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**STATEMENT OF
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BEFORE THE
SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
APRIL 17, 2018**

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 of the House Veterans' Affairs Committee. As you know, DAV is a non-profit veterans service organization comprised of more than one 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 offer our views on the bills under consideration by the Committee.

H.R. 1506, the VA Health Care Provider Education Debt Relief Act of 2017

DAV supports passage of this important legislation based on DAV Resolution 128, calling for enabling the Department of Veterans Affairs (VA) to compete for, recruit and retain the types and quality of VA employees needed to provide comprehensive health care services to sick and disabled veterans.

We recommend the Education Debt Reduction Program be extended beyond the current December 31, 2019 deadline, the baseline funding be increased to achieve the intent of this measure, and that additional program staff may be needed for successful implementation.

To recruit and retain health professionals to work at VA to meet the health care needs of over 6 million ill and injured veterans, VA provides financial incentives under four broad categories to improve on the rigid government pay scales that has less room for growth than in private practice: market-based salaries, recruitment, retention, and relocation incentives (3Rs), Continuing Medical Education funds (CME), and Health Professionals Educational Assistance Program (HPEAP).

This bill seeks to improve HPEAP, which includes other critical recruitment and retention programs such as the Education Debt Reduction Program (EDRP). EDRP is one of the most utilized programs and allows the Veterans Health Administration (VHA) to reimburse qualifying education loan debt for employees, including physicians, in

hard-to recruit positions. Physicians apply directly to the VA medical center, and applications are approved by VHA to repay student loans for up to five years.

Section 302 of Public Law 113-146, the Veterans' Access to Care through Choice, Accountability, and Transparency Act of 2014 (VACAA) made improvements to EDRP by increasing the monthly and annual caps on debt reduction payments to an individual participant from \$12,000 to \$24,000 and from \$60,000 to \$120,000, respectively. As a result, both the number of new EDRP awards are increasing, the current active participants increased by 45 percent and the current average award has increased by more than 40 percent.

This measure seeks to build on the success of EDRP due to the VACAA cap increases by increasing the current annual cap of \$24,000 and five-year cap of \$120,000 to \$30,000 and \$150,000 respectively.

As this Subcommittee is aware, the Government Accountability Office (GAO) October 19, 2017 reported, based on conversations with VA medical center officials, that their EDRP program funding was insufficient, given that both the number of applicants and the amount awarded to individual physicians increased significantly, and that they depleted their EDRP budgets early in the fiscal year. As a result, some facilities GAO reviewed would not commit to providing EDRP during the recruitment process. Instead, officials routinely told candidates that they would consider EDRP eligibility if funding was available.

The bill would also amend the conditions under which VA could waive such caps. Currently, the caps could be waived if the health professional is serving in a position for which there is a shortage of qualified employees, by reason of either location or requirements of the position. If enacted, the bill would change the waiver criteria to apply to health professionals working in a geographical area designated by the Department of Health and Human Services as a health professional shortage area with respect to such participant's specialty or assignment. Because of the difference between these two definitions, we urge the Subcommittee to ensure this change does not adversely impact the ability for local VA medical centers to use EDRP in meeting their staffing needs.

H.R. 2322, the Injured and Amputee Veterans Bill of Rights

This bill would require the Secretary of Veterans Affairs to ensure that the "Injured and Amputee Veterans Bill of Rights" (hereafter referred to as the Amputee Bill of Rights) is posted on signage and displayed prominently in each prosthetics and orthotic clinic of the VA. The measure includes provisions for targeted outreach to notify veterans and veterans service organizations of the Amputee Bill of Rights, including placement on the Department's website. H.R. 2322 also requires VA employees working in prosthetic and orthotic clinics, federal recovery coordinators, case managers, and those working as patient advocates to receive training on the Amputee Bill of Rights.

The bill includes provisions mandating that each fiscal quarter patient advocates and veterans' liaisons collect information related to complaints and alleged mistreatment from veteran patients and report it to the VA's Chief Consultant of Prosthetics and Sensory Aids. The Chief Consultant would then be required to address and investigate allegations and complaints in accordance with the Amputee Bill of Rights.

Based on the bill, injured and amputee veterans would have the right to:

- access prosthetic and orthotic devices of the highest quality, and appropriate technology, while receiving care from the best qualified practitioners;
- continuity of care between VA and DoD by including comparable benefits relating to prosthetic and orthotic services;
- select the practitioner that best meets a veteran's needs regardless of the practitioner's Department affiliation (VA/DoD), to include private practitioners that have entered into contracts with the VA Secretary;
- comparable services and technology at any VA medical facility;
- timely and efficient orthotic care, including a speedy authorization process with expedited authorization for veterans visiting from another area of the country;
- be included in rehabilitation decisions and have the ability to get a second opinion regarding their prosthetic and orthotic treatment and needs;
- receive a primary and functional spare prosthetic or orthotic device;
- access to VA vocational rehabilitation, employment programs, and housing assistance; and
- be treated with respect and dignity.

DAV does not have a resolution that specifically calls for an Amputee Bill of Rights; however, DAV Resolution No. 178 calls for sufficient funding for the Prosthetic and Sensory Aid Service and timely delivery of prosthetic items. It also urges VA to rededicate itself to becoming a leader in prosthetic care by providing cutting-edge services and items to help injured, ill and wounded veterans fully regain mobility and achieve maximum independence in their activities of daily living, and in sports activities such as running, cycling, skiing, rock climbing and other physical exercises if they so choose. For the reasons mentioned above, we have no opposition to the enactment of this legislation.

H.R. 3832, the Veterans Opioid Abuse Prevention Act

The Veterans Opioid Abuse Prevention Act requires the Secretary of Veterans Affairs to enter into a memorandum of understanding with the executive director of the national network of state prescription drug monitoring programs. The purpose of this agreement would be to allow VA to submit queries on veterans who are longer-term users of controlled substances to such programs in the states in which the clinicians practice, or for non-participating states, the nearest state with a monitoring program.

Submitting these veterans to these monitoring programs would enhance the safety and effectiveness of prescribing controlled substances to certain veterans who are prescribed such substances for more than 90 days by ensuring they are not receiving the same prescribed drugs from different clinicians.

DAV does not have a resolution calling for support of VA's participation in state prescription drug monitoring programs. However, we believe this enhances patient safety in prescribing controlled substances with many known adverse effects, including addiction and overdose, to veteran patients therefore; we have no objection to its enactment.

DAV also urges Congress to ensure that VA redoubles its efforts to conduct a uniform national pain management program to ensure that veterans with chronic pain who have been prescribed pain medications over long periods of time are managed in a patient-centered environment, with balanced regard for both patient safety and provided humane alternatives to the use of controlled substances. Additionally, while under VA care veterans should be confident they will receive their prescribed medications in a timely fashion to relieve unnecessary pain or anxiety. We urge VA to monitor pain management efforts and resolve any conflicts between the effects of the Controlled Substances Act of 1970 and its prescribing policies and procedures to ensure the Department is compliant with its own national pain management policy and guidelines and comport with its stated goals of patient-centered, safe care that offers appropriate alternatives and carefully monitors withdrawal from controlled substances for veterans who have been long-term users of such medications.

H.R. 4334, the Improving Oversight of Women Veterans' Care Act of 2017

DAV strongly supports H.R. 4334, in accordance with DAV Resolution No. 225, which calls for support for enhanced medical services and benefits for women veterans. This resolution seeks to ensure that health care services and specialized programs provided by VA to eligible women veterans are provided to the same degree and extent that services are provided to eligible male veterans, inclusive of counseling and/or psychological services incident to combat exposure or sexual trauma.

DAV urges VA to strictly adhere to stated policies regarding privacy and safety issues relating to the treatment of women veterans and to proactively conduct research and health studies as appropriate, periodically review, adjust and improve its women's health programs, and seek innovative methods to address barriers to care, thereby better ensuring women veterans receive the quality treatment and specialized services they so rightly deserve.

H.R. 4334, the Improving Oversight of Women Veterans' Care Act of 2017, would require the VA Secretary to submit an annual report to Congress on women veterans' access to covered sex-specific services under community care contracts including the average wait time for appointments, the veteran's driving time to the appointment and

reasons why appointments could not be scheduled with non-Departmental medical providers.

The bill would also require each VA medical facility to submit quarterly reports on compliance with environment of care standards to the VA Secretary and to develop a plan within 180 days of enactment for strengthening the process to verify non-compliance data is accurate and complete; that all patient care areas are inspected; and to include the list of inspected items to align with those outlined in the Women Veterans Program Manager's Handbook.

The provisions in this bill are also consistent with recommendations in DAV's 2014 report, *Women Veterans: The Long Journey Home*. I am pleased to report that DAV will be releasing an update to that report in the near future and we look forward to sharing our findings and recommendations with the Subcommittee.

H.R. 4635, to increase the number of peer-to-peer counselors providing counseling for women veterans

DAV is pleased to offer its support for H.R. 4635, legislation calling for an increase in the number of peer-to-peer specialists to provide support and counseling specific to women veterans. This bill is consistent with DAV Resolution No. 225, calling for enhanced health care services and benefits to meet the unique needs of women veterans.

If enacted, this bill would require the Secretary of Veterans Affairs to ensure the Department has a sufficient number of peer counselors for women veterans. These counselors may be employees of VA and have expertise in gender-specific issues and services, employment mentoring, service and benefits provided by the Secretary. The bill would also require the Secretary to emphasize facilitation of peer-to-peer counseling for women veterans who have experienced military sexual trauma (MST), have post-traumatic stress disorder (PTSD), or other mental health conditions, or are at risk of becoming homeless.

The Secretary would be required to conduct outreach to inform women about the peer-to-peer program, and facilitate engagement and coordination with community organizations, state and local governments, institutions of higher education, chambers of commerce, local business organizations, and organizations that provide legal assistance to facilitate the transition of women veterans. The bill would require the Secretary to use existing funds to carry out the mandates and provisions in H.R. 4635.

Women comprise a small, but growing portion of the veteran population using VA services. Many service-disabled women veterans face challenges reintegrating into their communities following military service. Researchers have found that women veterans often lack a supportive social network during the transition period and that they face a number of barriers to accessing the care and benefits they need. Women veterans often do not self-identify as veterans and seek benefits at lower rates than their male

peers. Lack of child care services is frequently noted as a barrier to accessing post-deployment mental health readjustment counseling. Exposure to military sexual trauma and abuse of alcohol are complicating factors among this population that also make them more prone to homelessness and suicide.

Peer specialists have been shown to be especially effective in engaging VA users in accessing needed mental health services. Ensuring that women peer specialists are available to assist and guide other women veterans with accessing the services they need, such as mental health care, child care, legal assistance and assistance with job placement or training and in identifying appropriate resources within and outside of VA, will lead to a more successful transition and better health outcomes for this population.

DAV supports using peer specialists as a means of expanding VA's workforce and providing additional support to veterans with complex and comorbid conditions such as PTSD, substance-use disorders and traumatic brain injury. However, we are concerned that other priorities such as filling critical health occupation vacancies within the Veterans Health Administration (VHA) such as physicians, nurses, psychologists, and other credentialed professionals may hamper VHA's ability to hire more women peer specialists. For these reasons, we recommend the Subcommittee consider adding funding for this important program.

It is critical that these peer specialists are available to provide culturally competent and gender-sensitive assistance in navigating the many federal government programs available to meet women veterans' needs. VA's existing peer support program has been shown to enhance patient engagement, increase veterans self-advocacy skills, increase quality of life and patient satisfaction and ensure more appropriate use of services.

Draft Bill, the VA Medicinal Cannabis Research Act of 2018

The VA Medicinal Cannabis Research Act of 2018 would allow the Secretary of VA to engage in research on the safety and efficacy of medicinal cannabis use on health outcomes for veterans with chronic pain, post-traumatic stress disorder (PTSD) and other conditions the Secretary deems appropriate. The bill would require that VA include certain forms of cannabis in addition to different delivery methods for using cannabis products in its research and develop a means of preserving data for future studies. It further requires that VA develop a five-year implementation plan for conducting such research, including issuance of requests for proposal, within 180 days of enactment. Finally, the bill would require VA to submit progress reports to Congress not less frequently than annually.

DAV understands that use of cannabis for medicinal purposes is now legal in 29 States and the District of Columbia. However, we note there have been no changes made to federal law regarding use of these products for any purpose. We further understand that, while the medical literature has been inconclusive about the

effectiveness of marijuana for improving symptoms of chronic pain and PTSD, noting both risks and, in some cases, benefits, many veterans report the use of cannabis for these purposes is beneficial.

While DAV has no specific resolution calling for VA to conduct research on the safety and efficacy of medicinal cannabis for veterans with chronic pain or PTSD, DAV Resolution No. 129 notes strong support for VA research on common conditions related to military service and effective treatments to help veterans recover, rehabilitate and improve the overall quality of their lives. We must ensure that any intervention for treatment of chronic pain and PTSD is both safe and effective for veteran patients especially veterans with clinically complex comorbid conditions such as traumatic brain injury, PTSD and chronic pain from amputations and other war-related injuries. For these reasons we have no objection to passage of this bill.

Discussion Draft, to make certain improvements in the family caregiver support program of the Department of Veterans Affairs

Public Law 111-163, the “Caregivers and Veterans Omnibus Health Services Act of 2010,” established the Program of General Caregiver Support Services and the Program of Comprehensive Assistance for Family Caregivers. The Program of Comprehensive Assistance for Family Caregivers (the Comprehensive Program) provides additional support services to caregivers beyond what is provided through the Program of General Caregiver Support Services, including a modest monthly financial stipend, health care coverage through CHAMPVA, counseling and mental health services, respite care, and technical assistance. However, the Program is only available to veterans who have serious injuries (including traumatic brain injury, psychological trauma, or other mental disorder) incurred or aggravated in the line of duty in the active military, naval, or air service on or after September 11, 2001 (post-9/11).

We are encouraged the program is working as intended based on comments from a qualitative online survey conducted by DAV, which received 1,833 validated responses from veterans and caregivers. This is described in greater detail in our testimony before the full Committee during its oversight hearing on February 6, 2018. But our members recognize there is always room for improvement.

Since the program’s enactment, DAV has fought for legislation that improves the program and provides family caregivers and veterans severely ill and injured before September 11, 2001 (pre-9/11) equitable access to comprehensive caregiver support services.

During the February 6, 2018 oversight hearing, DAV, along with virtually all of our VSO colleagues, called on the full Committee to take bold and decisive actions, similar to what the Senate Veterans’ Affairs Committee did last fall, and pass legislation extending eligibility for the full array of caregiver support services to veterans from all eras.

As such, we continue to advocate that the most equitable solution is for Congress to amend existing statute by removing “on or after September 11, 2001” so that all veterans and caregivers have equal access to the Program. Furthermore, Congress should amend the statute by including provisions allowing severely ill veterans and their family caregivers to be eligible for the Program.

DAV, along with our VSO colleagues, has been working with both the House and Senate Veterans’ Affairs Committees to come to an agreement and pass a legislative package, which includes extending the current eligibility criteria for the Comprehensive Program to family caregivers of veterans severely injured pre-9/11; requires the implementation and certification of an information technology system to assess, support, and improve the family caregiver support program, and modifies the annual evaluation report of the program.

In light of current circumstances, DAV has grave concerns regarding Section 3 of this draft measure, which proposes to address the unfairness of excluding pre-9/11 veterans from the Comprehensive Program by raising the bar for eligibility on both pre- and post-9/11 veterans. We could not support limiting or restricting eligibility to the Comprehensive Program for family caregivers and veterans when a more supportive and equitable caregiver policy has already tentatively been agreed to and is under active consideration by Congress.

We urge the Subcommittee to amend and reconsider the provision in this draft bill that would amend paragraph (3)(C) of section 1720G(a). The original intent of this paragraph remains sound and is an important one, which is to mitigate the financial impact of caregiving, by providing caregivers a modest stipend that would not be less than the amount a commercial home health entity would pay an individual in the geographic area of the veteran to provide equivalent personal care services. We believe the source of the issues surrounding both the labor intensive process in calculating local stipend rates and the resulting outlier stipend rates are more the result of the Department’s regulatory decision to calculate such rates by using the Bureau of Labor Statistics hourly wage for home health aides in a geographic area.¹

This draft measure could better address the disadvantages of this particular regulation by assisting VA in establishing a more appropriate stipend schedule that does not erode current benefits while addressing program inefficiencies. We urge the subcommittee to work with VA in crafting more suitable language to accomplish the desired intent and for VA to make improvements through regulatory action.

There is also a conditional effective date for the sections in draft bill amending title 38, United States Code, section 1720G. Rather than leaving the effective date open ended, we recommend a date certain be included in Section 3 of this bill to ensure program improvements contemplated in such section is realized and not left to uncertainty.

¹ 38 C.F.R. §71.40(c)(4)(v)

Finally, we urge the Subcommittee to consider additional provisions such as integrating a research component to VA's caregiver support program, which could help find answers such as how to most effectively support family caregivers of severely ill and injured veterans in a cost-effective manner and could better inform program managers, policy makers and the public. In addition, because the success of the Program and the quality of life of severely ill and injured veterans relies heavily on the ability for VA to provide in-home assistance, and based on DAV's report "American's Unsung Heroes: Challenges and Inequities Facing Veteran Caregivers," which found that family caregivers of severely ill and injured veterans often do not get the support they need, such as financial assistance, respite care, medical training or home health aide services, we urge the Subcommittee to include a provision that would instruct the Government Accountability Office to update its 2003 report on veterans' access to non-institutional/home- and community-based care.

In reviewing Section 2 of this draft bill, we believe it is intended to address the recommendations in GAO's September 2014 report on VA's caregiver support program that VA "expedite the process for identifying and implementing an [IT] system that fully supports the program and will enable [VHA] program officials to comprehensively monitor the program's workload, including data on the status of applications, appeals, home visits, and the use of other support services, such as respite care," and that VA "use data from the IT system, once implemented, as well as other relevant data to formally reassess how key aspects of the program are structured and to identify and implement modifications as needed to ensure that the program is functioning as envisioned so that caregivers can receive the services they need in a timely manner."

DAV continues to press VA to ensure it meets the GAO's recommendations to implement an IT system that fully supports the program. We are encouraged that VA's long-term IT solution for the caregiver program is due to be delivered by the end of September. We urge this Subcommittee to use its oversight powers to ensure progress in its development is maintained to meet the delivery date.

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.