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***STATEMENT OF  
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BEFORE THE  
COMMITTEE ON VETERANS' AFFAIRS  
SUBCOMMITTEE ON HEALTH  
UNITED STATES HOUSE OF REPRESENTATIVES  
JULY 14, 2015***

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting the DAV (Disabled American Veterans) to testify at this legislative hearing of the House Veterans' Affairs Subcommittee on Health. As you know, DAV is a non-profit veterans service organization comprised of 1.2 million wartime service-disabled veterans that is dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity.

DAV is pleased to be here today to present our views on the bills under consideration by the Subcommittee.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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