfo.org*

[6] MarkeTrak VIII: The Impact of the Hearing Health Care Professional on Hearing Aid User Success, The Hearing Review, Vol 17 (No.4), April 2010, pp. 12–34.

[7] Demand for Audiology Services: 30-Year Projections and Impact on Academic Programs, Journal of the American Academy of Audiology, Ian A. Windmill and Barry A. Freeman, 24:407–416, 2013

STATEMENT OF IRAQ & AFGHANISTAN VETERANS OF AMERICA

Statement of Iraq & Afghanistan Veterans of America on Pending Health Care Legislation

Bill #	Bill Name	Sponsor	Position
H.R. 183	Veterans Dog Training Therapy Act	Rep. Grimm	Support
H.R. 2527	A bill to provide counseling and treatment for MST that occurred during inactive duty training.	Rep. Titus	Support
H.R. 2661	Veterans Access to Timely Medical Appointments Act.	Rep. McCarthy	Support
H.R. 2974	A bill to provide for the eligibility for beneficiary travel for veterans seeking treatment or care for military sexual trauma in specialized outpatient or residential programs at facilities of the VA.	Rep. Walorski	Support
H.R. 3508	A bill to clarify the qualifications of hearing aid specialists within VHA.	Rep. Duffy	Support
H.R. 3180	A bill to include contracts & grants for residential care for veterans in the exception to the requirement that the government recover a portion of the value of certain projects.	Rep. Kaptur	Support
H.R. 3387	Classified Veterans Access to Care Act	Rep. Sinema	Support
H.R. 3831	A bill to review the dialysis pilot program implemented by the VA and submit a report to Congress before expanding that program.	Rep. Roe	No Position
H.R. 4198	A bill to reinstate an annual report on the capacity of the VA to provide for specialized treatment and rehabilitative needs of disabled veterans.	Rep. Denham	Support
Draft	A bill to authorize major VA medical facility leases for Fiscal Year 2014.	Rep. Benishek	No Position

Chairman Benishek, Ranking Member Brownley, and Distinguished Members of the Subcommittee:

On behalf of Iraq and Afghanistan Veterans of America (IAVA), we would like to extend our gratitude for being given the opportunity to share with you our views and recommendations regarding this important legislation that will impact the lives of IAVA's members and all of America's troops and veterans.

As the nation's first and largest nonprofit, nonpartisan organization for veterans of the wars in Iraq and Afghanistan, IAVA's mission is critically important but simple—to improve the lives of Iraq and Afghanistan veterans and their families. With a steadily growing base of nearly 270,000 members and supporters, we aim to help create a society that honors and supports veterans of all generations.

In partnership with other military and veteran service and advocacy organizations, IAVA has worked tirelessly to see that our members' needs are appropriately addressed by the Department of Veterans Affairs (VA) and by Congress. IAVA appreciates the efforts put forth by this Subcommittee to address the challenges facing our nation's veterans and their families, and we are proud to offer our support for the legislation that is the subject of this hearing today.

H.R. 183

IAVA supports H.R. 183, the Veterans Dog Training Therapy Act, which would direct the VA to establish a pilot program to allow veterans receiving post-deployment mental health care to train service dogs for disabled veterans.

The use of dog training as a therapy for post-traumatic stress disorder is a forward-thinking and unique option for veterans seeking care. Most importantly, there

is a strong body of evidence supporting the therapeutic value of dogs, and growing evidence supporting their therapeutic value specifically for servicemembers and veterans with PTSD. Using animals as therapy or as service dogs has been a successful model of care already supported by the DoD and VA. This particular program goes a step further, to equip veterans with vocational skills. Such skills and abilities are instrumental in helping veterans develop new career opportunities.

Additionally, the proposed program would train service dogs for other veterans. The use of occupational therapy to train new service dogs serves two populations of veterans and promotes innovative care to address the unique needs of every veteran.

H.R. 2527

IAVA supports H.R. 2527, which would provide veterans with counseling and treatment for military sexual trauma that occurred during inactive training.

The VA has a responsibility to provide the best counseling and treatment available to survivors of military sexual trauma. However, the men and women who courageously served in the National Guard or other reserve components of the armed services are not eligible for such counseling and treatment if the MST occurred during inactive training. IAVA supports enabling and facilitating this type of training in order to ensure that all survivors of MST are afforded prompt VA care and treatment.

H.R. 2661

IAVA supports H.R. 2661, the Veterans Access to Timely Medical Appointments Act, which would require the VA to implement a standardized policy to ensure veterans enrolled in VA health care are able to schedule primary care appointments and specialty appointments within a certain amount of time after requesting an appointment.

The lack of standardized appointment policies and inefficient data on adherence to appointment policies has been a routine issue among veterans seeking care at the VA. This legislation is directly reflective of Government Accountability Office recommendations, which were based on an audit stemming from veteran concerns. IAVA strongly supports increased access to medical care and encourages Congress and the VA to continue addressing ways in which increased access to care can be achieved.

H.R. 2974

IAVA supports H.R. 2974, which would authorize beneficiary travel for veterans seeking treatment or care for military sexual trauma at specialized outpatient or residential programs at VA facilities.

A 2012 survey released Pentagon report estimated nearly 26,000 servicemembers experienced unwanted sexual contact in 2012, with just 3,374 cases ultimately reported. Recent incidents continue to highlight the appalling presence of sexual assault in the U.S. military and the urgent need to ensure that servicemembers and veterans can access the appropriate assistance available to them.

Currently, the VA is required to operate a program that provides counseling and the necessary care to veterans that need help in overcoming the physical and psychological stress of sexual assault and harassment. By ensuring that the travel expenses of veterans seeking MST-related treatment are covered, this bill would serve as a natural extension of the care required by the VA for survivors of military sexual trauma.

H.R. 3508

IAVA supports H.R. 3508, which would clarify the qualifications of hearing aid specialists at the VA.

When veterans seek VA-provided hearing aid services at a VA medical facility, too often they encounter facilities that are overloaded with appointments and/or are forced to endure long wait times, substantial distances to travel, and limited follow-up care. This seems to indicate that the number of veterans in need of adequate hearing-related services is quickly surpassing VA's ability to sufficiently respond.

Since hearing impairment is one of the most common injuries faced by our newest generation of veterans, ensuring that these men and women receive the care they are entitled to is critical. IAVA supports this legislation because it seeks to ensure that qualified hearing aid specialists can work alongside the hearing professionals of the VA in order to better serve this nation's veterans and reduce the wait times and stress associated with seeking care at a VA facility.

H.R. 3180

IAVA supports H.R. 3180, which would exempt contracts and grants for residential care for veterans from the requirement that the government recover a portion of the value of certain projects.

The VA is authorized to provide grant money to state-run facilities that provide domiciliary care, medical care, or nursing home care to veterans. If the facility ceases to be run by the state within a certain amount of time, the VA is authorized to recapture up to 65 percent of the value of the project, but not more than the original grant amount. This legislation would exempt residential care facilities from these recapture requirements. IAVA supports the VA exempting residential care facilities from these recapture requirements so long as the facilities continue to maintain high levels of care for veterans.

H.R. 3387

IAVA supports H.R. 3387, the Classified Veterans Access to Care Act, which would improve access to mental health care for veterans who conducted classified missions or served in classified units.

Currently, the VA utilizes group therapy sessions as a form of mental health treatment. However, these group therapy sessions do not consider the security clearance of the veteran, often putting veterans in a position to choose between compromising classified information and utilizing this helpful form of mental health support. However, a veteran should never be forced to opt out of mental health treatment due to a lack of feasible treatment options. The mental health needs of each veteran are unique, as is the nature of many military occupational specialties and their associated missions. Likewise, the full range of mental health care treatments available from the VA should reflect the full range of unique needs and special circumstances of military service.

H.R. 3831

At this point in time, IAVA has no position on H.R. 3831, which would require VA to ensure that it's dialysis pilot program is not expanded until it has been implemented at its initial facilities, an independent analysis of the program has been conducted, and VA has provided a report to Congress detailing progress of the program.

H.R. 4198

IAVA supports H.R. 4198, which would require the VA to reinstate an annual report on the capacity of the VA to provide for specialized treatment and rehabilitative needs of disabled veterans. This report has provided invaluable data on the capabilities of the VA to meet the needs of disabled veterans, and this bill makes a common sense change to require the VA to reinstate these reports.

Draft 1

At this time, IAVA is still reviewing the draft bill to authorize major VA medical facility leases for Fiscal Year 2014. IAVA strongly encourages Congress and the VA to continue to invest in facilities to support the medical needs of veterans, and we therefore look forward to having the opportunity to evaluate this new draft legislation.

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 this Subcommittee to improve the lives of veterans and their families.

Thank you for your time and attention.

Statement on Receipt of Federal Grant or Contract Funds

Iraq and Afghanistan Veterans of America has not received federal grant or contract funds relevant to the subject matter of this testimony during the current or two previous fiscal years.

NATIONAL ASSOCIATION OF STATE VETERANS HOMES

TESTIMONY OF BRAD SLAGLE, PRESIDENT

Chairman Benishek, Ranking Member Brownley and Members of the Subcommittee:

Thank you for the opportunity to submit testimony on behalf the National Association of State Veterans Homes (NASVH) in support of H.R. 3180, legislation intro-

duced by Congresswoman Marcy Kaptur of Ohio. H.R. 3180 was drafted to remove existing legal and financial barriers that effectively prevent State Veterans Homes from operating certain homeless veterans programs. We applaud Congresswoman Kaptur for her lifelong commitment to supporting veterans, including homeless veterans, and for her leadership in introducing this legislation. If properly implemented, this legislation could have the effect of utilizing excess existing capacity in some State Home domiciliaries to support new homeless veterans programs. Although there may need to be some language changes made to H.R. 3180 to strengthen the bill, we hope that the Subcommittee will work with the bill's sponsor, VA and NASVH to move this important, innovative and commonsense legislation.

Mr. Chairman, as you know, NASVH is an all-volunteer, non-profit organization whose primary mission is to ensure that each and every eligible U.S. veteran receives the benefits, services, long term health care and respect which they have earned by their service and sacrifice. NASVH also ensures that no veteran is in need or distress and that the level of care and services provided by State Veterans Homes meets or exceeds the highest standards available. The membership of NASVH consists of the administrators and senior staffs at 146 State Veterans Homes in all 50 States and the Commonwealth of Puerto Rico.

Mr. Chairman, the State Veterans Homes system is a mutually beneficial partnership between the States and the federal government that dates back more than 100 years. Today, State Homes provide over 30,000 nursing home and domiciliary beds for veterans and their spouses, and for the gold-star parents of veterans. Our nursing homes assist the VA by providing long-term care services for approximately 53 percent of the VA's long-term care workload at the very reasonable cost of only about 12 percent of the VA's long-term care budget. VA's basic per diem payment for skilled nursing care in State Homes is approximately $100, which covers about 30 percent of the cost of care, with States responsible for the balance, utilizing State funding and other sources. On average, the daily cost of care of a veteran at a State Home is less than 50 percent of the cost of care at a VA long-term care facility. The VA per diem for adult day health care is approximately $75 and the domiciliary care rate is approximately $43 per day.

The bill before the Committee, H.R. 3180, is intended to address a problem in Title 38 that effectively prevents State Homes from operating certain homeless veterans programs, even when a domiciliary has excess capacity that could be used in other ways to help fight the pernicious problem of homelessness amongst veterans. According to the Department of Housing and Urban Development, on any given night there are almost 60,000 homeless veterans, and more than twice that many experience homelessness at some point each year. This shameful fact led VA Secretary Shinseki to make ending homelessness amongst veterans by 2015 one of his highest priorities and enactment of H.R. 3180, properly crafted and implemented, could add State Veterans Homes to his arsenal of tools in that effort.

Mr. Chairman, some State Homes currently have unused bed capacity in their domiciliary programs that could be used to operate specialized homeless veterans programs. For example, the Ohio Veterans Home in Sandusky, Ohio has both a 427 bed nursing home program and a separate 300 bed domiciliary program. While the nursing home program has a 98 percent or higher occupancy rate, the domiciliary is currently operating at less than 60 percent occupancy, leaving more than 125 beds available at any given time. The administrators at Sandusky have been exploring ways to use a small number of their unused domiciliary beds to help homeless veterans.

However, eligibility requirements for admission to the Ohio Veterans Home domiciliary program limit or restrict admission for most homeless veterans. To be admitted to the domiciliary, a veteran must provide a current medical history and physical completed by a physician, along with detailed financial documentation demonstrating need for this assistance, as well as other information. Often homeless veterans lack the resources to obtain such information required for possible admission so the Ohio Veterans Home has been looking for other ways to use their facility to support homeless veterans.

Learning about VA's Health Care for Homeless Veterans (HCHV) program, which provides grants to community homeless programs, the Sandusky Home drew up plans for a small homeless program using HCHV funding as a source of support. Under this proposed program, they would be able to admit homeless veterans without the tighter domiciliary requirements, allowing them immediate access to food, shelter, primary care, social services and other services. There are also a number of recently deployed veterans that may need a stable transition facility for post-acute care but who don't fall into the admissions criteria outlined in the VA domiciliary care program regulations. Because homeless veterans generally need more intense services initially to help them to stabilize and adjust, the Home also devel-

oped plans to work collaboratively with the VA Homeless Coordinators in an effort to help the veteran with any specific needs they may have, which could include education, job training and long term housing.

After approaching VA with this proposal, the Sandusky Home was told that under Title 38 regulations, State Homes are only authorized to use their federally-supported homes to operate three programs: skilled nursing care, adult day health care and domiciliary care. According to VA's Office of General Counsel, if a State Veterans Home applied for and received a grant to operate a homeless veterans program, VA would have to recapture a portion of the construction grant funding previously awarded to the State Home over the past twenty years. This recapture of federal funds would be such a severe financial penalty that it would effectively prevent any State Veterans Home from even considering new homeless veterans programs, even though domiciliaries were built to provide housing for veterans without homes.

In order to remove this obstacle, H.R. 3180 was drafted to amend the recapture provisions (38 USC § 8136) by providing an exemption for State Homes that receive a contract or grant from VA for residential care programs, including homeless veterans programs through HCHV. This legislation would not require VA to award grants or contracts to State Homes; VA would retain the authority and discretion to determine when and where it might make sense for a State Home to use a portion of its empty beds to help homeless veterans. Nor would it open the door to State Homes converting domiciliary beds into new homeless program beds on their own; only VA's decision to provide funding through a grant or contract, such as HCHV, would exempt them from the recapture provisions. This innovative and practical proposal would not increase federal spending, rather it would simply allow State Veterans Homes to compete for existing VA grants just as private community organizations presently do.

However, in further exploring how this legislation could be interpreted and implemented, we have become aware that the language may not be specific enough in terms of either the intended facilities or the intended programs. The broad exception in the current draft of the bill providing the Secretary the ability to award grants and contracts for resident care without triggering the recapture provision could theoretically be used for any number of residential programs, not just at domiciliaries, but at skilled nursing facilities as well. Moreover, there are some concerns that even though the Secretary would have broad new authority to award grants and contracts for additional residential programs, there is no guarantee VA would actually use this authority to support new homeless veterans programs in domiciliaries through HCHV.

Mr. Chairman, although H.R. 3180 as currently drafted could achieve its intended purpose, we would recommend that the Subcommittee work with the bill's sponsor, VA and NASVH to tighten and strengthen the language in the bill. We are confident that working together we can refine this legislation to create new opportunities for State Homes with underutilized bed capacity in their domiciliary programs to help VA end the scourge of homelessness amongst veterans using existing programs, such as HCHV.

SERVICEWOMEN'S ACTION NETWORK

Chairman Benishek, Ranking Member Brownley, and distinguished members of the Subcommittee:

On behalf of the Service Women's Action Network, thank you for the opportunity to submit written testimony for the record and thank you for your continued leadership on veterans' issues and for convening this hearing.

The Service Women's Action Network (SWAN) is a non-profit, non-partisan veterans led civil rights organization. SWAN's mission is to transform military culture by securing equal opportunity and freedom to serve without discrimination, harassment or assault; and to reform veterans' services to ensure high quality health care and benefits for women veterans and their families.

We challenge institutions and cultural norms that deny equal opportunities, equal protections, and equal benefits to service members and veterans. SWAN is not a membership organization, instead we utilize direct services to provide outreach and assistance to service members and veterans and our policy agenda is directly informed by those relationships and that interaction. SWAN extends opportunities to and promotes the voices and agency of service women and women veterans without regard to sex, gender, sexual orientation or gender identity or the context, era, or type of service.

SWAN welcomes the opportunity to share our views on two of the bills before the Subcommittee today, H.R. 2527 and H.R. 2974.

H.R. 2527

The National Guard is unique among components of the Department of Defense in that it has the dual state and federal mission. For example, while serving operationally on Title 10 active-duty status in Operation Iraqi Freedom or Operation Enduring Freedom, National Guard units are under the command and control of the president. However, upon release from active duty, members of the National Guard return to their states as serving members of the reserve component but under the command and control of their governors.

A reservist can complete a full Guard or Reserve career but never have served on Title 10 active duty for other than training purposes. Drill training, annual training and Title 32 service responding to domestic natural disasters and defending our nation's airspace, borders and coastlines do not qualify for veteran status and thus any of these service members if sexually assaulted have the potential to fall through the cracks, not receiving counseling and treatment for their assault if that assault happened during inactive duty training. Compounding this conflict is the risk of becoming a victim of sexual violence is just as great for these service members as it is for active duty troops. In fact, according to the Department of Defense, nearly 80% of reported sexual assaults occur CONUS, or stateside, in garrison-type installations. The remainder happen at overseas installations and still an even smaller percentage happen in "combat areas of interest." [1] Serving in your community stateside does not ensure a service member's safety when it comes to sexual assault.

Eliminating this gap in protection for our service members is why the Senate unanimously passed the Victims Protection Act of 2014. Sec. 107 of the bill requires the Department of Defense to provide for the availability of Sexual Assault Response Coordinators for members of the National Guard and the Reserve regardless of their training status. It only makes sense, then, that the VA close the similar gap in protections to veterans who need counseling and treatment for sexual trauma that occurred during inactive duty training. SWAN fully supports passage of H.R. 2527.

H.R. 2974

As DoD continues to makes changes to policy and programming for sexual assault survivors, it is imperative that the VA do likewise and provide the men and women veterans who suffer from the invisible wounds of sexual assault the full range of treatment, services and disability benefits available to veterans who are suffering from the visible wounds of war.

Since 2008, SWAN has been monitoring VA's treatment of veterans who carry these invisible wounds of sexual violence due to rape, sexual assault or sexual harassment. We have been encouraged by the progress that the Veterans Health Administration continues to show in the screening and treatment of Military Sexual Trauma and its related diagnoses; however, the Veterans Benefit Administration continues to process and award disability claims for Military Sexual Trauma diagnoses, specifically PTSD, inconsistently and unfairly. In spite of repeated requests by a chorus of military and veterans' organizations, individual survivors and Members of this committee, the VA continues to refuse to amend the language in their regulations to make evidentiary standards and the processing of a MST PTSD claims as consistent and fair as it is for the other particularized PTSD claims found in the regulation. [2] Data obtained by SWAN through litigation under the Freedom of Information Act demonstrates that since 2010, VA approval rate for MST PTSD claims have lagged behind the approval rates of all other PTSD claims, and male survivors—who constitute the majority of sexual assault victims—continued to be discriminated against in the awarding of claims. [3] VA's response to this has been to ignore the data and falsely claim that the gap between awarded MST PTSD and other PTSD claims is closing and their training efforts have worked. Unfortunately, this Jedi Mind Trick is betrayed by the facts. In 2013, the VA Appropriations bill included reporting language that required VA to submit to Congress data on MST claims. [4] The 2013 data in this report shows that the VA's efforts have not worked and both the claims gap continues to exist and male survivors continue to face discrimination in the awarding of their claims. It is clear that until VA changes the

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[1] *http://www.sapr.mil/public/docs/reports/FY12-DoD-SAPRO-Annual-Report-on-Sexual-Assault-VOLUME-ONE.pdf*

[2] 38 C.F.R. § 3.304(f).

[3] See enclosure 1: "The Battle for Benefits".

[4] See enclosure 2: Military Sexual Trauma: FY2014 Congressional Report to the House and Senate Appropriations Committees *www.servicewomen.org*

language in the regulations so that the evidentiary burden for MST PTSD claims matches that of other particularized claims, the disability benefits process will remain broken and continue to be another betrayal that serves to compound the trauma of a survivor's initial sexual assault.

As SWAN and members of both the House and Senate continue to work for this needed regulatory reform, it is imperative that VA provide whatever it can to our men and women who have suffered from the impact of sexual violence while serving in the military. This includes common-sense logistical support to survivors, like the support found in H.R. 2974. This bill requires VA to provide for the eligibility for beneficiary travel for Military Sexual Trauma survivors seeking treatment in specialized outpatient or residential programs at VA facilities. This is a simple, common-sense benefit. The fact that today an MST survivor would be unable to make required appointments, participate in prescribed treatment programs or attend a beneficial resident treatment program simply because he or she cannot afford to travel to the facility is beyond outrageous. It is inexcusable that transportation costs should be a detour on a survivor's road to recovery. SWAN wholeheartedly supports the passage of H.R. 2974.

Again, we appreciate the opportunity to offer our views on these important bills and we look forward to continuing our work together to improve the lives of veterans and their families. Any questions can be directed to Greg Jacob, Policy Director at 646–569–5216 or by mail at Service Women's Action Network, 1225 I St, NW., Ste 307, Washington, DC, 20005.

Non-Governmental Witness Declaration

Neither the Service Women's Action Network nor I have received during the current or previous two fiscal years any Federal grant or contract relevant to the subject matter of this testimony.

THE AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION

To the House of Representatives Committee on Veterans Affairs Health Subcommittee Regarding H.R. 3508

Allowing for the Appointment of Hearing Aid Specialists to the Veterans Health Administration

The American Speech-Language-Hearing Association (ASHA) appreciates the opportunity to submit a statement for the record regarding H.R. 3508, legislation that would allow for the appointment of hearing aid specialists to the Veterans Health Administration. While we understand the desire of Congress to ensure appropriate access to hearing health services, we believe that this legislation will not address the problems associated with long wait times for hearing aids and hearing health care services. Additionally we believe that the legislation could lead to fragmented care. For these reasons, ASHA opposes the legislation as currently written. ASHA is the national professional, scientific, and credentialing association for more than 173,070 audiologists, speech-language pathologists, speech, language, and hearing scientists, audiology and speech-language pathology support personnel, and students.

Unfortunately, as currently written the legislation may not have the desired outcome of decreasing wait times for veterans either seeking to obtain hearing aids or repairs. Hearing health care is more than fitting a veteran with a device. An audiologist must do a full diagnostic hearing evaluation and take into consideration health factors, such as tinnitus and brain injury, when determining appropriate amplification and audiologic rehabilitation for the patient.

Hearing loss and tinnitus are two of the top service-related disabilities of our nation's veterans, and these disabilities require more complex and comprehensive treatment. Although we acknowledge that hearing aid specialists have the knowledge and skills to dispense hearing aids, many of our veterans, especially those with traumatic brain injury or tinnitus, require the specialized care of an audiologist.

The VA Office of Inspector General (OIG) recently released the finding of an audit of the VA's hearing health services. The audit found that inadequate staffing to meet increased workloads as well as operations and processes at the Denver Acquisition and Logistics Center (where hearing aids are repaired) attributed to long wait times.

The OIG recommended that the VA develop a plan to implement productivity standards and staffing plans for audiology clinics. They also recommended that the

repair center determine appropriate staffing levels for its rehab lab to establish controls to timely track and monitor hearing aid repairs.

The VA should have the ability to review its current policies and develop productivity standards and staffing plans as recommended by the OIG prior to the adoption of any legislation that would require changes to the provision of hearing health care services in the VA.

Additionally, in order to enhance hearing health care services to our veterans ASHA makes the following recommendations to the committee.

- Work with the VA to identify areas of the country where veterans have difficulty accessing hearing health services, and authorize additional funding to hire more audiologists and/or contract to private audiologists to meet the needs of the veterans in those areas.
- Request the VA to review data on wait times and access to hearing health care services and identify best practices by those facilities that have implemented ways to reduce wait times for services and devices and provide this information to lower performing facilities as a means to improve.
- Amend the Non-VA Purchased Care provisions of Title 38 to include audiologists.
- Grant the VA the authority to hire more audiologists.

Legislation Redundant Of Current VA Practices

The VA has the authority to hire hearing aid specialists as technicians that work under the direction of an audiologist. According to the VHA handbook 1170.02, the job description of the health technicians for audiology is to, among other things, increase productivity by reducing wait times and enhancing patient satisfaction; and reducing costs by enabling health technicians to perform tasks that do not require the professional skills of a licensed audiologist. The role of these technicians includes performing checks on hearing aids and other amplification devices, performing troubleshooting and minor repairs to hearing aids, ear molds, and other amplification devices, and performing electroacoustic analysis of hearing aids, among other things. These responsibilities, which are already provided in the VA, are what hearing aid specialists are requesting to be recognized for under H.R. 3508.

Additionally, Appendix A of the VA handbook specifically addresses the use of hearing aid specialists and allows for referrals to these individuals when timely referrals to private audiologists and/or other VHA facilities are not feasible or when the medical status of the veteran prevents travel to a VHA facility or a private audiologist.

Given that hearing aid specialists are already permitted to be hired by the VA, we believe that H.R. 3508 adds an unnecessary mandate on the agency to specifically recognize hearing aid specialists for appointment by the Secretary.

Training and Education

Given the complex nature of a veteran's hearing health care needs, veterans should have timely access to an audiologist. Audiologists are the primary licensed health care professionals who evaluate, diagnose, treat, and manage hearing loss and balance disorders. Audiologists hold a doctoral degree in audiology from a program accredited by the Council on Academic Accreditation in Audiology and Speech-Language Pathology of the American Speech-Language Hearing Association. Under the scope of practice for audiology, these individuals serve the veteran through a broad range of professional activities including evaluating, diagnosing, managing, and treating disorders of hearing, balance, tinnitus, and other disorders associated with the practice of audiology. This includes determining the appropriateness of amplification devices and systems as well as selecting, evaluating, fitting and programming hearing aids.

Hearing aid specialists are trained in the interpretation of hearing assessment instrumentation, hearing aid electronics, specifications, analysis, modifications, and programming of hearing aids. While some states have gone to a college-level associate degree as a minimum education requirement for hearing aid dispensers, many states still require only a high school diploma or equivalent. There are no national standards or dedicated curriculum that outlines the core competencies of a hearing aid specialist. For example, in addition to the high school diploma or equivalent requirement, in the state of Wisconsin an individual must be 18, while in Minnesota they must be 21. Both licensure requirements require a test for proficiency. For more information and an analysis of each state's hearing aid specialist (dispenser) requirements for licensure, see *www.asha.org/advocacy/state/*.

Additionally, we are unaware of any nationally recognized accreditation body for hearing aid specialists. We are aware of the International Institute for Hearing Instruments Studies. This organization is not on the list of recognized accrediting

agencies by the U.S. Department of Education or the Council for Higher Education Accreditation (CHEA). This organization is also not listed as a member agency of the Association of Specialized and Professional Accreditors (ASPA). It appears the accreditation body is limited to continuing education courses and programs.

We appreciate the opportunity to express our concerns. ASHA remains committed to working with the Committee to address access to timely hearing health care services, but does not believe that H.R. 3508 is the solution. For additional information please contact Ingrida Lusis, ASHA's director of federal and political advocacy, at *ilusis@asha.org* or 202–624–5951.

WARRIOR CANINE CONNECTION,

RICK A. YOUNT, EXECUTIVE DIRECTOR

Mr. Chairman and Members of the Subcommittee, as the Executive Director of Warrior Canine Connection, I would like to thank you for your invitation to submit a statement for the record in support of H.R. 183, the Veterans Dog Training Therapy Act. I am pleased to have the opportunity to bring Members of the Subcommittee up to date on this promising therapy for symptoms of Post Traumatic Stress Disorder (PTSD) and Traumatic Brain Injuries (TBI) in combat Veterans, and to address the need for this legislation.

Warrior Canine Connection (WCC) is a 501(c) 3 nonprofit organization dedicated to empowering returning combat Veterans who have sustained physical and psychological wounds while in service to our country. Based on the concept of Warriors helping Warriors, WCC's therapeutic service dog training program is designed to mitigate symptoms of PTSD and TBI, while giving injured combat Veterans a sense of purpose, help in reintegrating back into their families and communities, and a potential career path as a service dog trainer. WCC currently provides its program to recovering Warriors at Walter Reed National Military Medical Center (WRNMMC), the National Intrepid Center of Excellence (NICoE), Palo Alto VA Medical Center (Menlo Park), Ft. Belvoir Warrior Transition Brigade, the NeuroRestorative Residential Treatment Center in Germantown, MD, and at WCC's "Healing Quarters" in Brookeville, MD.

Based on my experience as a licensed social worker and certified service dog instructor, I developed the concept of using the training of service dogs for fellow Warriors as a therapeutic intervention for the symptoms of combat trauma experienced by hundreds of thousands of returning Veterans. The program I designed specifically addresses the three symptom clusters associated with PTSD; re-experiencing, avoidance and numbing, and arousal. Working with Golden and Labrador Retrievers specially bred for health and temperament, Warrior Trainers must train the dogs to be comfortable and confident in all environments. In teaching the dogs that the world is a safe place, the Warrior Trainers challenge their symptoms of combat stress. By focusing on preparing the dogs for service as the partners of disabled Veterans, they are motivated and able to visit places they usually avoid, like stores, restaurants, and crowded public transportation stations. The program also emphasizes positive reinforcement, emotional affect, consistency, and patience—tools that make Warrior Trainers better parents and improve their family relationships.

Since launching the first therapeutic service dog training program as a privately funded pilot at the Palo Alto VA Trauma Recovery Program at Menlo Park in July 2008, I have seen significant improvement in symptoms of PTSD and TBI in participating Veterans. In some cases, this safe, non-pharmaceutical intervention has benefitted patients who were not responding to any other treatments being offered by their medical providers. Based on positive feedback from wounded Warriors and their clinical providers, the program has expanded to several new sites and is being sought by other treatment facilities caring for injured combat Veterans. In response to these encouraging patient outcomes, the House Armed Services Committee included the following language in its report accompanying the 2014 National Defense Authorization Act:

The committee is aware that recovering service members in treatment at the National Intrepid Center of Excellence (NICoE) and Walter Reed National Military Medical Center are reporting improvement in their symptoms of Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI) when participating in the service dog training programs currently operating in those facilities. In addition, clinical observations support the benefits of this animal-assisted therapy modality to psychologically injured service members, including: decreased depressive symptoms, improved emotional regulation, improved sleep patterns, a greater sense of

purpose, better reintegration into their communities, pain reduction, and improved parenting skills. The committee urges the Secretary of Defense to consider making this promising new therapeutic intervention more available to service members suffering from the invisible wounds of PTSD and TBI. Therefore, the committee directs the Secretary of Defense to conduct such studies as may be necessary to evaluate the efficacy of service dog training as an adjunctive treatment for PTSD and TBI and to maximize the therapeutic benefits to recovering members who participate in the programs. The committee further directs the Secretary to provide a report not later than March 1, 2015 to update the congressional defense committees.

WCC is currently collaborating with NICoE, WRNMMC, the Uniform Services University of the Health Sciences (USUHS), and civilian academic experts, to conduct research on the therapeutic service dog training programs at WRNMMC and NICoE. I look forward to obtaining the necessary scientific data to establish service dog training as an evidence-based treatment for the invisible wounds of war.

Despite anecdotal evidence of the benefits of service dog training therapy on the psychological injuries of wounded Warriors, and almost daily news reports of Veterans who say that dogs have helped them to deal with symptoms of combat stress, the Department of Veterans Affairs (VA) presently does not support the provision of service dogs for psychological injuries. It is my understanding that the VA is waiting for the results of the VA research study mandated by the 2010 National Defense Authorization Act before officials will consider revising VA policy with regard to service dogs for psychological disabilities. Unfortunately, as Subcommittee Members are aware, the VA research study has been significantly delayed and wrought with problems. Last month, the VA published a solicitation for service dogs to be used in the study. As a clinician and a member of the Assistance Dogs International (ADI) Subcommittee charged with recommending tasks to be carried out by service dogs for psychiatric disabilities, I was alarmed to read through the tasks the VA is requiring the dogs to perform for the study. They included blocking (standing in front of the Veteran to give them space), sweeping rooms for intruders, barking at intruders, and standing behind the Veteran to give them space. In my view, these tasks support symptoms of PTSD by reinforcing cognitive distortions, rather than mitigate them and will distract Veterans from addressing their challenges to fully reintegrate into their communities and families. Clearly there is a need for mental health experts, government policy makers, and service dog industry representatives to come together to develop standards and best practices for service dogs that will support our Nation's Veterans with psychiatric disabilities.

Results from the VA research study will not be available for several years. Meanwhile, hundreds of thousands of returning Service Members and Veterans with psychological injuries and their families are struggling to find treatments that will help heal the invisible wounds of war. Service dog training therapy programs at VA and DOD medical facilities offer combat Veterans a continuing mission to help their disabled brothers and sisters, as well as an innovative Animal Assisted Therapy for their invisible wounds. Each dog participating in the program touches the lives of approximately 60 wounded Warriors during training. The Warrior Trainers benefit from the close interactions with the dogs without the responsibilities of ownership. They also learn about the use, care, and training of service dogs. In some cases, Warriors may experience significant improvement in their symptoms, lessening their need for a service dog. When and if Warrior Trainers eventually decide to apply for a service dog to assist them with their disabilities, their experience working with service dogs in training sets them up for success with their new canine partners.

Veterans seeking industry standard service dogs often wait years on the waiting lists of the nonprofit organizations that provide them. The need for well-trained service dogs to support Veterans from the recent conflicts will remain for many decades to come. Creating additional program sites will enable more recovering Warriors to benefit from this Animal Assisted Therapy modality, while increasing the number of service dogs available to be placed with disabled Veterans. In my testimony to the Subcommittee on similar legislation in July 2011, I stated that when it comes to training dogs for Veterans, no one takes that task more seriously than those who served by their sides in conflict. After working alongside wounded Warriors these past six years, I am more convinced of that than ever.

Several Veterans who have participated in the training program have gone on to become professional service dog trainers and will continue to serve the needs of their fellow Warriors and other persons with disabilities.

Collaborative opportunities between VA and DoD

Warrior Canine Connection is currently operating the therapeutic service dog training program at both VA and DoD treatment centers. Both Departments are in-

dividually engaged in funding and carrying out research studies to fully understand the efficacy of using dogs to help Veterans and Service Members with PTSD. Collaboration between the VA and DoD would enhance their individual efforts as well as offer cost sharing opportunities. The Bob Woodruff Foundation recently sponsored a convening at the National Intrepid Center of Excellence to focus on the use of service dogs and Animal Assisted Therapy in helping Veterans with the invisible wounds of war. The convening included VA and DoD policy makers, mental health providers, researchers and service dog SME's. The convening was a great first step in fostering discussion and future collaboration related to using dogs to support the recovery of returning Veterans. The therapeutic service dog training concept resonated with almost all who attended the convening as an innovative Complementary Alternative Medicine (CAM) modality.

H.R. 183

As you are aware, legislation to create a VA pilot program on service dog training therapy has been approved by the U.S. House of Representatives in the past two Congresses. While VA officials have recognized the therapeutic value of the program at VA Menlo Park, and indicated that the Secretary does not need Congressional authorization to create a VA pilot program on service dog training therapy, the WCC program at VA Menlo Park continues to be supported exclusively by private donations.

The provisions of H.R. 183 are based on the original program launched in 2008 at VA Menlo Park through the Recreation Therapy Department. Since that time, service dog training therapy has been incorporated into additional programs at that facility. Consequently, it may be more appropriate at this point to provide the Secretary with more discretion to tailor the pilot program on this CAM modality to the needs of the Veterans at individual pilot sites.

In the past, all matters associated with service dogs have been delegated to the VA's Dept. of Prosthetics and Sensory Aid Services (PSAS). As reflected in the Congressionally mandated VA Inspector General's report on the VA Guide and ServiceDog Program, PSAS officials have been very slow to implement the VA's authority to provide service dogs to disabled Veterans and to provide related education and outreach to VA medical providers and Veterans. Since the pilot program established by the Veterans Dog Training Therapy Act is clearly first and foremost a mental health intervention and CAM modality, I would ask that the VA's Office of Patient Centered Care and Cultural Transformation be considered to take the lead on this effort, working closely with VA Mental Health consultants to maximize the therapeutic benefits to Veterans.

I appreciate this opportunity to provide my views on this legislation to create a VA pilot program on service dog training therapy. Based on my experience working with wounded Warriors, I know that making this CAM modality more widely available will contribute significantly to the psychological healing of returning Veterans.

Financial disclosure associated with the statement for the record of Rick A. Yount, Executive Director, Warrior Canine Connection

Rick Yount serves as an individual contractor providing service dog training therapy and education to patients and their family members at the National Intrepid Center of Excellence (NICoE) in Bethesda, MD. Funding for his services at NICoE and associated expenses are being provided through a NICoE (DoD) subcontract under which he received $121,240 annually in calendar years 2012 and 2013.

WOUNDED WARRIOR PROJECT

Chairman Benishek, Ranking Member Brownley, and Members of the Subcommittee: Thank you for inviting Wounded Warrior Project (WWP) to offer views today on legislation under consideration by the Subcommittee. Working closely with warriors who have sustained wounds, injuries, and illnesses in service since 9/11, WWP brings an important perspective to your deliberations regarding the VA health care system and the statutory framework under which it operates. Several bills on your agenda address issues of importance to our warriors, though we also want to alert the Subcommittee to concerns raised by other measures. For the record, however, we are concerned that today's agenda does not include either legislation or draft legislation to extend the VA's Assisted Living Pilot Program. That program has been an important resource for warriors who have sustained traumatic brain injuries and have required specialized residential rehabilitation. With veterans who need this level of care now "locked out" of the program and others at risk of being

discharged prematurely, we renew our request that this Subcommittee move legislation at the earliest opportunity to lift the program's "sunset."

Expanding Access to Care for MST-Related Conditions

WWP welcomes the Subcommittee's consideration of legislation to remove barriers to care and treatment for MST-related conditions. The importance of early access to counseling and treatment as well as assuring the quality and effectiveness of treatments for health problems associated with MST cannot be overstated. Researchers report that MST is an even stronger predictor of PTSD than combat [1] and victims' reluctance to report these traumatic incidents can also result in delaying treatment for conditions relating to that experience.[2] In-service sexual assaults have long-term health implications, including PTSD, increased suicide risk, major depression and alcohol or drug abuse and without outreach to engage victims of MST on needed care, the long-term impact may be intensified.[3] With the VA reporting that some 1 in 5 women and 1 in 100 men seen in its medical system responded "yes" when screened for MST4 and the Department of Defense reporting that 26,000 active duty service members experienced a sexual assault in 2012,[4] it is clear that there is a great need for resources, support, and effective treatment for those who are coping with health issues as a result of an in-service assault. While researchers cite the importance of screening for MST [5] and associated referral for mental health care, many victims do not currently seek VA care. Indeed, researchers have noted frequent lack of knowledge on the part of women veterans regarding eligibility for and access to VA care, with many mistakenly believing eligibility is linked to establishing service-connection for a condition.[6] A recent survey of WWP Alumni further demonstrates the great challenges in getting needed treatment for warriors affected by MST. Almost half of the respondents indicated accessing care through VA for MST related conditions was 'Very difficult'. And of those who did not seek VA care, 41% did not know they were eligible for such care. In our view, there is still a lot of work to do to improve care and treatment for veterans with MST related conditions.

With these challenges in mind, WWP offers our strong support for H.R. 2527 and H.R. 2974, which, respectively, would expand eligibility to counseling and treatment for MST-related conditions for veterans whose sexual trauma occurred during inactive duty training and provide eligibility for beneficiary travel for veterans seeking treatment or care for MST through VA. As the Subcommittee's important oversight work has documented, however, the scope of the problem is not limited to access to care. Testimony at a recent Subcommittee hearing provided strong evidence that both the Department of Defense and the VA are failing to provide adequate mental health services for veterans who had been assaulted by fellow service members. Veterans at that hearing detailed troubling, yet similar experiences relating not only to access to VA care, but to inadequate screening, providers who were either insensitive or lacked needed expertise, and facilities ill-equipped to appropriately care for MST survivors. [7]

We commend the VA for taking significant steps (described at the Subcommittee's February 26th oversight hearing) to improve veterans' screening and care for MST-related conditions. To date, however, too many warriors still have not received timely, effective treatment. In short, wide gaps remain between well-intentioned policies and on-the-ground practice. With those concerns, we urge the Committee to continue to pursue these issues through oversight, to include conducting a searching inquiry as to whether VA has yet achieved the level of mental health staffing needed to meet the mental health needs of our veterans. Further, we urge that such oversight focus on improving access to MST-related care and training providers, as needed, to provide effective screening and appropriate, sensitive care for those seeking treatment for MST-related conditions.

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[1] D. Yaeger, et al." DSM–IV Diagnosed Posttraumatic Stress Disorder in Women Veterans With and Without Military Sexual Trauma," 21(S3) J Gen Internal Medicine S65–S69 (2006).

[2] Rachel Kimerling, et al., "Military-Related Sexual Trauma Among Veterans Health Administration Patients Returning From Afghanistan and Iraq," 100(8) Am. J. Public Health, 1409–1412 (2010).

[3] M. Murdoch, et al., "Women and War: What Physicians Should Know," 21(S3) J. of Gen. Internal Medicine S5–S10 (2006).

[4] U.S. Dept. of Veterans' Affairs and the National Center for PTSD Fact Sheet, "Military Sexual Trauma," available at *http://www.ptsd.va.gov/public/pages/military-sexual-trauma-general.asp*.

[5] *http://www.defense.gov/transcripts/transcript.aspx?transcriptid=5233*

[6] See Donna Washington, et al., "Women Veterans' Perceptions and Decision-Making about Veterans Affairs Health Care," 172(8) Military Medicine 812–817 (2007).

[7] *http://docs.house.gov/Committee/Calendar/ByEvent.aspx?EventID=101095*

Legislation to Address Operational Challenges: H.R. 2661 and H.R. 4198

We are unable to support two other bills, in particular, H.R. 2661 and H.R. 4198, that propose to address operational challenges inherent in the administration of a health care system. H.R. 2661 would direct VA to implement a policy "to ensure" that a veteran enrolled in VA's health care system is able to schedule an appointment, within seven days in the case of primary care and within 14 days in the case of specialty care, of the date that the veteran or provider requests. The bill sets additional expectations VA is to achieve to further that policy.

In testifying before the Subcommittee in the past at hearings examining VA mental health care, WWP expressed deep concerns with the long waits warriors have encountered at many facilities with regard to both initial and follow-up mental health care visits. Those concerns have not vanished. But while there are certainly systemic problems with VA scheduling practices and with the reliability of VA's mechanisms for reporting wait times, scheduling cannot be altogether divorced from an array of other, often complex issues. To focus solely on implementation of a scheduling policy, as proposed in H.R. 2661, is to fall short of remedying deeper problems and to risk compounding those that already exist.

Repairing flaws in how VA accomplishes appointment-scheduling is unlikely by itself to ensure that veterans actually receive timely, needed treatment. To illustrate, sustained congressional oversight into severe timeliness problems in VA's provision of mental health care finally led to the Secretary's acknowledging in April 2012 a need for 1900 additional mental health staff. Just as it is important to take account of the link between adequate staffing and timeliness, we urge the Subcommittee to work toward ensuring that VA care is not only timely, but effective. The establishment of rigid standards of timeliness (not goals, but requirements)—without regard to staffing levels or other limitations—can create (and has in recent experience in VHA led to) perverse incentives to "game" the system and even to institute practices that compromise care quality. Well-intentioned VA performance requirements too often lead to inappropriate practices. We offer the following relatively recent examples arising from VA efforts to set policy for mental health care:

- A VA facility at which practitioners were directed not to ask veterans about their mental health problems lest it become necessary to provide them treatment (as required by performance measures) for which there was not adequate staff;
- VA facilities that have shifted staff to ensure that veterans are "seen" within 14 days (to meet a metric) but that, as a result, cannot begin real treatment until many weeks later;
- A VA facility that has instructed staff to substitute a diagnosis other than PTSD in instances where PTSD is a patient's primary diagnosis to avoid having to meet performance requirements relating to provision of evidence-based treatments for PTSD.
- VA facilities that have prematurely placed veterans who need individual therapy into group therapy that is being "counted" inappropriately as meeting a performance metric.

While we certainly acknowledge the importance of improving both VA's timeliness and systems for effective scheduling of appointments, we have real concern with setting rigid requirements that ignore not only patient acuity and differences between elective and necessary care, but overarching fiscal and other resource constraints. We do not in any way seek to minimize the importance of the issues raised by the Government Accountability Office in its report on the Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight. But we believe the well-intentioned prescription set in H.R. 2661 is not the "best medicine" to cure the problem, and do not support its enactment.

H.R. 4198 proposes to reinstitute a statutory reporting requirement established in 1996 that was aimed at preventing downsizing or even termination of certain specialized programs dedicated to the specialized needs of veterans with particular disabilities. A careful review of the impact of that well-intentioned law, and subsequent amendments to it, would likely call its effectiveness into question. The law employed 1996 as a baseline against which to gauge whether VA "maintained" then-existing programs. While this bill does implicitly raise highly important issues, there has been too much change in the VA health care system to employ a 17-year old benchmark as the framework for judging whether VA programs and services are meeting some of our veterans' most critical needs. We are more than sympathetic to the concerns underlying the bill, but urge the Subcommittee to avoid missing this important mark by simply reinstating a reporting requirement that for a number of the programs it aims to protect is substantially outdated.

Mental Health Care

H.R. 3387, the Classified Veterans Access to Care Act, would direct VA to establish standards and procedures to accommodate veterans' access to care without "improperly disclos[ing] classified information." It is our understanding that this legislation was developed as a response to a disturbing instance of a patient (with knowledge of classified information) being prematurely placed in group therapy. We share a concern that veterans needing mental health care should be afforded that care in an appropriate and timely manner and, particularly, without being made to attend group therapy before they are offered needed individual treatment. That concern is not limited to situations where a patient feels unable to discuss mental health problems in a group setting because of an obligation not to disclose classified information. Congressional testimony that many VA medical centers have routinely placed patients in group-therapy settings rather than provide needed individual therapy[8] highlights a broader problem than the bill addresses. As such, we recommend that the Subcommittee consider a more comprehensive solution than H.R. 3387 proposes. Providing effective care requires building a relationship of trust between provider and patient—a bond that is not necessarily easily established[9] and setting the foundation for such trust should generally begin in individual treatment. We also urge more focus on the soundness and effectiveness of the VA's mental health performance measures, which currently track adherence to process requirements, but fail to assess whether veterans are actually improving.[10]

A second measure, H.R. 183, would direct VA to carry out a five-year pilot program to assess training service dogs as a therapeutic medium to treat mental health and posttraumatic stress disorder symptoms. In our work with Wounded Warriors, we hear from many individuals who have benefitted greatly from the use of a service dog for a mental health condition. We are also aware of reports suggesting incarcerated inmates have derived benefits from participating in programs in which they train service dogs. WWP is not able to assess the strength or existence of evidence that might suggest that training dogs offers promise as a mode of therapy for veterans with mental health conditions. More importantly, however, H.R. 183 is in the nature of a directed research program. Given many other competing claims on VA's budget, we believe that decisions to fund research initiatives, however appealing they may appear, should be based on a peer-review evaluation process. However meritorious this proposal may be, we would urge the Subcommittee to discourage the direction of VA research. While we do not support H.R. 183, WWP is certainly not opposed to innovation. To the contrary, we are supportive of finding innovative ways to engage more veterans in needed mental health care. In that regard, we have specifically supported approaches that would integrate complementary medicine into traditional practices as well as using complementary practices as a gateway to evidence-based services to engage veterans who, for example, might otherwise be reluctant to seek or accept mental health treatment.

Hearing-Related Issues

With WWP's most recent annual survey of our wounded warriors showing that nearly 18% of our survey respondents report having severe hearing loss, evaluation, care and services for hearing-impaired veterans is certainly a concern. As such, we welcome the Subcommittee's consideration of hearing-related issues. In that regard, H.R. 3508 would set standards for, and authorize appointment under Title 38 to, hearing aid specialists, and require VA to report annually on timely access to hearing health services and contracting policies with respect to providing those services.

As discussed above, wait times for treatment and needed VA services is an overarching issue. And as discussed above, and in a recent IG audit report on VA's Hearing Aid Services,[11] the adequacy of VA staffing is an important dimension of providing timely service.

As with other VA services, there appears to be variability in the timeliness of VA hearing-related services. WWP field staff who reported very recently on their experience in several regions of the country advised that "warriors still have general complaints with wait times for appointments, [but] not any more so for hearing assist-

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[8] VA Mental Health Care: Evaluating Access and Assessing Care: Hearing Before the S. Comm. on Veterans' Affairs, 112th Cong. (Apr. 25, 2012) (Testimony of Nicholas Tolentino, OIF Veteran and former VA medical center administrative officer).

[9] VA Mental Health Care Staffing: Ensuring Quality and Quantity: Hearing Before the Subcommittee on Health of the H. Committee on Veterans' Affairs, 112th Cong. (May 8, 2012) (Testimony of Nicole Sawyer, PsyD, Licensed Clinical Psychologist).

[10] VA Mental Health Care Staffing: Ensuring Quality and Quantity: Hearing Before the Subcommittee on Health of the H. Comm. on Veterans' Affairs, 112th Cong. (2012) (Testimony of Ralph Ibson), supra note 21.

[11] VA Office of Inspector General, "Audit of VA's Hearing Aid Services," 12–02910–80 (Feb. 20, 2014).

ance than any other service," and even that "many [WWP staff and warriors] reported that hearing evaluations and administering of services (aids, battery replacements, etc.) are one of the more expedited facets of the VAMC." Another, however, cited "lag[s in service] universally around my region." Such delays could certainly continue to grow as earlier generations of veterans age, and hearing impairments worsen.

While WWP has no position on H.R. 3508, we do believe VA has much more work to do—across a broad range of health care services—to address the adequacy of health care staffing and the timeliness (as well as the effectiveness) of its provision of services. We would encourage the Subcommittee to continue to press VA on these important issues.

Finally, we applaud the Subcommittee's efforts to resolve the longstanding difficulty associated with authorizing major medical facility leases, and welcome the draft authorization bill being considered today.

Thank you for your consideration of our views.

VETSFIRST

Chairman Benishek, Ranking Member Brownley, and other distinguished members of the subcommittee, thank you for the opportunity to share VetsFirst's views on four of the bills under consideration today.

VetsFirst, a program of United Spinal Association, represents the culmination of over 65 years of service to veterans and their families. We advocate for the programs, services, and disability rights that help all generations of veterans with disabilities remain independent. This includes access to Department of Veterans Affairs (VA) financial and health care benefits, housing, transportation, and employment services and opportunities. Today, we are not only a VA-recognized national veterans service organization, but also a leader in advocacy for all people with disabilities.

H.R. 3508, To Amend Title 38, United States Code, To Clarify the Qualifications of Hearing Aid Specialists of the Veterans Health Administration of the Department of Veterans Affairs, and for Other Purposes

VetsFirst believes veterans should have timely access to professional hearing care services to ensure a higher quality of life.

The VA's Office of Inspector General's February 2014 audit of hearing aid services found that VA was not timely in issuing new hearing aids to veterans and meeting its 5 day timeliness goal. The report indicated that VA audiology staff attributed the hearing service delays to inadequate staffing.[1] In addition to providing hearing aid services, these staff members are also required to conduct compensation and pension examinations.

Tinnitus and hearing loss were the most prevalent service-connected disabilities in FY 2012 for veterans receiving disability compensation.[2] It is concerning that VA has not adequately anticipated the demand for hearing services, and in turn created a staffing model to meet the challenge. I, like many veterans of all eras, have experienced acoustic trauma due to my military service.

With the prevalence of explosions from artillery, and the sound of rifle-fire in training operations and combat operations, it is not surprising that many veterans have hearing loss. Audiology staff having to divide their time between compensation and pension exams is understandable. However, not adjusting current staff workloads appropriately to meet the timeliness delay is not acceptable.

This legislation would allow VA to appoint hearing aid specialists to assist veterans in receiving quicker access to needed services. These professionals are licensed in their respective states and can provide robust services that include: hearing testing; determining necessity for hearing assistive devices; performing hearing aid adjustments; taking impressions for ear molds, and providing counseling and aural rehabilitation. These hearing aid specialists have received extensive training and hundreds of professionals are currently entering the industry. The legislation's reporting requirements related to wait times and contract referrals will also help identify remaining gaps in hearing care services.

VetsFirst strongly supports H.R. 3508.

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[1] U.S. Department of Veterans Affairs, Office of Audits and Evaluations, Audit of VA's Hearing Aid Services, February 20, 2014.

[2] Ibid.

H.R. 183 Veterans Dog Training Therapy Act

Service animals promote independence for people with disabilities and break down societal barriers; thus, promoting community reintegration. Consequently, VetsFirst supports efforts to ensure that properly trained service animals are available to veterans who can benefit from their assistance.

This legislation would require VA to establish a pilot program to allow veterans with mental health needs to train service dogs for fellow veterans with disabilities. Specifically, this legislation addresses two critical needs by providing service dogs to veterans who are seeking the assistance of a service dog and giving veterans with post-deployment mental health concerns or post-traumatic stress disorder the opportunity to benefit from training these dogs. The dual nature of this approach will assist a wide range of veterans.

Veterans who assist with training the service dogs will be required to follow a structured training process to ensure that the animals are properly trained. The legislation also requires VA to collect data regarding the effectiveness of the program. Lastly, veterans participating may even be able to use the skills they acquired as a trainer to successfully pursue a career in the service animal field.

VetsFirst strongly supports H.R. 183.

H.R. 2527 To Amend Title 38, United States Code, To Provide Veterans With Counseling and Treatment For Sexual Trauma That Occurred During Inactive Duty Training

VetsFirst knows that access to VA health care is a lifeline for many veterans who seek assistance for mental health conditions that may result from military sexual trauma (MST).

Reservist and Guard personnel who are serving their weekend duty requirements are not considered to be on Active Duty under the law. Instead, these personnel are on Inactive Duty for Training (IADT) status. Title 38 currently excludes these service members from accessing needed VA counseling and treatment due to MST.

This legislation would provide Reservist and Guard personnel who suffer an MST while on IADT status with access to related health care services at VA. MST assaults occurring during military service can have a devastating impact on a service member's mental health and well-being. Timely access to quality VA health care is critical in assisting these service members with the counseling and treatment they need. This bill would expand those services to a greater number of our brave men and women.

VetsFirst strongly supports H.R. 2527.

H.R. 2974 To Amend Title 38, United States Code, To Provide for the Eligibility for Beneficiary Travel for Veterans Seeking Treatment or Care for Military Sexual Trauma in Specialized Outpatient or Residential Programs at Facilities of the Department of Veterans Affairs, and for Other Purposes

VetsFirst strongly supports access to beneficiary travel for veterans requiring treatment at VA health care facilities.

This legislation would expand beneficiary travel to veterans who need specialized outpatient or residential VA health care due to MST. We strongly believe that expanding access to beneficiary travel to include MST survivors sends a message that encourages veterans to pursue the treatments currently available for these conditions. By receiving the care they need, we hope that veterans who have experienced MST will be able to more fully reintegrate into their community.

VetsFirst strongly supports H.R. 2974.

Thank you for the opportunity to present our supportive views on these important pieces of legislation. We believe that passage of these bills will be of great value to veterans with disabilities. This concludes my statement.

Information Required by Clause 2(g) of Rule XI of the House of Representatives

Written testimony submitted by Christopher Neiweem, Director of Veterans Policy, VetsFirst, a program of United Spinal Association; 1660 L Street, NW, Suite 504; Washington, DC 20036. (202) 556–2076, ext. 7702.

This testimony is being submitted on behalf of VetsFirst, a program of United Spinal Association.

In fiscal year 2012, United Spinal Association served as a subcontractor to Easter Seals for an amount not to exceed $5000 through funding Easter Seals received from the U.S. Department of Transportation. This is the only federal contract or grant, other than the routine use of office space and associated resources in VA Regional Offices for Veterans Service Officers that United Spinal Association has received in the current or previous two fiscal years.

Christopher J. Neiweem is the Director of Veterans Policy at VetsFirst, which is a program of United Spinal Association.

Mr. Neiweem began his tenure with the organization in September 2013. His responsibilities include promoting the policy priorities of VetsFirst to the U.S. Congress, White House, federal agencies, and veteran service organization community.

He has been advocating for veterans at the federal level since 2011. After spending 6 years in the U.S. Army Reserve, which included a deployment to Iraq in 2003 to detain prisoners and support base security as a military police soldier, he attended college in his home state of Illinois. Chris completed a Bachelor's Degree in Political Science at Northern Illinois University, which included a summer internship in the Washington, DC office of Congressman Donald Manzullo. He went on to graduate school utilizing the Post 9–11 G.I. Bill and completed a Master's Degree in Political Affairs, at the University of Illinois at Springfield. During graduate school he completed 2 internships. The first at Springfield-based consulting firm Cook Witter Inc., and the other for the U.S. Senate campaign of now Senator Mark Kirk.

Since graduation Chris relocated to the Washington, DC area where he uses his experience in policy and military affairs to impact the federal benefits and services of our nation's veterans at VetsFirst.

QUESTION FOR THE RECORD

Context of Inquiry: On February 26, 2014, Dr. Robert Petzel, Dr. Robert Jesse, Dr. Rajiv Jain, Dr. Madhulika Agarwal and Mr. Phillip Matkovsky testified before the HVAC–Health committee at a hearing titled: "VA Accountability: Assessing Actions Taken in Response to Subcommittee Oversight". There were seven deliverables from the hearing.

Question 1: Please provide the complete list of specialty care services that have not yet implemented productivity standards.

Response: Specialties scheduled for implementation during the 3rd and 4th quarters this year:

- Cardiology
- Pulmonary/Critical Care
- General Surgery
- Physical Medicine and Rehab
- Anesthesiology
- Emergency Medicine
- Laboratory/Pathology
- Geriatrics

Question 2: Please provide an examination of the need for and potential incorporation of whistleblower protections for Veterans reporting military sexual trauma.

Response: As noted by Committee Member Kuster, the Department of Defense is currently reforming policies regarding Servicemembers' protection against retaliation after reporting experiences of military sexual assault. VHA cannot conceive of a scenario where a parallel set of policies in VHA would be necessary.

- Disclosures of MST to a VA staff member would be considered protected health information and thus subject to the provisions of the Health Insurance Portability and Accountability Act (HIPAA). Penalties for unauthorized use of medical record information are already covered under HIPAA and do not need to be duplicated by VA MST-specific whistleblower protections.
- VA does provide care for some active duty Servicemembers or Reservists who later return to active duty. In these cases, VA medical record information may be shared with the Department of Defense. If a disclosure of MST noted in a Servicemember's medical record subsequently led to retaliation against the Servicemember, the transgression would presumably be covered under the Department of Defense's whistleblower protections. Again, there is no need for a parallel set of VA policies.
- Eligibility for VA care is independent of any Department of Defense disciplinary or other proceedings, unless the Veteran was to ultimately receive an Other Than Honorable or Dishonorable discharge. If this discharge were the result of retaliation, this would also presumably be covered by the Department of Defense's whistleblower protections.

Question 3: The Circumstances surrounding the six members of the SES who had "serious disciplinary actions" taken against them over the last two years.

Response: The Department is currently working to provide the circumstances surrounding the six members of the SES who has disciplinary actions taken and will provide this information as soon as possible.

Question 4: Provide a report on MST anonymous callers (Mystery Shopper).

Response: The MST anonymous caller initiative targets a potential barrier to accessing MST-related care: difficulty contacting the MST Coordinator at a VHA health care facility. The initiative was first authorized in June 2010, and four rounds of review have been conducted since at an approximately yearly interval.

During each round, two members of the MHS national MST Support Team—one female and one male—placed calls to the primary switchboard phone number of each facility during normal business hours. Following a standard script, callers asked for assistance in reaching the facility MST Coordinator. Calls were rated based on the ability of operators and other frontline staff (e.g., clinic clerks) to identify the MST Coordinator, the seamlessness of the transfer, and staff members' courtesy and sensitivity to callers' privacy concerns. Each facility was rated as Satisfactory, Marginal, or Unsatisfactory based on results from both calls. All facilities with a Marginal or Unsatisfactory rating received detailed feedback on the calls, and, to date, have submitted action plans to VA Central Office to address the identified issues negatively impacting MST Coordinator accessibility.

The MST Support Team has taken several steps to assist facilities with preparing for the calls and with writing action plans. These include hosting a webinar presentation on the initiative, disseminating tip sheets of strategies on increasing and maintaining accessibility, and consulting with MST Coordinators to problem solve identified barriers.

The initiative has been successful in improving nationwide MST Coordinator accessibility. In Round 4 (Aug–Sep 2013), 83.6% of facilities were judged to have Satisfactory accessibility, 13.6% Marginal, and 2.9% Unsatisfactory. These results represent a nearly 30 percentage point improvement in Satisfactory accessibility and 16 percentage point drop in Unsatisfactory accessibility since Round 1 (Jul–Aug 2010).

Question 5: Provide the FY 2013 Office of Productivity and Efficiency's staffing standard report for MST (measuring the number of MST patients that VA facilities are treating and the staff resources available to treat them).

Response: The Annual Report on Counseling and Treatment for Military Sexual Trauma (MST) for Fiscal Year (FY) 2013 is currently being reviewed and we will provide the report to you as soon as it is available.

Question 5a: Please also provide information paper on the (2) FTE for MST.

Response: Please see below for the methods and results regarding decision to have (2) FTE for MST.

Methods

- The VA MHS MST Support Team completes an annual report to determine the number of trained full time equivalent employees (FTEEs) required to meet the mental health needs of Veterans who have experienced MST, to fulfill the requirements of 38 United States Code, Section 1720D(e). Because MST is associated with a variety of mental health conditions and is treated across multiple outpatient treatment settings, we could not rely solely on the number of providers in a given mental health service line or clinic. Therefore, we relied on methods developed by the VA Office of Productivity, Efficiency, and Staffing (OPES) to quantify workload associated with MST-related mental health care and calculate the effective number of FTEEs associated with this care at each VA Health Care System (HCS). From this we created a metric so that staffing levels could be compared across facilities.
- Each VA HCS varies in the number of Veterans that it serves who have experienced MST and therefore varies in the demand for MST-related mental health care. To enable comparisons across facilities, we calculated a ratio of provider staffing against population size: the total FTEEs providing MST-related mental health care for every 100 Veterans with positive MST screens. It is important to note that not all Veterans with a positive MST screen will want treatment and among those that do request care, the amount of MST-related care required by each Veteran will vary due to the range of mental health conditions associated with MST. But in general, a larger staffing ratio indicates greater staffing and availability of MST-related mental health services.

- We examined the amount of MST-related mental health care that each VA HCS provided and ranked facilities on two indicators: (1) The proportion of Veterans with a positive MST screen who received any MST-related mental health care; and (2) the median number of visits among patients who received MST-related mental health care. We identified health care systems that ranked in the top 25% for both indicators. We then used staffing ratio data from these "high volume" VA health care systems to establish the benchmark.
- The benchmark of 0.2 FTEE per 100 Veterans (or 2 FTEE per 1,000 Veterans) who experienced MST is based on a comparison with these "high volume" VA health care systems. This benchmark is within two standard deviations of the average staffing ratio at high volume health care systems. Even staffing levels that are only a portion of a single FTEE represent portions of workload from several different providers due to the wide range of mental health conditions and clinic settings associated with MST-related mental health care.

Results

- Knowledgeable in the treatment of MST-related mental health conditions. In the most recent analysis, 99 percent of VA health care systems were at or above the established benchmark for MST-related mental health staffing capacity. Over 64,000 Veterans received MST-related mental health care from a VA health care facility. These Veterans received a total of over 693,000 MST-related mental health care visits from over 17,950 individual providers. Not all of those 17,950 individual providers, however, spent all of their clinical hours delivering MST-related mental health care. The care delivered by those providers was equivalent to 580 FTEEs.

Question 6: Provide the committee with information about the VA employees that were held accountable for patient deaths at the Augusta VAMC and the Atlanta VAMC.

Response: Disciplinary actions for Atlanta and Augusta are below:

Disciplinary Actions

Atlanta VAMC

- Chief of Staff—Reprimand
- Associate Director—Reprimand
- Associate Director/Nursing and Patient Care Services—Reprimand
- Chief, Mental Health Service Line—Reassigned
- Mental Health Inpatient Nurse Manager—Reprimand
- Associate Nurse Executive/Mental Health and Geriatrics—Reprimand
- Mental Health Inpatient Unit Medical Director—Admonishment
- Former Medical Center Director—Retired
- Veterans Integrated Service Network (VISN) Chief of Mental Health Services—Retired

Augusta VAMC

- Chief of Staff—Received Performance Counseling (Voluntarily resigned from position)

Question 7: Please provide the timeline for VHA to contribute to the State Prescription Drug Monitoring Program.

Response: VA participation with State Prescription Drug Monitoring Program is estimated to begin August 2014. This is predicated on a contract award by May 5, 2014, with a contract start shortly after award. The timeline includes achieving Milestone 2 (development enters implementation phase) by May 30, with code changes to other patches and Medication Order Checking Application (MOCHA 2.0) completed, documentation updated, and identification of additional test sites by the end of June. It is expected that this work would enter the national release process near the middle of July with testing and deployment leading to a mid-August completion. The State Drug Monitoring Program patch is dependent on MOCHA 2.0 which will deploy in waves between March 24, 2014 and June 16, 2014, as well as a titration management patch that will start simultaneously with the State Drug Monitoring Program patch. There are potential risks of delays to the August 2014 start date that could arise from dependencies that include contract start date and unforeseen technical issues with states that are not part of the test site process. The VA Office of Information and Technology is responsible for oversight and management of software development and deployment for this program.

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