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LEGISLATIVE HEARING ON: DRAFT LEGISLATION, THE VETERANS AFFAIRS MEDICAL SCRIBE PILOT ACT OF 2017; H.R. 91; H.R. 95; H.R. 467; H.R. 907; H.R. 918; H.R. 1005; H.R. 1162; H.R. 1545; AND H.R. 1662

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

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

ONE HUNDRED FIFTEENTH CONGRESS

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Wednesday, March 29, 2017

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON DISABILITY ASSISTANCE
AND MEMORIAL AFFAIRS,
Washington, D.C.

The Subcommittee met, pursuant to notice, at 8:01 a.m., in Room 334, Cannon House Office Building, Hon. Brad Wenstrup [Chairman of the Subcommittee] presiding.

Present: Representatives Bilirakis, Radewagen, Dunn, Rutherford, Higgins, Gonzales-Colon, Brownley, Takano, Kuster, O'Rourke, and Correa.

OPENING STATEMENT OF BRAD WENSTRUP, CHAIRMAN

Mr. WENSTRUP. The Subcommittee will come to order. Good morning and thank you all for joining us early this morning for today's Subcommittee legislative hearing. Before I begin I would like to ask unanimous consent for our colleague and fellow Committee Member, Representative Coffman from Colorado, to sit on the dais and participate in today's proceedings. Without objection, so ordered.

This morning we will discuss ten bills that will address a number of issues impacting America's veterans and the health care services that they receive from the Department of Veterans Affairs. These proposals are sponsored by our colleagues both on and off the Committee and from both sides of the aisle, demonstrating the commitment that all of us feel towards improving the lives and well-being of those who have served our Nation in uniform.

I look forward to a thorough discussion of the merits and challenges of each of the bills on our agenda this morning and I am grateful to the bill sponsors, as well as the witnesses from VA and from our veteran service organization partners for being with us today to present their views, which are so critical to informing how we move forward.

Given our ambitious agenda and the early morning hour, I will refrain from commenting on all of the bills that we will discuss today. However, I do want to briefly discuss the bill that I am proud to sponsor, H.R. 1662. H.R. 1662 would prohibit smoking in-

side any Veterans Health Administration facility immediately, and prohibit smoking outside of any VHA facility over the next five years. Legislation enacted in 1992 requires VHA to provide smoking areas for patients and visitors. This is contrary to common practice in private sector hospitals and clinics, most of which adopted 100 percent smoke free policies for their facilities, grounds, and buildings many years ago in recognition of how harmful smoking and secondhand smoke exposure can be for patients, visitors, and employees alike.

I recognize that some veterans and VA employees are smokers and that quitting can be a challenging uphill battle. That is why H.R. 1662 would allow smoking outside of VHA's facilities to be phased out over a five-year period rather than right away. And VA offers a variety of programs and interventions to support those who are trying to kick their smoking habit. And I am hopeful that those who are struggling to quit smoking will take full advantage of those resources.

However, as a doctor and as a veteran I feel strongly that we cannot continue to allow a practice as toxic and damaging as smoking to continue taking place on VA medical facility campuses where our most vulnerable patients are trying to heal and our hardest working employees are trying to work.

H.R. 1662 would ensure that VA is in line with industry standards with regard to smoke free polices, while also ensuring that the money that VA currently spends to maintain designated smoking areas, estimated at more than 1.2 million annually, and the space the VA designates to smoking both inside and outside of VA medical facilities across the country, which VA told me in January couldn't be estimated, can be reallocated to efforts and improve the health of our veterans and employees, rather than an outdated requirement that we know that will continue to harm them.

This is a common sense legislation I hope we will have the support of everyone here today. I would ask unanimous consent to include a letter of support for H.R. 1662 from the Commissioned Officers Association of the U.S. Public Health Service into the record.

Without objection so ordered.

Mr. WENSTRUP. I now yield to Ranking Member Brownley for any opening statements she may have.

OPENING STATEMENT OF JULIA BROWNLEY, RANKING MEMBER

Ms. BROWNLEY. Thank you, Mr. Chairman. And thank you for holding this hearing. We have some great legislation that we are considering today. And your expertise and input, the VA's, and our VSO organizations, their expertise and input is going to be very valuable to us as we consider what changes might need to be made to be of the most benefit to our veterans.

As we near the end of Women's History Month I am pleased that two of my bills that will help our women veterans are being considered today: H.R. 91, the Building Supportive Networks for Women Veterans Act, and H.R. 95, the Veterans Access to Child Care Act. I introduce these two bills because I believe that we should be doing more to ensure our women veterans are able to access the

care they need and work to break down barriers that may be preventing women veterans from receiving VA care.

The Building Supportive Networks for Women Veterans Act will permanently authorize a VA pilot program that offers counseling at a retreat for women veterans who are recently separated from the military. VA's data shows that for the 272 women who have participated in the retreat since 2011, many saw a decrease in symptoms associated with post-traumatic stress disorder, had better coping mechanisms, and scored higher on psychological well-being tests after completion of the retreat. In fact, two months later 84 percent showed a decrease in stress symptoms. Due to the success of this program, I am also interested to hear from the VA and from our VSOs about how this program might be expanded to help other groups of veterans.

I am also glad to see the Subcommittee consider the Veterans Access to Child Care Act, which I introduced with my colleague, Congressman Higgins. This bill will help ensure that veterans do not have to choose between caring for their children and getting the health care they need.

Just yesterday I was able to attend a roundtable with our VSOs, including many of you here today to discuss supporting women veterans, and we discussed this very issue. I heard from many of you about what a challenge the lack of affordable child care can be, especially for women veterans. Since women veterans are more often responsible for caring for their children, lack of convenient and affordable child care can be a barrier for women who need reoccurring mental health care or even intensive care services. That is why I introduced the bill to allow the VA to provide child care services at VA facilities, provide veterans with a stipend for child care, or make direct payments to child care providers for veterans in need of intensive care or mental health treatments.

I hope that VA can provide a better estimate of the necessary resources for his program and some better data on whether lack of child care is creating a barrier for woman veterans to access care at VA facilities. I am also interested to hear more about VFW's idea to include child care services for homeless veterans attending employment training programs. For our homeless veterans or veterans at risk of being homeless, lack of child care can—lack of child care access may pose an even greater challenge to accessing care and receiving additional services and assistance. I hope to work with the VA, the VSOs testifying here today, and our other stakeholders to ensure child care is available to those veterans who need to access VA health care.

Finally, I want to thank my colleagues here today who have introduced legislation intended to improve the lives of veterans and their families. I welcome the input of the VA and our VSOs so that we can continue to work together to develop the best legislation that will achieve this purpose. Thank you, Mr. Chairman, and I yield back.

Mr. WENSTRUP. Thank you, Ms. Brownley. I am honored to be joined this morning by several of my colleagues who are going to be testifying about the bills on our agenda that they have sponsored. I appreciate you all taking time out of your morning to be here with us and for sponsoring legislation to help our veterans.

With us this morning are Representative Jackie Walorski from Indiana, Representative Doug Collins from Georgia, Representative Mike Coffman from Colorado, Representative Steven Knight from California and Representative Ann Kuster from New Hampshire. Chairman Roe, who is sponsoring the draft bill on our agenda, will be joining us shortly and I will recognize him upon arrival.

Representative Walorski, we will begin with you. You're now recognized for five minutes.

OPENING STATEMENT OF HONORABLE JACKIE WALORSKI

Ms. WALORSKI. Thank you. Good morning, Chairman Wenstrup, Ranking Member Brownley. I can say it is an honor to be here. I miss working with you on the official committee, but thanks for hearing this bill today.

This is H.R. 467, the VA Scheduling Accountability Act. First I would like to thank Chairman Wenstrup and Ranking Member Brownley for holding this hearing allowing me to testify on the reintroduction of this bill that we passed last year.

In 2014 news reports uncovering gross mismanagement and scheduling manipulation at a Department of Veteran Affairs Hospital in Phoenix shook us to the core. Through hearings held in this Committee and investigations by the VA Office of Inspector General and Government Accountability Office we substantiated many of the allegations of manipulated scheduling and falsified wait time data at the Phoenix facility.

The manipulation of appointment schedules and data in Phoenix led to at least 40 veterans dying while they were waiting for care. However, three years after this tragedy VA is still plagued with facilities unable to get their act together when it comes to scheduling appointments. Earlier this month the OIG released yet another report that identified flaws in the scheduling system still used by VA facilities nationwide. Instead of owning up to the problems that continue to prevent veterans from getting timely care they need, the new secretary disputed the findings of inaccurate wait times.

We need to let the VA know that we will never give up in holding their feet to the fire. That is why I reintroduced the VA Scheduling Accountability Act. VA Directive 2010–027 is VA's implementation processes and procedures policy for scheduling at their facilities and contains 19 different items on the checklist. The directive requires an annual certification of full compliance with all items on the list. For instance, facilities are required to conduct an annual audit of the timeliness and appropriateness of scheduling actions and the accuracy of desired dates. They are also required to ensure that deficiencies of competency or performance that are identified by the audit are effectively addressed.

In August 2014 OIG report uncovered that in May of 2013 the then Deputy Undersecretary for Health and Operations Management waived the fiscal year 2013 annual requirement for facility directors to certify compliance with the VHA scheduling directive. Allowing facilities to only self-certify reduced oversight over wait time data integrity and compliance with appropriate scheduling practices. This in turn allowed VA's data to be easily manipulated contributing to the wait time scandal. While the VA has reinstated

the certification requirement, there's nothing stopping them from waiving it again.

The VA Scheduling Accountability Act would codify into law that each facility director is required to annually certify compliance with the scheduling directive or any successor directive that replaces it, and would prohibit any waivers in the future.

Should a director be unable to to certify compliance, either because a facility is not in compliance or the director refuses to sign the certification for some other reason, the director must submit a report to the Secretary explaining why the facility is out of compliance. The Secretary will then report yearly to the House and Senate VA Committees with the list of facilities in compliance and those that are not, with an accompanying explanation as to why they were not in compliance. To incentivize a facility's compliance there is a provision that allows the VA Secretary to revoke an award or bonus for non-compliance.

Lastly, the legislation requires that any time VA waives or allows non-compliance with requirements in any other directive or policy beyond scheduling, VA must provide a written explanation for the decision to the House and Senate Veteran Affairs Committee. This will provide more oversight of the department and ensure Congress is aware when VA is waiving these policies. We need this legislation in order to end the reckless practice of avoiding compliance.

I look forward to working with the Members of this Committee, veterans' service organizations in addressing this critical issue. I thank you again today for this opportunity to testify. Thank you, Mr. Chairman.

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

Mr. CHAIRMAN. Thank you very much.

Representative Collins you are now recognized for five minutes.

OPENING STATEMENT OF HONORABLE DOUG COLLINS

Mr. COLLINS. Thank you, General Wenstrup. Thank you

Ranking Member Brownley and the Members of the Subcommittee.

It is my opportunity to introduce this legalization H.R. 907, the Newborn Care and Improvement Act. This bill is—we have come before this Committee before and testified. We are bringing it back again as we go forward. This bill improves the care provided by the Department of Veterans' Affairs to the newborn children of female veterans. And I appreciate your consideration.

In the second inaugural address President Lincoln derived his idea for the VA from scripture stating "The challenge for us is to care for him who shall have borne the battle and for his widow and his orphan." In the 21st century we must apply Lincoln's statement more broadly to "She who hath borne the battle." And the way—one way we can do that is to provide better maternity and newborn care to our female services members.

Historically much of the VA health care system was designed to meet the needs of men. An increasing number of female serve in our military. It is essentially that the VA to expand its services for

the care of female veterans and their families effectively. Our female veterans often need maternity care. And I believe that the Newborn Care Improvement Act is one important way to support these services while honoring their contributions to society.

When the Care Givers and Veterans Omnibus Health Savings—Services Act was signed into law in 2010 it provided short-term newborn care for female veterans who receive maternity care through the VA. Under this law newborns became eligible for up to seven days of care at hospitals covered by the VA. Since then we have learned significantly more about the health care challenges facing female veterans and about the levels of neonatal care that their newborns may require.

According to a 2008/2012 study in one women's health journal, for example, the overall delivery rate of female veterans using VA maternity benefits increased by 44 percent. And a majority of these women had disabilities connected to their military service. A recent December 2016 GAO report found that the maternity care was significantly delayed at approximately 27 percent of VA facilities, according to the facilities' own reports, and that all veterans, including women, face consistent challenges in receiving timely access to care.

We know that we must take action to address access to care issues at the VA, including maternity and newborn medical services. Without congressional action to achieve parity between the number of days new mothers and newborns can receive care covered by the VA, female veterans may be forced to now get complex insurance options and financial decisions even as their child's life is in danger.

I introduce H.R. 907, the Newborn Care Improvement Act to ensure that newborns have access to the care they need, particularly if they are born prematurely or face complications from birth.

As some of you may remember, this was a legislative initiative that I introduced in the 114th Congress. And last Congress this legislation extended the covered VA care for newborns from seven to fourteen days and provided an annual report on the number of newborns who received such care during each fiscal year.

This Congress the bill provides an important improvement to the length of neonatal care that newborns can receive in extending infant's access to medical care from 14 to 42 days. I appreciate the Chairman Roe's influence in this and others of the Committee on this vital addition. This 42-day standard corrects a disparity in the length of the time the VA covers care for mothers and for their newborn children by incorporating an amendment offered by Chairman Roe that was included when the House passed this legislation last year.

I hope that the Committee will once again place the Newborn Care Improvement Act on its markup calendar on behalf of newborns and their mothers. Many of our female veterans have served us at great risk and great personal cost, and these heroes deserve the highest standard of care we can offer. Our responsibility to the women of our armed services do not end because they complete their time of active duty. Any female veteran who chooses to receive maternity or neonatal care at the VA should be confident in the quality of those services.

It is therefore important for us to understand that research has indicated that some female veterans may have unique maternity needs as a result of their military service. One recent study illustrated a link between veterans having PTSD in the year prior to giving birth and a 35 percent increase in the risk of spontaneous premature delivery. This study indicates that PTSD could represent a significant epidemiological risk factor for pre-term delivery.

And this is only one of the health issues that our female veterans may face as a result of their sacrifices they have made as part of the military. Tragically PTSD impacts a substantial number of our female veterans. More than 20 percent of the female veterans in recent conflicts of Iraq and Afghanistan have been diagnosed with PTSD. These diagnoses are not limited to women serving in combat role.

As a father who has a special needs daughter who just turns 25 on Saturday, I know the effect of having that first few weeks or even months being found in a neonatal facility. I know what it is like to have a daughter who went through multiple surgeries and the impact it takes. It should not be an issue for our VA, for our females who have served, and the babies that they bring into this work.

I thank this Committee and I ask for your favorable consideration in markup in moving this bill forward.

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

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

Mr. CHAIRMAN. Thank you, Mr. Collins.

Representative Coffman, you're now recognized for five minutes.

OPENING STATEMENT OF HONORABLE MIKE COFFMAN

Mr. COFFMAN. Thank you, Mr. Chairman.

Thank you for having me at this hearing for H.R. 918, Veterans Urgent Access to Mental Health Care Act. Mr. Chairman, I would like to begin by obviously thanking you for today's legislative hearing. To our witnesses, thank you for your testimony and for ensuring Congress and the American public a better understanding of the challenges facing our veterans today.

As a Marine Corp combat veteran, I would like to live by the rule that we never leave anyone behind. And the Veteran Urgent Access to Mental Health Care Act makes sure that we do not forget those who bravely served our country in their time of need.

Here is what we know for a fact. An average of 20 veterans take their lives daily. Likewise, VA evidence suggests a decrease in suicide risk among those who have received VA health care services, and since 2009 a decrease in those who have had mental health services. And since 2009 the Army has separated approximately 22,000 combat veterans diagnosed with mental health disabilities or TBI for alleged misconduct, leaving them without access to VA's critical mental health care services.

While the correlation between their illness and minor misconduct could be linked, this made no difference to the character of the discharge. Historically a veteran with other than honorable—with an

other than honorable discharge, has been able to seek VA care for a service-connected disability. However, due to the way these veterans were discharged and the failure to connect the dots between the other than honorable discharge and mental health services, this precedent has failed to recognize this problem. My bill will stay with tradition and correct this disconnect by authorizing urgent mental health care to these veterans. And to note, it would not limit VA's existing authority should the VA choose to provide services beyond what is covered in my legislation.

My bill also calls for a third-party study to review the effect of combat service on veteran suicide rates, as well as the rate and method of suicide among veterans who have received health care from the VA and those who have not. Before the rate of veteran suicides increases anymore, we have to make sure that these servicemembers get the critical mental health care they need and that the Nation has a better understanding of why veterans think that taking their own lives is the only way out to end their pain and suffering. This is something that we need to get to the bottom of as quickly and as accurately as possible. My legislation would do that.

Over the years Congress has been looking into inefficiencies and mission disconnect at the VA. And I believe this has been a key disconnect at the VA. It is time to right this wrong and permanently authorize the Secretary to provide initial mental health assessments and urgent mental health care services to veterans at a risk of suicide or harming others regardless of their discharge status. When someone puts on the uniform, they take an oath to defend our freedoms. We, in turn, promise to make sure they receive the care and services they need upon returning from their mission.

Mr. Chairman, thank you for allowing me to testify today on behalf of my legislation. I look forward to continue working with the Committee, as well as our Nation's VSOs to make sure that the men and women in uniform are never left behind. I yield back.

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

Mr. WENSTRUP. Thank you, Mr. Coffman.

Mr. Knight, you're now recognized for five minutes.

OPENING STATEMENT OF HONORABLE STEPHEN KNIGHT

Mr. KNIGHT. Thank you, Chairman Wenstrup and Ranking Member Brownley. Members of the Committee, thank you for the opportunity to testify today on my legislation H.R. 1162, the No Hero Left Untreated Act. We are working to get our military the most advanced weapons, vehicles and equipment in the world in order to defeat any enemy. We owe it to those who selflessly serve to match this commitment to innovation when it comes to their medical treatment when they need it most. Our fighting men and women will always face incredible danger and put their lives on the line in service to our Nation.

PTS and TBI are some of the most prevalent and misunderstood injuries our troops face upon returning home from answering the call to duty. A recent study and many studies have shown that about 20 veterans commit suicide every day. This is unacceptable

and the VA must adopt new ideas to help prevent and decrease veteran suicide rates.

An emerging technology is achieving compelling results in restoring veteran's mental health and shows promising potential to prevent more suicides from needlessly occurring, magnetic EEG/EKG guidance resonance therapy. This reliable effective protocol uses a suite of FDA approved medical innovations to uniquely image the brain, identify areas that may need repair, and most importantly treat sub-optimal regions of the brain with the goal of restoring optimal neurological function using non-invasive neuromodulation. This protocol is an individualized non-pharmaceutical, non-invasive procedure to prevent patient specific application of repetitive magnetic stimulation to help restore proper brain function.

Over the course of several treatments, patients experienced improved quality of sleep, increased motivation and ability to manage stress, improved mood and better concentration and focus. With veteran patients, magnetic EEG/EKG guided resonance therapy has achieved excellence in success rates in both open-label trials and randomized placebo-controlled double-blind studies. In fact, to date 98 percent of veterans in recent trials have experienced at least a 10-point change in their PTS checklist military PCLM score and averaged a 61 percent reduction in symptom severity after four weeks of treatment based on PCLM.

Veterans who depend on the VA can benefit from this treatment, which why I introduced H.R. 1162, the No Hero Left Untreated Act. This bill would establish a pilot program for two VA medical centers to treat 50 veterans using magnetic EEG/EKG guided resonance therapy. It's interesting to note when I bring up the 98 percent and the 61 percent that they have done this on 500 veterans already. So they have seen the therapy work to this date.

The VA is currently behind and unequipped to deal with this growing problem and must take advantage of innovative treatments that can help veterans who struggle with mental health issues. I urge my colleagues to support this vitally important piece of legislation and get our veterans the best treatment possible. Innovation is the key to effectively treat these conditions. And Congress does—can bring this new therapy services like magnetic EEG/EKG guided resonance therapy into the 21st century.

I know that the American Legion has come out with a letter that they said they have not supported this bill yet. I am an American—or a member of the American Legion and we will be working with them closely. And I thank you for this opportunity to testify and I look forward to working with you and providing innovative solutions to treat our brave men and women in uniform.

[THE PREPARED STATEMENT OF REPRESENTATIVE STEPHEN KNIGHT APPEARS IN THE APPENDIX]

Mr. WENSTRUP. Thank you, Mr. Knight, I appreciate that and I appreciate the statistics, and might ask that you submit any study results for the record within five days.

Mr. KNIGHT. Yes, sir.

Mr. WENSTRUP. Thank you.

Representative Kuster, you are now recognized for five minutes.

OPENING STATEMENT OF HONORABLE ANN M. KUSTER

Ms. KUSTER. Thank you, Mr. Chairman and distinguished colleagues of the Subcommittee on Health. And thank you for inviting me to speak on behalf of my proposed bill, H.R. 1545, the VA Prescription Data Accountability Act. My bill would resolve a peculiar problem with the VA's initiative to connect VA medical facilities to state prescription drug monitoring programs.

As you know, in 2012 the VA was authorized by Congress to provide state PDMPs, the prescription data of VA beneficiaries. As a Member of the House Veterans' Affairs Committee and as the Co-Founder and Co-Chair of the bipartisan heroin task force, I recognize that PDMPs are an important tool to prevent the spread of prescription opioids in our communities.

The VA has provided prescription opioids at a rate nearly twice that of the general population. Many veterans utilize both the VA and private providers to meet their health care needs. Additionally, many drugs, excuse me, including opioids can be dangerously and lethally combined with other drugs. Often these lethal combinations are accidental and could have been resolved with better available information. These are the reasons why it is critical to ensure that the VA is fully connected to our state PDMPs.

Thankfully the VA has taken action to connect all its medical facilities to available PDMPs, and all indications are that the VA is on schedule to connect all VA medical facilities with PDMPs. However, the VA has reported that they cannot provide non-veteran data to state PDMPs. This problem is twofold: VA's authority is currently confined to veterans and their dependents, and VA's IT systems cannot distinguish between dependents and non-dependent users of the VA. Consequently, hundreds of thousands of non-veterans do not have their data reported. That would include the largest population of non-veterans, beneficiaries of CHAMP VA, as well as some active servicemembers.

My bill would expand VA's authority to include all VA beneficiaries that are prescribed a drug at the VA. This will close the gap without requiring the VA to update its electronic health records, a process that is neither quick nor inexpensive. Consequently, the VA and the CBO have preliminary reported that my bill would have little to no cost. And thank you for this opportunity to speak on behalf of the legislation.

[THE PREPARED STATEMENT OF REPRESENTATIVE ANN M. KUSTER APPEARS IN THE APPENDIX]

Mr. WENSTRUP. Thank you, Ms. Kuster. At this time I have reviewed these bills have no questions at this time. And I yield to Ranking Member Brownley.

Ms. BROWNLEY. I have no questions either.

Mr. WENSTRUP. All right. Are there any other Committee Members that have questions at this time? If there are none, then the first panel is now excused.

And I now welcome our second panel to the witness table. Joining us is Dr. Jennifer Lee, VA's Deputy Under Secretary for Health for Policy and Services, who is accompanied by Susan Blauert, the Chief Counsel for the Healthcare Law Group; Kayda Keleher, Legislative Associate for the Veterans of Foreign Wars of the United

States; Shurhonda Love, the Assistant National Legislative Director for the Disabled American Veterans; and Sarah Dean, the Associate Legislative Director for the Paralyzed Veterans of America.

And I apologize if I butchered any of those names, but I thank you all for being here today and for your advocacy on behalf of our veterans today and every day. And I look forward to hearing the views of your Members.

We will begin with Dr. Lee. You are now recognized for five minutes.

STATEMENT OF JENNIFER LEE, M.D.

Dr. LEE. Good morning, Chairman Wenstrup, Ranking Member Brownley, and Members of the Subcommittee. Thank you for inviting us here today to present our views on a number of bills that affect VA's programs and services. Joining me today is Susan Blauert, Chief Counsel for the Healthcare Law Group and our Office of General Counsel.

First I want to thank the Members of this Committee and our colleagues from the VSOs for their tremendous support on behalf of our Nation's veterans, especially on a special day like today, which is National Vietnam War Veterans Day. I know that we all share the same goal, to ensure VA provides the best possible care and services that they have so nobly earned.

I would like to focus on several bills on today's agenda that VA supports because they provide us with authorities and flexibilities to better meet the needs of veterans and their families. We would like to note that there are some bills that we do not support because we lack the necessary resources needed to implement them as drafted, have determined that they could lead to potential duplication with existing programs, or have concerns about technical aspects of the bills even as we support their intent.

First, VA strongly supports H.R. 1662, Dr. Wenstrup's bill to prohibit smoking in any VHA facility. VA has proposed legislation for many years to reverse the requirement for smoking areas at VHA facilities and appreciates the Chairman and the Committee's interest in working to accomplish this. We believe veterans and employees should be protected from secondhand smoke exposure at VA health care facilities, as they would be in thousands of other hospitals currently smoke free across the country. While the rate of smoking among veterans is at an all-time low, less than 20 percent of enrolled veterans are smokers, VA supports implementation of this bill in a veteran-centric and compassionate way.

VA appreciates the intent of H.R. 91, which directs VA to provide readjustment counseling services in a retreat setting to women veterans who are separated from military service. Studies show these retreats to be quite successful with participants having improvement in overall psychological well-being and a decrease in PTSD symptoms. We believe the bill could be improved by expanding access to these services to even more veterans and would be happy to provide assistance to that end.

VA also supports H.R. 1545, which directs the Secretary to disclose information about not just veterans, but all covered individuals to state controlled substance monitoring programs. This bill would help ensure VA has authority to be able to fulfill its public

health role in sharing vital clinical information and guiding treatment decisions.

Regarding the draft bill, the VA Medical Scribe Pilot Act of 2017, VA does not support the bill as written because we are currently expanding the use of medical scribes in over a dozen VA facilities and would like the opportunity to evaluate this project for its impact on productivity and patient satisfaction. VA is utilizing a dual role, the health advocate, to service both a health coach and a medical scribe in the primary care setting. And we have obtained early positive results from implementation of this model.

VA supports H.R. 907, expanding access to newborn care in part. VA is particular supportive of the extension of newborn coverage from today's eight through fourteen, as a newborn needing care for a medical condition may require treatment extending beyond the current seven days authorized by law. However, we cannot responsibly support the full extension of newborn services through day 42 without additional appropriations for this specific care. The resources necessary to implement this bill must be carefully considered alongside considerations for resources needed to fund other core direct to veteran services.

H.R. 467 would require each VA medical facility to comply with requirements related to scheduling veterans for health care appointments and to ensure the uniform application of VA directives. VA supports the intent of this bill in terms of ensuring veterans are appropriately scheduled for the care that they need and that scheduling processes are reliable and timely. However, VA needs the flexibility to set scheduling standards that can change and improve over time in step with other changes in the way that transacts as health care.

With regard to H.R. 918, VA definitely supports the principles in this bill and appreciates the leadership of Congressman Coffman and other Members of this Committee in this proposal. Secretary Shulkin, in fact, announced several weeks ago his own intent to expand access administratively to mental health services for former servicemembers with other than honorable discharges. Before finalizing the plan in the summer, VA will continue to seek input from Congress, VSOs, and DoD officials to determine the best way to connect these former servicemembers with the care they need.

My written statement provides the Department's views on the remaining bills. Thank you, Mr. Chairman and Ranking Member for the opportunity to testify before you today. My colleague and I would be pleased to respond to questions you or other Members may have. Thank you.

[THE PREPARED STATEMENT OF JENNIFER LEE, M.D. APPEARS IN THE APPENDIX]

Mr. WENSTRUP. Thank you, Dr. Lee.

Ms. Keleher, you are now recognized for five minutes.

STATEMENT OF KAYDA KELEHER

Ms. KELEHER. Chairman Wenstrup, Ranking Member Brownley, and Members of the Subcommittee, on behalf of the men and women of the VFW and our auxiliary I would like to thank you for the opportunity to present our legislation pending before the Sub-

committee. The VFW supports and thanks the Subcommittee for their consideration of Building Supportive Networks for Women Veterans Act and the Newborn Improvement Act. These two pieces of legislation have long been a priority of the VFW in our efforts to improve care and services to women and homeless veterans.

Since the implementation of the original retreat counseling programs, women veterans have reported it as invaluable in their seamless transitions into civilian life. By making this important program permanent, it will have a positive impact on the fastest growing sub-population of veterans. Yet for those who are not so fortunate to have a successful transition from the military, the Veterans Access to Childcare Act can also prove invaluable.

In 2016 the VFW conducted a survey of nearly 2,000 female veterans. In our study, 38 percent of homeless female veterans reported having children. These women face unique challenges with accessing not only medical care, but services to assist them in finding meaningful employment. Currently, VA has three successful pilot programs which offer childcare services to veterans attending health care appointments. The VFW believes expanding this legislation to include homeless veterans in need of employment services would assist some efforts to reduce veteran homelessness.

The VFW supports the intent of the Veteran Urgent Access to Mental Healthcare Act, but believes it must be expanded before it is passed. VA does not and should not provide sporadic care to veterans, but rather it provides a full continuum of high quality care which regularly outperforms the private sector. For this reason, the Veteran Urgent Access to Mental Healthcare Act must be expanded to provide more than just urgent mental health care to veterans with bad paper discharges.

At this time it is no longer a secret that DoD failed to comply with its own regulations intended to protect injured and ill servicemembers before issuing bad paper discharges to many who experienced trauma as a result of their service. These veterans deserve the care they earned, prior to the wrongful discharges, as a direct result from the traumas of service, war, or sexual assault.

Veterans with other than honorable discharges are currently three times more likely to die by suicide. Suicide prevention cannot be addressed in a fragmented nature; it must be done holistically.

The VFW opposes the No Hero Left Untreated Act. VA is a primary contributor of mental health research and has been leading the way in finding effective treatments to address PTSD, TBI, and other disorders associated with trauma. Implementing the No Hero Left Untreated Act would, in fact, leave heroes untreated.

MeRT would be an unfounded mandate for VA to conduct unproven research, which is not FDA approved. MeRT derives from transcranial magnetic stimulation, or TMS, which is empirically proven to be effective for mental health issues from trauma and is also FDA approved, though MeRT is not TMS.

VA has been conducting repetitive TMS research at more than 25 sites and has received positive outcomes, as well as feedback from the veterans undergoing this treatment.

By passing mandates such as this, Congress would be forcing VA to ration an estimated $2 million in appropriation, which is already going toward effective proven research.

The VFW believes VA should be leaders in innovative research and therapies, but they must have empirical data showing they are effective, as well as paid for.

The VFW cannot support the VA's Scheduling Accountability Act. The VFW agrees with the intent of this legislation, but Congress and VA must address the underlying issues with scheduling, instead of requiring compliance with archaic and flawed metrics that are susceptible to data manipulation.

One solution to this could be to provide VA the authority to hire and retain medical support assistance. The VFW also has serious concerns about withholding bonuses from VA Medical Center directors who fail to comply with scheduling standards as the Choice Act prohibits this from determination of performance awards. This was done due to the VA, OIG, and congressional oversight findings that VA employees were manipulating data to receive awards and bonuses.

VA must move away from arbitrary standards of wait-time measurement and adopt industry best practices before enacting compliance requirements that very well could lead to another culture of cover-ups.

Mr. Chairman, Ranking Member, this concludes my testimony. I am happy to answer any questions you or the other Members of the Subcommittee may have.

[THE PREPARED STATEMENT OF KAVDA KELEHER APPEARS IN THE APPENDIX]

Mr. WENSTRUP. Thank you very much.

Ms. Love, you are now recognized for five minutes.

STATEMENT OF SHURHONDA Y. LOVE

Ms. LOVE. Chairman Wenstrup, Ranking Member Brownley, and Members of the Subcommittee, thank you for inviting DAV to testify at this legislative hearing. We appreciate the opportunity to share our comments on several bills before the Subcommittee.

H.R. 91 would make permanent, the pilot program on counseling in a retreat setting for women veterans, following a wartime deployment. During a wartime deployment, many women cope with being away from their families and their normal everyday lives by replacing their feelings and thoughts of home with survival in their immediate roles and duties during the deployment.

This coping mechanism, coupled with constant serious risk factors during deployment can result in difficulty reintegrating into their familial and everyday roles; a process that is further complicated when those roles include parenting and marriage.

Women attending the retreat are able to connect with each other and rebuild many of the life skills that were lost during or damaged during the deployment in an atmosphere that is created for them. Counseling in the setting allows women veterans to freely relate to each other, while rebuilding supporting networks which were useful in completion of the retreat and when they return home. Women report access to the new networks as critical in their recovery months after the retreat. It is for these reasons DAV supports this bill and urges its enactment.

H.R. 95 would provide child care assistance to an eligible veteran during any period that the veteran is receiving a mental health or intensive health care services at a VA facility. All veterans deserve to have access to specialized mental health care offered by the VA. The need for child care should not be a barrier for receiving that treatment.

A high percentage of women veterans who serve in Iraq and Afghanistan are within child-bearing years and many are the sole-care providers for young children. We also note that these women have been diagnosed with service-related mental health conditions.

For many women, the need for child care is not just a convenience, but a necessity for them to take advantage of the specialized services that VA offers for their recovery. For these reasons, we are pleased to support this measure.

H.R. 907 would provide up to 42 days of health care to newborn children of women veterans who are enrolled in VA health care and receiving maternity care authorized by VA. DAV has no specific resolution on this particular measure; however, we feel it important to note that women use mental health services at higher rates than their male peers.

Having service-related psychological disorders, like post-traumatic stress, places women at a higher risk for a pre-term delivery or other birth-related complications. Data from the Chief Business Office estimates that 11 percent, roughly 2,200 births occurring each year are complicated births, requiring neonatal care beyond seven days. It is for these reasons DAV would not oppose this legislation.

H.R. 918 would allow VA to furnish initial mental health assessment and urgent mental health care treatment to a veteran of the Armed Forces, with an other-than-honorable discharge. As we know, many veterans with these types of discharges may have suffered a head or combat trauma, sexual trauma, or an other event that went undiagnosed, leading to behavioral issues and a less-than-honorable discharge. DAV is pleased to support H.R. 918 in accordance with DAV Resolution 226, calling for a more liberal review of the discharges for the purposes of access to VA care and mental health services.

H.R. 1005 authorizes the secretary to enter into agreements with state veteran homes to provide adult day health care to veterans whom are not in nursing homes, but require a skilled level of care, due to a service-connected disability. Veterans want to be independent for as long as they can be without being burdensome to their families. In addition, they still want to remain an active part of the family unit.

Adult day health care helps to accomplish this goal by allowing the caregiver, respite to take care of their personal needs while the veteran has an opportunity to interact with their peers and obtain the services that they need. For these reasons, we are pleased to support H.R. 1005.

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

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

Mr. WENSTRUP. Thank you, Ms. Love.

Ms. Dean, you are now recognized for five minutes.

STATEMENT OF SARAH S. DEAN

Ms. DEAN. Chairman Wenstrup, Ranking Member Brownley, and Members of the Subcommittee, on behalf of Paralyzed Veterans of America, I would like to thank you for the opportunity to present our views on the legislation before you today.

PVA supports H.R. 95, the Veterans' Access to Child Care Act; this legislation would make permanent, the provision of child care services for a veteran receiving covered health services at VA. PVA believes child care is critical to expanding access to care for veterans. There is no denying that when a primary care provider had reliable child care, their participation in their own health and well-being increases.

Women veterans, in particular, have reported time and, again, that one of the greatest barriers to VA is the inability to obtain child care. A permanent program will help to prevent no-shows, cancellations, or a veteran having to choose between the needs of their family and their health.

While providing child care is the right thing to do, it is also the economic one. If veterans have timely access to care, we decrease the compounding costs that come with treating an injury or mental illness later down the line.

A trustworthy child care option alleviates stress for the veteran and encourages they maintain their contact and treatment plan with their VA provider.

The extended pilot program is set to expire on December 31st of this year. PVA encourages Congress to make this program permanent in order to care for veterans who would otherwise not be able to access VA.

PVA supports H.R. 907, the Newborn Care Improvement Act, to amend Title 38 to authorize hospital stays of up to 42 days for newborns under VA care. The current provision allows for the maximum coverage of seven days, and as the average hospital stay for a healthy newborn is two days, any newborn needing additional coverage is likely to be facing serious complications. Women veterans with VA maternity care must bear the total cost after the seven days.

We know, well, that the welfare of the infant impacts the recovery and well-being of the veteran and their families, and the stress of an impending medical bill for the care of an ill newborn is an unnecessary burden.

PVA is particularly concerned about those veterans with catastrophic injuries or mental illnesses that can cause high-risk pregnancies or pre-term deliveries. A seven-day limit arguably impacts veterans with disabilities at a greater rate than other veterans. Extending newborn coverage is the right thing to do.

PVA supports H.R. 1545, the Prescription Data Accountability Act of 2017. VA now shares prescription information of veterans and their dependents with the state's Prescription Database Monitoring Program or PDMP, however, due to a technical oversight in the law, the information of non-dependent, non-veteran VA beneficiaries is not shared and H.R. 1545 would require the prescription

data of everyone by VA—covered by VHA, be submitted to the appropriate PDMP.

And while PVA strongly supports the H.R. 1545, we are concerned that PDMPs may not be capturing another group: veterans who travel to different states to receive their specialized care. It is our understanding that VA medical centers only share prescription day with the state PDMP in which the medical center is located. Some states have established regional memoranda of understanding, sharing—communicating information with neighboring states.

But there are veterans, particularly veterans with spinal cord injury or disease, who regularly travel across multiple state lines to receive care from one of the 24 SCI centers across the country. There is yet to be any assurance that the prescription data of an SCI veteran who receives care in Minnesota but lives in Wyoming will be shared. We urge the Subcommittee to make sure these specialized patient populations are benefitting from the opioid safety initiatives in the same way as non-traveling veterans.

Mr. Chairman, PVA thanks the Subcommittee for the opportunity to submit our views and I am happy to take any questions you may have.

[THE PREPARED STATEMENT OF SARAH S. DEAN APPEARS IN THE APPENDIX]

Mr. WENSTRUP. I want to thank you all for your testimonies here this morning. At this time, will yield myself five minutes for questions and I want to start with you, Dr. Lee, if you don't mind, if you could help me understand the difference between the Health Advocate Pilot Program and the Medical Scribe Pilot Program that would be created by Chairman Roe's bill.

What we are looking at, right, is to increase productivity of the provider, really, in this situation. And so as a follow-up question to that, when you are doing any of this and you are studying the results, are you looking at the physical environment that the provider is operating in so that we are comparing apples-to-apples; in other words, if you have one provider who has three treatment rooms to work with and you are comparing to a provider with one treatment room, it is really not a fair comparison as far as productivity, because it is hard to produce if you only have one treatment room, which those are the types of things that we see in some of the clinics.

So, if you could help me with that, I would appreciate it.

Dr. LEE. So, our Health Advocate Pilot Program is now rolling out in 14 different VA facilities, but really came from the field, this idea. The site that is probably the most advanced is White River Junction and we have some data from implementation of this program there.

So, rather than the health—just having a medical scribe, the health advocate has a dual role. So, they scribe, helping the provider physician to document the clinical encounter, but they also are trained as a health coach, so, as they spend time with that patient during that visit, they help educate the patient, help the patient to clarify healthy behaviors and things they can do at home and really advocate for that patient.

We have heard good results, feedback from the program so far in terms of productivity, in particular. So, at this site, some providers are saying that they typically could only see 12 patients a day, but now with the help of the health advocate, they are able to see anywhere from 16 to 20 patients per day.

And we have also heard good feedback from patients who like having that advocate there, so they don't have to retell their clinical history over and over and they can also help interpret what the providers are telling to the patients.

Mr. WENSTRUP. So, if I can, with that component of it, what is the licensure, what is the background of the health coach that allows them to operate in that capacity?

Dr. LEE. Right. Most of our health advocates are either licensed practical nurses or licensed vocational nurses and they are directly employed by the VA. And we looked at both, the model of employing the scribe advocates or contracting with them and our sites chose, in most cases, to directly hire them because they might—they had difficulty finding contractors or, again, having a licensed individual, allowed them to use that role for more than just scribing.

Mr. WENSTRUP. What would you anticipate, if you took this VA-wide, what would you anticipate the ability to recruit and retain people in that role, as opposed to just a scribe, because obviously you are talking about a higher level of education to have the authority to act in that role. So, what do you think the field is like for hiring for that?

Dr. LEE. I think it would vary from location to location, but we are hopeful. What we would really like to do is finish out this project and get some good data on the broader impact at all of these 14 different sites, since we have just the data from the one site so far. So, I think we will have a better idea as we get more data from our program.

Mr. WENSTRUP. Yeah, fair enough. I guess what I am saying is I think we need to keep in mind that there might not be a pool out there to fill that role across the country if it is a good program, so we might want to consider scribes as, although they may not be able to operate at as high a level, but still could increase productivity. So, what is ideal may not be real as far as being able to provide that across the country, but I appreciate the input on that.

And I do have another question, Dr. Lee: Does VA partner with nonprofit groups to provide the retreats for the pilot program?

Dr. LEE. So, for the—in the case of this particular pilot program, we have actually contracted with entities to provide the retreat services, but we would definitely be open to looking at ways to partner with nonprofits as well.

Mr. WENSTRUP. Currently, what type of monitoring or oversight is there on the retreats to gain information from the effectiveness?

Dr. LEE. So, we have a full report that we would be happy to share, evaluating the effectiveness and outcomes from our—the retreats in the pilot program, overall, really great results; a good satisfaction from the women veterans who participated, and as I mentioned, positive results, in terms of clinical symptoms and coping mechanisms that have actually sustained over time.

Mr. WENSTRUP. Well, thank you.

And I yield back, and Ms. Brownley, you are now recognized for five minutes.

Ms. BROWNLEY. Thank you, Mr. Chairman.

I just want to comment that it is very nice to see all women testifying here today; that is an unusual occurrence in this hearing room. So, thank you very much to all of you for being here.

I wanted to also follow up on the Supportive Networks for Women Veterans Act. Dr. Lee, you had advocated in your testimony to allow for more veterans in this kind of setting, so, to clarify, are you advocating for inclusion of other veteran cohorts in the women's retreat or are you advocating for separate retreats for different cohorts that might find it beneficial?

Dr. LEE. I think the results were so positive from the pilot program that we just saw it as a great opportunity to extend those positive results to other veterans. And I think the flexibility to be able to design the program in a way that makes sense for veterans is what would be great here. So, clearly—

Ms. BROWNLEY. So, you may have young men, let's say, as a cohort, right?

Dr. LEE [continued]. Exactly. Other veterans, and in particular, those who go to the vet centers, who are combat veterans, or may have been victims of sexual trauma or even families, potentially.

Ms. BROWNLEY. Thank you. And in terms of the Child Care Act, I noticed that you did not testify today regarding your position on it, but you stated in your written testimony that the inability to find child care was not shown to be a significant factor, whether veterans choose to utilize VA care. And so, what data do you have to support that statement?

Dr. LEE. So, this—the data comes from a study we did in 2015 titled, "The Study of Barriers to Care for Women Veterans." And from a statistical analysis of the study results, the study showed that the lack of child care was not a significant factor in whether the women veterans chose to utilize VA care; however, more than three out of five women did indicate that on-site child care would be helpful. So, those are the results from our survey.

Ms. BROWNLEY. So, I'm sorry, the three out of five said yes, but the first part of your statement was what?

Dr. LEE. So, from a statistical analysis—

Ms. BROWNLEY. Uh-huh.

Dr. LEE [continued]. —the surveyed respondents said having ability of child care would not be a significant factor in deciding whether they chose to go to VA—

Ms. BROWNLEY. Uh-huh.

Dr. LEE [continued]. —chose to use VA services or not; however, a majority of them said they would find it helpful.

Ms. BROWNLEY. And so, did you ask those veterans if they were having treatment that was going to be two months, three months long and had to go to the VA frequently for this, whether it is mental health therapy or cancer treatments, or whatever; if that wouldn't be beneficial in making sure that they got the treatment that they needed?

Dr. LEE. I don't think the question specifically asked about the frequency of the visits, but we did survey a wide range, over 8500 women veterans, to get these general results.

Ms. BROWNLEY. So, if the VSS could weigh in, I know that many of you have also done your own surveys in terms of the need for child care, if you could make a comment. I know you did already in your statements, but I think if you have some data-driven analysis to indicate the need, that would be, I think, helpful for countering this argument.

Ms. KELEHER. So, last year, as I said earlier, VFW did a survey of women veterans. In our survey, we had 72 women identify as being homeless or on the verge of homelessness and I believe it was 58 of them requested assistance from us. Of those 72 women, 38 percent of them responded as having children—and I cannot remember the number off the top of my head; I'd be happy to get that to you—but the majority of them did specify that access to, particularly, employment services was difficult for them, due to them having children.

I think it would be common sense that if somebody is homeless and living on the street with their children, they are not going to be able to afford access to child care. We had one particular—one of our members who actually said they attempted taking their child to access the employment training and was told they had to leave because the child was, I believe the terminology was something along the lines of "it was dangerous to have the child there."

Ms. BROWNLEY. Thank you.

Ms. Love?

Ms. LOVE. Congresswoman Brownley, this morning during the process of preparing for the testimony, I Googled the cost of child care and I found that it was about $11,666 a year, breaking down to $972 a month. So, when you take that into perspective of the cost that it takes to take care of children, this is surely a factor when you have veterans that will need long-term care.

These veterans are having a hard time and it could lead to them choosing not to receive the care that they need if—as they experience these high costs.

Ms. BROWNLEY. Thank you.

And Ms. Dean?

Ms. DEAN. Following up on what they have already shared, I think the other consideration is the children of catastrophically disabled veterans who have to have their caregiver go along with them to appointments, for whom staying behind with the child is not perhaps an option. This then allows the caregiver to be with the veteran in the appointment, which isn't included, I don't think, in the survey for—the women veterans survey—but certainly is a significant factor for our population.

Ms. BROWNLEY. And I appreciate, also, your economic argument in your testimony by virtue of saying that by providing the service, it could be an economic plus or saver, if you will, in terms of just resources, if people are not getting the appropriate care that they need and preventing other issues that may arise. So, thank you very much for that, and I will yield back.

Mr. WENSTRUP. At this time, if I may indulge the Committee and the panel for five minutes to allow Chairman Roe, who just joined us, to discuss his bill.

Dr. Roe, you are recognized for five minutes.

OPENING STATEMENT OF HONORABLE DAVID P. ROE

Mr. ROE. Thank you, Mr. Chairman and Ranking Member Brownley.

It is a pleasure to join the Subcommittee on Health today to talk about my draft legislation to require VA to implement a pilot program for medical scribes within the VA medical centers.

As a physician in practice, years ago, I took on the arduous task of converting from paper medical records to a million-dollar-plus electronic health records system. For me, it took time, lots of time to get used to using a new electronic system. And as we all know, electronic health records are extremely helpful tools in organizing and analyzing a patient's medical data, but you would be hard-pressed to find a doctor's office or hospital today that doesn't use some form of EHR; it is about 80 percent now, I believe.

And after my practice converted to an EHR, I finally familiarized myself with it and it became a normal part of my practice. I say this as a joke, but it was an electronic health record that made me congressman; however, I also learned that in order to fully utilize a new EHR, I had to divert my attention away from patients and toward the computer screen. That never did set well with me and it is—but it is what I had to do and what every practice was doing to accommodate the new her technology.

Today, medical scribes are often used to assist clinicians by navigating and entering data into the patient's her, allowing the clinician to focus on the patient and not paperwork. Medical scribes can improve efficiency in areas with a high demand of appointments, but a low supply of providers and can be especially helpful in a high-paced area of practice like an emergency department where every moment that is focused away from the patient could potentially lead to a tragic outcome.

Medical scribes are often recruited as undergraduates or recent graduates, having an interest in entering into a medical career. For them, scribing provides an opportunity to glimpse firsthand at what life in medicine is really like and gain valuable experience for future careers. I wholeheartedly believe that veteran patients and VA providers, alike, could benefit from embracing medical scribes within the VA medical facilities.

My draft bill would require the secretary to implement a two-year pilot practice to establish positions for 40 scribes across ten VA medical centers within areas of emergency medicine and specialty care. This pilot seeks to improve both, efficiency and more importantly, the patient-doctor experience, by allowing physicians to focus on their personal interactions with patients.

Under this draft legislation, VA would submit a report on the efficiency of the pilot every 180 days following its commencement and the GAO would submit an independent report within 90 days of the conclusion of the pilot to include a comparison of the pilot program with similar private-sector programs. The next in my legislation would prohibit any additional appropriations, with which to carry out this pilot.

And I am disappointed that the VA's testimony is not supportive of my draft legislation. I would note that VA's current Health Advocate Pilot Program is largely incongruent with the intent and scope of my draft legislation. Not only is VA's current program

lended to primary care, while my draft is exclusively to emergency and specialty care, but it also requires the scribe take on the clinical role of health coach which brings a litany of licensure issues into the equation.

Nonetheless, I look forward to working with the Department and the Members of this Subcommittee to address any outstanding concerns and move this legislation to regular order very quickly.

With that, I appreciate very much you allowing me to be here, and I know Dr. Wenstrup and other physicians, one of the things that being a data-entry person took a lot of the joy out of the practice and took your attention away from the patient. Me, personally, I never took the computer in the room with me; I walked in with a piece of paper, put the information down, looked at the patient and took care of them. And one of the problems were—and then went out later and entered the data, so it didn't interfere with that relationship.

One of the things that we are having is a shortage of providers and if you can make the provider more efficient by having a person enter that data, when they could spend their time with the patient, I think that does improve the care. And, certainly, I don't want the scribe to be a health coordinator; I want them to enter the data so that the health care people that are there are able to focus on that purpose, which is to provide health care for patients.

With that, I yield back.

[THE PREPARED STATEMENT OF REPRESENTATIVE DAIVD P. ROE APPEARS IN THE APPENDIX]

Mr. WENSTRUP. Thank you, Dr. Roe.

Yes, I will concur that that transition to becoming a data-entry person, away from being a physician the whole time was very challenging, decreased our productivity, and made your days a little bit longer. So, there is definitely some benefit to having assistance in that regard, and I thank you for your testimony.

At this time, we will resume our questions to the panel, if we may, and Ms. Radewagen, you are now recognized for five minutes.

Ms. RADEWAGEN. Thank you, Mr. Chairman.

I want to welcome the panel. Thank you for being here today. And I want to thank Chairman Wenstrup and Ranking Member Brownley for holding this hearing today.

And good morning, Chairman Roe.

There are some very good bills on our agenda today and I am happy to be a Member of a Subcommittee that is committed to addressing veteran accessibility to care, especially in the area of mental health and PTSD treatment.

Regarding that topic, I also want to thank Congressman Coffman and Congressman Knight for introducing H.R. 918 and 1162, respectively, and I am proud to be a co-sponsor of both bills.

Dr. Lee, would you please provide for the record, a list of the recent or ongoing research regarding the effective combat surveys on suicide and serious mental illness that your testimony notes the study required by 918 would be largely duplicative of.

Dr. LEE. Sure. Congresswoman, there is one study—there are several studies ongoing now, but there is one study in particular that involved OEF and OAF veterans who had been deployed and

their risk for suicide and that study actually did not find a direct relationship between the deployment to combat situations and the suicide risk, but we do have some studies ongoing right now.

Ms. RADEWAGEN. Dr. Lee, a statement for the record from The American Legion alleges that VA has recently implemented a pilot program in 23 medical centers to provide electromagnetic therapy via a repetitive transcranial magnetic stimulation. Is that true, and if so, how is that ongoing pilot different from the pilot that H.R. 1162 would create?

Dr. LEE. Yes. So, VA is supportive of a repetitive transcranial magnetic stimulation, or RTMS, which as you said, Congresswoman, is now being used in approximately 25 VAs. We are hoping to see that expand to other VA facilities, because there has been evidence to show it helps with conditions like PTSD.

This bill speaks specifically to a proprietary treatment that is different from RTMS or a variation on it, that doesn't have specific evidence that shows a benefit for the conditions listed in the bill. So, we would—and for that reason, we are not supportive of this and, instead, would like to advance expansion of access to RTMS in our facilities.

Ms. RADEWAGEN. Thank you, Mr. Chairman. I yield back.

Mr. WENSTRUP. Mr. Takano, you are now recognized for five minutes.

Mr. TAKANO. Thank you, Mr. Chairman.

I still want to congratulate my colleague, Ranking Member Brownley for her legislation on access to care—on child care, in light of the roundtable we had yesterday.

I want to ask Ms. Keleher to expand on the barriers to the training issues, because I think you cited in the roundtable, an example, of how that not only impedes—lack of child care impedes access to health care, but also maybe employment training.

Ms. KELEHER. Yes. Thank you, Congressman.

So, as I said before, when you have a homeless woman who has primary custody of her children and they are sleeping on the streets, homeless under a bridge, as my colleague Shurhonda said, the average cost of child care in the United States is just over $11,000, I believe. I know, particularly, here in D.C., it is over $20,000 at this point.

So, if you have a homeless female veteran sleeping on the streets with her children and she needs to access VA for employment training, whether it be VRE or one of the other programs, and they can't afford the child care, much less to seek housing, then that is a barrier for them in trying to find the meaningful employment that is required for them to put a roof over their children's heads and make sure that they are able to go to school and get an education, so on, and so forth.

Mr. TAKANO. Well, thank you. I appreciate that. Thank you for that.

In the statements for the record, the Vietnam Veterans of America and Swords to Plowshares expressed concerns over the scope of the bill that relates to other-than-honorable discharges. And I want to know if Ms. Keleher, Ms. Love, and Ms. Dean, whether your organizations support the scope of this legislation, if you can be brief, yeah.

Ms. KELEHER. The VFW supports the intent of the legislation, but we strongly believe it needs to be expanded. No matter what form of health care you are looking at, you can't look at it from a small level; it has to be done holistically.

Mr. TAKANO. Okay. Ms. Love?

Ms. LOVE. DAV supports the legislation. We want to make sure that the veterans have ever opportunity to access VA health care. As this bill would do, is allow them the opportunity to now receive the care, I think it is important for DoD to get it right the first time, but this bill would help for those veterans that are not receiving the care, to get the care that they need.

Mr. TAKANO. Okay. Ms. Dean?

Ms. DEAN. Thank you. We do find the scope appropriate, if only, because we are concerned about the potential pressure that it would put on the existing system, having a wave of new patients in the system and making sure that VA is staffed and able to care for those coming in.

Mr. TAKANO. What do you think about expanding access to these veterans for care that is more than mental health care and can we really separate the impact of physical health on mental health?

Ms. KELEHER. Congressman, physical health most definitely has an impact on mental health and vice versa and the way Title 38 is currently stated—I don't have it off the top of my head—but they do define the way they look at dishonorable differently than DoD does. So, the VFW believes that VA should already be providing this care to those who have paper discharges.

One example of that we talk about in our office would be Desmond Doss, who is a Medal of Honor recipient. He was a conscientious objector—sorry, I slaughtered that word—and under current definition, VA could deny them access to VA because of his conscientious objection, even though he has a Medal of Honor recipient.

Ms. LOVE. The objective of the bill is to take care of those veterans that suffer from these conditions that are stemming from experiences that they had in the military. And the mission of the VA would be to take care of the whole veteran, so whether it is mental health or other intensive needs, we think the intent of the bill is to provide care to those veterans that need it.

Ms. DEAN. Absolutely, you can't separate mental health care from physical care, however, I think the aim of this bill is to address imminent mental health crisis, something that is occurring right away. But it is our understanding that VA is already able to, as they said, to care for these other-than-honorable discharges, so if those could be linked or if Congress can encourage VA to have a less-strict interpretation, then by all means.

Mr. TAKANO. All right. Mr. Chairman, my time is up.

Mr. WENSTRUP. Mr. Rutherford, you are now recognized for five minutes.

Mr. RUTHERFORD. Thank you, Mr. Chairman.

And I want to thank all the panel Members this morning.

Dr. Lee, I am going to follow up where Mr. Takano was at. In light of the secretary's announcement before a Full Committee here last month, that they were actually going to begin accepting and treating at the VA, those with less-than- honorable discharges, can

you explain how 918, does that compliment or complicate what the secretary is already intending to do at VA?

Dr. LEE. Congressman, I think it is very aligned with our intent and our work now at VA. We are focusing on those veterans. We are using—flexing our current administrative authority to ensure we are meeting those urgent mental health needs for veterans, even if they have an other-than-honorable discharge.

And we are working now to get input and to see how we can specifically roll out this program, what services should be covered or not over the course of the next few months.

Mr. RUTHERFORD. And I think it is important to point out, as well, as Mr. Coffman said earlier, that this does not preclude the VA from expanding into other than mental health care; that is correct, Ms. Lee?

Dr. LEE. That would—that is our understanding. I think the focus, though, is on mental health care.

Mr. RUTHERFORD. Yeah, Mr. Coffman, do you want to comment?

Mr. COFFMAN. Sure, if I could? The—what this does is it has essentially a prioritized mandate, so where the Department has discretion, they would not have discretion on this particular population that is in the bill right now.

Mr. RUTHERFORD. Okay. And for Ms. Lee, particularly, but all of you in general, a statement from the record from the Wounded Warrior Project notes that many veterans suffering from PTSD, TBI have received bad-paper discharges. Is there any data that shows how many veterans there are with other than—because I agree with Ms. Dean, there are some issues about if you open this up to everyone with bad paper for all treatment, mental health and other, is there any idea what numbers we are talking about that currently suffer PTSD and have a bad paper discharge?

Dr. LEE. I am not sure of the specific numbers. We can certainly take that for the record and come back to you with that. But I know that there are, in total, approximately 500,000 individuals with other-than-honorable discharges from the military.

Mr. RUTHERFORD. And, Ms. Dean, do you know of any numbers out there?

Ms. DEAN. Sorry, no, I don't. But I do—the only number we are—I am aware of is the 500,000.

Mr. RUTHERFORD. Okay. And I will yield back, Mr. Chairman. Thank you.

Mr. WENSTRUP. Mr. Higgins, you are now recognized for five minutes.

Mr. HIGGINS. Thank you, Mr. Chairman.

Ms. Keleher, you stated in your testimony that veterans with bad-paper discharges are three times more likely to die by suicide. Where did you get that information from and can you share that with us?

Ms. KELEHER. I have that data in my office and I would be more than happy to get it to your office as quickly as possible, but I can't remember it off the top of my head.

Mr. HIGGINS. But you feel confident that those are accurate numbers based on some—of course I trust your testimony, ma'am, I just hadn't seen that data myself and I would be very interested. I am

quite sure my colleagues on the Committee would like to see that research.

Ms. KELEHER. Yes, sir.

Mr. HIGGINS. Thank you very much.

Dr. Lee, I understand your assertion in your written testimony that the VA cannot responsibly support the creation of a new child care assistance program for veterans without a, what you refer to a "realistic consideration of the resources necessary." That being said, your testimony didn't include a cost estimate and the pilot program has been in place, very new, since 2010, and we are looking for a permanent renewal.

Can you share with us, when can we expect to receive that information regarding the cost?

Dr. LEE. We will be happy to get it—we are working on it actively and we will be happy to try to get that back to you as soon as possible.

The—I would like to point out that we have seen favorable responses from veterans who have used the child care pilot programs and we would like to see that continue. We like the discretionary—the permanent, but discretionary authority to see the child care programs continue.

Mr. RUTHERFORD. My experience, ma'am, as a veteran and a police officer, seems there are a lot of cops who are veterans and historically, my personal observation has been that there is a double-standard, somewhat of a societal double-standard divided by gender between guys that are veterans and their female counterparts. There seems to be an assumption that female veterans would just, at their—when they end their time of service, would just right back into their roles as mothers and wives, et cetera; whereas, the comradery and esprit de corps for my male veteran counterparts seems to continue, and that level of support seems to continue, whereas, for my female, veterans, it does not.

So, I am very encouraged by my colleague's—Gentlewoman Brownley's legislation of H.R. 91. And I would like you to, if you don't mind, please, expand upon your feelings about that legislation that I have very much in support of.

Dr. LEE. VA is also support I have of the bill to make permanent the retreat centers, the retreat programs for women veterans. Again, we have done—we have run the retreat programs for a small number of women veterans for the past several years in multiple sites, including California, San Bernardino, and other states, and we found good results in evaluation from women veterans who have engaged in the program.

So, they have, as you said, Congressman, they have benefitted from that comradery of being with other women veterans. They have learned better coping skills and mechanisms and actually have had a decrease in their clinical symptoms from PTSD as a result and those improvements have sustained over time at the end of the retreat program.

Mr. RUTHERFORD. And some of the research indicates that 75 or 80 or 85 percent of the female veterans that have participated in retreat programs, even months after the retreat itself, have shown a significant increase in coping and reintegrating into civilian society.

Dr. LEE. That is correct.

Mr. RUTHERFORD. Is that correct?

Dr. LEE. That is correct.

Mr. RUTHERFORD. Thank you, ma'am.

Mr. Chairman, I yield back.

Mr. WENSTRUP. Dr. Dunn, you are now recognized for five minutes.

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

I am interested in the number also, 500,000 bad-paper discharges; over what period of time is that? Anybody can answer—500,000, I have heard multiple people say that—bad-paper discharges.

Dr. LEE. At least, sir, that represents a snapshot of currently how many?

Mr. DUNN. Five hundred thousand veterans currently in the country with bad-paper discharges?

Dr. LEE. Correct.

Mr. DUNN. How do they get that? What—how does—what administrative—we aren't talking about dishonorable discharges, or are we, dishonorable and general discharges?

Dr. LEE. Well, the discharges—so, not being a veteran myself, and I may defer to other Members of the panel up here—I will share that my understanding of the discharge—the character of the discharge is basically determined by the Department of Defense during the military—

Mr. DUNN. Yeah, I was just—

Mr. WENSTRUP. Let's defer.

Yes, sir?

Mr. COFFMAN. Thank you, Mr. Chairman, and I thank the gentleman for yielding.

The other-than-honorable discharges are certainly below honorable and above a bad-conduct discharge or a dishonorable discharge, and so, you know, often sometimes and currently are given for really—could be given for non-judicial punishment under a—

Mr. DUNN. Sort of like an AR–15?

Mr. COFFMAN [continued]. An Article 15.

Mr. DUNN. Article 15.

Mr. COFFMAN. Right. Uh-huh.

And so, just to give you a metric, in 2009, the Army separated approximately 22,000 combat veterans diagnosed with mental health disabilities, or TBI, for misconduct in the category of other-than-honorable discharge in that one year.

Mr. DUNN. So, if I can opine—if you will yield back, thank you.

Mr. COFFMAN. Go.

Mr. DUNN. I opine, I think that is pretty harsh.

But, let me—Dr. Lee, regarding H.R. 467, you said that the VA national policies already apply uniformly across the Department, however, the Committee continues to receive, daily, examples of VA directives that are only partly followed or not at all followed or complied in the field.

What is the mechanism for ensuring compliance out in the field throughout the VA when we have these directives?

Dr. LEE. In general, sir, or specifically in regard to the scheduling directives?

Mr. DUNN. Well, scheduling, yes.

Dr. LEE. So, with regard to the scheduling directive, there are two mechanisms of oversight that we are really pushing on right now. One is called—an actual tool, an IT tool, called the "scheduling trigger tool" that allows us to see across the system if there are any unusual aberrations in scheduling that might indicate a problem. So, that is one.

The second is that we have increased the frequency of our scheduling audits. So, this used to be done only once per year; now, it is at least twice per year.

Mr. DUNN. Are those announced or unannounced, those audits? So, they are surprise or not surprise?

Dr. LEE. Those—the way those audits work are at each facility, the supervisors for the schedulers pull a random sampling of appointments that are scheduled and look to see if the—our policies have been followed in scheduling those.

Mr. DUNN. And that software system you mentioned there where you could see across the system, that is what was subverted by those lists that we all have read about in the papers; is that what I understand?

Dr. LEE. I think some of the concerns from the scheduling, the behaviors before, led to the trigger—this tool that allows us to monitor.

Mr. DUNN. And I would like to change the subject to H.R. 91. We are talking about retreats for the female veterans. Is that something that doesn't apply to the male retreats for their PTSD?

Dr. LEE. Well, we actually think, Congressman, that other veterans would also benefit from those types of programs. We know there are many out there in the community.

Mr. DUNN. And do you partner with those community programs?

Dr. LEE. We would be interested in exploring how to do that.

Mr. DUNN. But right now, we are not reaching out and partnering with the numerous community-based VA programs; is that fair?

Dr. LEE. We are referring veterans to programs like that across the system, and there may very well be facilities that have more robust and direct partnerships, but there—we do support access for veterans to programs like this.

Mr. DUNN. Thank you very much.

Mr. Chairman, I yield back.

Mr. WENSTRUP. Thank you. Mr. Coffman, you are now recognized.

Mr. COFFMAN. Chairman, I have no questions.

Mr. WENSTRUP. Are there any further questions?

Mr. RUTHERFORD. Mr. Chairman?

Mr. WENSTRUP. Yes, Mr. Rutherford?

Mr. RUTHERFORD. If I could just point out one thing about Mr. Coffman's bill, H.R. 918, I think the important element in this bill is the fact that these men and women were actually discharged because of behavior that was not, at that time, tied to PTSD or TBI, which later, we find out that they suffer that consequence and that that behavior was, in fact, the result of their combat service.

And that is why I support this, whatever the cost might be, because we owe that to those combat veterans. I just wanted to add that in. Thank you.

Mr. WENSTRUP. Well, I think if there are no further questions, the—I am sorry.

Mr. Higgins, you are recognized.

Mr. HIGGINS. I would just like to state that regarding Chairman Roe's draft bill, any measure, any measure that we can take as a body, as a citizenry, to allow veterans, doctors to have increased facetime, one-on-one relationship with their patients, rather than typing on a keyboard of a computer, we should all, and I urge all my colleagues, to be in full support of any measure that allows a doctor to have a real relationship with a veteran. It is a problem in the system and I believe this draft improves that.

Thank you, Mr. Chairman.

Mr. WENSTRUP. I want to thank you all once again. And seeing no further questions, the second panel is now excused.

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

Without objection, so ordered.

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

[Whereupon, at 9:31 a.m. the Subcommittee was adjourned.

APPENDIX

Prepared Statement of Honorable Jackie Walorski

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

First, I would like to thank Chairman Wenstrup and Ranking Member Brownley for holding this hearing and allowing me to testify on the reintroduction of this important legislation. In 2014, news reports uncovering gross mismanagement and scheduling manipulation at a Department of Veterans Affairs (VA) hospital in Phoenix shook us to the core. Through hearings held in this committee and investigations by the VA Office of Inspector General (OIG) and Government Accountability Office (GAO), we substantiated many of the allegations of manipulated schedules and falsified wait-time data at the Phoenix facility. The manipulation of appointment schedules and data in Phoenix led to at least 40 veterans dying while they were waiting for care. However, three years after this tragedy VA is still plagued with facilities unable to get their act together when it comes to scheduling appointments. Earlier this month the OIG released yet another report that identified flaws in the scheduling system still used by VA facilities nationwide. Instead of owning up to the problems that continue to prevent veterans from getting timely care they need, the new Secretary disputed the findings of inaccurate wait times. We need to let the VA know that we will never give up in holding their feet to the fire. That is why I reintroduced the VA Scheduling Accountability Act.

VA Directive 2010–027 is VA's implementation processes and procedures policy for scheduling at their facilities and contains 19 different items on the checklist. The directive requires an annual certification of full compliance with all items on the list. For instance, facilities are required to conduct an annual audit of the timeliness and appropriateness of scheduling actions and the accuracy of desired dates. They are also required to ensure that deficiencies of competency or performance that are identified by the audit are effectively addressed.

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

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

We need this legislation in order end the reckless practice of avoiding compliance. I look forward to working with the members of this Committee, and Veteran Serv-

ices Organizations in addressing this critical issue. I thank you again for this opportunity to testify today.

Prepared Statement of Honorable Doug Collins

Chairman Wenstrup and Members of the Subcommittee, thank you for the opportunity to testify on legislation that I introduced, H.R. 907, the Newborn Care Improvement Act. This bill improves the care provided by the Department of Veterans Affairs to the newborn children of female veterans, and I appreciate the Subcommittee's consideration of this legislation.

In his Second Inaugural Address, President Lincoln derived his idea for the VA from Scripture stating, ".the challenge for us is to care for him who shall have borne the battle and for his widow and his orphan." In the 21st Century, we must apply Lincoln's statement more broadly to "she who hath borne the battle," and one way we can do that is to provide better maternity and newborn care.

Historically, much of the VA healthcare system was created and designed to meet the needs of men. As an increasing number of females serve in our military, it is essential for the VA to update and expand its care and services to meet the needs of female veterans and their families.

Maternity care is often among the needs of our female veterans, and I believe the Newborn Care Improvement Act is one important way to help. In 2010 when the Caregivers and Veterans Omnibus Health Services Act was signed into law, it provided short-term newborn care for female veterans who receive maternity care through the VA. Under this law, newborns were provided with up to seven days of care at hospitals covered by the VA.

In January 2012, the Department of Veteran's Affairs issued a rule to officially implement the law. The rule was retroactively applied to newborn care provided to eligible female veterans on or after May 5, 2011.

Since the law's implementation, we have learned significantly more about the challenges impacting female veterans and the evolving needs of veterans seeking care for their newborns from the VA. According to a 2008–2012 study in one women's health journal, for example, the overall delivery rate of female veterans using VA maternity benefits increased by 44 percent, and a majority of these women had service-connected disabilities.

However, a recent December 2016 Government Accountability Office (GAO) report illustrated that there is still a long way to go to meet the care needs of our female veterans and their newborns. The GAO found that approximately 27 percent of VA facilities reported maternity care was "significantly delayed" and that all veterans, including women, face consistent challenges in receiving timely access to care.

We know we must take action to address access to care issues at the VA, including maternity and newborn care.

Absent Congressional action to achieve parity between the number of days new mothers and newborns can receive care covered by the VA, female veterans may be forced to navigate complex insurance options and face challenging financial decisions - even as their child's life is in danger.

I introduced H.R. 907, the Newborn Care Improvement Act, to ensure that newborns are better able to receive the care they need, particularly if they are born prematurely or face birth complications.

As some of you may remember, I introduced similar legislation in the 114th Congress, and it was favorably reported by this Committee. Last Congress, my legislation extended the length of covered VA care for newborns from 7 to 14 days and provided an annual report on the number of newborns who receive such care during each Fiscal Year.

The 115th Congress' version provides an important update to the length of covered care for newborns by extending it from 14 to 42 days. This 42 day standard creates parity for newborns with the length of time the VA covers care for mothers, incorporating an amendment offered by Chairman Roe that was included when the House passed this legislation last year. I hope that the Committee will once again place the Newborn Care Improvement Act on its markup calendar to move forward this legislation for newborns and their mothers.

Many of our female veterans have paid the ultimate price, and those who have risked their lives to serve our nation deserve the highest standard of care. Our duties to the women in our Armed Services do not end because they are no longer serving on active duty, and should they choose to receive maternity care at the VA, they should be confident it will be quality care.

In fact, research has indicated that some female veterans may have unique maternity needs as a result of their service. One recent study illustrated a link between a veteran having PTSD in the year prior to giving birth and a 35 percent increase in risk of spontaneous premature delivery. This study indicates that PTSD could be a significant epidemiological risk factor for pre-term delivery, and it is only one of the service-connected issues that our female veterans, who have bravely sacrificed for us, may face.

Tragically, PTSD impacts a substantial number of our female veterans. Over 20 percent of female veterans in the recent conflicts in Iraq and Afghanistan have been diagnosed with PTSD. These diagnoses are not limited to women serving in combat roles.

Female veterans who may have higher-risk pregnancies should feel confident they will receive appropriate and necessary maternity care and care for their newborns. This care becomes even more critical for premature babies who may face greater complications than full-term infants and potential long-term developmental problems absent proper care.

From a personal perspective, I understand the fear and heartache of parents when their beautiful new baby needs intensive medical care. My daughter, Jordan, was born with spina bifida and was over 10 days old before I could hold her.When a parent is in this situation, they shouldn't be worried that their insurance will no longer cover the child or that the facility where the baby was born can't or won't provide necessary care. As a parent, I know the only thing you're thinking about is the safety, health, and well-being of your child. That's why I introduced this legislation-in those situations where longer care is necessary, it should be available for the newborns of our female veterans.

Our goal should be to ensure that mothers receive the best pre-natal and maternity care possible, so that newborns can have the best chance of a healthy delivery and a long life. Our female veterans have served our country with honor and distinction, and this is one small step we can take to show our gratitude.

The Newborn Care Improvement Act is a commonsense measure to support the changing needs of women in the Armed Services. H.R. 907 represents a significant step forward for maternity and newborn care at the VA that builds on research and existing programs.

Thank you again for the opportunity to testify before you today, and for all that you do to improve care for our nation's veterans.

I yield back.

Prepared Statement of Honorable Mike Coffman

Mr. Chairman, I would like to begin by thanking you for including my bill in today's legislative hearing. To our witnesses, thank you for your testimony, and for ensuring Congress and the American public better understand the challenges facing our Veterans today.

As a Marine Combat Veteran, I like to live by the rule that we never leave anyone behind, and the Veteran Urgent Access to Mental Healthcare Act makes sure that we do not forget those who bravely served our county in their time of need.

Here is what we know for a fact - an average of 20 veterans take their lives daily. Likewise, VA evidence suggests a decrease in suicide risk among those who have received VA healthcare services. And since 2009, the Army has separated approximately 22,000 combat veterans diagnosed with mental health disabilities or TBI for alleged misconduct—leaving them without access to VA's critical mental healthcare services.

While the correlation between their illness and minor misconduct could be linked, this made no difference to their character of discharge. Historically, a veteran with an other than honorable discharge has been able to seek VA care for a service-connected disability. However, due to the way these veterans were discharged and this failure to connect the dots between an other than honorable discharge and mental health services, this precedence has failed to recognize this problem.

My bill will stay with tradition and correct this disconnect by authorizing urgent mental healthcare to these veterans. And to note, it would not limit VA's existing authority, should the VA choose to provide services beyond what is covered in my legislation.

My bill also calls for a third-party study to review the effect of combat service on veteran suicide rates, as well as the rate and method of suicide among veterans who have received healthcare from the VA and those who have not.

Before the rate of veteran suicides increases anymore, we have to make sure that these service members get the critical mental healthcare they need and that the nation has a better understanding of why veterans think that taking their own lives is the only way out to end their pain and suffering. This is something that we need to get to the bottom of, as quickly and as accurately as possible. My legislation will do just that.

Over the years, Congress has been looking into inefficiency's and mission disconnect at the VA and I believe this has been a key disconnect at the VA. It is time to right this wrong and permanently authorize the Secretary to provide initial mental health assessments and urgent mental healthcare services to veterans at risk of suicide or harming others, regardless of their discharge status.

When someone puts on the uniform, they take an oath to defend our freedoms. We in turn promise to make sure they receive the care and services they need upon returning from their mission.

Mr. Chairman, thank you for allowing me to testify today on behalf of my legislation I look forward to continue working with the committee, as well as our nation's VSOs, to make sure the men and women in uniform are never left behind.

Prepared Statement of Honorable Stephen Knight

Chairman Wenstrup, Ranking Member Brownley and Members of the Committee, thank you for the opportunity to testify today on my legislation H.R. 1162 No Hero Left Untreated Act.

We are working to get our military the most advanced weapons, vehicles, and equipment in the world in order to defeat any enemy. We owe it to those who selflessly serve to match this commitment to innovation when it comes to their medical treatment when they need it most.

Our fighting men and women will always face incredible danger and put their lives on the line in service to our nation. Post-Traumatic Stress (PTS) and Traumatic Brain Injury (TBI) are some of the most prevalent and misunderstood injuries our troops face upon returning home from answering the call of duty. A recent study found that 20 veterans commit suicide EVERY DAY. This is unacceptable and the VA must adopt new ideas to help prevent and decrease veteran suicide rates. An emerging technology is achieving compelling results in restoring veterans' mental health and shows promising potential to prevent more suicides from needlessly occurring: Magnetic EEG/EKG-guided resonance therapy.

This reliable, effective protocol uses a suite of FDA approved medical innovations to uniquely image the brain, identify areas that may need repair, and, most importantly, treat suboptimal regions of the brain with the goal of restoring optimal neurological function using non-invasive neuromodulation.

This protocol is an individualized, non-pharmaceutical, non-invasive procedure, to provide patient specific application of repetitive magnetic stimulation to help restore proper brain function. Over the course of several treatments, patients experienced improved quality of sleep, increased motivation and ability to manage stress, improved mood, and better concentration and focus.

With veteran patients, magnetic EEG/EKG-guided resonance therapy has achieved excellent success rates in both open-label trials and randomized, placebo-controlled, double-blind studies. In fact, to date, 98% of veterans in recent trials have experienced at least a 10 point change in their PTSD Check List Military (PCL–M) score, and averaged a 61% reduction in symptom severity after four weeks of treatment based on PCL–M.

Veterans who depend on the VA can benefit from this treatment, which is why I introduced H.R. 1162, the No Hero Left Untreated Act, earlier this year. This bill would establish a pilot program for two VA medical centers to treat 50 veterans using magnetic EEG/EKG-guided resonance therapy.

The Department of Defense has already begun clinical trials on EEG/EKG at Tinker Air Force Base and the U.S. Special Operations Command is also about to launch a larger two-site trial study to treat a cohort of military personnel as well.

The VA is currently behind and unequipped to deal with this growing problem, and must take advantage of innovative treatments that can help veterans who struggle with mental health issues. I urge my colleagues to support this vitally important piece of legislation and get our veterans the best treatment possible. Innovation is the key to effectively treat these conditions and it's time Congress does something to bring new treatment services like the magnetic EEG/EKG-guided resonance therapy into the 21st century.

Thank you for this opportunity to testify and I look forward to working with you on providing innovative solutions to treat our brave men and women.

Prepared Statement of Honorable Ann M. Kuster

Written Testimony on H.R. 1545, VA Prescription Data Accountability Act

Mr. Chairman and distinguished colleagues of the Subcommittee of Health, thank you for inviting me to speak on behalf of my proposed bill - H.R. 1545, the VA Prescription Data Accountability Act.

My bill would resolve a peculiar problem with the VA's initiative to connect VA medical facilities to state Prescription Drug Monitoring Programs. As you know, in 2012, the VA was authorized by Congress to provide state PDMPs the prescription data of VA beneficiaries. As a member of the House Veterans Affairs Committee and as the co-founder and co-chair of the Bipartisan Heroin Task Force, I recognize PDMPs as an important tool to prevent the spread of prescription opioids to our communities.

The VA has provided prescription opioids at a rate nearly twice that of the general population. Many veterans utilize both the VA and private providers to meet their healthcare needs. Additionally, many drugs - including opioids - can be dangerously and lethally combined with other drugs. Often, these lethal combinations are accidental and could have been resolved with better available information. These are reasons why it is critical to ensure the VA is fully connected to state PDMPs.

Thankfully, the VA has taken action to connect all its medical facilities to available PDMPs. All indications are that the VA is on schedule to connect all VA medical facilities with PDMPs.

However, the VA has reported that they cannot provide non-Veteran data to these state PDMPs. This problem is two-fold: VA's authority is currently confined to "Veterans and their dependents," and VA's IT systems cannot adequately discriminate between "dependents" and "non-dependent" users of the VA. Consequently, hundreds of thousands of non-Veterans do not have their data reported. That would include the largest population of non-Veterans - beneficiaries of CHAMPVA - as well as some active service members.

My bill would expand VA's authority to include all VA beneficiaries that are prescribed a drug. This will close the gap without requiring VA to update its electronic health records, a process that is neither quick nor inexpensive. Consequently, the VA and the CBO have preliminarily reported that my bill would have little to no cost.

Thank you for the opportunity to speak on behalf of my legislation.

Prepared Statement of Honorable David P. Roe

It's a pleasure to join the Subcommittee on Health today to talk about my draft legislation to require VA to implement a pilot program for medical scribes within VA medical centers (VAMCs).

As a physician in private practice years ago, I took on the arduous task of converting from paper medical records to a million-dollar electronic health record system (EHR).

For me, it took time - lots of time - to get used to using the new electronic system.

As we all know, EHRs are extremely helpful tools for organizing and analyzing a patient's medical data and you would be hard-pressed to find a doctor's office or hospital today that doesn't use some form of EHR.

After my practice converted to an EHR, I eventually familiarized myself with it and it became a normal part of my practice.

However, I also learned that in order to fully utilize the new EHR, I had to divert my attention away from the patient and towards the computer screen.

That never sat well with me, but it was what was needed - and what every practice was doing - to accommodate the new EHR technology.

Today, medical scribes are often used to assist clinicians by navigating and entering data into a patient's EHR, allowing the clinician to focus on the patient and not on the paperwork.

Medical scribes can improve efficiency in areas with a high demand of appointments but a low supply of providers -and can be especially helpful in high-paced

areas of practice like an emergency department (ED) where every moment focused away from the patient could potentially lead to a tragic outcome.

Medical scribes are often recruited as undergraduates or recent graduates having an interest in entering into a medical career.

For them, scribing provides an opportunity to glimpse first-hand what life in medicine is like and gain valuable experience for their future careers.

I wholeheartedly believe that veteran patients and VA providers alike could benefit from embracing medical scribes within VA medical facilities.

My draft bill would require the Secretary to implement a 2-year pilot program to establish positions for 40 scribes across 10 VAMCs, within the areas of emergency and specialty care.

This pilot seeks to improve both efficiency and, more importantly, the patient-doctor experience by allowing physicians to focus on their personal interactions with patients.

Under this draft legislation, VA would submit a report on the efficacy of the pilot every 180 days following its commencement and the Government Accountability Office would submit an independent report within 90 days of the conclusion of the pilot, to include a comparison of the pilot program with similar private sector programs.

The text of my legislation would prohibit any additional appropriations with which to carry out this pilot.

I am disappointed to see that VA's testimony is not supportive of my draft legislation and would note that VA's current Health Advocate pilot program is largely incongruent with the intent and scope of my draft legislation. Not only is VA's current program limited to primary care while my draft is exclusively for emergency and specialty care, but it also requires the scribe to take on the clinical role of "health coach", which brings a litany of licensure issues into question.

Nonetheless, I look forward to working with the Department and with the members of this Subcommittee to address any outstanding concerns and move this legislation through regular order very quickly.

With that, I thank you for allowing me to be here today and yield back the balance of my time.

Prepared Statement of Jennifer S. Lee

Good morning, Chairman Wenstrup, 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 the Department of Veterans Affairs' (VA) programs and services. Joining me today is Susan Blauert, Chief Counsel for the Health Care Law Group, Office of General Counsel.

H.R. 91 Building Supportive Networks for Women Veterans Act

H.R. 91 would direct VA to provide reintegration and readjustment counseling services, in a retreat setting, to women veterans who are recently separated from service in the Armed Forces after prolonged deployments.

VA currently is in the final year of a pilot program, authorized by Public Law 111–163 and reauthorized through several extensions of this authority, to determine the feasibility and advisability of such retreats. Under this program, a total of 12 retreats were provided to 272 women veterans between 2011 and 2016. Three more retreats are planned for calendar year 2017. These retreats focus on building trust and developing peer support for the participants in a therapeutic environment. Data have shown that those who participated in these retreats were able to increase their coping abilities and decrease their symptoms associated with posttraumatic stress disorder. Eighty-seven percent of participants are scoring higher on the Ryff Scale of Psychological Well Being immediately post-retreat, and 78 percent had higher scores two months later. Eighty-four percent showed a decrease in stress symptoms at two months post-retreat. VA is expecting similar results for those who participate in the 2017 retreats.

VA agrees that providing these retreats is beneficial to women veterans, other veteran and Service member cohorts could also benefit from this treatment modality. While VA appreciates the intent of this bill, we would request that the bill language be amended to allow VA the ability to conduct these retreats for all veteran or Service member cohorts eligible for Vet Center services. Examples include those who have experienced military sexual trauma, veterans and their families, and families that experience the death of a loved one while on active duty. Also, rather than creating a separate biennial report, as would be required by the bill, VA rec-

ommends that this bill amend 38 U.S.C. § 7309 to include a report on this program as part of the annual report to Congress on the activities of the Readjustment Counseling Service.

VA estimates that this legislation would cost $467,347 to conduct six retreats in Fiscal Year (FY) 2018, $2.5 million over five years, and $5.6 million over 10 years. There retreats would serve an average of 138 woman veterans annually, for a total cost of $3,400 per person.

H.R. 95 Veterans' Access to Child Care Act

H.R. 95 would require VA to carry out a program to provide assistance to qualified Veterans to obtain child care so that the veterans can receive covered health care services. Such assistance may include stipends for payment of child care by licensed centers, direct provision of child care at VA facilities, payment to private child care agencies, and collaboration with other Federal facilities or programs. Covered health care services would include regular and intensive mental health care services and other intensive health care services access to which could be improved by provision of child care assistance. While VA is aware of the challenges faced by veterans with children in regard to access to medical appointments and other medical care, counseling, and care giving services, VA does not support this bill as written. In a 2015 Study of Barriers to Care for Women Veterans, when queried about the possibility of on-site child care, more than three out of five women (62 percent overall) indicated that they would find on-site child care very helpful. However, this was not shown to be a significant factor in whether they chose to utilize VA care.

VA believes it would be better to have permanent but discretionary authority to provide child care assistance for the children of eligible veterans while those veterans are accessing health care services at facilities. In addition, VA cannot responsibly support the creation of a new child care assistance program for veterans without a realistic consideration of the resources necessary, including an analysis of the future resources that must be available to fund other core direct-to-veteran health care services.

VA does not have cost estimates at this time but will be happy to follow up shortly with the Committee.

H.R. 467 VA Scheduling Accountability Act

H.R. 467 would require each VA medical facility to comply with requirements relating to scheduling veterans for health care appointments and to ensure the uniform application of VA directives.

Section 2(a) would require the director of each VA medical facility to annually certify to the Secretary that the medical facility is in full compliance with all provisions of law, regulations, and VA directives relating to scheduling appointments for Veterans to receive hospital care and medical services. If the director did not make a certification, section 2(b) would require the director to submit a report explaining why the director was unable to make such a certification and a description of the actions the director is taking to ensure full compliance. Section 2(c) of the bill would prohibit VA from awarding any award or bonus to certain covered officials if the director of a medical facility did not make a certification under subsection (a)(1) for any year. Section 3 of the bill would require VA to ensure that its policies apply uniformly to each office or facility of the Department.

VA supports the intent of this bill in terms of ensuring veterans are appropriately scheduled for the care they need and that scheduling processes are reliable and timely. Existing Departmental policies require VA directors to certify compliance with the scheduling directive and explain gaps in compliance based on scheduling data collected at the facility level.

In addition, VA national policies already apply uniformly across the Department. At the same time, these policies provide some flexibility so that facilities may develop and pilot innovative ideas or implement policies and procedures that are specific to the needs of the local Veteran community, while remaining consistent with the principles and procedures established in national policy. Codifying activities that VA already does administratively could potentially limit VA facilities' ability to implement policies and procedures needed to tackle local challenges, adapt to changing conditions, and address veterans' needs in real time.

Finally, VA is actively working with Members of Congress on a consolidated-care-in-the-community program and other efforts to improve access to health care. In this dynamic environment, particularly with the increased use of community care, VA needs the flexibility to set scheduling standards that are clinically appropriate and that can change and improve over time in step with other changes in the way Veterans access health care.

VA estimates that there would be no costs associated with implementing the requirements in this bill.

H.R. 907 Newborn Care Improvement Act

H.R. 907 would amend section 1786 of title 38, United States Code, to increase from 7 to 42 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 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.

VA supports extending, from seven to 14 days, coverage of newborns of a woman veteran receiving delivery care. A newborn needing care for a medical condition may require treatment extending beyond the current 7 days that are authorized by law. Additionally, the standard of care is to have 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 a medical condition. Extending care to 14 days would provide time for further evaluations appropriate for the standard of care, as well as sufficient time to identify other health care coverage for the newborn. VA also notes the bill would not address travel benefits associated with the newborn's care. VA would support authorizing the provision of travel benefits under 38 U.S.C. § 1786.

VA estimates this bill would cost $25.9 million in FY 2018, $136.8 million over 5 years, and $293.6 million over 10 years.

H.R. 918Veteran Urgent Access to Mental Healthcare Act

H.R. 918 would create a new section 1720I in title 38 that would direct VA to furnish to certain former members of the Armed Forces an initial mental health assessment and the mental health care services the Secretary determines are required to treat the urgent mental health needs of the former members, including risk of suicide or harming others. To be eligible for this care, an individual must be a former member of the Armed Forces, including the reserve components, who served in the active military, naval, or air service and was discharged or released therefrom under a condition that is not honorable but who did not receive a dishonorable or bad conduct discharge. The member would also have to have applied for a character of service determination that is still pending and otherwise be ineligible to enroll in the VA health care system established by section 1705 by reason of such discharge or otherwise not meeting the requirements for "veteran" status under section 101(2) of title 38. Furthermore, the former Servicemember must have been deployed in a theater of combat operations or an area at a time during which hostilities occurred in that area, participated in or experienced such combat operations or hostilities, or was the victim of a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment.

VA would be authorized to furnish such mental health care in a non-Department facility if treating the person in a VA facility would be clinically inadvisable or if VA facilities are not capable of furnishing such care economically because of geographic inaccessibility. The Secretary would be required to ensure that mental health services are furnished in a setting that is therapeutically appropriate and provide referral services to assist former Service members who are not eligible for services under this chapter to obtain services from outside VA. VA would also be required to provide information on the availability of services and to coordinate with the Secretary of Defense to ensure that Service members who are being separated from active service are provided appropriate information about such services. VA would be required to submit an annual report on the provision of services under this authority and would be required, in consultation with the Secretary of Defense, to seek to enter into a contract with an independent nongovernmental entity to carry out a study on the effect combat service has had on suicide rates and serious mental health issues among veterans. VA would be required, within one year of enactment, to submit a report to Congress on this study.

VA supports this bill in principle. Veterans who were discharged or released with an other-than-honorable (OTH) administrative discharge or a punitive bad conduct discharge issued by a special court-martial may or may not be eligible for VA benefits. The determination is made based on the character of discharge standards in

38 C.F.R. § 3.12. An individual with an OTH administrative discharge that VA has determined to be disqualifying under 38 C.F.R. § 3.12 is eligible to receive health care for service-incurred or service-aggravated disabilities unless he or she is otherwise subject to one of the statutory bars to benefits set forth in 38 U.S.C. § 5303(a).

We note that requiring a study on the effect combat service has had on suicide rates and serious mental health issues would be largely duplicative of a number of recent research efforts in this area.

In addition, Secretary Shulkin recently announced his intention to expand access to mental health services for former Service members with OTH administrative discharges. It is estimated that there are slightly more than 500,000 former service members with OTH administrative discharges. As part of Secretary Shulkin's plan, former Service members with OTH administrative discharges would be able to seek treatment at a VA emergency department, Vet Center or contact the Veterans Crisis Line. Before finalizing the plan in early summer, Secretary Shulkin plans to meet with Congress, Veterans Service Organizations, and Department of Defense officials to determine the best way forward to get these former Service members the care they need.

H.R. 1005 Improving the Provision of Adult Day Health Care Services for Veterans

H.R. 1005 would amend 38 U.S.C. § 1745 to require the Secretary to enter into an agreement under 38 U.S.C. § 1720(c)(1) or a contract with each State Veterans Home (SVH) for payment by VA for adult day health care (ADHC) provided to an eligible Veteran. Eligible veterans would be those in need of nursing home care for a service-connected disability or who have a service-connected disability rated at 70 percent or more and are in need of nursing home care. Payments would be made at a rate that is 65 percent of the payment VA would make if the veteran received nursing home care, and payment by VA would constitute payment in full for such care. Currently, under a grant mechanism, VA pays States not more than half the cost of providing ADHC. States may currently obtain reimbursement for this care from other sources in addition to VA's per diem payments.

VA supports growing ADHC programs in general as they are a part of VA's home- and community-based programs that have been demonstrated to benefit the health and well-being of older veterans. However, VA does not support this bill as written for several reasons.

First, VA notes that the bill would base payment rates for ADHC on nursing home care rates, though these are two distinctly different levels of care and are furnished for different periods of time. Nursing home residents live at the facility and receive 24-hour skilled nursing care, including services after normal business hours with registered nurses involved in care at all times. ADHC is a distinctly different level of care that provides health maintenance and rehabilitative services to eligible Veterans in a group setting during daytime hours only. The nursing home rates that would be used to compute the ADHC rates under this bill are based on a formula that was developed in partnership with VA's State home partners and is specific to nursing home care. VA would like the opportunity to thoroughly review the cost of providing ADHC and, as was accomplished for nursing home care, establish a mutually agreeable ADHC rate with our SVH partners. VA believes revising the language to allow for VA to propose a formula for computing ADHC rates and for SVHs to provide comments on the formula would be consistent with the way the nursing home care rates were developed under 38 U.S.C. § 1745.

Second, VA has technical concerns with the legislation. We note that the bill directs VA to "enter into an agreement under section 1720(c)(1) of this title or a contract" with each SVH. VA does not have the authority to enter into individual agreements, and thus this provision would need to be implemented through contracts. VA has requested this specific authority.

Third, this legislation would impact VA's anticipated implementation of a proposed regulation that would allow SVHs to offer ADHC using either a medical supervision model or a socialized model. Currently, VA requires states to operate ADHC programs exclusively using a medical supervision model. In June 2015, VA published a proposed rule, "Per Diem Paid to States for Care of Eligible Veterans in State Homes," RIN 2900–AO88. VA proposed these regulations in part so that states may also establish ADHC programs using only a socialized model. A medical supervision model would include physician services, dental services, and administration of drugs, whereas these would not be required for a socialized model. Although the intent of the legislation may be to limit a higher per diem to medical supervision model programs, VA is concerned that H.R. 1005 does not make this distinction, which would result in VA being required to pay the same rate for a socialized model as for a medical supervision model.

Additionally, VA expects the numbers of both socialized and medical supervision model ADHCs to increase after publication of the proposed regulation. VA is not able to predict how many SVHs will adopt the new socialized model, nor how the new model's use will affect costs. Until VA has such information, VA recommends against codifying a payment rate, as such a limitation could result in VA overpaying or underpaying States in the future.

VA estimates H.R. 1005 would cost an additional $492,972 in FY 2018, $3.8 million over 5 years, and $11.6 million over 10 years.

H.R. 1162 No Hero Left Untreated Act

H.R. 1162 would require VA, within 90 days of enactment, to begin a one-year pilot program in no more than two VA facilities by providing access to magnetic EEG/EKG-guided resonance therapy (Magnetic eResonance Therapy or MeRT) to treat veterans suffering from post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), military sexual trauma (MST), chronic pain, or opiate addiction. The bill would not authorize additional amounts to be appropriated to carry out the requirements of this bill.

While preliminary experience with this technology is promising, a study by the Newport Brain Research Laboratory to establish the efficacy of MeRT in treating PTSD in veterans is still in progress. VA offers repetitive transcranial magnetic stimulation (rTMS), which is a treatment related to MeRT that has FDA approval for treatment-resistant depression, a common comorbid condition in PTSD, TBI, MST, and chronic pain and opioid addiction. There is no existing evidence that MeRT is superior to rTMS for treating any disorder. To date, no medical device using MeRT technology has been cleared or approved by the Food and Drug Administration for the uses described in the legislation. While VA research continuously examines new treatment methods and modalities, independently collected evidence of the safety and efficacy of this technology has yet to be obtained. The additional pilot data that would be obtained under the proposed legislation would not address the critical issues of determining MerT's efficacy against a placebo or against rTMS. For these reasons, VA does not support the legislation.

VA estimates the bill have a one-time $1.83 million cost to implement.

H.R. 1545 Disclosure of Patient Information to State Controlled Substance Monitoring Programs

H.R. 1545 would amend 38 U.S.C. § 5701(l) to direct the Secretary to disclose information about covered individuals to a State controlled substance monitoring program, including a program approved by the Secretary of Health and Human Services under section 399O of the Public Health Service Act (42 U.S.C. 280g-3), to the extent necessary to prevent misuse and diversion of prescription medications. Covered individuals would include an individual who is dispensed medication prescribed by a VA employee or a non-Department provider authorized to provide such medication by VA.

VA supports this bill. Currently, VA is required to provide information on veterans and their dependents, but this bill would expand that authority to include any person who is dispensed medication prescribed by a VA employee or a non-VA provider authorized to prescribe such medication by the Department. Under our current authority, VA does not disclose information for other persons who receive care, such as in humanitarian cases or family members or caregivers who are eligible to receive care. This bill would provide an important authority to ensure that VA is able to fulfill its public health role in sharing vital clinical information to help guide treatment decisions. However, we note that there are information technology challenges relating to variations in State prescription drug monitoring program requirements that would prevent immediate implementation of this provision.

We estimate there would be negligible costs associated with this bill.

H.R. 1662 To Prohibit Smoking in Any Veterans Health Administration (VHA) Facility

H.R. 1662 would repeal section 526 of Public Law (P.L.) 102–585 and amend section 1715 of title 38, United States Code, to prohibit any person from smoking indoors in any VHA facility. It would also prohibit, beginning October 1, 2022, any person from smoking outdoors at any VHA facility. The bill would prohibit the use of cigarettes, e-cigarettes, cigars, pipes, and any other combustion of tobacco. The prohibition would apply to any land or building that is under VA's jurisdiction, under the control of VHA, and not under the control of the General Services Administration. The amendments made by the bill would take effect 90 days after the date of enactment.

VA strongly supports H.R. 1662. For several years, VA has proposed legislation to reverse the requirement in P.L. 102–585, section 526 for designated smoking areas at VA facilities. Currently P.L. 102–585, section 526, enacted in 1992, requires VHA to provide suitable smoking areas, either an indoor area or detached building, for patients or residents who desire to smoke tobacco products. As of January 2, 2017, there were over 4,000 local and/or state/territory/commonwealth hospitals, health care systems and clinics, and four national health care systems (Kaiser Permanente, Mayo Clinic, SSM Health Care, and CIGNA Corporation) in the United States that have adopted 100 percent smoke-free policies that extend to all their facilities, grounds, and office buildings. Numerous Department of Defense (DoD) medical treatment facilities have become tobacco free as well. VHA health care providers and visitors do not have the same level of protection from the hazardous effects of second-hand smoke exposure as do patients and employees in these other systems. Currently, approximately 20 percent of veterans enrolled in VA health care are smokers. Many of the non-smokers are also older veterans who may be at higher risk for cardiac or other conditions that may make them even more vulnerable to the cardiovascular events associated with secondhand smoke. As with patients of other health care systems, VA believes veteran patients have a right to be protected from secondhand smoke exposure when seeking health care at a VA facility. For veteran smokers who are inpatients, nicotine replacement therapy is available.

VA estimates that it would see no savings in FY 2018, as the substantive changes made by this bill would not become effective until the beginning of FY 2023. VA estimates it would save approximately $8.2 million in FY 2023.

Draft Bill Veterans Affairs Medical Scribe Pilot Act of 2017

Section 2 of the draft bill would require VA to carry out a 2-year pilot program under which VA would increase the use of medical scribes at VA medical centers (VAMCs). The pilot program would be carried out at 10 VAMCs, with four located in rural areas, four in urban areas, and two in areas with need for increased access or efficiency. Under the pilot program, VA would hire 20 new medical scribes and would seek to enter into contracts with appropriate entities for the employment of 20 additional medical scribes. Two scribes would be assigned to each of two physicians, 30 percent of the scribes would be employed in the provision of emergency care, and the rest would be employed in the provision of specialty care. Every 180 days, VA would be required to report on the pilot program, and 90 days after completion, the Comptroller General would submit a report to Congress on the pilot program. No additional funding would be authorized to be appropriated to carry out the program.

While VA is exploring the use of medical scribes, VA does not support this draft bill as written. In the first quarter of FY 2017, VA began a demonstration project that includes the use of scribes (contracted or hired) and transcription, as well as a health advocate. There are eight sites in varying implementation stages, and VA has developed an evaluation plan for all methods of provider documentation support. VA also has an Enterprise Wide Front End Speech Recognition contract that includes unlimited licenses for clinical end users for the Nuance Dragon Medical 360 Network Edition (DMNE) Version 2.3, which is the current version. DMNE provides advanced, secure, speech recognition solutions that allow clinicians to document the complete patient story using voice while allowing healthcare organizations to deploy and administer medical speech recognition across the enterprise. VA does not have a cost estimate for this bill at this time, but will continue to work to provide this to the Committee shortly.

Members of the Committee, this concludes my statement. I would be happy to answer any questions you may have.

Prepared Statement of Kayda Keleher

Chairman Wenstrup, 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 its Auxiliary, I want to thank you for the opportunity to present the VFW's views on today's pending legislation.

H.R. 91, Building Supportive Networks for Women Veterans Act

The VFW strongly supports this legislation, which would make permanent VA's counseling in retreat setting program for women veterans. VA's retreat counseling program has served as an invaluable tool to help newly discharged women veterans seamlessly transition back into civilian life. The VFW supported the original pro-

gram established by the Caregivers and Veterans Omnibus Health Services Act of 2010 and subsequent year-long extensions. The VFW believes it is time to make this important program permanent.

H.R. 95, Veterans' Access to Child Care Act

This legislation would extend and expand the VA child care pilot program, which helps veterans attend their health care appointments and complete their treatment plans by providing necessary child care services. The VFW supports this legislation and has a recommendation to improve it which we urge this subcommittee to consider.

Veterans with dependent children face diverse barriers when obtaining their earned care and benefits. A barrier specific to parents is finding child care so they can attend medical appointments. Currently, VA has three pilot programs which offer child care services to enable veterans to attend medical appointments. Veterans who have used this program tell the VFW they would not have completed their treatment plans if it were not for the VA child care program.

The lack of child care is particularly difficult for homeless veterans who may forgo needed inpatient treatments for fear of losing custody of their children. The VFW firmly believes child care service would also improve access to employment training and counseling services that homeless veterans need to obtain meaningful employment that will allow them keep their homes and stay off the streets. That is why the VFW urges this subcommittee to expand eligibility for this important program by giving homeless veterans the opportunity to receive child care services while they attend employment training programs.

H.R. 467, VA Scheduling Accountability Act

The VFW believes all VA medical facilities must comply with scheduling laws and directives. However, the VFW cannot support this legislation because it would not resolve the underlying issue with scheduling at VA medical facilities.

Before requiring compliance, Congress and VA must first improve VA's wait time metric and scheduling directives. In the VFW's most recent VA health care report, only 67 percent of veterans indicated they obtained a VA appointment within 30 days, which is significantly less than the 93 percent of appointments VA reported were scheduled within 30 days during the same timeframe. This is because the way VA measures wait times is not aligned with the realities of scheduling a health care appointment.

VA also uses a wait time metric called the "preferred date" to measure whether a veteran is given an appointment within 30 days from the date a veteran would like to be seen or is told it is clinically necessary, which fails to account for the full length of time a veteran waits for care. The VFW is also concerned that VA's preferred date metric remains susceptive to data manipulation. For example, when veterans call to schedule appointments, they are asked when they prefer to be seen. The first question a veteran logically asks is, "When is the next available appointment?" Schedulers have the ability to input the medical facility's next available appointment as the veteran's preferred date—essentially zeroing out the wait time. VA must correct its wait time metric to more accurately reflect how long veterans wait for their care.

VA has established an arbitrary wait time goal of scheduling appointments within 30 days of a veteran's preferred date. This not only ignores whether a veteran should be seen earlier, but it is not aligned with how the health care industry measures wait times. In a recent report, the RAND Corporation found the best practices in the private sector for measuring timeliness of appointments are generally based on the clinical need of the health care requested and in consultation with the patient requesting the care. That is why the VFW has urged VA and Congress to move away from using arbitrary standards to measure whether an appointment was delivered in a timely manner, and adopt industry best practices by basing the timeliness of appointment scheduling on a clinical decision made by health care providers and their patients.

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

The VFW also has serious concerns with the requirement to withhold bonuses from VA medical center directors who fail to comply with scheduling standards. Section 205 of Public Law 113–146, the "Veterans Access, Choice, and Accountability Act of 2014" prohibited the use of scheduling and wait time metrics in determination of performance awards. Congress did so because the VA Office of the Inspector General and congressional oversight found VA employees were manipulating sched-

uling and wait time data to receive bonuses or appease management. The VFW fears this legislation would reinstate a culture of cover ups to receive awards.

Instead of linking bonuses to compliance with scheduling requirements, which will not result in veterans receiving more timely care, Congress must focus on evaluating and addressing the underlying reasons for high wait times. The VFW has highlighted many of these issues in the past. VA's medical support assistance (MSA) positions, who handle scheduling for the veterans, face the highest rate of turnover in the VA health care system. Due to the cumbersome hiring process and the low compensation levels for MSAs, it takes an average of six months to fill an MSA vacancy. The VFW urges Congress to expand VA's direct hire authority for this critical position.

VA's scheduling system is also archaic and hard to use. VA is in the process of implementing a modification to its scheduling system and is pursuing a commercial off the shelf (COTS) scheduling system. The VFW supports a COTS solution to VA's scheduling system and urges Congress to make certain VA has the resources needed to finally update its outdated scheduling system with a state-of-the-art COTS system.

H.R. 907, 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 seven to 42 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. The VFW understands the importance of high quality newborn health care and its long term impact on the lives of veterans and their families. Congress must ensure newborn children receive the proper postnatal health care they need.

H.R. 918, Veteran Urgent Access to Mental Health Care Act

This legislation would ensure veterans with other than honorable discharges, also known as "bad paper" discharges, have the opportunity to receive urgent mental health care from VA. The VFW supports the intent of this legislation, but believes it should be expanded before it is passed.

Under current law, eligibility for VA health care and benefits is based on many different factors. Most benefits, including VA health care and disability compensation, require veterans to have obtained a discharge that is other than dishonorable to be eligible. This means veterans who receive bad paper discharges and meet other eligibility requirements are eligible for VA health care and most benefits. However, VA has implemented a stringent interpretation of current law. In a recent report entitled Underserved: How the VA Wrongfully Excludes Veterans with Bad Paper, Swords to Plowshares found VA's process for determining health care and benefits eligibility is not consistent with the law, and results in 90 percent of veterans with bad paper discharges being denied eligibility to much needed health care and benefits.

When veterans go to a VA medical center for non-emergent care as a new patient, they are required to undergo an eligibility determination before they can receive care. Veterans who have an honorable discharge and meet other criteria—such as having service-connected disabilities, combat service, low income, or certain earned service medals—are allowed to receive care immediately or schedule an appointment. When veterans with bad paper discharges present to a VA medical facility for the first time, they are told they must undergo a VA character of discharge determination before they can receive care, which takes an average of 1,200 days according to Swords to Plowshares' report.

It is also important to clarify that the term "dishonorable" has different legal definitions for the Department of Defense (DOD) and VA. Whereas DOD only issues dishonorable discharges to service members who have been convicted of major offenses in a general court martial, title 38, United States Code (U.S.C.) specifies that veterans can be characterized as "dishonorable" when they are discharged for specific offenses, conscientious objector status, desertion, or for being AWOL for more than 180 days, regardless of whether or not such veterans received a dishonorable discharge from DOD. For that reason, VA created a character of discharge evaluation process to evaluate whether a veteran received a discharge that is considered dishonorable under title 38 U.S.C., but not by DOD standards. The VFW believes that this review process has been misapplied to all bad paper discharges absent the specific disqualifying criteria, which has resulted in VA depriving certain veterans with bad paper discharges of benefits they not only earned, but in many cases need.

Veterans who served honorably in combat, but were administratively discharged upon returning home due to relatively small infractions, like missing formations or self-medicating undiagnosed conditions, should not have to wait years before they can receive VA health care and benefits. Currently, veterans with bad paper discharges are three times more likely to die by suicide. Without access to VA health care, those suffering from service-related mental health injuries are left on their own to deal with their mental health symptoms, making recovery nearly impossible

The VFW is pleased that Secretary of Veterans Affairs David J. Shulkin has announced he will expand access to urgent mental health care to veterans who have received bad paper discharges. However, the VFW firmly believes VA does not and should not provide sporadic care. VA provides veterans a full continuum of high quality care that has been found to outperform the private sector and leads to a lower likelihood of attempts or death by suicide. That is why the VFW has urged VA to expand its proposed regulations to ensure veterans with bad paper discharges receive full eligibility to VA health care, rather than simply receiving access to sporadic urgent mental health care.

If VA fails to act, the VFW urges Congress to amend relevant sections of title 38, U.S.C., to make clear these veterans are eligible for full VA health care, not just urgent mental health care. The VFW recognizes that doing so would significantly increase VA's patient load and could exacerbate access issues. That is why the VFW urges Congress to make certain VA receives the resources it needs to care for these vulnerable veterans.

H.R. 1005, to improve the provision of adult day health care services for veterans

The VFW supports this legislation, which would expand adult day health care benefits for veterans who are eligible for long-term inpatient care.

Currently, veterans who are at least 70 percent service-connected are eligible to receive cost free nursing home or domiciliary care at any of the more than 120 state veterans' homes throughout the country. While nursing home care is a necessity for veterans who can no longer live in the comfort of their home, the VFW strongly believes veterans should remain in their homes as long as possible before turning to inpatient and long-term care options. This legislation would ensure veterans have the opportunity to receive adult day care so they can remain in their homes as long as possible.

H.R. 1162, No Hero Left Untreated Act

The VFW opposes this legislation, which would require VA to carry out a pilot program to provide veterans Magnetic eResonance Therapy (MeRT) to treat post-traumatic stress disorder (PTSD) and other mental health conditions.

The VFW supports expanding access to integrated and complementary therapies that have proven to effectively treat veterans who have not responded to conventional or evidence-based mental health care. However, MeRT is not approved by the U.S. Food and Drug Administration (FDA) and has shown little to no evidence of effectiveness in treating PTSD. VA already offers similar treatments that have been proven to work, cost less, and are FDA approved.

Additionally, this legislation would not provide VA additional funding to test the efficacy of MeRT. The VFW believes that VA must spend its already scarce health care resources on therapies which have shown promise or have a proven track record.

H.R. 1545, VA Prescription Data Accountability Act 2017

The VFW supports this legislation, which would expand VA's requirement to report prescription data to state prescription drug monitoring programs (PDMP).

Current law requires VA to report certain data on prescription of opioids and other narcotics to state PDMPs. The requirement is for VA to share the data of veterans and dependents. However, VA systems cannot differentiate between dependents and other non-veterans who have received care through the VA health care system. While the vast majority of non-veterans receive VA care through the Civilian Health and Medical Program of the VA (CHAMPVA) outside of VA medical facilities, VA does provide care to some non-veterans in its medical facilities, particularly in the emergency room. The VFW supports the sharing of prescription data with state agencies and agrees VA should share data for non-veterans as well.

H.R. 1662, to prohibit smoking in any facility of the Veterans Health Administration

The VFW does not have a position on this legislation that would prohibit smoking in and around VA medical facilities. We do have some points to consider, however.

According to the Centers for Disease Control and Prevention, smoking is the leading cause of preventive death in the United States. The VFW is aware of the health hazards associated with smoking and understands that the overwhelming majority of America's health care systems and facilities have moved to smoke-free campuses. On the other hand, VA is required by Public Law 102–585, the "Veterans Health Care Act of 1992," to establish and maintain "a suitable indoor area in which patients or residents may smoke."

As a result, 120 VA community living centers (nursing homes) have co-located smoking facilities for veteran residents. Recent news reports also indicate that VA operates nearly 1,000 outdoor and 15 other designated smoking areas. While the VFW understands the reasons for shifting VA medical facilities to smoke-free campuses, we are concerned that this legislation would force VA to comply with arbitrary implementation dates that would require a significant lifestyle change for veterans who rely on VA for their health care without enough time to adjust to new requirements, particularly for veterans who reside in VA nursing homes.

This legislation would require VA to prohibit indoor smoking within 90 days of enactment, and outdoors by October 2022. This means that veterans who reside in the 120 VA nursing homes with co-located smoking areas, most of which are ventilated indoor smoking rooms, would only be given three months to adjust to a smoke-free environment. Approximately 9,225 veterans currently reside in VA community living centers. This legislation would force approximately 20 percent of veterans estimated to be smokers (2,000 average daily census) to either leave or quit smoking within 90 days—neither of which are easy decisions. If this subcommittee advances this legislation, the VFW urges it to consider extending the effective date to allow veterans more time to adjust to a new lifestyle.

If VA medical facilities are to become smoke-free campuses, VA must strengthen and expand its smoking cessation programs. This includes nicotine replacement therapy for veterans residing in VA nursing homes who tend to be older with severe service-connected disabilities, and who may not be able to easily travel off campus to smoke, as well as veterans using VA rehabilitation therapies for substance abuse of illicit drugs and alcohol. Treatment must be provided to veterans, not forced upon them. By forcing veterans to not smoke, unintended consequences of veterans' not seeking care and treatment they need will be inevitable. VA must also find ways to mitigate the loss of non-clinical benefits veterans identify with smoking, such as socializing with other veterans in smoking rooms.

Draft legislation, Veterans Affairs Medical Scribe Pilot Act of 2017

This legislation would require VA to carry out a pilot program to evaluate the efficacy of using medical scribes. The VFW supports this bill and has a recommendation to improve it.

A recent VA study evaluating common challenges faced by clinicians in their day-to-day environments, conducted by VA's Emerging Health Technology Service, concluded that burdensome non-clinician-centered electronic health care systems have a significant impact on morale and retention of VA physicians and veterans' experiences due to reduced facetime with providers. This legislation would reduce the time physicians spend on the keyboard and maximize face-to-face time with their patients.

The Emerging Health Technology Service assessment determined that searching and navigating disparate data systems consumes vast amounts of time VA clinicians can spend interacting with their patients. That is why the VFW is glad this legislation would require medical scribes to help providers navigate a veteran's electronic medical record and respond to messages, such as secure messages, in addition to serving as a scribe during appointments.

VA currently operates a Health Advocate Program in six VA medical facilities that is very similar to the medical scribe pilot programs this legislation would establish. However, the majority of VA's Health Advocate Program uses nurses instead of medical scribes to assist VA physicians. In addition to serving as a scribe during medical appointments and helping physicians navigate a veteran's electronic health care record, health advocates ensure veterans understand their treatment plans when the appointment has concluded. They also have appointments with veterans to evaluate whether they are making progress with their treatment. While the VFW does not believe scribing is the most effective use of nurses, we do urge this subcommittee to base the medical scribe pilot programs on VA's health advocate program. Medical scribes should be trained to help veterans understand their treatment plan and ensure veterans are on track to successfully complete their treatments.

Prepared Statement of Shurhonda Y. Love

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting DAV (Disabled American Veterans) to testify at this legislative hearing of the Subcommittee on Health. As you know, DAV is a non-profit veterans service organization comprised of 1.3 million wartime service-disabled veterans that is dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity. DAV is pleased to be here to present our views on the bills under consideration by the Subcommittee, and we appreciate your invitation.

H.R. 91–Building Supportive Networks for Women Veterans Act

If enacted, beginning January 1, 2018, this bill seeks to make permanent the pilot program to provide reintegration and readjustment counseling in a retreat setting for women veterans newly separated from service in the Armed Forces, after a prolonged combat theater deployment. Participation in this program is voluntary, and done through an application and screening process, which requires active participation in counseling through a VA Vet Center, or Medical Center. This bill would provide: information and assistance on reintegration into family, employment, and community; financial and occupational counseling; information and counseling on stress reduction and conflict resolution; and any other counseling VA considers appropriate to assist participants in reintegrating back into their families and communities. This measure also requires VA to provide a biennial report on the program.

Based on information taken from the biennial reports of the program, nearly all participants identified some element of the curriculum that was useful to their readjustment. One report indicates, as a group, 85 percent of the participants showed significant improvement in psychological well-being based on pre-treatment and post- treatment testing. 75 percent of participants maintained significant improvement in psychological well-being at two months post retreat. After the retreat, participants were administered a Stress Symptoms and Stress Coping Skills survey; more than 80 percent of participants showed a decrease in stress symptoms, and improvement in positive coping skills during the two-month period after the retreat. Participants expressed high satisfaction with the results of the retreat. The positive statistics of the program coupled with satisfaction of women veterans serve as testament to the success of the program. It is for this reason, we support making the program permanent.

We thank the Subcommittee for its continued efforts to improve women veterans' programs and services and are pleased to support the Building Supportive Networks for Women Veterans Act, which is in line with DAV Resolution No. 129, which calls for enhanced medical services and benefits for women veterans.

H.R. 95–Veterans' Access to Child Care Act

The Veterans' Access to Child Care Act would provide child care assistance to an eligible veteran during any period that the veteran is receiving mental health or intensive health care or mental health services at a VA facility. Child care assistance payments may be provided to an onsite facility of the Department, directly to a private child care agency, in collaboration with a facility or program of another federal department or agency, or in the form of a stipend paid to a licensed child care provider. This bill requires that, to the extent practicable, the program should be modeled after the VA's Child Care Subsidy Program.

All veterans deserve to have access to the high quality health care offered by the VA. The need for child care should not be a bar to receiving such care. The VA's April 2015 study, Barriers for Women Veterans to VA Health Care Final Report, indicates 42 percent of VA health care users report finding child care to attend medical appointments is somewhat difficult. This is especially true for women who are not married, and are the primary care takers of young children. As the number of women enlisting into military service continues to grow, so too will the number of women veterans seeking care at VA. VA must ensure all veterans have every opportunity to access the services they have earned and need to fully readjust following military service. For many veterans, the provision of child care assistance by VA is not a convenience, it is a necessity.

DAV is pleased to support H.R. 95. Our report, Women Veterans, The Long Journey Home, recommends child care services to support better access to VA health care. DAV resolution 129 calls for support of legislation to enhance medical service and benefits for women veterans, and is consistent with the intent of this bill.

H.R. 467–VA Scheduling Accountability Act

This bill would mandate a report be provided to both chambers of Congress to indicate whether or not the VA medical centers have been annually certified to be in compliance with all VA regulations, policies, and directives relative to veteran patient appointment scheduling for health care and medical services. This bill requires directors of each medical facility to submit an annual report to the Secretary indicating the status of their compliance with appointment scheduling requirements. If the medical center is in full compliance with said policies, regulations and directives, they are to certify compliance to the Secretary. In the event a facility is unable to certify full compliance, the director is to provide the Secretary with an explanation of the failure, and corrective measures being taken to bring the facility into full compliance. The bill mandates that the Secretary is barred from providing a waiver to medical centers failing to certify, and must report the status of each medical facility along with reports received from the directors of these facilities to Congress. The bonuses for officials responsible for the uncertified medical facility would be withheld the following year of non-certification.

Although DAV has no specific resolution, we support the intent of this bill and the requirement for VA to be in full compliance with all regulations, policies, and directives related to scheduling; however, if a lack of resources or antiquated technology or other items outside the control of local directors, are the underlying reasons for noncompliance, these factors should be taken into consideration before withholding bonuses to otherwise well performing medical center directors.

H.R. 907–Newborn Care Improvement Act

If enacted, this bill would provide up to 42 days of health care to newborn children of women veterans who are receiving maternity care through the Department of Veterans Affairs (VA). Current law authorizes VA to cover the cost of newborn care for up to seven days. This bill not only expands post-natal care, but also requires VA to provide an annual report to Congress no later than October 31 of each year that includes the number of newborn children who received services during each fiscal year.

Of great concern to DAV are those women whose service-connected disabilities contribute to high risk pregnancies, or pre-term deliveries. According to VA, in an analysis of VHA utilization of health care by Operations Enduring and Iraqi Freedom and New Dawn (OEF) (OIF) (OND) veterans, spanning from October 1, 2001 to June 30, 2015; of the 1.2 million veterans who have obtained VA health care, almost 12 percent of these veterans are women. A significant number of women veterans from this group have a mental health diagnosis and it is important to take into consideration the effect these potential service-related conditions have on their pregnancies.

According to the estimate provided by VA's Chief Business Office report dated November 19, 2015, 11 percent of the 2,200 births to women veterans occurring each year are complicated births requiring neonatal care beyond seven days. Likewise, the juxtaposition of pregnancy and mental health related issues is to be noted since pregnancy itself can precipitate or exacerbate mental health conditions, and maternal anxiety during pregnancy can give rise to pre-term deliveries and lower birth weights.

DAV has no specific resolution on this particular measure; however, we have no objection to its passage, based on the above-noted findings.

H.R. 918–Veteran Urgent Access to Mental Healthcare Act

This legislation would allow VA to furnish an initial mental health assessment and urgent mental health care treatment to a veteran of the Armed Forces having an "other than dishonorable" or "bad conduct" discharge. This treatment includes an initial mental health assessment and the treatment of an urgent health care need, to include suicide prevention efforts. The veteran must have participated in or experienced combat operations or hostilities, including the use of unmanned aerial vehicles; or was a victim of a physical assault, battery of a sexual nature or suffered military sexual trauma and must not be eligible for VA care under any other provision in statute and has applied for a character of service determination and such determination has not been made.

In the event that VA care is clinically inadvisable, or if facilities are not located in a place that would allow reasonable access to a VA medical campus capable of providing the required assessment or treatment, non-Department care would be authorized. To fulfil the obligations of this bill, the Secretary is authorized to enter into contracts or agreements with non-Department facilities to furnish hospital care and medical services to veterans at said facilities. In furnishing health care services to veterans under this section, the Secretary shall seek to ensure that health care services are furnished in a therapeutically appropriate setting, and provide referral

service to assist former service members who are not eligible for services under this chapter to obtain services from sources outside of the Department.

The Secretary shall provide information regarding this program in coordination with the Secretary of Defense to members separating from the Armed Forces and to veterans to ensure awareness of the program, and the process by which to utilize services. The Secretary would be required to establish an 800 number, and keep updated information regarding the services offered, ensure information is posted in VA facilities where it is highly visible, and also make information regarding this program available through public information services. No later than one year after the date of enactment, the Secretary is to submit an annual report to Congress detailing the number of individuals receiving care under this program to include gender and any additional information the Secretary deems necessary. In conjunction with this program, a suicide study is to be conducted that compares the rate and method of suicide among veterans receiving heath care from VA and those who have not. An additional comparison is to be done on the rate of veterans committing suicide, and the incidence of serious mental health issues among combat and non-combat veterans.

DAV is pleased to support H. R. 918, which is in line with DAV Resolution No. 226, calling for support of a more liberal review of other than honorable discharges in cases of posttraumatic stress disorder, traumatic brain injury, mental health conditions related to military sexual trauma, and other trauma for the purpose of eligibility for VA benefits and services.

H.R. 1005-to improve the provision of adult day health care services for veterans

H.R. 1005, if enacted, would authorize the Secretary to enter into agreements with state veterans homes to provide adult day health care for veterans who are eligible for, but do not receive, skilled nursing home care under section 1745(a) of title 38, United States Code. Eligible veterans are those who require such care due to a service-connected disability, or who have a VA disability rating of 70 percent or greater and are in need of such care. The payment to a state home under this program would be at the rate of 65 percent of the amount payable to the state home if the veteran were an inpatient for skilled nursing care and payment by VA would be considered payment in full to the state home.

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

DAV is pleased to support H.R. 1005, which is in line with DAV Resolution No. 127, calling for support for the state veteran home program, recognizing state home care as the most cost-effective care available for sick and disabled veterans with long-term care needs outside the VA health care system.

H.R. 1162–No Hero Left Untreated Act

This bill seeks to implement a one-year pilot program using Magnetic EEG/EKG-guided resonance therapy (MeRT) to veterans in no more than two VA Facilities, with no more than 50 veteran participants suffering from posttraumatic stress, traumatic brain injury, conditions related to military sexual trauma, chronic pain, or opiate addiction. Not later than 90 days after the termination of the program, the Secretary is to submit a report to the House Committee on Veterans' Affairs on the pilot. The pilot is to be funded through existing funds already appropriated to VA.

The measure notes that 400 veterans with post-traumatic stress disorder, traumatic brain injury, military sexual trauma, chronic pain, and opiate addiction have successfully been treated with MeRT. Likewise, recent clinical trials and randomized, placebo-controlled, double-blind studies, have produced promising measurable outcomes. According to VA, Repetitive transcranial magnetic stimulation (rTMS), a similar treatment option is currently available to veterans. rTMS has been FDA approved in the treatment of resistant depression, and opioid addiction. It is unknown if one method of treatment is better than the other.

DAV has no resolution on this issue and generally does not oppose or support a specific therapeutic intervention; however, we do support the use of complementary and alternative medicine and research to confirm new therapies as beneficial to veterans.

H.R. 1545–VA Prescription Data Accountability Act

This bill would amend title 38, Unites States Code, to clarify the authority of the Secretary to disclose patient information to state-controlled substance monitoring programs when controlled drugs are dispensed by VA. Current law authorizes the Secretary to disclose said information for veterans and their dependents when VA prescribes a state-controlled substance. This bill would expand the Secretary's authority to report all individuals who receive these drugs from VA.

DAV has received no national resolution from our membership that addresses this particular legislation; therefore, we take no official position.

H.R. 1662-to prohibit smoking in any facility of the Veterans Health Administration

This bill seeks to amend title 38, United States Code, to prohibit smoking by all persons in all facilities of the Veterans Health Administration (VHA). Persons may continue to smoke outdoors at VHA facilities until October 1, 2022; after which date, smoking will be prohibited. The term smoking is to include all forms of combustion of tobacco, including e-cigarettes, cigars, and pipes. The term facility includes any medical center, nursing home, domiciliary facility, outpatient clinic, or center that provides readjustment counseling that is under the jurisdiction of the VA, under the control of the Veterans Heath Administration.

DAV has no resolution on this issue; however, the prevalence of smoking among people with mental illnesses is startling. According to the Substance Abuse and Mental Health Services Administration, 36–80 percent patients with major depression use tobacco; 45–60 percent with Post-traumatic stress disorder; 51–70 percent with bipolar mood disorder; 62–90 percent with schizophrenia, and; 32–60 percent with anxiety disorders. VA has a high percentage of veterans receiving mental health services. In fiscal year 2015, more than 1.6 million veterans received specialized mental health treatment from VA.

Individuals with mental health concerns are disproportionately affected by, and suffer from the negative consequences of, tobacco use disorder; perhaps because they are not receiving adequate information and cessation services or that smoking has historically been part of psychiatry's culture. While research has shown high levels of patient support for indoor smoking bans in psychiatric settings, even among current smokers, patients have a unique perspective on their experience in psychiatric inpatient facilities, and every effort should be made to include their voices in policy decision-making at a national level and at individual facilities.

While we know the health benefits that come with smoking cessation, we hope the implementation of this measure takes a compassionate approach to eliminating tobacco use in VA facilities, as it is a substance misuse disorder particularly impacting patients with mental illness. While VA is a leader in treatment of substance use disorder and focuses significant resources on tobacco cessation, many veterans do not avail themselves of counseling and medication options to quit smoking. If this bill is enacted, we suggest the measure require VA to conduct a comprehensive tobacco cessation outreach program targeting all veteran patients that smoke to raise awareness about options for quitting. The policy must recognize that nicotine dependence is a chronic, relapsing disorder; with most tobacco users in the general population requiring multiple attempts before they are finally able to quit for good.

Draft bill-to carry out a pilot program on the use of medical scribes in VA medical centers

If enacted, this bill seeks to implement a two-year pilot program to employ a total of 40 scribes at 10 different medical centers, where a minimum of four medical centers are located in rural areas, and four located in urban areas. Medical scribes would be assigned at a ratio of two scribes to each of two physicians with 30 percent deployed in the provision of emergency care, 70 percent in the provisions of specialty care having the longest patient wait times, or lowest efficiency ratings as determined by the Secretary.

These scribes would assist the physician or practitioner in navigating the electronic health record, responding to messages as directed by the provider, and entering information into the electronic health record as directed by the provider. Reports on the pilot program are to be provided to Congress beginning six months after enactment, and every six months for the duration of the pilot. These reports are to include an analysis of each of the scribes in the areas of provider efficiency, patient satisfaction, average wait time, the number of patients seen per day by each physician or practitioner and the amount of time required to hire and train the scribe.

Upon termination of the scribe pilot program, the Comptroller General shall submit a report to Congress that includes a comparison of the pilot program with similar programs carried out in the private sector. Funding for the program is to come from existing funding appropriated to the Department.

In response to the growing complexity of health care and the electronic medical record, medical scribes have been used in the private sector to improve productivity, clinical documentation, completion of medical records, as well as provider satisfaction.

We recommend the flexible deployment of scribes to areas in which they are not only needed, but can be the most effective. We caution about the restrictive deployment of scribes as directed by this bill, as this could lead to not enough resources in one area, and too many in another. VHA should reserve the ability to place the scribes in the areas of the greatest need, and in accordance with performance measures as well as accessibility.

DAV Resolution No. 244 adopted at our most recent National Convention calls for quality care for veterans to be achieved when health care providers are given the freedom and resources to provide the most effective and evidence-based care available. We believe the use of medical scribes could help to accomplish this goal, and, therefore, we support the intent of this bill.

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.

Prepared Statement of Sarah S. Dean

Chairman Wenstrup, 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 percent 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. 91, the "Building Supportive Networks for Women Veterans Act"

PVA supports H.R. 91, the "Building Supportive Networks for Women Veterans Act," a bill to make permanent the pilot program on counseling in retreat settings for women veterans newly separated from service in the Armed Forces. The bill would provide VA with the authority to extend the program using the same measurements and eligibility requirements. PVA supported the original program established by the "Caregivers and Veterans Omnibus Health Services Act of 2010" and has been pleased to see it continue.

In surveys conducted after the program, participants consistently showed better understanding of how to develop support systems and to access resources at VA and in their communities.

The OEF/OIF women veterans at these retreats are most often coping with effects of severe Post-Traumatic Stress and Military Sexual Trauma. They work with counselors and peers, building on existing support. If needed there is financial and occupational counseling. To be eligible, women veterans must have been deployed in OEF/OIF, and have completed at least three sessions of counseling in the past six months.

The program, managed by the Readjustment Counseling Service, has been a marked success since its inception in 2011. The results have been overwhelmingly positive for women veterans, who experience consistent reductions in stress symptoms as a result of their participation. Other long lasting improvements included increased coping skills. It is essential for women veterans that Congress make this program permanent. We believe the value and efficacy is undeniable.

H.R. 95, the "Veterans' Access to Child Care Act"

PVA supports H.R. 95 the "Veterans' Access to Child Care Act." This legislation would make permanent the provision of child care assistance to veterans receiving certain medical services from the Department of Veterans Affairs.

PVA believes child-care is a critical avenue for veterans to access health care, vocational rehabilitation, education, and employment services. There is no denying that when heads of households have access to reliable child care their participation in their own health care and wellbeing increases.

A VA report from 2015, Barriers for Women Veterans to VA Health Care, discussed nine primary barriers, one of which was child care. Forty-two percent of

women surveyed for the report said they had difficultly securing child care in order to seek VA health care services and would find on-site child care to be useful. PVA urges Congress to make this program permanent in order to care for veterans who would otherwise not be able to access VA.

Similarly, for veterans seeking mental health care, GAO has identified several barriers that deter veterans, including stigma, lack of understanding of the potential for improvement, lack of child care or transportation, and work or family commitments. Timely access to mental health care is imperative to preventing suicide, obviating long-term health consequences, and minimizing the disabling effects of mental illness.

While the permanent presence of child care services is the right thing to do, it is also economic. Ensuring veterans have timely access to health care decreases the compounding costs that come with treating an injury or mental illness later down the line. A trustworthy child care option alleviates stressors for the veteran, and encourages they maintain their contact and treatment plan with their VA providers. The extended pilot program is set to expire on December 31, 2017. PVA urges Congress to continue this vital service.

H.R. 467, the "VA Scheduling Accountability Act of 2017″

PVA supports the "VA Scheduling Accountability Act of 2017," requiring all VA medical facilities to certify compliance with scheduling laws and directives. This legislation would require each facility director to annually certify compliance with VHA Directive 2010–027, or any successor directive that replaces it. The aim is to increase transparency of scheduling practices at VA. In May 2013, VA waived the annual certification requirement. This legislation makes permanent the requirement for each VA medical center report its scheduling compliance certification. If a facility director is unable to certify compliance the director will then submit a report to the Secretary of VA explaining why the facility is out of compliance and what steps are being taken to achieve compliance. In turn, the Secretary will report to the House and Senate Committees on Veterans' Affairs a full list of the facilities that have or have not certified compliance. Lastly, if a facility does not make a certification, their leadership would then be prohibited from receiving any award or bonus during the following year the certification was not made.

While PVA supports this bill it is unclear how this legislation will resolve the underlying problems with scheduling at VA medical facilities. Preferred date metrics do not properly measure how long a veteran waits for an appointment. A GAO report from April of 2016, "Actions Needed to Improve Newly Enrolled Veterans' Access to Primary Care" highlighted inaccurate recording of appointment request and wait times for that appointment in the scheduling system. Using the request date as the starting point is flawed because VA uses an arbitrary time goal of 30 days for all appointments, a standard used by no other health care system. The overwhelming best practices for measuring timeliness is clinical need of the requested care, and in consultation with the patient. The usefulness of this legislation is unclear as long as VA's wait time metrics remain flawed and vulnerable to manipulation. Compliance with the certification does not guarantee better scheduling practices and improved health care access for veterans.

H.R. 907, the "Newborn Improvement Act"

PVA supports H.R 907, the "Newborn Improvement Act." This bill would amend Section 1786 of title 38, United States Code, to authorize hospital stays of up to 42 days for newborns under VA care. The current provision allows a maximum stay of seven days. As the average stay for a healthy newborn is two days, any newborn needing additional coverage is likely to be facing complications immediate after birth or a severe infant illness.

The current seven day coverage is in a non-department facility for eligible women veterans who are receiving VA maternity care. Beyond the seven days, the cost of care is the responsibility of the veteran and not VA, even if complications require continued care beyond the coverage period. Post-natal health is critical to newborn health which directly impacts the lives and wellbeing of veterans and their families.

H.R. 918, the "Veterans Urgent Access to Mental Health Care Act"

PVA supports H.R. 918, which would provide urgent mental health care to former members of the military who are not otherwise eligible to receive care in the VA due to having an other-than-honorable discharge status. The Secretary's recent announcement that VA will be pro-actively offering mental health care services in urgent situations demonstrates the importance of the issue and passage of supporting legislation.

The scope of this bill is appropriately limited to former military members who are facing an imminent mental health care crisis and have already begun the review process of their discharge status. Those undergoing review have specifically alleged that the circumstances leading to their other-than-honorable discharge were a direct or indirect product of the physical or mental wounds of war. The scope is also properly limited to those who deployed, participated in or experienced combat operations or hostilities, or were the victims of sexual assault, battery or harassment.

H.R. 1005, "to improve the provision of adult day health care services for veterans"

PVA supports H.R. 1005, a bill that would provide "no cost" medical model adult day health care (ADHC) services to veterans who are 70 percent or more service-connected disabled. By authorizing the Secretary to enter into agreements with state veterans homes the bill would provide ADHC to those veterans who are eligible for, but do not receive, skilled nursing home care under section 1745(a) of title 38, USC. Currently, VA pays State Homes a per diem for ADHC. The per diem rate covers around one-third the cost of the program. H.R. 1005 is an extension to the Veterans Benefits, Health Care, and Information Technology Act of 2006 (Pub. L. 109–461), which provides "no cost" nursing home care at any State Veterans Home to veterans who are 70 percent or more service connected disabled. This means there are veterans making a choice between 100 percent free nursing home care or expensive, out of pocket ADHC. The payment to a state home under this legislation would be 65 percent the amount payable to the state home if the veteran were an inpatient for skilled nursing care.

Adult day health care is a crucial service that allows veterans to remain in their homes and communities and delay entry into traditional nursing care. While a veteran may need long-term services and supports, it is not always necessary those services be received in an institutional setting. Rather, a veteran can receive comprehensive medical care and socialization without the disruption of permanently leaving their home. The program is staffed by a team of multi-disciplinary healthcare professionals who evaluate each participant and customize an individualized plan of care specific to their health and social needs. ADHC is designed to promote social stimulation and maximize independence while also receiving quality of life nursing and personal care services.

Additionally, we know the wellbeing of a caregiver directly impacts the quality of care they provide to their veteran. ADHC gives caregivers the ability to meet other professional and family responsibilities. Especially for those caregivers whose veteran was injured before 9/11 and is not eligible for the VA Comprehensive Caregiver Program. ADHC offers critically needed support. Delayed institutional care for the severely disabled is a rare jewel in health care; it is the least costly care for the taxpayer while at the same time, the highest quality care for certain populations. And perhaps the most important benefit, ADHC for disabled veterans allows spouses, children, parents, friends and communities more time together.

H.R. 1162, the "No Hero Left Untreated Act"

PVA has no official position on H.R. 1162, the "No Hero Left Untreated Act." This legislation would establish a pilot program with the Department of Veterans Affairs (VA) to use Magnetic eResonance Therapy technology, or MeRT technology. This therapy, while not yet FDA approved, is used to treat post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), military sexual trauma (MST), chronic pain, and opiate addiction. The legislation would establish a one-year pilot program on MeRT technology for fifty veterans at two VA medical centers.

VA currently offers veterans access to repetitive transcranial magnetic stimulation (rTMS). This treatment is FDA approved to address treatment-resistant depression, a comorbid condition in PTSD, TBI, MST, and chronic pain and opioid addiction. While it is functionally similar to MeRT there is no existing evidence that MeRT is superior to rTMS for treating any disorder.

H.R. 1545, the "VA Prescription Data Accountability Act of 2017″

PVA supports H.R. 1545, the "VA Prescription Data Accountability Act of 2017." In 2016, the "Comprehensive Addiction and Recovery Act" (CARA) required providers at the Veterans Health Administration (VHA) to participate in their respective state's Prescription Drug Monitoring Program (PDMP). Prescribers must check patient records in the state databases before prescribing pain killers. The pharmacists are responsible for recording when they fill those prescriptions.

However, data for hundreds of thousands of non-veteran patients seen at VA is unable to be shared due to a technical oversight in the law. Current statute authorizes VA to send prescription data for two groups; veterans, and dependents of vet-

erans. Yet there is a third group of patients who receive prescriptions through VA; non-dependent, non-veteran, VA beneficiaries. These patients include CHAMPVA enrollees, descendants of veterans with birth defects from toxic exposure, VA health employees, some active duty service members, and those receiving care through sharing agreements with academic affiliates. To complicate matters, VistA cannot differentiate between dependents and other non-veterans. VHA is only sending data for veteran and dependents. Approximately 10 percent of VHA's patient population are dependents or non-veteran, non-dependents who receive prescriptions from VHA. H.R. 1545 would rectify this oversight by stipulating the prescription data of all those covered by VHA, regardless of patient group, be submitted to the appropriate PDMP.

The United States is in the midst of an opioid epidemic. PDMPs are critical to ensuring safe prescribing practices and prevent inappropriate pushing of narcotics by providers. Forty-nine states and the District of Columbia have PDMPs. VA has been authorized to share prescription data with PDMPs since 2011 and last year, CARA required VHA to participate. The effectiveness of Opioid Safety Initiatives is dependent on the availability of all prescription data. This loophole allows for these non-dependent, non-veterans, to access prescriptions within VA and a community setting, with neither entity the wiser. VA's 2017 projection of non-veteran patients is 715,000. These patients must have the same safety protections as anyone else. VA would be better able to mitigate the potential consequences of opioid use.

While PVA strongly supports H.R. 1545, we are concerned that PDMPs may not be capturing another group; veterans who travel to different states to receive their specialized care. It is our understanding that each VA Medical Center (VAMC) only shares prescription data to the state PDMP in which the VAMC is located. There is little clarity at this point if state PDMPs can share with other states. Some have established regional Memoranda of Understanding, communicating information with neighboring states. But there are veterans, particularly veterans with a spinal cord injury or disease (SCI/D) who regularly travel across multiple state lines to one of the 24 SCI Centers across the country. There has yet to be any assurance that the prescription data of an SCI/D veteran who receives care at an SCI/D center in Minneapolis, but lives in Wyoming, will be shared. We urge the committee to make sure these specialized patient populations are benefiting from the opioid safety measures in the same way as non-traveling veterans.

H.R. 1662

PVA has no official position on H.R. 1662, a bill that would ban smoking at all VA facilities within five years. While we understand the intent of this legislation and applaud its intent, we would offer one note of caution. Many veterans smoke as a form of stress relief. It also serves as a form of social interaction for veterans who are inpatients for extended periods of time. We have seen this to be particularly true with veterans who often spend many months as inpatients in VA's spinal cord injury centers. Smoking serves as a form of mental health treatment for some of these veterans, albeit not an optimal one. While it makes perfect sense to eliminate all smoking inside VA facilities, we believe that the legislation should consider the impact this prohibition will have on the many veterans who cannot simply give up the habit.

"Veterans Affairs Medical Scribe Pilot Act of 2017″

PVA supports the draft "Veterans Affairs Medical Scribe Pilot Act of 2017." This legislation would allow for a pilot program to increase the use of medical scribes to maximize the efficiency of physicians at medical facilities of the Department of Veterans Affairs. A medical scribe helps to decrease the burden of data entry on the part of the medical provider. They accompany a provider to document the physician-patient interaction, and enter it into the Electronic Health Record (EHR) at that time. The physician later reviews and approves the data entry. This dynamic allows for the physician to spend more uninterrupted time interacting with the patient, and less time dictating notes. Multiple studies have indicated that medical scribes increase physician-patient satisfaction. Further, because the physician is relieved of data entry, they are able to see more patients, thus impacting wait times. In a time when VHA is struggling to hire and retain physicians, allowing for medical scribes to help existing providers carry the patient volume is essential.

PVA would once again like to thank the Subcommittee for the opportunity to submit our views on the legislation considered today. Enactment of much of the proposed legislation will significantly enhance the health care services available to veterans and their families. I would be happy to answer any questions that you may have.

Statements For The Record

CONGRESSMAN LEE ZELDIN

Testimony on behalf of H.R. 1005, To Improve Provisions of Adult Day Health Care Services for Veterans

Good Morning Chairman Wenstrup, and thank you for the opportunity to testify on behalf of my bill, H.R. 1005, which provides no-cost medical model adult day health care services for our 70% or more service connected disabled veterans.

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

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

In order to address this issue and expand access to care for our heroes, I introduced bipartisan legislation in Congress, H.R. 1005, which would ensure that 70% or more service connected disabled veterans are able to receive Adult Day Health Care at no cost to the veteran and their family by defining the program as a reimbursable treatment option through the VA. My bill would guarantee that all severely disabled veterans are able to access Adult Day Health Care. By providing disabled veterans with access to Adult Day Health Care programs, we can ensure that all veterans receive the best and most efficient outpatient services to provide them with the assistance and special attention that they need in their day to day lives, while still allowing them to maintain their independence.

Adult Day Health Care also helps keep families together and strong. With the inclusion of Adult Day Health Care services as a covered VA expense, family members and caregivers can rest easier knowing that their loved ones are receiving top notch care during the day, while being treated with the same respect and dignity that they would receive at home. Not only does the Adult day Health Care model care for the medical needs of a veteran, but it also addresses their social and emotional needs as well. Adult Day Health Care allows veterans to interact and socialize with their peers and other individuals enrolled in the program. Rather than sitting home alone all day, participants in the adult day health care program receive one-on-one attention from medical and support staff while also maintaining an active social schedule through planned events and activities. Family members and caregivers can go about their day without the worry that their loved ones are unattended, and the veteran can continue to remain as active members of their community.

This legislation passed the House with unanimous support in the 114th Congress and it is my hope that we can continue the progress that was made last year. It is a top priority of mine to ensure that all veterans on Long Island and across the country receive the proper treatment and care they deserve, which is why I fully support the adult day health care program. I will continue working every day to spread awareness of this bill, so that we pass this bill as soon as possible to expand Adult Day Health Care for our disabled veterans, and I thank you for considering this essential piece of legislation.

THE AMERICAN LEGION

(19 FOOTNOTES)

Chairmen Wenstrup, Ranking Member Brownley and distinguished members of the Subcommittee on Health, on behalf of National Commander Charles E. Schmidt, the country's largest patriotic wartime service organization for veterans, comprising over 2.2 million members and serving every man and woman who has worn the uniform for this country, we thank you for the opportunity to submit this statement of The American Legion's positions on the following pending legislation.

H.R. 91: Building Supportive Networks for Women Veterans Act

To amend title 38, United States Code, to make permanent the pilot program on counseling in retreat settings for women veterans newly separated from service in the Armed Forces.

This bill makes permanent the Department of Veterans Affairs' (VA) successful pilot program, established under the Caregivers and Veterans Omnibus Health Services Act of 2010, to provide counseling and reintegration services in retreat settings for women veterans coping with Post-Traumatic Stress Disorder (PTSD) and other wounds of war who, are recently separated from service after a prolonged deployment.

Women veterans are the fastest growing demographic serving in the military, so we can expect the number of women veterans using VA care to increase dramatically. Resolution No. 147: Women Veterans, passed during our 2016 National Convention in Cincinnati, Ohio, calls on The American Legion to work with Congress and the VA to ensure that the needs of current and future women veteran populations are met. Just as women veterans have dedicated themselves to service, so should a grateful nation be dedicated to providing them with the specialized services they require.[1] The American Legion actively supported the legislation that introduced this program two years ago, and we support the continuation of the program now.

The American Legion supports H.R. 91.

H.R. 95: Veterans' Access to Child Care Act

To amend title 38, United States Code, to direct the Secretary of Veterans Affairs to provide child care assistance to veterans receiving certain medical services provided by the Department of Veterans Affairs.

In 2010 Congress established a childcare pilot program as part of the 2010 Caregivers and Veterans Omnibus Health Services Act, (Public Law 111–163), which was signed into law in 2011. The program was established so that veterans had access to child care while receiving health care services at a Department facility.

Currently, the pilot program is only available to the primary caretaker of a child or children receiving regular mental health care services, intensive mental health care services, or such other intensive health care services that the Secretary determines; that provision of assistance to the veteran to obtain child care would improve access to such health care services by the veteran; or in need of regular or intensive mental health care services from the Department, and but for lack of child care services, would receive such health care services from the Department.

The pilot program has been extended several times and is due to expire on December 31, 2017. This bill would make the VA's Child Care Pilot Program permanent and expanded so that all veterans, who are primary caretakers, have a safe, reliable, and cost-free option for child care when they use the services of the VA.

During The American Legion's System Worth Saving visits, our research tells us that failure to enact this legislation will discourage women veterans who lack access to reliable childcare, from maintaining and attending their healthcare appointments at VA. This is an unacceptable outcome and disproportionately disenfranchises

[1] American Legion Resolution No. 147 (Sept. 2016): Women Veterans

women veterans who happen to be single parents, and women veteran spouses who live in regions where cultural norms expect woman to care for the dependent children absent paternal assistance during work hours.

The American Legion, by Resolution No. 43 (2016): Department of Veterans Affairs Child Care Program, supports legislation to provide child care services to veterans with children in order for the veteran to receive access to the quality care they have earned.[2]

The American Legion supports H.R. 95.

H.R. 467: VA Scheduling Accountability Act

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

This bill would require the director of each VA health care facility to annually certify to the VA Secretary that their medical facility is in full compliance with VHA Scheduling Directive 2010–027, VHA Outpatient Scheduling Processes and Procedures, or any successor directive. It would also direct the VA Secretary on a yearly basis to report to both Veterans Affairs' Committees a list of medical centers that have certified compliance and a list that have not. VA would also have to provide an explanation of why those facilities did not meet the requirements set forth within the VHA directive.

A 2014 report issued by the VA Office of Inspector General found that a senior VA official in May 2013 waived a requirement that medical facility directors annually certify their compliance with the VA's scheduling policies. Waiving this requirement reduces accountability for facilities charged with caring for veterans and damages the integrity of wait time data.[3]

While The American Legion does not oppose this provision, we find it troublesome that Congress feels the need to pass a law to require VA to adhere to VA regulations. The American Legion has long been a supporter of VA accountability[4] and if proper accountability measures were in place, then there would be no need to this legislation. We are also cognizant of the cost and employee burden these additional requirements consume, and while advocating for reduced middle management at VA in favor of committing more resources to providing direct healthcare, The American Legion calls on Congress to review the reams of reports required by statute in favor of a more digestible and streamlined oversight plan. The American Legion has called on Congress in the past and renews our call here to require VA to provide a quadrennial plan to Congress outlining VA's strategic plan for program implementation as well as program funding.[5]

The American Legion Supports H.R. 467.

H.R. 907: 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. This bill would extend the time frame VA would be responsible for costs, up to 42 days.

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.[6] Beyond 7 days, the cost of care is the responsibility of the veteran and not VA.

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:

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[2] American Legion Resolution No. 43 (Sept. 2016): Department of Veterans Affairs Child Care Program

[3] American Legion Resolution No. 3 (Sept. 2016): Department of Veterans Affairs Accountability

[4] Ibid

[5] American Legion Resolution No. 1 (Sept. 2016): Department of Veterans Affairs Quadrennial Plan for Budget

[6] VA Women's Health Care FAQ

- 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 mitigate 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. We bold this section to highlight the disparity between the quality of care at VA, and readily available care at Medicare rates, which is often the foundation on which VA contracted care is based. Continued discussions surrounding VA outsourcing and Choice need to account for the cost associated without restrictions as established by Medicare rates. These differences were highlighted by The Commission on Care's report on estimating costs part 3[7], and 4 ([8]&[9]) and CBO's report, Comparing VA's cost with civilian care costs.[10]

The Task Force report recommended that Business Office managers be required to track women veterans' gender-specific fee-basis expenditures.[11] Furthermore, it was also recommended that these expenditures should be rolled up by VA Central Office and disseminated to stakeholders and the public to better facilitate planning for future needs within VA.

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.[12]

The American Legion supports H.R. 907.

H.R. 918: Veteran Urgent Access to Mental Healthcare Act

To amend title 38, United States Code, to direct the Secretary of Veterans Affairs to furnish mental health care to certain former members of the Armed Forces who are not otherwise eligible to receive such care and for other purposes.

Being dismissed involuntarily from the military can have profound consequences for servicemembers, their families, and their future. The American Legion places a premium value on an honorably discharged status, but also recognizes that some veterans are wrongfully discharged with characterizations that are less than Honorable due to medical injuries incurred during their honorable military service. Former Secretaries of Defense Chuck Hagel and Ash Carter, as well as the President of the United States has called on the Department of Defense (DoD) to ensure that they properly screen service members for illness or injury, and especially PTSD before discharging them with less than honorable discharges, and further called on DoD to enjoin with veterans who have discharges characterized as less than honorable for the purposes of a generous review to ensure these veterans were not wrong-

[7] https://s3.amazonaws.com/sitesusa/wp-content/uploads/sites/912/2016/04/Estimating-Costs-for-Veterans-Health-Part-3.pdf

[8] https://s3.amazonaws.com/sitesusa/wp-content/uploads/sites/912/2016/05/Estimating-Costs-for-Veterans-Health-Part-4–Day-1.pdf

[9] https://s3.amazonaws.com/sitesusa/wp-content/uploads/sites/912/2016/05/Estimating-Costs-for-Veterans-Health-Part-4–Day-2.pdf

[10] https://www.cbo.gov/sites/default/files/113th-congress-2013–2014/reports/49763–VA—Healthcare—Costs.pdf

[11] The American Legion System Worth Saving Report: "Women Veterans Health Care"- 2013

[12] American Legion Resolution No. 147: (Sept. 2016) Women Veterans

ly discharged due to medical complications that should have been addressed by DoD prior to discharge.[13]

This legislation seeks to minimize rewarding bad behavior by narrowing the eligibility to those veterans who had a higher propensity for being wrongfully discharged, because the story of former servicemembers who don't get help when their combat injuries fuel misconduct happens all too often when DoD fails to properly address these sustaining mental and physical health issues. The unfair result is that these veterans have been discarded with involuntary discharges that prevent them from receiving military retirement, medical care, disability and GI Bill benefits - all in the interest of speed and cost savings.[14]

Many of these veterans end up homeless and are at greater risk of suicide when they have no access to health care, even though VA has the discretion to provide medical benefits on a case-by-case basis. Veterans who were kicked out of the military for misconduct related to PTSD, TBI and other invisible wounds are also excluded from receiving help from many nonprofits.

Involuntary discharges have become an issue during the wars in Iraq and Afghanistan. A litany of negative media prompted Congress to order the military to carefully review the combat experiences of servicemembers before discharging them for misconduct. Yet another 22,000 soldiers have been involuntarily discharged since that 2008 legislation was passed, according to an investigation by National Public Radio[15], and involuntary discharges for misconduct are only part of the problem. A significant number of U.S. servicemembers who are discharged for personality disorders or adjustment disorders are also diagnosed with combat-related mental health issues such as PTSD during military medical exams.

Two weeks ago, VA Secretary Dr. David Shulkin announced that VA would begin providing "urgent care" mental health services for veterans with bad paper discharges. But these services will be very limited.

The American Legion is pleased to offer our support for H.R. 918, the Veteran Urgent Access to Mental Healthcare Act. This important bill would direct the VA to provide initial mental health assessment and urgent mental healthcare services to certain veterans at risk of suicide or harming others, even if they have an Other Than Honorable (OTH) discharge. We believe this bill targets a specific group of veterans that have possibly been wronged by DoD, and is in concert and theme with our Resolution No. 26: Mischaracterization of Discharges for Servicemembers with Traumatic Brain Injury.[16]

The American Legion Supports H.R. 918.

H.R. 1005

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

State Veterans Homes are facilities that provide nursing home and domiciliary care. They are owned, operated and managed by state governments. They date back to the post-Civil War era when many states created them to provide shelter to homeless and disabled veterans.

Currently, there are only two Adult Day Health Care programs at State Veterans Homes in the United States. Both are located on Long Island, New York. However, these programs could easily be offered at the other 151 State Veterans Homes located throughout the country.

H.R. 1005 would provide no cost medical model Adult Day Health Care to veterans at State Veterans Homes who are 70 percent or more service-connected disabled. This bill is an extension of Public Law (P.L.) 109–461: Section 211, Veterans Benefits Health Care, and Information Technology Act of 2006, which currently provides no cost nursing home care at any State Veterans Home to veterans who are 70 percent or more for their service-connected disability and who require significant assistance from others to carry out daily tasks.

Adult Day Health Care is a daily program for disabled veterans who need extra assistance and special attention in their day to day lives. Adult Day Health Care programs provide disabled veterans and their families with a high quality alternative to nursing home care and quality outpatient services for those suffering from

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[13] http://archive.legion.org/bitstream/handle/123456789/2498/2013S026.pdf?sequence=1&isAllowed=y

[14] Olsen, K. (2016, May). Booted after battle. American Legion Magazine. Retrieved from https://www.legion.org/magazine/232778/booted-after-battle

[15] http://www.npr.org/2016/12/01/498557687/army-contests-npr-investigation-of-dismissed-soldiers-in-misleading-report

[16] Resolution No. 26 (2016): Mischaracterization of Discharges for Servicemembers with Traumatic Brain Injury

debilitating illnesses or disabilities. These programs provide a range of services, from daily activities such as bathing, to full medical services, like physical therapy. The focus of the program is on improving a disabled veterans' quality of life, which is why we support expanding this great option of care for our veterans.[17]

The American Legion Supports H.R. 1005.

H.R. 1162: No Hero Left Untreated Act

To direct the Secretary of Veterans Affairs (VA) to carry out a pilot program to provide access to magnetic EEG/EKG-guided resonance therapy to veterans.

In the wake of serious concerns about over prescription of medications by VA physicians, The American Legion agrees that VA can do more to ensure that veterans and servicemembers have the most dependable and precise treatment available to treat their combat-related illnesses and injuries with the least amount of negative side effects. The American Legion, like the rest of the nation is desperate to see the rate of suicide among our veteran population begin to decrease, and hopes that efforts by VA will help guide the rest of the nation in treating this epidemic.

The American Legion has recently learned that the Veterans Health Administration (VHA) has implemented a pilot program at approximately 23 VA Medical Centers across the country using Electromagnetic Therapy to treat veterans with depression. VHA is using Repetitive Transcranial Magnetic Stimulation, or RTMS therapy, which involves up to 30 sessions over a six-week period. The American Legion is following this pilot closely and is hopeful that this non-pharmaceutical noninvasive therapy will prove successful and provide VA with another tool to help deal with depression and Post Traumatic Stress Disorder.

The American Legion has long advocated for complementary and alternative medicines (CAM) to be further explored by VA and applaud this pilot. Additionally, The American Legion's PTSD/TBI Committee has reviewed several promising CAM treatments that include using EEG technology to help better determine the efficacy of certain medications on patients with correlating quantitative electroencephalogram (EEG) neurometrics, treatment with lesser toxic and addictive substances such as the drugs CBD and THC, both found in the cannabis plant, and Hyperbaric Oxygen Therapy (CBOT). The American Legion urges Congress to first review VA's current pilot program, monitor the strategic objectives and plans for evaluating how RTMS therapy will benefit veterans before embarking on a therapy that has not received FDA approval for the purposes that it is being suggested VA use it for.

Once the therapy outlined in H.R. 1162 is evaluated and approved by the FDA for this intended purpose, The American Legion will call on VA to compare a Magnetic EEG/EKG-guided resonance therapy program to determine which would be in the best interest of veterans and the most cost effective to American tax payers. Until that time, The American Legion is unable to support this bill

The American Legion opposes H.R. 1162.

H.R. 1545: VA Prescription Data Accountability Act of 2017

To amend title 38, United States Code, to clarify the authority of the Secretary of Veterans Affairs to disclose certain patient information to State controlled substance monitoring programs, and for other purposes.

In 2016, over 80,000 people died from drug overdoses or accidental drug toxicity caused by lethal combinations of opioids and benzodiazepines and Prescription Drug Monitoring Programs (PDMPs) are designed to combat these two public health epidemics. PDMPs ensure health care providers do not accidently prescribe dangerous and potentially lethal combinations of drugs to patients who also see other healthcare providers. These state programs also have been proven to curb "doctor shopping" whereby people visit multiple health care providers to solicit more prescription medications than their original doctor has agreed to prescribe.

This bill would amend Title 38, U.S.C. Section 5701 by clarifying the authority of the Secretary of VA to disclose certain patient information to state controlled PDMPs. This bill also expands that group of individuals to anyone who is prescribed medication through the VA to include descendants of veterans, staff at VA, and individuals receiving disaster relief.

The American Legion supports the use of Electronic Health records as a method of coordinating care provided to veterans outside VA medical facilities and the controlled but widespread sharing of electronic medical records so that veterans can receive the highest possible quality healthcare available.[18]

The American Legion Supports H.R. 1545.

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[17] American Legion Resolution No. 377 (Sept. 2016): Support for Veteran Quality of Life

[18] American Legion Resolution No. 83 (Sept. 2106): Virtual Lifetime Electronic Record

H.R.1662

To amend title 38, United States Code, to prohibit smoking in any facility of the Veterans Health Administration, and for other purposes.

Over the years, many hospitals across the country have been implementing smoke-free campuses in order to promote a healthy environment and their commitment to a person's overall health. The draft bill would prohibit any person from using tobacco products on the grounds of any VA medical facility on or after October 1, 2022. The American Legion is unable to determine whether this bill seeks to provide a safe patient environment by protecting staff and patients from second hand smoke, is a proposed law to eliminate a perceived nuisance, or an overreach by government to legislate personal choices. The American Legion is holding this bill for further review before we offer any recommendation.

The American Legion currently has no position on this bill.

Draft Bill: Veterans Affairs Medical Scribe Pilot Act of 2017

To direct the Secretary of Veterans Affairs to carry out a pilot program on the use of medical scribes in Department of Veterans Affairs medical centers.

Veterans are experiencing long wait times for VA health care for a variety of reasons, but in part due to high patient load and not enough doctors to serve the population. This shortage is a nationwide problem in both government and nongovernment medicine.

A medical scribe is a paraprofessional who specializes in charting physician-patient encounters in real time, such as during medical examinations. Depending on which area of practice the scribe works in, the position may also be called clinical scribe, ER scribe or ED scribe (in the emergency department), or just scribe (when the context is implicit). A scribe is trained in health information management and the use of health information technology to support it. A scribe can work on-site (at a hospital or clinic) or remotely from a Health Insurance Portability and Accountability Act (HIPAA) secure facility. Medical scribes who work at an off-site location are known as virtual medical scribes and normally work in clinical settings.

A medical scribe's primary duties are to follow a physician through his or her work day and chart patient encounters in real-time using a medical office's electronic health record (EHR) and existing templates. Medical scribes also generate referral letters for physicians, manage and sort medical documents within the EHR system, and assist with e-prescribing. Medical scribes can be thought of as data care managers, enabling physicians, medical assistants, and nurses to focus on patient in-take and care during clinic hours. Medical scribes, by handling data management tasks for physicians in real-time, free the physician to increase patient contact time, give more thought to complex cases, better manage patient flow through the department, increase productivity to see more patients, help ease physician burnout, and can help incentivize physicians to come to work for, or stay at VA.

The draft bill would require VA to carry out a 2 year pilot program in no less than 10 VA medical centers located in rural areas, urban areas, and areas in need of increased access or increased efficiency. The draft bill would increase the use of medical scribes to assist VA physicians with their workload and would ensure doctors have more time to see patients rather than entering in medical data. By VA utilizing medical scribes in health care settings, it will serve as a recruitment tool for doctors who want an employment package comparable to the private sector.

The American Legion supports any legislation and programs within the VA that will enhance, promote, restore or preserve benefits for veterans and their dependents, including timely access to quality VA health care.[19]

The American Legion supports the draft bill.

Conclusion

As always, The American Legion thanks this subcommittee for the opportunity to explain the position of the over 2.2 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.

[19] American Legion Resolution No. 377 (Sept. 2016): Support for Veteran Quality of Life

NATIONAL ASSOCIATION OF STATE VETERANS HOMES

TESTIMONY OF FRED S. SGANGA, LEGISLATIVE OFFICER

ON H.R. 1005 - LEGISLATION CONCERNING ADULT DAY HEALTH CARE AT STATE VETERANS HOMES

Mr. Chairman and Members of the Subcommittee, thank you for this opportunity to offer testimony regarding H.R. 1005, legislation introduced by Congressman Lee Zeldin (R–NY) and Congresswomen Kathleen Rice (D–NY) to provide severely disabled veterans with an enhanced option to receive adult day health care services from State Veterans Homes.

Last year, identical legislation (H.R. 2460) strengthening adult day health care programs at State Veteran Homes was unanimously approved by this Committee in the 114th Congress, and subsequently passed the full House without any opposition. Both H.R. 2460 and a Senate companion bill (S. 3198) were reviewed by the Congressional Budget Office (CBO) last year and neither received a score that needed to be offset. However, the Senate failed to take any action on either bill prior to adjournment, necessitating reintroduction of the legislation this year.

As you may know, the State Veterans Home program was established by a Congressional Act on August 27, 1888, and for more than 125 years State Homes have been in a partnership with the federal government to provide long term care services to honorably discharged veterans; in some states, widows and spouses as well as Gold Star Parents are also eligible for admission. There are currently 153 State Veterans Homes located in all 50 states and the Commonwealth of Puerto Rico. The National Association of State Veterans Homes (NASVH) was conceived at a New England organizational meeting in 1952 because of the mutual need of State Homes to promote strong federal policies and to share experience and knowledge among State Home administrators to address common problems. NASVH is committed to caring for our nation's heroes with the dignity and respect they deserve.

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

Mr. Chairman, a decade ago, NASVH led the effort on Capitol Hill to assist our most disabled veterans by allowing them to receive skilled nursing care in State Veterans Homes under a new program that would provide the "full cost of care" to the State Home and thereby expand the options available to these deserving veterans at no cost to them. In 2006, Congress passed and the President signed Public Law 109–461 which guaranteed "no cost" skilled nursing care to any honorably discharged veteran who has a 70% or higher service connected disabled rating. Unfortunately, the bill did not extend the same "no cost" program to cover alternatives to traditional institutional care, such as the medical model Adult Day Health Care currently provided at three State Veterans Homes in Stony Brook, New York, Minneapolis, Minnesota and Hilo, Hawaii. H.R. 1005 would fix that.

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

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

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

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

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

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

H.R. 1005 will fix this disparity that prevents some of the most deserving and severely disabled veterans from taking advantage of this valuable program to help keep living in their own homes. This legislation would authorize VA to enter into agreements with State Veterans Homes to provide Adult Day Health Care for veterans who are eligible for, but do not receive, skilled nursing home care under section 1745(a) of Title 38, the "full cost of care" program. Veterans who have a VA disability rating of 70 percent or greater or who require ADHC services due to a service-connected disability would be eligible for this program. The payment to a State Home under this program would be at the rate of 65 percent of the amount that would be payable for skilled nursing home care under the same "full cost of care" program. This legislation would not only offer a lower cost alternative (ADHC) for severely disabled veterans who might otherwise require full time skilled nursing care, but it would also allow them to continue living in their own homes.

Mr. Chairman, in reviewing this legislation last year and in some additional meetings since, the VA has argued that because a veteran participating in the ADHC program is physically inside a State Home facility for only about one-third of each day they are in the program, therefore the per diem should be only about one-third of the skilled nursing care per diem. However, this significantly misrepresents the level of care and services provided to veterans in medical model ADHC programs. First, it completely ignores the cost of transportation, which alone accounts for a significant cost for transporting elderly, frail, disabled veterans to and from their homes to State Homes. Second, the overwhelming majority of services - particularly medical, therapeutic and rehabilitation - are provided during the day shift, not overnight when veterans residing in State Homes are sleeping. In fact, the 65% ratio is identical to the ratio that Medicaid pays for adult day health care in New York as compared to Medicaid per diems for skilled nursing care. Finally, it is critical to note that allowing veterans to use ADHC services two to three times a week is enormously less expensive then placing them full-time into a skilled nursing facility.

Moreover, the VA has been stressing the need to provide essential long-term care services in non-institutional settings for our most frail, elderly disabled veterans. Medical model Adult Day Health Care is a tremendous solution to this challenge being faced by the VA, one that can keep veterans living in their homes while allowing them to receive skilled nursing services and supports. There are a number of State Homes across the country interested in providing medical model ADHC services, however the current basic ADHC per diem is not nearly sufficient for most State Homes to be cover the costs of this program. Enactment of H.R. 1005 would provide a higher ADHC per diem rate for severely disabled veterans in medical model ADHC programs and thereby allow additional State Homes across the country to offer this service.

For the Saladino family, receiving "no cost" medical model Adult Day Health Care for their loved one would relieve a huge financial burden that they currently incur. Even though Jim's service ended 50 years ago, he is still paying a price for his valor related to his service in Vietnam. Passing H.R. 1005 would send a strong message to all those who have worn the uniform to protect our freedoms that they will never be forgotten.

H.R. 1005 has strong bipartisan support in the House, as does the companion Senate bill, and has also been supported by major veterans service organizations, including The American Legion, the Veterans of Foreign Wars and Disabled American Veterans.

On behalf of the National Association of State Veterans Homes, I urge you to favorably consider and pass H.R. 1005 for Jim and Noreen Saladino, and for thousands of others across the country just like them. Thank you for the opportunity to offer this testimony to the Subcommittee.

SWORDS TO PLOWSHARES

GETTING IT RIGHT:

"BAD PAPER" LEGISLATION THAT WORKS

Submitted by

Swords to Plowshares, a Veteran Rights Organization

With the Assistance of Veterans Legal Clinic at Harvard Law School

I. The urgency of health services for "bad paper" veterans

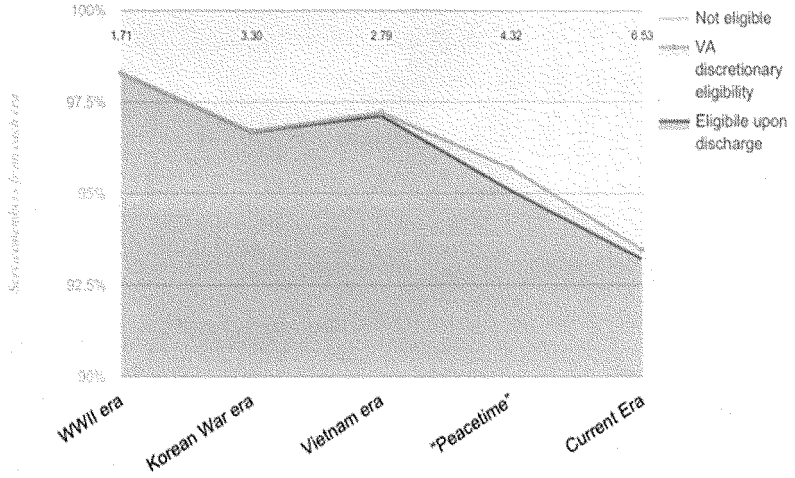
Post-9/11 veterans are denied basic veteran services at a higher rate than those of any previous era. Tens of thousands of servicemembers who would have received Honorable or Honorable Conditions discharges in prior eras today receive Other Than Honorable (OTH) discharges. Our "zero-tolerance," high op-tempo military has little patience for even routine discipline and behavior issues. This is true even when the behavior change is symptomatic of mental health issues that arose in service. The statistics are alarming. Combat-veteran Marines with PTSD diagnoses are 11 times more likely to get an OTH discharge than others [1]; between 2009 and 2012, the Army gave misconduct discharges to 20,000 servicemembers even after diagnosing them with PTSD [2]; survivors of military sexual trauma are 50% more likely to get misconduct discharges. [3] Denying veterans basic services for minor misconduct issues is unfair; denying them basic services because they are disabled or traumatized is unconscionable. It is happening now more than ever.

[1] https://www.ncbi.nlm.nih.gov/pubmed/20974004

[2] NPR, "Missed Treatment: Soldiers With Mental Health Issues Dismissed For 'Misconduct'" (Oct. 28, 2015).

[3] Gary Noling, "What the Military Owes Rape Survivors Like My Daughter," New York Times (Aug. 29, 2016) citing DOD Inspector General, "Evaluation of the Separation of Service Members Who Made a Report of Sexual Assault" (May 9, 2016).

Figure 1: Eligibility for basic veteran services since WWII

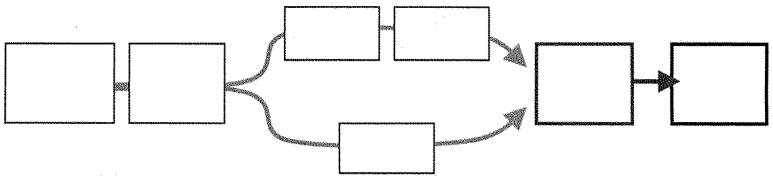


Source: Adapted from Veterans Legal Clinic, Underserved *(2016), available at https://www.swords-to-plowshares.org/sites/default/files/Underserved.pdf.*

Exclusion from basic veteran services is not only unfair, it is also deadly. Denying basic services means no health care for former servicemembers who are disabled, and no income support if disabilities prevent the servicemember from working. For veterans struggling with mental health problems, this abandonment is life-threatening. The suicide rate for veterans excluded from VA health care is twice the suicide rate for VA-recognized veterans.[4] For all of the issues surrounding VA access, the fact is that VHA health care works. The suicide rate for veterans under VHA care is decreasing, while the suicide rate for those outside of VHA care is increasing.[5]

We have created a suicide pipeline. Traumatic mental health disabilities are one of the major contributors to misconduct discharges. These veterans are some of those most at risk of suicide. We have the tools at VHA to prevent people at a mental health risk from committing suicide. However, we deny them many of them access to mental health care because the behavior symptomatic of their condition in the first place.

Figure 2: The Suicide Pipeline



Effectively managing this problem requires more than short-term mental health services. Most importantly, it requires access to primary and preventative care. One of the reasons that VHA mental health care is so effective is that it is integrated with somatic care. Many people, including veterans, do not like to seek mental health care, so we know that a great way to reach at-risk veterans is through referral by primary care providers. We also know that pain management cannot safely be separated from psychiatric care. In cases of TBI, which is a significant precursor of behavioral health problems, somatic and psychological conditions are inseparable.

[4] https://www.ncbi.nlm.nih.gov/pubmed/25533155
[5] http://www.mentalhealth.va.gov/docs/suicide—data—report—update—january—2014.pdf

Effective mental health care cannot be provided in isolation from overall health care.

Second, preventing mental health crises requires requires management of life stressors beyond the hospital. Congress has recently ended the shameful practice of turning away homeless veterans from veteran shelters when they had bad paper discharges. However, that is not enough. When a person's military disability prevents them from earning a living, leaving them unemployable without income support is short-sighted and unjust. Congress has designated certain services to be rewards for exemplary service, notably the G.I. Bill; other benefits are protective services to care for actual injuries that a person has experienced, and withholding these basic veteran services on the basis of minor behavior issues does not serve our nation's interests.

II. How not to do it: the lessons of P.L. 95–126

Congress faced this problem before. Like now, it faced a generation of veterans returning home with mental and physical injuries, an unprecedented percentage of whom were discharged less-than-honorably and faced challenges accessing basic care and treatment. Tremendous effort from Congress and advocates resulted in new legislation that was similar to what is under consideration today. But it did not work.

In 1977, Congress saw that more than 260,000 Vietnam-era servicemembers had received less-than-honorable discharges from the armed forces, and that many struggled with unemployment, homelessness, substance abuse, and mental illness. Congress held numerous hearings investigating the issue and contemplating potential solutions. Its solution was Public Law 95–126.

Section 2 of that bill granted to OTH veterans lifetime VA health care for any disabilities that arose in military service, unless they were otherwise barred by statute. This bill was broader than bills currently under consideration, because it was not limited to mental health care, it was not limited to temporary care, and it was not limited to combat vets or MST survivors.

Although that provision is still on the books[6], it does not do the job it was intended to. If it had been successful, none of the bills currently under consideration would be necessary: the servicemembers, conditions, and services that the currently-proposed bills describe are all encompassed by the already-existing provision under P.L. 95–126. Yet, almost none of them are accessing the services that Congress knows they need. In the 40 years since it was enacted, the OTH health care provision created by P.L. 95–126 has reached only 9,450 servicemembers.[7] This is only 1.3% of the OTH veterans discharged during this period, and only 7% of the OTH veterans who sought the help of VA for in-service disabilities.

P.L. 95–126 has not been effective because it was too targeted. First, and most importantly, VBA has to adjudicate multiple complicated questions before the veteran can get any care. The requirement of adjudication slows everything down and renders a system unable to serve veterans in moments of crisis. Second, VHA and VBA have difficulty transferring information between them. The more times that a form or notification has to be sent from one to the other, the more likely it is that something will go astray.[8] Third, the law has narrow criteria that many find hard to remember and a complicated procedural structure that is difficult to explain. The lack of simplicity makes it difficult for VHA eligibility employees to consistently and reliably implement the law, thus contributing to its ineffectiveness. Furthermore, the referral process is invisible to the servicemembers: there is no public VA form to request this, so there is no way for a potentially-eligible person to start the proc-

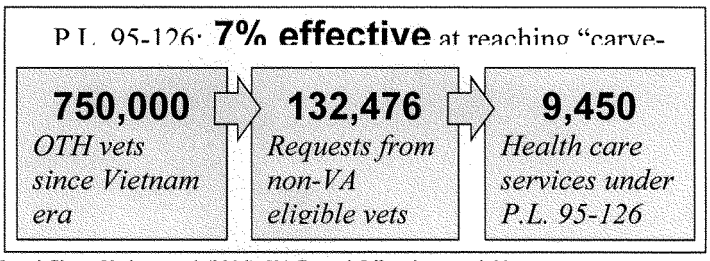
[6] 38 C.F.R. § 3.360.

[7] Data provided VA Central Office analyst, details available on request.

[8] The following is a description of how the process technically works. A veteran with an OTH discharge presents at a VA health facility seeking care. VHA eligibility staff should ask the veteran to fill out a health care application, and should then fill out an internal VA form referring the veteran's application to the VBA Regional Office for adjudication as to character of discharge. If the adjudication finds the veteran's service was "other than dishonorable," then the veteran can receive full VA health care; if the adjudication finds the veteran's service not "other than dishonorable" under VA regulatory bars, then the veteran is advised that he or she may be eligible under Public Law 95–126 for "Chapter 17" health care. Adjudication then stops. There is no form or application to request "Chapter 17" health care. However, the veteran—often assisted by an advocate—can send a letter and health care application asking for "Chapter 17" health care and requesting that VBA adjudicate service-connection for listed conditions. VBA, now looking at the issue a second time, should then make the determination and inform VHA as to its outcome. There are many ways in which the procedures can and do fail.

ess without the assistance of an informed and willing VHA eligibility workers.[9] In practice, this simply does not happen.

Figure 3: Legacy of P.L. 95-126



Source: Veterans Legal Clinic, Underserved *(2016); VA Central Office data available on request.*

The impact of these bureaucratic obstacles cannot be overstated. In our experience, even the insistence of an attorney, carrying the relevant regulations in hand, may not be sufficient to force the internal adjudication referral process to happen. We are working with one veteran where we succeeded in starting the process at the VA hospital, but have now been waiting three years for a result. Another client just received notice of health care eligibility five years after beginning the process. Needless to say, it is unrealistic for a veteran experiencing a mental health crises to navigate this system more effectively.

As a practical matter, health care eligibility criteria must be immediately discernible by the VHA eligibility clerk, or it will not have its intended impact. VHA service databases (BIRLS) and DD214s do not show whether disabilities arose in service, whether mental health disabilities contributed to discharge, whether a person served in a combat theater or in combat, or whether a person experienced Military Sexaul Assault (MST). This can only be decided by having a VBA adjudicator request and read a person's military service record. A health care eligibility law that relies on any of these eligibility factors will require an eligibility inquiry from the VHA to the VBA, and experience shows that this cannot be operationalized. The 1.3% reach of P.L. 95–126 after 40 years should be conclusive evidence that this is not a local problem, and that it is not the fault of a certain bureaucracy. The law, though well-intentioned, was not written to operate within our veteran health care eligibility system.

Our lesson from P.L. 95–126 should be this: we cannot ensure health care access to vulnerable populations by "carving out" services to specific people or conditions. Each carve-out is a condition that a different branch of the VA has to adjudicate, and veterans cannot be expect to know how to navigate that. The eligibility criteria must be simple and available on a DD214 or in BIRLS; this may require extending to more than intended, however that is the cost of ensuring no deserving veteran is abandoned.

III. H.R. 918 as currently drafted will not reach its target group

H.R. 918 proposes an approach similar to what P.L. 95–126 attempted. It identifies a specific target group and authorizes services only to them: servicemembers with OTH discharges, but not those barred by 38 U.S.C. 5303(a), who served a combat theater or in combat, or who experienced MST. Like P.L. 95–126, VHA eligibility staff will have to refer any claims to the VBA for adjudication of these criteria, based on a review of military service records. As with P.L. 95–126, these conditions will almost certainly be too cumbersome for service members to navigate effectively, particularly those facing mental health crisis. And it will almost certainly be too difficult for the VA to adjudicate rapidly.

[9] Instructions to VHA eligibility staff were removed from the latest edition of the VHA eligibility procedures manual. VHA Handbook 1601A.02 (2015). Incomplete and confusing instructions are provided in a public Information Bulletin. VHA IB 10–448 "Other than Honorable Discharges - Impact on Eligibility for VA Health Care Benefits" (2014). The VBA recently amended its Adjudication Procedures manual so that an OTH veteran who applies for Compensation will automatically be considered for the health care eligibility exception, if they receive a negative Character of Discharge decision. M21–1 Part III.v.1.B.1.f. Although promising, it creates a situation where the only pathway to health care passes through a Compensation application, filed not at a hospital but at a Regional Office, without any instruction to this effect to service members. Implementation of this new procedure has been uneven.

H.R. 918 faces an additional obstacle that P.L. 95–126 did not face. H.R. 918 only proposes to provide tentative health care: health care while the VA decides permanent eligibility based on character of discharge review. However, because H.R. 918 has its own eligibility criteria that have to be adjudicated, servicemembers will never be able to access immediate health care. Because the H.R. 918 eligibility determination process will look very similar to the permanent eligibility determination process, it is likely that H.R. 918 will not create anything: the servicemember will learn their H.R. 918 eligibility at the same time as they learn their permanent eligibility, so the H.R. 918 eligibility will be irrelevant.

IV. H.R. 918 may limit more effective regulatory and policy changes already underway

The Department of Veterans Affairs is currently reviewing its regulations that govern access to basic services for veterans with less-than-honorable discharges, including tentative eligibility for health care while a veteran's eligibility review is underway. It has made this announcement publicly, in response to the Commission on Care's recommendations to do so. It has told Congressional offices that it plans to issue regulations on this during 2017.

Through this rulemaking, VA could propose regulations that would fully accomplish the goals of H.R. 918. Using existing legal authority, VA could amend its current tentative healthcare eligibility regulation [10] to extend care to veterans who served in or supported combat operations or who experienced military sexual trauma.

Furthermore, it is likely that the VA would propose a tentative eligibility rule that exceeds what H.R. 918 proposes. The VA will consider its internal systems and procedures, including the capabilities of front-line eligibility staff and the availability of information in existing databases. It will likely avoid criteria that, like the criteria proposed with H.R. 918, require cumbersome intra-agency adjudication referrals. Therefore a rule VA proposes may be easier to implement and more likely to achieve the goal of ensuring access to these at-risk veterans.

A more narrow rule enacted through legislation would be unnecessary, and may potentially complicate the ongoing regulatory action. It is unclear whether VA would still have regulatory discretion to craft a workable standard, when Congress had just specified a particular standard; this may be true even when the Congressionally-mandated standard is less feasible.

Because adequate agency action is underway, it is imprudent to issue legislation that may interfere with those outcomes. Where the agency has the will and authority to take appropriate action, Congress should provide guidance and oversight rather than micromanagement.

V. Better options: legislation with impact

Alternative options are available. Based on our direct experience navigating the system from the veterans' perspective, we have developed the following possible avenues to expanding access to mental health care for vulnerable servicemembers, without exceeding the Committee's intent to focus on combat-exposed veterans and MST survivors.

To the extent possible, the proposed solutions build on the significant amount of authority that VA already has to provide mental health care, as well as other treatment and services, to veterans with bad-paper discharges. Eligibility for basic VA services—including health care, disability compensation, and vocational rehabilitation—require only that the veteran have been discharged under "other than dishonorable" conditions and not be excluded under enumerated statutory bars. [11] Veterans with bad-paper discharges who served in a combat theater or experienced military sexual trauma also can seek counseling at a Vet Center. [12] Therefore, under current law, veterans with other-than-honorable or bad-conduct (by special court-martial) discharges may be entitled to full or limited health care from VA. VA only provides such care after it has conducted a lengthy eligibility review process, known as a character of discharge determination. While those reviews are pending, current VA regulations do not allow such veterans to receive "tentative" eligibility for health care, [13] but VA could adopt new regulations that would allow as much. Despite the VA's existing authority to offer care to veterans with bad-paper discharges, both statistical and anecdotal evidence demonstrate that many such veterans face challenges in accessing that care and that the vast majority are presently excluded from

[10] 38 C.F.R. § 17.36.
[11] 38 U.S.C. §§ 101(2), 5303(a); 38 C.F.R. § 3.12.
[12] 38 U.S.C. § 1712A.
[13] 38 C.F.R. § 17.34.

VA.[14] Encouraging and supporting VA's utilization of existing statutory authority to provide care to veterans with bad-paper discharges could allow for a quicker roll-out of services, with greater certainty that the agency could successfully operationalize Congress's goals.

Option 1. Amend H.R. 918 from U.S. Code provision to rulemaking requirement

As described above, VA has considerable authority under existing law to provide mental health care services to certain veterans with bad-paper discharges, including veteran with other-than-honorable discharges who served in combat or experienced military sexual trauma. By enacting a law that directs VA to implement a policy that it already had authority to implement, Congress could potentially narrow VA's authority. For example, it is possible that VA would interpret the law to prohibit it from providing tentative health care to veterans who are having mental health crises but did not serve in combat or experience MST, or to veterans who served in combat but are experiencing severe physical injuries. To ensure that the Bill clearly communicates its goal of expanding—rather than narrowing—access, one option is to require that VA revise its tentative health care regulations to include, at a minimum, access to mental health care services for combat veterans and veterans who experienced MST.

REVISION OF REGULATIONS RELATING TO TENTATIVE HEALTH CARE.—No later than one year after the date of enactment of this Act, the Secretary shall issue a Final Rule amending its Regulations relating to tentative eligibility for health care. Section 17.34, Title 38, Code of Federal Regulations. The Final Rule shall address the ability of former service members to receive tentative eligibility for health care when their eligibility under Sections 101(2) and 5303, Title 38, United States Code, must be determined. The Final Rule shall, at minimum, require that VA provide mental health care services to any former service members who served during a period of war (as defined in section 1521 of this title) or, while serving in the Armed Forces,was the victim of a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment (as defined in section 1720D(f) of this title) and who has filed an application for hospital care or other benefits administered by the Secretary that requires an adjudication as to any eligibility prerequisite which cannot immediately be established. This minimum requirement does not limit the Secretary from establishing other provisions as allowed under existing authority.

Option 2. Authorize Vet Centers to provide psychiatric and neurobehavioral services

The Vet Centers are community-based outpatient clinics that provide counseling and readjustment services to veterans who served in a combat theater, served in an unmanned aerial vehicle crew that support combat operations, or experienced military sexual trauma. These services are available to veterans with bad paper, and so target a similar veteran cohort as H.R. 918. However, Vet Centers do not provide psychiatric care or inpatient treatment programs, nor do they provide neurobehavioral treatment for Traumatic Brain Injury. Some veterans therefore will find that the Vet Centers cannot fully treat their mental or neurological injuries. Rather than create an adjudication process to carve out limited access to VA hospitals, Congress could expand the authority and resources of Vet Centers, which are already reaching the target population, so that they could provide or arrange for improved mental health services directly or through community care.

IN GENERAL.—The Secretary shall use the existing assessment, referral, and contracting authorities assigned to Vet Centers under Sections 1712A(b)(1) and (e)(1), Title 38, United States Code, to ensure that the mental health care services available to Vet Center patients include psychiatric care for mental health disorders and neurobehavioral care for patients who experienced Traumatic Brain Injury. The Vet Centers are encouraged to use their contracting authorities to refer patients to community care providers in cases where Department facilities are unavailable. The Vet Centers shall continue their existing practice of providing services on a tentative, emergency, or reintegrative basis pending eligibility review in cases where that is required.

SCOPE OF MENTAL HEALTH SERVICES.—Include the following paragraph as Section 1712A(b)(3):

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[14] See generally Veterans Legal Clinic, Underserved: How the VA Wrongfully Excludes Veterans with Bad-Paper Discharges (March 2016), available at https://www.swords-to-plowshares.org/sites/default/files/Underserved.pdf.

"(3) Mental health services furnished under paragraph (1) of this subsection may, if determined to be essential to the effective treatment and readjustment of the patient, include psychiatric care and neurobehavioral care."

UTILISATION OF COMMUNITY CARE. Amend Section 1712A(b)(1), Title 38, United States Code, as follows:

"(1) If, on the basis of the assessment furnished under subsection (a) of this section, a licensed or certified mental health care provider employed by the Department (or, in areas where no such licensed or certified mental health care provider is available, a licensed or certified mental health care provider carrying out such function under a contract or fee arrangement with the Secretary) determines that the provision of mental health care services to such veteran is necessary to facilitate the successful readjustment of the veteran to civilian life, such veteran shall, within the limits of Department facilities, be furnished such services on an outpatient basis. For the purposes of furnishing such mental health care services, the counseling furnished under subsection (a) of this section shall be considered to have been furnished by the Department as a part of hospital care. Any hospital care and other medical services considered necessary on the basis of the assessment furnished under subsection (a) of this section shall be furnished only in accordance with the eligibility criteria otherwise set forth in this chapter (including the eligibility criteria set forth in section 1784 of this Title)."

Option 3. Create a "Veteran" eligibility determination process

Ninety percent of veterans with bad-paper discharges are ineligible for basic VA services not because they applied and were denied but because VA has never adjudicated their eligibility at all.[15] These veterans may never have applied, perhaps because they wrongly believed that they were categorically ineligible, or they may have attempted to apply but encountered barriers to doing so. Currently, there is no method for a veteran with a bad-paper discharge simply to request that VA determine whether he or she is eligible. That is, a veteran cannot "appl[y] for a character of service determination," as H.R. 918 requires to be covered by its provisions. Instead, the veteran must apply for a specific benefit, e.g., disability compensation, and VA then initiates an eligibility review as its first step. VA's current procedures for these reviews may not gather information critical to its determination, such as from the veteran about the circumstances surrounding his or her discharge or from medical professionals about any in-service mental health conditions. These inadequate procedures and low rate of applications could be remedied in part by requiring VA to create a separate application by which a veteran with a bad-paper discharge can ask for an eligibility review. Furthermore, veterans might then know whether they are eligible for full VA services or not before they are in crisis and seeking urgent mental care, rather than having to grant temporary access to services while VA adjudicates their eligibility.

CHARACTER OF DISCHARGE ADJUDICATION.—

(1) FORM.—The Secretary shall create a form by which a former service member may request that the Department determine whether the member qualifies as a veteran under sections 101(2) and 5303, title 38, United States Code. The form shall elicit information relevant to a character of discharge determination, including any honorable or meritorious service, any combat or hardship service, any physical or mental health injuries or conditions that existed during the member's service, any mitigating or extenuating circumstances that affected the member's ability to serve, and any personal assaults or military sexual trauma that the member experienced.

(2) PROCEDURES.—

(a) Upon receipt of a form referenced in subsection (1) from a former member, the Secretary shall determine whether the former member is a veteran under Sections 101(2) and 5303, Title 38, United States Code.

(b) If the member is found to be a veteran under sections 101(2) and 5303, Title 38, United States Code, and if the member submits an application prior to or within one year after that determination that the Secretary grants, then the effective date for that benefit shall be the date that the Secretary received the subsection (1) form or the application, whichever is earlier.

(c) If a former service member whose eligibility must be determined under sections 101(2) and 5303, title 38, United States Code, submits any other form that expresses a desire to apply for benefits administered by the Secretary that is not the form referenced in subsection (1), the Secretary shall send a subsection (1) form to the veteran with instructions on how to complete and submit it. If the member submits an application for a benefit but does not submit a completed subsection (1) form, the Sec-

[15] Veterans Legal Clinic, Underserved, supra note 15, at 10.

retary shall make a character of discharge determination and shall determine whether the member qualifies for such benefit, notwithstanding the member's failure to submit a completed subsection (1) form.

(d) In determining whether a former service member is a Veteran under sections 101(2) and 5303, Title 38, United States Code, the Secretary shall furnish all due assistance to the former member. If the former member indicates that he or she may have experienced a mental health disorder during his or her service, such assistance shall include any physical or mental health evaluation necessary to determine whether the former member meets the standards set forth in sections 101(2) and 5303(b), Title 38, United States Code.

Option 4. Express "Sense of Congress" concerning eligibility regulations

The current eligibility standard for basic VA services dates back to World War II, when Congress and the nation were preparing to welcome home sixteen million service members. At that time, based on their experiences after the First World War and prior conflicts, Congress chose to help nearly all who served access VA's rehabilitation and reintegration programs, barring only those who received or should have received a "dishonorable" discharge. Congress recognized that many service members returning from combat might be experiencing mental distress, struggle with substance abuse, or have difficulty readjusting and then engage in minor misconduct, but Congress determined that they should nevertheless be eligible for VA services. At the time, that meant that only 1.7% of WWII veterans were barred from VA, and that generation of veterans, with support from the G.I. Bill, ushered in a period of unprecedented growth and productivity. However, because of imperfect regulations as well as shifting military practices, the number of veterans excluded from VA has now more than tripled, to 6.5% of Post-9/11 veterans. Congress would do well to reaffirm its commitment to the 1944 eligibility standard, and thereby allow this newest cohort of veterans to become our next Greatest Generation.

CONGRESSIONAL INTENT RELATING TO CHARACTER OF DISCHARGE.—Congress hereby reaffirms its commitment to the existing statutory limitations on access to veteran services based on in-service conduct, namely the statutory provisions at Sections 101(2) and 5303, Title 38, United States Code. These provisions were originally adopted as part of the the Servicemen's Readjustment Act of 1944, better known as the G.I. Bill of Rights. They were informed by this country's most broad-based participation in military service. Congress did at that time, as now, hold the two goals of rewarding faithful service and taking care of its service members despite the hardships and inconsistent experiences associated with military service, particularly in wartime. The standards adopted in 1944 reflected Congress's best judgement on how to reconcile those two goals. The transition to an All-Volunteer Force has changed military retention practices significantly, but it has not changed Congress's commitment to both of those goals. Congress has adjusted its response since 1944 by limiting Education benefits to those with fully Honorable discharges, with enactment of the 1981 Montgomery GI Bill. Congress tightened eligibility for that benefit in order that it may best serve as an incentive to enlistment and reward for faithful service. For veteran services that do not serve this inducement function, Congress's judgement from 1944 remains prudent and its statutory formulation is intact. In particular, Congress affirms that the itemized bars in Section 5303(a), Title 38, United States Code, are intended to indicate the types of disqualifying conduct foreseen by the general provision in Section 101(2), Title 38, United States Code. Furthermore, Congress affirms that the intent of the statute is as much to promptly identify eligible service members as it is to correctly identify those who are ineligible. The intent of the statute is not achieved by undue delays or bureaucratic obstacles that interfere with timely access to basic services. This is particularly true with respect to mental health care services. Congress encourages the Secretary to adopt regulations, policies, and procedures that effectively implement our intent with respect to these limitations on access to services.

Option 5. Ensure treatment eligibility for veterans who experienced MST notwithstanding conditions of discharge

For a period of time, VHA facilities provided counseling and health care services to treat conditions related to military sexual trauma, including to veterans with bad-paper discharges, even if VA had not yet adjudicated their character of discharge or questions of service connection.[16] Under that policy, victims and survivors of MST were able to access critical mental health supports without undue delay or excessive paperwork. However, currently, veterans with bad-paper discharges can-

[16] Department of Veterans Affairs, Directive 2010–033 (July 10, 2010); see 38 U.S.C. § 1720D.

not access such services until they have undergone a lengthy character of discharge review process.[17] Congress could restore this salutary policy by amending the statute. It further could expand the provision to include veterans who deployed or served in support of combat operations.

ACCESS TO CARE RELATED TO MILITARY SEXUAL TRAUMA (MST).—In order to ensure timely access to essential care related to MST, the VA shall not require prior adjudication of line-of-duty, minimum time in service, or character of discharge prior to provision of counseling or health care services due to MST.

Amend Section 1720D(a) as follows:

"(1) The Secretary shall operate a program under which the Secretary provides counseling and appropriate care and services to eligible persons whom the Secretary determines require such counseling and care and services to overcome psychological trauma, which in the judgment of a mental health professional employed by the Department, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the veteran was serving on active duty, active duty for training, or inactive duty training.

"(2) Eligible persons.

"(A) In operating the program required by paragraph (1), the Secretary may, in consultation with the Secretary of Defense, provide counseling and care and services to members of the Armed Forces (including members of the National Guard and Reserves) on active duty to overcome psychological trauma described in that paragraph.

"(B) A member described in subparagraph (A) shall not be required to obtain a referral before receiving counseling and care and services under this paragraph.

"(C) The services described in paragraph (1) may be provided to prior and current service members without limitation on the basis of 38 U.S.C. 5303A (Minimum Active-Duty Service Requirement), 38 U.S.C. 5303 (Certain bars to benefits) or 38 U.S.C. 101(2) (Requirement for federal active service under conditions other than dishonorable)."

Option 6. Implement mandatory training on eligibility for all front-line VA staff

There is often confusion and misunderstanding about the eligibility criteria for accessing VA services, particularly as relates to character of discharge. To ensure that no veterans are wrongfully turned away from access to care and support they deserve, Congress can require that those who regularly interact with veterans who may not yet be accessing VA services understand the eligibility criteria, eligibility determination procedures, and their role in facilitating eligibility processes.

TRAINING OF EMPLOYEES OF THE DEPARTMENT.—

(1) IN GENERAL.—Not later than one year after the date of the enactment of this Act, the Secretary shall develop and implement a comprehensive training curriculum for all employees whose duties include regular interaction with former service members who are or may be not enrolled in or receiving benefits administered by the Secretary under Title 38, United States Code, and all employees who adjudicate claims involving eligibility determinations for benefits administered by the Secretary under Title 38, United States Code. The curriculum shall address the basic eligibility criteria for benefits administered by the Secretary, including eligibility for former service members who were discharged or released under conditions that were not honorable.

(2) TRAINING.—

(A) IN GENERAL.—Each person for whom such training is required shall undergo retraining at least once every five years during that person's tenure at the Department.

(B) CURRENT EMPLOYEES.—Each person for whom training is required under subsection (1) shall undergo training not later than 90 days after the curriculum implementation date.

(C) NEW EMPLOYEES.—Each person who becomes a person for whom training is required under subsection (1) shall undergo training not later than 90 days after the date on which that person fills the qualifying position.

Option 7. Study VA practices and procedures relating to health care access

Many veterans with bad-paper discharges may be eligible for some health care from VA, but for various reasons are not currently utilizing that care. While policymakers, department staff, and advocates can speculate as to the causes for that phe-

[17] Department of Veterans Affairs, Memorandum, Eligibility for Military Sexual Trauma-Related Counseling and Care and Services at the Department of Veterans Affairs (VA) (July 26, 2016).

nomenon, further study is warranted to fully understand the causes and propose recommendations for how it could remedied. Congress can direct the Government Accountability Office to study and report back about this question, which can then inform what policies Congress and VA adopt going forward.

STUDY OF IMPLEMENTATION OF SECTIONS 101(2) AND 5303, TITLE 38, UNITED STATES CODE.—The Comptroller General shall, no later than one year after adoption of this provision, present a review of Department of Veterans Affairs policies, activities, and performance that relate to implementation of Sections 101(2) and 5303, Title 38, United States Code. The purpose of the study shall be to determine whether potentially eligible former service members receive timely access to health care services and whether former service members barred under statute are screened appropriately and efficiently. The study shall include examinations of Veterans Benefits Administration adjudication and performance of benefit applications where these provisions are implicated; Veterans Health Administration staff performance in receiving the applications and requests for care from former service members where these provisions may be implicated; and coordination and communication between the Veterans Benefits Administration and Veterans Health Administration where these provisions may be implicated. The study shall assess, to the extent possible, health care access exclusion rates under existing policies and procedures and the reasons therefor. The study shall assess whether information exchange or coordination between the Department of Veterans Affairs and the Department of Defense can affect the timely and effective access to care for potentially eligible former service members.

Please address questions and comments to Bradford Adams (415) 252–4788 x317 or badams@stp-sf.org.

For more information about access to VA for veterans with bad-paper discharges, consult Underserved, a report by the Veterans Legal Clinic at Harvard Law School published on behalf of Swords to Plowshares and the National Veterans Legal Services Program, available online at
https://www.swords-to-plowshares.org/2016/03/30/Underserved.

WOUNDED WARRIOR PROJECT

RE: H.R. 918

Dear Chairman Wenstrup and Ranking Member Brownley,

Over the past several months, a groundswell of community support has drawn attention to veterans with so-called "bad paper discharge" and reinvigorated discussion about what benefits should be available to those whose service was determined to be less than honorable. In many cases, access to educational assistance, disability compensation, and other Department of Veterans Affairs ("VA") benefits represents fair and deserved reward for sacrifice. For those with mental health challenges arising from service, access to mental health care must be recognized as a pressing entitlement, regardless of discharge status.

Wounded Warrior Project appreciates and agrees with the intent of H.R. 918, the Veterans Urgent Access to Mental Health Care Act, which addresses access to mental health care for those with other than honorable discharges. For too many veterans, trauma in service is the nexus between yesterday's bad paper discharge and today's mental health challenges. In our experience, many veterans suffering from post-traumatic stress disorder, traumatic brain injury, or military sexual trauma have received bad paper discharges for behavioral problems rooted in the same circumstances that led to those diagnoses. Regardless of cause, it remains that veterans with bad paper discharges are at greater risk for homelessness, substance abuse, incarceration, untreated physical and mental injuries, and suicide.

Given the gravity of this situation, WWP encourages this Subcommittee to continue prioritizing this issue. We look forward to working with the committee to ensure that H.R. 918, and other relevant policy changes, appropriately and fully address the challenges at hand. For instance, while we support H.R. 918's intent, we believe that it can be improved. The legislation's eligibility criteria may place administrative demands - such as the need to verify a veteran's combat service - at odds with the need to provide urgent care. And although H.R. 918 authorizes care for veterans who present with urgent mental health care needs, VA should not be placed in a position where it must turn individuals away until their problems wors-

en and their needs become emergencies. A broader solution can more effectively address needs and diminish the likelihood of bureaucratic hurdles to delivering care.

On March 7th, before members of this Subcommittee, Secretary Shulkin testified that VA would begin providing urgent mental health care for veterans with other than honorable discharges, and indicated that VA is poised start to providing such care under existing authority. Although the implementation details remain to be seen, Secretary Shulkin's signal of support should allow this Subcommittee the extra time needed to ensure that any legislative solutions are appropriately crafted, and that VA has more permanent capacity to handle a surge of veterans seeking mental health care. Time is still of the essence - VA has not announced plans to provide mental health care for veterans with bad paper discharges in non-emergency situations - but care must be taken to ensure that VA is prepared and able to provide the care and support that these veterans need.

Earlier this March, Wounded Warrior Project reached a major milestone in its service to our nation's wounded warriors, their families, and their caregivers. Just weeks ago, Wounded Warrior Project registered its 100,000th post-9/11 injured veteran, who will now have access to our free, life-changing programs and services. This milestone clearly demonstrates that the needs of our nation's veterans are great and growing, and that it is more important than ever for us to stand behind them in their recovery and rehabilitation. Thank you for the opportunity to submit this statement for the record.

Sincerely,

Michael S. Linnington, LTG (ret), U.S. Army
Chief Executive Officer
Wounded Warrior Project

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL–CIO (AFGE)

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

The American Federation of Government Employees, AFL–CIO (AFGE), appreciates the opportunity to submit a statement for the record on the Medical Scribe Pilot Act of 2017. AFGE represents nearly 700,000 employees in the Department of Veterans Affairs (VA), including 230,000 employees at the Department of Veterans Affairs on the front lines providing services for veterans.

AFGE opposes the draft legislation, the Veterans Affairs Medical Scribe Pilot Act of 2017. This bill would direct the Secretary of Veterans Affairs to carry out a pilot program on the use of medical scribes in Department of Veterans Affairs medical center.

AFGE opposes this bill because it will not increase access or reduce wait times, but is likely to have unintended adverse consequences. Therefore, AFGE urges further study by the GAO (rather than a private entity that could benefit from the increased use of scribes) that looks at all options for freeing up provider time before enacting this legislation.

Our physician and other provider members report that they already have adequate technology through the Computerized Patient Record System (CPRS) and dictation software to record their patient notes. They urge lawmakers to consider other options for reducing pressures on providers, most significantly, strengthening the "PACT" teams through full staffing and better team training. Our providers also urge a reduction in the number of computer view alerts to which they must respond and management compliance with requirements to provide regular "admin" time slots during which they can address lab reports, call backs and other non-appointment patient needs.

Such a study should include the views of front line providers and their labor representatives. It is very disappointing that a recent 'physician engagement" workgroup that was convened within the VA did not include the views of front line providers. Similarly, we believe that the view alert pilot project that was developed by that workgroup was not fully implemented and did not adequately reduce the number of view alerts placing undue pressures on providers.

This study should also examine the experiences of Kaiser Permanente where medical assistants were used as scribes in some facilities; that effort did not appear to increase the number of patients that could be seen in a day.

Finally, we urge the GAO to consider the impact of scribes on the provider-veteran relationship. The presence of a third party playing a non-clinical role could

interfere with the patient's ability to build trust with the provider and share very personal information about his or her veteran experience.

Thank you for considering the views of the American Federation of Government Employees.

VIETNAM VETERANS OF AMERICA

Presented by

Kristofer Goldsmith, Assistant Director for Policy and Government Affairs

Regarding

H, R, 918, H.R. 95, H.R. 91, H.R. 1162, H.R. 1545, H.R. 907, H.R. 1162, H.R. 1005 and H.R. 467

Chairman Wenstrup, Ranking Member Brownley and distinguished members of the House Veterans' Affairs - Subcommittee on Health, on behalf of President John Rowan, our Board of Directors, and our membership, Vietnam Veterans of America (VVA) thanks you for the opportunity to present our statement for the record for today's legislative hearing.

HR 918 - Veteran Urgent Access to Mental Healthcare Act - *A bill to amend title 38, United States Code, to direct the Secretary of Veterans Affairs to furnish mental health care to certain former members of the Armed Forces who are not otherwise eligible to receive such care, and for other purposes.*

Vietnam Veterans of America thanks Congressman Coffman and the members who have joined him in fighting for veterans who have experienced PTSD, TBI, or MST, who have been issued the lifetime punishment of a less-than-honorable discharge without the due-process rights of a court-martial. However, we must strongly oppose this bill in its current form.

This legislation was inspired by reports revealing that veterans with less-than-honorable discharges are more likely to be unemployed, experience homelessness, suffer from substance abuse, be incarcerated, and die by suicide. Furthermore, the bill responds to reports from the Government Accountability Office that the Department of Defense has failed to comply with its own regulations and Congress's directives intended to protect veterans who have experienced post-traumatic stress disorder, traumatic brain injury, military sexual trauma, and other service-related illnesses and injuries from being discharged without access to benefits.

Congress has attempted to fix this problem before. According to Public Law 95–126, the Department of Veterans Affairs must provide treatment to veterans with Other Than Honorable discharges for their service-connected injuries and illnesses. Now, the Veteran Urgent Access to Mental Healthcare Act seeks to build on that law so that tentative access to mental healthcare is provided to veterans who have experienced PTSD, TBI, or MST, until the Department of Veterans Affairs makes a "characterization of discharge determination"—which is typically a lengthy process.

However, the bill may face challenges in implementation because, under current VA policies, veterans cannot directly apply for a character of discharge determination. Instead, the process is initiated only after a veteran applies for some VA benefit. Because veterans cannot simply request a character of discharge review, few veterans with other-than-honorable discharges are aware of the fact that they may be eligible for some benefits. Furthermore, most of those veterans whose service is reviewed are eventually denied eligibility, because of regulations that fail to give due credit to the meritorious and valuable service of those veterans.

The bill may also have the unintended effect of limiting access to VA, because it narrowly defines which veterans can get tentative healthcare, where under existing law VA has the authority grant access more broadly. VA could accomplish what the bill mandates under laws already on the books.

The reason that VA could do that is because access to basic VA benefits does not require an honorable discharge. According to 38 U.S.C. §101(2), a "veteran" is "a person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable" (emphasis added).

Under current law, the Department of Veterans Affairs has the statutory authority to provide comprehensive healthcare to most veterans who were not discharged by General Court-Martial (whether Dishonorable or Bad Conduct) or who are other-

wise barred by statute. Indeed, VA can allow veterans with Other Than Honorable discharges to get not only healthcare, but also disability compensation, pension, vocational rehabilitation, and other supportive services intended to rehabilitate and support former service members. For service members who require an adjudication of eligibility on this issue—what the VA calls a character of discharge determination—existing law already allows the VA to provide tentative eligibility for comprehensive health care, not limited to mental health care and not limited to combat theater veterans. The VA chose not to extend the tentative health care as a policy matter alone, it does not require legislation to do so now.

However, in recent decades, the Department of Veterans Affairs has excessively employed its regulatory powers in determining eligibility to deny care and benefits to hundreds of thousands of veterans, including many who are suffering from wounds and illnesses caused by their service.

The use of less-than-honorable administrative discharges has grown significantly for recent generations of veterans. As a result of Department of Veterans Affairs' self-imposed regulations, these administratively issued less-than-honorable discharges are for many veterans a lifetime ban on earned benefits. The Department of Veterans Affairs' refusal to provide care to veterans who were discharged under "other than dishonorable" conditions is an absolute contradiction of the congressional intent expressed by the 1944 G.I. Bill of Rights, which sought to protect the due process rights of all veterans and ensure that they could access the care that they needed.

In sum, laws already on the books should allow veterans with Other Than Honorable discharges access to healthcare, at the very least for service-connected injuries. Any delay in care to veterans due to a lengthy characterization of discharge review is a failure of the Department of Veterans Affairs to live by its motto "to care for him who shall have borne the battle and for his widow, and his orphan".

Vietnam Veterans of America recommends that rather than risk narrowing the scope of the VA's statutory authority to provide care to veterans with OTH discharges, Congress instead exercise its considerable oversight powers and encourage the Secretary of Veterans Affairs to use his existing authority to review and replace the VA's self-imposed regulatory restrictions with rules that provide timely, fair, and patient-centered care for veterans with OTH discharges.

Congress must not limit healthcare to veterans impacted by PTSD, TBI, or MST to those conditions alone, as care for the mind cannot be successful without care for the body.

We would like to strongly support this well-intended legislation, but it must be amended to replace sections which, as introduced, would have the unintended effects of limiting the statutory authority of the Department of Veterans Affairs to provide prompt and comprehensive healthcare to the hundreds of thousands of veterans with less-than-honorable discharges. Especially in light of the Secretary of Veterans Affairs' March 7, 2017 announcement that he intends to expand and improve VA's treatment of veterans with Other Than Honorable discharges, we recommend that this bill be amended to support and expedite those regulatory changes.

Specifically, the bill should require the VA to promptly issue a Proposed Rule regarding eligibility and, at minimum, impose eligibility standards as outlined in Recommendation # 17 of the Commission on Care Report. The Commission on Care Report was required by the Veterans Access, Choice, and Accountability Act of 2014. Recommendation #17 of the Commission on Care Report was to "Provide a streamlined path to eligibility for healthcare for those with an other-than-honorable discharge who have substantial honorable service." This recommendation suggested VA regulatory changes rather than legislation. The Veteran Ugent Access to Mental Healthcare Act could serve as an excellent vehicle to expedite these long overdue amendments and ensure fair and just treatment for all veterans. In line the the Report's recommendations, we ask Congress to require that VA:

1.Amend 38 C.F.R. 17.34 to provide for tentative eligibility for health care for individuals with Other Than Honorable discharges who have had substantial honorable service, such as service in a combat theater, service in support of combat operations, and other hardship service.

2.Amend 38 C.F.R. 3.12(d) to require consideration of mitigating and extenuating circumstances that show that service was "other than dishonorable."

HR 95 - Veterans' Access to Child Care Act - *A bill to amend title 38, United States Code, to direct the Secretary of Veterans Affairs to provide child care assistance to veterans receiving certain medical services provided by the Department of Veterans Affairs.*

VVA strongly supports the Veterans' Access to Child Care Act. This bill would expand the successful pilot program created in 2011 with the passage of the Caregivers and Veterans Omnibus Health Services Act of 2010 (PL 111–163). In doing so, it would help the VA to fulfill its mission to care for veterans and their families, and prevent veterans from having to choose between the needs of their children and their own health. The VA pilot program found in its first three years that nearly half of its users were mothers or step-mothers, Access to childcare is one of the top unmet needs for women and men Veterans, when enacted into law H.R. 95, will improve patient satisfaction, prevent appointment no-shows and cancellations, provide much-needed child care services for veterans and veteran families especially those living in rural areas.

HR 91 - Building Supportive Networks for Women Veterans Act - *A bill to amend title 38, United States Code, to make permanent the pilot program on counseling in retreat settings for women veterans newly separated from service in the Armed Forces.*

VVA strongly supports the Building Supportive Networks for Women Veterans Act. This bill makes permanent the requirement for the Department of Veterans Affairs to carry out, through the Readjustment Counseling Service of the Veterans Health Administration, a program to provide reintegration and readjustment services in group retreat settings to women veterans who are recently separated from service after a prolonged deployment. Currently, such program is required as a pilot program under the Caregivers and Veterans Omnibus Health Services Act of 2010.

HR 1162 - No Hero Left Untreated Act - *A bill to direct the Secretary of Veterans Affairs to carry out a pilot program to provide access to magnetic EEG/EKG-guided resonance therapy to veterans.*

VVA supports the No Hero Left Untreated Act. This bill would develop a pilot program at the VA to explore the effects of Magnetic eResonance Therapy technology, or MeRT technology, to treat patients suffering from PTSD, TBI, MST, opiate addiction, and chronic pain. This non-surgical, non-pharmaceutical treatment has shown promising results in limited studies.

HR 1545 - VA Prescription Data Accountability Act - *A bill to amend title 38, United States Code, to clarify the authority of the Secretary of Veterans Affairs to disclose certain patient information to State controlled substance monitoring programs, and for other purposes.*

VVA strongly supports the VA Prescription Data Accountability Act. This bipartisan bill would improve data sharing between the VA and State controlled substance monitoring programs so that prescriptions for non-veteran patients of VHA are tracked the same way that veterans' prescriptions already are. This data sharing would help to combat the opioid crisis.

HR 907 - Newborn Care Improvement Act - *A bill to amend title 38, United States Code, to improve the care provided by the Secretary of Veterans Affairs to newborn children.*

VVA strongly supports the Newborn Care Improvement Act. This bill allows the Department of Veterans Affairs (VA) to provide the newborn child of a woman veteran who is receiving VA maternity care with post-delivery care services for 42 days after the child's birth if the veteran delivered the child in a VA facility or another facility with which VA has a contract for such services. Under current law, such care may not be provided for more than 7 days. This bill will help the VA to fulfill its mission, to improve its care for women veterans and their families.

HR 1662 - *A bill to amend title 38, United States Code, to prohibit smoking in any facility of the Veterans Health Administration, and for other purposes.*

VVA must oppose this legislation, which is intended to protect veterans and their families from the harmful effects of secondhand smoke, but may have the unintended effect of discouraging veterans from getting the care that they need. VVA is concerned that veterans addicted to nicotine may face serious psychological and physiological stress when denied access to cigarettes, especially if they require inpatient care. For many veterans, the prospect of having to go "cold-turkey" from cigarettes may dissuade them from getting care that they need.

Furthermore, VVA members report value in the so-called "smoke pit" where veterans often find camaraderie and build upon relationships formed during group therapy.

VVA would support this legislation if it were amended so that nicotine addicted veterans were guaranteed access to smoking areas in weather-protected spaces that are outfitted with HEPA (high-efficiency particulate air) filtration technology.

HR 1005 - *A bill to amend title 38, United States Code, to improve the provision of adult day health care services for veterans.*

VVA strongly supports this legislation.

This bill directs the Department of Veterans Affairs (VA) to enter into an agreement or a contract with each state home to pay for adult day health care for a veteran eligible for, but not receiving, nursing home care. The veteran must need such care specifically for a service-connected disability or the veteran must have a service-connected disability rated 70% or more. Payment under each agreement or contract between the VA and a state home must equal 65% of the payment that the VA would otherwise pay to the state home if the veteran were receiving nursing home care.