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***STATEMENT OF
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BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
MARCH 27, 2014***

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

On behalf of the DAV and our 1.2 million members, all of whom are wartime wounded, injured and ill veterans, I am pleased to present our views on legislative measures that are the focus of the Subcommittee today, and of DAV and our members.

H.R. 183, the Veterans Dog Training Therapy Act

This bill would require the Secretary of Veterans Affairs to conduct a 5-year pilot program to assess the effectiveness of a therapeutic medium 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 Department of Veterans Affairs (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. The bill would require a facility to offer wheelchair accessibility, dedicated indoor space for grooming and training dogs; 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 certified service dog trainers 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 certain 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; 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 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, maximum independence and improved 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. DAV is supportive of non-traditional therapies and expanded treatment options for veterans. For these reasons we have no objection to this bill.

H.R. 2527, to provide veterans with counseling and treatment for sexual trauma that occurred during inactive duty training

Unfortunately, the sexual assault and harassment scourge continues in the active military services, and often results in lingering emotional or chronic psychological symptoms or conditions in victims of these attacks. Currently, title 38, United States Code, section 1720D authorizes VA to provide priority counseling and specialized treatment for eligible veterans who have experienced military sexual trauma (MST), but this eligibility is limited to only those who served on active duty or active duty for training.

This measure would amend Section 1720D to include veterans serving in the reserve components of the armed forces during inactive duty for training so that they, too, will be eligible for VA counseling services for conditions related to sexual trauma that occurred during their training.

DAV Resolution 125 calls on VA to ensure that all military sexual trauma survivors gain access to the VA specialized treatment programs and services they need to fully recover from sexual trauma that occurred during their military service. Therefore, DAV is pleased to support H.R. 2527 and urges its enactment.

H.R. 2661, the Veterans Access to Timely Medical Appointments Act

This bill would direct the Secretary of Veterans Affairs to establish a standardized scheduling policy for veterans enrolled in the VA health care system. This measure would propose to improve veterans' timely access to health care in the VA based on an external finding

of unreliable waiting time data, lack of local adherence to national scheduling policy, and ineffective oversight by VA on the scheduling process itself.

If enacted, the bill would require VA to implement recent Government Accountability Office (GAO) recommendations (GAO-13-130, <http://www.gao.gov/assets/660/651076.pdf>) to improve the reliability and accuracy of appointment waiting time measures; ensure VA medical centers (VAMC) consistently observe and adhere to official VA scheduling policy; require VAMCs to allocate staffing resources based on actual scheduling needs; and, ensure that VAMCs provide oversight of, and implement best practices to improve, veterans' telephone access to care. The bill would also require VA to make a series of reports to Congress on its efforts to improve scheduling under the mandates of this bill.

DAV has testified on numerous occasions before this Committee on the topic of timely access in general, and of a variety of individual VA health care scheduling challenges, such as those in outpatient primary care, in mental health, in prosthetics and sensory aids and in other specialized services. While policies made at VA's Central Office seek to standardize a set of goals and actions across all VA facilities and programs, such as for timely access, or access-to-care standards, the mechanisms by which these policies are implemented locally may vary over time for a variety of reasons.

We also note that VA's national waiting time policies have been changed over the years, and were re-defined and re-interpreted as they encountered conflicts with realities on the ground. For example, about 20 years ago, to respond to criticisms about long waiting times, particularly for specialty services, VA established its "30/30/20" goal. For outpatient care, patients were to receive initial, non-urgent appointments with their primary care or other appropriate providers within 30 days of requesting visits; receive specialty care appointments within 30 days when referred by primary care providers; and, be seen by providers within 20 minutes of scheduled appointments. In 2000, to replace paper waiting lists, changes were made to VHA's automated scheduling module, measuring actual waiting times versus VA's 30-day standard. Over time, VA has used several different waiting time measures defining and refining which patients would be included in waiting time analysis, which outpatient and specialty clinic services would be counted in waiting time calculations, and when waiting times started and ended. VA's access goals changed again in 2010 when VA began measuring performance for all outpatients based on a new 14-day waiting time benchmark. All these shifts and amendments have encountered challenges when they were implemented locally.

While the intent of the bill is laudable and we appreciate the sponsor's interest in this ongoing challenge at VA, DAV believes the overriding critical component to solving many of VA's access challenges, unaddressed and lingering for several years now, is lack of an effective, sensitive and contemporary automated VA health care scheduling system.

VA's outpatient clinic scheduling module is a core component of the Veterans Health Information Systems and Technology Architecture (VistA), a landmark multi-functional computerized patient records system, first deployed 30 years ago. The system has been modified many times since, and now performs multiple interrelated functions affecting patients, clinicians and other VA resources. The VistA scheduling module captures data which enables VA to measure, manage and improve access, quality and efficiency of care, and monitors operating and capital resources used in providing care. However, as has been continually reported and observed

by GAO, “the VistA scheduling system is outdated and inefficient, which hinders the timely scheduling of medical appointments.” (See GAO-13-130, page 24.) We believe when a new scheduling system is eventually installed, VA could reasonably begin to assess demand versus capacity, as well as determine associated staffing needs and resources more accurately for management and oversight purposes.

Measuring capacity, patient access and demand is a complex issue. DAV believes that progress toward successful implementation of VA’s timely access policy must be assessed to ascertain what is or is not being achieved and why. Valid and reliable information is crucial because it helps shape decisions and actions at various levels to ensure compliance with policy directives, reaching intermediate performance indicators or benchmarks, and achieving long-term policy goals and objectives. Many of these important objectives are hampered because of weaknesses and failures of VA’s current IT scheduling infrastructure. Furthermore, trying to standardize waiting times may result in VA having to contract for services if staffing levels and appropriate resources are not identified to resolve excessive waiting times.

While DAV supports the intent of this legislation based on our Resolution No. 204, which calls on VA and Congress to ensure timely access to quality VA services, to identify and correct the related underlying data, scheduling and reporting problems that exist, and to provide sufficient resources and staff to achieve this goal, we believe this bill may bring an opposite effect. Despite its good intentions, enactment of this bill would not address these issues, and may only further complicate VA’s ongoing quest to meet its own national access standards. Like the author of this bill, we want veterans to gain and keep access to timely care in VA. Therefore, we urge the Subcommittee to work with VA to fully address the core issues to determine how the intent of this measure could be best achieved.

H.R. 2974, to provide for the eligibility for beneficiary travel for veterans seeking treatment or care for military sexual trauma in specialized outpatient or residential programs at facilities of the Department of Veterans Affairs

This bill would amend title 38, United States Code, section 111, to provide veterans new eligibility for VA beneficiary travel reimbursement if they need to travel to specialized outpatient or residential programs at VA facilities for treatment of mental health conditions related to sexual trauma that occurred during their military service.

The Sexual Assault Prevention and Response Office (SAPRO) in the Department of Defense (DOD) reports that over 3,000 sexual assaults are acknowledged each year across the military branches. However, SAPRO estimates 87 percent of these assaults actually go unreported—meaning that as many as 26,000 sexual assaults are likely to occur in DOD each year. The VA provides specialized residential and outpatient counseling programs and evidence-based treatments to military sexual trauma (MST) survivors, and notes that nearly 800,000 MST-related patient encounters take place annually.

According to VA’s Office of the Inspector General (VAOIG) Report No. 12-03399-54, *Inpatient and Residential Programs for Female Veterans with Mental Health Conditions Related to Military Sexual Trauma*, VA facility and mental health services staff interviewed by the VAOIG consistently indicated difficulties obtaining VA authorization for patient transportation funding to VA’s specialized centers for MST. We believe these difficulties arise from

conflicting VA authorities and policies. Specifically, VHA Directive 2010-033, *Military Sexual Trauma (MST) Programming*, establishes policy that veterans and eligible individuals must have access to VA residential or inpatient programs able to provide specialized MST-related mental health care. However, access to such care is affected for veterans eligible and not eligible for beneficiary travel benefits.

In the case of a veteran who is eligible for beneficiary travel benefits under current statutory authority,¹ applying VHA Directive 2010-033 requires clearer guidance on inter-facility referrals for care, consistent implementation of current policy, and oversight.

Clearer guidance to VA facilities from VA Central Office is needed to help determine which VA facility would be responsible for paying beneficiary travel benefits when more than one VA facility is involved in a veteran's care, or when treating VA facilities are located in different Veterans Integrated Service Networks (VISN). This lack of guidance for beneficiary travel affects all types of care including for MST-related conditions. Ostensibly, the memorandum of understanding on inter-facility referrals required in VHA Directive 2010-033, should address this problem.

Consistent implementation and oversight is required when mileage reimbursement is calculated to the nearest VA facility. The VAOIG report indicates that reimbursement is only authorized to the VA facility "where the care or services could be provided." This interpretation is not wholly accurate.

Title 38, Code of Federal Regulations, section 70.30(b)(1) and VHA Handbook 1601B.05 state that reimbursement for beneficiary travel to an eligible beneficiary "[i]s limited to travel from a beneficiary's residence to the nearest VA facility where the care or services could be provided and from such VA facility to the beneficiary's residence." However, the Handbook also indicates that the nearest appropriate VA facility *is subject to a clinician's determination*. The "nearest appropriate VA facility" means the particular VA facility that a VA provider determines is capable of providing the treatment or service required. Thus, if a VA clinician indicates a veteran who is eligible for beneficiary travel requires specialized treatment for MST at a VA facility located in a different VISN, current policy states the amount of beneficiary travel payment or reimbursement shall be calculated from the veteran's residence to the distant facility, not the home VA facility.

In the case of a veteran who is *not* eligible for beneficiary travel under current statutory authority, we believe successfully achieving the intentions of VHA Directive 2010-033 regarding access to specialized MST-related residential or inpatient MST-related care would require enactment of H.R. 2974.

As you may be aware, DAV called for enactment of a similar measure in testifying before the Senate Veterans' Affairs Committee on October 30, 2013, regarding a draft bill, the Survivors of Military Sexual Assault and Domestic Abuse Act of 2013. Thus, in accordance

¹ Traveling for treatment or care: 1) for a service-connected disability; 2) for any disability of a veteran rated 30 percent or more for a service-connected disability; 3) for a scheduled compensation and pension examination; 4) of a veteran receiving pension under 38 U.S.C. § 1521, and; 5) a veteran whose annual income (as determined under 38 U.S.C. § 1503) does not exceed the maximum annual rate of pension under 38 U.S.C. § 1521 (as adjusted under 38 U.S.C. § 5312) if the veteran was eligible for pension.

with DAV Resolution No. 125, which calls for supporting legislation to change beneficiary travel policies to meet the specialized clinical needs of veterans receiving MST-related treatment, DAV supports H.R. 2974. However, DAV also testified on May 21, 2013, before this Subcommittee on a related bill that proposed to amend Section 111 by expanding eligibility for beneficiary travel reimbursement benefits to another select group of veterans. That bill, H.R. 1284, would have given new eligibility for VA beneficiary travel reimbursement to veterans needing specialized care for vision impairment, for spinal cord injury or disorder, or for double or other multiple amputations. In that testimony, we urged this Subcommittee, as we do now, to consider a more equitable approach to beneficiary travel eligibility.

Specifically, in addition to a handful of specialized MST residential programs targeted by H.R. 2974, VA operates 24 spinal cord injury/dysfunction rehabilitation centers, 13 blind rehabilitation centers, 7 geriatric research, education and clinical centers, 7 mental illness research, education and clinical centers, 3 war-related illness and injury study centers, and a number of other clinical centers of excellence. Access to these centers is important for veterans with conditions connected to the expertise of these centers.

In DAV's view, the developing care delivery model for MST-related specialized treatment is similar to the concentrations of other specialized VA clinical services that often require patients to travel long distances to gain access to these services. Without VA's support for their transportation costs to reach these centers, some veterans encounter challenging barriers to care and do not benefit from the higher quality care and outcomes intended by VA and Congress in establishing and operating these centers of excellence. This problem should be addressed through the legislative process.

H.R. 3180, to include contracts and grants for residential care for veterans in the exception to the requirement that the Federal Government recover a portion of the value of certain projects

H.R. 3180 was introduced with the intention of allowing some state veterans homes to compete for existing grants to support the operation of homeless veterans programs using a portion of excess bed capacity in state home domiciliaries. The bill would amend title 38, United States Code, to authorize a state veterans home to receive contracts or grants from VA for any residential care program, including a homeless veterans program, without being subjected to required federal recapture of prior VA construction grants to the home for the building of those beds. Under current statute, state veterans homes receive federal support, including both per diem payments for veterans' care and construction grants, to operate only three authorized programs: skilled nursing care, adult day health care, and domiciliary care. Under current law, were a state home to use facilities previously granted by VA to operate any other type of program, the federal government would seek to recapture a proportionate value of the construction grant funds that had been provided over the prior 20 years.

The legislation as currently drafted, however, does not specifically reference either domiciliaries or homeless veterans programs, nor would it assure the intended outcome. The bill's current language would create a broad exception to the recapture provision that could be applied to any residential care program for veterans, and its enactment could raise the potential for other unintended consequences. Based on DAV Resolution 165, DAV supports the intention of H.R. 3180—to use existing excess capacity to help homeless veterans—but recommends that

the Subcommittee work with VA, state homes and veterans service organizations to craft more targeted and effective legislative language to achieve the goal of this bill.

H.R. 3387, the Classified Veterans Access to Care Act

This bill would seek to 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 DOD 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 be a reason 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 has not received a resolution from our membership concerning mental health services for veterans who once worked in classified or sensitive military activities, we did receive Resolution No. 193, at our most recent national convention, that 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. 3508, to clarify the qualifications of hearing aid specialists of the Veterans Health Administration of the Department of Veterans Affairs

If enacted, this bill would authorize the appointment of hearing aid specialists in the Veterans Health Administration (VHA). The bill would specify that such individuals hold associate degrees in hearing instrument sciences, or the equivalent, from colleges or universities approved by the Secretary, or have successfully completed approved hearing aid specialist apprenticeship programs. Individuals eligible for appointment would need to be licensed by a state as a hearing aid specialist, or its equivalent.

The Secretary would also be required to submit an annual report on timely access to hearing health services to include staffing levels and average waiting times for patients seeking appointments, a description of how the Secretary measured performance related to appointments and care in hearing health, and information on contracting policies with respect to providing hearing health services in non-VA facilities. Not later than 180 days after enactment of this bill, the Secretary would be required to update and reissue the VHA handbook, "VHA Audiology and Speech-Language Pathology Services," to reflect these new requirements.

On February 20, 2014, the VA's Office of the Inspector General (VAOIG) issued a report and findings of its audit of VA hearing aid services (VAOIG 12-02910-80). The purpose of the audit was to evaluate the effectiveness of VA's administration of hearing aid orders. According to the report, VA is not issuing hearing aids to veterans in a timely manner or meeting its own five-day goal to complete repair services of hearing aids issued previously. Specifically, VHA issued 30 percent of its hearing aids to veterans more than 30 days from the estimated date the facility received hearing aids from vendors. Audiology staff attributed the delays to inadequate staffing levels and the large number of veterans requiring compensation and pension examinations, which they reported take priority over other types of clinic appointments. The VAOIG further noted that with the veteran population aging, demands for hearing aid services have increased from 596,000 in FY 2011 to over 665,000 in FY 2012. Also, the VAOIG estimated that about 19,500 sealed packages of hearing aids were awaiting repairs at VA's

Denver Acquisition and Logistics Center and that 17-24 days were being consumed by the center to complete the repair services, exceeding VA's five-day timeliness standard for such services.

The VAOIG recommended VA develop a plan to implement productivity standards and staffing plans for audiology clinics as well as to determine appropriate staffing levels for its repair laboratory, and to establish controls to track and monitor received hearing aids pending repair. The VA Under Secretary for Health concurred with the audit recommendations and submitted corrective action plans. We understand these actions have been initiated and look forward to VA's report.

DAV has no specific resolution from our membership related to the employment of hearing aid specialists within VA. However, the findings of the VAOIG report cited demonstrate that VA is now struggling to meet timely access for the delivery of hearing aids and for completing necessary repairs on malfunctioning ones. Because hearing loss (including tinnitus) is the most prevalent service-connected disability for veterans, and the demand for audiology services and hearing aid repairs and adjustments continues to rise, having qualified hearing aid specialists available for basic services (within their scope of practice, for necessary repairs and cleaning) may significantly reduce the waiting times found by VAOIG. We do, however, defer to VA to ensure that hearing aid specialists would meet VA's quality standards, through their certified scope of practice, and could contribute in reducing the backlog of hearing aid repairs and delivery of hearing aids to veterans. If this can be verified by VA we have no objection to passage of this measure.

H.R. 3831, the Veterans Dialysis Pilot Program Review Act of 2014

This measure would require the Secretary to undertake an independent analysis of the existing dialysis program implemented by the VA and provide a report to Congress on the review prior to expanding the existing dialysis pilot program at VAMCs in Durham and Fayetteville, North Carolina; Philadelphia, Pennsylvania; and Cleveland, Ohio, or creating any new dialysis capability.

VA estimates show that in FY 2011, approximately 35,000 veterans enrolled in the VA health care system were diagnosed with end-stage renal disease (ESRD), reflecting a higher prevalence of this condition in the VA population than in the general U.S. population. (*Comparison of outcomes for veterans receiving dialysis care from VA and non-VA providers*, Wang et al., BMC Health Services Research 2013, 13:26.) VA initiated several studies of this population based on the rapidly rising cost of VA-financed hemodialysis treatment in non-VA facilities and the high rates of morbidity and mortality of veteran patients with ESRD. (*Comparing VA and private sector healthcare costs for end-stage renal disease*, Hynes et al., Medical care 2012, 50(2):161-170.)

ESRD patients are one of the most resource-intensive population cohorts in the VA health care system. The reality of hemodialysis is often overwhelming to these patients. Kidney failure is a life-altering disease that has a significant impact on a veteran's overall physical and mental health, lifestyle, and livelihood. A veteran diagnosed with ESRD who needs dialysis typically requires three outpatient treatments per week, each requiring about four hours, to be repeated for the remainder of his or her life, absent kidney transplant.

In a May 2012 report, the GAO evaluated VA's dialysis pilot. GAO reported VA had not fully developed performance measures for assessing the dialysis pilot locations, even though the Department had already begun planning an expansion of the pilot to additional sites. Further, GAO concluded that such an expansion "should not occur until after VA has defined clear performance measures for the existing pilot locations and evaluated their success."

DAV has no approved, specific resolution on this issue, and therefore takes no formal position on this bill. We do, however, offer some concerns that we ask the Subcommittee to consider.

While Congress has been focused on the accuracy of VA's data, analysis, and plan of action to address the growing demand for dialysis therapies depicted in recent Committee reports (House Appropriations Report 112-094, page 41, May 31, 2011 and House Appropriations Reports 112-491, pages 39-40, May 23, 2012), DAV is concerned that enactment of this measure would, at least through July 2015, restrict VA's capacity to provide life-sustaining dialysis treatment through fee-basis dialysis, except for those under sharing or other negotiated agreements.

We note for the Subcommittee that VA testified on October 30, 2013, before the Senate Veterans' Affairs Committee, and indicated that requiring continuation of the four initial pilot sites without change beyond these activities for at least the next two years would prohibit activation of any additional free-standing VA dialysis centers until at least 2015. The VA also testified that a restriction of this type had the potential to "...adversely impact VA's efforts to optimize Veterans' dialysis care." Given the brittle nature of these veterans' health problems and their very high morbidity and mortality rates due to this fatal disease, in our judgment new projects that the VA is currently working to activate should continue without interruption or further delay, and certainly should go forward without regard to the fate of these four pilot programs. Further, DAV would be deeply concerned if this bill were to halt or restrict VA from continuing to provide dialysis care to veterans within the system itself, or through private providers under contract.

Discussions surrounding the dialysis pilot of the Department's purchased and provided dialysis therapy appear generally to be centered on cost. We find insufficient emphasis on the veteran patient; therefore, we appreciate this legislation's inclusion of non-cost factors such as access to care, quality of care, and veteran satisfaction in the bill's provisions related to independent analysis of the VA dialysis pilot program.

As one of four *Independent Budget* veterans service organizations (IBVSOs), we note that coordinating care among the veteran, dialysis clinic, VA nephrologists, and VA facilities and physicians, is essential to improving clinical outcomes and reducing the total costs of care. The benefits of an integrated, collaborative approach for this population have been proven in several Centers for Medicare and Medicaid Services demonstration projects and within private-sector programs sponsored by health plans and the dialysis community. Such programs implement specific interventions that are known to avoid unnecessary hospitalizations, which, when they occur for these patients, frequently cost more than the total cost of dialysis treatments. These interventions include a focus on behavioral modification and various motivational techniques. The potential return on investment in better clinical outcomes, higher quality of life, and lower

costs could be substantial for VA and veteran patients if integrated care coordination were emphasized.

We understand that some community dialysis providers are piloting the integrated care management concept among their veteran population cohorts. The IBVSOs believe that VA should also provide integrated care management in this pilot program that can test and demonstrate the value of such an approach to VA and the veterans it serves.

H.R. 4198, the Appropriate Care for Disabled Veterans Act

H.R. 4198 would amend title 38, United States Code, to reinstate the requirement for an annual report to Congress on the capacity of the VA to provide for specialized treatment and rehabilitative needs of disabled veterans. The renewed report would emphasize a special – but not exclusive – focus on maintenance of programs of care for spinal cord injury/dysfunction (SCI/D); blindness; traumatic brain injury (TBI); prosthetic, orthotic and sensory aids; and mental health.

We have received no national resolution approved by our membership to support reinstatement of this previous reporting requirement; however, we wish to offer some thoughts to the Subcommittee for its consideration in determining how to manage this proposal.

Section 1706, title 38, United States Code, was formulated by the Committee in the mid-1990's and was first authorized in Public Law 104-262. The section was subsequently revised in three additional acts, the last of which was Public Law 109-461, an act that extended the reporting requirement through 2008. The capacity report has been suspended since that time, but other provisions of section 1706 are still applicable to VA.

Several elements in the report that H.R. 4198 would reauthorize rely on the year 1996 (the year of enactment of Public Law 104-262) as the benchmark year for VA capacity comparisons and reporting going forward. Given changes in the veteran patient population, their health care needs, and the manner in which health care is delivered today, we believe reinstating the existing comparison year of 1996 for a number of important programs would not produce information useful for Congressional oversight, for review by members of our community of veterans service organizations, and for others with interest in VA capacity.

Due to the nature and severity of veterans' contemporary war injuries from Iraq and Afghanistan, and the consequent massive investment in new and innovative prosthetics made by both VA and the Department of Defense since 2002, VA's prosthetic and sensory aids program is now more innovative, extensive and expensive today than in 1996. Thus, 1996 would not be an appropriate benchmark in our view. In this light a more effective date for comparative reporting purposes in the prosthetics program might be 2001 or, perhaps even 2010, so that Congress could more closely gauge how VA capacity to provide these specialized services may be changing annually during a more meaningful interval.

Importantly, in no small part because of this Committee's advocacy and the benevolence of Congressional appropriators, VA mental health programs including those for substance-use disorder, have been reformed, revised and expanded to such an extent that they barely resemble those of nearly twenty years ago. In staffing alone, since 2002, VA has added over 20,000

mental health personnel to its employment rolls. VA already reports to Congress in its annual budget submissions estimated total expenditures on mental health, but reporting of detailed subsets is not currently required. We believe more detail on mental health program capacity should be made available.

As an example of the need for public reporting, we note that substance-use disorder bed units were prevalent in VA and elsewhere in 1996 when the expired reporting requirement was first established, but they are much rarer now. In fact over the past decade and more, VA has severely curtailed inpatient residential substance-use disorder programs. Most of these programs are now conducted on an outpatient basis. The expired language of section 1706 assumes inpatient substance-use programs are still prevalent today. Also, VA maintains a number of detoxification beds for acute substance-use disorder intake cases, but we have experienced challenges in determining the number and location of these beds since no publicly available inventory of them is maintained by VA.

In another evolution in VA, traditional long-term, skilled nursing care (historically a bed-intensive program) has given way to VA's establishment of an array of institutional and non-institutional long-term services and supports. The expired language is silent on VA long-term services and supports capacity, but as an important and growing component of VA's clinical care mission, we believe it should be included. DAV is supportive of the VA's initiative to rebalance its long-term services and supports portfolio to care for veterans closer to where they live by increasing access to and creating new and innovative home and community-based services. However, variation in availability and accessibility of VA long-term services and supports across the 21 VA health care networks has been critiqued in multiple reports by the GAO. These reports collectively could offer insights into how a capacity report might be structured.

In certain discrete bed units (such as VA SCI/D centers, designated TBI rehabilitation units, and residential blind rehabilitation centers, for example), year-to-year comparative bed capacities by unit, and full-time employee equivalents assigned to each such unit (as well as the distribution of those staff by health profession, compared to VA's "objective standards of job performance," as also prescribed by section 1706), could provide a meaningful yardstick to ascertain VA's true capacity to care for and rehabilitate veterans in these particular specialized bed-based units. Given the bill sponsor's coordination with Paralyzed Veterans of America in crafting this bill, DAV would support amendments to this bill that would require VA to report to Congress on discrete bed-intensive rehabilitation programs along the parameters of the expired section. As described in this testimony, for other VA specialized health care programs we believe a more nuanced report to gauge capacity taking into account the changes that have occurred in these programs would be more beneficial for oversight and monitoring purposes.

Representatives of DAV and other veterans organizations recently have discussed these concerns and needs with the bill's sponsor, and have offered our assistance in crafting a possible substitute amendment that would accomplish our goal of reinstating a capacity-reporting statute that would track capacity resources in discrete bed-intensive units along the lines of the intent of this bill, yet also would provide Congress information on VA capacities that are not bed-intensive or bed-relevant as described above.

Taking into account these concerns, DAV asks the Subcommittee to consider approving the bill in its current form, with the understanding that at a future legislative meeting of the

Committee an amendment in the nature of a substitute will be offered by the bill's sponsor, incorporating the agreed-on changes that we hope to achieve in a collaborative fashion.

Draft Bill, to authorize major medical facility projects for the Department of Veterans Affairs for fiscal year 2014

Sections 1, 2, and 3 of this bill would authorize, or amend a prior authorization of, 27 major medical facility leases, primarily outpatient clinic facilities, in fiscal year 2014, and would authorize appropriations of \$236.6 million, an amount sufficient for VA to execute these leases. These are the same leases that are included in H.R. 3521, a bill passed by the House in 2013, and that are also embedded in S. 1982, now pending before the Senate.

DAV strongly supports these sections on the basis that these new or expanded community-based clinics and other leased facilities would improve access to convenient VA primary and specialty outpatient care, and provide other positive health outcomes that support veterans, consistent with DAV Resolution No. 028. We urge the Committee to advance these provisions, and to deal as well with the ongoing stalemate between the Office of Management and Budget and the Congressional Budget Office on an acceptable method of treating the long-term costs of these facilities under the Budget Control and Impoundment Act of 1974, as amended.

Section 4 of the bill would broaden the statutory definition of VA "medical facility" in title 38, United States Code, section 8101(3), by adding the term "or as otherwise authorized by law" that conveys jurisdiction of a capital entity to the VA Secretary. This section of the bill also would amend the definition of "major medical facility project" to exclude shared federal facilities constructed, altered or acquired, so long as the cost of VA's share did not exceed \$10 million; the section would apply this same logic to federally shared major medical facility leases when VA's share did not exceed \$1 million in annual rental costs. We have no objection to this change in definition that would provide VA additional flexibility to establish VA health care facilities in the future with other federal health partners.

This section of the bill would create a new section 8111A in title 38, United States Code, to authorize the Secretary to enter into agreements with other federal agencies to plan, design and construct shared federal medical facilities for the stated purpose of improving access, quality and cost effectiveness of health care provided by VA to veterans, and by other federal agencies to their respective beneficiaries. The authorization would also empower the Secretary to transfer funds to another federal agency for these purposes, so long as such transfer did not exceed the applicable existing thresholds in title 38, United States Code, for major medical facilities or major medical facility leases (\$10 million, and \$1 million, respectively). The Secretary would also be authorized to receive funds from other federal agencies for these same purposes, for VA construction or leases of shared federal facilities.

We understand that VA has been stymied in the past in cooperating with the DOD on shared facilities projects due to lack of clear statutory authority within VA to do so. This language, if enacted, would provide VA this specific authority. Our only concern is that this policy be applied to shared VA-DOD facilities and not become the basis for shared activities with numerous other potential federal health agencies with missions unrelated to the care of

veterans and military beneficiaries. With that understanding DAV offers no objection to this language.

Section 5 of the bill would amend VA's existing authority for enhanced-use leases by liberalizing the purposes of such leases to two clear options: enhance the use of the property concerned; or, provide supported housing for homeless veterans. Because the enhanced-use lease authority has been moribund since Congress last amended it, now adding general language that would enhance the use of unneeded VA structures, in a complementary manner, in addition to their use for homeless veterans (the only approved use under current law) might stimulate new lease activity. VA anticipates this more flexible language will generate receipt of new funds from leaseholders of unused VA structures producing no income now. On that basis, DAV would not object to enactment of this section.

Sections 6 and 7 of the bill would modify a prior act of Congress that authorized a major medical facility construction project at the Tampa, Florida VAMC, in effect authorizing a new bed tower at that facility in the amount of \$231.5 million, in lieu of upgrades of the existing tower previously authorized by law in 2008. It is our understanding from VA that a determination has been made that constructing a new tower in lieu of renovating the existing one would be a more cost-effective use of these funds. Section 7 also would restrict the use of certain funds in carrying out the Tampa project. DAV takes no position on this section, but makes no objection to this proposed change.

In summary, we would offer no objection to the Committee's approval of this bill in its current form.

Mr. Chairman and Members of the Subcommittee, thank you for inviting DAV to testify before the Subcommittee on these legislative proposals. I stand ready to respond to any questions you wish to ask that are related to these proposals, DAV's positions on them, or other matters related to this testimony.