

LEGISLATIVE HEARING ON H.R. 2460; H.R. 3956;
H.R. 3974; H.R. 3989; DRAFT LEGISLATION TO
ENSURE THAT EACH VA MEDICAL FACILITY
COMPLIES WITH REQUIREMENTS RELATING TO
SCHEDULING VETERANS FOR HEALTH CARE
APPOINTMENTS AND TO IMPROVE THE UNI-
FORM APPLICATION OF DIRECTIVES; AND
DRAFT LEGISLATION TO DIRECT VA TO ESTAB-
LISH A LIST OF DRUGS THAT REQUIRE AN IN-
CREASED LEVEL OF INFORMED CONSENT

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

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Wednesday, April 20, 2016

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

The Subcommittee met, pursuant to notice, at 10:01 a.m., in Room 334, Cannon House Office Building, Hon. Dan Benishek [Chairman of the Subcommittee] presiding.

Present: Representatives Benishek, Roe, Coffman, Wenstrup, Abraham, Brownley, Takano, Ruiz, Kuster, and O'Rourke.

Also Present: Representatives Bost, Walorski, and Zeldin, and Kuster.

OPENING STATEMENT OF DAN BENISHEK, CHAIRMAN

Mr. BENISHEK. The Subcommittee will come to order, and before we begin, I would like to ask unanimous consent for our colleagues and fellow Committee Members, Representative Zeldin from New York, Representative Bost from Illinois, Representative Kuster from New Hampshire, and Representative Walorski from Indiana, to sit on the dais and participate in today's proceedings. So without objection, so ordered.

Good morning, and thank you all for joining us for today's legislative hearing. Our agenda this morning includes six bills. The bills are H.R. 2460, to improve the provision of adult day health care services for veterans; H.R. 3956, the VA Health Center Management Stability and Improvement Act; H.R. 3974, the Grow Our Own Directive: Physician Assistant Employment and Education Act of 2015; H.R. 3989, the Support Our Military Caregivers Act; and draft legislation to ensure that each VA medical facility com-

plies with the requirements related to scheduling veterans for health care appointments, and to improve the uniform application of directives; and draft legislation to direct the VA to establish a list of drugs that require an increased level of informed consent.

These pieces of legislation cover a wide range of topics facing our veterans and their families. One bill on our agenda that I look forward to discussing is H.R. 3956, the VA Health Center Management Stability and Improvement Act. This bill, which is sponsored by Representative Bost, would require the VA to develop and implement a plan to hire directors at VA medical facilities, prioritizing those that have been without permanent leaders for the longest time. The number of VA medical facilities that have gone without stable, consistent, long-term leadership is alarming. We have to encourage the VA to take every possible action to bring high-quality leaders to the helm.

Another bill I look forward to discussing is H.R. 2460, a bill sponsored by Lee Zeldin that would authorize the VA to cover costs for adult day health care at State veterans' homes for certain veterans. It is critical that we increase long-term care options for our veterans, particularly for those who can and want to live at home for as long possible, but need additional assistance during the day.

I am also here to discuss H.R. 3989, a bill sponsored by Representative Stefanik, to address the growing application backlog in the Family Caregiver Program, and draft legislation sponsored by Representative Walorski to ensure that VA medical facilities comply with scheduling directives.

I am grateful to all my colleagues for introducing the bills on our agenda this morning and thank them for being here today to discuss them with us. I am also grateful to the representatives from our veterans service organizations and to the Department of Veterans Affairs for being here this morning as well, and I will now yield to the Ranking Member, Ms. Brownley, for any opening statement she may have.

OPENING STATEMENT OF JULIE BROWNLEY, RANKING MEMBER

Ms. BROWNLEY. Thank you, Mr. Chairman, and thank you for holding this hearing today. Among the many bills being considered today is my draft legislation on increased informed consent. Over the past few years the Committee on Veterans Affairs has heard testimony from veterans using opioids for long-term pain management and the severe side effects that are often associated with that treatment. Time and time again we have heard from veterans who were not fully aware of the potential side effects of these medications or that alternative treatments to prescription medications were, indeed, available. My draft legislation is designed to open up a meaningful dialogue between the veteran and the physician by raising the standard for informed consent for certain drugs prescribed by doctors at the Department of Veterans Affairs. It would also require the Veterans Health Administration to form a clinician panel that would establish and maintain a list of drugs which may only be furnished to a patient with increased informed consent. In the past few years, the VA has worked to address the prescription drug crisis. While I appreciate the Department's work to prevent

prescription drug abuse and overdoses, I still feel their efforts have not gone far enough. The goal for the draft legislation is to encourage a real conversation between the veteran and doctor at the point when a treatment plan is presented to the veteran and a conversation that goes beyond the VA's existing standardized form, which was last updated in 2014. Under the discussion draft, if a drug identified by the clinician panel, is prescribed by a VA doctor, that provider would prepare and present a written, improved consent form to the patient.

For drugs with improved informed consent, the veteran's doctor would provide written information and discuss with the veteran the risk of dependency, known interactions between the drug and other drugs or substances including alcohol, if the drug has an FDA black box warning, and if any alternative treatments are available and might be helpful. This form would not require the patient to commit to that treatment plan. It would also give the patient the opportunity to review the information provided regarding the recommended treatment and any other possible treatments. Additionally, the patient would have the opportunity to speak to a VA pharmacist if the patient has additional questions about the drug being described. I recognize that veterans, their families, or, indeed, some Members of this Committee, like me, are not experts in medical care. The intent of this legislation is to not tell doctors how to treat their patients, but to ensure that veterans are confident they have the information they need to make an informed decision about what would be best for their long-term health. Before they pick up that first prescription, the veteran deserves to have all of their options laid out.

Since the discussion draft was released, I have received support on the principles behind the draft from many veteran groups and constructive comments from health care providers regarding the scope of the language. I look forward to working with all interested parties to improve on the proposal and bring some level of control and decision back to the veteran when the treatment of his or her injury or illness is being addressed.

I thank the VA for their testimony this morning as well as their willingness to meet with my staff to address the concerns raised in the draft language. We can all agree that including the veteran in the decision-making process in a meaningful way is the right way to go when it comes to the veteran's health care. This language is my attempt to bring that about.

Thank you for this opportunity, Mr. Chairman, and I yield back the balance of my time.

Mr. BENISHEK. Thank you, Ms. Brownley. I am honored to be joined this morning by several of my colleagues to speak in support of their legislation. I think Mr. Zeldin will be joining us. We do have the Honorable Mike Bost from Illinois, the Honorable Ann Kuster from New Hampshire, the Honorable Elise Stefanik from New York, and the Honorable Jackie Walorski from Indiana. Thank you all for being here today.

I am going to yield first to Representative Stefanik and then Mr. Bost because I understand they both have markups to attend in other Committees this morning.

So Representative Stefanik, please proceed with your testimony.

STATEMENT OF ELISE M. STEFANIK

Ms. STEFANIK. Chairman Benishek, Ranking Member Brownley, thank you for the invitation to testify on this important legislation. I truly appreciate the opportunity to appear before you and look forward to discussing this key issue. As a Member of the House Armed Services Committee with a critical Army base and Navy nuclear training facility located in my district, I am dedicated to providing support to servicemembers, veterans, and their families.

Since September 11, 2001, the Army's 10th Mountain Division at Fort Drum has been the most actively forward deployed division in the global war on terror. Over the last 15 years of war, our servicemembers have bravely served our Nation, and their families have sacrificed an immeasurable amount. So it is vital that we ensure they receive the best possible care. This is especially true for our military caregivers, loved ones of our servicemembers who selflessly care for our heroes behind the scenes. These men and women are often left out when discussing veterans' issues. Military caregivers are essential component of the communal and family support system for our disabled veterans. They are usually spouses and other family members who spend their days transporting and caring for disabled veterans in order to provide an environment that enhances their everyday lives.

In 2010, Congress passed a law implementing the Family Caregiver Program. This was an important piece of legislation that made veterans who sustained injuries in the line of duty eligible for a package of benefits that includes access to a primary caregiver. These benefits would ensure that the family members who dedicate their lives as caregivers, receives access to health care, caregiver training, and stipends for additional costs associated with their disabled veteran. Unfortunately, the Department of Veterans Affairs has had a difficult time managing the high demand of family caregiver enrollees, which is much larger than originally accounted for during implementation.

According to the Government Accountability Office, VA officials estimated they would receive 4,000 enrollees and staffed the program based on this estimate. However, in the first few months of implementation, there were over 15,000 enrollees to the Family Caregiver Program. VA medical centers lack sufficient caregiver support coordinators and the necessary clinical staff to carry out medical assessments for eligibility for this program. These implementation issues have led to a delay in both the application and the appeals process. Application deadlines are not being met by their own internal standards, and the staff is still shorthanded.

These issues are not only unacceptable, but I believe they are preventable, and after meeting with a constituent who is a caregiver facing the burden of the VA backlog, I introduced H.R. 3989, the Support Our Military Caregivers Act. This bill would use pre-existing funds already appropriated for the current review and appeals process to then allow for an objective, independent party to conduct external clinical reviews. This bill would ensure that new, or modified processes are veteran-centric, outcome-based, and continually improved through the use of best practices. We can accomplish this by permitting a third party to work within the VA to streamline claims and reduce the caregiver backlog through a more

clinical analysis, rather than benefits adjudication. The VA would maintain this third party until appeals are streamlined, and the backlog is down to an acceptable rate and addresses the issues highlighted by the GAO.

Military caregivers are truly the silent heroes in our communities and deserve the respect and benefits proportionate to their significant contributions. I would also like to highlight that this legislation is supported both by the Elizabeth Dole Foundation and American Veterans. I look forward to discussing this issue further in order to implement a solution and get our military caregivers the benefits they deserve. Thank you.

[THE PREPARED STATEMENT OF ELISE STEFANIK APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you very much, Ms. Stefanik. Mr. Bost, you are now recognized.

STATEMENT OF MIKE BOST

Mr. BOST. Thank you, Mr. Chairman, Chairman Benishek, Ranking Member Brownley. Thank you for allowing me to testify on this bill today. We must be very, very careful in consideration of how to reform the Department of Veterans Affairs and ensure access to quality health care our veterans deserve. As a Marine and the father of a Marine, I recognize the sacrifices that so many Americans have made in defense of our freedom. There is no doubt that we must fight for the brave men and women who have fought for us. I know my colleagues on both sides of the aisle feel the same way. But we need steady leadership and long-term vision. No organization can operate under a revolving door of interim leadership, and certainly not one that is given the task of caring for our American heroes.

Yet, this revolving door is occurring at VA medical centers across this country. This undermines the quality and speed of the care that our veterans receive. That is unacceptable. That is why I introduced House Resolution 3956, the VA Health Center Management Stability and Improvement Act. The bipartisan legislation requires the VA Secretary to create a plan for hiring a permanent and qualified director at every VA Medical Center. My bill is endorsed by the American Legion, Vietnam Veterans of America, Paralyzed Veterans of America, AMVETS, Disabled American Veterans, and the Association of the United States Navy.

The issue first came to my attention in my own back yard. Many southern Illinois veterans receive treatment from the St. Louis VA Medical Center. The St. Louis VAMC provides health care for 45,000 veterans annually, all under the cloud of temporary leadership. I remain very concerned about the lack of stability and how it impacts system operations.

Over the last several years, the St. Louis VA has been managed by more than seven different acting directors. After I began looking into the local issue at the St. Louis VA Medical Center, it came to my attention that this isn't a problem that just exists in that area. Upon further investigation, I found dozens of VA medical centers that have lacked a permanent director for quite some time.

The problem is due to the OPM requirements, which stipulate that the temporary directors can serve no more than 120 days with a 240-day maximum total if their tenure is extended. The lack of stability and permanent leadership is no doubt one of the reasons the Department of Veterans Affairs has been struggling to provide appropriate health care to those it serves. House Resolution 3956 seeks to fix the problem and fix it now. Specifically, it requires the VA Secretary to, one, report the status of any unfilled vacancy to the House and Senate Veterans' Affairs Committee; two, identify possible issues leading to the lack of staffing for these unfilled permanent positions, directors' vacancies; three, assess the possibility of promoting and training qualified candidates from within the VA for promotion to these leadership positions; four, develop a plan to hire highly qualified medical directors for each VA Medical Center which lacks a permanent director; and, five, submit this plan to Congress within 120 days of enactment of the bill.

I have reached out to my local congressional colleagues and sent letters to the department regarding the lack of leadership at the St. Louis VAMC. Last week, I received a reply from the VA Under Secretary of Health giving me an update on the issue. According to his timeline, the St. Louis position has been vacant since July 14, 2013. That is 33 months. I have enclosed a copy of the St. Louis VA Medical Center Director timeline with a formal statement to illustrate just how long this gap has been.

This problem doesn't end in St. Louis. Unfortunately, similar scenarios can be found in the Department of Veterans Affairs Medical Centers across the country. According to the VA Health Under Secretary Shulkin yesterday, in his testimony before this Committee, there are currently 34 VAMCs without permanent directors. House Resolution 3956 would help improve the leadership at the VA medical centers and so many of our Nation's veterans rely on.

I thank the Subcommittee for considering House Resolution 3956, and I look forward to working with you in a bipartisan way to advance this legislation, and thank you. And I yield back.

[THE PREPARED STATEMENT OF MIKE BOST APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you very much, Mr. Bost. Ms. Kuster, you are now recognized.

STATEMENT OF ANN M. KUSTER

Ms. KUSTER. Thank you very much, Chairman Benishek, and Ranking Member Brownley, and the Members of the Subcommittee, for the opportunity to discuss H.R. 3974, the Grow Our Own Directive: Physician Assistance Employment and Education Act of 2015. Our full Committee has worked hard to improve veteran access to health care and to create opportunities for veteran education and employment. This legislation will allow us to merge those efforts and allow veterans to continue serving their country while in service to their fellow veterans.

In the 14-1/2 years since September 11, and the 13 years since the invasion of Iraq, the men and women of the United States military have repeatedly demonstrated their skill, valor and professionalism. They have repeatedly placed their lives on the line, been

separated from their families, and deferred their own personal life goals in order to serve our country. As many in this room recognize, that service on our behalf creates an obligation on our part to ensure that our veterans have the opportunity to succeed, and have access to the medical care they may require.

Veterans today often leave the service with an incredible skill set. Our corpsmen and medics have proven medical experience in high-pressure training and real-world environments. They have also demonstrated an interest in public service by volunteering to serve in the military, and many hope to continue in service to the public after they leave active duty. Meanwhile, as this Subcommittee in particular knows well, veterans often face challenges in accessing care. As we discussed last week, sometimes this is due to IT and scheduling changes, but at other times, it is due to a lack of medical providers available.

In a time of shortage for primary care providers both in the private sector and in the VA, with the Office of Inspector General listing physicians assistants as one of the VA's top five occupations with the largest staffing shortages, creating a pathway of opportunity for our veterans to fill that gap, and continue to serve their country seems to me to be like an excellent opportunity. H.R. 3974 would accomplish that objective by creating a pilot program to provide educational assistance to qualifying veterans for education and training as VA physician assistants.

A veteran would qualify for this program who has medical or military health experience gained while serving in the Armed Forces, has received a certificate, Associate's degree, Baccalaureate degree, Master's degree, or post-baccalaureate training in a science related to health care, has participated in the delivery of health care services or related medical services, and does not have a doctorate in medicine, osteopathy, or dentistry.

Eligible veterans would be able to apply during the 5-year pilot program to receive one of 35 scholarships available each year to cover the cost of obtaining a Master's degree in physician assistant studies or a similar Master's degree. Selection would be prioritized for those veterans that participated in an earlier veteran recruitment program known as the Intermediate Care Technician Pilot Program, and those veterans agreeing to be employed by the VHA in a community that is medically underserved and in a State with a significant veteran population.

Those veterans that use the program would then owe the VHA a period of obligated service, based either on the scholarship program used or 3 years. To ensure that veterans are prepared to succeed, participants will be paired with a mentor at their facility, and the VA will partner with institutions of higher learning to guarantee physician assistant educational seats.

As it is currently written, the bill would also establish standards to improve the education and hiring of VA physician assistants, and enhance retention and recruitment through competitive pay standards. As this bill moves through the House and the Senate, there have already been several discussions to find ways to improve the bill to increase its chances of passage and to create this opportunity for our veterans. I am happy to continue those con-

versations in the coming weeks and days, and based on feedback from this hearing and from my colleagues.

Mr. Chairman, this concludes my statement, and I would be happy to answer any questions. Thank you.

[THE PREPARED STATEMENT OF ANN KUSTER APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you very much, Ms. Kuster. Ms. Walorski, you are now recognized.

STATEMENT OF JACKIE WALORSKI

Mrs. WALORSKI. Thank you, Mr. Chairman. Good morning, and good morning, Ranking Member Brownley and my fellow colleagues. I appreciate the opportunity to discuss House Resolution 4977, the VA Scheduling Accountability Act.

In 2014, news reports uncovering gross mismanagement and schedule manipulation at a Department of Veterans Affairs hospital in Phoenix shook us all to the core. Through hearings held in this Committee and investigations by the VA, OIG, and GAO, we, together, substantiated many of the allegations of manipulated schedules and falsified wait times data at the Phoenix facility. The manipulation of appointment schedules and data in Phoenix led to at least 40 veterans dying while they were waiting for care. However, as we all took a closer look, we discovered that, sadly, this was not an issue unique to Phoenix. It was systemic.

Here we sit 2 years later, digging deeper into some of the root causes to ensure that no veteran ever dies again waiting for care. So I introduced legislation this week, the VA Scheduling Accountability Act, that gets at one of the key drivers of the wait-time manipulation, a 2010 VA directive in VA's implementation processes and procedures policy for scheduling at their facilities, and contains 19 different items on the checklist. The directive requires the annual certification of full compliance with all items on the list. For instance, facilities are required to ensure completion using VISN-approved processes and procedures of a standardized yearly schedule or audit of the timeliness and appropriateness of scheduling actions and of the accuracy of desired dates.

They are also required to ensure that deficiencies in competency or performance are identified by the annual schedule or audit are effectively addressed. An August 2014 OIG report uncovered that in May of 2013, the then-Deputy Under Secretary for Health For Operations Management waived that fiscal year 2013 annual requirement for facility directors to certify compliance with the VHA scheduling directive, allowing facilities to only self-certify reduced oversight, over wait time, data integrity, and compliance with appropriate scheduling practices. This, in turn, allowed VA's data to be easily manipulated, contributing to the wait-time scandal. There was a noticeable substantial improvement in VHA's appointment scheduling after VA waived the directive, but as we all know now, that improvement was an illusion.

Although VA has reinstated the certification requirement, there is nothing stopping them from waiving it again. The VA Scheduling Accountability Act would simply require each facility's director to annually certify compliance with a scheduling directive or any suc-

cessor directive that replaces it, and it prohibits any waivers in the future.

Should a director be unable to certify compliance, either because the facility is not in compliance, or the director refuses to sign the certification for some other reason, the director must submit a report directly to the Secretary explaining why the facility is out of compliance. The Secretary will then have to report yearly to the House and Senate VA Committees with a list of facilities in compliance and those that are not with an accompanying explanation as to why they were not in compliance. This will provide more oversight of the Department and ensure Congress is aware when VA is waiving these policies.

Waiving compliance requirements was a key driver in the wait-time scandal, which continues to be an issue at the Department. This legislation will begin to end that reckless practice once and for all, while increasing accountability and transparency at the VA, as we work on ways and continue to work on ways to ensure that those who risk their lives for their country receive the prompt quality care that they have earned.

I look forward to working with the Members of this Committee, veterans service organizations, and the VA, addressing this critical issue, and I, again, thank you for allowing me the opportunity to speak today. And I yield back.

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

Mr. BENISHEK. Thank you, Ms. Walorski. Mr. Zeldin, you are recognized.

STATEMENT OF LEE M. ZELDIN

Mr. ZELDIN. Good morning, Chairman, and thank you for the opportunity to testify on behalf of my bill, H.R. 2460, which provides no-cost medical model adult day health care services for our 70 percent or more service-connected disabled veterans. It must always be a top priority of Congress to ensure that all veterans receive the proper treatment and care they deserve after fighting for our country. While overseas, these brave men and women are exposed to hardships and trauma, and when they come home, many return with the physical and mental wounds of war. Despite various care options for veterans, their choices are often limited and can come at a great expense.

Servicemembers who are 70 percent or more disabled from a service-connected injury often require significant assistance from others in order to carry out basic everyday tasks. In many instances, veterans must rely on family members for assistance, creating many financial and emotional hardships. Alternatively, some veterans, without the proper support system, may even be forced to rely on the assistance of trained medical professionals and reside in an institutionalized facility for daily assistance. Veterans in these facilities often spend significant sums of money each day just to be enrolled, and these expenses can be expected to span the remainder of the veteran's life in many cases.

While alternative options currently exist, accessing these services, however, can often be very difficult. One such program that

is currently available is adult day health care, a daily program for disabled veterans who need extra assistance and special attention in their day-to-day lives. Adult day health care programs provide disabled veterans and their families with a high-quality alternative to nursing care, providing quality outpatient services for those suffering from debilitating illnesses or disabilities.

These programs provide a range of services from daily activities such as bathing, to full medical services like physical therapy. Adult day health care is only offered currently at three facilities in the United States. Long Island, where I represent, is fortunate to be the home of one of these three locations, which offer adult day health care, the Long Island State Veterans Home in Stony Brook, New York.

But this program could easily be offered at any of the 153 State veterans homes across the country. However, the Department of Veterans Affairs does not currently cover the cost of participation in this program at State veteran homes, and the expense of the program is put directly on the veteran and their family, which significantly limits the number of veterans who can enroll.

In an effort to address this and expand access to care for our heroes, I introduced bipartisan legislation, H.R. 2460, which would ensure that 70 percent or more service-connected disabled veterans are able to receive adult day health care at no cost to the veteran and their family by defining the program as a reimbursable treatment option through the VA. My bill would guarantee that all severely disabled veterans are able to access adult day health care.

By providing disabled veterans with access to adult day health care programs, we can assure that all veterans receive the best and most efficient outpatient services to provide them with the assistance and special attention that they need in their day-to-day lives, while still allowing them to maintain their independence.

Adult day health care also helps keep families together and strong. With the inclusion of adult day health care services as a covered VA expense, family members and caregivers can rest easier knowing that their loved ones are receiving topnotch care during the day, while being treated with the same respect and dignity that they would receive at home.

Not only does the adult day health care model care for the medical needs of a veteran, but it also addresses their social and emotional needs as well. Adult day health care allows veterans to interact and socialize with their peers and other individuals enrolled in the program. Rather than sitting home alone all day, participants in the adult day health care program receive one-on-one attention from medical and support staff, while also maintaining an active social schedule through planned events and activities. Family members and caregivers can go about their day without the worry that their loved ones are unattended, and the veterans can continue to remain as active members of their community.

It should be noted that treatment at adult day health care is \$40 to \$50 less on average than nursing care would cost.

It is a top priority of mine to ensure that all veterans on Long Island and across the country receive the proper treatment and care they deserve, which is why I fully support the adult day

health care program. Thank you, Chairman, and I yield back the balance of my time.

[THE STATEMENT OF THE HONORABLE LEE ZELDIN APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you, Mr. Zeldin. Do any of the Members here have questions for these Members that have proposed legislation before us? Dr. Roe.

Mr. ROE. I do. I think one of Ms. Brownley's legislation, I, at least from a practicing-physician standpoint, it makes it extremely difficult as it is. I would like to work with you on that, but this is virtually impossible to do as it is currently written. There is not enough time in a day to go through all the possibilities that you have laid out.

And I pulled up fluoxetine, which is Prozac, and just went through the list of side effects of that drug. It would take you a day to go through all that the way it is listed. I think, certainly, the intent is to inform people about the possibility of addiction to opioids. That, everybody at this dais agrees on. The question is just how to do it. I know as I read this, I thought I don't see how I could do this the way it is currently written and see patients the rest of the day. I would like to hear some of my other colleagues step up, Dr. Ruiz or others. I will yield to Ms. Brownley.

Ms. BROWNLEY. Thank you, Dr. Roe, and I appreciate the comments and would like very much to work with you. I think, you know, part of the bill says we are going to set up a panel of clinicians to decide those, in my layman terms, most dangerous drugs to have this interaction with. So it wouldn't be—Prozac probably wouldn't be on the list. It would just be those opioids and other kinds of high-level drugs that we see as sometimes can have the wrong effect.

So, I think, you know, this is draft legislation right now. That means it still needs to be worked on, but I wanted to introduce it to the Committee to get people's feedback so that we can get to a bill that everyone can support, so I appreciate the feedback.

Mr. ROE. I would like to work on it. And just to give you an example here of one particular drug, if you have stiff muscles, high fever, sweating, fast or uneven heartbeat, tremors, overreactive reflexes, nausea, vomiting, diarrhea, loss of appetite, feeling unsteady, loss of coordination, headache, trouble concentrating, memory problems, weakness, confusion, hallucinations, fainting, seizures, shallow breathing, breathing that stops—I would certainly think that would be a problem—skin reactions, fever, sore throat, swelling on your face or tongue, burning on your skin—I could go on for another 15 minutes.

So this is why I think we have to back up and really narrow this down so that we—people understand, look, if I am progressively increasing more and more narcotic, I have a high-risk. That is something fairly reasonable. I would love to work with you on it. I know the intent, but the application of this could be very difficult, I think.

Ms. BROWNLEY. Very good. Thank you.

Mr. BENISHEK. Any other questions? Well, I thank—I guess most of the people on that panel are gone. Ms. Kuster, thank you for

participating this morning. I appreciate you being here. So the first panel is excused.

I now welcome our second panel to the witness table. Joining us on the second panel is Diane Zumatto, the National Legislative Director from AMVETS; Shurhonda Love, the Assistant National Legislative for the Disabled American Veterans; and Fred Sganga, the Legislative Officer for the National Association of State Veteran Homes. I would like to thank you all for being here and for your hard work and advocacy on behalf of our veterans, so I look forward to hearing the views of your Members.

And, Ms. Zumatto, you may begin when you are ready.

STATEMENT OF DIANE M. ZUMATTO

Ms. ZUMATTO. Thank you, Mr. Chairman. I am happy to be here today on behalf of AMVETS. Before I begin my specific remarks, I just want to ask that this Committee remembers that the health care obligations imposed by the sacrifices of our veterans are met in a timely, professional, and compassionate manner. I would also urge you to reject any plan to eliminate the VA from hands-on care of our veterans.

As far as H.R. 2460, AMVETS supports this legislation, which seems like the best of both worlds in that it provides the appropriate and necessary care for veterans in a more cost-effective manner, while also providing an improved quality of life. The legislation directs the Secretary of the VA to enter into an agreement or contract with each State home to pay for adult day health care for a veteran eligible for but not receiving nursing home care.

H.R. 3956, AMVETS supports this legislation, which seems to be a bit of a no-brainer to us. Medical centers without directors will most likely not perform as well or as consistently as those that do.

H.R. 3974, AMVETS supports the legislation which builds upon and leverages the training and experience of former military members. This bill directs the VA to carry out the Grow Our Own Directive Pilot Program to provide educational assistance to certain former members of the Armed Forces for education and training as VA PAs.

3989, AMVETS is very supportive of this bill, which permits an individual to elect to have an independent contractor perform an external clinical review related to their caregiver or their caregiver benefits. This is important because things change over time. The needs of both the veteran and the caregiver are likely to change, including but not limited to, the amount of care the veteran requires, could increase or decrease the amount of time the caregiver has available to assist that veteran, could increase or decrease.

The caregiver might prove to be unable to perform the necessary duties. The caregiver also might prove to be unethical or irresponsible, and their level of expertise will change. So we just feel that this will provide a much-needed way out of a possibly unsuitable situation.

The draft legislation to ensure that VA medical facilities comply with requirements related to appointment scheduling and to improve the uniform application of directives, AMVETS feels strongly that there needs to be continuity across the VA health care system, and this bill should help to make that recommendation a reality.

Finally, draft legislation on informed consent. This is a top issue for AMVETS, and we wholeheartedly support this legislation, because we believe that the health and welfare of our veterans needs to come first. This means that their interests come before any VA employees, including physicians. AMVETS believes that having the veterans buy-in and clear understanding of any proposed risky medications will not only provide much-needed peace of mind for the veteran and their family, but will be instrumental in the overall healing process. An informed patient is much more likely to fully comply with their doctor's instructions, and much less likely to complain or be dissatisfied with their treatment.

Let me be clear that our intention in supporting this legislation is not to burden or disrespect VA doctors, but to provide veterans the opportunity to be more actively involved in their health care treatments. In order to minimize the burden on physicians, AMVETS suggests utilizing nationally standardized medical educational materials which could be adopted by the VA and made available, either digitally or in a preprinted format, such as a medication guide.

All of the medications which would require informed consent would either be available in a database, whereby each medication with its additional information could be printed for each specific covered medication and provided to the patient. If utilizing the preprinted medication guide, each covered medication would be included with all of the same additional information as the database option, which is in the written testimony, so I am not repeating that. The physician would then merely have to check off the recommended medications and hand that information to the patient. In both cases, a consent form would be provided to the patient for his or her signature in either an electronic or paper format.

The patient's signature, at this point, merely indicates that they have been provided with the information regarding any covered medications and should not yet be understood as an acceptance of the proposed treatment plan. At this point, the patient should be given the opportunity to ask any immediate questions of the physician, or the veteran could be referred to a pharmacist for further information. The patient then would be given 3 full business days from the issuance of the initial recommended prescription to either consider and internalize the information provided by the doctor, conduct any additional research, seek a second opinion, discuss with family, or get a legal opinion. At the end of the three-day period, the patient would then convey their approval or disapproval of a suggested medication or medications by a secure messaging, phone, email, or fax, directly to the prescribing physician or his or her office. The veteran's signature, along with the follow-up, whether it is oral or written at the end of the 3 days would jointly fulfill the informed consent signature requirement, so there would be no further reason for the veteran to return to the doctor's office on this matter, unless there were extenuating circumstances.

It appears that I have gone over time, so I am going to leave it at that, and I would be happy to answer any questions. Thank you.

[THE PREPARED STATEMENT OF DIANE ZUMATTO APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you very much. Ms. Love, you are recognized.

STATEMENT OF SHURHONDA Y. LOVE

Ms. LOVE. Mr. Chairman, and Members of the Subcommittee, thank you for inviting DAV, Disabled American Veterans to testify at this legislative hearing. As you know, DAV is a nonprofit veterans service organization comprised of 1.3 million service-disabled wartime veterans.

I will provide comment on three of the bills before the Subcommittee. My written statement covers all bills and drafts relative to this hearing. DAV is pleased to support the intent of the discussion draft for increased informed consent. However, we recommend VA include pharmacy personnel on all PACT teams to lessen the burden on physicians.

H.R. 2460, if enacted, would authorize the Secretary to enter into agreements with State veteran homes to provide adult day health care for veterans who are eligible for but not receiving skilled nursing home care. Eligible veterans are those who require such care due to service-connected disabilities, or who have a disability rating of 70 percent or more disabling, and are in need of such care. The payment to the State home under this program would be at the rate of 65 percent of the amount that would be payable to the State home if the veteran were an inpatient receiving nursing care. Payment by the VA would then be considered payment in full.

The adult day health care program is a program for veterans who need assistance with activities of daily living, nursing services, and case management. It is also beneficial for those veterans with caregivers who may be experiencing isolation from their own lives, and are in need of respite from the constant care of their loved ones. During the time spent at the adult day health care program, veterans receive the health care services they need in addition to peer support, companionship, recreation, and social activities. The health care services received would be based on their personal needs, and could range from a full or half day, two to three times per week.

Veterans want to be independent for as long as they can without being burdensome to their families. In addition, they still want to remain an active part of the family unit. Adult day health care helps to accomplish this goal by allowing the caregiver respite to take care of their personal needs while the veteran has an opportunity to interact with their peers while obtaining the health services that they need.

DAV is pleased to support H.R. 2460, which is in line with DAV Resolution No. 101 adopted at our most recent national convention calling for the support of State veteran home programs, recognizing State home care as the most cost-effective care available for sick and disabled veterans with long-time health care needs outside of the VA health care system.

H.R. 3989, if enacted, would establish an external review process in cases in which the VA has denied caregiver benefits, approved a level of benefits considered inadequate to the needs, or revoked benefits. A decision on this review, once requested by the caregiver, would be required by the bill to be completed within 120 days. DAV

has continued to express the need for an independent mechanism through which a caregiver can appeal the clinical team's decision. That decision can be reviewed de novo, and an unwarranted decision can be reversed, altered, or sent back to the clinical team with instructions to reassess or consider additional factors.

H.R. 3989 offers a review of VA decisions. However, it is unclear if the review will be binding on VA, or whether the recommendations from the contractor would be cause for VA to issue a new decision based on the review findings. For caregivers who feel they are unduly denied benefits, VA must establish a systematic recourse and provide a publicly accessible program handbook, or directive, outlining mandatory program policies, procedures, and operational requirements, which would serve to inform and educate those enrolled and seeking enrollment into the program.

DAV is pleased to support H.R. 3989, as it is in line with DAV Resolution No. 106 calling for legislation to provide comprehensive support and services to caregivers of all veterans severely injured, and ill, from military service.

DAV has no objection to the passage of the remainder of bills before the Subcommittee.

Mr. Chairman, DAV appreciates the opportunity to provide testimony. I will be pleased to address any questions you or the Subcommittee Members may have on these bills.

[THE PREPARED STATEMENT OF SHURHONDA LOVE APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you, Ms. Love. Mr. Sganga, you are recognized.

STATEMENT OF FRED S. SGANGA

Mr. SGANGA. Mr. Chairman, and Members of the Subcommittee, thank you for this opportunity to testify in support of H.R. 2460, introduced by Congressman Lee Zeldin of New York, to provide severely disabled veterans with an enhanced option to receive adult day health care services from a State veterans home. I am Fred Sganga, the legislative officer and past president of the National Association of State Veterans Homes. I also have the high honor of serving as the executive director of the Long Island State Veterans Home at Stony Brook University, a 350-bed State veterans home that also operates a 40-slot medical model adult day health care program.

Mr. Chairman, a decade ago, Congress passed legislation to assist our most disabled veterans by allowing them to receive skilled nursing care in State veterans home under a new program where VA paid the full cost of care to the State veterans home with no cost charged to the veteran. Unfortunately, the law did not cover alternatives to traditional institutional care, such as medical model adult day health care, which is currently being provided at three State veterans homes in Stony Brook, New York; Minneapolis, Minnesota; and Hilo, Hawaii.

H.R. 2460 would fix that. Adult day health care is designed to promote wellness, health maintenance, socialization, stimulation, and maximize the participant's independence while enhancing their quality of life. A medical model adult day health care program also

provides comprehensive medical, nursing, and personal care services.

As a licensed nursing home administrator, I would like to thank Congressman Zeldin for recognizing the need to offer noninstitutional alternatives to our veterans. The legislation would also be especially important to veterans like Jim Saladino and his wife, Noreen.

Fifty years ago Jim answered the call of his country and served in the United States Army during the Vietnam War. Today Jim suffers from the ravages of Agent Orange exposure, including diabetes and Parkinson's disease. He also recently suffered a stroke. The Saladino family could have easily decided to put Jim into my nursing home because he is a 100 percent service-connected veteran, and his nursing home care would have been fully paid for by the VA, but this is not their choice.

They would like their loved one to continue enjoying the comforts of his own home for as long as he can, and our medical model adult day health care program does just that. Three days a week, we pick up Jim and bring him to our home. Working closely with his personal physician, we provide services to help maintain his wellness and keep him out of the emergency room, and even avoid unnecessary hospitalizations. During his 6-hour day with us, Jim receives a nutritious breakfast and lunch. He receives comprehensive nursing care. He also receives physical therapy, occupational therapy, and speech therapy. He can get his eyes checked by an optometrist, his teeth cleaned and examined by our dentist, his hearing checked by our audiologist. If required and his physician orders it, we can get him a blood test, or even an X-ray. We can have his vital signs monitored, and we can even bathe and groom him while he is on site. For Jim's wife, Noreen, his primary caregiver, this program gives her peace of mind knowing that he is in a safe and comfortable environment, and allowing her to get a break.

However, because of the way the law is currently structured, despite Jim's eligibility for no-cost skilled nursing care, the Saladinos are required to pay out of pocket for a portion of Jim's adult day health care. Mr. Chairman, H.R. 2460 will fix this disparity by authorizing the VA to enter into agreements with State veterans homes to provide adult day health care for veterans who are eligible for but do not receive skilled nursing home care under the current full cost of care program. The payment to the State veterans home under this program would be at a rate of 65 percent of the full amount paid for skilled nursing care, the full cost of care program. This will save the VA money while keeping veterans like Jim Saladino in their own home.

For the Saladino family, receiving no cost medical model adult day care would relieve a huge financial burden they currently incur. Even though Jim's service ended 50 years ago, he is still paying the price for his valor related to his service in Vietnam.

Passing H.R. 2460 would send a strong message to all those who have worn the uniform to protect our freedoms that they will never be forgotten. H.R. 2460 has bipartisan support in the House, and has also been supported by the DAV, VFW, American Legion, AMVETS. I would also ask that the Legion's letter of support be made part of the record.

On behalf of the National Association of State Veterans Homes, I urge you to approve H.R. 2460 for Jim and Noreen Saladino and for thousands of others across the country just like them.

Mr. Chairman, that concludes my testimony, and I would be happy to answer any questions you or Members of the Subcommittee may have, and thank you again for this opportunity.

[THE PREPARED STATEMENT OF FRED S. SGANGA APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you, Mr. Sganga. I am going to yield myself 5 minutes for questioning. I just have a couple questions that relate to the bill of Mr. Zeldin.

Mr. Sganga, the VA is going to testify because of the level of services for adult day care and nursing home care are different, and the period of time in which services are furnished are different, they believe that the payment rate proposed for 2460 was inappropriate.

So, would you please respond to that assertion and explain what, if any, the monetary benefit is available to veterans or to State veterans homes through the VA through adult day health care, and why the provisions and the rate in H.R. 2460 are appropriate and necessary in your opinion?

Mr. SGANGA. Well, in my opinion, back in 2006 when Congress had said any veteran who is 70 percent or more service-connected disabled is entitled to skilled nursing care, it didn't include adult day health care. Currently in my home, I am being paid \$489 a day to care for that veteran who falls into that category. At 65 percent of that rate, I would be paid about \$318 a day. That includes, Chairman Benishek, transportation to and from the home. Clearly \$318 a day is less than \$489 a day and it would allow the veteran to live in the comfort of his or her own home.

I think what we used as a model was recognized by CMS. In the State of New York, if you receive nursing home care, the State of New York will reimburse that same nursing home who provides adult day health care at a rate of about 65 percent. So that 65 percent number is a highly recognized number within CMS.

Mr. BENISHEK. So the services that you described in your testimony, the veteran gets a bed then for the day, and then he may get his bath—

Mr. SGANGA. That is a great question. Let me give you an example. We had an 85-year old Marine who was going to be admitted into the home. His wife could feed him. She could put his clothes on. She could even assist him with toileting. But what puts people in nursing homes is their ability to deal with their activities of daily living. For this spouse, she couldn't bathe this gentleman, and for that reason, he qualified for the nursing home. We provided her with the alternative of adult day health care, and now he comes to program 3 days a week, and now when he comes to the program, we bathe him in the program, put him in a clean set of clothes, and send him home at the end of the day. This couple got to enjoy their 65th wedding anniversary in their own home living together. So it is those kinds of stories that we want to help our vets with.

Mr. BENISHEK. Let me get this straight now. So these are veterans that are actually eligible for nursing home care?

Mr. SGANGA. Yes. And the VA pays for it.

Mr. BENISHEK. So this would keep somebody out of a nursing home—

Mr. SGANGA. Correct. At lesser cost.

Mr. BENISHEK [continued].—and cost the VA less than if they had applied to go to a nursing home?

Mr. SGANGA. That is correct.

Mr. BENISHEK. That makes a lot of sense then. I will yield back. Ms. Brownley, do you have any questions?

Ms. BROWNLEY. Yes, just briefly. And first, I wanted to thank Ms. Zumatto for helping and working with our staff in terms of drafting the legislation in my draft bill, so thank you very much for that.

I think I just wanted to ask all three of you, really, you know, I think the goal of this bill is to really kind of reach a level of excellence in terms of, you know, the appropriate communication between the doctor and the patient, particularly when a drug may be prescribed that could have serious side effects, like addiction and other kinds of things, because that is what we have heard so much about in this Committee.

So I guess, you know, if you could all comment in terms of, you know, feedback from your veterans on how well the current system is working and, you know, why you believe, you know, that this bill, taking it to kind of another level, to a level, in my opinion, of excellence, is important. Ms. Zumatto.

Ms. ZUMATTO. Thank you for the question, Ms. Brownley. There are so many veterans that their quality of life has been compromised because of some of these medications. And many times—I mean, since most of us are not doctors, if a doctor tells us, you need to take this, or you need to do this, we often don't question them because we don't feel qualified. And so we just tend to do whatever the doctor says, which may be the appropriate thing to do. But what we would like to do is ensure that the veteran understands any of the risks that are going to be involved, or if there may be perhaps a less invasive procedure, medication, that could be tried, before perhaps moving to this more dangerous medication.

And to your question, Dr. Roe, or your comment about not having the time as a physician, we do appreciate the short amount of time that doctors have, although I would say that VA doctors have a much lower panel of patients that they are expected to see on a daily basis than non-VA physicians. But I think by having this automated in a system, or in a piece of material that can be preprinted and just handed to the patient, and then it is up to the patient at that point to do any further research or read whatever is in there. We don't expect the doctor to spend 30 minutes or more talking about a list of medications and its side effects. We are expecting them to provide the information that is already created by the VA or whomever, and then the onus is on the patient and his family to do the research if they want to.

Ms. BROWNLEY. And I think, you know, that just leads into the current system in terms of the informed consent form. I don't think, and I am looking for confirmation from you, that the current

system is not really generating that sort of more robust conversation between a doctor and patient so that they can go home. They want to talk to a pharmacist, they can do that; they can discuss it with their family members; they can do the research that they need to do. And I am just concerned, and I am looking for confirmation from you that you feel the same, is that, yes, they are going through and checking off and getting the patient to sign to say, you know, I have given you this information, you might not have read it, but I have given you the information, that that is not getting to where we want to get to in terms of having a more robust conversation.

Ms. ZUMATTO. I would definitely agree. There are very few medications right now that require a signed form within the VA. They do require it for certain things, but generally, medications are not included.

And I just had surgery last week at the VA, and when they gave me prescriptions to send me home, nobody told me anything about it, and one of them is an opioid. So that is the type of thing that we are trying to prevent.

Ms. BROWNLEY. Thank you. And my time is up, so I yield back.

Mr. BENISHEK. Dr. Roe, you are recognized.

Mr. ROE. I would like to comment. Look, handing somebody a piece of paper is not health care in the same degree. You have to have a doctor and patient or a nurse practitioner or a nurse sit down and discuss the medication, what its risks and benefits and side effects. I did that for 30 years. And signing a piece of paper that is just checking a box is not going to accomplish what we want to accomplish.

I think what Ms. Brownley wants to accomplish, we all on this Committee want to accomplish. We have an opioid epidemic in the United States. We have, in the State of Tennessee, more people dying of overdose of prescription drugs than car wrecks. So it is a huge—and it is not just Tennessee. It is a huge problem.

And so I think one way to do it, and obviously, it is training the medical personnel better, training patients better, but I don't want to put another barrier. We are complaining now about not enough access for care for our veterans, and I think we are adding another layer of bureaucracy here that may not get the benefit that you desire and I desire, and that is the adequate use of prescription that is written. I think that is what you really want at the end of the day.

So those are my comments, and, certainly, we can work on this. I would like to. But I would say in its current form, I can't support it like it is.

The other thing I didn't—not with this panel, but that Mrs. Walorski brought up that I didn't bring up a minute ago was on the scheduling issue, I think it is fine to do these things. But once again, there is no teeth, there is no penalty if you don't do it. That is what I was listening to her legislation.

In other words, we are going to—I have been sitting here now for 7-1/2 years, and we find the VA doesn't comply or do something, there are no teeth in it, there is no penalty that if you don't comply. Okay, so they didn't comply.

I think we have got to look and have some teeth in this bill that she has, and I would like to work with her on that. She is not here right now, but I think we need to do that.

I have seen that over and over and over again here. I yield back.

Mr. BENISHEK. Thank you, Dr. Roe.

Mr. Takano, do you have any questions?

Mr. TAKANO. Yeah. Thank you, Mr. Chairman.

My question relates to H.R. 3956, the VA Health Center Management Stability and Improvement Act. And you are in medical centers every day. How important is it to have a full-time medical center director in the facility and making day-to-day decisions and strategic decisions about care for veterans?

Ms. LOVE. Mr. Takano, DAV has not received a resolution to the hiring of VA medical center directors. However, we recognize the importance of VA being fully staffed with enough personnel to take care of veterans. Leadership would be part of that process.

Mr. TAKANO. Can you comment on how having the leadership, having a permanent full-time director instead of acting directors, what effect that has on the morale of VA employees who go to work every day in a particular facility?

Ms. LOVE. Not from an organization standpoint, but from a veteran standpoint, being an employee and having my leader present to direct the operations of the establishment would always be a plus.

Mr. TAKANO. And related to H.R. 2460, Adult daycare in State Veterans' Homes, what concerns do you have for the VA to contract some of its services to the State veteran home?

Mr. SGANGA. Well, unfortunately, back in 2006, when Congress passed a bill to provide no cost skilled nursing care, it took the VA to implement that. It took about 3 years to implement the reimbursement process. It was very painful to a lot of veterans who truly deserved the care, and they did work with us to go retrospective—retroactive, I mean, to get the care paid for.

What I am concerned about now is the fact that a lot of Members of this Committee understand that the VA is going to establish new regulations for adult day health care and for domiciliary care. Back in 2008, 8 years ago, I was part of a team that worked on Vermont Avenue with the VA to try to update the adult day health care regulations, which hadn't been done for years; and it is now 8 years later, and we are still waiting for that regulation.

My nursing home on Long Island in Stony Brook serves as a model for adult day health care. I think it is a wonderful program. We have had visits from about 16 different States over the past 3 years, and I can tell you assuredly that there are many State veterans' homes that want to get into the game.

Two things have to happen: We need the new regulations published. We have been told for 8 years that any minute now, they are coming out. And secondly, this bill for us, 70 percent population will help, with the proper funding, to keep those veterans out of the nursing home side and back into their communities while accessing the services they truly deserve.

Mr. TAKANO. Thank you. Thank you for your response. On H.R. 3989, the Support our Military Veterans' Caregivers Act, have you

heard any concerns with the caregiver program as currently managed by the VA?

Ms. LOVE. Some of the—Representative Takano, some of the concerns that we have is that the—there is not clear guidance with the current directive that VA has. Some of the issues will be a medical determination versus a clinical determination. These things are not clear for veterans to understand and decipher through.

Another issue that we have would be, should a VISN director decide to request an external review, the key word there is “should,” so that process should be automatic if the veteran is requesting a review.

Mr. TAKANO. Well, is it necessary to set up an independent appeals process?

Ms. LOVE. Can you rephrase that question?

Mr. TAKANO. Well, is it necessary to set up an independent appeals process that is conceived in this bill?

Ms. LOVE. Absolutely. It is necessary to set up some process in which the veteran has an opportunity to have a decision reviewed, and it should be a clear process to where all steps in the process are known to the veteran throughout the entire process.

Mr. TAKANO. Well, what I am trying to get is, are there changes that could be implemented instead to improve the existing appeals process we have of VA, instead of setting up an entirely new separate independent process?

Ms. LOVE. Well, the process needs to be made clear. It is not clear at all. It is not clear in the steps that the veteran is to take. It's not clear as far as the language that is used in the terminology of the directive that is currently before us.

Mr. TAKANO. Okay. Well, Mr. Chairman, I think, you know, this has been a long problem for us, and it is a subject of much further examination, but anyway, I yield back.

Mr. BENISHEK. I agree with you, Mr. Takano.

Dr. Wenstrup.

Mr. WENSTRUP. Thank you, Mr. Chairman. Thank you all for being here today.

You know, I think on Mr. Zeldin's bill, you know, as a practicing physician, the more you can do on an outpatient basis, keep people in their home, in their own home is typically better, or, at least, as an option for them. And it is otherwise helpful for the patient overall towards their quality of life. For some, it may be better to not be in their own home. And so, to me, that seems like a very viable option, as long as the care that is necessary is rendered.

As far as the opioids, you know, I always felt an obligation, and still do, when I prescribe, to make sure that I am informing patients of side effects. I make sure that I am not doing something that is contraindicated with their other medications. I make sure that they don't have any allergies to medications that I am prescribing. These are the things that doctors normally do.

Now, we know there is a problem not only in the VA, but outside the VA where people were overprescribing, and so, to me, a lot of that onus falls on the physician and patient relationship. But there was also always the double-check, if you will, from the pharmacy. And you get a prescription today, and you do get handed that infor-

mation, and you have got stickers all over your prescription that are giving you the warning.

So I think we really need to look at what really needs to be done to be effective to make sure that patients are aware of the risk, and in this case, of dependency and addiction, and maybe make sure that we are doing that.

But I agree with Dr. Roe, some of it can be too time consuming, and the doctors here would probably agree that sometimes one of the worst things the patient could have is access to too much information because they find out that 1 in 10 million has some side effect that suddenly they are paranoid about and they don't want to take the antibiotic that is supposed to help them and will help them.

So, we have to be a little careful about how we do that, but I think there is an obligation, obviously, to make sure that you are doing the right thing informing patients properly, so I would like to work with you on that.

I yield back. Thank you.

Mr. BENISHEK. All right. Dr. Abraham.

Mr. ABRAHAM. Thank you, Mr. Chairman. A couple of comments on Mr. Zeldin's bill, 2460 and Mr. Sganga. They have certainly a civilian side of that also, and being a family practice doc, it does work. So I am much in support of that. The thing that nursing homes do, I think, as good a job as they can with the patient load that they have, but if that patient is in an adult daycare 6 hours a day, you are providing OTPT, you are moving the patient, you are grooming the patient. That patient is being mobile as much as possible, and I understand the significant impairment that some of those patients unfortunately have.

But that increases joint mobility, it increases tissue oxygenation, just a better outcome for the patient. And if you look at objective data, which certainly I think most of us on the panel here have done so, either ones that are physicians, facilities such as yours at Stony Brook, compared to 24-hour, around-the-clock in a nursing home, less infection rate, less resistance to antibiotics, such as the MRSA epidemic that we are having now. So you know, I think it is a great thing, and hopefully, we can get this done.

In response to Ms. Brownley's bill, again, you know, again, I, like Dr. Wenstrup, we certainly, hopefully, provide the patient with information that he or she can make an informed decision, but it is like Dr. Roe said, opioid, the epidemic is not only in Tennessee, Dr. Roe, it is—there are more patients dying from opioid dependence all over the Nation than car accidents. So it is a huge problem. We have got to figure this out.

So I think it is great. I mean, we can tweak this, and we can certainly work with Ms. Brownley and make this—and we, you know, we, I think, smart enough to figure this out, but just the mere fact that we are having the discussion, I think, is important and we keep moving this legislation forward in some form or fashion.

And like my colleagues here, Dr. Roe and Dr. Wenstrup, you know, we want to make this work, and we are happy to work with you to find the right solution.

And I yield back, Mr. Chairman.

Mr. BENISHEK. I thank you, Dr. Abraham.

Well, I want to thank the Members of the panel for being here today, and I encourage you to continue to keep us informed as to changes that occur with you, we want to get your input on all the pieces of legislation that have been put forth today. So thank you very much for being here. You are now excused.

At this point, I welcome the third and final panel to the witness table. Joining us from the Department of Veterans Affairs is Dr. Maureen McCarthy, the Assistant Deputy Under Secretary for Health for Patient Care Services. And she is accompanied by Susan Blauert, the Chief Counsel for the Health Care Law Group of the Office of General Counsel.

Dr. McCarthy, you may begin your testimony when you are ready.

STATEMENT OF MAUREEN MCCARTHY M.D.

Dr. MCCARTHY. Thank you, sir. Good after—good morning, rather, Chairman Benishek, Ranking Member Brownley, and Members of the Committee. Thank you for the opportunity to be here today to present our views on several bills that would affect VA health care programs and services. Joining me today is Susan Blauert, Chief Counsel for General Counsel's Health Care Law Group.

First, I want to convey my gratitude and appreciation for the commitment of the Members of the Committee who seek to improve and provide these authorities to the VA. Though the Department, in writing, opposed a majority of the bills, we do so for purposes of resources, operations, and, in some cases, duplication of existing programs. We look forward to continued collaboration with the Committee and its Members to ensure we are providing the services and care our veterans deserve.

Regarding H.R. 4977. VA policies already require directors to certify compliance with the scheduling directors and explain gaps in compliance based on data collected at the facility. We also know veterans aren't required to schedule hospital care. They can walk into the emergency department or be admitted directly by primary care.

VA needs the flexibility to set scheduling standards that are clinically appropriate, and that can adapt to changes in the way veterans access health care, and I will be happy to explain some of the structures we have in place at this point to monitor that.

Regarding H.R. 2460, VA supports growing adult day health care programs, because we definitely want to rebalance how we use home- and community-based services versus institutional services.

Veterans and their families are supportive of initiatives that permit them to age in place and avoid nursing home care. However, H.R. 2460 would base payment rates for these programs on nursing home care rates, which are much higher, given the needed level of care.

Whereas nursing home residents live at the facility and receive 24-hour nursing home care, these adult day health care participants live at home, and they use the program for say 6 to 8 hours. Thus, this bill would require VA to pay two-thirds of the rate that VA pays for a higher level of care for furnishing a lower level of care for about a third of the time.

Additionally, VA believes that shifting payments from a grant to a contract mechanism would place additional requirements on State homes that have been proven burdensome and difficult to implement.

With regard to H.R. 3989, VA believes that the current process regarding review of eligibility determinations for the comprehensive program of support to caregivers effectively furthers VHA's policy to provide access to fair and impartial review of disputes.

Currently, when an individual appeals the treatment decision of the care team about eligibility for participation, decisions are made by VHA leadership who have direct oversight of the clinical team that has been more intimately involved in the veteran's care. In contrast, the proposed external clinical review would be provided to an independent contractor who, in turn, would employ a panel of health care professionals not necessarily familiar with the case. We also emphasize that our caregiver program was designed by Congress to be a clinical treatment program and not a benefit program.

Next, VA agrees that employment of physician assistants, a top five mission critical position within VA should be prioritized. Thus, VA supports the pilot program in section 2 of H.R. 3974. The pilot program is a win-win for VA and the scholarship recipients as VA will reduce future recruitment costs while scholarship recipients fulfill their service agreements. That being said, VA recommends removing certain prerequisites described in the bill, and also a relook at the timeline of the expected numbers of participants.

VA also supports section 4, including the PA occupation being included in the locality pay system in VA. We feel that would be an important element in addressing recruitment and retention difficulties associated with the pay disparity between private sector market pay and VA pay schedules.

While VA supports sections 2 and 4, VA believes that section 3 would not be the best tool to address the current PA shortage. As some facilities do not report issues recruiting PAs, requiring all facilities to advertise education debt reduction program for PA positions would deny some facilities the ability and flexibility to make these awards for other critical positions for them.

Next, VA is appreciative of your efforts to address challenges with recruiting and filling VA medical center director positions with H.R. 3956. VA has taken several steps to reduce the number of vacant positions. For example, VA anticipates having nominees identified for about 20 of the 34 vacancies by the end of April.

In addition, VA submitted a legislative proposal requesting the ability to transition all medical center directors from title 5 to title 38, which will provide additional compensation and staffing flexibilities, thereby relieving some of the current challenges with attracting highly qualified candidates to serve in these leadership roles. VA seeks your support of that proposal to ensure the resolution of the medical center director staffing challenges.

With regard to the draft bill to establish a list of drugs requiring an increased level of informed consent, VA believes that we have met these terms in what we have going at this point. I am happy to share a list of medications for which VA already requires informed consent. VA feels the draft bill would burden veterans and their care providers by introducing some unnecessary steps and

delays in what is standard informed consent process for high risk medications. We list several other concerns in the written statement.

That being said, we were, at the time, unaware of the problem the legislation was supposed to remedy, but acknowledge indeed, Ranking Member Brownley's statement about the opioids and the purpose of this to address that. So we request an opportunity to meet with the Committee to ascertain the Members' concerns and work together.

Thank you, Mr. Chairman and Ranking Member, for the opportunity to testify before you today. My colleague and I would be pleased to respond to questions that you or other Members may have at this time. Thank you.

[THE PREPARED STATEMENT OF DR. MAUREEN MCCARTHY APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you, Dr. McCarthy, for your testimony. I will yield myself 5 minutes for some questions.

So you think this medical center thing, this director program is primarily the fact that they don't pay them enough? Is that what we are getting at, you are changing the section to section 38? I don't remember the numbers.

Dr. MCCARTHY. I think the pay is part of the problem. A typical VA medical center director compared to someone running a similar hospital in the private sector makes a fraction of what the private sector person makes. Some of the challenges are where our medical centers are located and people's ability to move to those locations, but salaries are a big piece of it.

You may have noticed we have had some negative media attention over the last few years, and in particular, the sense of people who may, in the past, have considered becoming a director are feeling a lack of personal safety in assuming the role with the increased number of requirements placed on them. So I think it is multifactorial, but I do think salary would help.

I also think a greater sense of appreciation for what they are doing and the challenges they face would help. And I have personally reached out to numbers of individuals that might be in acting roles and talked with them about why they are not stepping up to apply, and a number of them are talking about really the challenges and the pressures that are on our medical center directors right now with the intense level of oversight. That said, that is not to say that we shouldn't have oversight, but it is very, very challenging for all of them right now.

Mr. BENISHEK. Thank you for that. I don't know if you are familiar, but I worked at a VA for 20 years as a physician, one of the challenges we had there was that the VA directors turned over every 2 years in many cases, and even with that 2-year tenure, things didn't get done. And with a 120-day tenure, you realize that these folks are not making the critical decisions that need to be made because they are worried about consequences of any decision they make as a temporary person.

I am willing to work to make this happen, and are there changes in the law that need to be done to get the medical director to get

this changed to this other section? Do we need to change the law to do that?

Dr. MCCARTHY. Sir, there was a proposed—a legislative proposal VA submitted on changing it, those positions from title 5 to title 38, which would give more salary flexibility.

Mr. BENISHEK. All right. Okay. I might want to go on to this, the stay-at-home home issue. You heard the testimony that these veterans that we are talking about, they are eligible for nursing home care now. So an effort to cut the cost of that and still provide them with the care they need seems like a no-brainer to me. Why do you object to that?

Dr. MCCARTHY. Sir, we definitely support veterans and their families as they make these decisions to age in place and want to do what we can to help them. We have a number of services in place already to support that.

Our concern is—

Mr. BENISHEK. We are not talking about people that aren't eligible for nursing home, we are talking about these are people that are eligible for nursing home care.

Dr. MCCARTHY. Right.

Mr. BENISHEK. And, either they go to a nursing home or they get this. You are saving money, aren't you? Or you want to provide the care a different way? I am not sure that that is actually happening, though.

Dr. MCCARTHY. So as we move, shifting that balance I was talking about between institutionalization and the care- and community-based services that help people stay in their home, we definitely are trying to shift that balance for sure. Our concern was with the actual dollar number and was it, indeed, a fair calculation to pay two-thirds of the cost of a nursing home for them to be there for 6 to 8 hours. We have—

Mr. BENISHEK. I think, to tell you the truth, if you had to pay somebody to go to the home for 6 to 8 hours, it would cost you more than \$300. And Dr. McCarthy, you understand what I am talking about? To get a nurse to go to the home for 6 to 8 hours and to do what they are going to do, you can't get one nurse to do that. They can't cut the hair more than one person needs to be doing it in the patient's home.

So I have a little bit of trouble trying to figure out that argument.

Dr. MCCARTHY. So just so you know, we have been working with the State Veterans Homes and have talked with them about two kinds of adult day health care models. One, which is a medical model, I think the classic example would be a post-stroke patient, for instance, that needs a lot of direct nursing care and a comprehensive health care team, and the other is the social model.

Mr. BENISHEK. I understand. I understand where you are going. I am just telling you this is not like respite care where you are just babysitting the patient and then the alternative is full care. You are talking about apples and oranges here. So to me, this—do you want to deny—you mean, it is cheaper to deny the patient the care, that is for sure.

Dr. MCCARTHY. Not in the long run, I don't think.

Mr. BENISHEK. Nobody—I don't think you are talking about that, but it kind of gives me the idea that that might be happening.

Dr. MCCARTHY. So if I could—could I just—

Mr. BENISHEK. It is definitely cheaper to deny the care.

Dr. MCCARTHY. Right.

Mr. BENISHEK. So I just want to—

Dr. MCCARTHY. I agree with you. I was about to say that there are two models, and one is a more medical model, and one is a more social model, and so the way it is written is that this would apply to both models, and what we feel is that if it were a more social model, then the compensation wouldn't be justified. So we do have a regulation that was out for comment, and we are addressing the comments at this point, but it is really to look at two different models and—

Mr. BENISHEK. I think we are talking about two different patient sets, though. We are talking about a patient set that the patient is 70 percent disabled and eligible for nursing home placement, as I understand it. So that is a different—that is different than what you are talking about.

Dr. MCCARTHY. Actually, that 70—

Mr. BENISHEK. I am out of time, though. I appreciate it, but I would like to have you follow-up so I understand this better.

Dr. MCCARTHY. I would be happy to do that.

Mr. BENISHEK. Mr. Takano, do you have any questions?

Mr. TAKANO. Yes, Mr. Chairman.

You know, regarding draft scheduling compliance. This Committee heard just yesterday about the continued challenges veterans face when scheduling access to care, and part of the inconsistency stems from the fact that schedulers are working under an interim scheduling directive. Once a comprehensive scheduling directive is finalized, it would seem to me that ensuring greater compliance will help improve wait times and get veterans the care they need.

Does the VAMC director currently have to comply with VA regulations and law?

Dr. MCCARTHY. Yes. We believe so, yes. There is an expectation, if we could talk about scheduling, in particular, that the medical center director and the network director would visit the frontline staff that are involved in scheduling periodically. And in addition, there has been a tool developed to look at scheduling and the process, to look for any kind of irregularities. It looks at a total of five measures of compliance and practice to help figure out if anybody is manipulating data in any particular way.

And if that is apparent, it will be apparent to the medical center, it will be apparent to the VISN, it would be apparent to leadership in VA central office. So there is a tool that people are using to help and verify, in addition to the expectations of the visits and the certifications.

Mr. TAKANO. And how does the central office verify the compliance?

Dr. MCCARTHY. So what is used as a database, and I have had this explained to me, what—what they use is a measure of five things. They look at the average new patient wait time, the cancel-by-patient rate, the established patient zero-day wait, and then in

terms of practice, what is going on with the electronic wait list and the established patient measures, and based on outlier status on any of those, it is a warning sign that things may not be accurately followed in terms of the scheduling directive and the scheduling processes in place. That is the warning sign. And then there is a review that happens that is triggered by those kinds of events.

But in addition, people are following all the time the wait lists, and in particular, the need for urgent care and so forth.

Mr. TAKANO. Well, do you think that this—that effective compliance, verification of compliance through the central office, would this lead to enhanced veterans' access to care?

Dr. MCCARTHY. So compliance and access are likely related, yes. But I think, in my mind, some of that is separate. I think we are all about improving access, and compliance is more asking are we doing it right and are we doing the right thing? But obviously, if we are compliant, we would get access. I just think about those in two parallel spheres. I am sorry.

Mr. TAKANO. Okay. I want to move on to the H.R. 3989, Support Our Military Caregivers Act. Can you quick—briefly explain the current process to determine if a family is eligible for caregiver assistance, and what recourse does a family have if they disagree with the decision?

Dr. MCCARTHY. So the way Congress wrote this for VA is different how it is written for DoD. For DoD, it is a benefit. For VA, it is part of the treatment plan. So the treatment team makes a recommendation for a veteran to have the caregiver based on the current needs of the veteran at the time the assessment is made.

There includes a series of events, including home visits and so forth. Typically, it is a 90-day process of evaluation, and so all of the kinds of things that are determined are if the veteran needs this care, what kind of level is needed, and then an assessment of how best to accomplish this and the support that the family member would need, there is training that goes in to what the family member gets. So there is a tier assigned for the level which corresponds to the compensation level that the family member receives.

Mr. TAKANO. If I could interrupt or add onto that. If the servicemember's health situation changes, will the family have to begin the process all over again of, you know, evaluating the caregiver assistance?

Dr. MCCARTHY. Yes, because it is considered a treatment and not a benefit, and I think that is where there is a lot of misunderstanding. So when someone is assigned a benefit, it is an ongoing payment; whereas, as part of the treatment plan, the veteran may or may not need the ongoing support of a caregiver. And initially, say after transitioning from a polytrauma facility, they may need a lot more support, but as time goes on, they may not need the assistance at the same level, the same tier, or they may even not need the assistance of the caregiver, which is a clinical decision.

Mr. TAKANO. All right. Thank you very much.

Thank you, Mr. Chairman.

Mr. BENISHEK. Dr. Roe.

Mr. ROE. Just a couple of brief questions. You know, yesterday, the VA has 32,000 schedulers for their VA system, and that is half

the population of the city I live in, which is the largest city in the 1st Congressional District of Tennessee. So there are only about three or four towns in the whole district that are bigger than the number of schedulers the VA has.

And you know, yesterday, we were sitting in this same room, and we heard two very different stories about scheduling. And I think that it is important for us to get that straight. And I would support her bill, and the reason is because we can't get information that we can understand up here about wait times. We hear the Secretary say it is 4 days, you go home, and you hear everybody you talk about it, nobody is getting in in 4 days. So I think that is a problem we have here is it is a definition.

And I know yesterday, when I went over it, it is like when a veteran calls in and they say, Well, we don't have an appointment for 6 weeks; would that be okay? When they would really like to be seen in about 2 weeks. And then that is considered the day that they actually agreed to, so there is no wait time, even though in reality there is a month's wait time or maybe longer than that.

So I think we do need to look at that and be—and first of all, I told the Secretary yesterday—I mean, the Under Secretary of Health, Dr. Shulkin, yesterday. We need just to define what that is, and whatever it is, it is, so we are all, you know, singing off the same song page.

The second thing. Dr. Benishek was drilling down this, and I just did some numbers. I can't understand your VA estimated cost on Mr. Zeldin's bill. And you look here and you say that the estimated cost is 1.7 million in the first year. I just did some simple arithmetic. If somebody goes 5 days a week to the adult daycare center we just heard about at \$318, that is \$76,000 a year. That means for 1.7 million, you can take care of 25 people. So how did you come up with that number?

And then it says, 2.1 million in the second year. It makes no sense to me. If you multiply 318 times 5 and multiply it times however many weeks, 52 weeks a year, how many you go, that is a—and if you—at \$450, it is—at his institution, it is \$164,000 into Dr. Benishek's point. That is a lot cheaper, almost \$100,000 a year less expensive. And I agree with you that you should look at medical and social because all patients are not the same.

Dr. MCCARTHY. Right.

Mr. ROE. That is totally correct on that.

Dr. MCCARTHY. Right. So sir, I would be happy to kind of do a breakdown of the cost, but I believe part of the issue is that many of the people that go to the adult day health care centers go 3 days a week and not 5.

Mr. ROE. Well, it is still—then it is 50,000 a year.

Dr. MCCARTHY. Okay.

Mr. ROE. I can do that math in my head pretty quick.

Dr. MCCARTHY. All right. If you wouldn't mind, I would like to get back with you with the description of the numbers.

Mr. ROE. You see where I am concerned, though. 1.7 million is 50,000, and 30 people is a 1.5 million a year, so I don't know how in the world the VA came up with that small of a number.

Dr. MCCARTHY. All right. I will rework that, and I promise we will get back to you.

Mr. ROE. Okay. Thanks. I yield back.

Mr. BENISHEK. Dr. Abraham.

Mr. ABRAHAM. Thank you, Mr. Chairman. Just a couple of things on Dr. Benishek's and Dr. Roe's, just comments on the adult daycare living. I think I can arguably make the argument that with adult daycare, the way it is now, and the way it is perceived in Mr. Zeldin's bill, that you need both the social and medical input there. So yeah, I think you are getting more bang for your buck than certainly, you know, in the nursing home situation.

I mean, I have known both. I have treated outpatients in both, and you know, they both do a great job. And I think when you are talking just strictly dollars with the adult daycare, I mean, you are certainly getting a little more bang for your buck, and the patient, more importantly, is getting maybe some improved therapy on joint mobility and that type of deal.

The other issue on the—you said you have got a list of drugs there that require—and I will just ask you if you will give me a copy to my office, I would appreciate it. But I am assuming that one of those already are the opioids. Is that a correct statement?

Dr. MCCARTHY. The long-term opioid.

Mr. ABRAHAM. Right. Okay. And you know, like Dr. Roe said, and the docs up here know, you know, it is burdensome, but Ms. Zumatto had some good alternatives as to how we get that patient to, I guess, become more informed.

So again, I think it is a good conversation, but I guess, again, let's go back to the objective data. We have already got informed consent for the long-term opioids, but we still have an increasing opioid epidemic. So the question bodes, well, is the informed consent model working as it is.

Evidently not. And again, my previous statement, I think we are smart enough to work with Ms. Brownley and to figure this out and get it right with Ms. Zumatto and the VSOs to get their input where we can hopefully get the right combination of what it does take to start chipping away at this opioid addiction stuff.

The question I have for you. You made the comment in your statement that in the bill of the PAs, that you—that the VA was somewhat opposed to some of the prerequisites required. Can you list those prerequisites that—I mean, I heard Ms. Kuster. I was listening very acutely to what the prerequisites are. Which ones are the VA opposed to knocking out of the box?

Dr. MCCARTHY. So it is just a few. There is a requirement for hiring executive director of one program and another position, and it requires that the person be currently employed by VA at the time of the passage of the legislation and that the person be a veteran. And there—that limits who would be eligible to apply for those positions.

Mr. Abraham. Would the VA be okay with or be in favor of giving the veteran the priority of that slot of the PA slot? I mean, we all know we need more health care providers in the system, and if we have got a combat veteran, either he or she, that has been on the frontline serving as a medic or in some health care job already, they are far ahead of the game as to as far as somebody coming off the street literally and just starting the program anew. So they bring so much knowledge base already, and that is what

it requires in a PA and an NP position to have that knowledge base, and they have already got that.

So the question is, is VA okay with the VA getting preference or the—

Dr. MCCARTHY. The veteran preference—

Mr. ABRAHAM. Yeah.

Dr. MCCARTHY [continued].—would—just changing that would help, that exact wording.

Mr. ABRAHAM. All right. Thank you, Mr. Chairman. I yield back.

Mr. BENISHEK. Thank you, Dr. Abraham.

Does anyone have any further questions?

Mr. TAKANO. Could you submit a list of the medications or drugs for the record?

Dr. MCCARTHY. I would be happy to do that, and I brought some copies with me.

Mr. TAKANO. Thank you. That is what I wanted. That is it.

Dr. MCCARTHY. And just so you know, this was derived from our list of informed consents, so it lists particular drugs, and you will see a lot of chemotherapy drugs and so forth. But in addition, it talks about, like, the spinal injections and so forth for anesthesia, but it does have—it certainly has all the other drugs. And under anesthesia and pain management, about the 10th one down is consent for long-term opioid therapy for pain. Okay.

Mr. TAKANO. All right. Thank you, Dr. McCarthy. Thank you.

Mr. BENISHEK. Thank you.

Mr. TAKANO. I yield back.

Mr. BENISHEK. There are no further questions. The third panel is now excused.

Dr. MCCARTHY. Thank you very much.

Mr. BENISHEK. I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks and include extraneous material.

Without objection, so ordered.

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

[Whereupon, at 11:43 a.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Honorable Elise Stefanik

Chairman Benishek, Ranking Member Brownley - thank you for the invitation to testify on this important legislation. I look forward to discussing this key issue moving forward.

As a member of the House Armed Services Committee with a critical Army base in my district, I am dedicated to providing support to servicemembers, veterans and their families. Since September 11th, 2001, the Army's 10th Mountain Division at Fort Drum has been the most actively forward deployed division in the Global War on Terror.

We have asked our servicemembers and their families to sacrifice an immeasurable amount over the last 14 years, so it is vital that we do not leave them behind - this is especially true for our military caregivers, the selfless group that cares for our heroes behind the scenes. These men and women are often left out when discussing veterans' issues.

Military caregivers are an essential component of the communal and family support system for our disabled veterans. Military caregivers are usually spouses and other family members who spend their days taking care of disabled veterans in order to provide an environment that enhances their everyday lives.

In 2010, Congress passed a law implementing the Family Caregiver Program. This was an important piece of legislation that made veterans who sustained injuries in the line of duty eligible for a package of benefits that includes access to a primary caregiver. These benefits would ensure that the family members who dedicate their lives as caregivers receive access to health care, caregiver training, and stipends for additional costs associated with their disabled veteran.

Unfortunately, the Department of Veterans Affairs (VA) has had a difficult time managing the high demand of Family Caregiver enrollees, which is much larger than originally accounted for during implementation. According to the Government Accountability Office (GAO), VA officials estimated that they would receive 4,000 enrollees and staffed the program based on this estimate. However, in the first few months of implementation there were over 15,000 enrollees to the Family Caregiver Program. VA medical centers lack sufficient caregiver support coordinators and the necessary clinical staff to carry out medical assessments for eligibility.¹

These implementation issues have led to a delay in both the application and the appeals process. Application deadlines are not being met by their own internal standards and the staff is still shorthanded. These issues are not only unacceptable, but I believe they are preventable.

This is why I introduced H.R. 3989, Support Our Military Caregivers Act after meeting with a constituent who is a caregiver facing the burden of the VA backlog.

This bill would use pre-existing funds currently appropriated for the review and appeals process for an objective, independent party to conduct external, clinical reviews. This bill would ensure that new or modified processes are veteran-centric, outcomes-based and continually improved through the use of best practices. We can accomplish this by permitting a third party to work within the Department of Veterans Affairs to streamline claims and reduce the caregiver backlog through a more clinical analysis rather than benefits adjudication. The VA would maintain the third party until the overage of appeals is streamlined and the backlog is down to an acceptable rate in accordance with recommendations from the Government Accountability Office.

Military caregivers are silent heroes in our communities and deserve the respect and benefits proportionate to their significant contributions. I look forward to discussing this issue further in order to implement a solution and get our military caregivers the benefits they have earned.

¹ Government Accountability Office (GAO). 2014. Actions Needed to Address Higher-Than-Expected Demand for the Family Caregiver Program. Informational, Washington, D.C. : GAO.

Prepared Statement of Honorable Mike Bost

Chairman Benishek and Ranking Member Brownley, thank you for holding this hearing on pending legislation which is critical to better oversight of the Department of Veterans' Affairs. Careful consideration of how the VA should be reformed is needed to ensure better health care access and medical treatment for our nation's veterans.

As a Marine and the father of a Marine, I recognize the selfless sacrifice that so many Americans have made in defense of our freedoms. There is no doubt that we must fight for the brave men and women who have fought for us. I know my colleagues on both sides of the aisle feel the same way.

Winning any battle requires steadfast and capable leadership. No organization can operate under a revolving door of interim leaders -and certainly not one tasked with caring for America's heroes. Unfortunately, that revolving door of leadership is exactly what is occurring at VA medical facilities across the country. This situation is simply unacceptable, as it may undermine the quality, consistency, and speed of care that our veterans receive.

Our nation's warfighters deserve better, and that is why I introduced H.R. 3956, the VA Health Center Management Stability and Improvement Act. This common sense bipartisan bill requires the Secretary of the Department of Veterans Affairs to submit a plan to Congress within 120 days of passage for finding and hiring a permanent, highly-qualified director at each VA Medical Center (VAMC) that is currently under temporary leadership. This legislation is endorsed by the American Legion, Vietnam Veterans of America, Paralyzed Veterans of America, AMVETS, Disabled Veterans of America, and the Association of the United States Navy.

The "interim leadership" problem happening at Department of Veterans Affairs Medical Centers across the country first came to my attention in my own backyard. I am proud to represent the Twelfth Congressional District of Illinois in Congress, and many Southern Illinois veterans access health care through the St. Louis Department of Veterans Affairs Health Care System. The St. Louis VA Medical Center provides health care to over 45,000 veterans annually, and I remain very concerned about the lack of stability in leadership there and how it may impact system operations.

Over the last several years, the St. Louis VA has been managed by more than seven different acting directors. According to the VA's hiring policies, there is no time limit for Senior Executive Service or Medical Center Directors to serve on a detail in an acting capacity, yet these details must be approved in increments not to exceed 120 days, with a possible extension to 240 days.

Consequently, the St. Louis VAMC has experienced a revolving door of interim directors. This short term leadership negatively impacts the ability to engage in long-term planning and other functions necessary to provide and improve health care for the veterans it serves.

After I began looking into the local issue at the St. Louis VA Medical Center, it came to my attention that this problem isn't just a problem in our area. Upon further investigation, I found that a large number of VA Medical Centers have lacked a permanent director for quite some time. This problem is due to Office of Personnel Management (OPM) requirements which stipulate that temporary directors can serve for no more than 120 days, with a 240 day maximum total if their tenure is extended. The lack of stable, permanent leadership is no doubt one of the reasons the Department of Veterans Affairs has struggled to provide appropriate health care to those it serves.

H.R. 3956 seeks to fix this problem by requiring the VA Secretary to develop and implement a plan to fill these vacancies.

Specifically, my bill requires the Secretary of the Department of Veterans' Affairs to:

- Report to the House and Senate Committees on Veterans' Affairs the status of any unfilled vacancies.
- To develop and submit to Congress a plan hire highly qualified medical directors for each VA Medical Center which lacks a permanent director. This plan must be submitted within 120 days after enactment of the bill.
- Identify possible impediments to staffing VA Medical Centers with permanent directors.
- Assess the possibility of promoting and training qualified candidates from within the Department of Veterans' Affairs for promotion to these Senior Executive Service (SES) positions.

I have reached out to my local Congressional colleagues on the issue and sent letters to the Department regarding the lack of leadership at the St. Louis VAMC. Last week, I received a reply from the Department of Veterans Affairs Under Secretary of Health, Dr. David Shulkin, giving me an update on the issue. According to the timeline chart he provided, the St. Louis position has been vacant since July 14, 2013 and is still vacant thirty-three months later. I have enclosed a copy of the St. Louis VA Medical Center director timeline with my formal statement to illustrate just how long this process has been and how long this critical leadership position has been vacant.

This problem doesn't end in St. Louis. Unfortunately, similar scenarios can be found at Department of Veterans Affairs Medical Centers across the country. As of July 2015, the VA reported that over 39 VAMCs were without a permanent director. H.R. 3956 would help correct this lack of permanent leadership at the health care centers that so many of our nation's veterans rely on.

I thank the Chairman, Ranking Member, and this Subcommittee for consideration of H.R. 3956 and look forward to working with my colleagues and the Committee to further this legislation. Thank you and I yield back the balance of my time.

Prepared Statement of Honorable Ann Kuster

Chairman Benishek, Ranking Member Brownley, and Members of the Subcommittee, thank you for the opportunity to discuss H.R. 3974, the Grow Our Own Directive: Physician Assistant Employment and Education Act of 2015. Our full committee has worked hard to improve veteran access to health care, and to create opportunities for veteran education and employment. This legislation would allow us to merge those efforts and allow veterans to continue serving their country while in service to their fellow veterans.

In the 14 and a half years since September 11th, and the 13 years since the invasion of Iraq, the men and women of the United States military have repeatedly demonstrated their skill, valor, and professionalism. They have repeatedly placed their lives on the line, been separated from their families, and deferred their own personal life goals in order to serve this country.

As many in this room recognize, that service on our behalf creates an obligation on our part to ensure veterans have the opportunity to succeed and have access to the medical care they may require.

Veterans today often leave the service with an incredible skill set. Our corpsmen and medics have proven medical experience in high pressure training and real world environments. They have also demonstrated an interest in public service by volunteering to serve in the military, and many hope to continue in service to the public after they leave active duty. Meanwhile, as this subcommittee in particular knows all too well, veterans often face many challenges in accessing care. As we discussed last week, sometimes this is due to IT and scheduling challenges. Other times it is due to the lack of providers available.

In a time of shortages for primary care providers both in the private sector and in the VA, and with the Office of Inspector General listing physician assistants as one of the VA's top five occupations with the largest staffing shortages, creating a pathway of opportunity for our veterans to fill that gap and continue to serve their country seems to me like an excellent opportunity.

H.R. 3974 would accomplish that objective by creating a pilot program to provide educational assistance to qualifying veterans for education and training as VA physician assistants. A veteran would qualify for this program who has medical or military health experience gained while serving in the Armed Forces; has received a certificate, associate degree, baccalaureate degree, master's degree, or post-baccalaureate training in a science relating to health care; has participated in the delivery of health care services or related medical services; and does not have a doctorate in medicine, osteopathy, or dentistry.

Eligible veterans would be able to apply during the five year pilot program to receive one of 35 scholarships available each year to cover the costs of obtaining a master's degree in physician assistant studies or a similar master's degree.

Selection would be prioritized for those veterans that participated in an earlier veteran recruitment program known as the Intermediate Care Technician Pilot Program and those veterans agreeing to be employed by the VHA in a community that is medically underserved and in a state with a significant veteran population.

Those veterans that use the program would then owe the VHA a period of obligated service based either on the scholarship program used, or three years.

To ensure that veterans are prepared to succeed, participants will be paired with a mentor at their facility, and the VA shall partner with institutions of higher learning to guarantee physician assistant educational seats.

As it is currently written, the bill would also establish standards to improve the education and hiring of VA physician assistants and enhance retention and recruitment through competitive pay standards.

As this bill moves through the House and the Senate, there have already been several discussions to find ways to improve the bill, increase its chances at passage, and create this opportunity for our veterans. I am happy to continue those conversations in the coming days and weeks based on feedback from this hearing.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or our fellow members of the Subcommittee may have.

Prepared Statement of Honorable Jackie Walorski

Good morning Chairman Benishek, Ranking Member Brownley and members of the Committee. I appreciate being given the opportunity to discuss the VA Scheduling Accountability Act.

First, I would like to thank Chairman Benishek and Ranking Member Brownley for holding this hearing and allowing me to testify on this important legislation. In 2014, news reports uncovering gross mismanagement and scheduling manipulation at a Department of Veterans Affairs (VA) hospital in Phoenix shook us to the core. Through hearings held in this committee and investigations by the VA Office of Inspector General (OIG) and Government Accountability Office (GAO), we substantiated many of the allegations of manipulated schedules and falsified wait-time data at the Phoenix facility. The manipulation of appointment schedules and data in Phoenix led to at least 40 veterans dying while they were waiting for care. However, as we took a closer look, we discovered that, sadly, this was not an issue unique to Phoenix. It was systemic. Here we sit two years later, digging deeper still into some of the root causes to ensure that no veteran ever dies again waiting for care. I introduced legislation this week, the VA Scheduling Accountability Act, that gets at one of the key drivers of wait time manipulation.

VA Directive 2010-027 is VA's implementation processes and procedures policy for scheduling at their facilities and contains 19 different items on the checklist. The directive requires an annual certification of full compliance with all items on the list. For instance, facilities are required to ensure completion, using Veterans Integrated Service Network (VISN)-approved processes and procedures, of a standardized yearly scheduler audit of the timeliness and appropriateness of scheduling actions and of the accuracy of desired dates. They are also required to ensure that deficiencies in competency or performance that are identified by the annual scheduler audit are effectively addressed.

An August 2014 OIG report uncovered that in May 2013, the then-Deputy Under Secretary for Health for Operations Management waived the FY 2013 annual requirement for facility directors to certify compliance with the VHA scheduling directive. Allowing facilities to only self-certify reduced oversight over wait time data integrity and compliance with appropriate scheduling practices. This, in turn, allowed VA's data to be easily manipulated, contributing to the wait time scandal. There was a noticeable, substantial improvement in VHA's appointment scheduling after VA waived the directive, but as we now know, that improvement was an illusion. While the VA has reinstated the certification requirement, there is nothing stopping them from waiving it again.

The VA Scheduling Accountability Act would require each facility director to annually certify compliance with the scheduling directive, or any successor directive that replaces it, and prohibits any waivers in the future. Should a director be unable to certify compliance, either because the facility is not in compliance or the director refuses to sign the certification for some other reason, the director must submit a report to the Secretary explaining why the facility is out of compliance. The Secretary will then report yearly to the House and Senate VA Committees with a list of facilities in compliance and those that are not, with an accompanying explanation as to why they were not in compliance. Lastly, the legislation requires that anytime VA waives or allows noncompliance with requirements in any other directive or policy beyond scheduling, VA must provide a written explanation for the decision to the House and Senate Veterans' Affairs Committees. This will provide more oversight of the Department and ensure Congress is aware when VA is waiving these policies.

Waiving compliance requirements was a key driver in the wait time scandal, which continues to be an issue at the Department. This legislation will end this reckless practice once and for all, while increasing accountability and transparency at the VA as we work on ways to ensure that those who risked their lives for their country receive the prompt, quality care they have earned. I look forward to working with the members of this Committee, Veteran Services Organizations, and the VA in addressing this critical issue. I thank you again for this opportunity to speak today.

Prepared Statement of Honorable Lee Zeldin

Good Morning Chairman Benishek, and thank you for the opportunity to testify on behalf of my bill, H.R. 2460, which provides no-cost medical model adult day health care services for our 70% or more service connected disabled veterans.

It must always be a top priority of Congress to ensure that all veterans receive the proper treatment and care they deserve after fighting for our country. While overseas, these brave men and women are exposed to significant hardships and trauma, and when they come home, many return with the physical and mental wounds of war. Despite various care options for veterans, their choices are often limited, and can come at a great expense. Service members who are 70% or more disabled from a service connected injury often require significant assistance from others in order to carry out basic everyday tasks. In many instances, veterans must rely on family members for assistance, creating many financial and emotional hardships for both the veteran and his or her family. Alternatively, some veterans, without the proper support system, may even be forced to rely on the assistance of trained medical professionals and reside in institutionalized facilities for daily assistance. Veterans in these facilities often spend significant sums of money each day just to be enrolled, and these expenses can be expected to span the remainder of the veteran's life in many cases.

While alternative options currently exist, accessing these services, however, can often be very difficult. One such program that is currently available is Medical Model Adult Day Health Care; a daily program for disabled veterans who need extra assistance and special attention in their day to day lives. Adult Day Health Care programs provide disabled veterans and their families with a high quality alternative to nursing home care, providing quality outpatient services for those suffering from debilitating illnesses or disabilities. These programs provide a range of services from daily activities, such as bathing, to full medical services, like physical therapy. Adult Day Health Care, however, is only offered currently at three facilities in the United States. Long Island is fortunate to be one of the three locations, with a facility right in the heart of my district in Stony Brook, New York, the Long Island State Veterans Home. There are however, 152 other State Veterans Homes across the country, and this program could easily be offered at any of the 153 total State Veterans Homes. Unfortunately, however, the Department of Veterans Affairs does not currently cover the cost of participation in this program at state veteran homes and the expense of the program is put directly on the veteran and their family, which significantly limits the number of veterans who can enroll.

In order to address this issue and expand access to care for our heroes, I introduced bipartisan legislation in Congress, H.R. 2460, which would ensure that 70% or more service connected disabled veterans are able to receive Adult Day Health Care at no cost to the veteran and their family by defining the program as a reimbursable treatment option through the VA. My bill would guarantee that all severely disabled veterans are able to access Adult Day Health Care. By providing disabled veterans with access to Adult Day Health Care programs, we can ensure that all veterans receive the best and most efficient outpatient services to provide them with the assistance and special attention that they need in their day to day lives, while still allowing them to maintain their independence.

Adult Day Health Care also helps keep families together and strong. With the inclusion of Adult Day Health Care services as a covered VA expense, family members and caregivers can rest easier knowing that their loved ones are receiving top notch care during the day, while being treated with the same respect and dignity that they would receive at home. Not only does the Adult day Health Care model care for the medical needs of a veteran, but it also addresses their social and emotional needs as well. Adult Day Health Care allows veterans to interact and socialize with their peers and other individuals enrolled in the program. Rather than sitting home alone all day, participants in the adult day health care program receive one-on-one attention from medical and support staff while also maintaining an active social

schedule through planned events and activities. Family members and caregivers can go about their day without the worry that their loved ones are unattended, and the veteran can continue to remain as active members of their community.

It is a top priority of mine to ensure that all veterans on Long Island and across the country receive the proper treatment and care they deserve, which is why I fully support the adult day health care program. I will continue working every day to spread awareness of this bill, so that we pass this bill as soon as possible to expand Adult Day Health Care for our disabled veterans, and I thank you for considering this essential piece of legislation.

Prepared Statement of Diane M. Zumatto

Distinguished members of the Subcommittee on Health, it is my pleasure, on behalf of AMVETS, to offer this testimony concerning the following pending legislation:

- HR 2460, to improve the provision of adult day health care services for veterans;
- HR 3956, the VA Health Center Management Stability and Improvement act;
- HR 3974, the Grow Our Own Directive: Physician Assistant Employment & Education Act of 2015;
- HR 3989, the Support our Military Caregivers Act of 2015;
- Draft legislation regarding informed consent; and
- Draft legislation regarding the scheduling of veteran appointments & to improve the uniform application of VA directives

Though I plan to focus the bulk of my remarks on Representative Brownley's "Informed Consent" bill, I would like to begin today's statement with the following introductory remarks prior to turning to each specific piece of legislation. I ask that this committee ensures that the health care obligations imposed by the sacrifices of our veterans are met in a timely, professional and compassionate manner and I urge you to reject any plan to eliminate the VA from the hands-on care of our veterans.

I know that each of you is aware of, and appreciates the numerous issues of importance facing our military members, veterans and retirees; therefore this testimony will be, following these introductory remarks limited to the specific pending health care legislation being considered today.

I would also like to highlight several general issues that AMVETS would like the committee to monitor and enforce as it goes about its work, followed by specific recommendations related to the VA.

General Recommendations:

- ensure that the VA provides a continuity of health care for all individuals who were wounded or injured in the line of duty including those who were exposed to toxic chemicals;
- ensure that all eligible veterans not only have adequate access, but timely and appropriate treatment, for all of their physical and mental healthcare needs;
- continue the strictest oversight to ensure the safety, physical and mental health and confidentiality of victims of military sexual trauma;
- ensure that the VA continues to provide competent, compassionate, high quality health care to all eligible veterans; and
- ensure that the VA continues to receive sufficient, timely and predictable funding.

Specific Recommendations:

- Ensure that both advanced appropriations and discretionary funding for VA keeps pace with medical care inflation and healthcare demand so that all veterans healthcare needs can be adequately met;
- Maximize the use of non-physician medical personnel, when appropriate, as a way to mitigate physician shortages and reduce patient wait times especially while utilization of the VA system continues to rise;
- Ensure that VA makes more realistic third-party medical care collection estimates so that Congress doesn't end up under-appropriating funds based on false expectations which in turn negatively impact veteran care. Additionally, VA needs to redouble its efforts to increase its medical care collections efforts, because taken together, the cumulative effects of overestimating and under-collecting only degrade the care available to our veterans. Furthermore, VA needs to establish both first- and third-party copayment accuracy performance meas-

ures which would help minimize wasted collection efforts and veteran dissatisfaction;

- VA needs to incorporate civilian healthcare management best practices and include a pathway to VA hospital/clinic management for civilians as part of their succession plan requirements, so that VA will be able to attract the best and the brightest healthcare managers in the industry;
- VA could immediately increase its doctor/patient (d/p) ratio to a more realistic and productive levels in order to cut wait times for veterans needing treatment and/or referrals. While the current VA (d/p) ratio is only 1:1200, the (d/p) ratio for non-VA physicians is close to 1:4200. Instituting this one change would drastically improve our veterans access to needed healthcare;
- VA needs to improve its patient management system so that veterans have more appointment setting options available to them, which could reduce staffing errors and requirements. VA should also consider utilizing a hybrid system whereby half the day might consist of scheduled appointment and the other half would be for walk in or same-day appointment. The elimination of the need for non-specialty appointments would allow veterans quicker access to their primary care providers;
- The current VA healthcare system appears to be top-heavy with administrative staff and short-handed when it comes to patient-focused clinical staff. This imbalance can only lead to noticeable veteran wait times;
- The VA needs to thoroughly review its entire organizational structure in order to take advantage of system efficiencies and to maximize both human and financial resources, while also minimizing waste and redundancies;
- VA must immediately improve its recruitment, hiring and retention policies to ensure the timely delivery of high quality healthcare to our veterans. VA currently utilizes a cumbersome and overly-lengthy hiring process which reduces its ability to deliver critical services. VA need to consider adopting a more expedient hiring/approval process which could include some form of provisional employment;
- VA needs to have, and utilize, the option to terminate non-performing employees at all levels of the organization so that only dedicated, accurate, motivated employees will remain in service to our veterans; and
- Finally, VA needs to reform their incentive programs so that only high-performing employees receive appropriate bonuses for their excellence in serving our veterans.

PENDING HEALTH CARE LEGISLATION

HR 2460, to improve the provision of adult day health care services for veterans - AMVETS supports this legislation, which seems like the best of both worlds, in that it provides the appropriate and necessary care for veterans, in a more cost effective manner while also providing an improved quality of life. This legislation directs the Secretary of Veterans Affairs to enter into an agreement or a contract with each state home to pay for adult day health care for a veteran eligible for, but not receiving, nursing home care.

The veteran must need such care either specifically for a service-connected disability or the veteran must have a service-connected disability rated 70% or more.

Payment under each agreement or contract between the Secretary and a state home must equal 65% of the payment that the Secretary would otherwise pay to the state home if the veteran were receiving nursing home care.

HR 3956, the VA Health Center Management Stability & Improvement Act - AMVETS supports this legislation which seems to be a bit of a no-brainer. Medical centers without directors will most likely not perform as well as or as consistently as, those that do. Specifically, the bill directs the VA to develop and implement a plan to hire a director for each VA medical center without a permanent director, giving the highest priority to medical centers that have not had a permanent director for the longest periods.

HR 3974, the Grow Our Own Directive: Physician Assistant Employment & Education Act of 2015 - AMVETS supports this legislation which builds upon and leverages the training and experience of former military members. This bill directs the VA to carry out the Grow Our Own Directive or G.O.O.D. pilot program to provide educational assistance to certain former members of the Armed Forces for education and training as VA physician assistants.

An individual is eligible to participate in the program if the individual:

- has medical or military health experience gained while serving in the Armed Forces;

- has received a certificate, associate degree, baccalaureate degree, master's degree, or post baccalaureate training in a science relating to health care;
- has participated in the delivery of health care services or related medical services; and
- does not have a degree of doctor of medicine, doctor of osteopathy, or doctor of dentistry.

The VA shall:

- provide educational assistance to program participants for the costs of obtaining a master's degree in physician assistant studies or a similar master's degree;
- ensure that mentors are available for program participants at each VA facility at which a participant is employed;
- seek to partner with specified government programs and with appropriate educational institutions that offer degrees in physician assistant studies;
- establish specified standards to improve the education and hiring of VA physician assistants, and
- implement a national plan for the retention and recruitment of VA physician assistants that includes the adoption of competitive pay standards.

HR 3989, the Support Our Military Caregivers Act - AMVETS is very supportive of this bill which permits an individual to elect to have an independent contractor perform an external clinical review of any of the following:

- a VA denial of an individual's application to be a caregiver or family caregiver eligible for VA benefits;
- with respect to an approved application, a VA determination of the level or amount of personal care services that a veteran requires;
- a request by a caregiver or family caregiver for a reconsideration of the level or amount of personal care services that a veteran requires based on post-application changes; and
- a revocation of benefits by the VA.

The VA shall ensure that each external clinical review is completed and the individual is notified in writing of the results within 120 days of the election.

Draft Legislation, to ensure that VA medical facilities comply with requirements related to appointment scheduling for veterans and to improve the uniform application of directives - AMVETS feels strongly that there needs to be continuity across the VA healthcare system and this bill should help to make that recommendation a reality.

Draft Legislation, to establish a list of drugs that require an increased level of informed consent - this is a top issue for AMVETS and we whole-heartedly support this legislation because we believe that the health and welfare of veterans needs to come first. This means their interests come before any VA employees, including physicians.

AMVETS believes that having the veteran's 'buy-in' and clear understanding of any proposed risky medications, will not only provide much needed 'peace of mind' for the veteran and their family, but will be instrumental in the overall healing process. An informed patient is much more likely to fully comply with their doctor's instructions and much less likely to complain or be dissatisfied with their treatment.

Let me be clear that our intention in supporting this legislation is not to 'burden' or disrespect VA doctors, but to provide veterans the opportunity to be more actively involved in their health care treatments.

In order to minimize the burden on physicians, AMVETS suggests utilizing nationally standardized medical educational material which could be adopted by the VA and made available either digitally or in a preprinted format (medication guide). All of the medications which would require informed consent would either be available in a database whereby each medication, with its additional information including, but not limited to:

- all the names of any drugs being offered to the patient, including any other trade or generic name for such drug;
- side effects, if any, including dependency;
- any alternative methods of treatment or therapy not involving a covered drug;
- whether the drug is being offered for a non-Food & Drug Administration (FDA) approved use;
- whether the drug is being given in a dosage that exceeds the dosages approved or tested by the FDA;
- any potential dangers of mixing drugs and dosages in sizes and combinations that have not been approved or tested by the FDA;

- any known interactions between a covered drug and other drugs or substances, including alcohol;
- any and all other appropriate warnings or information that a patient in similar circumstances would reasonably want to know

could be printed for each specific covered medication and provided to the patient.

If utilizing the pre-printed medication guide, the format of which is yet to be determined, each covered medication would be included with all of the same additional information as the database option, the physician would then merely ‘check off’ the recommended medications and hand the information to the patient. In both cases a ‘consent form’ would be provided to the patient for his/her signature, in either an electronic or paper format.

The patient’s signature, at this point, merely indicates that they have been provided with the information regarding any covered medications and should not yet be understood as an acceptance of the proposed treatment plan. At this point the patient should be given the opportunity to ask any immediate questions of the physician or the veteran could be referred to a pharmacist for further information.

The patient would then be given three full business days from the initial prescription recommendation to:

- consider and internalize the information provided by the clinician;
- conduct any additional research;
- seek a second opinion, discuss with family or get a legal opinion

At the end of the three day period, the patient would then convey their approval/disapproval of the suggested medication(s) via secure messaging (My HealtheVet), phone, email or fax directly to the prescribing physician or his/her office.

The veteran’s signature along with the follow up (oral or written) at the end of the three days would jointly fulfill the informed consent signature requirement, so there would be no further reason for the veteran to return to the doctor’s office on this matter unless there were extenuating circumstances. (This process could be even further streamlined by not requiring the veteran to do any follow up, unless they disagree with the proposed treatment plan. In which case, their previous signature plus their lack of disagreement with the proposed treatment plan could be taken as their complicit consent.)

An additional point of clarification I would like to make is that the VHA Handbook already mandates that side effects and alternative treatments be explained to a veteran prior to deciding on a treatment plan. This proposed legislation then is not asking for something entirely alien to the VA, it is merely asking for an increased ‘Informed Consent’ requirement.

Remember this added requirement would only be utilized when a physician prescribes a medication from the limited list of covered medications which carry ‘black-box’ warnings, have substantial risks or undesirable side effects, etc.

This type of information is especially critical for veterans who may have additional physical and/or mental health concerns and may already be taking or require a number of dangerous medications.

The need for this type of medical disclosure is also a concern in the non-veteran health care community as evidenced by the FDA’s recent announcement that immediate-release opioid painkillers such as oxycodone will now have to carry a “black box” warning about the risk of abuse, addiction, overdose and death. (“Black box” warnings are the FDA’s strongest, and they’re meant to help educate doctors as they’re prescribing medications to patients. See article below)

This completes my statement at this time and I thank you again for the opportunity to offer our comments on pending legislation. I will be happy to answer any questions the committee may have.

ADDITIONAL INFORMATION:

VHA Handbook on Informed Consent - sent as a separate attachment

Prepared Statement of Shurhonda Y. Love

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting DAV (Disabled American Veterans) to testify at this legislative hearing of the Subcommittee on Health. As you know, DAV is a non-profit veterans service organization comprised of 1.3 million wartime service-disabled veterans that is dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity.

DAV is pleased to be here to present our views on the bills under consideration by the Subcommittee, and we appreciate your invitation.

H.R. 2460

H.R. 2460, if enacted, would authorize the Secretary to enter into agreements with state veterans homes to provide adult day health care for veterans who are eligible for, but do not receive, skilled nursing home care under section 1745(a) of title 38, United States Code. Eligible veterans are those who require such care due to a service-connected disability, or who have a VA disability rating of 70 percent or greater and are in need of such care. The payment to a state home under this program would be at the rate of 65 percent of the amount payable to the state home if the veteran were an inpatient for skilled nursing care and payment by VA would be considered payment in full to the state home.

Adult day health care is an alternative to traditional skilled nursing care that can allow some veterans requiring long-term service and supports to remain in their homes near family and friends, rather than be institutionalized in nursing homes. This program is designed to promote socialization, stimulation, and maximize independence while enhancing quality of life as well as providing comprehensive medical, nursing, and personal care services for veterans.

DAV is pleased to support H.R. 2460, which is in line with DAV Resolution No. 101, adopted at our most recent National Convention, calling for support for the state veteran home program, recognizing state home care as the most cost-effective care available for sick and disabled veterans with long-term care needs outside the VA health care system.

H.R. 3956, the VA Health Center Management Stability and Improvement Act

If enacted, this bill would require VA to develop and implement a plan to hire a director for each VA medical center without a permanent director at the time of enactment. It would place the priority for hiring at facilities that have gone without a director for the greatest length of time. In the Secretary's plan, a deadline for hiring would be set at the Secretary's discretion.

This bill would also direct the Secretary to identify impediments to the hiring of directors, and identify candidates from within VA who could be promoted to fill these key positions. At the 120th day after enactment of this bill, it would require the Secretary to submit a report to Congress. Every 180 days after, the Secretary would be required to submit a report to Congress on facilities still lacking permanent directors.

Currently, 23 medical centers are without permanent directors. Prior to VA's adopting this more assertive approach, 35 vacancies were reported. We understand that VA is taking steps to hire medical center directors by posting national vacancy announcements in multiple locations across the system, and by leveraging social media outlets and other venues to increase public awareness of these leadership opportunities.

DAV has not received a resolution specific to the hiring of VA medical center directors, but DAV Resolution No. 126 calls for the support of modernization of VA's human resources management system to enable VA to compete for, recruit and retain the types and quality of VA employees needed to provide comprehensive health care services to sick and disabled veterans. Directors of VA medical centers are key officials in this respect; therefore, DAV would not object to the enactment of this bill.

H.R. 3974, the Grow Our Own Directive: Physician Assistant Employment and Education Act of 2015

If enacted, this bill would direct VA to carry out a pilot program to provide educational assistance to certain veterans with the goal of employment as VA physician assistants.

Under this bill, the pilot program would target veterans with experience gained in medical or military health care while serving, and who had received a certificate, associate degree, baccalaureate degree, master's degree, or post-baccalaureate training in a science related to health care, and had participated in the delivery of health care services or related medical services.

The bill would require VA to provide educational assistance, including scholarships, to no fewer than 250 participants, 35 of whom would be employed each year of the pilot program. VA would be required to reimburse their costs of obtaining master's degrees in physician assistant studies or similar master's degrees, con-

sistent with VA's existing health professions scholarship program authorized in Chapter 76 of title 38, United States Code. The bill would require VA to make available mentors for participants at each VA facility and would require VA to establish partnerships with other government programs and with a specific number of educational institutions that offer degrees in physician assistant studies. It would also require selectees to agree to an obligated work period in VA facilities in specified geographic areas, including areas of medically underserved populations, but also in states with per capita veteran populations of more than nine percent.

The bill also would require VA to establish standards to improve the education and hiring of VA physician assistants, and implement a national plan for the retention and recruitment of VA physician assistants.

The bill would establish a series of new, mandatory positions in VA's national Office of Physician Assistant Services in VA Central Office, including a Deputy Director for Education and Career Development, a Deputy Director for Recruitment and Retention, a designated recruiter of physician assistants, and an administrative assistant to support these functions. The bill would outline their major duties.

The bill would re-designate not less than \$8 million in funds appropriated prior to the passage of this bill to carry out its purposes. The bill is silent on sources of additional funding that might be needed to meet its mandates.

Finally, the bill would align VA physician assistant pay grades equivalent to the pay grades of VA registered nurses.

DAV has not received a resolution from our membership dealing with VA recruitment, training or employment of physician assistants as a single employment category, but we recognize the value of this bill in improving health manpower in the VA, and especially in addressing shortages being observed today in VA's primary care provider workforce. On this basis DAV would not object to enactment of this bill.

H.R. 3989, the Support Our Military Caregivers Act

This bill would establish an external review process in cases in which VA denied caregiver benefits for veterans, approved a level of benefits that was considered inadequate to a veteran's needs, or revoked these benefits. A decision on this review, once requested by a caregiver, would be required by the bill to be completed within 120 days.

Our concerns regarding the VA Comprehensive Caregiver Support Program continue to include the apparent lack of due process and transparency in the decision and appeal process for veteran and caregiver program applicants. DAV identified early on the need for an independent mechanism through which (1) a caregiver can appeal a clinical team's decision; (2) that decision can be carefully reviewed "de novo;" and (3) an unwarranted decision can be reversed, altered, or sent back to the clinical team with instructions to reassess or consider additional factors. Accordingly, DAV is pleased to support H.R. 3989 because it is in line with DAV Resolution No. 106, which calls for legislation to provide comprehensive support and services to caregivers of all veterans severely injured, wounded or ill from military service.

We note the intent of this bill would be to offer program applicants a review of VHA decisions; however, it is not clear if the external clinical review would be binding on VA, and whether the recommendations of the contractor would be cause for VHA to issue a new decision based on the findings of the review. We also bring to the Subcommittee's attention there is still no publicly accessible program handbook or directive outlining mandatory program policies, procedures and operational requirements, which would serve to inform and educate those enrolled or those seeking enrollment in the program.

Moreover, we believe VA's Caregiver Support Program office should have ready access to the types of data that would allow it to monitor and manage the program's workload due to the limited capabilities of VA's data system, which was designed to manage a much smaller workload. Veterans Integrated Service Network (VISN) officials and VA medical centers officials have reported that there are too few Care Support Coordinators (CSC) to handle the program's workload effectively. Specifically, at some medical centers, CSCs have been unable to perform all of the routine administrative tasks associated with their approved caregivers. Irrespective of inadequate staffing for the caregiver support program from VA Central Office, or not possessing the right tools or sufficient resources or support to properly manage, evaluate and improve the program, caregivers of, and injured veterans themselves, are being adversely affected and are not receiving the full benefits intended by Congress. In addition to passage of this bill, we urge VA and Congress to address these problems.

Discussion Draft, requirement of increased informed consent for certain drugs

If enacted, this bill would require VA to establish a panel of specialists that would reside within the Office of Specialty Care Services of VHA to establish and maintain a list of drugs to include psychotropic drugs that would require an increased level of informed consent. Under the bill, such drugs would only be prescribed to an enrolled veteran with written, informed consent of the veteran or appropriate representative of the veteran.

We understand that VA maintains an oral informed consent process covering the types of drugs contemplated by this bill. According to VA, at the point that a VA physician prescribes psychotropic medications to patients, an automatic process commences to gain a patient's informed consent. In addition, some medical centers have assigned pharmacists to Patient Aligned Care Teams (PACT), where the use of certain drugs is explained and patients gain the opportunity to speak directly with pharmacy staff about possible side effects and contraindications. Finally, prescribed medications are received with accompanying information sheets, and some medications are issued with both drug information sheets as well as FDA medication guidelines. However, we understand VA has not implemented a nationwide directive requiring the presence of pharmacy counselors within PACTs. To ensure VA physicians can continue to provide timely care it may be beneficial to require VA to include pharmacy personnel on all PACT teams systems to ensure patients have adequate time to gain a meaningful understanding of the medications prescribed and alternative treatments available.

DAV is pleased to support this draft measure which is consistent with DAV Resolution No. 126, and urges VA to promote and ensure health care quality and value, and to protect veterans' safety in the VA health care system.

Draft Bill, to ensure VHA medical facilities are uniformly in compliance with VHA appointment scheduling directives and policies

This bill would require that each VHA medical center certify that it is in compliance with current VHA directives and policies applicable to scheduling veterans' appointments for health care. In the event the facility was not in compliance, the facility director would be required to provide an explanation of why the facility was not in compliance, and what steps were being taken to achieve compliance. The Secretary would be required to submit an annual report to Congress regarding the status of medical centers in meeting this requirement. In addition, the Secretary would be required to ensure all facilities are uniformly in compliance with VHA directives and policies on scheduling. In the event of a medical center's having been waived from uniform compliance, the Secretary would be required to notify Congress of such waiver, and provide explanation.

DAV has received no specific resolution from our membership addressing the issue of VA certification of appointment scheduling, but we would not oppose passage of this bill.

Mr. Chairman, DAV appreciates the opportunity to provide testimony. I would be pleased to address any questions you, or members of the Subcommittee may have on the topics covered in this statement.

Prepared Statement of Fred S. Sganga

Mr. Chairman and Members of the Subcommittee, thank you for this opportunity to provide testimony regarding H.R. 2460, legislation introduced by Congressman Lee Zeldin of New York, to provide severely disabled veterans with an enhanced option to receive adult day health care services from State Veterans Homes.

I am Fred Sganga, the Legislative Officer of the National Association of State Veterans Homes (NASVH). I also have the high honor of serving as the Executive Director of the Long Island State Veterans Home (LISVH) at Stony Brook University, a 350 bed State Veterans Home that also operates a 40 slot medical model Adult Day Health Care (ADHC) program.

The State Veterans Home program was established by a Congressional Act on August 27, 1888, and for more than 125 years State Homes have been in a partnership with the federal government to provide long term care services to honorably discharged veterans; in some states, widows and spouses as well as Gold Star Parents are also eligible for admission. There are currently 153 State Veterans Homes located in all 50 states and the Commonwealth of Puerto Rico.

The National Association of State Veterans Homes (NASVH) was conceived at a New England organizational meeting in 1952 because of the mutual need of State Homes to promote strong federal policies and to share experience and knowledge among State Home administrators to address common problems. NASVH is committed to caring for our nation's heroes with the dignity and respect they deserve.

With over 30,000 beds, the State Veterans Home program is the largest provider of long term care for our nation's veterans. Current services provided by State Homes include skilled nursing care, domiciliary care and adult day health care. The Department of Veterans Affairs (VA) provides State Homes with construction grants to build, renovate and maintain the Homes, with States required to provide at least 35 percent of the cost for such projects in matching funds. State Veterans Homes also receive per diem payments for basic skilled nursing home care, domiciliary care and ADHC from the federal government which covers about one third of the daily cost of care.

Mr. Chairman, a decade ago, NASVH led the effort on Capitol Hill to assist our most disabled veterans by allowing them to receive skilled nursing care in State Veterans Homes under a new program that would provide the "full cost of care" to the State Home and thereby expand the options available to these deserving veterans at no cost to them. In 2006, Congress passed and the President signed Public Law 109-461 which guaranteed "no cost" skilled nursing care to any honorably discharged veteran who has a 70% or higher service connected disabled rating. Unfortunately, the bill did not extend the same "no cost" program to cover alternatives to traditional institutional care, such as the medical model Adult Day Health Care currently provided at three State Veterans Homes in Stony Brook, New York, Minneapolis, Minnesota and Hilo, Hawaii. H.R. 2460 would fix that.

Adult Day Health Care at the LISVH is designed to promote wellness, health maintenance, socialization, stimulation and maximize the participant's independence while enhancing quality of life. A medical model Adult Day Health Care program provides comprehensive medical, nursing and personal care services combined with engaging social activities for physically or cognitively impaired adults. These programs are staffed by a caring and compassionate team of multi-disciplinary healthcare professionals who evaluate each participant and customize an individualized plan of care specific to their health and social needs.

As a licensed nursing home administrator, I would like to thank Congressman Zeldin for recognizing the need to offer non-institutional alternatives to our veterans. Giving our veterans and families choices in how they can receive care is just the right thing to do. Making sure that there are no financial barriers to care is important to our most medically compromised veterans.

It would be especially important to veterans like Jim Saladino and his wife Noreen. Fifty years ago, Jim answered the call of his country and served in the United States Army during the Vietnam War. Today, he suffers from the ravages of Agent Orange exposure. Specifically, he suffers from chronic illnesses including diabetes and Parkinson's disease and he also recently suffered a stroke.

Although the Saladino family could have decided to put Jim into our State Veterans Home because he is a 100% service connected veteran so it would have been fully paid for by VA, but that is not their choice. They would like their loved one to continue enjoying the comforts of his own home - for as long as he can. By providing him the benefits of our medical model Adult Day Health Care program, Jim is able to keep living at home.

Jim's wife, Noreen, serves as his primary caregiver. She has publicly stated that the medical model Adult Day Health Care Program has been a true blessing for her. Jim comes to the ADHC program three days a week and we work closely with his personal physician to provide services that will maintain his wellness and keep him out of the emergency room. During his six hour day with us, Jim receives a nutritious breakfast and lunch. He receives comprehensive nursing care. He also receives physical therapy, occupational therapy and speech therapy. He can get his eyes checked by an optometrist, his teeth cleaned and examined by our dentist, and his hearing checked by an audiologist. If required, he can get a blood test or an x-ray, have his vital signs monitored and receive bathing and grooming services while on site.

For Jim's wife, having him come to our program allows her the peace of mind knowing that he is in a safe and comfortable environment. She can then get a break as caregiver and tend to those issues that allow her to run her household. However, because of the way the law is currently structured, despite Jim's eligibility for "no cost" skilled nursing care, they are required to pay out of pocket for a portion of his Adult Day Health Care.

Mr. Chairman, H.R. 2460 will fix this disparity that prevents some of the most deserving and severely disabled veterans from taking advantage of this valuable

program to help keep living in their own homes. This legislation would authorize VA to enter into agreements with State Veterans Homes to provide Adult Day Health Care for veterans who are eligible for, but do not receive, skilled nursing home care under section 1745(a) of Title 38, the “full cost of care” program. Veterans who have a VA disability rating of 70 percent or greater or who require ADHC services due to a service-connected disability would be eligible for this program. The payment to a State Home under this program would be at the rate of 65 percent of the amount that would be payable for skilled nursing home care under the same “full cost of care” program. This legislation would not only offer a lower cost alternative (ADHC) for severely disabled veterans who might otherwise require full time skilled nursing care, but it would also allow them to continue living in their own homes.

The VA has been stressing the need to provide essential long-term care services in non-institutional settings for our most frail, elderly disabled veterans. Medical model Adult Day Health Care is a tremendous solution to this challenge being faced by the VA, one that can keep veterans living in their homes while allowing them to receive skilled nursing services and supports. There are a number of State Homes across the country interested in providing medical model ADHC services, however the current basic ADHC per diem is not nearly sufficient for most State Homes to be cover the costs of this program. Enactment of H.R. 2460 would provide a higher ADHC per diem rate for severely disabled veterans in medical model ADHC programs and thereby allow additional State Homes across the country to offer this service.

For the Saladino family, receiving “no cost” medical model Adult Day Health Care for their loved one would relieve a huge financial burden that they currently incur. Even though Jim’s service ended 50 years ago, he is still paying a price for his valor related to his service in Vietnam. Passing H.R. 2460 would send a strong message to all those who have worn the uniform to protect our freedoms that they will never be forgotten.

H.R. 2460 has bipartisan support in the House and has also been supported by a number of veterans service organizations, including The American Legion and the Veterans of Foreign Wars. I would ask that The American Legion’s letter of support for this legislation be made a part of the record.

On behalf of the National Association of State Veterans Homes, I urge you to favorably consider and pass H.R. 2460 for Jim and Noreen Saladino, and for thousands of others across the country just like them. Mr. Chairman, that concludes my testimony and I would be happy to answer any questions you and members of the Subcommittee may have. Thank you.

Prepared Statement of Maureen Mccarthy

Good morning Chairman Benishek, Ranking Member Brownley, and Members of the Committee. Thank you for inviting us here today to present our views on several bills that would affect VA health programs and services. Joining me today is Susan Blauert, Chief Counsel for General Counsel’s Health Care Law Group.

Draft Bill: To ensure that each VA medical facility complies with requirements relating to scheduling veterans for health care appointments and to improve the uniform application of VA directives

The proposed draft bill would require each VA medical facility to comply with requirements relating to scheduling Veterans for health care appointments and to ensure the uniform application of VA directives.

Section 1 would require the director of each VA medical facility to annually certify to the Secretary that the medical facility is in full compliance with all provisions of law, regulations, and VA directives relating to scheduling appointments for Veterans to receive hospital care and medical services. VA does not support section 1 of this bill because it is unnecessary. Existing policies already require directors to certify compliance with the scheduling directive and explain gaps in compliance based on scheduling data collected at the facility level. This bill would not increase the amount or quality of information available regarding scheduling or meaningfully improve existing processes for certifying compliance.

The bill also over-prioritizes scheduling to a great extent. Scheduling, while important, is not the only way Veterans access care in VA. As a technical matter, we note this bill would provide that each VA medical facility Director must certify compliance with all laws and regulations relating to “scheduling appointments for Veterans to receive hospital care.” Veterans are not required to be scheduled for hos-

pital care; they can walk in the door and be admitted through the emergency room, if clinically appropriate, or their primary care provider may admit them directly. Within VA, the term “scheduling” typically is used in the context of outpatient care.

The bill also prohibits the Secretary from waiving any provision of law or regulation relating to scheduling. This provision would not benefit Veterans. VA is actively working with Members of Congress on a consolidated care in the community program and other efforts to improve access to health care. In this dynamic environment, particularly with the increased use of community care, VA needs the flexibility to set scheduling standards that are clinically appropriate and can change and improve over time in step with other changes in the way Veterans access health care.

Section 2 of the bill would require VA to ensure that its policies apply uniformly to each office or facility of the Department. VA does not support section 2 of the bill because it is unnecessary and, if interpreted broadly, unduly rigid. VA national policies already apply uniformly across the Department. At the same time, these policies provide some flexibility so that facilities can develop and pilot innovative ideas, or implement policies and procedures that are specific to the needs of the local Veteran community and consistent with the principles and procedures established in national policy. Section 2 could potentially limit VA facilities’ ability to implement policies and procedures needed to tackle local challenges and address Veterans’ needs.

We do not have costs for this bill at this time.

H.R. 2460: To Improve the provision of adult day health care services for veterans

H.R. 2460 would amend 38 United States Code (U.S.C.) § 1745 to require the Secretary to enter into an agreement under 38 U.S.C. § 1720(c)(1) or a contract with each State home for payment by VA for adult day health care (ADHC) provided to an eligible Veteran. Payments would be made at a rate that is 65 percent of the payment VA would make if the Veteran received nursing home care, and payment by VA would constitute payment in full for such care. Currently, under a grant mechanism, VA pays States not more than half the cost of care of providing ADHC. States may currently obtain reimbursement for this care from other sources in addition to VA’s per diem payments.

VA does not support this bill for the following reasons. Substantively, we note that the bill would base payment rates for ADHC on nursing home care rates, even though these are two distinctly different levels of care and are furnished for different periods of time. VA pays per diem for three levels of care at State Veterans Homes (SVH): nursing home care, domiciliary care, and adult day health care. The prevailing nursing home rate is calculated based on the cost of providing nursing home care. Nursing home residents live at the facility and receive 24-hour skilled nursing care. ADHC, however, is a much lower level of care where participants live at home and only use ADHC services for a portion of time during the day, normally about 8 hours, or one third of the length of time that skilled care is provided. A per diem payment is made only if the participant is under the care of the facility for at least 6 hours. Because the level of services for ADHC and nursing home care are different, and the period of time in which services are furnished are different, we believe the payment rate proposed in the bill is inappropriate. The bill, in essence, would pay two thirds of the rate that VA pays for a higher level of care for furnishing a lesser level of care for only one third of the time.

VA also has logistical concerns with the legislation. First, we note that the language in the bill directing VA to “enter into an agreement under § 1720(c)(1) of this title or a contract” with each State home is inadequate. VA does not have independent agreement authority under § 1720, and all agreements reached under this provision are contracts. The fact that these agreements are contracts places additional requirements on State homes that have proved burdensome and difficult to implement. To address this and similar situations, VA has requested congressional action to enact the Purchased Health Care Streamlining and Modernization Act that we submitted to Congress last year. This legislation would allow VA to enter into agreements that are not subject to certain provisions of law governing Federal contracts with providers on an individual basis in the community. Already, we have seen certain private nursing homes not renew their contracts, requiring Veterans to find new facilities for residence. We recommend Congress enact this new authority before requiring VA to transition payments to States for some ADHC participants from a grant to a contract mechanism.

Additionally, in June 2015, VA published a proposed rule, “Per Diem Paid to States for Care of Eligible Veterans in State Homes,” RIN 2900–AO88, along with a clarifying and correcting rule one week later. VA proposed these amendments to

its regulations regarding payments for ADHC care in SVHs so that States may establish diverse programs that better meet participants' needs for socialization and maximize their independence. Currently, VA requires States to operate these programs using a medical supervision model exclusively. We expect that the proposed changes to our regulations will offer a socialized model that would result in an increase in the number of States that have ADHC programs. Currently, the SVH ADHC program is underutilized, as only three SVHs operate ADHC programs. We do not know at this time how many SVHs will adopt this new model, nor how the new model's use will affect costs. Until we have such information, we recommend against codifying a payment rate, as such a limitation could result in VA overpaying or underpaying States in the future.

VA has other technical comments and recommendations we would be happy to provide at your request.

VA supports growing ADHC programs in general because they are a part of VA's home and community-based programs included in the medical benefits package available to enrolled Veterans. VA operates ADHC programs, pays for ADHC in the community, and pays per diem to SVHs for ADHC. Those who are able to utilize the ADHC program are able to avoid nursing home care, maximizing their independence to support their choices, while reducing costs to VA. Projections for the Long-Term Services and Supports Model demonstrate that VA utilization for ADHC in the community will increase. VA recommends forbearing any action at this time until we have clear authority to enter into agreements other than contracts for such services and until VA is able to finalize changes to its regulations allowing for the new social model of care.

VA estimates H.R. 2460 would cost \$1.7 million in the first year, \$2.1 million in the second year, and \$12.6 million over five years.

H.R. 3989: Support Our Military Caregivers Act

H.R. 3989 would add a new subsection (d) to 38 U.S.C. § 1720G that would set forth a process for external clinical reviews of certain determinations under VA's Program of Comprehensive Assistance for Family Caregivers (PCAFC) and Program of General Caregiver Support Services, as established in Public Law (P.L.) 111-163. Under the new subsection (d), "an individual may elect to have an independent contractor . . . perform an external clinical review" of: a denial of a caregiver's application for benefits under § 1720G, a determination or reconsideration of "the level or amount of personal care services that a veteran requires," or a revocation of benefits pursuant to § 1720G. The bill specifies that such reviews would be performed by an "independent contractor" as described in the bill, "[u]sing amounts otherwise appropriated" to carry out § 1720G."

VA does not support this bill because VA already has an existing mechanism in place to review eligibility determinations under § 1720G, including, where appropriate, consideration of recommendations from an external clinical review.

VA implemented Caregiver Support Programs under § 1720G in May 2011. Since then, more than 30,000 caregivers have received services and support through PCAFC. These additional services and support are essential aspects of a Veteran's treatment plan as VA provides Veteran-centered and family-centered care to Veterans.

As provided in 38 U.S.C. § 1720G(c), all decisions by the Secretary under § 1720G affecting the furnishing of assistance or support shall be considered medical determinations. Accordingly, when there are disagreements with or clinical disputes over a decision under § 1720G that are not resolved at the clinical team level, VHA follows the VHA Clinical Appeals policy and procedures that govern the appeals process for all VHA clinical programming (VHA Directive 2006-057, VHA Clinical Appeals). This policy sets forth the mechanism in VHA for both internal and external clinical appeals. As provided in VHA Directive 2006-057, "[i]t is VHA policy that patients or their representatives must have access to a fair and impartial review of disputes regarding clinical determinations or services that are not resolved at the facility level."

Providing a separate process for external clinical reviews, as set forth in H.R. 3989, would significantly impact the current process for reviewing eligibility determinations under PCAFC, in particular, as the program is currently operated. For example, when a Veteran (or eligible Servicemember) applies for the PCAFC, the individual's primary care team makes a series of clinical eligibility determinations. Once approved, the primary care team continues to remain involved by maintaining the individual's treatment plan and collaborating with clinical staff making home visits to monitor the individual's well-being, supporting both the Veteran (or eligible Servicemember) and family caregiver(s). The existing VHA Clinical Appeals policy

ensures that, in the event of an appeal, decisions are made by VHA leadership with direct oversight of the clinical team involved with the individual's care.

In contrast, the external clinical review under H.R. 3989 would be conducted by an independent contractor who "employs a panel of physicians or other appropriate health care professionals" and who does not provide health care to the individual. The independent contractor would need to be educated about PCAFC, applicable eligibility requirements, existing assessment and revocation procedures, as well as required assessment tools. This new process would require management and quality assurance oversight and Veteran-facing customer service and satisfaction supports that would require additional staffing or contract support.

Moreover, using an "independent contractor" to perform external clinical reviews, as provided in H.R. 3989, could not be achieved with existing funding. Additional funding for this new requirement would be necessary, to include funding for education and customer service and satisfaction supports.

VA is unable to provide a cost estimate on this bill as data required to construct costing is not readily available.

H.R. 3974: The Grow Our Own Directive: Physician Assistant Employment and Education Act of 2015

VA supports section 2 of H.R. 3974, subject to the availability of funds, which would require VA to carry out a pilot program to provide educational assistance to certain former members of the Armed Forces for education and training as physician assistants (PA). Having a pilot program will help alleviate the health care workforce shortages in VA by requiring scholarship recipients to complete a service obligation at a VA health care facility after graduation and licensure/certification. Additionally, scholarships will enable students to gain academic credentials without additional debt burdens from student loans. Future benefits are gained in reduced recruitment costs as scholarship recipients will have obligated service agreements to fulfill. These service agreement obligations secure the graduates' services for up to 3 years, which reduces turnover, and costs typically associated with the first 2 years of employment.

While VA supports H.R. 3947, we believe that the Congress should provide more flexibility in implementation. The bill is very specific, including in areas such as directing new pay levels, and the exact criteria for participant eligibility. VA should be afforded the flexibility to implement such a program in a manner that can minimize any unintended consequences, such as consistency across Title 38 programs in other Federal agencies.

While VA supports section 2, we recommend removing language in paragraph (j) that would require these positions to be filled by a Veteran and a current employee. While requiring a position be filled by a Veteran could be challenging, requiring that the individual be "employed by [VA] as of the date of enactment of the Act" would be legally problematic. In addition, the limitation of filling the proposed Deputy Director positions with Veterans only (as opposed to employing Veteran preference) would significantly limit the pool of applicants with the necessary experience and skill sets necessary to successfully carry out the responsibilities of the positions.

The total cost of section 2 of the Health Professional Scholarship Program (HPSP) with HPSP Stipend cost for 250 awards over 5 years would be \$19,812,531. This amount includes \$11,700,000 for scholarship assistance, \$7,652,584 for stipend costs, as well as additional costs for administration, information technology, and travel.

Section 3 would establish standards for the Department for using educational assistance programs to educate and hire PAs. VA does not support this section because Educational Debt Reduction Program (EDRP) assistance is targeted for specific positions that are designated as difficult to recruit and retain. In order to meet local Veteran population needs, local medical centers have the flexibility to determine the positions that have the most critical need for EDRP awards and advertise accordingly. Loan repayment awards are an attractive tool; however, EDRP is a limited resource and offering EDRP to an entire occupational series is contrary to the statutory mission of the program and sets a precedent for other occupations to seek similar authority.

The PA occupation is recognized as a top 5 mission-critical occupation within VA, ranking fourth and tied with physical therapy, according to the January 2015 VA Office of Inspector General (OIG) report after medical officer (physician), nurse, and psychologist.

Over the last several fiscal years (FY), the number of new PA hires has fluctuated between 250–350 annually. The number of EDRP awards made for newly hired PAs has gradually increased from 26 to 45 (62 percent increase) from FY 2014 to FY 2015, and currently comprises 13 percent of all new PA hires. In the FY 2015 EDRP

award cycle, the average EDRP award for PAs was \$63,000. Current projections estimate similar awards for the PA occupation based on qualifying student loan debt. Overall, the OIG top 5 occupations represented 82 percent of all EDRP awards made in FY 2015.

EDRP awards are typically 5-year awards. If EDRP was offered to every new PA hire, nearly \$4.6M would be needed each year for new awards, and additional funding would be required to sustain current participants. Furthermore, it can be expected that PAs currently employed within the VA network not receiving EDRP would expect to receive a similar award, or consider moving to a position elsewhere that authorized EDRP. Since EDRP may be awarded as a retention tool, additional funding would be required for current PAs as well.

Including EDRP in all announcements would also give interested candidates for hire the impression that EDRP would be available. EDRP awards are not made until after qualifying student loan debt can be confirmed with education institutions and lenders, which can take several months and occurs after employees are onboard. Without significantly increasing EDRP funding, including EDRP in all PA vacancy announcements will prevent facilities from offering the award to other positions that are more difficult for recruitment and retention locally. Advertising EDRP in all PA announcements, without significantly increasing funding, is misleading and likely to disenfranchise new employees early in their VA career.

Advertising EDRP for an entire occupation sets a precedent that will likely encourage other occupations to seek the same. Such costs are not only unsustainable, but in conflict with the statutory mission. PAs are nationally ranked as a mission-critical occupation; however, certain facilities report no issues recruiting PAs (i.e., Michael E DeBakey VA Medical Center in Houston, TX, has a strong PA program with academic affiliates and reports no issues hiring PAs). Requiring all facilities to advertise EDRP for positions would deny the facility the ability to make awards for positions that are the most critical.

Alternative approaches may be better suited for strengthening the PA occupation within VA. If compensation of PAs is the primary driver, rather than include EDRP in all vacancy announcements, VA supports the legislation in Section 4, which seeks to eliminate the pay disparity between VA and the private sector.

The cost to include EDRP in all PA vacancy announcements for 5,350 new awards over 5 years would be \$45,500,000. Salary costs and development costs are estimated at an additional \$659,037, bringing the total cost of this proposal to \$46,159,037.

The PA occupation has been a difficult to recruit and retain occupation for several years. A major barrier to recruitment and retention of PAs is the significant pay disparity between private sector market pay and VA pay schedules for PAs. Special Pay rate authority exists at the medical center level to address these disparities. Salary surveys performed during FY 2015 by several VA medical facilities have resulted in establishment or adjustment in local special salary rates for the PA occupation resulting in significant increases in salaries. This is an indication of the existing salary disparity overall. Including the PA occupation as a covered occupation under the nurse locality pay system in VA would be an important element in addressing recruitment and retention difficulties.

The total cost associated with this proposed legislation over 5 years would be \$135,149,625. This amount includes \$19,812,531 in Scholarship Support Costs, \$2,580,541 in Program Administration Costs, \$220,016 in Operational Costs, and \$112,536,537 associated with competitive pay for physician assistants.

H.R. 3956: The VA Health Center Management Stability and Improvement Act

Although the bill addresses the Department's challenges with recruiting and filling Medical Center Director positions, it does not offer any substantive solutions to address the challenges. Instead, it proposes legislation to develop and implement a hiring plan within 120 days of the legislation going into effect. By the time this draft language might become legislation, VA anticipates having significantly reduced the number of vacant Medical Center Director positions, such that the legislation would no longer be needed, but would impose another congressional reporting requirement on VA. Therefore, we do not support this bill. As an alternative to creating new reporting requirements, the Congress should consider options that would allow VA to achieve the same result through existing reports, such as the Agency's human capital plan. In fact, many of the topics under consideration should already be covered in the succession management and recruitment sections of the existing human capital plan.

Since the beginning of FY 2016, VA has been working hard to shorten the time to hire for these executive positions. In October 2015, we began using nationwide

announcements to identify and secure larger pools of qualified candidates, both internal and external to VA. This enterprise approach allows us to best match the candidate's skills and abilities with one of the vacant positions and do so in close to 120 days. Based on current recruitment efforts, we anticipate having nominees identified for approximately 20 of the more than 30 vacancies by the end of April 2016.

In addition, VA recently submitted a legislative proposal requesting the ability to transition all Medical Center Directors from Title 5 to Title 38, which will provide additional compensation and staffing flexibilities, thereby relieving some of the current challenges with attracting highly qualified candidates to serve in these leadership roles. Support of this proposal would be more beneficial to VA and ultimate resolution of the current staffing challenges rather than what is proposed in H.R. 3956.

Draft Bill: To direct the Secretary of Veterans Affairs to establish a list of drugs that require an increased level of informed consent

The draft bill would add new section 7335 to Title 38, U.S.C., to require VA to establish, within VHA's Office of Specialty Care Services, a panel to create and maintain a list of drugs (including psychotropic drugs) that may only be furnished with the "increased informed consent" of the patient or, in appropriate cases, a representative thereof. Such term would refer to full and informed consent that provides the patient with a meaningful understanding of the treatment to be provided based on such consent, an opportunity to ask questions and receive information regarding such treatment, and is acknowledged in written form.

The Secretary would be responsible for determining the composition, membership, and functions of the panel. VA medical professionals who then prescribe any drug on this list would need to prepare and present to the patient (or patient representative) a written form that meets a number of detailed criteria specified in the bill, (e.g., the names of any drugs being offered to the patient) including any other trade or the generic name for such drug, each side effect, alternative methods of treatment or therapy not involving that drug, etc. Before such form is used, however, the provider, except in emergency situations, would first need to: (1) ensure that the patient signs an initial form acknowledging that the patient has received information regarding the recommended treatment and any other possible treatments; (2) refer the patient to an appropriate pharmacy of the Department if the patient has additional questions about the drug in question; and (3) provide the patient with the opportunity to review the information.

Thereafter, the patient would have the opportunity to sign the form reflecting the mandated requirements, to call or email the medical professional to provide consent, or to schedule a follow-up appointment with the medical professional to discuss the recommended treatment during the 3-day period beginning on the date on which the patient requests the appointment. The form would also need to provide for acknowledgement by the patient that he or she has received the required information, as described in brief above, and has had adequate time to understand the information and consider alternative treatments, including, as appropriate, the opportunity to leave the medical facility.

VA does not support the draft bill. The terms of 38 U.S.C. § 7331, as implemented by 38 CFR § 17.32, VHA Handbook 1004.01, Informed Consent for Clinical Treatments and Procedures; VHA Handbook 1004.05, iMedConsent; and VHA Directive 1005, Informed Consent for Long-Term Opioid Therapy for Pain, already meet the objectives of the proposed measure and are aligned with professional best practice standards.

No medical treatment or procedure can be provided in VHA to any patient without the patient's full and informed consent first having been obtained and documented. Providers are required to appropriately document the informed consent in the patients' electronic health records. In addition, through its implementing regulations and policies, VA has already identified classes of treatment and procedures that, because of their inherent risk for significant pain, discomfort, complication, or morbidity, require signed informed consent, that is, a patient's (or surrogate's) and practitioner's signature on a VA-authorized consent form. These forms are developed by an established clinical expert process to include information about the treatment's risks, benefits, and alternatives at the appropriate reading level for the VA population. VA also provides written information about prescribed drugs each time the drug is dispensed to the patient. VA care is Veteran-centered, and the discussions described in the bill are already available to our patients.

Experts in law, ethics, and clinical implementation of informed consent in VA have also implemented appropriate means for seeking and documenting informed consent by patients and surrogates, including situations where the individual pro-

viding consent on behalf of the patient is not physically present, for example mechanisms for asynchronous signature. However, VA does not allow signed consent forms to be transmitted through commercial e-mail services. Until secure email is available, this prohibition in policy helps to ensure patient privacy and the security of patient information, and it also ensures the authenticity of the signed informed consent form confirming the identity of the sender.

The steps described in the proposed measure could significantly impede VA's ability to provide prompt care. The proposed legislation would add an undue time burden on Veterans and their care providers, by introducing unnecessary steps and delays in what is standard informed consent practice for high-risk medications. Of particular concern, the bill would apply the "increased informed consent" requirements to involuntarily committed inpatients in need of psychotropic drugs (because they have been found by the appropriate officials to be a danger to themselves or others). VA regulation and policy currently afford due process protections in these situations, while balancing the need for prompt medical intervention as defined by generally accepted standards of medical practice. Waiting on the completion of all the actions required by "increased informed consent" could well result in these clinical cases becoming exacerbated, with greater safety risks being posed, as a result, to the patients themselves, their surrogates, other patients, and/or VA staff.

Finally, it is unclear what problem this draft legislation purports to correct or remedy. For this reason, we request the Committee forbear in its consideration of this draft bill until we have a chance to meet with the Committee to ascertain the Members' concerns and together consider less formal and more flexible ways of satisfactorily addressing them.

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

Statements For The Record

THE AMERICAN LEGION

Chairman Benishek, Ranking Member Brownley, and distinguished members of the Subcommittee on Health, on behalf of National Commander Dale Barnett and The American Legion; the country's largest patriotic wartime service organization for veterans, comprising over 2 million members and serving every man and woman who has worn the uniform for this country; we thank you for the opportunity to testify regarding The American Legion's position on the pending and draft legislation.

H.R.2460

To amend title 38, United States Code, to improve the provision of adult day health care services for veterans.

State Veterans Homes are facilities that provide nursing home and domiciliary care. They are owned, operated and managed by state governments. They date back to the post-Civil War era when many states created them to provide shelter to homeless and disabled veterans. Currently, there are only two Adult Day Health Care programs at State Veterans Homes in the United States. Both are located on Long Island, New York. However, these programs could easily be offered at the other 151 State Veterans Homes located throughout the country.

H.R. 2460 would provide no cost medical model Adult Day Health Care at State Veterans Homes who are 70% or more service-connected. This bill is an extension of Public Law (P.L.) 109-461, Veterans Benefits Health Care, and Information Technology Act of 2006, which currently provides no cost nursing home care at any State Veterans Home to veterans who are 70% or more for their service-connected disability and who require significant assistance from others to carry out daily tasks.

VA pays State Veterans Homes a per diem that covers merely one-third of the cost of providing this service. This bill will expand disabled veterans' access to services such as Adult Day Health Care; a daily program for disabled veterans who need extra assistance and special attention in their day to day lives.

Resolution Number 21 entitled State Veteran Home Per Diem Reimbursement supports an increase in the per-diem rates for veterans in need of such care that State Veterans Homes provide.¹

The American Legion Supports H.R. 2460.

H.R. 3956: VA Health Center Management Stability and Improvement Act

To direct the Secretary of Veterans Affairs to develop and implement a plan to hire directors of the medical centers of the Department of Veterans Affairs.

For years, The American Legion has consistently been concerned with the Department of Veterans Affairs (VA) leadership, physicians, and medical specialist staffing shortages within the Veterans Health Administration. Since the inception of The American Legion's System Worth Saving (SWS) Program in 2003, we have tracked and reported staffing shortages at every VA medical facility across the country. The American Legion's SWS 2014 executive summary found that several VA medical centers continue to struggle to fill critical leadership positions across multiple departments resulting in communication breakdowns between medical center leadership and staff that work at the medical center.

This bill would address the growing problems of VA medical centers operating without permanent directors creating an instability that puts the care of those who have served at risk. The VA Health Center Management Stability and Improvement Act would require the Secretary of VA to develop and implement a plan to hire directors of the medical centers of the VA who are under temporary leadership. No later than 120 days after the date of the enactment of this Act, the Secretary of VA shall develop and implement a plan to hire highly qualified directors for each medical center of the VA that lacks a permanent director. The Secretary shall prioritize the hiring of such directors for the medical centers that have not had a permanent director for the longest periods of time.

The American Legion supports legislation addressing the recruitment and retention challenges faced by the Department of Veterans Affairs (VA) and encourage VHA to develop and implement staffing models for critical need occupations.²

The American Legion supports H.R. 3956.

H.R. 3974: Grow Our Own Directive: Physician Assistant Employment and Education Act of 2015

To require the Secretary of Veterans Affairs to carry out a pilot program to provide educational assistance to certain former members of the Armed Forces for education and training as physician assistants of the Department of Veterans Affairs, to establish pay grades and require competitive pay for physician assistants of the Department, and for other purposes.

This bill directs the Department of Veterans Affairs (VA) to carry out the Grow Our Own Directive (G.O.O.D.) pilot program that is designed to create a pathway for veterans who want to go to school to become a physician assistant in exchange for a three-year commitment to work within the VA healthcare system. H.R. 3974 proposes to reduce wait times at VA medical centers, while increasing the supply of physician's assistants within the VA healthcare system for the purpose of treating veterans.

The American Legion endorses the Grow Our Own Directive (GOOD): Physician Assistant Employment and Education Act of 2015 for the following reasons:

- Enhances opportunities for veterans seeking employment within the healthcare field - these are Careers, not jobs, which equal quality pay and benefits, along with mobility;
- Addresses employment issues for underserved areas. VA has been in dire need of these type of positions for rural and other underserved areas;
- Assists veterans who have experience in the healthcare field with education costs, which reduces debt and other financial barriers for gainful employment within this high growth industry; and
- Ultimately, this pilot program gives the VA a chance to properly fill these positions in order to fully maximize the veteran's experience, while providing excel-

¹American Legion Resolution No. 21 (Aug 2014): State Veteran Home Per Diem Reimbursement

²American Legion Resolution No. 101 (Sept. 2015): Department of Veterans Affairs Recruitment & Retention

lent care at the Veterans Affairs Medical Centers (VAMCs) or other VA healthcare facilities.

The American Legion supports legislative and administrative measures that seek to encourage and recognize organizations that hire veterans, particular the Department of Veterans Affairs.³

The American Legion supports H.R. 3974.

H.R. 3989: Support Our Military Caregivers Act

To amend title 38, United States Code, to improve the process for determining the eligibility of caregivers of veterans to certain benefits administered by the Secretary of Veterans Affairs.

A caregiver is an unpaid or paid person who helps another individual with an impairment with his or her activities of daily living. Any person with a health impairment might use caregiving services to address their difficulties. A military caregiver is a family member, friend, or acquaintance who provides a broad range of care and assistance for, or manages the care of, a current or former military servicemember with a disabling physical or mental injury or illness.

Typical duties of a caregiver might include taking care of someone who has a chronic illness or disease; managing medications or talking to doctors and nurses on someone's behalf; helping to bathe or dress someone who is frail or disabled; or taking care of household chores, meals, or bills for someone who cannot do these things alone.

The Support Our Military Caregivers Act, would reform the current VA's Caregiver Program to help better assist family members who are caring for seriously wounded veterans. The VA's Caregiver Program is currently experiencing delays in the approval process for family members to receive this benefit. This bill would establish an external clinical review process that would allow for the review of the veterans applications or when the application for caregiver benefits is denied, allowing for an independent contractor to review the case.

The American Legion does not have an official position on H.R. 3989, and are unable to comment at this time.

Discussion Draft

To direct the Secretary of Veterans Affairs to ensure that each medical facility of the Department of Veterans Affairs complies with requirements relating to scheduling veterans for health care appointments, to improve the uniform application of directives of the Department, and for other purposes.

This draft legislation as written, requires that the director of each VA health care facility annually certifies to the Secretary that their medical facility is in full compliance with all provisions of the law and regulations relating to scheduling appointments for veterans to receive hospital care and medical services that are listed under Veterans Health Administration Directive 2010-027, entitled VHA Outpatient Scheduling Processes and Procedures, or any successor directive.

The Secretary of VA on a yearly basis will report to both the House Veterans Affairs' Committee (HVAC) and the Senate Veterans' Affairs Committee (SVAC) with a list of medical centers that have certified compliance and a list of facilities that are not in compliance and to provide an explanation of why those facilities did not meet the requirements set forth within the VHA Outpatient Scheduling Processes and Procedures directive.

Requiring VA to adhere to the law, regulations and VA policies governing scheduling is common sense. However, this bill fails to spell out any consequences if VA medical center directors fail to comply with the proposed legislation.

The American Legion would only support this draft legislation if it includes an accountability statement holding medical center and Veterans Integrated Service Network (VISN) directors accountable when they have failed to comply with the intent of the discussion draft.

Discussion Draft

To amend title 38, United States Code, to direct the Secretary of Veterans Affairs to establish a list of drugs that require an increased level of informed consent.

³American Legion Resolution No. 95 (Sept. 2015): Support Employment of Veterans in the Public and Private Workforce

Informed consent is a process for getting permission before conducting a healthcare intervention on a person. A health care provider may ask a patient to consent to receive therapy before providing it, or a clinical researcher may ask a research participant before enrolling that person into a clinical trial.

This discussion draft, as written, directs the Secretary of VA to establish a list of drugs that require an increased level of informed consent. This bill would require the Secretary of VA to establish within the Office of Specialty Care Service of the Veterans Health Administration a panel to establish and maintain a list of drugs, including psychotropic drugs that may only be furnished under this title to a patient with increased informed consent of the patient or, in appropriate cases, a representative thereof.

Informed Consent has either become non-existent or hurried by health care providers. It is standard medical procedure to ensure that our veterans are fully informed of the side effects and other liabilities of drugs they are administered prior to their administration. As part of the Informed Consent process, doctors should be required to provide a list of alternative treatments and therapies to the veterans they serve. When providers utilize informed consent, veterans and their families can make informed decisions of what is in their best interest. Finally, this process needs to be a deliberative process, where the understanding of the veteran is consulted and is assured.

The American Legion calls for Congress to exercise oversight over DOD/VA to ensure servicemembers and veterans are only prescribed evidence-based treatments for TBI/PTSD and not prescribed off-label and non-Federal Drug Administration approved medications or treatments for TBI/PTSD.⁴

The American Legion supports the discussion draft.

Conclusion

As always, The American Legion thanks this subcommittee for the opportunity to explain the position of the over 2 million veteran members of this organization. Questions concerning this testimony can be directed to Warren J. Goldstein in The American Legion's Legislative Division at (202) 861-2700 or wgoldstein@legion.org.

AMERICAN PSYCHIATRIC ASSOCIATION

The American Psychiatric Association (APA), the national medical specialty society representing over 36,500 psychiatric physicians and their patients, is pleased to submit this statement for the Subcommittee's hearing that includes legislation designed to establish an informed consent protocol within the Department of Veterans Affairs (VA), as part of an effort to improve the overall clinical care of our nation's veterans.

Nearly two years after the incident surrounding delayed access to mental health services at the Veterans Health Administration (VHA), the matter of ensuring that veterans receive quality and timely care has been a priority for our nation. These issues are receiving considerable attention from Congress, and the APA is hopeful that attention will be translated into action. Towards that end, APA thanks Subcommittee Chairman Benishek and Ranking Member Brownley for holding this hearing.

United States veterans are a multifaceted population requiring a culturally competent approach to medical treatment and care. Veterans experience mental health disorders, substance use disorders, post-traumatic stress, and traumatic brain injury at disproportionate rates compared to their civilian counterparts. Often in combination with military-related diseases, many veterans develop substance use disorders and a large number ultimately complete suicide. Approximately 1.9 million OEF/OIF/OND veterans have become eligible for VHA health care services since 2002.¹ While a relatively small percentage of veterans utilize the health care services offered, the VHA has seen a 63 percent increase in the number of veterans receiving mental health care between 2005 and 2013. As of March 2015, 57.6% (685,540) of the veterans seeking care at VHA facilities received at least one provisional mental health diagnosis, with the most common conditions being post-traumatic stress dis-

⁴The American Legion Resolution 292 (Aug. 2014): Traumatic Brain and Post Traumatic Stress Disorder Programs

¹U.S. Department of Veterans Affairs. VHA Office of Public Health. Analysis of VA Health Care Utilization among Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) Veterans. Sept. 2015.

order, depressive disorders, and other anxiety disorders.² Through the expansion of the Choice Program under the Veterans Access, Choice, and Accountability Act of 2014, the VA anticipates the number of veterans seeking mental health services to rise.

The VHA operates the nation's largest integrated health care delivery system, providing care to nearly 6 million veteran patients, and employing more than 270,000 full-time staff. In 2015 the Government Accountability Office audited the VHA, and identified two key barriers to accessing quality and timely care: 1) the lack of scheduled medical appointment slots, and; 2) the acute shortage of physicians. Health care professionals play a central role in ensuring the well-being of our nation's veterans. The providers working with the veteran population must be able to address the patient's particular physical and mental health demands. Physicians, in particular, play a critical role to this distinct population in providing quality care by engaging the patient, being aware of the patients' military history, and recognizing risk factors.

With respect to the vital function of medical professionals at VHA, APA would like to convey a number of items that inadvertently create barriers to accessing mental health services and ensuring high quality care. The APA stands ready to assist the Subcommittee in advancing legislation that improves the overall care our veterans receive, and we ask that the Subcommittee take the following items under close consideration.

The APA believes that any legislative initiative should not segregate mental health from other medical care, such as segregating psychotropic medications as posing certain risks. Psychotropic medications are in a class of pharmaceuticals along with other classes of medications that contain potential adverse effects, including cardiac, hematologic, oncologic, rheumatologic, steroids, as well as most commonly prescribed antibiotics. The APA believes that all providers should have an open dialogue and participate in shared decision making with patients about any pharmacological treatment that may have potential adverse effects to their lifestyle.

The APA understands that the Subcommittee is entertaining the possibility of requiring a physician-patient dialogue concerning the warnings associated with psychotropic medications. The vast increase in the number of new psychopharmacologic agents over the last 20 years has made more therapeutic options available, but has also made treating patients more complicated. Prescribing practices, inclusive of the concurrent administration of a variety of psychotropic medications, have made the awareness of pharmaceutical interactions key for meeting the treatment needs of each individual patients. To date, the Food and Drug Administration has few indications on combination use with psychotropic drugs. To engage in a physician-patient discussion as entertained by the Subcommittee, the APA believes that the FDA must provide comprehensive data that would allow for informed decisions on complex treatment.

Frequently, veterans will utilize primary care office visits to seek care for mental disorders. In these incidents, antidepressants are more often prescribed by primary care providers than psychiatric physicians. Any additional steps for increased informed consent may unintentionally reduce a primary care provider's receptivity to prescribe psychotropic drugs. Regrettably, the patient will likely not receive the medical treatment needed to aid in their mental wellness.

The APA understands that the Subcommittee is entertaining a new way of measuring standards of care for informed consent for psychotropic drugs. Providers who do not comply with completing the required steps of increased informed consent would be vulnerable to a claim of negligence against them. The APA recommends establishing guidelines that would safeguard providers.

The military culture promotes inner strength and self-reliance, contributing heavily to a stigma associated with mental disorders and to seeking treatment. Where stigma creates barriers to care, the additional measures required may generate unintended consequence of over emphasizing risks to an extent that some patients would view psychotropic drugs as more dangerous and decide not to take them.

The Veterans Health Administration has multiple clinical practice guidelines and evidence-based tools to assist clinicians in identifying risk factors and measures to improve health outcomes. Physician and patient dialogue is a significant element in a patient's treatment, providing a platform for an informed discussion. The practice of medicine is a serious responsibility that encompasses providing a comprehensive understanding of treatment to the patient. The APA concurs a physician-patient dialogue may positively impact the decision of the patient's treatment. The APA asks that all classes of medications that pose adverse effects be included in the process

²U.S. Department of Veterans Affairs. Office of Informatics & Analytics. VA Mental Health Services Public Report. Nov. 2014.

of increased informed consent. This would eliminate an inherently discriminatory approach to mental health treatment, and further encourage a stigma associated behavior towards mental health services.

Thank you again for the opportunity to offer our expertise on the consideration of establishing an increased level of informed consent for the record. We look forward to continuing our work with members of the Subcommittee. If you have any questions, or if we can be of further assistance, please contact Jeffrey P. Regan, Chief of Department of Government Relations at jregan@psych.org.

EASTER SEALS

WRITTEN STATEMENT OF KATY NEAS, EXECUTIVE VICE PRESIDENT FOR PUBLIC AFFAIRS

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

Thank you for holding this hearing on proposed legislation to improve Veterans' access to health care and other benefits administered by the U.S. Department of Veterans Affairs (VA). Easter Seals especially applauds the Subcommittee's focus on adult day health care (ADHC) and how this community-based service can improve a Veteran's health and well-being while also meeting the Veteran's goal of remaining at home and in their community.

Easter Seals is changing the way the world defines and views disabilities by making profound, positive differences in people's lives every day. Through a network of 74-community-based affiliates, Easter Seals is a leading nonprofit provider that assists Veterans, military families, and others to reach their potential and succeed in their communities by providing and connecting them to local services and supports. Founded in 1919, Easter Seals began serving Veterans after World War II to help address the unmet needs of service members returning home with service-connected disabilities. Through our national network and Easter Seals Dixon Center for Military and Veterans Services, Easter Seals continues to fill the gap between the services Veterans need and the services currently available through government or other entities. Adult day health care is one of the community-based services that Easter Seals offers through more than 50 programs in 14 states. Through the program, Easter Seals affiliates offer a menu of person-directed care and social and recreational activities to older adults, including Veterans, and individuals with disabilities. Easter Seals partners with the VA at the local level and nationally as the contractor to develop and administer the National Veteran Caregiver Training Program, which falls under the jurisdiction of this Subcommittee. Easter Seals is proud of its record and service for and on behalf of America's Veterans and their families.

It is because of our long-term care expertise and Veterans' experience that we lend our support for the twin goals behind H.R. 2460: to expand local adult day health care options for eligible Veterans and to ensure the VA's reimbursement rate better reflects the true cost and Veteran need of skilled adult day health care.

Expansion of Local Adult Day Health Care Options:

The VA described ADHC as "a key component in the continuum of long-term care" that helps Veterans remain in their homes and provides needed care in the "least restrictive environment that is safe for Veterans."¹ The VA also noted that non-institutional extended care programs, such as adult day health care, have resulted in substantial reductions in nursing home placement, facilitates greater independence, and promotes enhanced quality of life for Veterans receiving the service.² With the passage of the Veterans Millennium Healthcare and Benefits Act of 1999 (P.L. 106-117), Congress recognized the importance of adult day services for Veterans and authorized the VA to furnish ADHC to Veterans who would otherwise require nursing home care. The VA can provide ADHS directly or by contracting with State Veterans Homes or community organizations "through non-VA care mechanisms such as sharing agreements, national or local contracts, and individual authorizations to

¹Adult Day Health Care, VHA Handbook 1141.03, September 29, 2009, <http://www.va.gov/vhapublications/ViewPublication.asp?pub—ID=2086>

²Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics, VHA Handbook 1140.11, November 4, 2015, <http://www.va.gov/vhapublications/ViewPublication.asp?pub—ID=2086>

the extent that the Veteran is eligible.” Some Easter Seals affiliates currently contract with the VA to provide ADHC for Veterans living in their communities.

H.R. 2460 would expand community-based options by directing the VA Secretary to partner with State Veteran Homes in each state to pay for adult day health care for a Veteran eligible for, but not receiving, nursing home care. While the VA is currently authorized to pay for ADHC at State Veterans Homes (SVH), only two of the 153 SVH currently offer ADHC at its facilities.³ Easter Seals supports efforts to expand long-term care options, including adult day health care, for eligible Veterans. Easter Seals believes the most effective approach in meeting the needs of eligible Veterans is to utilize the existing national network of more than 5,000 community-based adult day centers,⁴ which can include new and existing State Veteran Homes. This recommendation also recognizes the limited coverage of the 153 State Veteran Homes. Fourteen states, including large geographic states such as North Dakota and Alaska, are served by a single SVH.⁵ Expansion of ADHC in State Veteran Homes alone would not meet the needs of all eligible Veterans in a state. For example, there is a SVH in Marquette, Michigan, which is located in the Chairman’s 1st Congressional District. However, the Marquette SVH is more than 4 hours from Alpena, Michigan, also in the Chairman’s District. Michigan’s only other SVH is located in Grand Rapids, also several hours away from Alpena. So while SVH expansion would benefit some Veterans it would not make sense for all eligible Veterans looking for ADHC.

Easter Seals Recommendation: As H.R. 2460 advances, Easter Seals encourages the Subcommittee to add “or eligible non-Department extended care providers” after every “State home” reference in the bill to ensure that other non-VA providers are included in the bill’s other improvements.

Support for Adult Day Health Care Reimbursement That Reflects Costs:

Easter Seals fully supports H.R. 2460’s effort to ensure that the VA’s reimbursement rate for ADHC better reflects the true costs associated with providing this highly skilled service. Specialized adult day health care available through community providers could cost approximately \$90 per day or more, which is significantly less than the estimated \$250 per day associated with nursing home care. Current VA reimbursement for ADHC is under \$75 per day, which does not meet current costs.

H.R. 2460 would tie the VA’s adult day health care reimbursement rate to 65 percent of the payment the VA pays for State home nursing home care, a provision that Easter Seals strongly supports. In addition, the VA typically only authorizes up to two days of adult day health care despite the fact that some Veterans require additional care. For example, Easter Seals Serving DC, MD, VA provides adult day health care for about 30 Veterans through its Baltimore program. Some of the Baltimore-area Veterans that are covered through the VA’s ADHC program require more than the two days that the VA currently covers. These Veterans are paying out-of-pocket for the remaining days.

Easter Seals Recommendation: Easter Seals applauds efforts to more accurately reflect the cost of adult day health care and urges the Subcommittee to maintain the 65 percent rate provision. In addition, Easter Seals asks the Subcommittee to include report language urging the VA to increase the number of days a Veteran can receive VA-reimbursed ADHC, as long as the Veteran requires the additional care and is already eligible for the more comprehensive nursing home care.

Adult day health care is a critical long-term, extended care support that should be available to all eligible Veterans, no matter where they live. H.R. 2460 makes significant improvements to the provision of ADHC service at the VA. Easter Seals urges the Subcommittee to advance this important legislation with our recommended changes to ensure Veterans can maintain their health and independence by staying in their home and community through adult day health care.

Thank you for the opportunity to share Easter Seals’ views with the Subcommittee.

³ Caring for our Disabled Veterans Op-ed, Congressman Lee Zeldin, April 4, 2016, <https://zeldin.house.gov/media-center/press-releases/caring-our-disabled-veterans-fight-expand-adult-day-care>

⁴ National Adult Day Services Association, Research, <http://www.nadsa.org/research/>

⁵ National Association of State Veteran Homes, Directory of State Homes, <http://www.nasvh.org/StateHomes/statedir.cfm>

NATIONAL ASSOCIATION OF MENTAL ILLNESS

STATEMENT OF MARY GILBERTI, CHIEF EXECUTIVE OFFICER

Chairman Benishek and members of the Subcommittee, I am Mary Gilberti, Chief Executive Officer of NAMI (the National Alliance on Mental Illness). I am pleased to offer NAMI's views on the draft bill before the Subcommittee directing the Secretary to establish a list of drugs that would require a new set of informed consent protocols.

NAMI is the nation's largest grassroots advocacy organization dedicated to building better lives for the millions of Americans affected by mental illness. NAMI State Organizations and over 900 NAMI Affiliates across the country raise awareness and provide support, education and advocacy on behalf of people living with mental health conditions and their families.

Through our NAMI Veterans and Military Council, our state and local NAMI organizations are engaged with VA Medical Centers in working with veterans and their families. The VA recently renewed a Memorandum of Understanding (MOU) with NAMI that allows us to continue to offer NAMI's "Family-to-Family" and "Homefront" classes to veterans and their families.

NAMI would like to thank the Subcommittee on the important bipartisan work it has done in recent years to improve treatment and services for veterans living with mental health conditions. While enormous challenges still confront the VA in lowering wait times and expanding access to evidence-based practices such as Assertive Community Treatment (ACT) and crisis intervention, progress has been made in reaching veterans earlier. We encourage the Subcommittee to build on these accomplishments by continuing its oversight activities and supporting investments in evidence-based practices for treatment and services for mental illness.

NAMI, however, would like to raise a number of concerns regarding the draft bill before the Subcommittee.

1)The proposal unfairly singles out mental health conditions and the medications used to treat them as part of a new mandatory protocol that stigmatizes both these disorders and their treatment - NAMI believes that this proposal sets forth a dangerous precedent by singling out a category of medications, "psychotropic drugs" (referenced in Section 7335), as part of a separate informed consent protocol. While NAMI supports the goal of improving clinical care in the VA through appropriate informed consent, any new requirement designed to achieve this laudable goal should apply across all therapeutic areas: orthopedics, endocrinology, pulmonary medicine, neurology, nephrology, etc. Mental health medications should NOT be singled out in federal policy for different or separate treatment protocols.

2)The proposed mandatory informed consent requirement has enormous potential to limit access to psychiatric treatment in the VA - NAMI is extremely concerned that this mandatory, inflexible informed consent protocol would serve as a significant barrier to veterans engaging in needed mental health treatment. Forcing clinicians to go through a multi-step mandatory checklist which, as currently drafted in this legislation, informs a veteran only about negative risks is exactly the wrong way to engage individuals in treatment. Effective practice dictates that engagement in mental health treatment needs to be done carefully and on the patient's terms. Imposing a government-mandated protocol would be enormously disruptive to the process of engagement.

3)The proposed requirements in the draft legislation for disclosure contain a number of inaccurate statements regarding the FDA market approval process and authority over labeling of products - Page 5, line 4 of the draft legislation requires prescribers to state that "the FDA has not approved any psychiatric drugs to be used in combination with other psychiatric drugs." In fact, the FDA never approves medications to be used in combination with other therapies. Instead, in the pre-market approval process, the FDA reviews data from randomized controlled trials submitted by sponsors to ensure safety and efficacy of individual products. Further, page 4, line 15 of the current draft sets forth a requirement for the disclosure of "unknown dangers of mixing drugs and dosages in sizes and combinations that have not been approved or tested by the FDA." NAMI is concerned about any requirement dictating that prescribing physicians talk to their patients about "unknown dangers." Instead, NAMI feels strongly that physicians should be guided by evidence-based practice and peer reviewed treatment guidelines to tailor treatment and services to the unique person they are working with.

4) Use of the term “psychotropic” medications in the draft legislation lacks precision - It is unclear from the text of the legislation what the term “psychotropic medications” actually means. In fact, there are a broad range of therapeutic classes that are utilized for on-label treatment for mental health conditions. These include antipsychotics, antidepressants, anticonvulsants, benzodiazepines and others. Within these therapeutic classes, there are many other conditions for which there are FDA on-label indications. Does the legislation intend to apply these new disclosure mandates on this broad range of disorders and indications?

5) Discussion of alternative treatment should be grounded in evidence-based services - NAMI supports physicians discussing with their patients the broad range of available therapies and options throughout the course of treatment. This is especially important with mental health conditions where individuals often experience periodic acute episodes of symptoms such as mania, psychosis or suicidal ideation. However, in discussing therapeutic interventions and alternative therapies, it is critical that the options being discussed be limited to and grounded in evidence-based practice. Physicians in the VA, and any other health care setting, should not be forced to disclose treatment options for which there is no scientific basis for safety and efficacy.

Better Education and Training of Prescribing Physicians in the VA Will Improve Care

NAMI supports the goal of this draft legislation in promoting enhanced communication to veterans about diagnosis, treatment, outcomes and alternatives. A mandatory, inflexible informed consent protocol will not achieve this common goal. In order to achieve the goal of better-informed and engaged patients in the VA, Congress should require the VHA to develop training and consultation programs that promote communication and engagement with individual patients. Such a training program should apply across all areas of clinical practice in the VA, not just the prescribing of medications to treat mental health conditions.

As an organization that embraces veterans living with mental illness, NAMI is eager to assist the VA in developing a program of best practices for patient engagement. This would include developing a curriculum for primary care physicians and specialists in internal medicine as these clinicians write the majority of prescriptions for psychotropic medications in the VA.

Despite the progress that has been made in recent decades, there is still stigma associated with mental health conditions. Particularly among veterans, there is often reluctance to acknowledge symptoms such as depression, anxiety, mania and delusional thoughts associated with conditions such as schizophrenia, bipolar disorder, depression and PTSD. Engaging veterans in treatment is a careful and nuanced process, one that can only occur effectively on the individual veteran's terms. A mandatory, inflexible informed consent protocol will not achieve this goal. Education and training of prescribing physicians is the answer.

This Subcommittee has made significant progress in expanding access to mental health care in the VA. This record of accomplishment can be improved through training and education, not new government-mandated protocols that interfere with engagement and treatment.

Thank you for the opportunity to offer NAMI's views on this legislation.

VETERANS AFFAIRS PHYSICIAN ASSISTANT ASSOCIATION

President VAPAA

Rubina DaSilva PA-C

Chairman Benishek, Ranking member Brownley, and other members of the House Veterans Affairs Subcommittee on Health, on behalf of the entire membership of the Veterans Affairs Physician Assistant Association (VAPAA) we appreciate the invitation to submit this testimony for the record. We thank members of this committee for critical, bipartisan legislation on Physician Assistant (PA) Workforce issues in the VA. We are very appreciative of H.R. 3974, The **‘Grow Our Own Directive: Physician Assistant Employment and Education Act of 2015,’**) and we thank Congresswoman Ann Kuster for her leadership on this bill.

As committee members are aware, Public Law 113-146, the Veterans Access, Choice, and Accountability Act of 2014, directs the Secretary, under the VA's Health Professionals Education Assistance program, to give scholarship priority to appli-

cants pursuing education or training towards a career in a health care occupation that represents one of the five largest staffing shortages. However, despite the PA profession being ranked on 1/2015 and 9/2015 as 3rd and 4th on the OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, the VHA has not created a dedicated PA scholarship program for any prospective students wishing to become a PA.

When congressional leaders ask VHA about the availability of scholarship money for PA scholarships; Healthcare Talent Management (HTM) will state that scholarship money for PA students is available through the Employee Incentive Scholarship Program (EISP). Unfortunately, despite this assertion, the VAPAA has found that these programs are not applied for PA recruiting scholarships or educational support.'

For Example:

Congressional Question: What is the amount of scholarship monies that is currently available for Intermediate Care Technicians (ICT)?

VHA Response: The annual budgets for the following two Health Talent Management programs for which all VA staff including Physician Assistants (PA) and ICTs can apply are the following:

- The Employee Incentive Scholarship Program (EISP) - \$2,000,000 (Provides educational funding, i.e., tuition, books, fees)
- The VA National Education for Employees Program (VANEED) - \$14,573,000 (Provides educational funding and replacement salary)

A report from the Government Accountability Office in September 2015, shows that EISP has allocated from FY 2010 through FY 2014 - \$128,832,503.00 in funding for nursing and \$11,842,919.00 in support of NPs and NP programs, with only \$319,074.00 for PAs. Only 6 employees received scholarships to become PAs and 40 PAs who were master's prepared but received a bachelor's degree, completed additional course work to earn their Master's degree from University of Nebraska bridge program.

As of April 20, 2016, it appears that VHA is in violation of Public Law 113-146 as VHA has not created a scholarship program or given scholarship priority to PAs pursuing education or training towards a career in a health care occupation that represents one of the five largest staffing shortages.

In fact, the Health Professional Scholarship Program (HPSP) is a subcomponent of the Health Professionals Educational Assistance Program (HPEAP). The original authorization for HPSP expired in 1998. On May 10, 2010, Public Law 111-163, Section 603 of The Caregivers and Veterans Omnibus Health Services Act of 2010, eliminated the 1998 sunset date and re-authorized the use of HPSP through December 14, 2014. The final rule for reinstatement of HPSP was published in the Federal Register and became effective on September 19, 2013. This timeframe allowed approximately one year during which the scholarship program would be operative. On August 7, 2014, as a result of Section 302 of Public Law 113-146, VACAA extended the authorization for HPSP through December 31, 2019. In accordance with Section 301 of VACAA, *annual HPSP awards will be based on the top five healthcare occupations for which there are the largest staffing shortages throughout VA.*

However, the (Office of Nursing Services) ONS and the Office of Academic Affiliation (OAA) included HPSP to fund VA Nursing Academic Partnerships - Graduate Education. 1.2 million dollars in funding earmarked for this program to pay for Acute Care Nurse Practitioner, Adult-Gerontology Nurse Practitioner, or Psychiatric Mental Health Nurse Practitioner. In addition HPSP funding will be used for appointments to the affiliated School of Nursing to pay for non-VA staff instead of providing support for our veterans.

To maintain a PA workforce, the VA must invest in its PA workforce. By FY 2022 48.7% of PAs will be eligible to retire. PAs have a Total Loss Rate of 10.92% (1.) which is the second highest total loss rate of any of the Mission Critical Occupation 2015. PAs have 1 year quit rate of 9.6% and a 5yr quit rate of 32.3%. PAs current vacancy rate is 23% which is well above the overall VHA vacancy rate of 16%. Despite being on the Workforce Succession Planning MCO for several years, and being on the OIG top 5, PAs only netted a mere 129 new PAs for FY 2015.

The PA profession has a unique relationship with veterans. The very first classes of physician assistants to graduate from PA educational programs were all former Navy corpsmen and army medics who served in the Vietnam War and wanted to apply their knowledge and experience in a civilian role in 1967. Today, there are 210 accredited PA educational university programs across the United States and approximately 2,020 PAs are employed by the Department of Veterans Affairs (VA),

making the VA the largest single federal employer of PAs. These PAs provide high quality, cost effective quality health care working in hundreds of VA medical centers and outpatient clinics, providing medical care to thousands of veterans each year in their clinics. PAs work in both ambulatory care clinics, emergency medicine, CBOC's in rural health, and in wide variety of other medical, mental health, and surgical subspecialties.¹ In the VA system about a quarter of all primary care patients treated are seen by a PA. Approximately 32% of PAs today employed by VHA are veterans, retired military, or currently serving in the National Guard and Reserves.

The Veterans Affairs Physician Assistant Association (VAPAA) maintains that Physician Assistants are a critical component of improving VA health-care delivery, and have consistently recommended that VHA include them in all health-care national strategy staffing policy plans. However, since January 1993 when VA added the Title 38 GS-13, Chief Grade more than 22 years ago, little else has been done for this critical workforce and hope that as these committees review changes to improve access to care for veterans and oversight on VHA strategy for its healthcare workforce that changes will be included to address these PA problems.

Continued Delays in Hiring PA Employees

VAPAA has found since last May's HVAC hearing that whenever a PA employee leaves the VA, VA acknowledges that it can take still six months to a year to fill one vacant position-assuming a viable pool of candidates is interested and available. When the VA seeks to replace health care professionals, VA cannot compete with nimble private health care systems. The lengthy process VA requires for candidates to receive employment commitments and boarding continues to hinder the VA ability to recruit and officially appoint new employees.

Private health care systems can easily fill PA vacancies in a matter of days or weeks. While PA applicants may have noble intentions of working for VA and serving veterans, many will forgo what could be a 4 to 6 month long waiting period and pursue timely employment opportunities elsewhere. For these reasons, we ask Congress to carefully review VA appointment authorities, internal credentialing processes, and common human-resources practices to identify ways to streamline the hiring process. If VA takes months to fill its health care vacancies with top talent, VA will continue to fail the delivery of timely, quality care to our nations' veterans.

Members of HVAC and SVAC both introduced bipartisan legislation last October, providing for specific plans for Grow Our Own, asking that VA utilizing VHA provisions (Titles III and VIII of the newly enacted Veterans Access, Choice, and Accountability Act of 2014) to include the national VHA plans for expanding recruiting for new FTEE PA positions and for retaining an optimal PA workforce utilizing our recommendations below.

Department of Veterans Affairs "Independent Care Technician" (ICT) Program, One Solution to Support Transitioning Medics and Corpsmen OIF OEF OND into "Grow Our Own" to Physician Assistant Occupation

VAPAA points to another solution for meeting the healthcare workforce challenges in a recent pilot program. On October 26, 2011, the Administration announced its commitment to providing support to unemployed Post 9/11 combat veterans and it highlighted the PA profession as a prominent targeted career path for new returning veterans who had served as medics and corpsmen with combat medical skills similar to the history of returning Vietnam War veterans with these skills within the ICT pilot VA program at 19 VA sites. Medics and corpsmen receive extensive and valuable health care training while on active duty. They represent a large workforce - 74,000 medics and corpsmen, including Guard/Reserve, with 10,400 separating (FY 2011). According to a 2011 Army HR report, more than 20,000 medics were unemployed. Combat medics were the third largest military specialty drawing unemployment funds in 2011 from the Army.

Under this initiative, the Administration promoted incentives to create training, education, and certifications of medic and corpsmen in need of transitioning of their military medical skills, being hired to work inside VA emergency departments, and has expanded into primary care, mental health, and surgery clinic positions.

The VA has an excellent opportunity to facilitate and coordinate "Grow Our Own" combat medics, Corpsmen, or Air Force paramedics to transition to the physician assistant occupation. However the (ICT's) currently in the Grow Our Own VA program are being frustrated by statements they should not expect scholarships from VA, and there is lack of VHA policy language directing VAMC's to ensure edu-

¹Total loss rate Workforce Succession Planning 2016 reported 10.3, however, Workforce Analysis Dashboard 4.11.2016 shows PA total loss rate at 10.92%

cational support of these combat veteran PA program candidates, assisting them in admission to accredited PA university Masters programs with targeted scholarships for PA Education. Ten former OIF OEF combat veterans already enrolled in University PA program in Tennessee are told they will not be eligible for scholarships.

VAPAA is concerned over this ICT program that started in 2012 as it is being reported to be expanding to more full time ICTs. The continued lack of use of recruitment educational incentives within VHA and having it left at the discretion of the local hiring facility is setting up further frustration across the VA system with the lack of VHA scholarships for the critical PA occupation. The Office of VA Healthcare Retention and Recruitment and the VAMC's participating in the pilot ICT program have no dedicated VHA support to transition them into PAs. The barriers to PA recruitment and retention will continue unless congressional members provide oversight, VHA must ensure that employee incentive programs, such as the EISP and the VA Employee Debt Reduction Program are made consistently available to all critical healthcare workforce PA vacancy announcements and utilized in ICT the program. VISN and VA medical center directors they must be held accountable for the failure to utilize these recruiting tools.

The ICT Program establishment and expansion was authorized by the Under Secretary of the VA in March 2015. The program expansion will increase ICTs in the VA from the original 45 by hiring 234 more ICTs. Hiring the additional 234 ICTs has been left to the discretion of the Facility Directors of individual VAMC's.

Between March 2015 when the ICT expansion was approved and March 2016, less than 6 of the additional 234 ICTs have actually been hired by the VA. So VHA was supposed to develop a national VA veteran employment program targeting OIF OEF combat medics and corpsmen but it is being managed by local VAMCs with little oversight from VHA or VISN Directors.

Critical Workforce Occupations:

VA's mission statement for human resources is to recruit, develop, and retain a competent, committed, and diverse workforce that provides high quality service to veterans and their families. VA identifies specific occupations as "critical occupations" based on the degree of need and the difficulty in recruitment and retention. There are 3 types of primary care clinical providers within the VA that provide direct patient care - Physicians, Physician Assistants and Nurse Practitioners. Physicians have mandated yearly market pay survey. Nurse Practitioners, by virtue of being a nurse, are under the mandated yearly RN LPS.

PAs in a few facilities fall under Special Salary Rates; however, this is NOT mandated yearly. Some facilities have not performed a special salary survey for 11 years, resulting in the reporting in the VISN 2014-15 Workforce Succession Plan - 12 out of the 21 VISNs (88 VA main facilities) reported the reason that their VISN cannot hire PA's is because they cannot compete with the private sector pay. VA has refused to pursue steps to solve the current retention problems for PA's.

Recommendations: We ask that both committees recognize the need to invest in the Recruitment and Retention of the PA Workforce in the VA System by supporting enactment and supported by the veteran service organizations at the November 18, 2015 hearing on S. 2134 and call attention the VHA witness Dr. Carolyn McCarthy testified in favor of this legislation **'Grow Our Own Directive: Physician Assistant Employment and Education Act of 2015.'** (H.R. 3974). **Additionally, we recommend the following—**

A. Restructure VHA Handbook 1020 - Employee Incentive Scholarship Program (EISP).

B. Include PAs at all facility level to reflect Workforce Succession Planning and the OIG Top 5 as a hard to recruit occupation as this is the qualifying factor for EISP funding.

C. Include Education Debt Reduction Plan in all PA job postings.

D. Include targeted scholarships for the ICT program OIF OEF Grow Our Own returning veterans, and mandate VHA shall appoint PA ICT National director to coordinate the educational assistance necessary and be liaison with PA university programs.

E. H.R. 3974 would direct new Physician Assistant director position to work within the National Healthcare Recruiter, Workforce Management & Consulting VHA Healthcare Recruitment & Marketing Office.

a. This position then can develop targeted recruiting plans with 187 PA programs, working in a way that the local Human Resource Officer (HRO) often will not; due to lack of staffing.

F. The VA employed PA national Healthcare Recruiter would develop improvements in finding qualified candidate in a matter of days not months.

G.VHA must incorporate new PA consultant manager into this National Healthcare Workforce program office.

H. Health Professional Scholarship Program.-The Health Professional Scholarship Program (HPSP) provides scholarships to students receiving education or training in a direct or indirect health care services discipline. Awards are offered on a competitive basis and are exempt from Federal taxation. In exchange for the award, scholarship program participants agree to a service obligation in a VA health care facility. The Committee continues to support this program and is concerned that VA is limiting HPSP awards to only nursing students in fiscal year 2016. The Committee believes strongly that ample resources exist within the Department to ensure that hard to fill Top 5 OIG occupations are not excluded from participation. The Committee directs the VA to report to the Committee on Appropriations of both Houses of Congress no later than October 30, 2016, each profession that is eligible to receive the scholarship and any limitation that the Department is placing on awards

I. Establish PA Pay Grades I–V, to continue be competitive with the civilian job market

Conclusion:

Chairman Benishek, Ranking member Brownley, and other members of the HVAC Subcommittee on Health; as you strive to ensure that all veterans receive timely access to quality healthcare and as you build increased capacity for delivery of accessible high quality health care, and demand more accountability into the VA health care system, I strongly urge the full Committee to review the important critical role of the PA profession and to ensure legislatively that VHA takes immediate steps to address these longstanding problems and continue to work with us in supporting our Nation's veterans.

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

Veterans Affairs Physician Assistant Association

The Veterans Affairs Physician Assistant Association (VAPAA) does not currently receive any money from a federal contract or grants. During the past six years, VAPAA has not entered into any federal contracts or grants for any federal services or governmental programs.

VAPAA is a 501c (3) nonprofit membership organization.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

STATEMENT OF CARLOS FUENTES, SENIOR LEGISLATIVE ASSOCIATE

NATIONAL LEGISLATIVE SERVICE

MR. CHAIRMAN 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, thank you for the opportunity to offer our thoughts on today's pending legislation.

H.R. 2460, To improve the provision of adult day care services for veterans

The VFW supports this legislation, which would expand adult day health care for veterans.

Currently, veterans who are at least 70 percent service connected are eligible to receive cost free nursing home or domiciliary care at any of the more than 150 state veterans homes throughout the country. While nursing home care is a necessity for veterans who can no longer live in the comfort of their home, the VFW strongly believes veterans should remain in their homes as long as possible before turning to inpatient, long term care options. Adult day care is vital to ensuring such veterans are able to remain in their homes as long as possible.

However, veterans who are eligible for cost-free nursing home care at state veterans homes are largely denied the option to receive cost-free adult day care services at these facilities. Due to VA's delay in publishing regulations for adult day care, only three state veterans homes currently provide adult day care services. This legislation would rightfully ensure VA and state veterans homes have the authority to provide nursing home eligible veterans the ability to delay institutional care and remain in their homes with their loved ones.

H.R. 3956, VA Health Center Management Stability and Improvement Act

This legislation would require VA to develop and implement a plan to hire highly qualified directors for each VA medical center (VAMC). The VFW agrees with the intent of this legislation and has recommendations to improve it.

The VFW agrees that VA must urgently address the high volume of interim and acting directors throughout the VA health care system. According to recent VA data, more than 20 percent of VAMC and Veterans Integrated System Network (VISN) director positions are currently vacant. It is critical for VA to install permanent leadership at its medical centers to ensure it addresses the access crisis and is able to restore veterans' faith and confidence in their health care system.

However, the VFW does not believe a plan to hire permanent directors would be successful if VA is not given the authority to properly compensate VAMC and VISN directors. Director positions are difficult to fill because they are responsible for overseeing hundreds of employees, who deliver care and services to thousands of veterans. That is why the VFW recommends the Subcommittee authorize market-based compensation for VA medical directors.

VA must also have the leeway to quickly hire a qualified candidate when one is identified. The best qualified person for a medical center position may not be searching for a job on USA Jobs, and if VA identifies a qualified candidate it should not be required to have that candidate apply for an opening through USA Jobs. That is why the VFW urges the Subcommittee to authorize VA to directly hire VAMC and VISN directors.

Furthermore, VA will not be able to quickly fill vacancies amongst VAMC and VISN directors if it lacks the human resources staff needed to identify qualified candidates and process their employment applications. Recent VA data shows VA has 633 vacancies in human resources throughout the Department. The VFW urges the Subcommittee to work with VA to ensure it has the authority to recruit, employ and retain the human resources employees it needs to quickly fill vacancies and develop succession planning processes to prevent high vacancy rates.

H.R. 3974, Grow Our Own Directive: Physician Employment and Education Act of 2015

This legislation would build on the success of the Intermediate Care Technician (ICT) Pilot Program. Launched in December 2012, the ICT pilot program recruited transitioning veterans who served as medics or corpsmen in the military to work in VA emergency departments as intermediate care technicians. The ICT program offered transitioning medics and corpsmen, who have extensive combat medicine experience and training, the opportunity to provide clinical support for VA health care providers without requiring them to undergo additional academic preparation.

This legislation would go a step further by affording transitioning medics and corpsmen the opportunity to become physician assistants. With the end of the wars in Iraq and Afghanistan, and the continued drawdown of military personnel, more medics and corpsmen will be leaving military service and transitioning into the civilian workforce. The VFW strongly supports efforts to leverage their medical knowledge and experience to meet the health care needs of our nation's veterans.

H.R. 3989, Supporting Our Military Caregivers Act

This legislation would require VA to contract with an independent entity to review appeals regarding eligibility determinations for the program of Comprehensive Assistance for Family Caregivers, commonly known as the Caregivers Program. While the VFW agrees with the intent of this legislation, we cannot support it as written.

The VFW has heard too many instances of inconsistent implementation of the Caregivers Program. This is largely due to the fact that Caregivers Program eligibility is determined at the local VAMC level by a veteran's treatment team without proper guidance on how to make such a determination. The VFW has urged VA to establish a handbook for VA physicians to use as a reference when making a determination on whether a veteran is able to live independently without the assistance of others.

VA physicians must also have the proper guidance on how to conduct a clinical evaluation to determine the degree to which a veteran is unable to perform activities of daily living and how many hours of care a veteran requires per week. To this date, VA has failed to provide such guidance to the field and has allowed VAMC personnel to continue to make inconsistent eligibility determinations. VA has informed the VFW it is working diligently on a directive to address inconsistent implementation of this important program. The VFW looks forward to such directive and will monitor progress to ensure VA medical facilities comply with the directive.

The most common concern we hear from veterans regarding the Caregivers Program is that they were considered to be in the highest tier (requiring at least 40

hours of care per week), but were downgraded or discontinued from the program when they relocated to a different VAMC or VISN. The VFW has found that this is caused by an automatic re-evaluation that is triggered when a veteran moves from one VISN or VAMC to another.

For example, a veteran who is service connected for numerous severe mental health conditions from Tennessee, where he was determined to require at least 40 hours a week of caregiver support, moved to Colorado. When the veteran received a re-evaluation at his new VAMC, it was determined the veteran no longer needed the assistance of a caregiver and was discontinued from the program, despite needing the aid of his wife to perform activities of daily living. Furthermore, the determination to discontinue the veteran from the program was made without a VA health care professional from his new VAMC conducting a site visit.

The VFW strongly believes veterans who are determined to be eligible for the Caregivers Program should not be required to undergo a re-evaluation simply because they move to a different state or VISN catchment area. That is why we have urged VA to end such practice and ensure a qualified health care professional conduct a site visit to review a veteran's level of dependency before such veteran is discontinued from this important program.

Veterans who disagree with a clinical determination made by their treatment team are not given appropriate recourse for appealing such decisions. This legislation seeks to correct this issue by authorizing veterans to seek a second opinion from an independent entity. While the VFW strongly believes veterans who disagree with a decision made by their treatment team must be afforded a fair and expedient opportunity to appeal such decision, we do not believe an independent contractor would have the experience in diagnosing and treating the unique health care conditions veterans face. Furthermore, this legislation fails to address the larger issue that limits a veteran's ability to appeal an eligibility decision regarding the Caregivers Program - VA's inadequate clinical appeals process.

VA's current clinical appeals process does not afford veterans the ability to have their decision reviewed beyond the VISN level. Veterans who disagree with a clinical review conducted by the VAMC chief medical officer are given the opportunity to have the decision reviewed by the VISN director, who rarely overturns the VAMC decision. Moreover, the VISN level appeal is final, unless a veteran appeals to the Board of Veterans Appeal, which is not a viable option for veterans who require time sensitive medical treatments. That is why the VFW strongly urges this Subcommittee to review and reform the VA clinical appeals process.

Draft legislation to ensure each medical facility of the Department of Veterans Affairs complies with requirements relating to scheduling veterans for health care appointments

The VFW supports the intent of this legislation, which would require all VA medical facilities to certify compliance with scheduling laws and directives. However, the VFW does not believe this legislation would resolve the underlying issue with scheduling at VA medical facilities.

In the VFW's two reports on the Veterans Choice Program, which can be found at www.vfw.org/vawatch, we found VA's wait time metric is flawed and susceptible to data manipulation. For example, VA's preferred date metric does not properly measure how long a veteran waits for an appointment. A recent Government Accountability Office (GAO) report entitled "Actions Needed to Improve Newly Enrolled Veterans' Access to Primary Care" also highlights how a veteran who waited 20 days to see a primary care provider from the time he requested an appointment is recorded into the scheduling system as waiting 4 days for his appointment.

The VFW recognizes that using the request date as the starting point is also flawed because VA has established an arbitrary wait time goal of 30 days for all appointments, which does not represent how the health care industry measures wait times. In a recent report, the RAND Corporation found the best practices in the private sector for measuring timeliness of appointments are generally based on the clinical need of the health care requested and in consultation with the patient and their family. That is why the VFW has urged VA and Congress to move away from using arbitrary standards to measure whether an appointment was delivered in a timely manner and adopt industry best practices by basing the timeliness of appointment scheduling on a clinical decision made by health care providers and their patients.

The VFW does not believe this legislation can be successful if VA's wait time metric remains flawed and susceptible to data manipulation. Compliance with flawed metrics does not lead to better health care outcomes for veterans.

Discussion draft to direct the Secretary of Veterans Affairs to establish a list of drugs that require increased level of informed consent

This discussion legislation would ensure veterans are properly informed of the possible side effects and dangers of certain prescription drugs before beginning a treatment regimen. The VFW supports this draft legislation and has several recommendations to improve it.

The VFW has heard from veterans time and time again that they want to be incorporated in decisions regarding their health care. In particular, veterans who have been prescribed high dose medications to treat their health conditions would like to know whether they have alternatives to pharmacotherapy that are effective and lead to similar or better health care outcomes. This draft legislation would rightfully require increased informed consent before VA health care professionals prescribe potentially harmful drugs.

While informed consent is important to ensure veterans are incorporated in decisions regarding their health care, such consent cannot be used to waive a VA provider's liability if veterans are adversely impacted by such medications. The VFW recommends the Subcommittee include a provision to ensure informed consent, as detailed in this legislation, does not release VA from liability if an adverse action were to occur as the result of such treatment.

This legislation would also require VA to inform veterans of the potential danger of mixing drugs and dosages in sizes and combinations that have not been approved by the Food and Drug Administration. While general information on drug interactions is important, the VFW believes it would be more beneficial to give veterans an explanation of how the suggested prescription drug would affect the patient in accordance with all of the patients currently prescribed pharmaceuticals. By doing this veterans will be able make a personalized informed decision.

Information Required by Rule XI2(g)(4) of the House of Representatives

Pursuant to Rule XI2(g)(4) of the House of Representatives, the VFW has not received any federal grants in Fiscal Year 2016, nor has it received any federal grants in the two previous Fiscal Years.

The VFW has not received payments or contracts from any foreign governments in the current year or preceding two calendar years.

