

LEGISLATIVE HEARING ON: H.R. 272; H.R. 353;  
H.R. 359; H.R. 421; H.R. 423; H.R. 1356; H.R.  
1688; H.R. 1862; H.R. 2464; H.R. 2914; H.R.  
2915; H.R. 3016; AND, DRAFT LEGISLATION TO  
AUTHORIZE VA MAJOR MEDICAL FACILITY  
CONSTRUCTION PROJECTS FOR FY 2015 AND  
TO MAKE CERTAIN IMPROVEMENTS IN THE AD-  
MINISTRATION OF VA MEDICAL FACILITY CON-  
STRUCTION PROJECTS

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HEARING  
BEFORE THE  
SUBCOMMITTEE ON HEALTH  
OF THE  
COMMITTEE ON VETERANS' AFFAIRS  
U.S. HOUSE OF REPRESENTATIVES  
ONE HUNDRED FOURTEENTH CONGRESS  
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**Tuesday, July 14, 2015**

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

The subcommittee met, pursuant to notice, at 10:31 a.m., in Room 334, Cannon House Office Building, Hon. Dan Benishek [chairman of the subcommittee] presiding.

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

Also Present: Representative Walz.

**OPENING STATEMENT OF CHAIRMAN DAN BENISHEK**

Dr. BENISHEK. The subcommittee will come to order.

Before we begin, I would like to ask unanimous consent for my friend and colleague and member of the full committee, Mr. Walz from Minnesota, to sit on the dais and participate in today's proceedings. Without objection, so ordered.

Good morning, and thank you all for joining us today as we discuss legislation that would impact and improve the healthcare provided to our veterans by the Department of Veterans Affairs.

Our agenda this morning is ambitious. It includes 13 bills ranging in scope from ensuring quality healthcare outcomes for the growing number of women veterans to reforming VA's management of major medical facility construction projects.

Given that we have a lengthy hearing ahead of us, I will limit my opening comments to discussing the bill on our agenda that I am proud to sponsor, H.R. 2464, the Demanding Accountability for Veterans Act.

This bill would address a troubling pattern that we have seen repeatedly in subcommittee hearings and roundtables where the VA

inspector general identifies a recommendation to resolve a serious issue, the VA fails to take appropriate action, and veterans suffer as a result.

Such negligence and inaction would be unacceptable for any organization, but it is particularly unacceptable for a taxpayer funded Federal Government department that is charged with caring for the men and women who have served our Nation in uniform.

The Demanding Accountability for Veterans Act would require the IG to provide the Committee on Veterans' Affairs of the House and the Senate with copies of all reports submitted to the VA to including an explanation of any changes made to the report that were recommended by the VA during the drafting process and the name of the VA employee responsible for taking action in response to the report's content.

In turn, the VA will be required to promptly notify each named employee of his or her responsibility to take action, direct that the employee resolve the issue at hand, and provide the employee with counseling and a mitigation plan to support him or her in fully addressing the inspector general's recommendations.

The bill would further require the VA to include an evaluation of whether or not the employee took appropriate action in his or her annual performance review, prohibit the VA from paying a bonus or performance award to any employee who failed to resolve an issue under their purview.

An earlier version of the Demanding Accountability for Veterans Act passed the House resoundingly last Congress. I look forward to similar passage this Congress. We owe it to our veterans and to the taxpayers who pay VA's bills to ensure that poor-performing VA bureaucrats are held accountable for failing to provide the high-quality care that our veterans have earned and deserve.

The Demanding Accountability for Veterans Act is critical to doing just that and I encourage all my colleagues to join me in supporting it.

With that, I would like to thank all of our witnesses and audience members today for being here and I yield to Ranking Member Brownley for any opening statement she may have.

#### **OPENING STATEMENT OF RANKING MEMBER JULIA BROWNLEY**

Ms. BROWNLEY. Thank you, Chairman Benishek, and thank you for calling this hearing today.

These hearings are an important part of the legislative process. It is essential to our responsibilities to advance worthy legislation that addresses and improves medical services available to our veterans. Access to safe, quality healthcare is and must be the priority for the subcommittee.

I am particularly pleased to see so many of my colleagues here today to testify on their legislation and I thank you so much for your interest in the well-being of veterans across our country.

Mr. Chairman, while there are many worthy bills on the agenda today, I will focus on just three that are being considered at this hearing today.

H.R. 421, the Classified Veterans Access to Care Act, introduced by Congresswoman Sinema would ensure that veterans with classi-

fied experiences have appropriate access to mental health services from the Department of Veterans Affairs.

This bill was introduced in the last Congress and passed this committee as part of H.R. 4971 introduced by our colleague, Congressman O'Rourke. However, this bill was never considered by the full House, and I would like to thank the chairman for including it on the agenda today and would like to express my full support for this bill.

I have two bills on the agenda today that I have recently introduced. The first one, H.R. 2914, the Build a Better VA Act, is a bill that would modify the current process for approving Department of Veterans Affairs' medical facility leases.

Under current law, every major medical facility lease which incurs yearly rental costs of over a million dollars must be authorized by Congress. In addition, recent changes made to VA's leasing processes require the VA to submit leasing proposals to the General Services Administration for delegation to the VA.

This requires approval by the Committee on Transportation and Infrastructure in the House. Therefore, VA leases must be approved by the Transportation and Infrastructure Committee and be approved by Congress.

In 2012, the Congressional Budget Office changed its method of scoring VA leases. Instead of scoring the annual cost of the lease, CBO scores now reflect the cost for the duration of the lease, often 20 or more years.

For instance, CBO now scores a 20-year lease which costs the department \$5 million a year at \$100 million. Prior to 2012, CBO's score would have reflected the true cost of \$5 million, a considerable difference.

CBO's new scoring mechanism has made it impossible for the Veterans' Affairs Committee to authorize leases within the current budget caps despite the fact that no new money is actually spent. The result has been significant delays in leasing of new facilities, further delaying needed care for veterans across the country.

The population of veterans is growing. The demand for VA healthcare is increasing and many veterans trying to access VA care face long wait times and crumbling infrastructure at outdated VA clinics and medical centers.

CBO's actions have made authorizing new leases for veterans' medical facilities which are desperately needed in under-served veteran communities across the United States cost prohibitive.

This bill would simply allow major medical facility leases to be authorized by a committee resolution rather than the legislation. It would return the authorization process to the Veterans' Affairs Committee to what it was before requiring a committee resolution. It would also harmonize this process with the requirement of the General Services Administration and the longstanding practice of the Transportation and Infrastructure Committee for federal buildings.

This more rational approach would ensure that veterans have the facilities they need to get the healthcare they have earned and deserve and will help address the unacceptable wait times faced by many of our veterans.

I have also introduced H.R. 2915, the Female Veterans Suicide Prevention Act. This bill would direct the secretary of Veterans Affairs to identify mental healthcare and suicide prevention programs and metrics that are effective in treating women veterans as part of the evaluation of such programs by the secretary.

By analyzing data from 23 states and VA's suicide repository of more than 170,000 adult suicides over a ten-year period, VA researchers found in a May 2015 report that suicides among women veterans increased by 40 percent from 2000 to 2010 compared to a 13 percent increase in suicide among civilian women.

In fact, female veterans are nearly six times as likely as other women to commit suicide. My bill is intended to ensure that the VA addresses these tragedies by requiring that VA's evaluations of mental healthcare and suicide prevention programs include specific metrics on women veterans and by requiring the VA to identify the mental healthcare and suicide prevention programs that are the most effective and have the highest satisfaction rates among our female veterans.

While I am disappointed that the department has not submitted views on my two bills before us today, I look forward to receiving those views in the not too distant future.

Mr. Chairman, I look forward to the testimony from our witnesses today and their views on how to improve upon the many bills that we are considering. Thank you, and I yield back the balance of my time.

[THE PREPARED STATEMENT OF RANKING MEMBER JULIA BROWNLEY APPEARS IN THE APPENDIX]

Dr. BENISHEK. Thank you, Ms. Brownley.

I am honored this morning to be joined by several of my colleagues to speak in support of their legislation. Joining us this morning is the Honorable Tim Walberg from Michigan; Sean Duffy from Wisconsin I imagine will be joining us here shortly; Steve Stivers from Ohio; Honorable Kyrsten Sinema from Arizona; the Honorable Doug Collins from Georgia; the Honorable Mike Coffman from Colorado; the Honorable Jeff Denham will probably be joining us as well; and the Honorable Charles Boustany from Louisiana; as well as the Honorable Brad Wenstrup from Ohio. Thank you all for being here today.

Mr. Walberg, we will begin with you. You have five minutes to present your testimony.

**STATEMENT OF HON. TIM WALBERG, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN**

Mr. WALBERG. Chairman Benishek, Ranking Member Brownley, and members of the subcommittee, I thank you for allowing me the time to speak this morning in support of my legislation, H.R. 272, the Medal of Honor Priority Care Act of 2015, which raises the Medal of Honor recipients to Priority 1 level of care, I believe to be a common-sense, I hope noncontroversial and certainly bipartisan piece of legislation.

As members of this committee are well aware, the Congressional Medal of Honor is the highest award for valor which can be bestowed upon an individual serving in the United States Armed Forces and is awarded to soldiers who have displayed conspicuous



gallantry and intrepidity at the risk of life above and beyond the call of duty.

The Medal of Honor is a distinguished award given to a select few. Less than 3,500 have been awarded and 16 awards have gone to soldiers who fought in the recent conflicts in Iraq and Afghanistan. Currently there are only 79 living Medal of Honor recipients.

My State of Michigan, as you know, Mr. Chairman, is privileged to have two living recipients. Corporal Duane E. Dewey and Private First Class Robert Simanek both received the declaration for their heroic action in the Korean War and hearing of the harrowing stories of bravery has reminded me of the sacrifices American soldiers are willing to make to protect their comrades and their country.

Medal of Honor recipients are brought most appreciation and I believe the small portion of our servicemembers who have gone above and beyond the call of duty and earned the highest honor in our Nation's Armed Forces have earned the right to be placed in the top priority group to receive their healthcare benefits.

I would be remiss if I did not mention the idea for this legislation came from a veteran who lives in my district and works with the veteran community. All veterans deserve access to the healthcare they have earned. But as you all know, the VA uses a priority system to determine eligibility for these healthcare services.

Some of the factors that will affect a soldier's priority group ranking are whether the soldier has service-connected disability, whether they were a former prisoner of war, the time and place of service as well as income level.

Currently Medal of Honor recipients are in Priority Group 3. This bill is very similar to legislation approved by this committee during the 113th Congress. I am proud to have support of the VFW, Paralyzed Veterans of America, The American Legion, IAVA, and to once again have the support of my colleagues from both sides of the aisle on this bill.

I thank the chairman for permitting me to appear before the subcommittee today, and I certainly would appreciate your support. Thank you.

[THE PREPARED STATEMENT OF TIM WALBERG APPEARS IN THE APPENDIX]

Dr. BENISHEK. Thank you, Mr. Walberg.

Mr. Stivers, you are recognized for five minutes.

#### **STATEMENT OF HON. STEVE STIVERS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO**

Mr. STIVERS. Thank you, Mr. Chairman.

I want to thank Chairman Benishek and Ranking Member Brownley for including my bill, the bipartisan Veteran Dog Training Therapy Act, in today's legislative hearing.

As the committee members probably know, 22 veterans commit suicide every day. The ranking member just talked about her bill that she is working on on female suicide. This is a deeply personal issue for me. I am a colonel in the Ohio Army National Guard, served in Operation Iraqi Freedom, and I have known people who have sadly taken their own lives.

This epidemic requires immediate action. I appreciate what you are already doing, but I know there is more we can do. The tie between posttraumatic stress disorder and traumatic brain injury and suicide is well-documented, and I know you are taking steps to improve treatments for both those conditions.

However, every individual is unique and different people respond differently to different therapies. That is why I have introduced the Veterans Dog Training Therapy Act with my colleague, Tim Walz from Minnesota.

Thank you for your work on this. I appreciate it.

Our bill seeks to expand access to an alternative therapy that is proven effective and it works for a lot of people. Anybody that owns a dog knows that when you are petting your dog, hanging out with your dog, you know, your emotions just kind of ease away.

So essentially what our bill does is it creates three to five pilot programs in VA facilities around the country and then that pilot would be studied for expansion if it works or elimination if it doesn't work.

These veterans would essentially get a chance to help learn occupational skills while training a service dog and on completion of the dog's training, that dog would then be given to a disabled veteran for future service.

This is not a program we made from scratch. It emulates and copies a very successful model of a nonprofit called the Warrior Canine Connection which is at several Department of Defense medical facilities and one VA facility already in Menlo Park.

So it works and it is a model that we know will work. That is why we decided to copy it. Veterans that are enrolled in this program have shown significant improvements and I believe that this pilot would bear out the same results.

And it is important to note that some of the wounded warriors who benefit from service dog therapy had not been responding to other treatments. So this is something that works when a lot of other things fail.

Kaiser Permanente actually did some research on the effectiveness of service dogs in treating PTSD and traumatic brain injury related symptoms. The study has shown that veterans who own service dogs have fewer symptoms of PTSD and depression, better interpersonal relationships, and an overall improvement in mental health. Maybe we should get some service dogs in Congress.

It should also be noted that Congress did direct a research study in the 2010 NDAA which was signed into law in 2009, but that study won't be completed until 2019. There is already research out here that shows this works. We need to get this in the field as soon as possible.

Twenty-two suicides a day, almost one an hour. If we can do things to prevent it, we should not wait ten years. So that is why Mr. Walz and I have introduced this bill. Again, this is not made up from scratch. It emulates the Warrior Canine Connection successful model and tries to emulate it and expand it for the future into VA facilities.

I met one of the dogs from Warrior Canine Connection just last week and, you know, when she was in the office, everybody was calm. These service dogs just work. And so I know that this bill

will make a difference. I know that the study won't be completed until 2019, but I implore you don't wait on a study that we all know what it is going to say.

And I am a little disappointed I will say in the VA study. They have been training these dogs as like guard dogs and that is not what a service dog is. They need to train them in being gentle and, you know, very docile. And that is what Warrior Canine Connection has done.

Again, this bill will help us as we try to address some of these people that have traumatic brain injury and posttraumatic stress disorder that aren't responding to other therapies and it will help keep their mental health in a better state. The results have been proven in this Kaiser Permanente study.

I know my time is up, but I really appreciate you hearing my testimony today and I hope you will take this bill and help us get it done because it is really important and it can really help save lives.

Thank you so much. Again, I want to thank Tim Walz for his work on it. I want to thank the chairman and ranking member again for allowing me to be here. And I implore you to please take action on this bill. Thank you.

[THE PREPARED STATEMENT OF STEVE STIVERS APPEARS IN THE APPENDIX]

Dr. BENISHEK. Thank you very much.  
Representative Sinema, please go ahead.

**STATEMENT OF HON. KYRSTEN SINEMA, A REPRESENTATIVE  
IN CONGRESS FROM THE STATE OF ARIZONA**

Ms. SINEMA. Thank you, Chairman Benishek, and thank you, Ranking Member Brownley, for holding today's hearing.

I want to first start by saying thank you to my colleagues who have introduced important bills to improve the quality of care available to veterans, especially Chairman Benishek's legislative, the Demanding Accountability for Veterans Act.

We introduced this important bill together to improve accountability and to hold VA employees responsible for solving problems at the VA.

I am here today to discuss H.R. 421, the Classified Veterans Access to Care Act. And thank you, Chairman Benishek, for allowing me time to speak today and to both the ranking member and the chairman for cosponsoring this legislation.

The Classified Veterans Access to Care Act ensures that veterans with classified experiences can access appropriate mental health services at the Department of Veterans Affairs. Our bill directs the secretary of the VA to establish standards and procedures to ensure that a veteran who participated in a classified mission or served in a sensitive unit may access mental healthcare in a manner that fully accommodates the veteran's obligation to not improperly disclose classified information.

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

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

I am working on this issue because just over two years ago, a veteran in my district, Sergeant Daniel Somers, failed to receive the care he needed and tragically lost his life to suicide. No veteran or family should go through the same tragedy that the Somers family experienced.

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

Like many veterans, Daniel was haunted by the war when he returned home. He suffered from flashbacks, nightmares, depression, and additional symptoms of posttraumatic stress disorder made worse by a traumatic brain injury. Daniel needed help and he and his family asked for help.

Unfortunately, the VA enrolled Sergeant Somers in group therapy sessions which Sergeant Somers could not attend for fear of disclosing classified information. Despite repeated requests for individualized counseling or some other reasonable accommodation to allow Sergeant Somers to receive appropriate care for his PTSD, the VA delayed providing Sergeant Somers with appropriate support and care.

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

On June 10th, 2013, Sergeant Somers wrote a letter to his family. In the letter, he said I am not getting better. I am not going to get better and I will most certainly deteriorate further as time goes on. He went on to say I am left with basically nothing, too trapped in a war to be at peace, too damaged to be at war, abandoned by those who would take the easy route and a liability to those who stick it out and thus deserve better. So you see, not only am I better off dead, but the world is better without me in it. This is what brought me to my actual final mission.

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

Many of you have met with Howard and Jean. They are working closely with Congress and the VA to share their experiences with the VA healthcare system and find ways to improve care for veterans and their families.

Our office worked closely with Howard and Jean to develop the Classified Veterans Access to Care Act. And if the committee moves this bill forward, I ask on behalf of Dr. and Mrs. Somers that the committee amend the title of the bill to the Sergeant Daniel

Somers' Classified Veterans Access to Care Act in memory of Sergeant Somers' service and sacrifice.

I appreciate the support this committee gave to our bill during the 113th Congress. I look forward to continuing to work with the committee to ensure that no veteran feels trapped like Sergeant Somers did and that all veterans have access to appropriate mental healthcare.

Thank you, Chairman Benishek and Ranking Member Brownley, for including H.R. 421 in today's hearing. Thank you.

Dr. BENISHEK. Thank you.

Mr. Collins.

**STATEMENT OF HON. DOUG COLLINS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA**

Mr. COLLINS. Thank you, Mr. Chairman.

Chairman Benishek, Ranking Member Brownley, and distinguished members of the subcommittee, thank you for the opportunity to testify on H.R. 423, the Newborn Care Improvement Act.

My legislation amends Title 38 of the United States Code to improve the care provided by the secretary of Veterans Affairs to newborn children. And I am very appreciative of the subcommittee's consideration of this legislation.

The motto of the VA comes straight from Abraham Lincoln's second inaugural. He got that idea straight from scripture. So the challenge for us is to care for him who shall have borne the battle and for his widow and his orphans. This isn't new as we have already heard this morning.

Since September 11th, 2011, more than a quarter of a million women have answered the call to serve. They face terrorism in the deserts and in the mountains of Iraq and Afghanistan. So in the 21st century, we must also consider she who shall have the borne the battle. When she returns, what of her children?

The finest military in the world is powered by men and women in their physical prime. Young women who decided to serve this country in the Armed Forces aren't immune from the same questions that all young women face about whether to pursue a career, a family, or both, yet they are offered a healthcare system that for so many years has been designed to serve men.

With the increasing number of female veterans, the VA must expand its care and services to meet their needs. Maternity care tops that list of needs and I have offered one of the ways that we can help.

In 2010, Congress passed and the President signed the Caregivers and Veterans Omnibus Health Services Act of 2010 to provide short-term newborn care for women veterans who receive their maternity care through the VA. Signed into law on May 5th, 2010, this legislation authorized up to seven days of newborn care.

On January 27th, 2012, the Department of Veterans Affairs published a regulation officially amending VA's medical benefits package to include up to seven days of medical care for newborns delivered by female veterans who are receiving VA maternity care benefits. The rule which became effective December 19th applied retroactively to newborn care provided to eligible women vets on or after May 5th, 2011.

Since the seven-day authorization was enacted by Congress in 2010, we have learned about the unique challenges facing female veterans and changing trends in the veterans seeking maternity and newborn care from the VA. According to a study published in the Women's Health Journal this past year, 2008 to 2012, the overall delivery rate by female veterans utilizing VA maternity benefits increased by 44 percent and a majority of the women using VA maternity benefits had service-connected disability.

Just last week, the U.S. Navy announced that it has tripled the amount of paid maternity leave for personnel in the navy and marine corps. Effective immediately, 18 weeks of maternity leave will be available.

Secretary Mabus stated in a press release with increased maternity leave, we can demonstrate the commitment of the navy and marine corps to the women who are committed to serve.

In the same way, unless Congress extends the authorization for length of newborn care coverage provided by the VA, there will be veterans who face difficult financial decisions and complexities in navigating insurance options at the same time that their newborn is fighting for their life.

This is why I introduced H.R. 423 to demonstrate Congress's commitment to meeting the needs of female veterans and providing a little longer for their newborn care. My legislation extends the authorization of care from seven to 14 days and provides for an annual report on the number of newborn children who receive such services during such fiscal year.

Improved data on the trends in female veterans utilizing newborn care will help Congress and the VA better meet their needs in years to come. Should this subcommittee place my legislation on their markup calendar, which I hope they will do, I would request an amendment be adopted adding the reporting requirement to an existing report the VA is required to produce.

Although it is vitally important that Congress and the VA have this data, I don't want the VA to produce yet another report when instead we could add this requirement to an existing report.

Some may ask why the VA should provide more newborn care coverage to female veterans than the average private sector employee receives. These women have risked their lives to protect our Nation. Just because they are no longer serving in active duty does not mean that our responsibility to them ends. In fact, their service to our country may jeopardize the very lives of their future children, thus responsibility to them is even greater.

A recent study examined more than 16,000 births to female veterans. Having PTSD in the year before delivery increased a woman's risk of spontaneous premature delivery by 35 percent research showed. This study gives us a convincing epidemiological basis to say that, yes, PTSD is a risk factor for pre-term delivery.

The study's senior author said an investigator at the March of Dimes prematurity research center at Stanford University said mothers with PTSD should be treated as having high-risk pregnancies. Premature infants often need longer hospitalizations after they are born and are more likely than full-term infants to die. These premature infants who survive may face long-term develop-

mental problems and, unfortunately, the number of female veterans with PTSD is not insignificant.

According to the VA, 20 percent of female veterans in conflicts in Iraq and Afghanistan have been diagnosed with PTSD and these are not just the female veterans serving in combat.

And on a personal note, I know what it is like to be a parent of a little baby who needs intensive medical care. For an extended period of time after my daughter was born, I could not even hold her until she was over ten days old.

So it is my hope that any new mother who has given selflessly to her country wouldn't have to worry about Congress standing in her way if she tries to give selflessly to her own child. And our goal should always be to provide the mother with the best prenatal care she needs to give the newborn the best chance of healthy delivery.

To the members of the subcommittee, I know my time is short and I have submitted a statement. This is something that we can do to support those who supported us. In a new and changing world with women serving proudly and strongly, this is something we can do to protect them and also give best care to them and their newborns when they have served us and into a new world of the VA.

And with that, Mr. Chairman, I yield back.

[THE PREPARED STATEMENT OF DOUG COLLINS APPEARS IN THE APPENDIX]

Dr. BENISHEK. Thank you, Mr. Collins.

I think I am going to go back to Mr. Duffy.

Mr. Duffy, could you give your testimony, please.

**STATEMENT OF HON. SEAN DUFFY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WISCONSIN**

Mr. DUFFY. Yes. Good morning. Thank you, Chairman Dr. Benishek and Ranking Member Brownley, for holding today's hearing and I appreciate the opportunity to testify on H.R. 353, the Veterans Access to Hearing Health Act.

I introduced this bill along with Representative Walz from Minnesota and Ruiz from California to address the long wait times and lack of access to care for our veterans for audiology services.

Our aging and younger veterans are returning home from the battlefield and they are seeking care from the VA in regard to hearing loss and tinnitus more than any other disability facing them today, yet the VA does not have the capability to keep up with the demand of these services.

A recent Washington Post article cited that since the VA scandal broke last year, the number of veterans on wait lists for appointments has actually increased by 50 percent. Audiology services are a major factor in those wait times. According to the VA, nearly half of all patients waiting for care are waiting for audiology services.

So we are all talking about personal stories today and I have one from my district. Roger Ellison, a 70-year-old Vietnam vet from Marshfield, Wisconsin, he is having hearing problems. So he goes to the VA and tries to set up an appointment. And they tell him he has to wait six months to get an appointment.

I don't know how someone could go six days let alone six months when you can't hear. So instead he paid out of pocket, went to

someone in his local community, a hearing aid specialist, and was able to get fitted for hearing aids. Pretty simple solution, but it would have been nice if the VA could have actually cared for him.

Audiology services not only affect our older generation, but they are also affecting our younger generation too. Roger and thousands of other veterans are in situations because the VA, they are only allowed to use audiologists and not other capable providers to fulfill hearing aid services for our veterans.

While audiologists are great resources for the VA to provide good services for our veterans, there is just not enough of them. There is too much demand. And so if you look for solutions on the committee, you can say let's try to spend more money and hire more audiologists. Well, that is great, but it is pretty tough to hire people into the VA and we don't have a lot of money.

So what could we do that could actually resolve this problem, care for our veterans, and not spend really any more money? The answer is let's use hearing aid specialists. They are qualified. Veterans can get these services in their own communities. They can get their hearing aids fitted, adjusted, make minor repairs. And then we are going to lift the burden off the audiologists so they can actually focus on the more serious cases.

But why are we backing up audiology appointments with hearing aid tweaks, hearing aid fittings? This can happen actually in the home community. This is a simple solution that doesn't cost money that is going to help our veterans out and it lifts the burden. And I think that is why we have such a bipartisan coalition that has come together on this bill.

I would ask for you to respectfully consider a simple solution to a really big problem for veterans who can't hear. And if we come together, it is one of those small fixes that again makes a big difference.

So I thank you for allowing me to testify and thank you for your consideration. I yield back.

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

Dr. BENISHEK. Thank you, Mr. Duffy.

Mr. Coffman, are you ready to go ahead?

**STATEMENT OF HON. MIKE COFFMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO**

Mr. COFFMAN. Yes, Mr. Chairman.

Thank you, Chairman Benishek and Ranking Member Brownley, for holding this legislative hearing and including my bipartisan bill, the Women Veterans Access to Quality Care Act.

Although the Department of Veterans Affairs has made some progress in recent years, the fact remains that the VA is a system largely designed for male veterans.

A recent comprehensive study conducted by the Disabled American Veterans entitled Women Veterans, The Long Journey Home found serious gaps in almost every aspect of programs that serve women vets.

In recent years, the active-duty military has made incredible strides towards fully incorporating women into the ranks. Though more work needs to be done, those long overdue changes in the De-



partment of Defense have increased the pool of eligible recruits, raising the standards to make our military the most professional that our country has ever had.

As more and more of these women leave military service and become veterans, it is critical that the VA quickly adapt its facilities and culture. The aim of my bill is to increase gender-specific access to healthcare within the VA, improve healthcare outcomes for our women veterans, and improve VA's facilities to ensure that they protect the privacy and dignity of all veterans.

The need for this bill is largely illustrated simply by reviewing the rapidly changing demographic composition of the VA patient population. Between 2003 and 2012, the number of women veterans using VA healthcare nearly doubled. In 2012, women made up only 6.5 percent of the VA patient population, but are estimated to encompass over ten percent by 2020.

Meanwhile, nearly 20 percent of all new recruits in the military are women. The women veteran patient population also has unique characteristics when compared to the male VA population. The median age of a female patient in the VA is 49 years old compared to 64 for male patients. Only 13 percent of men within the VA were 45 years old or younger compared to 45 percent of women.

These are dramatic changes to the VA's patient population and the former almost exclusively male VA healthcare system simply hasn't kept up with the changes. My bill addresses the VA's lapses in healthcare quality and access for its women patients in five ways.

First, my bill requires the VA to establish standards to ensure VA facilities meet the specific needs of women and integrates those standards into its strategic capital investment planning process. The Government Accountability Office found in 2010 that none of the VA hospitals it surveyed were compliant with the VA's own policies related to privacy for women veterans.

Just to cite a few examples, the audit found that check-in desks were in busy mixed-gender areas and gynecological examination tables faced towards doorways. Additionally, despite VA's requirements that gynecological exam rooms have immediately adjacent restrooms, often women were required to walk down long hallways in high traffic, mixed-gender corridors to access restrooms.

At a hearing in this room in April, I asked a panel of veteran service organizations' experts whether these conditions have improved in the past five years. And the committee learned that these problems continue to persist nationwide.

Second, my bill holds VA medical facility directors accountable to performance measures which include women's healthcare outcomes and it requires the reporting of those outcomes. As with many other areas in the VA, there is an incredible lack of accountability which is hindering true progress and reform.

Third, my bill ensures the availability of OB/GYN services at VA medical centers and requires the VA to conduct a pilot program to increase residents and graduate medical education positions.

In 2010, nearly half of the women veterans who use VA healthcare had at least one reproductive health diagnosis. It is absolutely essential that these veterans have quick and reliable access to appropriate gender-specific care.

Fourth, my bill improves outreach to women veterans by requiring the VA to provide state and veterans' agencies with contact information for veterans. One of DAV's findings in its report was that information on veterans' programs and eligibility is often difficult to access and scattered across various programs or Web sites. Increasing outreach to women veterans through collaboration with VA's state agency partners is vital.

Finally, my bill mandates a new comprehensive GAO study of the VA's ability to meet the needs of women veterans including an examination of wait times, gender-specific care availability, VA training, differences in health outcomes, and security and privacy within VA facilities.

During my own military career, I have witnessed quite a number of challenges that the military has had to confront. Each time it overcame the obstacles and always emerged as a more effective fighting force. I have full confidence that the VA can do the same.

I hope my bill can jumpstart the cultural sea change required at the VA to ensure our women veterans are provided the same benefits they earned in service to our Nation just like their male counterparts. I am grateful for the support of many of our Nation's veterans and veteran service organizations have provided for this bill and I urge all of my colleagues on the committee today to join me in this effort.

Thank you, Mr. Chairman. I yield back.

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

Dr. BENISHEK. Thank you, Mr. Coffman.

Dr. Boustany, could you begin your testimony.

**STATEMENT OF HON. CHARLES BOUSTANY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF LOUISIANA**

Mr. \*Boustany.\* Thank you, Chairman Benishek, Ranking Member Brownley, and members of the subcommittee, for inviting me to testify before you today.

As the committee considers reforms to the Department of Veterans Affairs operations, I really appreciate the opportunity to speak on behalf of my legislation, H.R. 1862, the Veterans Credit Protection Act.

Unfortunately, the VA's long history of delayed payments has brought me here to testify before you today. Too many veterans are forced to contact offices across our districts to resolve credit issues caused by the VA's refusal to pay claims for emergency medical care.

When these brave Americans require a trip to the emergency room because they have a serious illness or they fear that their lives are in danger, the last thing on their minds should be fear that the VA will fail to pay their claims. The last thing that should be on their mind are concerns about the VA damaging their credit rating.

One such veteran in my district, Al Theriot of Abbeville, Louisiana, waited over two years for the VA to finally process and pay his emergency medical care bills which the agency did only after Mr. Theriot contacted my office and appeared on local television

twice to describe his experience. This is just unacceptable. It is terrible and disrespectful service for our veterans.

I submitted documentation from the VA to the subcommittee early in June demonstrating the scale of this problem. Just to reiterate some of the findings, data provided to me as of April 2015, the VA's chief business office indicated that only 14, 14 percent of emergency medical care claims originating from VISN 16, which includes my home State of Louisiana, were being processed within 30 days. In total, the data demonstrates a national backlog of over \$878 million.

The Veterans Credit Protection Act is an important step to rooting out the problems within the VA that caused this out of control backlog. First, the legislation mandates the VA to set up a toll-free hotline for veterans to report credit issues caused by delayed emergency medical care claims.

It also requires the VA to conduct outreach alerting veterans of how to resolve these issues. Too often veterans tell me they cannot get in touch with the VA or that the employees they speak with cannot adequately answer their questions.

Creating a dedicated call line and ensuring the VA implements a better framework for communicating solutions with veterans is an absolutely necessary step toward eliminating the backlog.

My bill also requires VA to report annually to Congress on the chief business office's effectiveness with respect to timely claims processing. Their report must include information on the number of veterans who have reported credit issues due to delayed payments, the number of proper invoices submitted, the amounts owed on those invoices, and how long it took the VA to pay those claims, among other bits of information.

In addition to requiring the VA to report on the status of claims, H.R. 1862 aims to improve the chief business office operations by requiring the VA to examine comments made by medical providers regarding the claims processing system and delayed payments and report these comments to Congress along with a description of best practices to ensure timely claims payment in the future.

No veteran should ever have to decide whether or not to sacrifice their health and safety to avoid a potential financial burden if the VA fails to pay for a trip to the emergency room.

I want to sincerely thank the subcommittee for your efforts to ensure better care for America's veterans and for inviting me to be a part of this important discussion. Thank you.

[THE PREPARED STATEMENT OF CHARLES BOUSTANY APPEARS IN THE APPENDIX]

Dr. BENISHEK. Thank you, Dr. Boustany, for your wise use of your time.

Mr. Denham, would you please begin your testimony.

**STATEMENT OF HON. JEFF DENHAM, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA**

Mr. \*Denham.\* Thank you, Mr. Chairman.

Committee members, eye clinics staffed by the VA doctors of optometry including residents are among the busiest primary care settings in the veterans healthcare system.

This bill, 1688, is aimed at improving access to primary eye care in the VA by making a modest increase in the number of optometry residency positions in the VA.

My bill seeks to amend the Choice Act by designating 20 of the 1,500 new graduate medical education residency positions to the field of optometry. Although VA optometrists provided comprehensive eye exams and other essential care to more than 1.2 million veterans last year, the need for eye health and vision care is expected to grow further in the coming years.

Serious eye trauma is the second most common injury among those who served in Iraq and Afghanistan, with 16 percent of all wounded servicemembers experiencing problems ranging from distorted vision to blindness. Additionally, up to 75 percent of all TBI patients experience vision problems.

Increasing the number of optometry residents at the VA is one of the ways to enhance the VA's ability to address chronic patient care backlogs as well as train new doctors of optometry in advanced practices.

Since the VA established its first optometry residency in the 1970s, the program has proven to be an essential, cost-effective force multiplier to boost eye care teams and make veterans healthier and more engaged in their own care.

I would appreciate your support on H.R. 1688 to improve access to this important care for our veterans by adding 20 additional optometry residents to the VA over the next ten years.

Thank you, and I yield back.

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

Dr. BENISHEK. Thank you, Mr. Denham.

Dr. Wenstrup, present your bill.

#### **STATEMENT OF HON. BRAD WENSTRUP, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO**

Dr. WENSTRUP. Good morning, Chairman Benishek, Ranking Member Brownley, and members of the committee. Thank you for the opportunity to speak on the VA Provider Equity Act, H.R. 3016.

This bipartisan legislation which is currently cosponsored by every doctor on the VA Committee and the ranking member of this subcommittee would increase access to care for our veterans by changing outdated standards to move VA podiatrists to the same fee schedule as doctors of medicine and osteopathy within the VA.

After years of war, we have a new generation of Iraq and Afghanistan veterans returning with lower extremity injuries. These needs along with diabetic-related complications, peripheral neuropathy often linked to Agent Orange exposure, orthopedic maladies, vascular compromise, and many other conditions require ongoing care from the Veterans Health Administration that podiatrists are uniquely trained to provide.

The need is dramatic. The Department of Veterans Affairs treats more than 45,000 veterans who have lost limbs and 1.8 million more veterans within the VA are at risk of amputation, but the wait times remain unacceptable.

For those veterans seeking podiatric care within the VA, 93 percent of new podiatry patients wait more than 15 days for an ap-

pointment. More than two-thirds of them wait more than 30 days. These wait times exist because the VA is struggling to recruit and retain experienced podiatrists.

Forty-two percent of VA podiatrists leave the VA system within five years of being hired and every time a podiatrist leaves, the average time to fill a vacant podiatry position is one year. The problem, a self-imposed one, is that the VA is not competitive with the private sector when it comes to hiring and retaining podiatrists.

While the maximum salary for a VA podiatrist is \$132,000, the average salary for podiatrists in the profession is \$183,269 according to a 2013 APMA survey. That is a \$50,000 difference between the industry average and the maximum that our VA podiatrists can make. It is no wonder that many of our veterans are losing their VA podiatrists to the private sector.

The VA Provider Equity Act would place podiatrists on the same fee schedule as doctors of medicine and osteopathy within the VA. Since the VA first established podiatric pay standards in 1976, podiatric education, training, and practice have increased exponentially. Medicare recognized these changes over 20 years ago and implemented fee schedule reform in 1991. I think it is time for the VA to do the same.

Additionally, H.R. 3016 would make podiatrists eligible for the same promotions in leadership positions within hospital systems that they often currently hold in the private sector.

I thank the chairman and ranking member for their support and the commitment to increasing access to healthcare for our Nation's veterans. I ask for the support of my colleagues in advancing this important legislation. Let's ensure that access to podiatric care is included in the comprehensive first-class healthcare that all veterans deserve.

Thank you.

[THE PREPARED STATEMENT OF BRAD WENSTRUP APPEARS IN THE APPENDIX]

Dr. BENISHEK. Thank you, Dr. Wenstrup.

And I want to thank all the members of the first panel, all my colleagues for their interest in improving veterans' healthcare and thanks for the great ideas.

I am not going to ask any questions, but I think Mr. Walz had asked to go first because he is on a tight schedule for comment. Is that true, Mr. Walz?

Dr. WALZ. Well, I don't want to irritate my colleagues, Mr. Chairman, but I would be honored and appreciative if I could.

Dr. BENISHEK. Yeah, go ahead.

Dr. WALZ. Well, thank you to the chairman and thank you to the ranking member, first for allowing me to be here, more importantly to all of my colleagues for putting forth thoughtful legislation to improve the lives of veterans and families.

I think it is really important that this committee, while we simultaneously hold people accountable for the failings that are unacceptable, we also provide alternatives, provide solutions.

And I think that that old adage of we can sit around and curse the darkness or we can light a few candles, there is certainly some cursing that needs to be done on some of these things, but I think each of these pieces of legislation provide the VA opportunities to

partner and to do things and continue to build on things that are working right.

I would just spend a minute. The two bills that I was lead co-sponsor on with my colleagues, Mr. Duffy's bill on getting the hearing aids and the backlog, this makes good sense. It is smart. It is cost effective. It gets veterans out there. And we are doing it in many cases. I think this codifies it to the point where we can more effectively use our private sector and local providers to get folks out there.

This one is personal to me, too, as nearly 25 years in the artillery, hearing loss is something that all of my peers experience and I know that the quality of life that improves when you get quality care makes a big difference.

And then Mr. Stivers was here to talk about it. It may seem like a small thing, but he is exactly right. The therapy dogs make a huge difference. And if it provides solace and care for one veteran and we have the opportunities to be out there and do that, I think he is right. His piece of legislation starts to move that forward.

And I know most of my colleagues here all have witnessed this with veterans. It is a very powerful thing. And there is research to support it, but this is one of those that seeing is believing with what happens.

So I thank the chairman again for a very productive hearing and my colleagues for bringing up thoughtful legislation. And, again, I do think it's incumbent upon us to provide our oversight, help provide that accountability, but then also to provide and partner with ways that find solutions. And each of these pieces of legislation we heard today, I think, does exactly that.

So thank you, Chairman, for the courtesy, and I certainly look forward to the support on all these pieces of legislation.

Dr. BENISHEK. Thank you, Mr. Walz.

I don't have any questions myself or further comments other than my statement.

Do any of my colleagues on this side? Dr. Roe, you have a comment—

Dr. ROE. Just a couple. Thank you.

Dr. BENISHEK [continuing]. Or question?

Dr. ROE. Thank you. I will be very brief.

But certainly Tim Walberg's, Congressman Walberg's, his bill ought to be passed. That is just so common sense. Those Medal of Honor winners ought to have Secretary McDonald on speed dial. We should honor them. That should be no question.

I think one of the things I think on Congressman Collins that caught my attention was I found it a little bit surprising that we only provide two weeks' care for the baby that is born of the mother and we provide her six weeks of care. I don't know why we wouldn't just parallel those, marry those up and say, look, the baby goes for a six-week checkup just like the mother does. And why in the world are we putting two weeks? I would encourage us to have the same thing for the baby, that the first six weeks of care—exactly like the mother. That makes no sense to me.

So I would ask my colleague if he would consider an amendment to his bill just to do that, if that would be something we would like to discuss. It makes absolute sense.

And I know that on the therapy dogs that Congressman Walz brought up, they can be very relaxing unless you have a Sheltie like I did which chewed up over a thousand dollars worth of my shoes. That was very stressful to me personally. I had to have therapy to keep from strangling that dog. Anyway, he is still at the house. And that wasn't all he chewed up either. I could go into a whole book on that. But I totally agree with that bill.

And I don't think we ought to be prescribing just as he was—congressman walks in, how many residency slots that—I don't think Congress ought to be doing that. I think those residency slots are—those 1,500 slots, the VA can see where their needs are. I believe the VA people can decide that. I truly believe that.

I think it would be very bad if I walked up and said we need six OB/GYN slots and 14 internal medicine slots. I don't think we need to micromanage that. I think the VA has the ability to see where their needs are. I would let them make those decisions. And just to comment there, I think that is a bad thing to get into for us to be telling those just how many they should have.

Other than that, I will yield back my time.

Mr. TAKANO. Mr. Chairman, before he yields back, would you yield just ten seconds to me?

I want to associate myself with your remarks on the GMEs. That is all. Thanks.

Dr. BENISHEK. Thank you, Dr. Roe.

Do you have any questions?

Ms. BROWNLEY. No.

Dr. BENISHEK. Ms. Kuster.

Ms. KUSTER. Thank you, Mr. Chair.

I just want to associate myself with the bills introduced by my colleague, Julia Brownley, and in particular the Female Veterans Suicide Prevention Act. And I wanted to address an issue.

I want to join Dr. Roe in the six weeks. I agree matching that up makes sense. I would imagine most of the babies are going home healthy in the first week, but the ones who stay, that is the most stressful situation and they should get the care that they need.

And I just had a few questions, but I don't need to get into the details right now on Mr. Coffman's bill because I know there was some question from the VA. This is more by way of a comment.

In White River Junction, Vermont, we have a new women's treatment facility that I would love to include if we get to do some kind of a hearing, field hearing from our oversight committee, but they had a chance to have a group of women veterans that participated in the planning of that. And so they were able to bring out some of the psychological issues for them about seeking care.

And even the architecture was designed—it is a renovation, by the way. We have nothing new up there, but it is a renovation of a very old facility. But they took into account their feelings of being safe and protected, even the way they designed the entrance, the way they designed the waiting room, the way they designed the actual physical rooms where they, you know, have their medical exams.

Obvious things once you think about it, but just very, very helpful. So I would love to work further with you on this. I think it is

really important and I appreciate our colleagues on the other side and how much interest they have in women, health for women veterans in the VA system.

So thanks.

Dr. BENISHEK. Thank you.

Any comments or questions? Dr. Abraham.

Dr. ABRAHAM. I just want to say I was a very proud cosponsor of Dr. Wenstrup's bill. The hearing aid, the accountability, the credit protection, I think they are great bills, and I just look forward to them advancing very quickly.

Dr. BENISHEK. Thank you, Dr. Abraham.

Any other comments?

All right. I guess the first panel is over with.

Let's invite the second panel to the witness table. Joining us on the second panel today is Ian de Planque, the Legislative Director for The American Legion; Adrian Atizado, the Assistant National Legislative Director for the Disabled American Veterans; and Carlos Fuentes, Senior Legislative Associate for the National Legislative Service of the Veterans of Foreign Wars of the United States.

I thank you all for being here this morning and for all your hard work and advocacy on behalf of our veterans. I look forward to hearing the views of your members.

And if you are ready, Mr. de Planque, you may begin.

#### **STATEMENT OF IAN DE PLANQUE**

Mr. DE PLANQUE. Good morning, Chairman Benishek, Ranking Member Brownley, and members of the committee. I am fortunate to be here today and speak on behalf of the American Legion, our National Commander Mike Helm, and more than two million members in over 14,000 posts across the country that make up the backbone of the nation's largest wartime service organization.

There are many excellent pieces of legislation for consideration today. You have our full written remarks and in the interest of time I would like to focus on a couple of key bills.

H.R. 1356, the Women Veterans Access to Quality Care Act of 2015, addresses critical needs the American Legion has worked to raise awareness of for many years. Women are currently the fastest growing demographic serving in the military; however, the VA healthcare system is still based on an older design from a time period when women did not represent a substantial portion of veterans seeking care. And the legacy of that older design is obstacles for women who seek care. The American Legion has surveyed women veterans and we have dedicated special focus of our System Worth Saving Task Force report to the experiences of women using the VA healthcare system.

We have learned women veterans often do not self-identify as veterans and that VA staff often do not see women as veterans. Women veterans do not need to be asked, how did your husband serve in the military? They need to be asked, how can VA serve you to thank you for your service?

This legislation should go a long way towards establishing consistency by establishing standards for all facilities. The reporting mechanisms in the bill will help all of the stakeholders keep apprised of VA's progress on better integrating women's healthcare.



More transparency leads to better communication between stakeholders.

Everyone wants to ensure all veterans are well served in VA. This legislation will help work to close gaps and ensure all veterans are served with equal attention to their care.

The American Legion is also glad to see attention being given to serious reform in VA large scale construction projects. The Construction Reform Act attempts to ensure competent management of serious large scale construction projects such as major hospitals so that those projects do not spiral out of control as they have in years past. The American Legion believes VA should be allowed to focus on what they do well, providing care to veterans, and that large scale construction management should go to organizations that are dedicated solely to that mission of construction. It only makes sense that a doctor to treat patients, select carpenters, masons, electricians for building the places to treat those patients. Keep VA in the business of treating patients.

Finally we are happy to see that attention is being given to fixing the long standing problem with CBO scoring of leases for community based outreach clinics. CBOCs are a critical component of the 21st Century model for delivery of care within the VA and for the last couple of years we have had to scramble to find slapped—together—work around measures once the Congressional Budget Office changed the manner in which the leases for CBOCs are scored. H.R. 2914, the Build a Better VA Act, will create a more permanent solution to the problems created by the change in scoring. Just last year the uncertainty surrounding leases for 27 CBOCs created doubt, concern, and fears of lost coverage for hundreds of thousands of veterans until a short term solution was worked into the Veterans Access to Care, Choice, and Accountability Act. As the American Legion has been involved in working towards a solution since the beginning we knew that last year the 27 leases only represented a temporary reprieve from the bigger problem. We still have to find a long term fix. The American Legion believes this legislation can work towards that fix.

Again, I thank the committee for their hard work and for your consideration of this large slate of legislation, as well as your dedication to finding solutions for problems that stand in the way of delivery of healthcare for veterans. I am happy to answer any questions.

[THE PREPARED STATEMENT OF IAN DE PLANQUE APPEARS IN THE APPENDIX]

Dr. BENISHEK. Thank you, Mr. de Planque. Mr. Atizado, you may begin.

#### **STATEMENT OF ADRIAN ATIZADO**

Mr. ATIZADO. Chairman Benishek, members of the subcommittee, thank you for inviting DAV to testify at this legislative hearing. As you know, DAV is a nonprofit veterans service organization. We are comprised of 1.2 million members and we are all dedicated to one goal, and that is to empower veterans to lead high quality lives with respect and dignity.

So today nearly 2.3 million women are veterans of the military service and that number is expected to continually grow into the

future as they comprise 50 percent of active duty personnel and 18 percent of the Guard and Reserve. There are three bills on today's agenda directed to improve healthcare and services to women veterans, H.R. 423, the Newborn Care Improvement Act; H.R. 1356, Women Veterans Access to Quality Care Act of 2015; and H.R. 2915, the Female Veterans Suicide Prevention Act.

H.R. 423 will provide a newborn child of certain women veterans receiving VA maternity care with post-delivery care for up to 14 days after the child's birth. H.R. 1356 seeks to improve the VA healthcare system to provide safe, comfortable, and high quality care to women veterans. It would establish standards for VA to meet in this regard and requires an accounting of those parts of VA that do not meet these standards. H.R. 2915 would direct VA to identify mental healthcare and suicide prevention programs that are most effective and have the highest satisfaction among women veterans.

These bills are in line with DAV Resolutions 39 and 40, both of which support program improvements and enhanced resources for VA mental health programs as well as medical services for women veterans. And as Mr. Coffman had mentioned, they are also in line with the recommendations put forth by DAV in our 2014 report, "Women Veterans: the Long Journey Home." For these reasons DAV is pleased to support all of these measures.

DAV also supports H.R. 3016, which would reclassify VA podiatrists for purposes of appointment and compensation in the same category as other VA physicians. Now podiatrists play a critical role in maintaining foot health and dealing with injuries and diseases of the foot and ankle, however doctors of podiatry were inexplicably excluded when Congress enacted VA physician pay reform back in 2004. We believe their appointments and compensation should be made commensurate with those of other physicians in the VA.

H.R. 2914, the Build a Better VA Act, would prohibit the appropriation of funds to support any VA major medical facility lease unless the Committee of Veterans' Affairs of both chambers adopt resolutions approving the lease. We thank the bill's sponsor for the intention of improving the authorizing committees' role in overseeing VA's leasing program and to provide more specific guidance to the Appropriations Committees in funding VA leases. DAV is aware of issues surrounding VA infrastructure and capital planning matters and our national resolution calls for modernizing aging VA facilities and to do so in a timely manner. It specifically calls on Congress to resolve, as my colleague Ian de Planque from the American Legion had referred to, as a delay of dozens of major medical facility leases for several years due to disagreements in the administration over out year costs for such leases.

While we oppose the bill in its current form, DAV stands ready to work with the bill's sponsor and the subcommittee and VA to ensure this legislation will indeed provide the improvements that it purports. We already understand that VA is experiencing delays ranging from six months to 13 years for major facility leases with an average delay of more than three years.

This concludes my testimony, Mr. Chairman. I would be happy to answer any questions you or members of the subcommittee may have. Thank you.

[THE PREPARED STATEMENT OF ADRIAN ATIZADO APPEARS IN THE APPENDIX]

Dr. BENISHEK. Thank you, Mr. Atizado. Mr. Fuentes, you may begin.

#### STATEMENT OF CARLOS FUENTES

Mr. FUENTES. Chairman Benishek, Ranking Member Brownley, and members of the subcommittee, on behalf of the men and women of the VFW and our auxiliaries, I would like to thank you for the opportunity to present our views on legislation pending before this subcommittee.

The bills we are considering today are aimed at improving the healthcare the VA provides our nation's veterans and we thank the subcommittee for bringing them forward. I would limit my remarks to bills we have recommendations to improve.

The VFW supports the Veterans Credit Protection Act, which would assist veterans with credit issues resulting from unpaid healthcare claims. In the past year VA has made organizational changes to the claims process to improve timeliness and accuracy of healthcare claims, however the VFW continues to hear that non-VA care providers continue to bill veterans for care VA is obligated to pay. The VFW believes that the best way to prevent veterans from being wrongfully charged is to ensure VA pay the claims on time and accurately. This is why we recommend that the GAO report include an evaluation of the accuracy of VA's healthcare claims process.

This legislation also requires VA to assist veterans with credit issues that result from any healthcare claim, regardless of if VA is authorized to pay such a claim. While the VFW believes the VA should assist veterans in achieving financial independence, we do not support overwhelming VA's chief business office with claims it is unable to resolve. We recommend that the subcommittee limit assistance through the VA toll free hotline to healthcare claims VA is authorized to resolve.

The VFW supports the Building a Better VA Act, which would streamline the congressional process for authorizing VA major facility leases. This legislation would authorize the Committees of Veterans' Affairs of the Senate and the House of Representatives to approve VA major facility leases without requiring legislation. However, it does not eliminate the requirement for the House Transportation and Infrastructure Committee to pass similar resolutions. The VFW recommends that the subcommittee exempt VA leases from such a requirement.

This legislation also fails to address other factors that hinder VA's ability to enter into major facility leases. Currently VA lacks a revolving fund to insure its major facility leases in the case it is unable to abide by contractual agreements and is required to pay out the full cost of the lease without receiving appropriations. VA currently relies on the GSA revolving fund to insure major VA facility leases. We urge the subcommittee to establish a VA revolving fund for VA leases.

The VFW supports the Female Veterans Suicide Prevention Act, which would improve VA mental healthcare and suicide prevention programs offered to women veterans. As VA and Congress work to expand availability of women—specific care at VA medical facilities, they must also focus on expanding research on the psychological and physical effects war has on women veterans. Without such research women veterans may go unnecessarily undiagnosed or untreated for serious conditions. The VFW strongly supports this legislation and recommends that the subcommittee expand it to include evaluation of which mental healthcare and suicide prevention programs produce the best healthcare outcomes for women veterans. VA and Congress have already identified several programs that are proven to work and are well received by women veterans, such as the childcare pilot program and the retreat counseling program for women veterans. The VA and Congress must ensure these programs are expanded and successfully implemented.

The VFW supports the Construction Reform Act of 2015, which would require VA to enter into project management agreements for major construction projects over \$100 million; calls on VA to apply industry standards when constructing medical centers; and authorizes the funding of four major construction projects. While the VFW agrees that VA's role in managing construction projects should be reduced, establishing a specific cap with no waiver process would lead to VA managing projects that would be better suited for third party managers, or prevent it from managing projects that are over the cap which they could clearly manage. We recommend that the subcommittee establish a waiver process in the plan and design phase that would allow VA to manage larger projects when appropriate and authorize the committee's jurisdiction to require appropriate below cap projects to be managed by the third party.

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

[THE PREPARED STATEMENT OF CARLOS FUENTES APPEARS IN THE APPENDIX]

Dr. BENISHEK. Thank you, Mr. Fuentes. I yield myself five minutes for questions. Mr. Atizado, I read your written statement about my bill 2464 was sort of surprising and different from some of your colleagues on your comments. You wrote, demanding accountability for veterans acts would result in a major chilling effect on candidates for VA management positions, as well as those already occupying those positions. Do you think that VA employees really are adverse to accountability, Mr. Atizado?

Mr. ATIZADO. Well Mr. Chairman, thank you for the question. I do not believe that the chilling effect and holding folks accountable in federal agencies are mutually independent. I think part of the problem here may be that applying this standard just to one federal agency will discount consideration of managers and SESers.

Dr. BENISHEK. Well believe me, I would like to have everybody in the government be accountable. Trust me. But this is a problem that really identified, you know, through this hearing process that, you know, the VA agrees there is a problem, and agrees they are going to fix it, and yet they never name anybody to be accountable and it never gets fixed. I mean, you have seen this yourself, haven't you?

Mr. ATIZADO. Yes, sir.

Dr. BENISHEK. How would I, other than holding somebody accountable and naming them, do you have any suggestions as to how else I should do this?

Mr. ATIZADO. Well I think one of the questions that we have asked which we have a hard time getting a straight answer for is, why is the current structure not working properly? It seems to me that—I believe it was a hearing in the Senate where it was intimated that the tools are there but VA seem to not be able to use them the way they are intended.

Dr. BENISHEK. Well maybe you are right about that. It is just that whenever I try to identify the person who is responsible for not making things happen within the VA, nobody seems to be that person. Do you understand what I mean? The reason I am doing this is that for 30 years the IG has told the VA, you need a plan to hire physicians. Eight different times the IG has told the VA that. And the VA has agreed with them every time. And yet, they never developed a central plan to hire physicians and nobody seems to know why. You understand my frustration here? I mean, I am just trying to solve this problem.

Mr. ATIZADO. Yes, Mr. Chairman. If you will notice in our testimony, we do not have specific resolutions to support or oppose the bill. We just raise concerns because of what it may do to the healthcare system, both good and bad. We understand, believe me, we understand on a daily basis that when we encounter employees in the VA healthcare system who do not meet the standards that we normally see in caring, compassionate employees, everywhere from the janitors to the surgeons. And we would like to have those individuals held accountable, whether it is for poor performance or just—

Dr. BENISHEK. Right. Right. Mr. Fuentes or Mr. de Planque, do you have any comments you would like to make on about Mr. Atizado's comments?

Mr. FUENTES. I do, Mr. Chairman. One of the things that I think is overlooked when it comes to accountability is the difficulties VA faces when hiring physicians and staff to replace the ones that they hold accountable. I mean, what we have seen is VA would rather have an underperforming employee than to have no employee for a year. So when it comes to accountability our recommendation is to also take a look at hiring practices and Congress should assist VA in addressing why it takes so long to hire a new employee.

Dr. BENISHEK. Mr. de Planque.

Mr. DE PLANQUE. I would agree with what he just said in that if you are going to be looking at removing employees you also have to look at shortening the amount of time it takes to bring new ones on. I think that is a critical component. But I also agree with kind of the point of this legislation. And that is, you know, taken from the example of, you know, if you come across somebody and you need to start performing CPR you look at somebody and say specifically, Dr. Benishek, go call 911. Because if you put it out to the group then everybody in that crowd standing around watching you is going to assume somebody else is going to do it. And we have seen this so many times with IG reports and GAO reports. There

are all these recommendations, and VA agrees to them, but it is not specifically tasked to any sort of thing.

Dr. BENISHEK. Right.

Mr. DE PLANQUE. And I think this is what you are trying to get to.

Dr. BENISHEK. Right.

Mr. DE PLANQUE. That notion that in a crisis give the task to somebody. And I think the legislation as you talked through it and as we looked at it, it is not necessarily about firing people if they do not do it. It is putting together a plan and giving those people who are tasked with fixing that thing that a report identified with a plan and if they cannot follow through that plan then there are follow up measures. And at some point down the road possibly if they continue to be unable to do it then you are talking about—

Dr. BENISHEK. Right.

Mr. DE PLANQUE. [continuing]. Removing that person. But it is more about assigning an individual accountability. And I think that is actually a pretty strong idea.

Dr. BENISHEK. Ms. Brownley.

Ms. BROWNLEY. Mr. Chairman, again, I thank everyone for being here today and being our partners in trying to move forward good policy for our veterans across the country. And I appreciate all of you for your support of the Female Veterans Suicide Prevention Act. I appreciate it very much. I think it is, if we are going to serve all veterans, and serve them well when it comes particularly to mental health, that we must with regard to our women veterans disaggregate the data, get the right metrics, get the best practices. Because I feel convinced and compelled that in many, many cases women are going to respond differently than men will and it is important for us to get that right and get the right data to inform us. So thank you for that.

And Mr. Atizado, I know that my bill has not been out for very long, on the Build a Better VA Act. I appreciate your willingness to sit down and work with us on it. And I would welcome that and look forward to it. Because I think, I mean I think this is a problem that has to be solved. I mean we, we go through all of the studying to determine where the needs are across the country, to have health clinics and CBOCs across the country. And yet the way we are addressing this issue now and the way it is scored, we have got a long list of needs but we cannot satisfy them because they are scored sort of outrageously and unrealistically. And I think that we need to help to streamline the process. I think we had a process that worked. I think we have a process right now that is not working for veterans. And that is what we are trying to do here, is to streamline it to bring some similarity about how we treat federal buildings and treat sort of health clinics for veterans in a similar fashion and bring the responsibility I think closer to this committee and to the, and to Congress itself.

So I appreciate your willingness to sit down and help. I appreciate the support from the other two panelists and really look forward to working with you to be able to solve this problem that we know the need out there is tremendous. We have talked a lot in testimony over the course of the years, is we want to push out and bring clinics to more rural areas and to areas that are going to

reach our veterans, make it easier for our veterans to access health services from the VA. And I think if we can fix the process we can meet our objective. So I thank you very much and appreciate your testimony today. And I yield back.

Dr. BENISHEK. Thank you, Ms. Brownley. Dr. Roe.

Dr. ROE. Just one. First of all, thank you all for advocating for veterans, what you do every day of your life. And it has got to be rewarding work. Thank you for doing it. My only question, Mr. Chairman, is on the Construction Reform Act. I am really, I am not sure, as I said here before, that I can vote to let the VA build another major project because they include us in the—I want to make sure that I understand this bill very carefully and I understand the intent of it. But there have been, I mean, there have been some fiascos out there that are beyond comprehension. The one in Aurora, Colorado where \$1 billion dollars was spent. And now we are, now this committee is part of it. I have to go back home and to talk to veterans and talk to taxpayers there that want to help veterans. But when they see these excesses they think, my gosh, I mean how much healthcare, how many visits could we have had to doctors and to the medical centers based on a \$1 billion dollar overrun? And I am afraid if we let the VA get in control of these again, the same thing is going to happen again. We will be sitting here talking about the same thing.

So I just want to understand this bill better. I certainly have read it and it does have a lot of good things in it. But I want us to really have incredible oversight over that process. Or as I think Mr. Coffman has recommended, the Corps of Engineers have done a great job. They bring these projects in on time, under budget. And that is what we need to look at. I do not know how in the world Aurora ever happened. I, to this day I cannot explain. And now we are going to have to provide \$1 billion in taxpayer funding, and it is not through yet, to get this project done. And we will finally get it done. I know we are going to, for the veterans that are waiting on care in Colorado. And that whole region, it will be a referral area. But that is just a comment. And I certainly look for help on the committee. And I yield back.

Dr. BENISHEK. Thank you, Doctor. Ms. Kuster? Do you have any questions? Mr. Coffman.

Mr. COFFMAN. Thank you, Mr. Chairman. And first on the construction, and I think, you know, obviously the bill is a step in the right direction. But I agree with Dr. Roe, it does not go far enough. And I think that the, having Aurora, Colorado in my district, the biggest cost overrun. But let me tell you, there have been a lot of other horrible cost overruns, although they do not exceed Aurora. I think there was a GAO report from 2013, April, 2013, that said that all major construction projects at that time were each hundreds of millions of dollars over budget and years behind schedule.

I think that they should be stripped of all new construction authority, period, and that should revert to the Army Corps of Engineers. And this bill, I think, has that \$100 million and below. But I think, you know, if you give them \$100 million it could be, you know, what is that in terms of cost overruns? Is that \$300 million by the time the project is done? And there is no ability to revert automatically once there is cost overruns to, say, an entity like the

Army Corps of Engineers who have built similar projects, you know, as you mentioned, Dr. Roe, on budget, within schedule.

Let me ask a question on H.R. 1356, the Women Veterans Access to Quality Care Act. I asked this question at a hearing in April and I would like to ask it again. Because there is a different representation on this panel today than there was then. In 2010 the GAO found that VA was not complying with its own privacy policies and facility standards for women veterans. These are policies designed to ensure the safety, dignity, and privacy of women patients at the VA. Based on the feedback of your membership, if GAO did the same review today, what would they find? Would anybody like to comment on that? Yes, Mr. Fuentes?

Mr. FUENTES. Thank you for the question, Congressman. Before drafting testimony for women specific hearings, we have actually reached out to women veterans in leadership roles in our organization and many other women veterans who have reached out to us. And they see and the ones that attend a women's clinic feel that they are appropriate and that it is great service. But there is a long way to go. One of the things that we heard consistently was when there are OB/GYNs on staff, many times they are part-time. Right? And they do not have the time or the staff to take care of all the women veterans that that facility serves.

Mr. COFFMAN. Thank you. Anyone else?

Mr. DE PLANQUE. I was going to say that is also very consistent with what we found and that we continue to go there. And you see that these things are not improving. I know Sergeant Major Walz once made a point about, you know, the VSOs come in and they say the same things over and over and people have criticized that, but if they say the same things over and over it means it is not getting fixed. And this is, to see this and to see legislation that is attempting to address that, to us, that is heartening because it means the message is getting through that these problems are still out there. When we talk to women veterans who are out there, I mean, we have them integrated on our staff, we have them, you know, throughout all levels. And you know, they just want to be treated right and that is not so crazy a thing to ask. And so when you go out there and you see that they still do not have the operating, or the examination tables aligned correctly, it is a basic fix that cannot be that hard to fix. And it is just not being done. That is a consistency factor. And so there has been an attempt to address it and they are getting better, but VISNs are inconsistent. From VISN to VISN, you know, you do not know what you are going to get. And I think that is kind of a watchword for VA.

Mr. COFFMAN. Okay. The 2010 GAO report also found that some of the VA medical centers surveyed offered specialized gender specific healthcare services, things like abnormal cervical cancer screening, obstetric care, and infertility evaluations only two or fewer days per week. Are you finding that your female membership is having difficulties getting appointments for gender specific healthcare services at the VA? Yes?

Mr. ATIZADO. Mr. Coffman, thank you for that question. I think that ties back to your original question. I think for the most part VA is doing better. It is doing better as a matter of policy. I think the field is really trying to catch up to what the policy that comes



out of VA headquarters is attempting to instill in the healthcare system.

As far as access to care, yes, at VA facilities, especially for those that do not have the critical number of women veteran patients, access at that facility can be a little, not as good, it could be much better. But what we do find out is they are much more apt to be able to provide that service in the community if they cannot provide it in the VA facility.

Mr. COFFMAN. Okay. Thank you, Mr. Chairman. I yield back.

Dr. BENISHEK. Mr. O'Rourke.

Mr. O'ROURKE. Mr. Chairman, I would just like to join my colleagues in thanking the representatives from the veterans service organizations for being here. I think they were very clear in their comments on the proposed legislation. And I would just join my colleagues in asking that where we find fault in how we are trying to achieve accountability, that we offer improvements and certainly not lose the urgency of addressing some of these issues and boldly working to change the culture and the performance and outcomes for veterans that we see at the VA today. But I know that that is what you are interested in doing and have made proposals to do that. So I thank you.

And I want to thank the chairman for his efforts to ensure accountability and my colleagues for the bills that they have proposed. And I think we are doing our best to strike that balance in ensuring accountability without being punitive and working constructively with the VA, and ensuring that ultimately that we serve the veteran and see improved performance outcomes. And I think that is what we are all interested in doing. And I hope, and I am looking forward to hearing the testimony of the VA, I hope that is the spirit in which the VA approaches this issue. Because the VSOs, the VA, the members of Congress, this is the team that is going to be able to fix this. And we need to make sure that each partner is willing to do that. So thank you and the ranking member for putting this hearing together today.

Dr. BENISHEK. Thank you. If there are no further questions, the second panel is now excused. And I will welcome our third and final panel to the witness table. Joining us from the Department of Veterans Affairs is Dr. Madhulika Agarwal, the Deputy Under Secretary for Health for Policy and Services; and Janet Murphy, the Acting Deputy Under Secretary for Health for Operations and Management. They are accompanied by Jessica Tanner, General Attorney with the Officer of General Counsel. Dr. Agarwal and Ms. Murphy, you are recognized for five minutes.

**STATEMENT OF MADHULIKA AGARWAL, MD, MPH, DEPUTY UNDER SECRETARY FOR HEALTH FOR POLICY AND SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND JANET P. MURPHY, MBA, ACTING DEPUTY UNDER SECRETARY FOR HEALTH FOR OPERATIONS AND MANAGEMENT, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY JESSICA TANNER, GENERAL ATTORNEY OF FICER OF GENERAL COUNSEL, U.S. DEPARTMENT OF VETERANS AFFAIRS**

**STATEMENT OF MADHULIKA AGARWAL**

Dr. AGARWAL. Good morning, well it is almost good afternoon, Chairman Benishek, Ranking Member Brownley, and members of the subcommittee. We appreciate your continued efforts to support and improve veterans healthcare. Thank you for the opportunity to testify on the bills on today's agenda and to discuss their impact on VHA's healthcare. Joining me today is Ms. Janet Murphy, Acting Deputy Under Secretary for Health for Operations and Management; and Ms. Jessica Tanner, Attorney in the Office of General Counsel.

Mr. Chairman, we appreciate the committee's attention to many subjects that are important to veterans. We support many of the bills on the agenda today, beginning with the Medal of Honor Priority Care Act which will ensure responsive and appropriate healthcare for Medal of Honor recipients.

We support H.R. 421, the Classified Veterans Access to Care Act. Currently veterans who serve in classified missions can receive mental health services with VA medical treatment facilities safely and at minimal to no risk to national security. We agree that it would be beneficial to establish standards and procedures to ensure that veterans have access to mental healthcare in a manner that accommodates the veteran's obligation to not improperly disclose classified information.

We agree that the Newborn Care Improvement Act should provide additional inpatient treatment for a full term newborn facing complications such as fever or respiratory distress after delivery. This support comes with a caveat for additional resources that are going to be needed to implement the bill.

We support the Veterans Credit Protection Act. The reporting required in this bill would result in improved relationships between veterans and providers by decreasing negative reporting of financial information on a veteran's credit history as a result of delayed payment by VA. It will also improve timeliness of payments to providers, decrease interest payments by VA, and protect veterans credit ratings. We also support the draft bill to amend the role of podiatrists in the VA.

At this time the department is still reviewing H.R. 2914, H.R. 2915 and the draft bill on construction reform. We would be glad to follow up with your staff to address any technical concerns.

In reference to H.R. 2464, the Demanding Accountability for Veterans Act of 2015, I would like to state that the vast majority of VA employees who come to work do their best serving veterans everyday. Ninety thousand of the 300,000 VA employees are veterans

themselves, which is the largest percentage of veterans employed by any civilian agency. Accountability remains a top priority for the Secretary and we would want to make sure that these accountability bills have no unintended consequences. This bill may affect the Secretary's ability to manage effectively and could adversely impact the collaborative process between the Inspector General and the Secretary.

VA supports the intent of H.R. 353, Veterans Access to Hearing Health Act of 2015, however we feel that this bill is unnecessary because the Secretary already has the authority to appoint other specialists such as licensed hearing aid specialists and to prescribe standards for these specialties. Similarly, the Secretary has the authority to accomplish the goals of H.R. 1688. VA currently has the ability to create additional optometry residency positions and therefore legislation is not needed.

As for the Women Veterans Access to Quality Care Act of 2015, we support the intent of the bill and are taking several actions already to address the issue of the structural standards. VA regularly outperforms the private sector in both cervical cancer screening and the breast cancer screening, and has significantly improved internally in closing the gender disparity in areas such as lipid screening, depression screening, and immunizations.

H.R. 359, the Veterans Dog Training Therapy Act, we value the identification of effective treatment modalities to address PTSD and other post-deployment mental health symptoms. However, VA has significant concerns about the provisions in this bill. These concerns are detailed in our written testimony.

Thank you, Mr. Chairman and Ranking Member for the opportunity to testify before you today. My colleagues and I are pleased to answer any questions that you all may have.

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

Dr. BENISHEK. Thank you, Dr. Agarwal, I appreciate it. I will yield myself five minutes for a few questions. Apparently the VA failed to provide views of our cost estimates for many of the bills on today's agenda, including Chairman Miller's draft bill on construction and both of Ranking Member Brownley's bills. When can the subcommittee expect to receive the official views and cost estimates for these bills?

Dr. AGARWAL. Chairman, that is a good question. They are currently under review in the department itself and as expeditiously as we can we will get it to you.

Dr. BENISHEK. Is there a date you have in mind?

Dr. AGARWAL. I—

Dr. BENISHEK. Because we always try to get, you know, Dr. Agarwal, a specific date.

Dr. AGARWAL. You know, sir, we will do our best to get it out as early as we possibly can. I could not give you a date.

Dr. BENISHEK. All right. Regarding my bill, 2464, the Demanding Accountability for Veterans Act, I believe that the VA's objections are a little overstated. I understand your concerns about how the bill will impact situations where the department does not concur with the IG and/or the IG's finding involve other federal agencies

with the VA. Would you be willing to work with me to provide technical assistance to address these issues?

Dr. AGARWAL. Yes sir, we will.

Dr. BENISHEK. Can you tell me how often the VA requests changes to draft IG reports?

Dr. AGARWAL. VA recognizes the independent role of the OIG and the draft changes, there are no changes made to the recommendations except to provide technical correction if that is needed or necessary. So it is not a matter of how many times we change the draft. We never do. The IG's recommendations remain the IG's recommendations. We only provide some technical corrections if they are needed.

Dr. BENISHEK. All right. How exactly do you think that the Demanding Accountability for Veterans Act would negatively impact the relationship between the VA and the Inspector General?

Dr. AGARWAL. So as I stated earlier, Chairman, most, I would say the vast majority of our employees continue to serve the veterans every single day with great integrity and care. The concern that has been expressed in relationship to the bill is the technical corrections that are necessary sometimes before any misinformation is communicated further down the road. And it is essential that—

Dr. BENISHEK. Well, I guess I do not understand that. What does that mean? Misinformation communicated down the road, what is that? I do not understand that.

Dr. AGARWAL. I, let me see, for Ms. Murphy, if you could provide some examples?

Ms. MURPHY. Thank you, Chairman Benishek. So I think what Dr. Agarwal is talking about is when we get the draft report we check, we look to see if there are misstatements. So for example, it might be 1,000 patients and when we go back and look at our data it is 859. I mean, and it is those kinds of changes. The IG's recommendations are their recommendations. And you know, they do not change them for us. But we sometimes can provide information to clarify, strengthen the recommendations, make them, make them more complete. And so those are the kinds of things that we try to work with the IG on.

Dr. BENISHEK. All right. Well you know, and my point of this legislation, which you have heard me speak of many times, is that we have a very difficult time here sometimes finding why something has not been implemented when you yourselves know that IG reports are often concurred with but not really implemented, the changes that are recommended in the IG report. And we want to move that process forward and have the changes that the IG recommends implemented on a timely basis and have someone's name we can identify who is responsible for that. Do you have a strong aversion to that idea, Dr. Agarwal?

Dr. AGARWAL. No, sir. Every employee is accountable and should be held accountable for their actions because we have a responsibility towards the organization and the veterans that we serve. But in many instances it is not one single individual who is responsible for some outcome.

Dr. BENISHEK. Well, but maybe there should be, though. That is the whole point of this. Because otherwise they all raise their

hands and say it was not my fault and then nobody ends up being accountable. Do you understand?

Dr. AGARWAL. And there are instances when it is necessary that there is only one entity or one individual who is responsible, then that person is, there are actions that are taken subsequently.

Dr. BENISHEK. It has been difficult for us to determine that. I am sorry. I am out of time, doctor. But I am going to yield to Ms. Brownley. Maybe she will be able to follow up, thanks.

Ms. BROWNLEY. Thank you, Mr. Chairman. And thank you both for, well three of you, for being here this morning. And you know, I just wanted to speak to the two bills that are, I have put forward that we have heard about today in the hearing. And I understand that you have not weighed in on either H.R. 2914 or H.R. 2915. But just wondering if you could just comment briefly about the intent of each one of those? And if you generally agree or generally disagree?

Dr. AGARWAL. I will comment on H.R. 2915 and I will ask Ms. Murphy to comment on H.R. 2914. With H.R. 2915, which is an amendment to the Clay Hunt in focusing on women's mental health and suicide prevention, we agree with the intent. In fact, we are going to be doing the evaluation as part of the Mental Health Act. And we believe that with that intent we can certainly see on how that can be accomplished.

Ms. BROWNLEY. And H.R. 2914, Ms. Murphy.

Ms. MURPHY. Thank you, ranking member. The, I will just start by stating that we will take all the help we can get on leases. It is a process now that we struggle with. I have something to do with leases everyday, where someone is having difficult getting leases through. We have, so it is a complicated process.

I would also say that Deputy Secretary Gibson has stood up a VHA-wide, VA-wide, excuse me, including VHA, process to really look at our lease process from start to finish. And we would really welcome working with you on this bill to see where we could provide technical assistance to help us get the help we need with our leasing process. It is partly on us but it is also partly a function of the current process and the requirements that we are, the hoops that we are required to go through for our leases.

Ms. BROWNLEY. Do you know what Secretary Gibson's timeline is?

Ms. BROWNLEY. Deputy Secretary Gibson? We have been meeting for about the past month. I do not know the exact timeline but he always likes things done fast. So I am presuming he has got a month timeline or thereabouts but I know he is all about getting it done fast.

Ms. BROWNLEY. Well I welcome your offer and would like very much to work with you. Because I do feel like we are, I think we are, you know, we are making progress in terms of what some of our objectives are of wait time, access to healthcare, so forth and so on. We understand where the needs are, we have identified where the needs are. And we have got a process that is just standing in the way where we had a process that seemed to work. And this was supposed to be the improved upon process but yet it is just putting us further behind. So I appreciate that.

I just wanted to comment briefly on H.R. 359, too, the Dog Training Therapy Act. And you know, I know that we are waiting for data to be able to make some decisions on this. I guess, you know, the first question would be when do you anticipate having results of a research study so that we can finally formulate and move forward on this decision? And I, you know, my comment would be is that I think all of us are always pressing for, you know, data driven, decision making here, up here on the dais. On the other hand, you can get to a place where you have the data or you let the data stand in the way from what a common sense solution might be for our veterans. And we talk a lot about alternative options for folks who are suffering from mental health. And I think we could all agree that this is common sense, that working with dogs is a very positive thing for some of our veterans and for the veterans that it works for it works for very, very well. So if you could just answer, you know, what your intention is in terms of moving forward on this concept?

Dr. AGARWAL. Ranking member, as you probably are aware there were several complications that took place in the pilot in Tampa with the paired dog study related to the service dogs and PTSD. And so right now there is a multi-site study going on in three places where the dogs are being paired as service dogs and the emotional support dogs. And the outcomes we believe would be available, the results would be available in three years.

Similarly there is a Department of Defense study which is about the dog training as a treatment modality for veterans with PTSD and other mental health related conditions. That is something that the Department of Defense is doing and we, I do not know exactly when to expect the results from that particular study.

Ms. BROWNLEY. Well, thank you. And I just would comment I think that there is plenty of data out there, probably outside of the VA there are a lot of nonprofits across the country that are providing dogs and utilizing dog therapy. And I just think that if we are going to wait three more years, you know, to make a determination on this, is just, you know, I think that we should find a way to really streamline this. And it has been something that I think our veteran community really wants, people believe in it, and we should move forward on it. So thank you, I yield back.

Dr. BENISHEK. Thank you, Ms. Brownley. Mr. Coffman.

Mr. COFFMAN. Thank you, Mr. Chairman. Dr. Agarwal, if I said it right, can you tell me why the Department of Veterans Affairs, why the leadership insists on being involved in construction management going forward after the incredible debacle in my congressional district with a VA hospital that is now projected to be over \$1 billion in cost overruns? I mean, with all the problems that we have identified in this committee on the healthcare side, why do you not want to focus on that? Instead of something you obviously, that the Department of Veterans Affairs obviously cannot do?

Dr. AGARWAL. So we certainly appreciate all the help that Congress, you and others have been providing our top leadership in helping manage the construction issues, especially in Denver. I do not know very much about construction. But I will ask and see—

Mr. COFFMAN. Well nobody in the department does so you are not alone.

Dr. AGARWAL. I certainly probably am the least informed about—

Mr. COFFMAN. You might know more than the folks that were managing the project in Aurora, but go ahead please.

Ms. MURPHY. Well, I did renovate my kitchen, sir.

Mr. COFFMAN. Oh, well I do not want to know how much it cost.

Ms. MURPHY. But truthfully, I think we would agree that some of the projects have been less than well managed. But I would say that hearkening back to Deputy Secretary Gibson's testimony at the recent hearing where he mentioned that we have an independent group looking at our construction process. That report will come to Congress at the end of September. I think it will help us understand where our issues are.

I think we have also put some things in place in the meantime that will help us, just things that you would commonly find in the industry. Thirty-five percent of design done before we give out a dollar. We have a construction advisory group, a project review board, it is called, that is helping us look at our projects. So I think better oversight, better management of the projects, bringing in more experts to help us, engineering, medical equipment experts, so that we are planning these things early on in the process. So I guess I would say there is information coming to Congress about our construction process from the independent third party and I think that will be revealing in terms of where we need to go.

Mr. COFFMAN. Well I would ask you to take a message back to your leadership, and that is that the Veterans Administration needs to focus on what their core responsibilities are, and that is taking care of our nation's veterans. Squandering \$1 billion on a single project that was supposed to cost \$600 million is simply inappropriate and is offensive to our nation's veterans. Because that could have gone to caring for our veterans. That could be, that could be in healthcare, or that could be in providing benefits for our veterans in terms of making sure that they get the care and the benefits that they deserve through their military service. And so, and the fact, and how many people have been fired in the construction management section besides one whistleblower? How many people have been fired in the Veterans Administration for, I mean, if we look at the GAO report for 2013, this is not a new issue. I mean, in 2013 it was identified that not only was the Aurora project hundreds of millions of dollars over budget and years behind schedule, but every major construction project that the VA was doing at that time was each hundreds of millions of dollars over budget and each years behind schedule, the four projects that were identified there. And at that time VA leadership took no action in terms of correcting its problems. And now the American people are somehow supposed to trust you, the Veterans Administration know that, oh, everything is going to be okay. Everything is not going to be okay. Please tell me how many people have been fired.

Dr. AGARWAL. I do not know the answer to that, sir.

Mr. COFFMAN. Can you get that information back to the committee?

Dr. AGARWAL. We could take it for the record.

Mr. COFFMAN. I believe the answer is zero. The answer, except for one whistleblower, the answer is zero outside of that. And if not for the whistleblowers in the VA, the rank and file, men and women who really care about serving our nation's veterans, let me tell you this committee would not be aware of all the problems that have come forward in the VA. It is that rank and file who truly want to care and some in leadership, but mostly just the rank and file. Men and women who work in the VA who fundamentally care about taking care of our nation's veterans. With that, Mr. Chairman, I yield back.

Dr. BENISHEK. Thank you, Mr. Coffman. Mr. O'Rourke.

Mr. O'ROURKE. Thank you, Mr. Chairman. For Dr. Agarwal, the concerns that you have about the chairman's bill Demanding Accountability for Veterans Act are understandable. I would like to know what the counter proposal is, though. Because it, I think it is easy and fair enough to point out from the VA's perspective weaknesses in a proposal to address accountability. But what is more important is actually getting that accountability. So what is the VA's proposal to address this issue that Dr. Benishek is trying to get at?

Dr. AGARWAL. Congressman, let me attempt to answer a fairly complex question as briefly as I can. I think it is very clear that we lay very, clarify all expectations of our employees up front, especially when we recruit them as to what is expected of them. And I know that it is done on somewhat, I would hope on a routine basis, but I think we have to be very consistent in how we sort of establish that. We need to have very specific and measurable goals that our employees understand on how they are going to help serve the veterans and achieve the goals of the department. We need to make sure that all the barriers that they face are eliminated and that is the support of the management and leadership in helping solve that.

I am not sure if I am exactly answering your question the way you have intended it to be. But I think those are some of the very specific things that we can begin to do.

Mr. O'ROURKE. Yes, I think for me at least the larger point is that I believe I have heard the Assistant Secretary and the Secretary both acknowledge the need for greater accountability within the VA. And that is important, admitting that you have a problem. But then the very next important step is detailing a plan to resolve that problem that has a defined goal and end date so that we can in turn know what the progress the VA is making towards that goal.

To date I have not heard that. Or at least, I have not heard it succinctly and in a way that I can understand and communicate to the veterans that I represent. And in the absence of that I think proposals like the one presented by our chairman are very compelling. And I think there is a natural tension between the VA and its oversight committee, or this committee which has oversight responsibility and authority and that is probably healthy. When it becomes adversarial and the proposals that we make are rejected, again, perhaps for good technical, legal, and reasons of function and form within the VA, and are not then answered with a pro-



posal from the VA itself, it makes it very hard not to move forward with something in the absence of anything else from the VA.

So I understand your, the answer that you just gave. But it is not a proposal or a plan that I can take back to my veterans who ask me, hey Beto, what are you guys doing about the VA? There is a steady drumbeat of unfortunate news from the VA, not because we have on the whole bad employees. And I agree with you. I think the vast majority of those who work for the VA are spectacular people doing very difficult jobs who could be making much more doing something else but they do it because they share that same mission that you and I have, which is to serve that veteran who has served this country. But we do have some people who are in the way of progress or who are actively stopping our ability to serve veterans and those people need to be held accountable. And so I think that is what we are looking for.

Let me quickly move to a statement that Ms. Murphy made in answer to Ms. Brownley's question about needing all the help you can get when it comes to leases. Beyond what Ms. Brownley has offered, do you have any other requests from Congress that would help you and give you additional statutory authority that you need to be able to execute leases more quickly and more effectively, and get more facilities online and more veterans treated sooner rather than later?

Ms. MURPHY. Thank you, Congressman. I am not an expert on leases. I am an expert in trying to get healthcare services up and running. So my interaction with leases is at that nexus. I certainly think we could get our really skilled and informed lease people with you and with this group to help figure out if there are other things that we need besides what Ranking Member Brownley has proposed. I mean, obviously we want to make sure that what we end up with actually works, and I think that is your goal too, and actually facilitates the process. So I would love to come back and provide more technical assistance and additional input that you might need. I am very glad to do that, and get the right people here to do that.

Mr. O'ROURKE. Mr. Chairman, let me just conclude by saying that I appreciate that answer. I look forward to working with you. I also appreciate your answer on the question about the Construction Reform Act and that the Secretary is going to be coming forward with something in September, at least having more information that can help us better understand the issue.

We are not likely to get a major facility in El Paso in part because of the royal screw up in Colorado, in Louisiana, in Nevada, in Florida. I mean, hundreds of millions of dollars, over \$1 billion in overage in all of those projects. And in part because of that being able to execute these leases with willing partners in communities like El Paso that are sorely underserved and have some of the worst performance metrics in the country are incredibly critical for our success. So I just want to let you know that you have a partner in our office in getting those leases done. Because if we do not that veteran in El Paso and other parts of the country will not be served. So we look forward to working with you on that. And with that I yield back to the chairman.

Dr. BENISHEK. Thank you, Mr. O'Rourke. Does anyone have any other questions they would like to ask? Well, I think we can excuse the third panel then. Thank you very much for coming this morning.

I ask unanimous consent that all members have five legislative days to revise and extend their remarks and include extraneous material. With no objection, so ordered.

I would like to once again thank all of our witnesses and audience members for joining this morning and this afternoon. This hearing is now adjourned.

[Whereupon, at 12:29 p.m., the subcommittee was adjourned.]

## APPENDIX

Ranking Member Julia Brownley  
Subcommittee on Health  
Committee on Veterans' Affairs  
U.S. House of Representatives  
Legislative Hearing  
Tuesday, July 14, 2015, at 10:00 a.m.  
334 Cannon House Office Building

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Thank you, Chairman Benishek, for calling this hearing today. These hearings are an important part of the legislative process. It is essential to our responsibilities to advance worthy legislation that addresses and improves the medical services available to our veterans. Access to safe, quality health care is, and must be the priority for this Subcommittee.

I am particularly pleased to see so many of my colleagues here today to testify on their

legislation. Thank you so much for your interest in the well-being of the veteran community.

Mr. Chairman, while there are many worthy bills on the agenda today, I will focus on just three that are being considered at this hearing today.

H.R. 421, the Classified Veterans Access to Care Act introduced by Congresswoman Kyrsten Sinema would ensure that veterans with classified experiences have appropriate access to mental health services from the

Department of Veterans Affairs. This bill was introduced in the last Congress and passed this committee as part of HR 4971, introduced by my colleague Congressman O'Rourke. However, this important bill was never considered by the full House of Representatives. I would like to thank the Chairman for including it on our agenda today and would like to express my full support for this bill.

I have two bills on the agenda today that I have recently introduced. The first one, H.R. 2914, the Build a Better VA Act is a

bill that would modify the current process for approving Department of Veterans Affairs medical facility leases.

Under current law, every major medical facility lease, which incurs yearly rental costs of over one million dollars, must be authorized by Congress. In addition, recent changes made to VA's leasing process require VA to submit leasing proposals to the General Services Administration for delegation to VA. This requires approval by the Committee on Transportation and Infrastructure in the House. Therefore, VA

leases must be approved by the Transportation and Infrastructure Committee **and** be approved by Congress.

In 2012, the Congressional Budget Office changed its method of scoring VA leases. Instead of scoring the annual cost of the lease, CBO scores now reflect the cost for the duration of the lease – often 20 or more years. For instance, CBO now scores a 20-year lease which costs the Department \$5 million a year at \$100 million. Prior to 2012, CBO's score would have reflected the

true cost of \$5 million, a considerable difference.

CBO's new scoring mechanism has made it impossible for the Veterans' Affairs Committee to authorize leases within the current budget caps, despite the fact, that no new money is actually spent. The result has been significant delays in leasing of new facilities, further delaying needed care for veterans across the country. The population of veterans is growing, the demand for VA healthcare is increasing, and many veterans trying to access VA care face long wait



times and crumbling infrastructure at outdated VA clinics and medical centers. CBO's actions have made authorizing new leases for veterans' medical facilities, which are desperately needed in underserved veteran communities across the United States, cost-prohibitive.

This bill would simply allow major medical facility leases to be authorized by a Committee resolution rather than legislation. It would return the authorization process to the Veterans' Affairs Committee to what it was before – requiring a committee

resolution. It would also harmonize this process with the requirements of the General Services Administration and the long-standing practice of the Transportation and Infrastructure Committee for federal buildings. This more rational approach would ensure that veterans have the facilities they need to get the healthcare they have earned and deserved, and will help address the unacceptable wait-times faced by many of our veterans.

I have also introduced H.R. 2915, the Female Veteran Suicide Prevention Act.

This bill would direct the Secretary of Veterans Affairs to identify mental health care and suicide prevention programs and metrics that are effective in treating women veterans as part of the evaluation of such programs by the Secretary.

By analyzing data from 23 states and VA's Suicide Repository of more than 170,000 adult suicides over a 10-year period, VA researchers found in a May 2015 report that suicides among women veterans increased by 40 percent from 2000 to 2010, compared to a 13 percent increase in suicide among

civilian women. In fact, female veterans are nearly 6 times as likely as other women to commit suicide. My bill is intended to ensure that the VA addresses these tragedies by requiring that VA's evaluations of mental health care and suicide prevention programs **include** specific metrics on women veterans and by requiring the VA to identify the mental health care and suicide prevention programs that are the most effective, and have the highest satisfaction rates, among our female veterans.

While I am disappointed that the Department did not submit views on my two bills before us today, I look forward to receiving those views in the not too distant future.

Mr. Chairman, I look forward to the testimony from our witnesses today and their views on how to improve upon the many bills that we are considering.

Thank you and I yield back the balance of my time.

PREPARED STATEMENT OF REP. WALBERG TESTIMONY FOR MEDAL OF HONOR  
PRIORITY CARE ACT (H.R.272)

Chairman Benishek, Ranking Member Brownley and Members of the Subcommittee, I thank you for allowing me the time to speak this morning in support of my legislation, H.R.272, the Medal of Honor Priority Care Act of 2015.

As the Members of this Committee are well aware, the Congressional Medal of Honor is the highest award for valor which can be bestowed upon an individual serving in the United States Armed Forces and is awarded to soldiers who have displayed conspicuous gallantry and intrepidity at the risk of life above and beyond the call of duty. The Medal of Honor is a distinguished award given to a select few. Less than 3,500 have been awarded, 16 awards have gone to soldiers who fought in the recent conflicts in Iraq and Afghanistan. Currently there are only 79 living Medal of Honor recipients.

My state of Michigan is privileged to have two living recipients, Corporal Duane E. Dewey and Private First Class Robert E. Simanek. Both received the decoration for their heroic action in the Korean War, and hearing of their harrowing stories of bravery has reminded me of the sacrifice American soldiers are willing to make to protect their comrades and their country.

Medal of Honor recipients deserve our utmost appreciation, and I believe the small portion of our servicemembers who have gone above and beyond the call of duty and earned the highest honor in our nation's Armed Forces have earned the right to be placed in the top priority group to receive their healthcare benefits. I'd be remiss if I did not mention the idea for this legislation came from a veteran who lives in my district and works with the veteran community.

All veterans deserve access to the healthcare they have earned, but as you all know, the VA uses a priority system to determine eligibility for these healthcare services. Some of the factors that will affect a soldier's priority group ranking are whether the soldier has a service-connected disability, whether they were a former prisoner of war, the time and place of service, as well as income level. Currently, Medal of Honor recipients are in Priority Group 3.

This bill is very similar to legislation approved by this committee during the 113th Congress, which was supported by the VFW, Vietnam Veterans of America, IAVA, the American Legion, and AMVETS. I'm proud to once again have the support of my colleagues from both sides of the aisle on this bill.

I thank the Chair for permitting me to appear before the Subcommittee today.

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PREPARED STATEMENT OF STEVE STIVERS

I want to thank Chairman Benishek for including my bipartisan bill, the Veterans Dog Training Therapy Act, in today's legislative hearing.

As the Committee Members are well aware, it is estimated that 22 current and former service members commit suicide each day. This is a tragedy that requires immediate action and I want to commend the Committee Members for their commitment to addressing this matter.

It is known that post-traumatic stress disorder (PTSD) contributes to suicide among the veteran population and Congress has taken steps to improve treatments of the condition. However, every individual is unique and responds differently to available therapies and treatments.

That is why I introduced the Veterans Dog Training Therapy Act with my colleague and good friend, Tim Walz. Our bill seeks to expand access to an alternative therapy that has been proven effective for many veterans who suffer from the invisible scars of war.

Specifically, our legislation would establish a service dog training pilot program at 3-5 VA facilities as selected by the VA Secretary. Results of the pilot would be studied for consideration of expanding the program. Under the pilot program, veterans suffering from PTSD would be connected to service dog training organizations. These veterans would learn useful occupational skills while training service dogs. Upon completion of their training, each dog would be provided to a disabled veteran—enabling veterans to help other veterans.

This program is not made from scratch; it is an almost identical model to the successful service dog training program conducted by the non-profit organization Warrior Canine Connection at several Department of Defense medical facilities and one VA Hospital location. Veterans enrolled in this program witnessed significant improvements in PTSD and TBI-related symptoms. It is also important to note that

some of the wounded warriors who benefited from the service dog training therapy program had not been responding successfully to other treatment options.

The effectiveness of service dogs in treating PTSD and TBI-related symptoms is supported by preliminary research from Kaiser Permanente, which has shown that veterans who own service dogs have fewer symptoms of PTSD and depression, better interpersonal relationships, a lowered risk of substance abuse and better overall mental health.

It should also be noted that Congress directed the VA to conduct a research study on the efficacy of service dogs in treating these injuries in the 2010 NDAA, which was signed into law in September of 2009. Since then, the agency has blundered so badly in the design and implementation of its own study that research results are not expected until 2019—10 years after the study was ordered by Congress. These veterans cannot wait any longer.

I do not claim that my bill will completely solve PTSD. But it is clear that many veterans have been helped by service dog training therapy programs and that it has promising potential to significantly aid in the treatment of many individuals who are struggling with invisible wounds in the VA system—brave men and women who are not responding to other treatment methods.

Lastly, psychological conditions like PTSD are not new. These conditions have confronted American soldiers returning from all wars. We must address this issue now so that we can end the current suicide epidemic and to ensure that the best treatments are available for soldiers returning from future conflicts.

Again, I appreciate the Chairman for allowing me to testify today and holding this hearing.

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#### PREPARED STATEMENT OF DOUG COLLINS,

Chairman Benishek, Ranking Member Brownley, and distinguished members of subcommittee, thank you for the opportunity to testify on H.R. 423, the “Newborn Care Improvement Act”. My legislation amends title 38, United States Code, to improve the care provided by the Secretary of Veterans Affairs to newborn children. I am very appreciative of the Subcommittee’s consideration of this legislation.

The motto of the Veterans Administration comes straight from Abraham Lincoln’s Second Inaugural. He got the idea straight from scripture. So the challenge for us to “care for him who shall have borne the battle, and for his widow, and his orphan,” isn’t a new one.

Since September 11, 2001, more than a quarter of a million women have answered the call to serve. They’ve faced terrorism in the deserts and mountains of Iraq and Afghanistan. So in the 21st century, we must also consider she who shall have borne the battle.

When she returns, what of her children?

The finest military in the world is powered by men and women in their physical prime. The young women who decide to serve this country in the armed forces aren’t immune from the same questions that all young women face about whether they pursue a career, a family, or both. Yet they are offered a healthcare system that for so many years has been designed to serve men.

With the increasing number of female veterans, the VA must expand its care and services to meet their needs. Maternity care tops that list of needs, and I’ve offered one way we can help. In 2010, Congress passed and the President signed the “Caregivers and Veterans Omnibus Health Services Act of 2010” to provide short-term newborn care for women veterans who received their maternity care through the VA. Signed into law on May 5, 2010, this legislation authorized up to seven days of newborn care.

On January 27, 2012, The Department of Veterans Affairs published a regulation officially amending VA’s medical benefits package to include up to seven days of medical care for newborns delivered by female Veterans who are receiving VA maternity care benefits. The rule, which became effective Dec. 19, applied retroactively to newborn care provided to eligible women vets on or after May 5, 2011.

Since this seven day authorization was enacted by Congress in 2010, we’ve learned more about the unique challenges facing female veterans and the changing trends in these veterans seeking maternity and newborn care from the VA. According to a study published in the Women’s Health Issues Journal this year, from 2008–2012 the overall delivery rate by female veterans utilizing VA maternity benefits increased by 44 percent and a majority of the women using VA maternity benefits had a service-connected disability.

Just last week, the U.S. Navy announced it has tripled the amount of paid maternity leave for personnel in the Navy and Marine Corps. Effective immediately, 18 weeks of maternity leave will be available. Secretary Mabus stated in a press release that “with increased maternity leave, we can demonstrate the commitment of the Navy and Marine Corps to the women who are committed to serve.”

In the same way, unless Congress extends the authorization for length of newborn care coverage provided by the VA, there will be veterans who face difficult financial decisions and complexity in navigating insurance options at the same time that their newborn is fighting for their life.

This is why I introduced H.R. 423—to demonstrate Congress’ commitment to meeting the needs of female veterans by providing a little longer for their newborn. My legislation extends the authorization of care from seven days to 14 days and provides for an annual report on the number of newborn children who received such services during such fiscal year. Improved data on the trends in female veterans utilizing newborn care will help Congress and the VA better meet their needs in the years to come.

Should this subcommittee place my legislation on their markup calendar, which I hope they do, I would request an amendment be made to add the reporting requirement to an existing report that the VA is already required to produce. Although it’s vitally important that Congress and the VA have this data, I don’t want VA to produce yet another report when instead we could add this requirement to an existing report.

Some may ask why the VA should provide more newborn care coverage to female veterans than the average private sector employee would receive. These women have risked their lives to protect our nation. Just because they are no longer serving in active duty does not mean our responsibility to them ends. In fact, their service to our country may jeopardize the very lives of their future children and thus our responsibility to them is even greater. A recent study examined more than 16,000 births to female veterans. Having PTSD in the year before delivery increased a woman’s risk of spontaneous premature delivery by 35 percent, the research showed.

“This study gives us a convincing epidemiological basis to say that, yes, PTSD is a risk factor for preterm delivery,” said the study’s senior author, Ciaran Phibbs, PhD, associate professor of pediatrics and an investigator at the March of Dimes Prematurity Research Center at Stanford University. “Mothers with PTSD should be treated as having high-risk pregnancies.”

Premature infants often need long hospitalizations after they are born and are more likely than full-term infants to die. Those premature infants who survive may face long-term developmental problems. And unfortunately, the number of female veterans with PTSD is not insignificant. According to the VA, 20% of female veterans of the conflicts in Iraq and Afghanistan have been diagnosed with PTSD. And these are not just the female veterans serving in combat.

I know what it’s like to be the parent of a little baby who needed intensive medical care for an extended period the moment she was born. It’s my hope that any new mother, who has given selflessly to her country, wouldn’t have to worry about Congress standing in her way as she tries to give selflessly to her own child.

Our goal should always be to provide the mother with the pre-natal care she needs to give her newborn the best chance of a healthy delivery with no post-natal complications. There are significant needs and challenges that a female veteran faces when returning home from the battlefield such as homelessness, sexual and physical abuse, and mental health conditions such as Post Traumatic Stress Disorder. And this legislation won’t solve all of those great challenges. But my hope is H.R. 423 will give her a little peace of mind knowing her newborn will get some extra help from the VA and that Congress is committed to her and her family.

In a focus group conducted on Women Veterans’ Reproductive Health Preferences and Experiences and published by Women’s Health Issues Journal in 2011, one Marine said, “I can essentially say that I gave my reproductive years to the Marine Corps. And those are the years you can serve . . . You know, you do sacrifice and you say, well, “mission first before a family mission,” type of thing and the more I think about I think, you know, the VA probably should address that part of womanhood and have that understanding.”

There are multitudes of ways that the VA must adapt to better meet the needs of female veterans. By increasing the authorization of care, we can ensure that Congress is not standing in the way of the VA seeking to do just that. Absent the legislative change made by H.R. 423, the VA cannot provide more than 7 days of care. And I believe that is unacceptable.

In closing, we owe it to our female veterans to expand and improve the healthcare services that the VA can provide them and their children. Female veterans face



unique challenges and barriers, including very limited newborn care coverage. While the majority of female veterans who receive maternity care from the VA are able to return home with their newborn within the current seven day time frame, some cannot due to newborn health complications. It is these veterans and their children that need Congress' help today.

Expanding the authorization of care from seven to 14 days will give these female veterans more time to make alternate arrangements and secure private or public insurance for their newborn's continued health needs.

I thank the Chairman and Ranking Member for holding this hearing and I'm happy to discuss this legislation further with any of my colleagues. Thank you.

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PREPARED STATEMENT OF SEAN DUFFY

Good morning. Thank you, Chairman Benishek and Ranking Member Brownley, for holding this hearing today. I appreciate the opportunity to testify on behalf of H.R. 353, the Veterans' Access to Hearing Health Act. I introduced this legislation, along with Rep. Tim Walz (MN-01) and Rep. Raul Ruiz (CA-36), to help address the long wait times and lack of access our veterans are facing in regard to audiology services.

Our aging and younger veterans returning from the battlefield are seeking help from the VA for hearing loss and tinnitus more than any other disabilities facing them today. Yet, the VA does not have the capability to keep up with demand for these services.

A recent Washington Post article cited that since the VA scandal broke last year, the number of veterans on wait lists for appointments has actually increased by 50%. Audiology services are a major factor in the wait times veterans are facing. According to the VA, nearly half of all patients awaiting care are waiting for audiology services.

Veterans, like my constituent Roger Ellison from Marshfield, should not be fighting the VA for care. Roger is 70 years old and a veteran of the Vietnam War. He suffers from hearing loss, but when he sought help from the VA, he was told he could not get an appointment for six months. Unfortunately, Roger couldn't wait that long, so he went to his local hearing aid specialist – and he was seen that day. Roger was willing to pay out of pocket for his hearing aids because six months was just too long to wait.

Audiology services not only affect the older generation, but also the younger generation returning from overseas. Roger and thousands of other veterans are in this situation today because the VA is allowed to use only audiologists—and not other capable providers—to fulfill hearing services to veterans. While audiologists are a great resource for the VA and provide good service for veterans, there are not enough to keep up with the demand.

Hearing aid specialists are a perfectly viable option and stand at the ready to help our veterans in need. Hearing aid specialists have gone through a 1–2 year apprenticeship training period, have completed a comprehensive written exam, and are certified by the state to test hearing, and fit and dispense hearing aids. They are qualified to support the specialized services of audiologists by fitting, adjusting, and making minor repairs to hearing aids. By allowing hearing aid specialists to serve in their licensed role at the VA, the current burden audiologists have of performing all hearing services will be lifted. With the provisions of H.R. 353 in place, VA audiologists can turn their attention to specialized cases and complex conditions, and people like Roger won't be waiting six months for hearing aids or simple adjustments.

My legislation also asks for a detailed report from the VA on the timely access of hearing health services, the contracting policies in regard to providing services outside the VA, the staffing levels in the audiology department, and a description of performance metrics.

H.R. 353 has the support of the National Guard, the Retired Enlisted Association, Veterans' Health Council, Vietnam Veterans of America, the American Academy of Otolaryngology, the Wisconsin American Legion Executive Committee, and 27 of our colleagues.

As Americans, we can never repay our debt to veterans like Roger, but Congress can pass common-sense measures like H.R. 353 to help make their lives back home a little easier. I urge the Committee to pass my legislation quickly and appreciate your support today.

I yield back the balance of my time.

## PREPARED STATEMENT OF THE HON. MIKE COFFMAN

Thank you Chairman Benishek for holding this legislative hearing and including my bipartisan bill—the Women Veterans Access to Quality Care Act.

Although the Department of Veterans Affairs has made some progress in recent years, the fact remains that the VA is a system largely designed for male veterans. A recent comprehensive study conducted by the Disabled American Veterans (DAV) entitled “Women Veterans: The Long Journey Home,” found serious gaps in almost every aspect of programs that serve women vets.

In recent years the active-duty military has made incredible strides towards fully incorporating women into the ranks. Though more work needs to be done, these long-overdue changes in the Department of Defense have increased the pool of eligible recruits, raising the standards to make our military the most professional that our country has ever had. As more and more of these women leave military service and become veterans, it is critical that the VA quickly adapt its facilities and culture.

The aim of my bill is to increase gender-specific access to care within the VA, improve healthcare outcomes for our women veterans, and improve VA’s facilities to ensure they protect the privacy and dignity of all veterans.

The need for this bill is largely illustrated simply by reviewing the rapidly changing demographic composition of the VA patient population:

1. Between 2003 and 2012, the number of women veterans using VA healthcare nearly doubled.

2. In 2012 women made up only 6.5% of the VA patient population, but are estimated to encompass over 10% by 2020.

3. Meanwhile, nearly 20% of new recruits are women.

The women veteran patient population also has unique characteristics when compared to the male VA population:

1. The median age of a female patient in VA is 49 compared to 64 for male patients.

2. Only 13% of men within VA were 45 years old or younger compared to 45% of women.

These are dramatic changes to the VA’s patient population, and the former—almost exclusively male—VA healthcare system simply hasn’t kept up with the changes.

My bill addresses the VA’s lapses in healthcare quality and access for its women patients in five ways:

First, my bill requires the VA to establish standards to ensure VA facilities meet the specific needs of women and integrates those standards into its Strategic Capital Investment Planning process.

The Government Accountability Office (GAO) found in 2010 that none of the VA hospitals it surveyed were fully compliant with the VA’s own policies related to privacy for women veterans. Just to cite a few examples, the audit found that check-in desks were in busy mixed-gender areas and gynecological examination tables faced towards doorways. Additionally, despite VA requirements that gynecological exam rooms have immediately adjacent restrooms, often women were required to walk down long hallways in high-traffic, mixed-gender corridors to access restrooms.

At a hearing in this room in April, I asked a panel of Veteran Service Organization (VSO) experts whether these conditions have improved in the past five years, and the Committee learned that these problems continue to persist nationwide.

Second, my bill holds VA medical facility directors accountable to performance measures which include women’s health outcomes and requires the reporting of those outcomes. As with many other areas in the VA, there is an incredible lack of accountability which is hindering true progress and reform.

Third, my bill ensures the availability of OB-GYN services at VA medical centers and requires VA to conduct a pilot program to increase residency and graduate medical education positions. In 2010, nearly half of the women Veterans who used VA healthcare had at least one reproductive health diagnosis. It is absolutely essential that these veterans have quick and reliable access to appropriate gender-specific care.

Forth, my bill improves outreach to women veterans by requiring the VA to provide state veterans agencies with contact information for veterans. One of the DAV’s findings in its report was that information on veteran programs and eligibility is often difficult to access and scattered across various programs or Web sites. Increasing outreach to women veterans through collaboration with VA state agency partners is vital.

Finally, my bill mandates a new comprehensive GAO study of the VA’s ability to meet the needs of women veterans, including an examination of wait times, gender-

specific care availability, VA training, differences in health outcomes, and security and privacy within VA facilities.

During my own military career, I have witnessed quite a number of challenges that the military has had to confront. Each time, it overcame the obstacles, and always emerged as a more effective fighting force. I have full confidence that the VA can do the same.

I hope my bill can jump-start the cultural sea change required at VA to ensure our women veterans are provided the same benefits they earned in service to our nation just like their male counter-parts.

I'm grateful for the support many of our nation's veterans and Veteran Service Organizations have provided for this bill, and I urge all of my colleagues on the Committee today to join me in this effort.

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PREPARED STATEMENT OF THE HON. CHARLES W. BOUSTANY, JR., M.D.

Chairman Benishek, Ranking Member Brownley and Subcommittee Members:

First, thank you to Chairman Benishek, Ranking Member Brownley and all Subcommittee members for inviting me to testify before you today. As the Committee considers reforms to Department of Veterans Affairs' operations, I appreciate the opportunity to speak on behalf of my legislation, H.R. 1862, the Veterans' Credit Protection Act.

Unfortunately, the VA's long history of delayed payments has brought me here today. Too many veterans are forced to contact my office to resolve credit issues caused by the VA's refusal to pay claims for emergency medical care. When these brave Americans require a trip to the emergency room because they believe their lives are in danger, the last thing on their minds should be fear that the VA will fail to pay their claims.

One such veteran, Mr. Al Theriot of Abbeville, LA, waited over two years for the VA to finally process and pay his emergency medical care bills, which the Agency only did after Mr. Theriot contacted my office and appeared on local television twice to describe his experiences. This is absolutely unacceptable.

I submitted documentation from the VA to the Subcommittee in early June demonstrating the scale of this problem. To reiterate those findings, as of data provided to me in April 2015, the VA's Chief Business Office indicated that only 14% of emergency medical care claims originating from VISN 16, which includes my home state of Louisiana, were being processed within 30 days. In total, the data demonstrates a nationwide backlog of over \$878 million.

The Veterans' Credit Protection Act is an important step to rooting out the problems within the VA that caused this out-of-control backlog.

First, my legislation mandates the VA set up a toll-free hotline for veterans to report credit issues caused by delayed emergency medical care claims. It also requires the VA to conduct outreach alerting veterans of how to resolve these issues. Too often, veterans tell me they cannot get in touch with the VA, or that the employees they speak with cannot adequately answer their questions.

Creating a dedicated call line and ensuring the VA implements a better framework for communicating solutions with veterans is an absolutely necessary step toward eliminating the backlog.

My bill also requires the VA to report annually to Congress on the Chief Business Office's effectiveness with respect to timely claims processing. Their report must include information on the number of veterans who have reported credit issues due to delayed payments, the number of proper invoices submitted, the amounts owed on those invoices and how long it took the VA to pay those claims.

In addition to requiring the VA to report on the status of claims, H.R. 1862 aims to improve Chief Business Office operations by requiring the VA to examine comments made by medical providers regarding the claims processing system and delayed payments, and report these comments to Congress, along with a description of best practices to ensure timely claims payment in the future.

No veteran should ever have to decide whether or not to sacrifice their health and safety to avoid a potential financial burden if the VA fails to pay for a trip to the emergency room. I sincerely thank the Subcommittee for your efforts to ensure better care of America's veterans, and for inviting me to be part of this important discussion.

## PREPARED STATEMENT OF REP. JEFF DENHAM

Despite making improvements in the backlog of veterans' care in the VA via the CHOICE Act, there remains long wait times for patients to be seen within the VA. Eye care clinics staffed by VA doctors of optometry, including residents, are among the busiest primary care settings in the veterans' healthcare system. As you know, lengthy wait times can make it more difficult and even discourage veterans from seeking care they need. H.R. 1688 is aimed at improving access to primary eye care in the VA by making a modest increase in the number of optometry residency positions in the VA. My bill seeks to amend the Choice Act by designating 20 of the 1,500 new graduate medical education residency positions to the field of optometry.

Although, VA optometrists provided comprehensive eye exams and other essential care to more than 1.2 million veterans last year, the need for eye health and vision care is expected to grow further in the coming years. Serious eye trauma is the second most common injury among those who served in Iraq and Afghanistan, with 16 percent of all wounded service members experiencing problems ranging from distorted vision to blindness (according to the Armed Forces Health Surveillance Center). Additionally, the joint Department of Defense/Department of Veterans Affairs Vision Center of Excellence has reported that up to 75 percent of all traumatic brain injury patients experience vision problems.

The VA is the largest integrated healthcare provider in the country and plays a leadership role in defining the education of future doctors of optometry. Through its partnerships with affiliated academic institutions, the VA optometry residency program has grown to be the largest clinical optometry training program and accounts for 50% of the profession's residency training. Optometry residents are valuable members of the healthcare team; they can provide early diagnosis and treatment for such vision threatening conditions as diabetic eye disease and neurological disorders, preventing costly procedures and rehabilitation later. Also, optometry residents, as members of the primary care team of medical providers, screen and refer veterans for untreated hypertension, diabetes and other systemic diseases.

These much needed primary health services are not available at all VA medical facilities and the demand outpaces the supply. Increasing the number of optometry residents at the VA is one way to enhance the VA's ability to address chronic patient care backlogs as well as train doctors of optometry in advanced practices. VA officials recently recognized the importance of eye exams in keeping veterans healthy and active in a March 2015 advisory they issued stating, "The eye is the only place in the human body that a functioning nerve, arteries and veins can be viewed without cutting the body open. These are all evaluated during the eye examination and reveal a lot about a person's general health. Early signs of diabetes, hypertension, atherosclerosis and carotid artery stenosis are often detected with an ocular health exam, and lead to diagnosis and management of these life threatening conditions."

Since the VA established its first optometry residency in the 1970s, the program has proven to be an especially cost-effective force-multiplier to boost the eye care team and make veterans healthier and more engaged in their own care. I would appreciate your support on H.R. 1688 to improve access to this important care for our veterans by adding 20 additional optometry residents to the VA over the next 10 years.

STATEMENT OF  
IAN de PLANQUE, LEGISLATIVE DIRECTOR,  
THE AMERICAN LEGION  
BEFORE THE  
SUBCOMMITTEE ON HEALTH  
COMMITTEE ON VETERANS' AFFAIRS  
UNITED STATES HOUSE OF REPRESENTATIVES  
ON  
PENDING LEGISLATION

**JULY 14, 2015**

Chairman Benishek, Ranking Member Brownley, and distinguished members of the subcommittee, on behalf of our National Commander, Michael Helm, and the over 2 million members of The American Legion, we thank you for this opportunity to testify regarding The American Legion's positions on the following pending legislation.

**H.R. 272: The Medal of Honor Priority Care Act**

*To amend title 38, United States Code, to increase the priority for enrollment of Medal of Honor recipients in the health care system of the Department of Veterans Affairs, and for other purposes.*

The Medal of Honor is the America's highest military award for valor. From the Civil War to the present Global War on Terror, this decoration has recognized those servicemembers who performed acts of uncommon valor far above and beyond the call of duty. The recipients have earned this award by displaying heroism and bravery while risking their lives during service to this great nation.

In 2009, when legislation at the time was being considered to assign priority status for hospital care and medical services for Medal of Honor recipients, The American Legion stated not only should they get a priority status (they were ultimately assigned Priority status 3) but that The American Legion would support legislation to place Medal of Honor recipients in Priority Group 1 for Department of Veterans Affairs (VA) health care.<sup>1</sup>

Medal of Honor recipients are currently assigned to VA Enrollment Priority Group 3. This bill would assign Medal of Honor recipients to Enrollment Priority Group 1, which is the highest priority group a veteran can be assigned.

**The American Legion supports H.R. 272.**

**H.R. 353: The Veterans' Access to Hearing Health Act of 2015**

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<sup>1</sup> Testimony of The American Legion -- HVAC Health Subcommittee Legislative Hearing June 18, 2009

*To amend title 38, United States Code, to include licensed hearing aid specialists as eligible for appointment in the Veterans Health Administration of the Department of Veterans Affairs, and for other purposes*

This bill aims to provide options for hearing impaired veterans in the hope of reducing wait times by allowing hearing aid specialists to be added to the list of the VA's approved health care providers. Recently, The American Legion reached out to the VA regarding wait times for audiology appointments. As of January 15, 2015, there were 23,813 veterans (15,230 new patients; 8,583 established patients) who were waiting longer than 30 days for an audiology appointment. Currently, under the Veterans Choice Program any veteran waiting over 30 days is given the option to seek care in the private sector. Nevertheless, the Denver Acquisition and Logistics Center (DALC) reported that there were no backlogs in processing hearing aids for veterans.

The American Legion believes VA already has the authority to address this problem.

**The American Legion does not have a position on H.R. 353.**

**H.R. 359: The Veterans Dog Training Therapy Act**

*To direct the Secretary of Veterans Affairs to carry out a pilot program on dog training therapy.*

Since 1991, the United States has been at war and as result thousands of soldiers have returned home with mental and physical injuries. In 2009, Congress amended Title 38, United States Code (U.S.C.) § 1714 by authorizing VA to extend benefits for the upkeep of service dogs used primarily for the aid of persons with physical disabilities and psychological wounds.

This legislation would expand the use of service dog program. The American Legion has urged the VA to clearly define regulations and current eligibility requirements for a veteran to receive a referral for mental and/or physical conditions, and to pass legislation for clarification of the original intent of Congress to VA in order to ensure VA provides service and guide dogs to veterans with mental health illnesses.<sup>2</sup>

This legislation is important to veterans because it allows the use of service dogs to assist in the therapy plan for injured veterans returning home from war with the signature wounds such as

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<sup>2</sup> Resolution No. 149 – Service Dogs for Injured Service Personnel and Veterans with Mental Health Conditions

traumatic brain injury (TBI) and posttraumatic stress disorder (PTSD). Service dogs can act as an effective complementary therapy treatment component, especially for those veterans who suffer on a daily basis from the physical and psychological wounds of war.

**The American Legion supports H.R. 359.**

**H.R. 421: *The Classified Veterans Access to Care Act***

*To amend title 38, United States Code, to improve the mental health treatment provided by the Secretary of Veterans Affairs to veterans who served in classified missions.*

This bill requires the Secretary to establish standards and procedures to ensure that a veteran who participated in a classified mission or served in a sensitive unit while in the Armed Forces may access VA mental health care in a manner that fully accommodates the veteran's obligation to not improperly disclose classified information. This bill also disseminates guidance to employees of the VHA, including mental health professionals, on such standards and procedures and on how to best engage such veterans during the course of mental health treatment with respect to classified information. Finally, the legislation ensures that an individual may elect to identify as such a veteran on an appropriate form.

The American Legion has urged Congress to annually appropriate sufficient funds for VA to ensure there are comprehensive mental health services available to veterans.<sup>3</sup> To be truly comprehensive, services must be available to all veterans, regardless of the classified nature of their service.

**The American Legion supports H.R. 421.**

**H.R. 423: *The Newborn Care Improvement Act***

*To amend title 38, United States Code, to improve the care provided by the Secretary of Veterans Affairs to newborn children.*

Currently, VA covers newborn care for the first seven days after birth in a non-department facility for eligible women veterans who are receiving VA maternity care.

Newborn care includes routine post-delivery care and all other medically necessary services according to generally accepted standards of medical practice. VA does not provide child delivery care in VA health care facilities, but rather refers women veterans outside the VA through contracted care. Under current law, VA only provides care for the first 7 days after birth, even if birth complications require continued care beyond that period.<sup>4</sup> Beyond 7 days, the cost of care is the responsibility of the veteran and not VA. If this bill is enacted into law, it would extend the time frame VA would be responsible to 14 days.

<sup>3</sup> Resolution No. 155- Department of Veterans Affairs Mental Health Services

<sup>4</sup> VA Women's Health Care FAQ

In 2011, The American Legion conducted a Women Veterans Survey with 3,012 women veterans in order to better understand their healthcare needs through VA. The survey found while there were improvements in the delivery of VA healthcare to women veterans, challenges with service quality in the following areas remained:

- tangibles,
- reliability,
- responsiveness,
- competence,
- courtesy,
- communication,
- credibility,
- security,
- access,
- understanding.

In 2012-2013, The American Legion's System Worth Saving Task Force report focused on women veterans' health care. The objectives of the report were to:

- Understand what perceptions and barriers prevent women veterans from enrolling in VA,
- Determine what quality-of-care challenges women veterans face with their VA health care, and to
- Provide recommendations and steps VA can take to improve these access barriers and quality-of-care challenges.

While maternity and newborn care is primarily purchased outside VA, the Task Force found several medical centers had challenges finding hospitals in the area that would accept fee-basis for maternity care services due to VA's required use of the Medicare reimbursement rate. At other medical centers, fee-basis expenditures on women veterans' gender-specific services were not even available.

The American Legion recommends that the Business Office managers be required to track women veterans' gender-specific fee-basis expenditures.<sup>5</sup> Furthermore, these expenditures should be rolled up by VA Central Office (VACO) and disseminated to stakeholders and the public to better facilitate planning for future needs within VA.

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<sup>5</sup> [The American Legion System Worth Saving Report: "Women Veterans Health Care" - 2013](#)



The American Legion is committed to working with VA in order to ensure that the needs of the current and future women veterans' population are met and the VA should provide full comprehensive health services for women veterans department wide.<sup>6</sup>

**The American Legion supports H.R. 423.**

**H.R. 1356: The Women Veterans Access to Quality Care Act of 2015**

*To improve the provision of health care for women veterans by the Department of Veterans Affairs, and for other purposes.*

Women veterans are the fastest growing demographic currently serving in the military.<sup>7</sup> They deserve a robust and comprehensive VA healthcare system to care for them when they transition from active duty to civilian life. Over the years, VA has made great strides in making health care services available for women veterans, such as ensuring more women veterans see providers who meet their gender-specific health care needs. However, there is still much work to be done to meet the overall health care needs of women veterans. Even though the military has seen a significant increase in the number of women joining the military, the number of women veterans enrolling in the VA health care system still remains relatively low when compared to their male counterparts.

Despite improvements VA has taken to broaden their health-care programs and services for women veterans, The American Legion has found there are still numerous challenges and barriers women veterans face with enrolling in the VA including<sup>8</sup>:

- Women veterans often do not self-identify as veterans,
- Women veterans are often not recognized by VA staff as veterans,
- Among women veterans, there can be a lack of awareness, knowledge, and understanding of their VA benefits,
- There is an incorrect but prevalent stigma that the VA healthcare system is an "all male" healthcare system, and
- The VA does not provide all of the gender specific health care needs for their enrolled women veterans.

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<sup>6</sup>Resolution No. 45: Women Veterans

<sup>7</sup>VHA Sourcebook Vol. 3: Women Veterans in the Veterans Health Administration

<sup>8</sup> The American Legion Women Veterans Survey Report

As a result, The American Legion believes in ensuring women veterans receive the highest quality VA health care, and that the care is tailored to meet their gender specific health care needs.<sup>9</sup>

This legislation directs VA to establish standards ensuring all VA facilities structurally meet gender-specific health care needs, integrate those standards into VA's prioritization methodology when determining funding needs, and to issue reports on those standards, especially where facilities may be failing to meet standards. The bill would make VA's compliance with women's health care needs more transparent through public dissemination of information on VA's websites. Finally, the bill would utilize multiple measures to ensure greater representation within VA of key women's health care provider positions including obstetricians and gynecologists.

All of these measures would go a long way towards addressing recognized concerns of women veterans and would improve the comprehensive nature of the health care available for women through VA.

**The American Legion supports H.R 1356.**

**H.R. 1688: To designate 20 graduate medical education residency positions specifically for the study of optometry**

*To amend the Veterans Access, Choice, and Accountability Act of 2014 to designate 20 graduate medical education residency positions specifically for the study of optometry.*

Currently, Section 301(b)(2)(A) of the Veterans Access, Choice, and Accountability Act of 2014 states that the Secretary shall, "allocate the residency positions under such paragraph among occupations included in the most current determination published in the Federal Register." This bill would amend the VACAA by ensuring that 20 of these positions are designated specifically for residencies in optometry.

Barring more specific information about the needs in optometry, as well as other medical specialties vying for residency positions, information is inconclusive about the impact of this legislation on VA's optometry needs, as well as the needs in other medical fields.

**The American Legion does not have a position on H.R. 1688.**

**H.R. 1862: The Veterans' Credit Protection Act**

*To direct the Secretary of Veterans Affairs to conduct outreach to veterans regarding the effect of delayed payments of claims for emergency medical care furnished by non-Department of*

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<sup>9</sup> Resolution No. 45: Women Veterans

*Veterans Affairs medical providers by the Chief Business Office and to direct the Secretary to submit to Congress an annual report regarding such delayed payments.*

When a veteran seeks emergency care outside of the VA, he or she has 90 days from the date of care to submit a claim to the VA if it is for a non-service connected condition, and two years for a service connected condition.<sup>10</sup> Nevertheless, several veterans have reported to The American Legion that delayed payments for emergency care by the VA to the non-VA provider have resulted in numerous credit issues for veterans. This legislation requires VA to conduct outreach to veterans to better educate them on resolving the credit issues caused by these delayed payments. The bill further establishes a toll-free telephone number that would allow veterans to report these issues to the Chief Business Office (CBO).

The American Legion has long urged VA to adopt a more definitive policy on Emergency Care that is consistently applied at every VA Medical Center. VA's policy cannot continue to result in unfair billing for veterans who require emergency care outside VA.<sup>11</sup>

**The American Legion support H.R. 1862.**

**H.R. 2464: The Demanding Accountability for Veterans Act of 2015**

*To amend title 38, United States Code, to improve the accountability of the Secretary of Veterans Affairs to the Inspector General of the Department of Veterans Affairs.*

This bill would require the Secretary to identify by name the employee responsible for fixing an issue that comes to light following any VA Office of the Inspector General (VAOIG) report. The designee would then provide a mitigation plan to help resolve the issue cited in the report. No responsible designee would then be permitted to receive a year-end bonus until such time as the issue cited in the report is resolved. If, during performance reviews, it is determined that the individual has repeatedly failed to solve the problem, the VA would then be equipped to relieve the individual from duty.

Because of the increased need for accountability, The American Legion urges Congress to enact legislation that provides the Secretary of Veterans Affairs the authority to remove any individual from service if the Secretary determines the performance of the individual warrants such removal.<sup>12</sup>

**The American Legion supports H.R. 2464.**

**H.R. 2914: The Build a Better VA Act**

<sup>10</sup> 38 USC § 1728 and § 1725

<sup>11</sup> American Legion Resolution No. 2-Uniform Payment Policy for Emergency Care at Non-Department of Veterans Affairs (VA) Medical Facilities

<sup>12</sup> Resolution No. 30-Department of Veterans Affairs Accountability

*To amend title 38, United States Code, to require congressional approval before the appropriation of funds for Department of Veterans Affairs major medical facility leases.*

This bill would modify the current process for approving Department of Veterans Affairs medical facility leases to include amending Title 38 of the United States Code, which requires congressional approval before the appropriation of funds for VA major medical facility leases.

In 2012, the Congressional Budget Office (CBO) unexpectedly changed its scoring methodology for capital leases after decades of precedence. CBO's new scoring method reflects the cost for the duration of the lease rather than scoring it on an annual basis. This bill also attempts to solve the issues caused by the CBO and allow major medical facility leases to be authorized by the Veterans' Affairs Committee.

Since the change in lease scoring became apparent, The American Legion has worked closely with both VA and Congress to try to provide an annual or permanent exemption for the VA leases from the new CBO scoring process. This is essential for the providing VA with the flexibility it needs to meet the health care needs of veterans.<sup>13</sup>

**The American Legion supports H.R. 2914.**

**H.R. 2915: Female Veteran Suicide Prevention Act**

*To amend title 38, United States Code, to direct the Secretary of Veterans Affairs to identify mental health care and suicide prevention programs and metrics that are effective in treating women veterans as part of the evaluation of such programs by the Secretary.*

This bill would improve female veteran suicide prevention programs within VA by amending Title 38 of the United States Code to direct the Secretary of Veterans Affairs to identify mental health care and suicide prevention programs and metrics that are effective in treating women veterans. This bill also strives to improve suicide prevention programs for female veterans enrolled in the VA healthcare system.

According to figures in a 2015 study, suicide rates among women veterans rose 40 percent during the decade from 2000-2010, compared to a more modest increase of 13 percent among the equivalent civilian cohort of women.<sup>14</sup> Women veterans are nearly 6 times more likely than civilian women to commit suicide. This legislation seeks to address this imbalance.

The American Legion continues to urge the President and Congress to expand and improve the care provided to veterans and servicemembers who have mental health issues or are at risk of

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<sup>13</sup> Resolution No. 282- Congressional Budget Office Scoring on Department of Veterans Affairs Leasing

<sup>14</sup> Changes in Suicide Mortality for Veterans and Non-Veterans by Gender and History of VHA Service Use, 2000-2010, *Psychiatric Services*, May 1, 2015

suicide.<sup>15</sup> This legislation to help women veterans who struggle with suicide is critical, as is all legislation designed to help veterans struggling with mental health issues and suicide, be they male or female.

**The American Legion supports H.R 2915.**

**Draft Bill: VA Provider Equity Act**

*To amend title 38, United States Code, to clarify the role of podiatrists in the Department of Veterans Affairs*

This legislation would address the recruitment and retention challenges VA faces regarding pay disparities among some physicians providing direct health care to our nation's veterans. This bill would specifically place podiatrists within the Veterans Health Administration (VHA) on the same pay schedule as VA physicians and provide them the same promotional and leadership opportunities they often hold in private sector healthcare systems. One of the areas VA consistently struggles with is recruiting and retention of certain health care providers. This includes podiatrists. This change would put podiatrists in the same classification as all other physicians and would assist VA with recruiting and retention. As a result VA will be able to attract and retain more experienced podiatrists to treat veterans suffering with lower extremity issues, which is a particular concern to large numbers of veterans suffering from Type II Diabetes associated with exposure to the herbicide Agent Orange.

**The American Legion supports this draft bill.**

**Draft Bill: Construction Reform Act of 2015**

*To authorize Department major medical facility construction projects for fiscal year 2015, to amend title 38, United States Code, to make certain improvements in the administration of Department medical facility construction projects, and for other purposes.*

**Section 1: Title**

**Section 2: VA Construction Reforms**

This portion of the legislation proposes a new subsection to 38 USC § 8103 by requiring the Secretary to enter into an agreement with an appropriate non-Department entity for the purpose of providing full project management services for any super construction project. Super construction projects are defined as "a project for the construction, alteration, or acquisition of a

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<sup>15</sup> Resolution No. 196 — Suicide Prevention for American Veterans

medical facility involving a total expenditure of more than \$100 million.” Under the provisions of this section, the Secretary may not obligate or expend funds for advance planning or design for any super construction project, until the date that is 60 days after the date on which the Secretary submits to the Committees on Veterans’ Affairs and the Committees on Appropriations of the Senate and House of Representatives notice of such obligation or expenditure.

**Section 3: Modification of Authorization of FY 2008 Major Medical Facility Project at Department Medical Center in Tampa, Florida**

This section deals with the construction of a new bed tower at the VA Medical Center (VAMC) in Tampa, Florida.

**Section 4: Authorization of Fiscal Year 2015 Major Medical Facility Projects**

This section authorizes construction and corrections to VA facilities in Canandaigua, NY; Long Beach, CA; West Los Angeles, CA; and San Diego, CA.

The American Legion is a strong supporter of legislation and oversight to improve future VA construction programs. The American Legion also urges VA to consider all available options, both within the agency and externally, including options such as the Army Corps of Engineers, to ensure major construction programs are completed on time and within budget.<sup>16</sup> This legislation, in particular Section 2, speaks directly to providing those outside options to better manage large construction projects where VA has recently struggled including hospitals in Colorado, Nevada, Florida and Louisiana.

**The American Legion supports this draft bill.**

**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.

For additional information regarding this testimony, please contact Mr. Warren J. Goldstein at The American Legion’s Legislative Division at (202) 861-2700 or [wgoldstein@legion.org](mailto:wgoldstein@legion.org).

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<sup>16</sup> Resolution No. 24-May 2015



National Service & Legislative Headquarters  
 807 Maine Avenue, S.W.  
 Washington, D.C. 20024-2410  
 Phone (202) 554-3501  
 Fax (202) 554-3581  
[www.dav.org](http://www.dav.org)

**STATEMENT OF  
 ADRIAN M. ATIZADO  
 ASSISTANT NATIONAL LEGISLATIVE DIRECTOR  
 BEFORE THE  
 COMMITTEE ON VETERANS' AFFAIRS  
 SUBCOMMITTEE ON HEALTH  
 UNITED STATES HOUSE OF REPRESENTATIVES  
 JULY 1, 2015**

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting the DAV (Disabled American Veterans) to testify at this legislative hearing of the House Veterans' Affairs Subcommittee on Health. As you know, DAV is a non-profit veterans service organization comprised of 1.2 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 today to present our views on the bills under consideration by the Subcommittee.

**H.R. 272, the Medal of Honor Priority Care Act**

Prior to enactment of Public Law 111-163, Medal of Honor awardees were not expressly covered in any priority group for the purposes of enrolling and receiving health care from the Department of Veterans Affairs (VA). Section 512 of this law positioned Medal of Honor recipients in priority group three along with former prisoners of war and Purple Heart awardees. At the time of enactment of Public Law 111-163, 96 of 3,492 total recipients were living. Today, according to the Congressional Medal of Honor Society, 79 survive.

H.R. 272 would elevate, from third to first, the priority given to Medal of Honor awardees in enrollment in the VA health care system, and the bill would exempt them from making a copayment for extended care services and medications. The Medal of Honor is the highest military award for valor issued to an individual in action against an enemy of the United States. This bill would uphold our nation's commitment to these few heroes by conveying to them a higher enrollment priority status for access to an array of VA hospital and medical services.

While the DAV has no national resolution received from our membership that endorses this particular legislation, we would offer no objection to its enactment, and we appreciate the effort being made on behalf of these extraordinary patriots.

#### **H.R. 353, the Veterans' Access to Hearing Health Act of 2015**

This bill would add authority under title 38, United States Code, to VA's current authority under title 5, United States Code, to employ licensed hearing aid specialists. In addition, the measure would require VA to submit to Congress an annual report on the timely access of veterans to VA's specialized hearing health services, and VA contracting policies regarding the provision of specialized hearing health services to veterans in non-VA facilities.

In a previous Congress, VA testified on a similar bill authorizing hearing specialists to be employed by the Veterans Health Administration (VHA). During that hearing, VA indicated that direct employment of hearing aid specialists would potentially fragment VA's well-established national audiology program. In addition, VA asserted a pre-existing statutory authority to employ hearing aid specialists should they be determined an unmet need.

The VA Office of Inspector General's (OIG) 2014 audit of VA's specialized hearing aid services describe the delays in providing such services as attributable to inadequate staffing to meet an increased workload, due in part to the large number of veterans requiring compensation and pension (C&P) audiology examinations, which take priority over other appointments, such as those to issue hearing aids, in order to process C&P claims timely.

Accordingly, the required wait time report would include the average time a veteran receives an appointment for a disability rating evaluation for a hearing-related disability. This time is measured beginning on the date the veteran makes the request.

The vast majority of C&P audiology examination appointments in the VHA are not made at the veteran's request but rather at the request of the Veterans Benefits Administration. We believe the no-show rate is much higher in these instances where an appointment is made without regard to the veteran's preference.

Thus we recommend amending these provisions to ensure the information being reported is more meaningful and provides greater granularity, particularly if VA policy continues to place a higher priority on C&P examinations over other hearing health appointments.

Moreover, the bill's required reporting of staffing levels and performance measures related to appointments and specialized hearing health within VHA should be considered in light of VHA's Audiology productivity standards (due to commence in fiscal year 2016) to provide a more accurate depiction of utilization rates of audiologists and hearing aid specialist in and outside of the VA health care system.

We laud the bill's efforts to create transparency in VA performance to provide specialized hearing health services; however, the Subcommittee must also ensure that sufficient funding is appropriated commensurate with the increase in services this measure would intend to



provide. DAV takes no issue with encouraging VA to use all professional avenues available in order to address the backlog and improve care for veterans as long as it does not diminish the quality of care and the capacity to provide such care within the VA health care system.

#### **H.R. 359 –Veterans Dog Training Therapy Act**

This measure would require the Secretary of Veterans Affairs to conduct a 5-year pilot program to assess the effectiveness of a therapeutic environment of service dog training and handling in addressing post-deployment mental health and post-traumatic stress disorder (PTSD) symptoms in veterans. The pilot program would be carried out in three to five VA medical centers with available resources to educate veterans with certain mental health conditions, in the art and science of service dog training and handling.

H.R. 359 would require a pilot facility to offer wheelchair accessibility, a classroom or lecture space for education; office space for staff; storage for training equipment; periodic use of other areas to train the dogs with wheelchair users; outdoor exercise and toileting space; and, transportation for weekly field trips to train the dogs in other environments. The pilot program would be administered through VA's Recreation Therapy Service led by a certified recreation therapist with sufficient experience to administer and oversee the pilot program.

The measure also would require that, when the selection of dogs was made, a deference would be given to dogs from animal shelters or foster homes with compatible temperaments to serve as service dogs, and with health clearances. Each service dog in training would live at the pilot program site or in a volunteer foster home in close proximity to the training site during the period of training. Veterans with post-deployment mental health conditions, including PTSD, would be able to volunteer to participate in the pilot if the Secretary determined adequate resources were available and those selected could participate in conjunction with VA's compensated work therapy program.

Under the bill, the Secretary would also give veterans preference in the hiring of service dog training instructors to those who had successfully completed therapy for PTSD or other residential treatment. The goal of the pilot would be to maximize the therapeutic benefits to veterans participating in the program and to ultimately provide well-trained service dogs to veterans with disabilities.

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

Although DAV has no specific resolution approved by our membership relating to the training of service dogs that would authorize DAV to formally support this measure, we recognize that trained service animals can play an important role in maintaining functionality and promoting veterans' recovery, maximize independence and improve their quality of life. We recognize this pilot program could be of benefit to veterans suffering from post-deployment

mental health struggles, including PTSD. We understand a similar program that operates at the Palo Alto VA Medical Center has been beneficial for veterans—and specifically in improving symptoms associated with post-deployment mental health problems, including PTSD. Likewise, DAV is supportive of non-traditional therapies, complementary and alternative medicine, and expanded treatment options for veterans. For these reasons we have no objection to the passage of this bill.

#### **H.R. 421 – the Classified Veterans Access to Care Act**

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

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

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

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

A reasonable approach would be to inform active duty personnel (and certain veterans) seeking mental health services in VA about all the limits of confidentiality, to include the fact that the care provider may not possess a security clearance. We note that mental health providers working in the Department of Defense routinely inform their patients about the limits of confidentiality, but not security clearance limitations. Nevertheless, VA mental health practitioners and counselors could be at times impeded in aiding particular individuals because

they may believe they are effectively “gagged,” and thus unable to describe in therapy certain military events or activities sheltered from disclosure that might be, or could become, keys to improved treatment. For example, in prolonged exposure therapy, reliving a traumatic event or incident repetitively has proven to be an effective treatment to reduce or control symptoms of post-traumatic stress disorder. In these cases, a talented, experienced practitioner should be able to use other techniques, such as cognitive behavioral therapy, to enable a service member or veteran to deal with his or her individual challenges, without disclosing classified information.

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

While DAV does not have a specific resolution concerning mental health services for veterans who once worked in classified or sensitive military activities, the delegates to our most recent National Convention passed Resolution No. 039, which supports “...enhanced [VA] resources for VA mental health programs to achieve readjustment of new war veterans and continued effective mental health care for all enrolled veterans needing such services.” We believe this bill is consistent with the purposes of our resolution; therefore, DAV offers its support of this measure.

#### **H.R. 1356—Women Veterans Access to Quality Care Act of 2015**

This bill would seek to improve VA health care facilities to better accommodate the needs of women veterans. Section 2 of the measure would require the VA Secretary to establish standards to ensure that all medical facilities modify or otherwise create the structural features necessary to meet basic gender-specific health care needs of veterans, including those for privacy, safety, and dignity. The bill would require a report to the House and Senate Veterans Affairs Committees with a list a facilities that fail to meet such standards and the cost for renovations or repairs necessary to meet them.

Section 3 would require the Secretary to evaluate the performance of VA medical center directors by measuring health outcomes for women veterans who use VA medical services. The VA would be required to publish health outcomes for women veterans on a publicly available website including comparisons of the data to male health outcomes, and explanatory information so the public could easily understand any differences reported.

Section 4 would require that every VA medical center employ a full-time obstetrician or gynecologist, and would mandate a pilot program to increase the number of residency program positions and graduate medical education positions for obstetricians and gynecologists at VA medical facilities, in at least three Veterans Integrated Service Networks.

Section 5 would require the development of procedures to electronically share veterans' military service and separation data; email address; telephone number; and mailing address with State veterans' agencies in order to facilitate the assistance of benefits these veterans may need. Under the bill, veterans would retain the option of to "opt-out" of this information exchange.

Section 6 would mandate the Government Accountability Office (GAO) examine whether VA medical centers are able to meet the health care needs of women veterans across a number of specific dimensions of care, including waiting time and access to specialized gender-specific care clinics, comparative health outcomes by gender, effectiveness of patient aligned care teams; adherence to safety and privacy policies; outreach to women veterans; and, other key elements.

The bill is also consistent with DAV Resolution No. 040 to support enhanced medical services and benefits for women veterans, approved by the delegates to our most recent National Convention. The intent of this bill is also consistent with DAV's 2014 Report, *Women Veterans: The Long Journey Home*. Thus, the bill carries DAV's full support.

**H.R. 1688 – to designate 20 graduate medical education residency positions specifically for the study of optometry**

This measure would amend a 5-year plan enacted as a part of Public Law 113-146 that requires the VA to add up to 1,500 graduate medical education residencies to VA's existing academic affiliations commitment. This bill would specify that 20 of these positions be designated for optometric residencies.

DAV has received no resolution on these matters to enable us to support this bill, but DAV would offer no objection to its enactment. As a general rule, however, the Veterans Access, Choice, and Accountability Act of 2014 gives discretion to VA on deciding which medical disciplines need additional personnel, including residency positions. We are unaware of the status of optometrists in VA health care, VA's role as an affiliate of any schools of optometry, or whether optometry is a shortage category of VA providers.

**H.R. 1862, the Veterans' Credit Protection Act**

This legislation is intended to scrutinize delayed payments by the VA for veterans' medical services, including late payments for emergency care, and the resultant cost impact on veterans and taxpayers.

When payments by VA of claims from private providers who have duly furnished health care to veterans are erroneously denied or significantly delayed, veterans are often made financially liable for their VA-authorized care. Because the financial liability is often daunting, veterans' credit ratings can be negatively affected.

We understand the VHA currently assists any veteran who experiences an adverse credit action due to VA's failure to process and pay a valid claim within 30 days of the date of receipt of the claim for purchased non-VA health care services.

DAV recommends adding provisions to this measure that would offer more protection to veterans through greater transparency and oversight. We urge the Subcommittee to consider requiring VHA to publicly clarify what constitutes “timely resolution” of the reporting, investigation, and resolution of all known cases of veterans’ adverse credit histories.

Assuming a newly clarified VA definition of timely resolution, we recommend the bill require a report from VA to include information on the occurrences of adverse credit history reports, as well as an accounting of unresolved adverse credit history reports. We do not believe this requirement would be a burdensome addition since VHA already obtains and reports this information internally.

#### **H.R. 2464 – the Demanding Accountability for Veterans Act of 2015**

This bill would restructure the relationship of the VAOIG to the VA Secretary and subordinate VA managers in the case of IG reports that document “an issue in the Department of public health and safety.” Also, the bill would require the OIG to provide a copy of each such report to Congress, along with an explanation if any such report in progress had been changed at the request of the VA Secretary, and to provide the identities of all managers responsible for the issue(s) documented in the report.

The measure would require the Secretary to notify each involved manager within seven days of receipt of a covered report, with direction to resolve the issue(s), and provide any such manager appropriate counseling, and a mitigation plan to resolve them.

Finally, the legislation would require performance reviews of VA managers to include evaluation of whether the managers took appropriate action on any reported issue, and would prohibit the payment of performance bonuses to any manager if the issue reported during the performance period covered by the evaluation remained unresolved.

DAV has received no resolution from our membership on these specific matters, but this bill is of concern to us. Similar to several other bills that have been introduced in the wake of VA’s access-to-care crisis uncovered last year, this bill would bring a major chilling effect on candidates for VA management positions, as well as those already occupying these positions. The bill would also cause a type of role reversal of VA’s top executive with the VAOIG. While the bill represents an understandable reaction to the events that transpired as VA’s crisis emerged, in the long run it may prove to be an unwise change in law. Applying these requirements solely to VA versus every other federal department and agency would create conditions that could dissuade talented managers from considering VA as an employer, and make VA’s recruitment and retention efforts more challenging than they are now.

Should the Subcommittee decide to advance this bill, DAV recommends that the term “public health and safety” be defined or reconsidered. The World Health Organization defines public health as “...refer[ring] to all organized measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole. Its activities aim to provide conditions in which people can be healthy and *focus on entire populations*, [emphasis

added] not on individual patients or diseases. Thus, public health is concerned with the total system and not only the eradication of a particular disease. The three main public health functions are:

- The assessment and monitoring of the health of communities and populations at risk to identify health problems and priorities.
- The formulation of public policies designed to solve identified local and national health problems and priorities.
- To assure that all populations have access to appropriate and cost-effective care, including health promotion and disease prevention services.”

Public safety carries a looser definition but generally it means the responsibility of a state, federal or local organization that looks after the safety of the public. Those who work in public safety are typically members of various organizations such as emergency medical services, police and fire departments, and other public officials.

By these definitions, arguments could be made that VA managers play no role in public health and safety—they manage programs that deliver services and benefits to a small fraction of the public; or alternatively, that any of a number of issues could be cast in terms of public health or public safety (contaminated food; water quality in a VA facility; snow removal from parking lots; slick waxed floors that constitute a falling hazard, etc.).

We believe the Subcommittee should clarify the intent of the bill with respect to the use of the concept of “public health and safety,” to avoid misinterpretation or misapplication of its meaning if this bill is advanced.

#### **H.R. 2914 – the Build a Better VA Act**

This bill would prohibit the appropriation of funds to support any VA major medical facility lease unless the Committees on Veterans’ Affairs of both chambers adopt resolutions approving the lease. Presumably the bill sponsor would intend to improve the authorizing committees’ role in overseeing the VA’s leasing program, and provide more specific guidance to the Appropriations Committees in respect to funds to support VA leases.

Delegates to our most recent National Convention approved Resolution No. 036, dealing with VA infrastructure and capital planning matters, and urging VA to request, and Congress to approve, sufficient funding to enable VA to modernize its aging facilities, and do so in a timely manner. The resolution also specifically calls on Congress to resolve a stalemate that delayed dozens of major medical facility leases for several years due to disagreements with the Administration over out-year costs associated with such leases.

While DAV supports strong oversight of the VA leasing program, we are concerned that this bill might in fact bring deleterious effects to the program by greatly slowing VA’s efforts, because this bill would add new legislative steps to the existing process for lease authorizations

and funding. Unclear in the bill is whether the resolutions to be approved under this bill would need to be identical in each chamber, or whether these resolutions would need to be negotiated between the chambers, or formally approved by them jointly before VA could propose a lease in its complex acquisition process.

A recent hearing of the House Oversight and Government Reform Subcommittee on National Security revealed that VA's performance in executing timely leases needs major improvements. During the hearing, the Chairman cited a 2014 report by the GAO indicating that 39 of the 41 projects reviewed by GAO with a contract value of about \$2.5 billion experienced scheduling delays ranging from six months to 13.3 years, with an average delay of 3.3 years. DAV is concerned that adding new steps involving Congress passing resolutions to an already troubled, delayed administrative process would further lengthen and complicate VA's efforts to obtain facilities through lease agreements. If it intends to advance this bill, DAV would recommend the Subcommittee add a provision to require the two committees to act on the resolutions contemplated by the bill within a date certain – perhaps within a 30-day period from VA's notification – the absence of which action would empower VA to proceed with its leasing activity in a given project.

On the strength of Resolution 036, and with these concerns in mind, DAV opposes enactment of this bill in its current form.

#### **H.R. 2915—Female Veterans Suicide Prevention Act**

This measure directs the VA to identify mental health care and suicide prevention programs that are most effective and have the highest satisfaction rates among women veterans. This bill is in line with DAV Resolution Numbers 039, and 040, both of which support program improvements and enhanced resources for VA mental health programs and medical services for women veterans, and also with recommendations put forth by DAV in our 2014 Report, *Women Veterans: The Long Journey Home*. For these reasons DAV is pleased to support this measure.

#### **Draft Bill – to clarify the role of podiatrists in the Department of Veterans Affairs**

This legislation would reclassify VA podiatrists for purposes of appointment and compensation in the same category as other VA physicians.

In 2004, when Congress enacted physician pay reform in Public Law 108-445, the Department of Veterans Affairs Health Care Personnel Enhancement Act of 2004, doctors of podiatry were inexplicably excluded. These professionals earn credentials equal to those of other physicians, must complete four years of post-graduate medical education, work in internships and successfully complete residencies no different from any other physician. They are licensed by the states on the same basis as physicians, and are held to the same standard of care and practice.

Podiatrists play a critical role in maintaining foot health and dealing with injuries and diseases of the foot and ankle. In fact they are specialized surgeons. We believe their

appointments and compensation should be made commensurate with those of other physicians in VA.

While DAV has received no resolution specific to the practice of podiatry, we have received Resolution No. 202 from our membership calling on VA to provide a comprehensive health care system for all enrolled veterans. Podiatry is an important element in comprehensive care. This change in law would be consistent with our resolution. Therefore, DAV supports this legislation and urges its passage.

#### **Draft Bill – the Construction Reform Act of 2015**

Enactment of this bill would introduce a new sub-category of major medical facility construction (including alterations and acquisitions), entitled “super construction project.” This super project definition would apply to any VA project whose estimated cost exceeded \$100 million. In such cases the Secretary would be obligated to enter contracts with non-VA entities for full project management services. Also, this bill would require the Secretary to use industry standards, standard designs, and best practices in carrying out any VA construction project.

In the case of super construction projects, the bill would obligate the Secretary, 60 days before obligating or expending funds for advance planning or design, to notify Congress of the intent to obligate or spend funds for these purposes.

This measure would impose an overage cap of 10 percent on deviance from the approved Congressional authorization level of any super construction project. Any excess expenditure above this cap would need approval in writing from authorizing and appropriations committees of both Congressional chambers.

The legislation would require quarterly reports to Congress on the progress of super construction projects, including various budgetary matters and schedules.

This bill also would establish a mandate for 10-year facility-based master planning, for both existing and new facilities. The bill would specify the types of information to be contained in such master plans, including information on the facility’s history, its patient population’s needs, the involvement of community providers in providing care to enrolled veterans, and the maximal use of the land and structures of such facility.

Finally, the measure would modify a previously approved construction project authorization at the Tampa, Florida VA Medical Center; and would authorize, and authorize appropriations for, new projects for VA medical centers in Canandaigua, New York, and Long Beach and San Diego, California.

Delegates to our most recent National Convention approved Resolution No. 036, urging the Administration and Congress to properly support VA’s construction and infrastructure needs. This bill is consistent with the intent of our resolution; therefore, DAV supports this bill and urges its enactment.



This concludes my testimony, Mr. Chairman. DAV would be pleased to respond for the record to any questions from you or the Subcommittee Members concerning our views on these bills.

STATEMENT OF  
CARLOS FUENTES  
SENIOR LEGISLATIVE ASSOCIATE  
NATIONAL LEGISLATIVE SERVICE  
VETERANS OF FOREIGN WARS OF THE UNITED STATES  
BEFORE THE  
VETERANS' AFFAIRS SUBCOMMITTEE ON HEALTH  
UNITED STATES HOUSE OF REPRESENTATIVES  
WITH RESPECT TO  
**H.R. 272, H.R. 353, H.R. 359, H.R. 421, H.R. 423, H.R. 1356, H.R. 1688, H.R. 1862, H.R.  
2464, H.R. 2914, H.R. 2915 and DRAFT LEGISLATION**

WASHINGTON, D.C.

July 14, 2015

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

**H.R. 272, Medal of Honor Priority Care Act**

The VFW supports this legislation which would elevate Medal of Honor recipients from Department of Veterans Affairs (VA) Priority Group 3 to Priority Group 1. It would also explicitly grant Priority Group 1 benefits to those veterans, including eligibility for nursing home, domiciliary, and extended care services, as well as eliminating copayment requirements.

The 79 living Medal of Honor recipients are held in the highest esteem by the veterans and military community. These men have turned the tide of battle against overwhelming enemy forces, and saved the lives of their comrades at great risk to themselves. Accordingly, we believe it is entirely appropriate to grant them Priority Group 1 status as a small but meaningful symbol of our appreciation for their heroic actions.

### **H.R. 353, Veterans' Access to Hearing Health Act of 2015**

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

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

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

### **H.R. 359, Veterans Dog Training Therapy Act**

The VFW supports this legislation, which would require VA to establish a pilot program at three to five locations to assess the effectiveness of treating veterans for post-traumatic stress disorder (PTSD) by instructing them in the art and science of service dog training.

The VFW recognizes the potential value of canine training therapy as an alternative or complement to traditional pharmacological treatments for PTSD. The Palo Alto VA Medical Center has been operating a similar program since 2008 in partnership with the Bergin University of Canine Studies, known as Paws for Purple Hearts. This program resulted in positive feedback from veterans and staff, and we believe an expanded canine training pilot for the purpose of collecting data to determine its effectiveness in treating veterans for PTSD is warranted. The fact that the dogs would be trained and kenneled at off-site contracted locations ensures that the program would not interfere with the delivery of safe, quality care at VA Medical Centers.

**H.R. 421, Classified Veterans Access to Care Act**

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

We are aware that this legislation was inspired by the case of Daniel Somers, a veteran of sensitive missions in Iraq, who felt that he was unable to participate in the group therapy sessions offered to him at the Phoenix VAMC, believing that he would be required to share classified information with other group members. Tragically, Daniel Somers took his own life in 2013. The VFW has been in contact with his parents, who strongly believe that had their son been offered individual therapy from the beginning due to the nature of his service, his suicide may have been prevented. The VFW believes that requiring VA to develop standards for those who served on sensitive missions is reasonable, and would ensure that veterans feel that they can access the services they need without violating any nondisclosure responsibilities they may have.

**H.R. 423, Newborn Care Improvement Act**

The VFW supports this legislation which would expand VA's authority to provide health care to a newborn child, whose delivery is furnished by VA, from 7 to 14 days post-birth.

According to the Centers for Disease Control and Prevention, newborn screenings are vital to diagnosing and preventing certain health conditions that can affect a child's livelihood and long-term health. We understand the importance of high quality newborn health care and its long-term impact on the lives of veterans and their family. VA must ensure newborn children receive the proper post-natal health care they need.

**H.R. 1356, Women Veterans Access to Quality Care Act of 2015**

This legislation would improve the health care VA provides women veterans by establishing women health care standards, expanding access to gender-specific services and evaluating VA's ability to meet the health care needs of women veterans. The VFW supports this legislation and would like to offer suggestions to strengthen it.

Recent years have seen unprecedented levels of women serving in the U.S. military. Likewise, the demand for VA services by women veterans has increased dramatically. According to VA data, the number of women using VA services grew from more than 200,000 in 2003 to more than 400,000 in 2014, a 100 percent increase. In addition, recent VA data shows that approximately 19 percent of women using VA health care served in either Iraq or Afghanistan, compared to only 9 percent of men. Accordingly, women veterans receiving VA care are younger than their male counterparts, with 42 percent of women under the age of 45, compared to only 13 percent of men. As a result, the number of women using VA services as a percentage of the total population will only continue to grow in the coming years, along with their need for health care.

Although VA has made a concerted effort to increase capacity and quality of women's health care, gaps in services remain for women enrolled in VA, particularly in gender-specific specialty care. Today, only 52 VA facilities provide onsite mammography. According to VA testimony to this Subcommittee on April 30, 2015, many VA medical centers still have no onsite gynecological services; of those that do, many of the doctors work part-time. The VFW supports requiring all VA medical centers to have a full time obstetrician or gynecologist on staff.

Regardless of what services are available, women veterans will not be afforded the opportunity to utilize them if they are unaware such services exist. This legislation seeks to improve outreach to women veterans by requiring VA to share veterans' information with state veterans' agencies. The VFW supports sharing data between government agencies to ensure veterans are aware of the benefits and services they have earned and deserve. This legislation would afford veterans the opportunity to opt out of the data sharing mechanism VA is required to establish. The VFW urges Congress and VA to ensure veterans are fully informed that their personal information will be shared and are given clear notification of such action, and are granted an easily accessible and user friendly mechanism to opt out.

In drafting testimony for women specific hearings, the VFW has sought the input of women VFW members from across the country. A consistent issue identified by women VFW members was lack of child care at VA medical facilities. Without access to child care services veterans are often reluctant to take their small children to medical appointments with them. Veterans may even choose to forgo the care they need and deserve. Veterans should not be forced to choose between their own wellbeing and that of their children. For this reason, we urge the Committee to amend this legislation to expand the VA child care pilot program to all VA medical centers.

**H.R. 1688, to amend the VACAA of 2014 to designate 20 graduate medical education residency positions specifically for the study of optometry.**

This legislation would require up to 20 of the 1,500 graduate medical education residency positions established under the Veterans Access, Choice and Accountability Act of 2014 to be designated for residencies in optometry. While the VFW appreciates its intent, we cannot support this legislation.

The Veterans Access, Choice and Accountability Act of 2014 also requires the VAOIG to annually determine the five health care occupations with the largest staffing shortages within the Department. It further requires VA to prioritize residency slots among such health care occupations and any other occupations the Secretary of Veterans Affairs determines appropriate. The VFW agrees that graduate medical education residency slots must be allotted for health care specialties that face the largest staffing shortages to ensure veterans have access to the health care they need. However, we believe the prioritization requirement set forth by the Veterans Access, Choice and Accountability Act of 2014 is the most equitable mechanism for determining which health care specialties receive residency slots.

**H.R. 1862, Veterans Credit Protection Act**

This legislation would require VA to assist veterans in resolving credit issues caused by delayed health care claim payments. It would also establish a national phone number for veterans to report credit issues. The VFW supports this bill and has several recommendations to strengthen it.

VA has an obligation to ensure veterans are not held liable for health care claims it fails to pay on time or accurately. In the past year, VA has made organizational changes to its claims process to improve timeliness and accuracy of health care claims. In testimony to this Subcommittee on June 3, 2015, VA reported that nearly 73 percent of health care claims were being paid within 30 days. However, the VFW continues to hear that non-VA health care providers bill veterans for health care services VA is responsible for paying because providers are unable to receive timely payment from VA. The VFW believes that the best way to prevent veterans from being wrongfully charged is to ensure VA pays claims on time and accurately. That is why we recommend the Subcommittee amend this legislation by expanding the Government Accountability report to include an evaluation of the accuracy of VA's Chief Business Office's health care claims process.

This legislation also requires VA to assist veterans with credit issues that result from any medical service or emergency health care claim, regardless if VA is authorized to pay such claim. While the VFW believes VA should assist veterans in achieving financial independence, we do not support overburdening VA's Chief Business Office with claims it is unable to resolve. That is why the VFW recommends the Subcommittee amend this legislation to limit assistance through the VA toll-free telephone number to health care claims VA has authorization to resolve.

**H.R. 2464, Demanding Accountability for Veterans Act of 2015**

The VFW agrees with this legislation, which would prevent VA employees who have failed to comply with VAOIG recommendations from receiving bonuses. Employees receive bonuses as an incentive and recognition for their superior work performance. Those who have failed to comply with VA directives or have been found to have caused harm to veterans or delayed their access to the health care they have earned and deserve cannot be rewarded for their wrongdoing.

**H.R. 2914, Build a Better VA Act**

This legislation would streamline the congressional process for authorizing VA's major facility leases. The VFW supports this important legislation and has several recommendations to strengthen it.

VA leases property throughout the country for community-based outpatient clinics, medical centers, and an array of other purposes. Since the 1990s, leases \$1 million and above have required congressional authorization. In 2012, the Congressional Budget Office changed its accounting practice on how major facility leases are to be funded, hindering the congressional authorization process. As a result, 27 major facility leases went unauthorized for more than two years. The two year delay resulted in a number of proposed clinics being delayed. Such a delay

negatively impacts access to health care for veterans who rely on leased VA medical facilities for their health care.

This legislation seeks to streamline the authorization process by authorizing the Committees of Veterans' Affairs of the Senate and the House of Representatives to authorize VA major facility leases without requiring legislation. However, it does not eliminate the requirement for the House Transportation and Infrastructure Committee and the Senate Environment and Public Works Committee to pass Committee resolutions. The VFW recommends the Subcommittee amend section 3307 of title 40, United States Code, to exempt VA leases from such requirement.

This bill also fails to address other factors that hinder VA's ability to enter into major facility leases. Currently, VA lacks a revolving fund to insure its major facility leases in the case it is unable to abide by contract requirements for a lease and is contractually required to pay out the full cost of the lease without receiving appropriations for the full amount of such lease. VA currently relies on the General Services Administration's revolving fund authority to insure major VA facility leases. The VFW urges this Subcommittee to establish a VA revolving fund to insure VA leases.

#### **H.R. 2915, Female Veteran Suicide Prevention Act**

The VFW supports this legislation to improve VA mental health care and suicide prevention programs offered to women veterans.

As VA and Congress work to expand the availability of women-specific care at VA medical facilities, they must also focus on expanding research on the psychological and physical effects war has on women veterans. VA and Congress must make a concerted effort to understand any differences in the causes, symptoms and treatment modalities between male and women veterans as they relate to mental health conditions and suicide. Without such research, women veterans may go unnecessarily undiagnosed and untreated for serious conditions. The VFW strongly supports this legislation and recommends that this Subcommittee expand it to include an evaluation of which mental health and suicide prevention programs produce the best health outcomes.

In addition to identifying mental health programs with the highest patient satisfaction and health outcomes among women veterans, VA must also work to implement successful programs and adjust existing women veteran programs. VA and Congress have already identified several programs that have proven to improve health outcomes and are well received by women veterans, such as the childcare pilot program and the retreat counseling program for women veterans. VA and Congress must ensure these programs are expanded and successfully implemented.

#### **Draft Legislation, to clarify the role of podiatrists in the Department of Veterans Affairs.**

The VFW supports this legislation, which would improve access to VA podiatry care by authorizing VA to properly compensate podiatrists.

VA estimates an increase in the amount of veterans that will require podiatry care in the coming years. Yet, VA has historically been unable able to recruit and retain enough experienced podiatrists to meet the podiatric needs of veterans. In testimony to the Subcommittee on May 15, 2015, the American Podiatric Medical Association cited the lack of pay equality between podiatrists and physicians as the primary reason for VA's recruitment and retention challenges. This legislation is a common sense solution to this issue. The VFW thanks Congressman Wenstrup for his leadership in bringing it forward.

**Draft Legislation, Construction Reform Act of 2015**

This legislation would require VA to enter into project management agreements for major construction projects over \$100,000,000, calls on VA to apply industry standards when constructing medical centers, increases congressional oversight, and authorizes the funding of four FY 2015 Major Construction projects.

While the VFW supports this legislation, we would like to make a recommendation to strengthen it. As written, this legislation defines medical facility construction projects with expenditures of more than \$100 million as "super construction projects" that must be fully managed by a non-departmental entity. While the VFW agrees that VA's role in managing major construction projects should be reduced, mandating any project over a specified cap with no waiver process could lead to VA managing projects that would be better suited for a third party manager or prevent it from managing projects that are over the cap which they could clearly manage.

The VFW recommends amending Section 2 to include a waiver clause in the plan and design phase that would allow VA to manage larger projects when appropriate and allow the committees of jurisdiction the authority to insist that below cap projects be managed by a third party. This will provide VA and Congress flexibility in the construction process and prevent the third party management agent from becoming overburdened with VA construction projects.

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



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

Pursuant to Rule XI2(g)(4) of the House of Representatives, the VFW has neither received any federal grants in Fiscal Year 2013, nor has it received any federal grants in the two previous Fiscal Years.

STATEMENT OF

DR. MADHULIKA AGARWAL  
DEPUTY UNDER SECRETARY FOR HEALTH  
FOR POLICY AND SERVICES  
VETERANS HEALTH ADMINISTRATION (VHA)

JANET MURPHY  
ACTING DEPUTY UNDERSECRETARY FOR HEALTH  
FOR OPERATIONS AND MANAGEMENT  
VETERANS HEALTH ADMINISTRATION (VHA)

DEPARTMENT OF VETERANS AFFAIRS (VA)  
BEFORE THE  
SUBCOMMITTEE ON HEALTH  
COMMITTEE ON VETERANS' AFFAIRS  
U.S. HOUSE OF REPRESENTATIVES

July 14, 2015

Good morning Chairman Benishek, Ranking Member Brownley, and Members of the Subcommittee. Thank you for inviting us here today to present our views on several bills that would affect VA health programs and services. Joining us today is Jessica Tanner, General Attorney, Office of General Counsel.

We are providing views on H.R. 353 and H.R. 2464. We are providing views and costs on H.R. 272, H.R. 359, H.R. 421, H.R. 423, H.R. 1688, H.R. 1862, and the draft bill to clarify the role of podiatrists. We do not have cleared views and costs on H.R. 2914, H.R. 2915, and for the draft bill on the Construction Reform Act.

**H.R. 272 Medal of Honor Priority Care Act**

H.R. 272 would place Medal of Honor (MOH) recipients in VA's health care system in enrollment priority group (PG) 1 under the Veteran health care enrollment

priorities established by Congress. Additionally, H.R. 272 would exempt MOH recipients from having to pay copayments for inpatient care, outpatient care, long-term care, and prescription drugs.

VA supports efforts to ensure responsive and appropriate health care for MOH recipients. The MOH recipients have been recognized as extraordinarily courageous Veterans who served their country without regard for their own safety. VA would support legislation designed to recognize their service and ensure that they can receive cost-free care to maintain their health and well-being.

There are currently 79 living recipients of the MOH. Sixty-five are currently enrolled in PG 1 and are not subject to copayments. Placing the remaining MOH recipients, who currently are in PG 2 or 3, in PG 1 will provide equity and further recognition for recipients of this nation's highest military honor.

A change to make MOH recipients copayment exempt would require some system changes to the Veterans Health Information Systems and Technology Architecture (VistA) and the enrollment system, but they would be relatively minor. Because these system changes would be combined with other funded projects, the cost would be insignificant. The MOH recipient population is extremely small and exempting them from copayments would not have any significant impact on our medical care collection fund.

#### **H.R. 353      Veterans Access to Hearing Health Act of 2015**

H.R. 353 would amend 38 U.S.C. § 7401(3) to specifically include Licensed Hearing Aid Specialists among the list of positions that the Secretary may appoint under title 38 of the United States Code. The bill would also allow the Secretary to set

standards for Licensed Hearing Aid Specialists under 38 U.S.C. § 7402(b)(14) and require VA to submit an annual report to Congress about Veterans' access to hearing health services at VA and VA's contracting policies with respect to providing hearing health services to Veterans in non-VA facilities.

Although VA supports the intent of this bill, it does not believe that this bill is necessary as the Secretary already has the authority under 38 U.S.C. § 7401(3) to appoint other specialists, such as Licensed Hearing Aid Specialists, as are needed by VA, and to prescribe standards for these specialists under 38 U.S.C. § 7402(b)(14).

VA provides comprehensive hearing health care services and employs both audiologists and audiology health care technicians who deliver high-quality and efficient hearing health care services to Veterans. VA audiologists are doctoral-level professionals trained to diagnose and treat hearing loss, acoustic trauma and ear injuries, tinnitus, auditory processing disorders, and patients with vestibular complaints.

VA audiology health technicians (commonly known as audiology assistants) perform under the supervision of audiologists. VA audiology health technicians have a broader scope of practice than the typical hearing aid specialist. Examples of the scope of practice for audiology health technicians include: cerumen management; aural rehabilitation; hearing conservation and prevention of noise induced hearing loss; tinnitus management; hearing aids and other amplification technologies including implantable auditory devices; and helping manage Veterans' hearing health care with other health care disciplines in the context of their overarching patient-centered needs.

Apart from having a broader scope of practice than the typical hearing aid specialist, a number of VA audiology health technicians are also licensed hearing aid

specialists. VA currently employs 320 audiology health technicians and believes that with its current hiring authorities, it can successfully meet the demands of Veterans for timely access to hearing health services.

VA is unable to determine the costs of this bill without further consultation with other federal agencies that employ licensed hearing aid specialists (e.g., the Departments of Defense and Health and Human Services) and manage federal personnel, budget, and labor policies (e.g., Office of Personnel Management, Office of Management and Budget, and the Department of Labor).

#### **H.R. 359      Veterans Dog Training Therapy Act**

H.R. 359 would require the Secretary, within 120 days of enactment, to commence a 5-year pilot program under which the Secretary enters into a contract with one or more non-government entities for the purpose of assessing the effectiveness of addressing post-deployment mental health and post-traumatic stress disorder (PTSD) symptoms through a program in which Veterans suffering from PTSD are educated in the training and handling of service dogs for other Veterans with disabilities. The bill would require the Secretary to enter into contracts with non-government entities located in close proximity to a minimum of three and not more than five VA medical centers. The bill requires that the non-government entities be certified in the training and handling of service dogs and have a training area that meets certain enumerated specifications.

The bill also includes provisions concerning the service dogs themselves and the personnel assigned to the program. The bill would require VA to ensure that each service dog in training have adequate temperament and health clearances. Dogs in

animal shelters or foster homes would be considered. The Secretary would be required to ensure that each service dog in training is taught all essential commands and behaviors required of service dogs. The bill would also require each pilot program site to have certified service dog training instructors with preference given to Veterans who have graduated from a residential treatment program and are adequately certified in service dog training. In addition, the bill would require VA to collect data to determine how effectively the program assists Veterans in various areas such as reducing stigma associated with PTSD, improving emotional regulation, and improving patience. Not later than one year after the date of commencement of the pilot program and annually thereafter, VA would be required to submit to Congress a report regarding the number of participating Veterans, a description of the services carried out by the pilot program, the effects of the pilot program in various areas, and recommendations with respect to extension or expansion of the pilot program.

VA supports the identification of effective treatment modalities to address PTSD and other post-deployment mental health symptoms; however, VA does not support the specific provisions in H.R. 359 because VA has significant concerns about the proposed legislation. Although anecdotal evidence has been offered to show the benefits of participating in such a dog training therapy program, there is no published scientific evidence to date that shows that such a program benefits PTSD patients specifically, or that such a resource-intensive program is any better than other therapies known to be effective in alleviating PTSD symptoms. By propagating a yet unproven therapy, the bill may result in unintended and negative consequences for the Veterans who would be participating in this unsubstantiated treatment regime. Also, the pilot program would be

duplicative of the Department of Defense (DoD) study of this same therapy program at the Uniformed Services University of Health Sciences. In addition, the service dog training therapy program currently in place at the Palo Alto VA Medical Center (VAMC) is organized as part of an integrated set of services provided for their in-patient Trauma Recovery Program, and is not offered as a stand-alone program or as an out-patient service. VA has no prior experience in offering or managing such a program as an outpatient program.

VA notes that the bill would also make a number of restrictive stipulations regarding the structure and operation of the pilot program. For instance, contractor service dog trainers would be required to be certified, but there is currently no national certification program for service dog trainers. The bill would also require the contractor to preferentially hire Veterans who have graduated from a PTSD or other residential treatment program and received "adequate certification in service dog training." Such programs at the Palo Alto VAMC and other DoD sites do not provide adequate training to qualify a Veteran as a dog trainer, and they focus on basic commands rather than the advance tasks required by service dogs. The legislation would also require establishing a Director of Service Dog Training who is experienced both in teaching others to train service dogs and has a background in social services, with at least one year of experience working with Veterans or active duty military members with PTSD. These criteria would reduce the number of eligible candidates to almost none.

VA also notes that the proposed legislation prompts the use of shelter or rescue dogs, when statistics indicate that an extremely low proportion of such dogs have the temperament and behavioral characteristics to be a good service dog candidate, and

VA's experience with shelter dogs as service dogs in the Tampa VAMC PTSD service dog pilot study suggests that such dogs should not be considered as service dog candidates. In addition, if any service dogs successfully trained through the program for Veterans with disabilities are to be eligible to participate in VA's service dog medical benefit program, the non-government entities chosen would have to be accredited by Assistance Dog International. Thus, the number of potential non-government entity partners who could produce dogs eligible for VA's service dog medical benefit program would be relatively limited.

VA estimates that this bill would cost \$2,461,222 in fiscal year (FY) 2016 and \$13.3M over five years.

#### **H.R. 421      Classified Veterans Access to Care Act**

H.R. 421 would require VA to establish standards and procedures to ensure that certain covered Veterans, as that term is defined in the bill, are able to access VA mental health care without having to improperly disclose classified information. Guidance on the standards and procedures would be disseminated to Veterans Health Administration employees, including mental health professionals. Lastly, VA would be required to ensure that a veteran would be able to self-identify as a covered veteran on an appropriate form.

VA supports H.R. 421. Veterans who served in classified missions can currently receive mental health services within VA medical treatment facilities safely and with minimal to no risk to national security.

VA mental health providers respect and work within the limits of the information that Veterans can share and within the confines of their clinical confidentiality



requirements and security clearance levels. When VA providers are examining Veterans or active duty personnel with security clearances and exposure to sensitive material, it generally does not prevent the Veteran from being able to discuss their experiences without revealing classified information. Veterans are generally able to engage in treatment irrespective of whether their health care provider has a comparable level (or any) security clearance. Even in exposure-based therapy for PTSD, it is not the case that every detail of the event has to be shared with the provider in order for treatment to be effective.

The Veterans who hold security clearances while receiving services and treatment are the first line of security for protecting classified information. However, VA recognizes the benefit of medical provider sensitivity to Veterans who may have had exposure to non-disclosable classified material. VA agrees that it would be beneficial to establish standards and procedures to ensure that Veterans have access to mental health care in a manner that accommodates the veteran's obligation to not improperly disclose classified information.

VA estimates that there would be minimal costs associated with H.R. 421. VA mental health professionals already deliver mental health services to Veterans and active duty personnel with little or no risk to national security resulting from improper disclosure of classified material. VA's review of current policies to identify improvements would not result in additional cost.

#### **H.R. 423      Newborn Care Improvement Act**

H.R. 423 would amend section 1786 of title 38, United States Code, to increase from seven to fourteen the number of days after the birth of a child for which VA may

furnish covered health care services to the newborn child of a woman veteran who is receiving maternity care furnished by the Department and who delivered the child in a facility of the Department or a another facility pursuant to a Department contract for services related to such delivery. Not later than October 31 of each year, VA would be required to submit a report to the Committees on Veterans' Affairs of the House of Representatives and the Senate on such services provided during the preceding fiscal year, including the number of newborn children who received such services during that fiscal year.

Although VA supports this bill, VA would require additional appropriations to implement this legislation as written. If a full term newborn has fever or respiratory distress after delivery, they may need additional inpatient treatment to manage these complications. This treatment may extend beyond the current 7 days that are allowed in the VA medical benefits package. Additionally it is standard of care for further evaluations during the first two weeks of life to check infant weight; feeding; and newborn screening results. Pending these results, there may be a need for additional testing and follow-up. There are also important psychosocial needs that may apply, including monitoring stability of the home environment, or providing clinical and other support if the newborn requires monitoring for neonatal abstinence syndrome (e.g. withdrawal for maternal drug use during pregnancy). However, VA must carefully consider the resources necessary to implement this bill, including an analysis of the future resources that must be available to fund other core direct-to-Veteran health care services. That consideration includes the budget levels included in the fiscal year 2016 budget resolution adopted by Congress, S. Con. Res 11, as well as the fiscal year 2016

Military Construction/VA appropriations measures passed in the House and awaiting action in the Senate (H.R. 2029). VA estimates that this bill would add additional costs of \$2,300,000 in FY 2016; \$12,700,000 over five years; and \$28,200,000 over ten years.

**H.R. 1356 Women Veterans Access to Quality Care Act of 2015**

Section 2 of H.R. 1356 would require VA to establish standards to ensure that all VA medical facilities have the structural characteristics necessary to adequately meet the gender-specific health care needs, including privacy, safety, and dignity, of Veterans at these facilities. VA would be required to promulgate regulations within 180 days of the date of enactment to carry out this section. Within 270 days of the date of the enactment of the Act, VA would be required to integrate these standards into the prioritization methodology used by VA with respect to requests for funding of major medical facility projects and major medical facility leases. Not later than 450 days after the date of the enactment of the Act, VA would be required to report to the Committees on Veterans' Affairs of the House and Senate on the standards established under this section, including a list of VA medical facilities that fail to meet the standards; the minimum total cost to ensure that all VA medical facilities meet such standards; the number of projects or leases that qualify as a major medical facility project or major medical facility lease; and where each such project or lease is located in VA's current project prioritization.

VA appreciates the intent of section 2 of H.R. 1356, but we do not believe it is necessary given other actions we are already taking. For example, in 2012, VA developed and published a Space Planning Criteria Chapter for Women Veterans

Clinical Service, which provides standards for Women Veterans Clinical services within VA. A standard examination room plan for Women Veterans Clinics was developed including access to bathroom facilities directly connected to the examination room. VA's Medical/Surgical Inpatient Units and Intensive Care Nursing Units Design Guide, developed in 2011 and 2012, addresses the gender-specific needs of women Veterans. These standards are available online at: [www.cfm.va.gov/TIL](http://www.cfm.va.gov/TIL). Moreover, it is unclear why VA would need to promulgate regulations for this section. Absent the requirement in the bill, VA would not need to promulgate regulations. VA's construction standards have been established through policy for years, and revising our standards through this process is less resource intensive and faster than formal regulations.

Section 3 of H.R. 1356 would require the Secretary to use health outcomes for women Veterans furnished hospital care, medical services, and other health care by VA in evaluating the performance of VA medical center directors. It would also require VA to publish on an Internet Web site information on the performance of directors of medical centers with respect to health outcomes for women Veterans, including data on health outcomes pursuant to key health outcome metrics, a comparison of how such data compares to data on health outcomes for male Veterans, and explanations of this data to help the public understand this information.

We do not support section 3 of H.R. 1356. Many important health outcomes, such as mortality and readmission, are normally not reported by gender in hospitals. The inherent problem relates to the difficulty of measurement at individual facilities where numbers of outcome events for women Veterans may be few, which would mean that any findings would not be statistically significant or reliable. VA could report

outpatient experience by gender, but to obtain valid results at the facility level, we would need to implement over-sampling of women Veterans for the Survey of Healthcare Experiences of Patients (SHEP). This would be costly and is likely to be perceived as burdensome on women Veterans.

Furthermore, the Institute of Medicine (IOM), in its report "Vital Signs: Core Metrics for Health and Health Care Progress" (2015), has raised concerns about the increasing burden on providers posed by the proliferation of performance measures. Valid and actionable metrics are difficult and costly to develop and implement. Flawed measures, however well-intentioned, can produce programmatic distortions such as an overly narrow focus on measured activities rather than what is most important to the patient (IOM, p 19). VA already monitors gender-specific performance system wide and has other mechanisms in place, such as site surveys, to ensure equitable provision of care. For these reasons, we do not support inclusion of gender-based outcome measures for evaluating the performance of medical center directors.

Section 4 of H.R. 1356 would seek to increase the number of obstetricians and gynecologists employed by VA. Paragraph (a) of this section would require, not later than 540 days after the date of the enactment of this Act, that VA ensure that every VA medical center have a full-time obstetrician or gynecologist.

VA supports the intent of section 4(a) and is already taking steps to expand access to gynecological care throughout VA. Currently, approximately 78 percent of VA medical centers have a gynecologist on staff, and we plan to add this service at roughly another 20 facilities. This will ensure that all facilities with a surgical complexity of intermediate or complex will have a gynecologist on staff. At facilities with a surgical

complexity designation of standard or less, we do not believe that there is sufficient patient demand to support a full-time gynecologist or obstetrician. For Veterans needing gynecological or obstetric services at these facilities, VA uses its non-VA care authorities to ensure these Veterans are able to access care. Moreover, in some areas of the country, particularly in smaller or more rural areas, VA faces recruitment challenges in hiring new staff, and we anticipate we would face similar challenges if this legislation were enacted.

Paragraph (b) of section 4 of H.R. 1356 would require VA, within 2 years of the enactment of this Act, to carry out a pilot program in not less than three Veterans Integrated Service Networks (VISN) to increase the number of residency program positions and graduate medical education positions for obstetricians and gynecologists (OB-GYN) at VA medical facilities.

VA supports the intent of paragraph (b) of section 4, and is already using authority Congress has previously provided to recruit residents in these fields. Currently, VA funds over 25 OB-GYN residency positions across 32 sites. While gynecologic services are widely available throughout VA, the limited patient population and scope of services at some sites makes broad-based national increases in these residency positions difficult. Additionally, section 301(b) of the Veterans Access, Choice, and Accountability Act of 2014 ("the Choice Act," Public Law 113-146) allows the Secretary to support primary care, mental health, and other specialty residency positions as appropriate. VA is using the authority and resources from the Choice Act to increase OB-GYN residency positions in locations demonstrating significant access issues for Women Veterans, as long as these sites can also demonstrate sufficient

educational infrastructure such as faculty supervision and space, and willing educational program partners. We do not have costs at this time.

**H.R. 1688 To amend the Veterans Access, Choice, and Accountability Act of 2014 to designate 20 graduate medical education residency positions specifically for the study of optometry**

H.R. 1688 would amend section 301(b)(2)(A) of the Veterans Access, Choice, and Accountability Act of 2014 (Choice Act), which requires VA to increase the number of graduate medical education residency positions at its facilities by up to 1,500 positions, to include up to 20 positions designated for residencies in optometry.

We appreciate the intent but VA already has the authority to create additional optometry positions and does not require additional legislation. The VACAA educational expansion is already in year two of a five-year expansion. Shifting its focus to include optometrists will significantly complicate processes that are well underway.

VA anticipates that the total cost for including optometry residents as part of the Choice Act's expansion of graduate medical education residency positions would be approximately \$1,928,195. This cost excludes the current cost of the Choice Act's expansion of graduate medical education residency positions currently being undertaken by VA.

**H.R. 1862 Veterans' Credit Protection Act**

Section 2(a) of H.R. 1862, the Veterans' Credit Protection Act, would require VA to conduct outreach to Veterans regarding how to resolve credit issues caused by delayed payment for emergency health care furnished through non-VA providers. This would include establishing a toll-free number for Veterans to report such issues to the

Veterans Health Administration's Chief Business Office (CBO). The bill, in sections 2(b) and (c), would also require VA to submit to Congress reports on the effectiveness of CBO in providing timely payment for non-VA emergency care (annually) and the number of pending claims for reimbursement (quarterly). Finally, section 2(d) of the bill would require the Comptroller General of the United States to conduct a study of the effectiveness of CBO in providing timely payments for emergency health care furnished through non-VA providers. VA supports this proposed legislation as written.

In some instances, Veterans' credit histories have been negatively impacted as a result of VA's late payments to providers for emergency hospital care, medical services, or other emergency health care furnished through non-VA providers. Several strategies and actions are already underway to improve claims processing timeliness including expediting the filling of vacancies, utilizing claims processing support teams, and employing overtime for existing staff to process backlog claims and address growing claims volume. In addition to these short term solutions, VHA is deploying several longer-term improvement strategies. This legislation would provide for consistent reporting regarding the timeliness of claims processing, number of claims reimbursed or denied, interest penalties paid, and Veterans' adverse credit actions reported to VA, as well as comments regarding delayed payments made by medical providers. Establishing this reporting would result in improved relationships with Veterans and providers, by decreasing negative reporting of financial information on a Veteran's credit history as a result of delayed payment by VA; improving timeliness of payments to providers; decreasing interest payments by VA; and protecting Veterans' credit.



At this time, the cost of establishing a toll-free number as required by section 2(a) is not known. We do not have costs at this time.

**H.R. 2464 Demanding Accountability for Veterans Act of 2015**

H.R. 2464 would add a new section 712 to title 38 of the United States Code. Under section 712(a), as proposed by the bill, a report issued by VA's Office of Inspector General (OIG) would be accompanied by two lists: (1) a list of changes that were made to the report at the recommendation of the Secretary and (2) a list of names of managers responsible for issues addressed in the OIG report. Section 712(a) would require that the OIG send a copy of the report, including both lists, to the Committees on Veterans' Affairs of the Senate and House of Representatives at the same time that the OIG transmits the report to the Secretary.

Section 712(b)(1) would require that the Secretary: (1) notify a manager within seven days after the Secretary receives an OIG report, about the issues for which the manager is responsible; (2) direct the manager to resolve the issues identified in the OIG report; and (3) provide the manager with appropriate counseling and a mitigation plan with respect to resolving the issues identified in the OIG report.

Section 712(b)(2) would require the Secretary to evaluate actions taken by a manager in response to issues raised in an OIG report when reviewing the manager's performance. Section 712(b)(3) prohibits the Secretary from granting a performance award to any manager, identified by the OIG as being responsible for an issue in an OIG report, if an issue raised by the OIG is unresolved.

H.R. 2464 would curtail the Secretary's authority to properly manage VA and its employees, negatively affect employee morale, and adversely impact the collaborative

process between the Inspector General and the Secretary. Consequently, VA does not support this bill.

With regard to section 712(a), views on this section may be best addressed by the OIG. VA is extremely concerned that this section would have an adverse effect on the relationship between the Secretary and the OIG and would contravene the deliberative process component of executive privilege by requiring the disclosure of pre-decisional intra-Executive Branch deliberations. Requiring the OIG to explain changes that were made to a draft report at the recommendation of the Secretary would impede the deliberative process that occurs prior to the OIG finalizing its report. The deliberative process allows an agency, of which the OIG is a component, to talk freely within itself prior to reaching a decision or conclusion. Section 712(a) also presents other practical challenges, such as identifying responsible managers when issues are more systematic rather than related to the misconduct or performance failure of a manager.

Sections 712(b)(1), (b)(2), and (b)(3), raise a number of shared practical concerns. For example, the sections do not take into account OIG reports where the Secretary disagrees with the findings of the OIG or only partially concurs with the OIG's findings. Requiring an employee to take an action in accordance with the OIG's findings in these circumstances is tantamount to the Inspector General managing VA rather than the Secretary. The sections also do not take into account OIG reports that require actions involving multiple federal agencies (e.g., the Department of Defense). In these cases, VA managers may not be given performance awards until the matter has been resolved. This leads VA into an accountability problem, which is that a manager is now

being held accountable for actions above and beyond his or her control. This would not only penalize the manager for actions that he or she cannot control it would also have a negative impact on employee morale.

For the foregoing reasons, VA is unable to support the bill. VA is also unable to determine the costs for this bill.

**H.R. XXXX To amend title 38 to clarify the role of podiatrists in VA**

This bill would amend the term "physician" under chapter 74 of title 38, United States Code, to include podiatrists. Under this bill, VA would treat podiatrists in a similar fashion to VA physicians for the purposes of pay, recruitment, and retention.

VA supports this bill as a way of improving its ability to recruit and retain podiatrists at its facilities. VA anticipates that the salaries and benefits for podiatrists under this bill would go up from \$69,646,104 to \$74,096,352 in FY 2016 and from \$392,264,620 to \$417,330,788 over five years.

This concludes out statement, Mr. Chairman. We would be happy now to entertain any questions you or the other members of the Subcommittee may have.

THE AMERICAN ACADEMY OF AUDIOLOGY AND THE AMERICAN SPEECH-LANGUAGE  
ASSOCIATION

Regarding H.R. 353

The American Academy of Audiology (Academy) and the American Speech-Language-Hearing Association (ASHA) respectfully submit this joint statement for the record in opposition to H.R. 353, a bill that would permit the VA to hire hearing instrument specialists to deliver hearing healthcare services that currently can be provided only by or under the supervision of a licensed audiologist. While we appreciate and support the intent of the bill's sponsors to ensure appropriate access to hearing health services by our nation's veterans, we do not believe that the legislation will accomplish this goal or address problems that may exist related to wait times for hearing aids or hearing healthcare services.

Hearing loss is one of the top service related disabilities for veterans and requires complex and comprehensive treatment. While noise-induced hearing loss is common, veterans frequently present with complex auditory and vestibular pathologies that may be exacerbated by tinnitus, traumatic brain injury, or post-traumatic stress disorder. This complexity is further intensified by the increased number of veterans with combat-related hearing loss.

The provision of hearing aids is neither simple nor straightforward. As with all technologies, the technology of hearing aids is becoming increasingly more complex, and the options beyond hearing aids, such as streaming capabilities, direct audio input, or Bluetooth coupling, are becoming more numerous. Coupled with advances in understanding complex ear-brain interactions, the provision of hearing aids requires advanced education and training to effectively serve our veterans.

Audiologists are doctoral-level professionals who are qualified to evaluate the effects of acoustic trauma and ear injuries on hearing, and to diagnose and treat tinnitus, hyperacusis, vestibular issues, auditory processing disorders, and hearing loss. Audiologists can determine appropriate sound amplification devices and systems as well as select, evaluate, fit and verify the performance of all amplification devices, including hearing aids. More importantly, audiologists are trained to determine the appropriate treatment program for hearing loss—which may or may not include hearing aids—and to evaluate the effectiveness of the treatment. The VA currently employs more than 1,100 audiologists.

Hearing aid specialists are trained in the fitting of hearing aids. While some states require a college-level associates degree as a minimum educational requirement to become a hearing aid specialist, many states still require only a high school diploma. Further, there are no national standards or dedicated curricula that outline the core competencies of a hearing aid specialist. In its testimony before the committee last year on legislation similar to H.R. 353, the Veterans Affairs Administration expressed concern that the lack of standardized education for hearing instrument specialists could lead to fragmented hearing healthcare services and limit delivery of comprehensive care. Given the minimal training required to become a hearing instrument specialist in comparison to the rigor of training for an audiologist, this provider type is poorly equipped to deliver the level of care that veterans require. Veterans would not be well served by expanding the list of eligible providers to include hearing aid specialists. Indeed, we believe the legislation could result in a compromise in the quality of hearing healthcare services that already exists for veterans.

Another career classification for hearing aid specialists as proposed by H.R. 353 is unnecessary and administratively burdensome. Hearing aid specialists can now be hired under the Health Aid and Technician Series 0640 of title 5. The level of education and training for hearing aid specialists is consistent with the knowledge, skills, and abilities of health technicians who work in VA audiology clinics under the supervision of an audiologist. Many VA audiology health technicians are hearing aid specialists. The VA also has the capability to contract services from hearing aid specialists “where timely referral to private audiologists or other VHA facilities is not feasible or when the medical status of the veteran prevents travel to a VHA facility or a private audiologist”. VHA Handbook 1170.02. Section 1170.02 defines the role of the audiology health technician, in part, to increase productivity by reducing wait times, to enhance patient satisfaction, and to reduce costs by enabling health technicians to perform tasks that do not require the professional skills of a licensed audiologist. The job of these technicians includes, for example, checks of hearing aids and other amplification devices, trouble shooting and minor repairs to hearing aids, ear molds and other amplification devices and electroacoustic analysis of hearing aids. No modification of existing law is needed for the VA to hire or contract with hearing aid specialists, consistent with their scope of practice.

The Academy and ASHA are aware that the VA Office of Inspector General (OIG) report dated February 20, 2014, found that the VA was not timely in issuing new hearing aids to veterans or in meeting timeliness goals to complete hearing aid repair services. We are hopeful that the Veterans Access, Choice, and Accountability Act, enacted on August 7, 2014, will help to address access to care issues that may exist within the VA. Our organizations stand ready to provide assistance to the VA and the committee in developing a sustainable and workable system that ensures quality care and outcomes to our veterans. To that end, we would propose that the committee consider granting the VA the authority to hire more audiologists. There is no shortage of audiologists seeking employment with the VA. We would also propose that the committee consider authorizing additional funding both to hire additional audiologists for the VA and to contract with private audiologists.

The American Academy of Audiology is the world's largest professional organization of, by, and for audiologists. The active membership of more than 12,000 is dedicated to providing quality hearing care services through professional development, education, research, and increased public awareness of hearing and balance disorders.

The American Speech-Language-Hearing Association is the national professional, scientific, and credentialing association for 182,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students. ASHA supports its members through professional development, research, advocacy and public awareness of communication, hearing and balance disorders.

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#### CHILDREN OF VIETNAM VETERANS HEALTH ALLIANCE

Chairman Benishek, Ranking Member Brownley, and other distinguished members of the subcommittee, thank you for the opportunity to share Children of Vietnam Veterans Health Alliance's stance on H.R. 353, before you today.

Children of Vietnam Veterans Health Alliance (COVVHA) is committed to serving as a voice for the children of Vietnam veterans, including second and third generation victims of Agent Orange and Dioxin Exposures worldwide. We believe in empowering each other to hold the companies and governments responsible for causing so much devastation and suffering to our generations.

On behalf of COVVHA, I am writing to express our appreciation for the House Veteran's Affairs Committee Subcommittee on Health's efforts on H.R. 353, which would increase veterans' access to hearing healthcare services by enhancing the Department of Veterans Affairs' (VA) ability to utilize hearing aid specialists.

In a February 2014 audit of hearing aid services, the VA's Office of Inspector General found that new hearing aids were not being issued in a timely manner and that the VA was failing to meet its five day timeliness goal. Inadequate staffing was partially attributed to the delays in hearing service.

It is particularly troubling that the VA has not created an appropriate staffing model to meet the ever growing need for hearing services amongst veterans. With hearing loss and Tinnitus continuing to be the most prevalent service-connected disabilities affected veterans who receive disability compensation, failure to adjust staffing is unacceptable.

This legislation would allow the VA to hire hearing aid specialists—an ability the VA currently does not have the authority to do—and ask that the VA report back to Congress on an annual basis regarding wait times and the number of audiologists, hearing aid specialists and hearing techs hired by the VA. It truly is a common sense piece of legislation that would help deal with the current backlog faced by many of our nation's veterans.

As you may be aware, COVVHA expressed our support for H.R. 353 in a letter addressed to Congressmen Duffy, Ruiz, and Walz on following the bills introduction in the 114th Congress and we continue to strongly support the bill. We believe that passage of this bill will help those Veterans in need of hearing aids, who are unable to access them due to physical limitations, long distances to VA facilities, and long wait times for appointments.

Sincerely,  
 Kelly L. Derricks,  
 Founder and President,  
 Daughter of Vietnam Veteran Harry C. Mackel, Jr., U.S. Air Force (deceased).

## INTERNATIONAL HEARING SOCIETY ON H.R. 353

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

International Hearing Society thanks you for the opportunity to comment on H.R. 353. IHS stands in full support of the bill, which would create a new provider class for hearing aid specialists within the Department of Veterans Affairs (VA), thereby enabling the VA to hire hearing aid specialists to help deliver hearing aid services to Veterans. The bill would also require the VA to report annually to Congress on appointment wait times and the utilization of providers for hearing-related services, which would make the VA's efforts to address the backlog more transparent and provide much needed data to inform Congress about Veterans' experiences in accessing hearing aid services through the VA.

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

The VA continues to see a dramatic rise in the demand for audiology services. According to the VA the number of unique Veterans that received VA audiology services in FY 2014 was 903,075, an increase of 19% since 2011, with 52,138 new Veterans in 2014 alone (a 5.8% increase).<sup>1/2</sup> The number of hearing aids ordered per year by the VA has also dramatically increased with more than 800,000 ordered in 2014,<sup>3</sup> up 34% since 2011.<sup>4</sup> With tinnitus and hearing loss being the two most prevalent service-connected disabilities for veterans receiving federal compensation combined with the aging Veteran population, the demand will continue to rise. And despite clinical audiologist-hiring within the VA following a similar growth track with a 26% increase in staffing between 2011 and 2015,<sup>5</sup> the high demand and subsequent backlog continue to affect the VA's ability to deliver timely and high-quality hearing healthcare.<sup>6</sup>

IHS and its members have a great deal of respect for VA audiologists. They provide a wide variety of critical services to our Veterans, including compensation and pension exams (over 151,000 performed in 2012),<sup>7</sup> programming and providing support for cochlear implant implantation and use, vestibular (balance) disorder services, tinnitus services, hearing conservation, hearing aid services and assistive device use, and advanced hearing testing. They also partner with several medical disciplines and are part of the Traumatic Brain Injury and Polytrauma teams, addressing balance and auditory issues. Further, VA audiologists also responsible for training and supervising audiology health technicians.

The high demands on VA audiologists' time and expertise means that the VA is not currently able to meet all Veterans' needs for hearing healthcare services. To that point, in February 2014, the VA Inspector General released a report, "Audit of VA Hearing Aid Services" that found that "during the 6-month period ending September 2012, VHA issued 30 percent of its hearing aids to veterans more than 30 days from the estimated date the facility received the hearing aids from its vendors." The audit also found that deliveries of repaired hearing aids to Veterans were subject to delay partially due to "inadequate staffing to meet an increased workload, due in part to the large number of veterans requiring C&P audiology examinations." Further, in an April 2015 presentation to the Institute of Medicine's Committee on Accessible and Affordable Hearing healthcare for Adults, VA Rehabilitation and Prosthetic Services Department Chief Consultant, David Chandler, PhD, cited that "nearly half of all patients awaiting care in the VA are for audiology services."

In a practical sense, as a result of the backlog and delays, many Veterans are experiencing long wait times for appointments, shortened appointments, and limited follow-up care and counseling. Hearing aid specialists are observing an increase in the number of Veterans who seek care in their private offices as well. These Vet-

<sup>1</sup>David Chandler, PhD, "Perspective from Department of Veterans Affairs," Presentation to the Institute of Medicine's Committee on Accessible and Affordable Hearing healthcare for Adults, April 27, 2015. Lucille Beck, PhD, "Meeting the Challenges of VA Audiology Care in the 21st Century," presentation to the Association of VA Audiologists, March 19, 2012.

<sup>3</sup>Chandler, "Perspective from Department" (see footnote 1).

<sup>4</sup>Beck, "Meeting the Challenges" (see footnote 2).

<sup>5</sup>Chandler, "Perspective from Department" (see footnote 1).

<sup>6</sup>Beck, "Meeting the Challenges" (see footnote 2).

<sup>7</sup>VA Office of Inspector General, "Audit of VA's Hearing Aid Services," February 20, 2014.

erans request hearing aid specialists' help with hearing aid adjustments and repairs, oftentimes because they do not want to wait for the next available VA appointment, which may be months away, or because the distance to the closest VA facility that offers audiology services is too far to travel. There are also many Veterans who choose to purchase hearing aids at their own expense through a private hearing aid specialist, rather than using the benefits they've earned and are entitled to, because they want to work with someone local who they trust and ensure their hearing aids are properly programmed, address their loss, and can be adjusted or repaired in a timely fashion. This relationship also enables them to obtain support from their hearing professional on demand, which is important to those with daily commitments or who are employed, and is especially critical to those who are new users of hearing aids. For a point of reference, in the private market, a new user would typically see their hearing aid specialist 4–6 times in the first three to six months to help them to adapt to a hearing world and optimize their success with hearing aids.

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

H.R. 353 provides the VA a much needed solution by creating a new provider class for hearing aid specialists to work within the VA. Hearing aid specialists can help the VA hearing healthcare team by providing hearing aid evaluations; hearing aid fittings and orientation; hearing aid verification and clinical outcome measurements; customary after care services, including repairs, reprogramming and modification; and the making of ear impressions for ear molds—just as they are currently authorized to do in the VA's fee-for-service contract network.

By adding hearing aid specialists to the audiology-led team to perform these specialized hearing aid services independently, audiologists will be able to focus on Veterans with complex medical and audiological conditions, as well as perform the disability evaluations, testing, and treatment services for which audiologists are uniquely qualified to provide—thereby maximizing efficiency within the system and supporting the team-based approach, a common model in the private market. Adoption of the hearing aid specialist job classification at this juncture will also be advantageous given the fact that VA Audiology and Speech Pathology Service management will be developing staff and productivity standards as a result of the Inspector General's audit and recommendations,<sup>8</sup> and would be able to consider the use of hearing aid specialists as they develop their model.

Also, by virtue of the report language in H.R. 353, which would shine a light on the VA's utilization of hearing aid specialists in its contract network, it is our hope that the VA would take better advantage of this willing and able provider type to help address the need for hearing aid services. To open up additional points of access, the VA can and should eliminate unnecessary policy restrictions that impact VA clinics' abilities to utilize hearing aid specialists in the contract network.

#### HEARING AID SPECIALIST QUALIFICATIONS

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

Training for the profession is predominantly done through an apprenticeship model, an accepted and appropriate path given the hands-on and technical skill involved in the profession. And while licensure requirements vary from state to state, in addition to the apprenticeship experience, candidates generally must hold a minimum of a high school diploma or an associate's degree in hearing instrument sciences. These requirements merely create a floor, evident in the fact that 87% of hearing aid specialists have obtained some college coursework, or an associates or

<sup>8</sup>VA Office of Inspector General report "Audit of VA's Hearing Aid Services," February 20, 2014.

higher academic degree.<sup>9</sup> In nearly every state, candidates must pass both written and practical examinations, and in many states a distance learning course in hearing instrument sciences is required or recommended. Ultimately, when making hiring decisions, the VA will have the ability to determine which candidates meet their needs.

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

Finally, evidence shows that there is no comparable difference in the quality and outcomes of hearing aid services based on site of service or type of provider (audiologist or hearing aid specialist). A well-respected industry study found that instead the best determinant of patient satisfaction is whether the provider used best practices like fit verification, making adjustments beyond the manufacturer's initial settings, providing counseling, and selecting the appropriate device for one's loss and manual dexterity.<sup>10</sup>

#### VA STRATEGIES TO ADDRESS DEMAND

To address the demand for audiology and hearing aid services, the VA has been relying on the use of teleaudiology, audiology health technicians, and contract audiologists outside the VA setting. While IHS applauds the VA for its efforts to better serve the needs of Veterans, each of these strategies has its limitations. Though teleaudiology can make audiological services more available in remote settings, the cost of staffing and facilities are needlessly high, especially given that hearing aid specialists have fully-equipped offices, oftentimes operate in rural settings, and perform home and nursing home visits. Audiology health technicians have a very limited scope of duties, which does not include hearing aid tests or the fitting and dispensing of hearing aids, and they must be supervised by audiologists. Hiring hearing aid specialists to work as health technicians, as the VA currently does, significantly limits their role and effectiveness. Finally, increased reliance solely on audiologists may also limit access as there are not enough audiologists to fill the current and future need for hearing care services. In order to fill the need, the number of licensed audiologists needs to double in size within the next 30 years to 32,000; however only about 600 are entering the profession annually. Even the best case scenarios for increasing the number of graduates and reducing attrition still fall short.<sup>11</sup>

In a June presentation, VA Deputy Chief Patient Care Services Officer for Rehabilitation and Prosthetic Services, Dr. Lucille Beck, PhD, cited several barriers to the delivery of hearing healthcare services for the VA, including "Some VA sites having space constraints that challenge expansion of current audiology services", "Some veterans are very old or sick and cannot travel outside of the home", and "Lack of developed hearing healthcare networks and standards for VA to partner with the community." In each of these areas, hearing aid specialists, both internally and through their expanded use in the fee-for-service network can help.

As the federal government seeks to become more efficient and cost-effective, we urge the Subcommittee to pass H.R. 353, which will round out the VA hearing healthcare team to mirror the private-market model, and increase Veterans' access to care, improve overall quality, and reduce cost. Again, using hearing aid specialists as health technicians is not the answer; this limits service delivery and underutilizes the skills and expertise hearing aid specialists can offer to the VA hearing healthcare team. Now is the time to embrace hearing aid specialists in the role they are trained and licensed to play to help meet the hearing healthcare needs of our Veterans, which will only continue to rise in the coming years.

<sup>9</sup> International Hearing Society, Health Policy and Payment Survey, June 2013.

<sup>10</sup> MarkeTrak VIII: The Impact of the Hearing Healthcare Professional on Hearing Aid User Success, The Hearing Review, Vol 17 (No.4), April 2010, pp. 12–34.

<sup>11</sup> Demand for Audiology Services: 30-Yr Projections and Impact on Academic Programs, Journal of the American Academy of Audiology, Ian A. Windmill and Barry A. Freeman, 24:407–416, 2013.



Thank you for your consideration and for your service to our Veterans. With questions, please contact government affairs director Alissa Parady at 571-212-8596 or *[aparady@ihsinfo.org](mailto:aparady@ihsinfo.org)*.

NATIONAL MEDICAL ASSOCIATION, SUBMITTED BY LAWRENCE SANDERS, JR., MD,  
MBA

On behalf of the National Medical Association (NMA), I am pleased to express our support for H.R. 353, aimed at improving hearing healthcare services and outcomes for our nation's Veterans. We acknowledge that Veterans' hearing healthcare needs could be better served through increased access to services and improved quality of care, and believe that hearing aid specialists can help accomplish this goal. Specifically, we support the inclusion of hearing aid specialists as a provider class within the Department of Veterans Affairs (VA). NMA also supports the lifting of restrictions that currently limit the circumstances in which the VA can contract with hearing aid specialists to provide hearing aid services to VA-eligible Veterans, and in doing so create parity with audiologists for the provision of VA-hearing aid services.

Founded in 1895, the NMA is a national, professional and scientific organization representing over 30,000 African American physicians who are committed to improving the quality of health among minorities and disadvantaged people through its membership, professional development, community health education, advocacy, research and partnership with federal and private agencies. The NMA advocates for policies that would assure equitable and quality healthcare for all people.

Hearing aid specialists are a member of the hearing healthcare team, comprised of otolaryngologists, audiologists, and hearing aid specialists; and are credentialed by all 50 states through licensure to perform hearing tests and provide hearing aid dispensing and fitting services. By integrating this team member into the VA provider system and utilizing the team-based approach, NMA believes service delivery can become more efficient and effective for the Veterans who are currently enrolled and those who will be transitioning into the VA system in the years to come. Further, increasing the external network of VA hearing healthcare providers to include hearing aid specialists would improve Veterans' access to convenient, comprehensive, and timely care; and would provide them the standard of care that currently exists in the public marketplace.

It is for the aforementioned reasons, that the National Medical Association respectfully urges the Subcommittee and full Committee to pass H.R. 353 favorably. Thank you.

**STATEMENT FOR THE RECORD  
PARALYZED VETERANS OF AMERICA  
FOR THE  
SUBCOMMITTEE ON HEALTH  
OF THE  
HOUSE COMMITTEE ON VETERANS' AFFAIRS  
CONCERNING  
PENDING LEGISLATION**

**JULY 14, 2015**

Chairman Benishek, Ranking Member Brownley, and members of the Subcommittee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to present our views on the broad array of pending legislation impacting the Department of Veterans Affairs (VA) that is before the Subcommittee. No group of veterans understand the full scope of care provided by the VA better than PVA's members—veterans who have incurred a spinal cord injury or disease. Most PVA members depend on VA for 100% of their care and are the most vulnerable when access to health care, and other challenges, impact quality of care. These important bills will help ensure that veterans receive timely, quality health care and benefits services.

**H.R. 272, “Medal of Honor Priority Care Act”**

PVA supports H.R. 272, “Medal of Honor Priority Care Act,” to amend title 38 of the United States Code to move Medal of Honor recipients from priority group three to group one for enrollment in the Department of Veterans Affairs (VA) health care system. Currently, under Section 1705(a)(3), Medal of Honor awardees are listed in priority group three. As our most revered and decorated veterans, awarded for valor in action against an enemy of the United States, they deserve nothing less than to be granted rapid access to hospital care and the highest possible quality medical services.

**H.R. 353, the “Veterans’ Access to Hearing Health Act of 2015”**

PVA supports H.R. 353, the “Veterans’ Access to Hearing Health Act of 2015,” legislation to amend title 38, United States Code, to clarify the qualifications of hearing aid specialists of the Veterans Health Administration of the Department of Veterans Affairs. Hearing loss and tinnitus are the most common service-connected disabilities treated by VA healthcare. Demand for hearing services has increased, dramatically, over recent years. This is due to the large cohort of aging veterans compounded by a newly returned veteran population from the most recent conflicts. With limited resources VA cannot meet the demand in a timely manner. Currently, hearing aid specialists are not authorized by VA as an approved care provider, and as such, VA can only procure hearing services from an audiologist. Authorizing hearing aid specialists would expand VA’s network of providers and reduce veterans’ need to travel long distances.

**H.R. 359, the “Veterans Dog Training Therapy Act”**

PVA supports H.R. 359, the “Veterans Dog Training Therapy Act.” This legislation would require the Department of Veterans Affairs (VA) to contract with certified non-government entities to test the effectiveness of addressing veterans’ post-development mental health and post-traumatic stress disorder (PTSD) symptoms through training service dogs for fellow veterans with disabilities.

PVA knows that service animals provide tremendous benefits for many veterans living with disabilities. The benefits of service animals are multi-faceted. Service animals promote

independence for veterans with disabilities and help them to break down barriers in their communities. Many PVA members have personally experienced these benefits. The Veterans Dog Training Therapy Act will allow VA to explore potential therapies for veterans with certain mental health issues to include training of service animals. Not only could this provide additional treatment options for veterans living with PTSD and other similar conditions but it will provide highly trained service animals for veterans living with disabilities. Requiring VA to contract with non-government entities that have expertise in training service animals will ensure that VA is able to test the effectiveness of the pilot without having to develop its own service dog training program. We believe that this construct will provide the conditions that lead to effectively trained service animals for veterans with disabilities.

#### **H.R. 421, the “Classified Veterans Access to Care Act”**

PVA supports H.R. 421, the “Classified Veterans Access to Care Act,” which proposes to improve the mental health treatment provided by the VA to veterans who served on a classified mission. It is PVA's position that all VA mental health care should meet the specific, individual need of the veteran seeking medical services on a consistent basis. The VA should also ensure that veterans seeking mental health services have access to care options provided in appropriate settings. This is particularly important for veterans who served on classified missions. This particular cohort of veterans should not be compromised by inappropriate care settings that force them to choose between their duty not to improperly disclose classified information and their access to much needed help. If this legislation is enacted the VA should make a concerted effort to inform veterans of the option to self identify as a “covered” veteran to help provide immediate mental health care, and alleviate any concerns regarding veterans’ military service records not indicating that they participated on classified missions.

#### **H.R. 423, the “Newborn Care Improvement Act”**

PVA supports H.R. 423, the “Newborn Care Improvement Act,” a bill to amend Section 1786 of title 38, United States Code, to authorize hospital stays of up to 14 days for newborns under VA care. The current provision allows for a maximum stay of seven

days. As the average hospital stay for a healthy newborn is two days, H.R. 423 would provide enormous relief for families facing complications immediately after birth or severe infant illness.

**H.R. 1356, the “Women Veterans Access to Quality Care Act of 2015”**

PVA supports H.R. 1356, the “Women Veterans Access to Quality Care Act of 2015.”

This bill would establish structural standards in VA health care facilities that are necessary to meet the health care needs of women veterans. Implementation of this bill would generate a report to the House and Senate Veterans’ Affairs Committees listing the facilities that fail to meet these standards and the projected cost to do so. VA would be required to publish the health outcomes of women in each facility, juxtaposed with the men that facility serves. VA would be required to hire a full-time obstetrician or gynecologist at every VA Medical Center, and pilot an OB-GYN graduate medical education program to increase the quality of and access to care for women veterans. The women veteran population who use VA health care nearly doubled between 2003 and 2012, from 200,631 to 362,014. By 2040, it is expected to double again. Given this projection, VA must increase their capacity to meet the needs of women veterans. This legislation is a crucial step in assessing the quality of care women veterans receive and the steps needed to improve it.

**H.R. 1688**

PVA supports H.R. 1688, a bill to amend the Veterans Access, Choice, and Accountability Act of 2014 to designate 20 graduate medical education residency positions specifically for the study of optometry.

**H.R. 1862, the “Veterans’ Credit Protection Act”**

PVA supports H.R. 1862, the “Veterans’ Credit Protection Act.” This bill would require the Secretary of Veterans Affairs to conduct outreach informing veterans of how to resolve credit issues manifested by delayed payments to non-VA care. Further, the Secretary would be required to report on the effectiveness of each Veterans Integrated Service Network (VISN) to pay claims on time. The report would also determine the

worst performing VISNS and require their directors to submit a performance improvement plan.

**H.R. 2464, the “Demanding Accountability for Veterans Act of 2015”**

PVA supports H.R. 2464, the “Demanding Accountability for Veterans Act of 2015.” The bill would require the Secretary of the Department of Veterans Affairs (VA) to identify by name the employee responsible for resolving an issue as identified by a report by the Inspector General. As a “responsible manager” that employee would be made aware of the issue and provided a mitigation plan to rectify the problem. No end of year bonuses would be paid to the responsible manager if an unresolved issue remains. Lastly, if the issue remains at the time of a performance review, VA can terminate the manager’s employment. In light of the seeming glacial pace VA moves to utilize accountability measures in eliminating bad actors, it is clear a more direct means, as outlined in this bill, is necessary.

**H.R. 2914, the “Build a Better VA Act”**

PVA supports H.R. 2914, the “Build a Better VA Act,” as it is consistent with our position on the draft bill, the “Construction Reform Act of 2015.”

**H.R. 2915, the “Female Veteran Suicide Prevention Act”**

PVA strongly supports H.R. 2915, the “Female Veteran Suicide Prevention Act.” This bill would direct the Secretary of Veterans Affairs to identify mental health care and suicide prevention programs and metrics that are effective in treating women veterans. Newly published data by VA determined that female military veterans commit suicide at nearly six times the rate of other women. For young women, ages 18-29, the suicides are twelve times as high. The rate among women veterans nearly reaches the rate of male veterans. The annual suicide deaths for every 100,000 people, male veterans comprised 32.1, and other men 20.9. Among women veterans they comprised 28.7 compared to just 5.2 among other women. This is a particularly concerning statistic since men, on average, are far more likely than women to commit suicide. VA is woefully ill-equipped to address women veterans’ mental health needs, particularly as

relates to risk for suicide. H.R. 2915 would make a first and giant step in addressing these inadequacies.

**Draft bill, to clarify the role of podiatrists in the Department of Veterans Affairs**

PVA supports the draft bill to clarify the role of podiatrists in the Department of Veterans Affairs. Podiatrists at VA are currently classified among optometrists and other allied health professionals, rather than among physicians and dentists. The VA pay scale incorrectly differentiates podiatrists from other physician providers. The resulting salary discrepancies are significant and create further challenges for VA in the recruitment and retention of podiatrists. With a growing aging veterans population, so too is the demand for podiatrists. Parity in pay among other physicians will allow VA to better resource the health care system to meet the demand of veterans needs.

**Draft bill, the “Construction Reform Act of 2015”**

PVA supports the draft legislation to “authorize Department major medical facility construction projects for fiscal year 2015, to amend title 38, United States Code, to make certain improvements in the administration of Department medical facility construction projects, and for other purposes.” In light of the egregious construction management failures in places like Denver, Colorado, Orlando, Florida, and New Orleans, Louisiana, a serious discussion about VA's responsibility in the construction business is finally taking place. The fact is VA construction management reform is long overdue. This bill reflects the critical need for such reform.

PVA particularly appreciates the provision of the bill authorizing the funding for a Spinal Cord Injury (SCI) center in San Diego, California. This project will replace the current 30 acute care beds, outpatient clinic, and therapy clinic at the SCI center while also adding 20 long term care SCI beds for the growing aging population. SCI long term care beds have been identified as a critical shortage across the VA health care system.

This concludes PVA's statement for the record. We would be happy to answer any questions for the record that the Committee may have.



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

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

***Fiscal Year 2015***

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events — Grant to support rehabilitation sports activities — \$425,000.

***Fiscal Year 2014***

No federal grants or contracts received.

***Fiscal Year 2013***

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

**Disclosure of Foreign Payments**

Paralyzed Veterans of America is largely supported by donations from the general public. However, in some very rare cases we receive direct donations from foreign nationals. In addition, we receive funding from corporations and foundations which in some cases are U.S. subsidiaries of non-U.S. companies.



**Statement for the Record  
of  
VetsFirst, a program of United Spinal Association**

**Submitted by**

**Ross A. Meglathery**

**Director of VetsFirst**

**Before the**

**Subcommittee on Health  
Committee on Veterans' Affairs  
United States House of Representatives**

**Regarding**

**H.R. 353**

**July 14, 2015**



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

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

H.R. 353, the Veterans' Hearing Health Act of 2015

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

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

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

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

This legislation would allow VA to appoint hearing aid specialists to assist veterans in receiving quicker access to needed services. These professionals are licensed in their respective states and can provide robust services that include: hearing testing; determining necessity for hearing

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<sup>1</sup> U.S. Department of Veterans Affairs, *Office of Audits and Evaluations*, Audit of VA's Hearing Aid Services ,February 20, 2014.

<sup>2</sup> Ibid.

assistive devices; performing hearing aid adjustments; taking impressions for ear molds, and providing counseling and aural rehabilitation. These hearing aid specialists have received extensive training and hundreds of professionals are currently entering the industry. The legislation's reporting requirements related to wait times and contract referrals will also help identify remaining gaps in hearing care services.

VetsFirst strongly supports H.R. 353.

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

Written testimony submitted by Ross A. Meglathery, Director of VetsFirst, a program of United Spinal Association; 1660 L Street, NW, Suite 504; Washington, D.C. 20036. (202) 556-2076, ext. 7103.

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

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

### **Biography of Ross Meglathery**

Ross Meglathery is the Director of VetsFirst, a program of the United Spinal Association. Ross has been with VetsFirst since April, 2015. Prior to his tenure at VetsFirst, Ross spent over 15 years in the military, Homeland/National Security and private sectors. As a high school student he interned for Representative Ted Weiss in his New York City district office. As a college student he attended Officer Candidates School where upon graduation, he was commissioned a second lieutenant of Marines. Highlights of his active duty career include a deployment to Western Sahara, Africa as a United Nations Military Observer serving as one of 15 US military personnel in a multi-nation contingent. In 2004-05 Ross deployed with the 24<sup>th</sup> Marine Expeditionary Unit (Special Operations Capable) where he received the Combat Action Ribbon and the Purple Heart Medal for wounds received. He deployed once again to Iraq as part of the 2007 Surge in Al Anbar where he performed the duties of a Joint Terminal Attack Controller and led a specialized team in support of US, and Iraqi Army units. For his service, he was awarded the Navy and Marine Corps Commendation Medal with Valor Device. In 2010, Ross was selected as a Congressional Marine Fellow where he worked for Representative Mike Coffman. In this capacity, he worked on Defense, Homeland Security, Veterans, Small Business and Rare Earth Metals issues.

As a reservist, Ross has commanded an artillery battery and currently serves as a lieutenant colonel at MAGTF Staff Training Program.

As a civilian, Ross has worked as a Program Analyst at the Office of Special Programs at the Department of Homeland Security for Intelligence, Surveillance and Reconnaissance matters. Additionally, he has experience with unmanned aerial system policy, test & evaluation, modeling & simulation, intelligence production as a subject matter expert in both the public and private sectors.

Ross is a graduate of Harvard University where he earned a Master in Public Administration. In addition, he holds a Master of Science in the Management of Information Technology degree from the University of Virginia and a Bachelor of Arts in History from Trinity College, Hartford.

In his spare time, Ross volunteers with Deeper Missions an organization devoted to clean energy and safe water in Africa.

Ross serves the Resource Center through VetsFirst's programs to answer veterans' question regarding educational, health, and disability benefits that they deserve based on their service. Additionally, his lobbying efforts support legislation that is designed to address the issues where veterans and disability community issues intersect.



**STATEMENT FOR THE RECORD**

**RICK A. YOUNT, EXECUTIVE DIRECTOR**

**WARRIOR CANINE CONNECTION**

**BEFORE THE**

**SUBCOMMITTEE ON HEALTH**

**COMMITTEE ON VETERANS' AFFAIRS**

**U.S. HOUSE OF REPRESENTATIVES**

**JULY 14, 2015**

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

Thank you for inviting Warrior Canine Connection to provide our view on H.R. 359, the Veterans Dog Training Therapy Act, and to address the need for this legislation. I welcome this opportunity to bring Members of the Subcommittee up to date on this promising therapy for symptoms of Post Traumatic Stress Disorder (PTSD) and Traumatic Brain Injuries (TBI) in combat Veterans.

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



[www.warriorcanineconnection.org](http://www.warriorcanineconnection.org)

the NeuroRestorative Residential Treatment Center in Germantown, MD, and at WCC's "Healing Quarters" in Brookeville, MD.

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

Since launching the first therapeutic service dog training program as a privately funded pilot at the Palo Alto VA Trauma Recovery Program at Menlo Park in July 2008, I have seen significant improvement in symptoms of PTSD and TBI in participating Veterans. In some cases, this safe, non-pharmaceutical intervention has benefitted patients who were not responding to any other treatments being offered by their medical providers. After seven years of operation, there have been no hints of negative outcomes among the several thousand Warriors who have volunteered to participate in the program. In fact, based on the overwhelmingly positive feedback from wounded Warriors and their clinical providers, the program has expanded to several new sites and is being sought by other treatment facilities caring for injured combat Veterans. In response to these encouraging patient outcomes, the House Armed Services Committee included the following language in its report accompanying the 2014 National Defense Authorization Act:

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

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

Congress provided the funding to carry out these studies and DOD researchers have embraced this opportunity to get the science behind the positive patient outcomes that have been reported and observed. WCC is currently collaborating with the Uniform Services University of the Health Sciences (USUHS), NICoE, WRNMMC, and civilian academic experts, to conduct research on the therapeutic service dog training programs at WRNMMC and NICoE. There is a significant amount of published scientific evidence that supports the therapeutic use of dogs in addressing mental health issues. In particular, close positive interactions with animals have been shown to trigger the natural production of oxytocin, often referred to as the calming and connecting hormone. The first collaborative research study on the Service Dog Training Program at WRNMMC is underway and was designed to investigate the neurobiology of the human-animal bond and the treatment of PTSD, including oxytocin levels. A larger research protocol has been developed and is currently going through the Institutional Review Board (IRB) process. It will assess the sense of purpose, accomplishment, emotional regulation, sleep quality, pain reduction, reduced symptoms of depression and anxiety, improved parenting skills and couple relationship of Service Members who have participated in our Service Dog Training Program. We look forward to obtaining the necessary scientific data to establish service dog training as an evidence-based treatment for the invisible wounds of war.

Despite the tragic loss of 22 Veterans to suicide each day, and almost daily news reports of Veterans who say that dog have helped them to deal with symptoms of combat stress, the Department of Veterans Affairs (VA) still does not support the provision of service dogs for psychological injuries. It is my understanding that the VA is waiting for the results of the VA research study mandated by the 2010 National Defense Authorization Act before officials will consider revising VA policy with regard to service dogs for psychological disabilities. Unfortunately, as Subcommittee Members are aware, the VA research study has been significantly delayed and wrought with problems. I believe the current study design is also flawed. As a clinician, I was alarmed to learn of the tasks the VA has required the dogs in the study to perform. They included blocking (standing in front of the Veteran to keep people away), sweeping their homes for and barking at possible intruders, and standing behind the Veteran to watch



their back. In my view, these tasks support symptoms of PTSD by reinforcing cognitive distortions, rather than mitigate them and will distract Veterans from addressing their challenges to fully reintegrate into their communities and families. Clearly there is a need for mental health experts, government policy makers, and service dog industry representatives to come together to develop standards and best practices for service dogs that will support our Nation's Veterans with psychiatric disabilities.

Reportedly, results from the VA research study will not be available until 2019. Meanwhile, hundreds of thousands of returning Service Members and Veterans with psychological injuries and their families are struggling to find treatments that will help heal the invisible wounds of war. Enactment of this legislation will make therapeutic service dog training more widely available and will supplement, not duplicate, research being conducted by the DOD. In fact, this legislation will provide a valuable opportunity for a VA/DoD collaborative effort to study this program at multiple sites.

Service dog training therapy programs at VA and DOD medical facilities offer combat Veterans a continuing mission to help their disabled brothers and sisters while they are receiving treatment, as well as an innovative Animal Assisted Therapy for their invisible wounds. Each dog participating in the program touches the lives of approximately 60 wounded Warriors during training. The Warrior Trainers benefit from the close interactions with the dogs without the responsibilities of ownership. They also learn about the use, care, and training of service dogs. Our program's aim is to help Veterans gain their fullest function and independence. In many cases, Warriors may experience significant improvement in their symptoms, lessening their need for a service dog. When and if Warrior Trainers eventually decide to apply for a service dog to assist them with their disabilities, their experience working with service dogs in training sets them up for success with their new canine partners.

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

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

#### **Collaborative opportunities between VA and DoD**

Warrior Canine Connection is currently operating the therapeutic service dog training program at both VA and DoD treatment centers. Both Departments are individually engaged in funding and carrying out research studies to fully understand the efficacy of using dogs to help Veterans and Service Members with PTSD. Collaboration between the VA and DoD would enhance their individual efforts as well as offer cost sharing opportunities. The Bob Woodruff Foundation sponsored two convenings to focus on the use of service dogs and Animal Assisted Therapy in helping Veterans with the invisible wounds of war. Held in 2013 and 2014, the convenings included VA and DoD policy makers, mental health providers, researchers, service dog SME's, and service dog organizations. The convenings served to foster discussion and future collaboration related to using dogs to support the recovery of returning Veterans. The therapeutic service dog training concept resonated with almost all who attended the convening as an innovative Complementary Alternative Medicine (CAM) modality.

#### **H.R. 359**

As you are aware, legislation to create a VA pilot program on service dog training therapy was approved by the U.S. House of Representatives in the 111<sup>th</sup> and 112<sup>th</sup> Congresses. While VA officials have recognized the therapeutic value of the program at VA Menlo Park, the Department has consistently opposed legislation that would create additional sites and provide collaborative opportunities with the DOD to study the program's efficacy. The Department has indicated that the Secretary does not need Congressional authorization to create a VA pilot program on service dog training therapy, yet since 2008, program services to Veterans at VA Menlo Park have been supported exclusively by private donations.

The provisions of H.R. 359 are based on the original program launched in 2008 at VA Menlo Park through the Recreation Therapy Department. Since that time, service dog training therapy has been incorporated into outpatient as well as inpatient programs at that facility. Consequently, it may be more appropriate at this point to provide the Secretary with more discretion to tailor the pilot program on this CAM modality to the needs of the Veterans at individual pilot sites.

Based on my experience in providing this clinically based therapy, I believe it is best delivered at VA and DOD medical treatment facilities as an adjunctive treatment that complements other modalities. WCC service dog training instructors develop close working relationships with medical providers in these facilities in order to support each patient's clinical goals. The clinical underpinnings of the program have served as the foundation for its success to date. Therefore, it is important that any organization selected to conduct a service dog training therapy program pursuant to this legislation has the necessary clinical expertise to work with wounded Warriors with psychological injuries as well as experience in training industry standard mobility service dogs. It is equally important that these pilot sites are physically located to facilitate collaboration between VA and service dog organization clinical staff.

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

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

**Financial Disclosure Associated with the Statement for the Record of Rick A. Yount, Executive Director,****Warrior Canine Connection**

Rick Yount serves as the Director of the Service Dog Training Program at the National Intrepid Center of Excellence (NICoE) in Bethesda, MD . From January 2013 through July 2014, he was an individual contractor and funding for his services to NICoE and associated program expenses were provided through a NICoE (DoD) subcontract under which he received \$170,589. In 2014, Warrior Canine Connection (WCC) received \$77,696 in funding from a subcontract with NICoE (DoD) to provide the WCC program and service dog training instructors. That NICoE subcontract has provided WCC \$99,700 in 2015. WCC has received \$26,745 from the Henry M. Jackson Foundation in conjunction with its collaborative role in the first DoD research study associated with the WCC program at Walter Reed National Military Medical Center.