LEGISLATIVE HEARING ON H.R. 93; H.R. 501; H.R. 1063; H.R. 1066; H.R. 1943; H.R. 1972; H.R. 2147; H.R. 2225; H.R. 2327; AND, A DRAFT BILL TO MAKE CERTAIN IMPROVEMENTS IN VA'S HEALTH PROFESSIONALS EDUCATIONAL ASSISTANCE PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

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

ONE HUNDRED FIFTEENTH CONGRESS

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CONTENTS

Tuesday, September 26, 2017

STATEMENTS FOR THE RECORD

LEGISLATIVE HEARING ON H.R. 93; H.R. 501; H.R. 1063; H.R. 1066; H.R. 1943; H.R. 1972; H.R. 2147; H.R. 2225; H.R. 2327; AND, A DRAFT BILL TO MAKE CERTAIN IMPROVEMENTS IN VA'S HEALTH PROFESSIONALS EDUCATIONAL ASSISTANCE PROGRAM

Tuesday, September 26, 2017

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

The Subcommittee met, pursuant to notice, at 10:00 a.m., in Room 334, Cannon House Office Building, Hon. Brad Wenstrup, [Chairman of the Subcommittee] presiding.

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

Also present: Representative Coffman.

OPENING STATEMENT OF BRAD WENSTRUP, CHAIRMAN

Mr. WENSTRUP. Good morning and thank you all for joining us today.

Before we begin, I would like to ask unanimous consent for our colleague and fellow Member Representative Coffman from Colorado to sit on the dais and participate in today's proceedings.

Without objection, so ordered.

It is a pleasure to be here this morning with all of you to discuss ten pieces of pending legislation that would impact our Nation's veterans and the care provided to them by the Department of Veterans Affairs.

I am grateful to my colleagues who sponsor the bills on our agenda for their hard work and leadership and for being here this morning to testify about their proposals. I am also grateful to our witnesses from VA and from the veterans' service organization community, as well as those stakeholders and advocates who provide statements for the record, for their insightful comments, thoughtful recommendations, and ongoing efforts on behalf of veterans and their families.

The agenda for today's hearing includes bills that would help the VA health care system become a more transparent, streamlined, well-staffed, patient-centered, accountable, and innovative organi-

zation. While I look forward to examining all the legislation we are considering this morning, I am particularly interested in Representative Rutherford's draft bill to strengthen VA's recruitment and retention programs.

Previous legislation of mine to improve VA's ability to hire high-quality employees was signed into law as part of a larger VA bill in August. However, VA's staffing shortages and workforce retention issues are complex and will not be fully overcome without strong efforts to improve VA's ability to identify talented clinicians early in their medical careers, recruit them during or straight out of residency, and bring them quickly on board to begin serving veteran patients and bolstering the strength of the VA health care system. Representative Rutherford's bill would do that and I look forward to discussing it, and the many other bills before us this morning.

I now yield to Ranking Member Brownley for any opening statement that she may have.

OPENING STATEMENT OF JULIA BROWNLEY, RANKING MEMBER

Ms. BROWNLEY. Thank you, Mr. Chairman.

And thank you to all of today's witnesses for participating in our legislative hearing, and particularly to all of the Members who are here representing very, very good bills. So thank you for that.

I will say right up front that unfortunately I will be unable to remain for the entire hearing. I have a constituent testifying at the T&I Committee and I need to be there for my constituent. I sit on the T&I Committee. Mr. Takano has kindly agreed to sit in for me to finish out today's hearing.

We have a number of important bills on the agenda for today and I want to thank my colleagues for offering their legislation to improve the care and services we provide to veterans.

After reading the witnesses' prepared statements ahead of today's hearing, I would also like to extend a special thank you to each of the VSOs for supporting my legislation, H.R. 93, that will ensure women veterans have access to gender-specific services at VA facilities.

The Women Veteran Equal Access to Quality Care Act will increase access to health care for the every-growing population of women veterans enrolled in VA care by requiring the Department to offer gender-specific services at each of its medical facilities. This legislation is critical to ensure that women veterans receive the equal access to health care that they have earned.

Almost 10 percent of the total veteran population, over 2 million veterans are women, and the VA projects that this percentage will continue to rise. In the years since 9/11, more American women have served our country in uniform than ever before. Nearly 280,000 women have served in Iraq and Afghanistan and through their service have earned the full range of health care services provided by the VA. We must ensure that our Nation's women veterans have access to the full range of health care services that they need, including dedicated women's health providers and gender-specific care.

I am also eager to hear from our witnesses about the two pieces of legislation related to service dog therapy on the agenda today. Both the PAWS Act and the Veteran Dog Training Therapy Act serve as important discussion points in ensuring VA is exploring the efficacy of alternative forms of treatment, especially treatments that have seemingly obvious benefits. I have yet to meet a veteran assigned a service dog that did not appreciate the assistance and therapy offered by the dog.

We must continue to look at these complementary and alternative treatments that help veterans cope with the invisible wounds of war. I welcome the input of the VA and our VSOs, so that we can continue to work together to develop the best legislation that will achieve this purpose.

Mr. Chairman, thank you for the opportunity to discuss the legislation in front of the Committee today and I yield back.

Mr. WENSTRUP. Thank you, Ms. Brownley.

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

With us this morning is Congresswoman Debbie Dingell from Michigan; Congressman Beto O'Rourke from Texas; Congressman Derek Kilmer from Washington; Congressman Steve King from Iowa; Congressman Lloyd Smucker from Pennsylvania; Congressman Mike Coffman from Colorado; Congressman Steve Stivers from Ohio; Congressman Ron DeSantis from Florida; and Congressman John Rutherford from Florida as well.

Congresswoman Dingell, we will begin with you. You are now recognized for 5 minutes.

OPENING STATEMENT OF HONORABLE DEBBIE DINGELL

Mrs. DINGELL. Thank you, Mr. Chairman.

Chairman Wenstrup, Ranking Member Brownley, thank you for your tireless dedication—and all the Members of this Subcommittee and Full Committee, thank you for your tireless dedication to our veterans and allowing me to testify in support of my legislation, H.R. 501, the VA Transparency Enhancement Act.

This bipartisan legislation, which I introduced with my colleague Congressman Tim Walberg from Michigan, is a commonsense measure we can take to improve transparency and the quality of care for our veterans, and I urge the Committee to consider this bill as soon as possible.

The bill would simply require the director of each VA medical center to send quarterly reports to the Secretary on the number of surgical infections at each facility and the number of surgeries which were cancelled or transferred to another hospital. The Secretary would then transmit these reports to Congress and publish them on the Department's Web site to help improve transparency.

This legislation is a direct response to an unfortunate incident at a VA hospital in my district, which actually lasted over a period of almost two years. The VA and our health care system had a reoccurring problem with particulate matter appearing on trays of surgical equipment that are supposed to be sterile. In addition to

raising the risk of infections, many veterans had their surgeries cancelled or moved to a different location. Cancelling or delaying a surgery could result in adverse health for our veterans and we must know as soon as possible if this is happening at VA facilities.

This is not the only instance of cancelled surgeries at a VA hospital. In September 2015, the Star Tribune reported that the Minneapolis Veteran Affairs Medical Center was forced to postpone and reschedule dozens of surgical procedures after an unidentified substance was found in sterilizing equipment.

As I dug into the issue, I learned that VA hospitals are not required to publicly report on surgical infections and cancellation rates as other hospitals do. The VA Transparency Enhancement Act will help Congress and the veterans themselves understand when, where, and why infections are happening or if surgeries are being cancelled, so the VA and Congress can effectively address the problem.

We should know as soon as possible if surgical infections or cancellations are increasing at any VA hospital.

Other hospitals throughout the country are required to make this data available and it is a transparent metric for all of us to ensure our veterans are receiving quality health care. Surgical infection rates are an important measurement and all patients in any hospital have the right to know. This should be critical for our veterans.

Improving transparency at the VA by requiring these quarterly reports will help ensure we are doing everything we can to give our veterans the care they deserve, and will help policymakers and the VA staff craft an appropriate response to help fix the problem.

The number-one priority for all of us is to ensure that veterans receive the highest quality health care. We do not want to see any more surgeries cancelled or delayed because of unsterile equipment, but if it does happen again we must know right away. We also need to know when people are having an increased infection rate; that is a simple measurement of quality of care.

The VA Transparency Enhancement Act is a good government bill that represents a modest step to help improve confidence in our VA health care system. By increasing transparency, we can prevent bad outcomes for our veterans and identify problems at the VA hospital sooner. Our responsibility as Members of Congress is to be a voice and an advocate for veterans across this country and serve our veterans as they have served us.

Thank you again for inviting me to testify and allowing me to testify on this critical legislation. I thank the Chairman and Ranking Member for holding this important hearing and do hope that this bill will get marked up soon and moved to the House floor for consideration.

Thank you, Mr. Chairman.

[THE PREPARED STATEMENT OF DEBBIE DINGELL APPEARS IN THE APPENDIX]

Mr. WENSTRUP. Well, thank you very much. I think those are key components to quality assurance that exist in virtually every hospital setting and it is the tool to manage adverse trends and be

able to nip those in the bud. So I appreciate you bringing that forward.

Congressman O'Rourke, you are now recognized for 5 minutes.

OPENING STATEMENT OF HONORABLE BETO O'ROURKE

Mr. O'ROURKE. Thank you, Chairman Wenstrup. I will be brief in describing H.R. 1063, the Veteran Prescription Continuity Act.

Essentially, what this does is it harmonizes the formulary between DoD and the VA, so that if a servicemember is receiving a prescription for their hypertension, pain control, sleep disorder, or a psychiatric issue to include post-traumatic stress disorder, that they can continue to receive that same medication in the VA. Today, unfortunately, that is not the case.

And if we want to make that transition from active service to civilian life as a veteran as seamless and successful as possible, then we need to make sure that those two formularies are really one. This bill would do that. It has the support of many veteran service organizations, for which I am grateful, and is cosponsored by Representative Mike Coffman of Colorado, to whom I am grateful as well.

So that's it. Thanks.

[THE PREPARED STATEMENT OF BETO O'ROURKE APPEARS IN THE APPENDIX]

Mr. WENSTRUP. I appreciate that as well, especially if their medications are working that they don't have to change.

Congressman Kilmer, you are now recognized for 5 minutes.

OPENING STATEMENT OF HONORABLE DEREK KILMER

Mr. KILMER. Thank you, Chairman and Ranking Member, and Members of the Subcommittee. I appreciate the opportunity to join you today to discuss how we can improve the operations of the Veterans Administration, so that those who have served our Nation actually get the care that they have earned.

I have the honor of representing more than 82,000 military veterans, more than almost any other Member of my party, and one of the largest concentrations in the House of Representatives. In my region, we know that those who have served and their families have made tremendous sacrifices for us, and we know they have had our backs and part of our job is to have theirs too.

And that means, if you fight for your country, you shouldn't have to fight for a job when you come home. It means, in the land of the free and the home of the brave, every brave servicemember should have a home. And it means that anywhere in this country, if you are a veteran, you should have access to the benefits that you have earned.

That last point is what brings me here today. It is a conversation we have been having for far too long. I have heard in VA halls and the grocery store and from members of my Veterans Advisory Council, why can't we fix the VA once and for all? Why does it take so long to see a practitioner? Why do folks in smaller towns have to travel so far to get served? These questions have arisen because of the inability of veterans to schedule appointments, the difficulty to build a community-based outpatient clinic in my district, and

other issues. And they are symptoms of a larger problem: systemic management challenges at the VA.

I appreciate all that this Committee and this Congress have done to deliver answers to veterans like those that I represent. I am glad that we have passed legislation seeking information, providing enhanced authorities and funding, and calling for accountability, but we also know that there is more to do.

In 2013, I partnered with then Ranking Member Brown and eventually Chairman Miller to request the Government Accountability Office to conduct a management review of the Veterans Health Administration. In our minds, this would help us get to the root of the problem. And the GAO team dove in and what started with three reports on our organizational structure, human capital, and information technology has doubled. These findings have begun to see the light of day and are accompanied by specific solutions to fix the problems that the GAO found.

One of the key findings that stood out is that, after a number of reviews from both within and outside the VA, there was a clear menu of recommendations to fix things for the better. These specific recommendations included clarifying different responsibilities between local and national facilities, evaluating if core duties were being met, and improving services, planning, and communications, but the GAO found that these recommendations were never implemented. That is not fair to veterans, it is not fair to the staff that conducted these reviews, and, frankly, it is not fair to taxpayers who paid for them.

On top of that, the Veterans Health Administration struggles to implement new policies and procedures due to a severe lack of clarity regarding the roles, missions, and accountability of senior leaders and organizations within the agency. The scale of the VA is so large that we need to go beyond position descriptions and office missions. There has to be clear, transparent, and enforced relationships between the leaders and the layers of the VA.

How can we expect leaders and staff at more local levels to seek opportunities for collaboration and efficiency if there is not a clear understanding of how they are supposed to work together to care for veterans? We need all of the oars in the water rowing in the same direction, rather than the oars out of the water, beating each other over the head.

And that is why I introduced the VA Management Alignment Act, to make sure that we follow through on the GAO recommendations. This bill simply requests that the Secretary of the VA provide a report to Congress within 180 days on the organizational structure of the VA. Specifically, the bill would require the Secretary to outline the roles, responsibilities, and accountability measures of senior leaders and branches of the VA informed by existing recommendations on the matter, and to provide Congress with a series of legislative options to assist the Secretary in realizing positive change.

Before coming to Congress, I worked as a management consultant for McKinsey & Company and then worked in economic development, and my experience in both roles led me to understand that good management requires clarity from the top. To do that, we need to better measure outcomes, we need to work collaboratively

with the administration to set an environment for success, and this bipartisan bill, which was drafted in consultation with the GAO and consistent with their recommendations, meets both of those tests.

It is also important to note that the VA Management Alignment Act is supported by the American Legion and the American Federation of Government Employees. I am grateful that the largest veterans service organization and the Federal employees union has joined me in this effort.

I know this is a legislative hearing and not a markup, and I would just request that we continue to work together to move this policy forward. I am with you in the effort to improve the VA and to turn words into deeds. And, again, I appreciate the opportunity to join you today and look forward to working with you to honor the service and sacrifices of our Nation's veterans.

Thank you.

[THE PREPARED STATEMENT OF DEREK KILMER APPEARS IN THE APPENDIX]

Mr. WENSTRUP. Thank you very much. I appreciate your deep dive into some of the issues with GAO and seeking solutions. Thanks again.

Mr. KILMER. Thank you.

Mr. WENSTRUP. Congressman King, you are now recognized for 5 minutes.

OPENING STATEMENT OF HONORABLE STEVE KING

Mr. KING. Thank you, Mr. Chairman, and good morning, and Ranking Member and Members of the Committee.

I am Steve King from Iowa and I represent the 4th District, and I am honored to testify before you today in support of my bill, H.R. 1943. The designated title is Restoring Maximum Mobility to Our Nation's Veterans Act of 2017.

This critical legislation aims to ensure that our Nation's veterans with service-connected disabilities are not simply afforded a wheelchair, but are instead equipped with the very best wheelchair, one that affords maximum achievability of mobility and in the activities of daily life.

The ability to pursue life to the fullest possible degree, even in the face of disability, is critical to ensuring that our Nation's veterans are as healthy as possible in body, in mind, emotions, and spirit. And the statistics prove the truth of that statement. An average of 20 veterans die each day due to suicide and six of them have been receiving VA service, the veterans and VHA services, I should say, in the two preceding years leading up to the tragic decision to commit suicide. In my home state of Iowa, there were 75 veteran suicides in 2014 alone. We mourn these lives and they were lost unnecessarily many of them, and we find it unthinkable that these trends should continue.

But according to current practice, when determining which wheelchair is best equipped for a particular veteran, a VA clinician will take into account medical diagnosis, prognosis, functional abilities, limitations, goals, and ambitions. Evaluation of those mobility accesses include a number of medical evaluations, but these capac-

ities in response are to effort, quality, speed and mobility, and overall function. That really gives them enough latitude, except the VA recommendations clarify in addition that, quote, "motorized and power equipment or equipment for personal mobility intended solely for recreational leisure activity should not be provided. Motorized and power equipment designed for recreational leisure activities do not typically support a rehabilitative goal."

That is their opinion and I think this Congress has an opportunity now to weigh in on how we really want to take care of our veterans. And in view of the suicide rates and a number of other observations, how can motorized and power equipment designed for recreational leisure activities not support a rehabilitative goal?

According to a study made available by the National Center for Biotechnical Information, which operates under the NIH, quote, "Leisure activities are defined as preferred and enjoyable activities participated in during one's free time, and characterized as representing freedom and providing intrinsic satisfaction. Individuals can recover from stress, restore social and physical resources through leisure activities. Leisure activities with others may provide social support and in turn mediate the stress-health relationship, enrich meaning of life, recovery from stress, and restoration of social and physical resources," close quote.

This description will sound accurate to anyone who has found this kind of rest and solace.

And I think that I will allow the rest of my prepared text into the record or ask that it be included into the record, but I want to tell a couple narratives into this on how this came together for me. And each year for a number of years, a decade or more, I have hosted the Bud Day Pheasant Hunt. Bud Day at the time of his passing about three or four years ago was the most decorated living American hero. He had 70-some Federal medals, including the Medal of Honor, which he received as a POW in North Vietnam. He was my hunting buddy and my friend.

In that hunt, we would welcome Jack Zimmerman, a double amputee who had lost his legs at the hip and the use of most of his right arm and some of the use of his left arm. He hunted in a track chair with us. He had to shoot left-handed because his left hand was the only one that could operate the trigger and his right forearm he used to hold up the gun. But as he is tracking down through the field, I noticed that he only could shoot between 12 o'clock and 3 o'clock, because he has to shoot left-handed and he can't turn. I have hunted ducks from a canoe, I know what that's like. I'm 9 o'clock to 12 o'clock from a canoe.

And so I started watching Jack. And he was limited and he couldn't rotate the chair, he couldn't rotate the seat in the chair, and you've got one second to get turned when a bird gets up. He loves to hunt and fish and outdoors. So I wanted him to have a rotating table that could turn in one second. I saw him going down the hill and that chair would push down to where he had to fight to keep from falling out of the chair. And I sit on dozers and equipment on side hills that now automatically level the seat. When you sit on the side, it will turn it this way; when you're going downhill, it turns you back to level; when you're going uphill, it sets you

level. Jack can have that and every veteran that wants to hunt should have something like that.

And so we need to remember that these wheelchairs are archaic and there is a lot of progress that will be made, let's make sure we provide that for our veterans.

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

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

Mr. WENSTRUP. Thank you. I appreciate your interest in getting the best care for our patients and the decision-making process being between the physician and the patient.

Congressman Smucker, you are now recognized for 5 minutes.

OPENING STATEMENT OF HONORABLE LLOYD SMUCKER

Mr. SMUCKER. Thank you, Chairman Wenstrup, for the invitation to participate today. I would like to thank you, Ranking Member Brownley, and Members of the Subcommittee for the opportunity to testify before the Committee on legislation entitled the VA Billing Accountability Act.

In August of this year, the Veterans Affairs Office of Inspector General reported that in the fiscal year 2015, of roughly 15.4 million bills that the Veterans Health Administration issued during 2015, approximate 1.7 million of those were improper bills for the treatment of service-connected conditions.

To put this in perspective, the Veterans Health Administration collected a staggering 13.9 million from our Nation's veterans inappropriately. That is simply unacceptable. Our servicemen and women should not be responsible to pay when there are errors or delays by the Department of Veterans Affairs.

For more than a decade, the Department has failed to address its broken medical billing system that leaves our Nation's veterans to pick up an inaccurate or expensive bill. That is why I introduced the bipartisan VA Billing Accountability Act to relieve veterans of financial burdens caused by delays at the VA.

My congressional district is home to more than 38,000 veterans, all of them deserve the highest quality medical care and the assurance from the VA that they will not be forced to foot the bill for the mistakes made by the VA bureaucrats.

To address this ongoing issue, my bill authorizes the VA to waive veterans' copayments if a veteran received a copayment bill more than 120 days after they received care at the VA or if they have received care at a non-VA facility after 18 months.

The VA Billing Accountability Act also holds the VA accountable by giving the Secretary of the VA the authority to get rid of the requirement that veterans make a copayment if the VA does not abide by the billing timing mandates.

To ensure accountability, my bill requires the Secretary of Veterans Affairs to review the agency's copayment billing controls and notification systems to see if there are better solutions that can monitor and prevent erroneous bills within 180 days after enactment of this legislation. It is imperative that the Department of

Veterans Affairs prioritizes improving its internal billing procedures.

Our Nation's veterans and their families have sacrificed so much in defense of our Nation, we should be making it easier, not harder, for them to transition to post-military life. That starts with making sure that the VA not only delivers quality health care, but also timely bills that our veterans can count on.

Thank you again for the opportunity to testify before the Committee today and for all the work that the Members of this Committee do to ensure quality and affordable care for our Nation's veterans.

I yield back.

[THE PREPARED STATEMENT OF LLOYD SMUCKER APPEARS IN THE APPENDIX]

Mr. WENSTRUP. Well, thank you very much. There is no doubt that the billing process in the VA is in need of some help as we move forward.

Congressman Stivers, you are now recognized for 5 minutes.

OPENING STATEMENT OF HONORABLE STEVE STIVERS

Mr. STIVERS. Thank you, Chairman Wenstrup and Ranking Member Brownley for holding this very important hearing and giving me the opportunity to testify on the Veteran Dog Training Therapy Act.

I want to thank my cosponsor, Tim Walz from Minnesota, for his support on this important bill. It is a bipartisan bill that can help us with the devastating mental health crisis facing many of our veterans.

You know, when veterans return home, many of them are struggling with visible, physical wounds; however, it is the invisible wounds that our veterans suffer that are sometimes overlooked. This includes post-traumatic stress, depression, and other mental health-related issues.

Today, I want to discuss a few of the ways that this bipartisan bill can help our Nation's veterans in a unique way and build on the already-proven benefits of therapy dogs. First and foremost, therapy dogs work. Anybody who has ever had a pet understands the calming presence that they can be. We have a bunch of therapy dogs in the room today and, you know, it just kind of warms your heart just to look around and see what they are doing for our veterans.

We have so many veterans who are struggling with service-connected mental health issues and having the presence of the service dog can make all the difference in the world for them, and there is scientific evidence to back it up. A Kaiser Permanente study showed that veterans who have service dogs have fewer symptoms of post-traumatic stress, depression, anxiety, have better interpersonal relationships, and lowered risk of substance abuse and overall better mental health.

Dog training therapy can clearly make a difference and we are losing too many veterans every day to suicide, I believe this is something that can really make a difference. The pilot program that this bill establishes would have the Department of Veterans

Affairs Secretary contract with local therapeutic dog training organizations to help veterans who are seeking treatment learn the art and science of dog training. So they get to bond with the dog, they get to actually train with the dog, there is real therapeutic benefit there. Upon completion, the dog would be provided to a disabled veteran. And, you know, obviously, hopefully it would be those veterans who trained them, but we want to work with the Committee to make sure that that is something that we can have happen.

The Compassionate Innovation Office at the Veterans Health Administration would be responsible for managing the program, ensuring only the best organizations who are certified and specialize in service dog training receive contracts. The bill establishes a Director of Therapeutic Service Dog Training, who would have a background in social services, experience in teaching and experience with service dogs, and at least one year of experience working with veterans dealing with post-traumatic stress.

The unique part of this legislation will help veterans work with other veterans who are struggling. We know the value of veteran-on-veteran engagement in assisting our servicemen and women. This legislation adds preference to the pilot dogs for contracting with the veterans who have graduated from post-traumatic stress treatment programs and service dog training certification to conduct the training.

This is just another way that we can help engage other veterans and help work on post-traumatic stress, make connections between veterans.

We are working and want to continue to work with the staff to put a pay-for in the bill. The pay-for that we had last year got taken away and used in another bill that the Committee did, which we appreciate and it was a good pay-for. We want to make sure that we work with the Committee with this year's pay-for and make it appropriate. Right now the bill does not have a pay-for in it, but we want to work with you to find a pay-for that you think is appropriate and the right thing to do.

The Veteran Dog Training Therapy Act is bipartisan, it establishes a pilot program to measure real outcomes of connecting veterans to therapeutic training and interaction with service dogs, and gives veterans the opportunity to help other veterans. I hope that you can support this bill. It is supported by numerous organizations: The Paralyzed Veterans of America, Iraq and Afghanistan Veterans of America, the VFW.

More ever, this legislation was passed last year out of this Committee, included in a bigger bill, and unfortunately the Senate didn't get this portion of the bill done. So we are looking forward to working with you to bringing the benefit of therapy dogs to our veterans and to help our mental health issues.

Thank you for allowing me to testify and I hope you will all consider this legislation.

I yield back the balance of my time.

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

Mr. WENSTRUP. Well, thank you. Thank you, General Stivers, for your firsthand insights on the issues that our troops face.

Congressman DeSantis, you are now recognized for 5 minutes.

OPENIG STATEMENT OF HONORABLE RON DESANTIS

Mr. DESANTIS. Well, thank you, Chairman. Thank you, Ranking Member Brownley.

I will submit my statement for the record, the prepared remarks. You know, I would just say that we have I think a wide acknowledgment that the suicide rate among veterans is appallingly high. There are obviously a number of factors that go into that. I think there is a broad agreement that post-traumatic stress for veterans and all of our veterans, but particularly some of the post-9/11 veterans who have done multiple deployments in very difficult circumstances, you know, that that is a problem that we need to address and that the VA's prescription for that typically is counseling and prescribing drugs, which can be helpful, but doesn't really answer the call for all the veterans. So you have a lot of veterans who go through the VA suffering from really significant post-traumatic stress; they do some counseling, they do drugs, and then they are still symptomatic and sometimes they're even worse off.

And so how can you deal with that problem? And what you have seen throughout our country is a number of organizations that have taken it up upon themselves to harness the use of service dogs. And these are not just dogs that are just pulled off the street and given new veterans. I mean, they go through training programs so that the dogs understand the symptoms of PTS when the veterans are in circumstances where this is triggered, whether it is in public or whether it is having nightmares. The service dog understands that and can respond accordingly. And so what that ends up doing is that allows these veterans to get back into society and function.

So we have a number of people who have endorsed, you know, our bill who have some great stories to tell. I mean, what our bill would basically do is have the VA recognize this as a possibility, write grants to some of the organizations that are accredited and that have been proven to do a good job. And if you look at the cost of, you know, the service dog, the training, the veterinary care, even traveling the veteran to go and pick up the dog, if you end having a veteran where that works well and they stop using some of the prescription drugs, that is actually going to save a lot of money. I mean, we are doing it to save lives, but it really will, it is a bargain in many respects.

And so we have got almost 200 cosponsors on this. It is definitely a bipartisan bill, been endorsed by the major veterans organizations. But I have just had a number of veterans come up to me who, you know, had gone through the VA treatment and were not doing well. And I have had a number tell me, look, I was lucky enough to get a service dog through this organization or through a family friend, or however they got referred, and if I didn't have that, you know, I don't think I would be here today, because they were suicidal.

I have in the crowd here one of the guy who has really pushed for this named Cole Lyle, who is a Marine, former Marine, and he, you know, can tell you about he was in the dumps, he had a service

dog and, you know, went to school. He is now up here, he has worked on the Hill, he is doing all kinds of things.

So the results are there for us to see. There is more medical research now coming out that is showing that this is a positive effect, declining use of drugs, and a lot of the good indicators. So I appreciate the Committee's interest in this issue.

I think that this bill, the pilot program, it is only five years, it is not a lot of money overall, but I think you will see real results. And I think the VA then—and I give Secretary Shulkin credit, he said, look, we can't wait, if this can work, we've got to do it. So I think what will happen is that will really open up even more possibilities so that we can get that suicide rate down, so that we can get veterans who are suffering from post-traumatic stress back on their feet and back to being productive members of society because, when they are, they do an awful lot of good in society too even after their military service.

So I appreciate you giving me the time to say a few words about this bill and I yield back the balance of my time.

[THE PREPARED STATEMENT OF RON DESANTIS APPEARS IN THE APPENDIX]

Mr. WENSTRUP. Well, thank you, and I appreciate that you as a veteran are continuing to advocate on behalf of our veterans.

Mr. Coffman, you are now recognized for 5 minutes.

OPENING STATEMENT OF HONORABLE MIKE COFFMAN

Mr. COFFMAN. Thank you, Mr. Chairman.

My bill, H.R. 2147, the Veterans Treatment Court Improvement Act, builds upon an existing and successful program that connects veterans who go into the criminal justice system with a VA representative in these Veterans Treatment Courts, and they are Veterans Justice Outreach Specialists. This is to keep veterans who may have substance abuse issues, may have mental health issues oftentimes related to their military service, to keep them out of jail. And so I was very suspicious of whether or not these programs actually work and so I went to one of the Veterans Courts, Treatment Courts to actually witness it. And what was amazing to me was that what it did was it touched on something in their lives where they were successful, something in their lives where they held something in common, and that was they all were successful at one point in time in the military. They got through basic combat training in the Army, they got through boot camp in the Army, basic in the Air Force and the Navy. And the judge in the court that I went to in Adams County, Colorado, the prosecutor was a Marine Corps combat veteran from Vietnam, and I think that to see the pride in these veterans come out in the court.

And it is amazing, in the 18th Judicial District in the State of Colorado, they have a 74-percent success rate, which is much higher; the rate of recidivism normally is the vast majority re-offend.

So you have a representative from the VA who is there to make appointments, make mental health appointments, substance abuse appointments right on the spot for these veterans who are periodically required to show up for these court proceedings. And so in effect what this bill asks is an additional 50 VIO Specialists.

And so I just want to say how impressed I am with this program, how it keeps our veterans out of the criminal justice system in terms of being incarcerated, gets them back into being contributing members of society, and I just think this is a very important program and would urge the passage of the bill.

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

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

Mr. WENSTRUP. Thank you. I know that in my home county the Veterans Treatment Court has been very successful and includes mentoring from a veteran of similar background, and we have seen very good results with that and I appreciate that.

Mr. COFFMAN. Mr. Chairman, if I could for one second?

Mr. WENSTRUP. Yes.

Mr. COFFMAN. That is another point is that there are mentors that are associated with the program and I did fail to mention that. I think they are not generally with the VA, they are volunteers that do that. There is again one VA employee associated with the court that we discussed here. And, you know, to be able to where they don't have to navigate the bureaucracy of the VA, to have somebody right there that will set up that mental health appointment, that will set up that substance abuse appointment for that veteran is so important.

This is such a tremendous savings to the taxpayers of the United States by keeping these veterans from being incarcerated and keeping them on as taxpayers.

I yield back, Mr. Chairman.

Mr. WENSTRUP. Thank you.

Mr. Rutherford, you are now recognized for 5 minutes.

OPENING STATEMENT OF HON. JOHN RUTHERFORD

Mr. RUTHERFORD. Chairman Wenstrup, Ranking Member Takano, and fellow Members of the Subcommittee, I want to thank you for this opportunity to speak on behalf of this draft legislation that would improve the Health Professional Education Assistance Program at the VA.

This Subcommittee has frequently heard testimony regarding the high number of physician vacancies at the VA and the negative impact that this has on the care of our Nation's veterans. And currently the VA has several programs to address recruitment in their profession ranks, including the Education Debt Repayment Program and the Health Professions Scholarship Program. And while these programs have improved recruitment, physician remains at the top of VA's critical mission shortage with the current estimate of physician vacancies to be 3500.

One way to ensure that the VA is long-termed staffed with qualified providers is to recruit those who are currently in medical school or in residency and assist in their educational expenses in exchange for their service within the VA system.

As we as a Congress work with our partners in the Administration and in our communities to improve care and decrease wait times, I believe it is critical that the VA has

the tools to recruit and retain providers in areas that are desperately needed throughout the system.

This draft legislation really makes three primary improvements to the program.

First, it requires the VA to provide a minimum total of 50 2-to-4-year scholarships annually for students studying to become physicians or dentists any time the shortage of these professions is 500 or greater. These students will then be obligated to provide clinical service at a VA facility for 18 months for each year of scholarship support.

Second, the legislation requires the VA to create a pilot program to fund two scholarships at each of the five Teague-Cranston Act medical schools for veterans who qualify for admission to those medical schools. The schools that participate in this program will each receive two seats in each class for the veteran recipients of those scholarships. The veterans are obligated to provide clinical service at a VA facility for a minimum of 4 years in exchange for the scholarship.

Third, and finally, it standardizes and increases the VA Loan Repayment Program for newly graduated medical students or those currently in residency who will be training in specialties deemed as shortages in VHA. The loan payments will be a maximum of $40,000 per year with a maximum total of $160,000.

Following completion of residency training, the loan recipients would be obligated to provide clinical service at a VA facility for 1 year for each $40,000 of loan repayment, but in no case fewer than 2 years. The current program varies among the various VISNs and is not actually adequately competitive, quite frankly.

So the VA has made many impactful changes in recent years, but it is important that we consider ways, alternative ways that the VA can attract talent on the front end to improve the system long term. A key part of this is attracting young talent and getting that to come into the system and compete. To do that, we are going to have to compete with the private sector.

In closing, I would like to thank the Chairman, the Ranking Member, my colleagues on the Committee, and the Subcommittee staff for their commitment to this and other pieces of legislation that are under consideration today that would continue to improve our VA health care system.

Thank you. I yield back.

[THE PREPARED STATEMENT OF HONORABLE RUTHERFORD APPEARS IN THE APPENDIX]

Mr. WENSTRUP. Thank you, and I appreciate that premise. It is something that has been very successful within the military as far as recruitment and gaining good medical providers, I appreciate that.

If there are no questions of our two remaining panelists, then we will move on to the second panel, and I will now welcome our second panel to the witness table.

Joining is Dr. Harold Kudler, the Acting Assistant Deputy Under Secretary for Health for Patient Care Services for the Department of Veterans Affairs, who is accompanied by Catherine Biggs-Silver, the Executive Director for Mission, Planning, and Analysis for

Human Resources and Administration; Keronica Richardson, the Assistant Director of Women and Minority Veterans Outreach for the National Security Division of The American Legion; and Amy Webb, the National Legislative Policy Advisor for AMVETS.

Thank you all for being here and for your advocacy on behalf of our veterans, today and each and every day.

As soon as you get settled, we will begin with Mrs. Richardson, and you are now recognized for 5 minutes.

STATEMENT OF KERONICA RICHARDSON

Ms. RICHARDSON. Good morning, Chairman Wenstrup, Ranking Member Brownley, and distinguished Members of the Subcommittee on Health. On behalf of the National Commander Denise H. Rohan and The American Legion family, we thank you for the opportunity to testify on behalf of The American Legion.

The American Legion is the country's largest patriotic wartime service organization to veterans, with over 2 million members and serving every man and woman who have worn the uniform for this country, we welcome the opportunity to speak on behalf of our constituents.

I am Keronica Richardson, the Assistant Director of the Women and Minority Veterans Outreach, and it is my duty and honor to present The American Legion's position and we appreciate this opportunity to testify and expand on these important issues.

Since the American Revolution, women have volunteered to serve in the U.S. military. In fact, according to the Department of Veterans Affairs, the female veteran population accounts for 10 percent of U.S. veterans and that number is expected to grow to 15 percent by 2030.

Women veterans are significantly different than their male counterparts; as such, the care that women veterans receive at medical centers and community out-patient clinics should be gender-specified. Although the VA has made some progress in providing gender-specific services, more work needs to be done. H.R. 93, Medical Services for Women Veterans, would amend Title 38 to provide increased access to care for women veterans at the Department of Veterans Affairs.

To understand the need for this bill, some of the important issues that female veterans encounter are obstacles in receiving gender-specific health care in rural areas; the lack of female providers for military sexual trauma, treatment, and therapies; a full-time gynecologist on staff, the lack of a full-time gynecologist on staff; and female veterans are more likely than their male counterparts to be referred to an outside VA system for specialty care.

If enacted, H.R. 93 will require the VA to meet the health care needs of women veterans across the VA health care system. When the VA is unable to meet their needs, the Secretary may enter into contracts with third-party organizations to provide the necessary services. The American Legion supports this bill and stands ready to assist in however we can help expand the health care needs of women veterans.

Shifting focus to H.R. 2327, the PAWS Act of 2017, we feel that it is important to make service dogs accessible to veterans wanting an alternative post-traumatic stress disorder treatment. Currently,

the Department of Veterans Affairs does not fund service dogs or recognize the use of service therapy dogs as a possible method for veterans suffering from PTSD.

There have been multiple studies proving that service dogs can provide many different forms of mental healing to veterans suffering from the invisible wounds of war. Service dogs can act as an effective complementary therapy treatment, especially for those veterans who suffer on a daily basis from the physical and psychological wounds of war.

PTSD has become an epidemic and the VA has estimated that between 11 and 20 percent of veterans who served in Afghanistan or Iraq have PTSD. While the VA continues to stall on their dog-based therapy studies, veterans are being denied alternative forms of treatment.

The American Legion supports H.R. 2327 because it allows for an alternative treatment to injured veterans suffering from traumatic brain injury or post-traumatic stress disorder.

Lastly, I would like to shift my focus to H.R. 1063, the Veteran Prescription Continuity Act. This legislation will require the VA to continue serving medications, supplying medications prescribed to DoD health care providers while the DoD health care provider determines that such pharmaceutical agent is critical for transition out of the military. The American Legion feels that this legislation serves in the best interest of transitioning servicemembers and veterans by allowing them the comfort in knowing that their medical treatment will continue even after their military discharge. The American Legion supports H.R. 1063.

Again, I would like to thank you for this opportunity to testify and I welcome your questions.

[THE PREPARED STATEMENT OF MS. KERONICA RICHARDSON APPEARS IN THE APPENDIX]

Mr. WENSTRUP. Thank you.

Ms. Webb, you are now recognized for 5 minutes.

STATEMENT OF AMY WEBB

Ms. WEBB. Good morning, Chairman Wenstrup, Ranking Member Brownley, and Members of the Subcommittee. AMVETS is truly pleased to be invited to testify today.

While AMVETS is on the record in support of all of the bills and the discussion draft under consideration, I would like to start by talking about the concerns or the cautionary way in which we offer support for H.R. 2327, the PAWS Act.

AMVETS has long advocated for the pairing of well-trained service dogs with veterans to assist the veteran with a myriad of physical and emotional health issues. On its face, we wholeheartedly support the PAWS Act, but, as mentioned in our written statement, there are several stipulations to this support.

First, it is vital that organizations that train the service dogs are well vetted, and it seems that great care has been taken in writing the bill to ensure this. We appreciate the quality measures put in place, such as requiring that any eligible organization is Assistance Dog International or ADI accredited, and that it meets the Associa-

tion of Service Dog Providers for Military Veterans Service Dog Agency standards.

Per the ADI Web site, there are currently 65 accredited programs in the country and of those just nine mention PTSD or veterans. And in extrapolating the funding request for the bill, it looks like the intention is to place about 80 dogs with veterans per year for five years. Our hope is that the limited number of accredited programs can meet the demand for this wonderful pilot.

Second, it is also vital that veterans chosen to participate in the pilot are very closely monitored, especially in the first year of the pairing, which should be implemented into the contact plan outlined in the bill. There should also be some type of recourse for the veteran if they are not getting a response to their questions or requests for follow-up training, and recourse for the organization if the veteran does not respond or keep their part of the contact agreement.

Veterans chosen for this pilot remain diagnosed with PTSD after completing evidence-based treatment with no improvement. It is well known that PTSD can manifest in sleep issues, losing interest in activities that you used to enjoy, along with depression. This can be as simple as losing interest in taking a shower, going to the store to buy food, or going out with family and friends. Having a service dog requires consistency and work on the handler's part.

Our reasoning for suggesting very close follow-up stems from the alarming issues that occurred in the first part of VA's study on PTSD service dogs and the fact that AMVETS has paired with an ADI accredited service dog organization for nearly 30 years and they will not train PTSD service dogs.

AMVETS and this particular organization does believe that dogs can be trained to perform concrete tasks to help a person with PTSD in a heightened state of anxiety or in the midst of a nightmare, but they do not employ a full-time psychiatrist and therefore they do not feel they have the insight needed to properly pair dogs or provide the follow-up. AMVETS wants to ensure that all measures are proactively put in place to set this pilot up to have as much of a positive impact that we know that it can and we look forward to passage of this bill.

On a separate note, as an organization we have to mention H.R. 2147, the Veterans Treatment Court Act. This bill goes straight to the heart of our organization.

In 2008, our then National Commander J.P. Brown worked in Buffalo, New York with Judge Russell on the country's first Veterans Treatment Court. To this day, Commander Brown stays highly involved with the Veterans Treatment Court he helped found in his home state of Ohio. These courts reach out and hold the proverbial hand of justice-involved veterans and guide them down a better path. The results and percentages of veterans that complete the 2-year program is quite incredible and we wholeheartedly support this bill.

Lastly, AMVETS would like to comment on H.R. 501, the VA Transparency Enhancement Act. This straightforward, bipartisan bill requires VA to publicly report on post-surgical infections and cancelled or transferred surgeries. The origin of this bill, as we heard earlier, stems from an ongoing issue at the Ann Arbor VA,

and the intent is simply to provide veterans knowledge and safe health care. The reporting requirement would also alert Congress if something more needs to be done.

AMVETS members strongly support VA accountability and we believe that transparency is part of being accountable. AMVETS supports this bill and urges its passage.

Thank you again for the opportunity to speak on behalf of AMVETS and I welcome any questions.

[THE PREPARED STATEMENT OF AMY WEBB APPEARS IN THE APPENDIX]

Mr. WENSTRUP. Thank you.

Dr. Kudler, you are now recognized for 5 minutes.

STATEMENT OF HAROLD KUDLER, M.D.

Dr. KUDLER. Thank you and good morning, Chairman Wenstrup, Ranking Member Brownley, and Members of the Subcommittee. Thank you for inviting us to present our views on several bills that would affect the Department of Veterans Affairs programs and services.

Joining me today is Catherine Biggs-Silvers, Executive Director of Management, Planning, and Analysis for VA's Human Resources and Administration.

VA and Congress are closely aligned in what we want to accomplish for veterans, their families and the Nation. In the few instances where we're not in concurrences, it's generally a matter of details. We see these bills as opportunities to collaborate with you to work these details out.

We share Congress' concern about services for women veterans, but because the language of H.R. 93 doesn't specify what is meant by gender-specific, it may require more than you intend.

The percentage of women veterans increases yearly across VA and we have primary care services for all women in all our medical centers, as well as women veterans comprehensive care centers in more than half of our VA medical centers, 81 of these in total. But we want to work with Congress to best meet this growing need.

H.R. 501 would impose new reporting requirements regarding surgical infections and cancelled or transferred surgeries. Currently, each facility collects data on surgical infections, but this information is not rolled up nationally. The VA Surgical Quality Improvement Program, VASQIP, examines a statistically significant sample, approximately 30 percent of all complex surgeries completed across VA, to study surgical infections. Nationally, 1.5 percent of VASQIP-assessed surgeries are associated with infection.

There are no good comparators in the community because no other system of our size and scale keeps such records, nor does the Joint Commission require them to do so.

We do not support this bill because the VASQIP system already addresses surgical infections and examining all surgeries would siphon resources away from clinical care without any appreciable improvement in quality. Furthermore, we are concerned that the summaries called for could expose veterans' protected personal information.

We would therefore like to discuss this bill further with you to see if our current systems could satisfy your objectives.

VA does not support H.R. 1063 because of unintended risks and requirements. While continuity between DoD and VA care is critically important, we are concerned that this bill as currently written would tie clinician's hands and create the potential for serious harm.

VA looks forward to working with Congress to ensure that before any change in medication is made patients get an individualized assessment, and have an opportunity to discuss their needs and their concerns with VA clinical staff.

The VA supports H.R. 1066, which requires a report on VA's organizational structure. We are already working to ensure that we in VA are held accountable.

Regarding H.R. 1943, VA already provides whatever a veteran needs for biking, driving, or other mobility issues, including adaptive equipment. Access to this level of support is not currently limited to service-connected injuries, as this bill would require. But it depends only on medical necessity and on the veteran's individual rehabilitation plan.

We agree with Congress that veterans have a right to know whether they are going to be charged a copay in a timely manner. Unfortunately, H.R. 1972 does not take into account the multiple steps and stakeholders required to generate an accurate bill. We place priority on giving the veteran an accurate statement as quickly as possible and look forward to working with Congress to align our timeframes in accomplishing this.

Congress' support for VA's Veterans Justice Outreach Program has had a major impact on homelessness and mental health problems among veterans. H.R. 2147 would require VJO Specialist hiring without providing the additional funds needed. But VA is already working to hire and train more than 50 new VJO Specialists using funds prioritized for exactly this purpose rather than to require new offsets, which would harm other programs.

H.R. 2225 proposes a five-year pilot for veteran training of service dogs. However, both DoD and VA are already piloting similar programs. We do not believe that creating yet another program would add significant value.

VA is already helping veterans obtain service dogs when that best supports their recovery. However, H.R. 2327 specifies a funding strategy which would predictably undermine statutorily required VA functions.

Mr. Chairman, this concludes my prepared statement.

We look forward to working with the Subcommittee to achieve our shared goals. My colleague and I would be pleased to answer any questions which you or other Members of the Subcommittee may have.

Thank you.

[THE PREPARED STATEMENT OF DR. HAROLD KUDLER APPEARS IN THE APPENDIX]

Mr. WENSTRUP. Thank you.

I am going to yield myself some time for questions before we go to the others.

Dr. Kudler, I would say that I think the more data you have on infection and infection control is important. You know, our troops when they come from all parts of the country, they come together and they go to common places, but then when they come back as veterans they are all over the country. And if you want to follow trends and where that infection maybe came from, you have to look at it nationally, because now our troops are all across the country.

So I think we can take a look at that. I understand some of your concerns, but I think that is important data to collect and try and find the origin and cause of certain infections, if indeed it came from their military service especially and where the common origin is. They don't all come back to the same VA hospital when they leave. So I think that is important.

But I do have a question for you on women's health especially. But, you know, a VA medical facility may not have a large enough female population to be able to recruit and retain a woman's health provider or OB/GYN because of the low volume, so how do you plan to engage in that and be able to provide that opportunity for our women?

Dr. KUDLER. Well, we have been training 500 clinicians a year in women's health in order to try to meet that need. We have been, as you say, looking to work with communities and under Choice we can do a great deal more of that. And under Choice as we imagine in the future even more, not just to meet the needs that we identify, but to meet the convenience and the desires of women veterans in their own communities.

We need to scale this. We are growing at about 6 percent per year in women veterans, and women veterans do have different needs and different ways they would like to use services. One thing that is really interesting about women veterans and VA is when they do use VA, they tend to use more of our services than the men do, and I think that reflects back to women are smarter and speak up for their own health better than men do.

The bottom line is, we need to work together with you to figure out how to scale this and also how to pay for it.

Mr. WENSTRUP. Thank you.

And in the same vein, Ms. Richardson and Ms. Webb, what are your feelings today at the current state of VA services for women?

Ms. RICHARDSON. Keronica from The American Legion. At this current moment, I feel that the VA has made improvements. There are some gender-specific services available; however, there is still a lot of work that needs to be done. As I mentioned, there are still not any on-site gynecologists, there are still issues in rural areas about not being able to have the gender-specific services available. Even on a smaller scale not having sanitary items in the restrooms or not having the privacy curtains at the VA utilized when female veterans are present.

So I think there is still room for growth.

Mr. WENSTRUP. Thank you.

Ms. Webb?

Ms. WEBB. Yes, I agree that over the years a lot of progress has been made in each facility, the development of the Women Veteran Program managers at every facility, but there is a lot of work to be done. You know, each woman needs to be able to go in and feel

not only welcome, recognized, but have someone that knows her specific health care needs. It is a priority.

Mr. WENSTRUP. Thank you.

Mr. Takano, you are now recognized for 5 minutes.

Mr. TAKANO. Thank you, Mr. Chairman.

I have long said that we need to improve the human resources function of the VA and the co-chairs of the Commission on Care testified before this Committee that they agreed that we needed to improve the human resource function.

I support Representative Kilmer's work to improve accountability at the VA with H.R. 1066, the VA Management Alignment Act of 2017. The VA has said that they are working to improve accountability, but I think Mr. Kilmer's legislation helps expedite the process.

Now, can any of the VSOs who are present today expound on how you see Representative Kilmer's legislation helping to improve accountability at the VA?

Ms. WEBB. Well, I believe that it is, you know, very important to have each department take a really good look at what they are doing and streamline functions and make sure that every role, you know, is working at its full capacity. And that if there are cost-saving measures and downsizing, or if they need to bring in more staff on the other side of it, it is just always a good business practice to do such things and it does speak to them being accountable for what each department is doing and you can't be accountable if you don't know what's going on.

Mr. TAKANO. Great.

The American Legion, anything to add?

Ms. RICHARDSON. I don't have anything to add to that. I think she covered exactly how The American Legion feels on that stance as well. We just feel like being accountable would allow them to have the service provider or the veteran more informed and make more informed decisions about whichever VA that they decide to choose from.

Mr. TAKANO. Wonderful.

Ms. RICHARDSON. Other than that, we don't have any more stance.

Mr. TAKANO. Well, moving on to a different topic, having reviewed the written testimony from the VSOs, I noted there was broad support for the Veterans Treatment Court Improvement Act of 2017, and based on what you have heard from your members, why is this legislation so important?

Ms. WEBB. Well, a lot of people have post-deployment readjustment issues and the whole point is that, you know, sometimes they misbehave or sometimes there are undiagnosed mental health issues, or perhaps they have gotten into drugs, and instead of just throwing someone away into the jail system or into the criminal justice system, you know, these courts, the mentorship is a really big part of it, working with them. They have to make a commitment to get through this program so their charges can be dropped, and we hear time and time again, that the ones that get through these programs, they lead better, fuller lives, they don't know what they would have done without that mentorship, and then many of them proceed to give back.

Ms. RICHARDSON. The American Legion's stance on that is when you look at an overview of the Veterans Treatment Court, it is a hybrid of veterans with drugs and mental illnesses that relates back to PTSD.

So we definitely fully support the Veterans Treatment Court because we feel it would give the veteran another opportunity to readjust to society, so we support that bill.

Mr. TAKANO. Great. Thank you.

Dr. Kudler, accountability remains a key focus of this Committee and as I just asked the VSOs about and their testimony about 1066, you in your written testimony noted that the VA is not waiting for legislation to improve the Department's organizational structure and internal management, and the VA has already taken aggressive steps to address these areas. Can you provide some insight into these efforts?

Dr. KUDLER. Yes. VA has taken on a modernization program that exceeds the rest of the Federal agencies. We have been working on it before it was ordered down from the White House to be done by all agencies. And I think the real principle is increasing accountability and transparency, and moving the fulcrum of control from Washington closer to the point of service. So that local facilities will have more responsibility, but also more flexibility in how do you provide service in Beckley, West Virginia versus New York City in Manhattan or the Bronx.

It makes sense to answer veterans' needs in community terms. But we also want the networks, which are large enough to have more buying power and more centralized control and more data to pull together, but also small enough to know regional issues to then be able to roll that up and coordinate with them. And we in central office will be there to offer support, but not try to use a 3,000-mile screwdriver to adjust everything that happens everywhere around the country. And this I think is a key principle of where we are trying to go.

Mr. TAKANO. Thank you very much, Dr. Kudler.

And thank you, Mr. Chairman, my time is up.

Mr. WENSTRUP. Mrs. Radewagen, you are now recognized for 5 minutes.

Mrs. RADEWAGEN. Thank you, Mr. Chairman. And I want to thank the panel for appearing today, thank you for your service.

As everyone here is acutely aware, VA still has a significant shortage of health care professionals despite existing educational assistance programs. For example, in my home district of American Samoa, we are currently facing difficulties in finding physical therapists and other health care specialists for our small VA clinic.

American Samoa is a remote area with no VA hospital of our own and because of staffing problems we cannot even make use of the limited facilities we do have.

So, Dr. Kudler, what can VA do to address staffing shortfalls in remote areas like the U.S. Territories and how can we ensure that once we have an adequate supply of trained professionals they end up where they are needed most?

Dr. KUDLER. Yes, thank you.

The citizens of American Samoa serve at a higher rate than most other groups in the United States and they do have not the 3,000-

mile screwdriver, but I am going to say probably more like a 10,000-mile screwdriver of us trying to get in there and fix things directly. But there are different ways that we can work together.

For example, you mentioned physical therapy and I work with the Physical Medicine Department in Durham, North Carolina to help promote a rural physical therapy program that used a point-to-point telehealth to actually do physical therapy. You can provide equipment to help somebody increase their range of motion and measure it within a micron of movement to work with a physical therapist who isn't even on the same island where you are. So it is just one of many possibilities.

Obviously, we need to hire more people, we need to make transportation more available, we need to think about how do we project our strength and our talent, and how do we also bring people in when it meets their needs and it is their wish to be brought in. I know not everybody wants to get on a plane and fly to a remote location either for their care. So we have a long way to go, but fortunately new tools are being developed and we have to keep using innovation to apply them properly.

Mrs. RADEWAGEN. Thank you.

Mr. Chairman, I yield back the balance of my time.

Mr. WENSTRUP. Dr. Dunn, you are now recognized for 5 minutes.

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

Let me start out by saying to Ms. Webb, I am a life member of AMVETS and I invite you to come see your chapter in Panama City. Maybe when it is cold and nasty up here you will find the time to do that.

Dr. Kudler, I want to turn my attention to the Health Professionals Educational Assistance Program. I know you are working on providing a formal view on the cost estimates of this bill, when do you think that will be available?

Dr. KUDLER. Well, we did get that bill a little bit later and too late to prepare, but let me say as quickly as possible and we are looking forward to responding, because—

Mr. DUNN. I am just looking for a timeframe.

Dr. KUDLER. I would have to get that for you, sir; I don't have it.

Mr. DUNN. Okay. We are anxious to have your thoughts on it, because we think it may help.

Do you agree on the estimate of the shortage in the VA of medical professionals that Congressman Rutherford mentioned, 3500?

Dr. KUDLER. There is a national medical shortage—

Mr. DUNN. There is.

Dr. KUDLER [continued]. —and we are not gearing up to meet it. And the VA as the largest employer of physicians, and especially of psychiatrists and psychologists in America, is really in need of any help we can get.

Mr. DUNN. I am just trying to quantify it. Is it about 3,500 in the VA nationwide?

Dr. KUDLER. Oh, I would have to get that for you, sir.

Mr. DUNN. Okay. So we need a lot of data, it sounds like. We can't fix a problem without data.

What is the attrition rate for medical professionals in the VA annually?

Dr. KUDLER. Once again, I would have to get that for you.

Mr. DUNN. Okay. So you get a sense of the data things we are looking for. Do you know how many people, how many medical professionals you hire in a year?

Dr. KUDLER. I know that we are—

Mr. DUNN. Just roughly.

Dr. KUDLER. In mental health, which is the area I work in, I think we are now up in the last year about almost 900.

Mr. DUNN. Nine hundred in a year?

Dr. KUDLER. Professionals, yes.

Mr. DUNN. Good, that is an important area.

Dr. KUDLER. Psychologists, psychiatrists, licensed professional counselors, social workers, all of whom are employed in the mental health field in VA.

Mr. DUNN. How about the—do you know how many you anticipate resigning or retiring in the next year?

Dr. KUDLER. I really hesitate. I have got some numbers kicking in my head, but I am not sure they are accurate, sir.

Mr. DUNN. How about how many of your scholarship programs have been granted to physicians in the last X amount of time, year, 2 years, whatever, anything you are familiar with?

Dr. KUDLER. I am not aware of VA having a scholarship program for physicians at this time. We do have under the Clay Hunt Act medical debt reduction for psychiatrists and we are fully engaging that, and we are spending every dollar that is in there, we are matching every person that is in there.

Mr. DUNN. Yeah, I'm sure.

Dr. KUDLER. That has been very effective.

Mr. DUNN. Let's turn our attention to H.R. 501, the Transparency Enhancement Act. Do you have a feeling for the number of surgeries performed in your system, systemwide in a year?

Dr. KUDLER. Sir, I wish I did, I do not.

Mr. DUNN. Okay. So that would be a really important number for us to have when we are talking about infection rates.

I want to echo the Chairman's comments on tracking infections that have started, you know, we picked up in some other country and brought back with all the other problems we bring back from those countries. So we need to have—I will say I have built and operated at least a half a dozen surgery centers in my career and worked at a number of hospitals too, we had 100-percent surveillance on infection rates in all of our hospitals and in our surgery centers, and I actually was surprised to hear that the VA doesn't have 100-percent tracking. Everybody else that I am aware of on the civilian side is doing this already and they are doing it with far fewer resources, honestly, per surgical case than the VA has. So, I mean, we never considered or occurred to us that we were going to be in the situation where we weren't reporting all of our surgical infections.

And I think that the fact the VA, as you said, it is burdensome to implement, it is just the cost of doing business. Everybody else in the country is doing it. So I would urge you to reconsider that and get on board with the, you know, 100-percent surveillance rate and the reporting nationally. You are a hospital system that takes people from all over the world and treats them all over the country.

So I just want to turn my attention now in my diminishing seconds here and applaud my friend and fellow Floridian Representative Rutherford for his educational enhancement bill that he has advanced. We really feel like this has worked for the military. I went through the military on a health professional scholarship and I think that this kind of program for the VA is a jolly good thing.

Thank you. I yield back my time, Mr. Chairman.

Mr. WENSTRUP. If I may add to the point that you made, Dr. Dunn, is even our outpatient facilities we assured that we followed up with the surgeon to say were there any adverse problems with the patient's care. Was there a post-operative infection? Was there any type of complication? Which is more challenging when they are not in the hospital where you can collect that data as they are sort of a captive audience, but we made sure that we captured all that information because it is imperative to the quality and to follow trends?

So I think we really need to consider that and I hope the VA would change their position on where we are going with that data that I think is very valuable and needed.

Did you want to make a comment, sir?

Dr. KUDLER. May I clarify that every hospital in the VA system does track its own data on infection, but rolling it up using the VASQIP system, we look nationally, we use a 30-percent sample of incision infections within 30 days, which is different than bio surveillance if people bring communicable diseases home, which I absolutely agree is a vital national issue.

Mr. WENSTRUP. And that is why I think we need the data nationwide and not just a sample. Thirty percent seems like a pretty small sample for the opportunity to miss something important that may exist. But we will talk more about that, I am sure.

Mr. Higgins, you are now recognized for 5 minutes.

Mr. HIGGINS. Thank you, Mr. Chairman. And I thank the panel for appearing, your service to your country, and I recognize and appreciate the presence of the many VSOs represented in the audience and the concerned citizens.

Dr. Kudler, you stated that the VA is already working to hire more than 50 additional Veterans Justice Outreach Specialists to provide Treatment Court services to justice- involved veterans or VA courts. As a police officer for 14 years, I understand the importance of addressing the root causes of misbehavior and crime, and I appreciate the VA's commitment to our veterans in this area.

How many of the 50 new VJO Specialists has the VA hired thus far, sir, are you aware?

Dr. KUDLER. I am not sure how many have been hired so far, but I can assure you we have no problem hiring and training this staff; we will hire them expeditiously.

Mr. HIGGINS. Thank you.

Additionally, you had highlighted concerns regarding funding that other bills may result in a reduction of funding for other programs. How is the VA funding the 50 new positions?

Dr. KUDLER. We prioritized this as critically important for our mission and therefore found that money in other funds. And what concerns us about the bill as currently written is it would have a similar number, but it is a zero-sum game, we would have taken

funds from still another program and it does come to a lot. We believe that other veterans would suffer.

The current new 50, 51 actually will bring us to 312 Veterans Justice Outreach Specialists in VA, which we feel right now would match the available Veterans Courts around the country. We would continue to scale as those numbers grew.

Mr. HIGGINS. Thank you, sir. That brings me to my real question.

Within my own district, I represent the 3rd District of Louisiana, we have the highest density of population of veterans in the State of Louisiana. I am humbled and honored to represent 133,000 veterans in my district. We are attempting to set up VA courts in our district, jurisdictional authorities across the district, and it is quite difficult, it is quite difficult. Where a VA court, a diversion court does not exist in this manner, it is quite challenging to establish within the judicial system, at least those that we are encountering within my own district.

Would we as representatives of the citizens that we serve in an effort to set up a VA diversion court within the judicial systems to help our veterans navigate criminal issues as they encounter them, is there a process, sir, within the VA where you can help us set this up? I would certainly, you know, humbly raise my hand and ask for that assistance.

Dr. KUDLER. We would be very glad to work with you. I have helped set up Veterans Courts and worked with law enforcement Mecklenburg County, that's Charlotte, North Carolina, I know it is a challenge. You need a judge who is ready and willing to take this up, prosecutors, defense. You need local law enforcement to sign on, because they play a critical role in this. We would be glad to work with you. And also SAMHSA, in the past at least, has provided grants for communities to develop this capacity.

So we would be glad to work with you on doing this together.

Mr. HIGGINS. Would I be able to communicate with you directly, sir, about that? I represent ten parishes of Louisiana. We don't have counties, because we are Louisiana. But that is ten jurisdictional districts and you are talking about ten seated judges and it is quite challenging. And I would like to communicate with you after this event, sir, so perhaps you can give me a hand.

Dr. KUDLER. It would be a pleasure. We have been involved in many communities of all sizes and shapes and I am sure that we could be of help. I look forward to it.

Mr. HIGGINS. And I look forward to that ongoing conversation.

Mr. Chairman, thank you. I yield the balance of my time.

Mr. WENSTRUP. Mr. Rutherford, you are now recognized for 5 minutes.

Mr. RUTHERFORD. Thank you, Mr. Chairman.

Dr. Kudler, I would like to talk a little bit about the Veterans Prescription Continuity Act. And I was glad to hear your testimony when you asserted that medical necessity, not formulary status, drives prescription decisions. Do you have an idea how many requests for off-formulary prescriptions were filed last year and what percentage were actually approved?

Dr. KUDLER. You know, as a VA clinician who many times did ask for non-formulary prescriptions, I was pretty lucky in mine. I

couldn't tell you nationally where that stands now, but when it comes to people transferring from DoD, we always give the benefit of the doubt to that this might be exactly the regimen this person needs.

When it comes to mental health, some time ago working with Congress we have established that we will continue these medications. For example, if someone came to us on Lexapro Escitalopram, which is more expensive and was non-formulary at that time, it is now generic, we were going to continue to provide that and not change to say Citalopram, one of the other medicines that can be used. But in mental health, we have not only decided we are going with what DoD did, we have been measuring the outcomes, and we found generally very good outcomes in these groups.

What we worry about and one specific thing is opiates and perhaps opiates plus a benzodiazepine. And if a patient came to me from DoD and was on a medicine for pain, and unfortunately military service often generates chronic pain, but was also getting a benzodiazepine and they said, well, Doctor, aren't you going to sign off on this script, I would say, well, within my practice that would be a very bad idea, but let's sit and talk about it. So I think what is critical and you captured it, sir, is we would figure out what is clinically appropriate, not have our hands bound and not have the veteran's hands bound. I could make somebody happy saying I am not going to touch anything, sir, but I would be endangering them and I don't think it would be ethically and certainly not medically appropriate.

Mr. RUTHERFORD. And I presume the VSOs all agree with the concept that it needs to be medical necessity, not formulary, or what is on the formulary.

But, Dr. Kudler, you also in your statement said that this act would usurp a prescriber's professional responsibility and that would carry for the patient-provider relationship and also for the overall strength of the VA health care system some implications. Can you talk a little more about that, because I—make me understand that part?

Dr. KUDLER. Well, what I mean by that, you know, I learned how to drive in New York City and I learned how to practice medicine in Brooklyn, and the rule of thumb was the same, you practice, you drive like everyone else was crazy. You are responsible, you are this person's doctor, you cannot take for granted what another doctor writes, even if you like and respect that person. And you have a professional responsibility to make your own clinical decision and stand by it. This does not mean be high-handed with the patient. Part of being a doctor is collaborating with a patient, because you don't get any compliance and they may not take any medicine you write unless you and the patient have a rapport, an understanding, a trust.

So what I was trying to get at there is simply, when I say this is my patient, I have a responsibility to make my own assessment, make my own decisions, but then collaborate with the patient to see if we can agree on this.

And by the way, if the patient says no way on earth am I doing that, I am not going to settle for simply being right, I am going to work out something we can both agree on.

Mr. RUTHERFORD. But, Doctor, I think the issue that is trying to be captured here is exactly what you were—I don't think the sponsor of this bill would disagree with what you just said. The challenge, though, is as they transferred from DoD to VA there is that time that it takes you to evaluate, to determine what the medical necessity needs are of that particular patient. Because, as you said, I'm not just going to take somebody else's word for it, I am actually going to, you know, do my job and make those decisions for myself, formulary and otherwise, but surely you must understand that that is going to take some time.

So there is a delay between coming from DoD over to VA, you know, and I don't think that that continuity of care until you as the doctor make an informed decision—look, even the doctor that was treating them in DoD may at some point change the formulary because their needs change. Can you address that?

Dr. KUDLER. You know, I think that gets at the core issue, which is the continuity of care between DoD and VA, and we have to address that as a critical area where people fall between the cracks, that might be one day or it might be five years, and we have to create a warm handoff between our agencies which would include this. We developed that for traumatic brain injury years ago where if you were coming say out of the Richmond VA for our polytrauma program, I would actually sit in Richmond and talk over a telehealth hookup with your doctors in Landstuhl and we would work this out together.

Mr. RUTHERFORD. Right.

Dr. KUDLER. We need to create that continuity and I think that is a missing element in this bill. But I have got to tell you this, we are working—and this was the Secretary's demand and he is absolutely right—same-day assessment in primary care and mental health. And I don't see a reason why if you have a mental health issue say, you shouldn't be able to walk into a VA and get a clinical assessment on that spot, on that day, and review your medicines and confront issues.

Mr. RUTHERFORD. Thank you, Mr. Chairman. I yield back.

Mr. WENSTRUP. Thank you. I appreciate that was a good conversation, and the handoff is important and how we can facilitate that. No one wants there to be a gap, no one wants there to be someone who falls through the cracks, but how do we assure that there isn't that situation.

I want to thank you all once again for being here today, and if there are no further questions, the second panel is now excused.

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

Without objection, so ordered.

I would like to again thank you all, our witnesses and the audience members for joining us here this morning.

This hearing is now adjourned.

[Whereupon, at 11:31 a.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Honorable Debbie Dingell

Chairman Wenstrup, Ranking Member Brownley, thank you for inviting me to appear before you today. The important work of this committee is invaluable to bettering the lives of all those who have served and the families at their sides. Thank you for your tireless dedication to serving our veterans.

As you know, today's hearing includes bipartisan legislation introduced by Congressman Tim Walberg (R–MI) and I that aims to add enhanced transparency requirements at VA hospitals nationwide. Our bill, H.R. 501, the VA Transparency Enhancement Act, is a commonsense measure we can take to improve overall quality of care for veterans.

The bill simply requires the Department of Veterans Affairs to report quarterly to Congress on the number of patients who contracted an infection as a result of a surgery and report the number of surgeries cancelled or transferred by the VA. It would also require the VA to publish these reports on the Department's website for all our veterans, their families, and the public to have and understand.

While the VA currently provides completed and pending appointment data from local VA medical facilities to the public monthly, the VA does not publically release data on rates of surgical infection or cancelled or transferred surgeries. Patients have a right to see surgical infection rates and other issues impacting quality of care at VA hospitals. Improving transparency at the VA will help ensure we are meeting the quality standards we owe our veterans.

The VA Transparency Enhancement Act will also help Congress understand when, where, and why infections are happening or surgeries are cancelled so we can respond to changing conditions more effectively. Should surgical infection or cancellation rates rise at any VA hospital, Congress and the public need to know about it as soon as possible. As policymakers we need to understand whether cancelled surgeries are affecting the health of a veteran. Ensuring our veterans have access to timely, quality health care is a critical responsibility of the Congress, and this is one more important step to ensure they do.

In late 2015, my office and Congressman Walberg became aware of a contamination issue at the VA Ann Arbor Healthcare System after particulate matter was observed on sterile surgical equipment. This led to surgeries for veterans being intermittently cancelled or moved to different hospitals. For many months the issue persisted putting great stress and uncertainty on our veterans who were scheduled for operations.

The staff at the Ann Arbor VA is a dedicated group of individuals. This issue came to light because they were doing their job inspecting surgical instruments and discovered the problem. To be clear, it does not appear that the contamination issue caused any infections or harm to a patient-but, for us, this remains a concern for any future cases.

Throughout this problem we remained in constant communication with Ann Arbor VA leadership. In the process, we learned that VA hospitals are not required to report on surgical infection and cancellation rates as other hospitals do.

This is not the only instance of cancelled surgeries at a VA hospital. In September 2015, the Star Tribune reported that the Minneapolis Veterans Affairs Medical Center was forced to postpone and reschedule dozens of surgical procedures after an "an unidentified substance" was found in sterilizing equipment. [1]

We do not want to see this happen again in Michigan or any state, which is why we took action and introduced this bill. We believe it is important that, like other hospitals, the VA be open and transparent and report the number of patients that

[1] Brunswick, Mark, "Minneapolis VA shuts down surgeries over unidentified substance," Star Tribune, September 23, 2015, http://www.startribune.com/minneapolis-va-hospital-shuts-down-surgeries-after-a-substance-is-found-in-sterilization-equipment/328878601/

have acquired surgical infections while receiving care at the VA, and the number of surgeries that have been canceled or moved to another hospital.

The number one priority for all of us is to ensure that veterans receive the highest quality health care. By increasing transparency we can prevent the worst scenarios for our veterans and identify problematic VA hospitals sooner. Our responsibility as Members of Congress is to be a voice and advocate for veterans all across this country, and serve our veterans as well as they have served us.

Thank you again for inviting me to testify before this committee on legislation that will improve VA transparency and patient care for all our veterans. We urge every member of the committee to support this legislation and we stand ready to work with you in any way to move this bipartisan bill out of this committee for consideration on the House floor. At this time, I look forward to answering any questions the committee may have.

Prepared Statement of Honorable Beto O'Rourke

CONCERNING

H.R. 1063, THE VETERAN PRESCRIPTION CONTINUITY ACT

Than you Chairman Wenstrup, Ranking Member Brownley, and members of the Subcommittee. I appreciate the opportunity to join you today to discuss how we can improve care for our veterans as they transition out of the military.

Our nation asks much of its service members. We ask them to uproot their families, put themselves in harm's way, and endure pain and suffering. As members of the Veterans' Affairs Committee, we have an obligation to ensure that our service members and their families receive the best care possible when they leave the service. With as many as 20 veterans committing suicide a day, we are failing to fulfill that obligation.

We may not be able to solve all of the Department of Veteran Affair's problems today, but we can take meaningful steps towards improving the care our veterans receive. One common sense measure to achieve this is my legislation before the Committee today, the Veterans Prescription Continuity Act. In the past, the pharmaceutical agent formularies used by the Department of Defense (DoD) and Veterans Health Administration (VHA) had numerous differences. This meant that a service member may not have been able to receive the same DoD prescribed medication when he or she enters the VHA system.

Section 715 of the FY2016 National Defense Authorization Act (NDAA; Public Law 114–92) included a provision that attempted to improve prescription medication continuity when service members left the DoD health care system and entered the VHA system. This section required the Secretary of Defense and Secretary of Veterans Affairs to establish a joint formulary for prescription medications, with the intended goal to ensure veterans would receive the same medication under the VHA as they were prescribed during their service.

Unfortunately, this section has shortcomings. It only accounts for certain medications. It did not cover some common, widely used drugs available to the DoD but not the VA as well as new or emergent medications for pain control, sleep disorders, and psychiatric conditions (including post-traumatic stress). Additionally, it did not require the DoD and VHA to regularly update their formularies to ensure they matched in the future.

My legislation, the Veteran Prescription Continuity Act, will fix these shortcomings. It will allow transitioning service members the ability to retain their current regimen of pharmaceutical agents under their VA health care provider, even if it is not on the VA's formulary. It will require regular updates between the DoD and VA formularies and allow the VA to prescribe medications not on their formulary between these updates.

Transitioning out of the military is a challenging task. Doing so while being forced to change medications increases the stress and burden on our service members and does not represent the best possible care we can give them. I thank my colleague, Mr. Coffman of Colorado, for his partnership with me to enact this common sense legislation. Together, we are taking steps towards improving our nation's care for its veterans.

It is also important to note that the Veterans Prescription Continuity Act is supported by fourteen veteran service organizations that are a part of the National Military and Veterans Alliance. We have worked hand in hand with these organizations to create this common sense legislation.

I appreciate the opportunity to speak before you today and look forward to continuing this committee's work in improving the care for our veterans.

Prepared Statement of Honorable Derek Kilmer

CONCERNING

H.R. 1066, THE VA MANAGEMENT ALIGNMENT ACT

Than you Chairman Wenstrup, Ranking Member Brownley, and members of the Subcommittee. I appreciate the opportunity to join you today to discuss how we can improve the operations of the Veterans Administration so those who have served our nation actually get the care they have earned.

I have the honor of representing more than 82,000 veterans, more than most any other member of my party and one of the largest concentrations in the House of Representatives. In my region we know that those who have served, and their families, have made tremendous sacrifices for us. We know they have had our backs. And we understand we should have theirs too. That means if you fight for your country you shouldn't have to fight for a job. In the land of the free and the home of the brave, every veteran should have a home. And anywhere in our country if you are a veteran, you should have access to the benefits you've earned.

That last point is what brings me here today. It's a conversation we've been having for far too long. I've heard it in VA halls, in the grocery story, and from members of my Veterans Advisory Council - why can't we fix the VA once and for all? Why does it take so long to see a practitioner, why do folks in smaller towns have to travel so far to get served? These questions have arisen because of the inability of veterans to schedule appointments, the difficulty to build a new Community Based Outpatient Clinic (CBOC) in my district, and other issues. And they are symptoms of a larger problem - systemic management challenges at the VA.

I appreciate all this committee and Congress has done to deliver answers to veterans like those I represent. I'm glad we've passed legislation seeking information, providing enhanced authorities, funding, and calling for accountability. But we all know there is more work to do.

In 2013, I partnered with then Ranking Member Brown and eventually Chairman Miller to request the Government Accountability Office (GAO) conduct a management review of the Veterans Health Administration. In our minds, this would help us get to the root of the problem.

The GAO team dove in, and what started with three reports on organizational structure, human capital, and information technology has expanded to more than six. These findings have begun to see the light of day and are accompanied by specific solutions to fix the problems GAO found.

One of the key findings that stood out is that - after a number of reviews from both within and outside the VA - there was a clear menu of recommendations to fix things for the better. These specific recommendations included clarifying different responsibilities between local and national facilities, evaluating if core duties were being met, and improving services, planning, and communications. But the GAO found these recommendations were never implemented.

That is not fair to veterans, the staff that conducted the reviews, or the taxpayers who paid for them.

Moreover, the VHA struggles to implement new policies and procedures due to a severe lack of clarity regarding the roles, missions, and accountability of senior leaders and organizations within the agency. The scale of the VA is so large that we need to go beyond position descriptions and office missions. There has to be a clear, transparent, and enforced relationship between the leaders and layers of the VA. How can we expect leaders and staff at more local levels to seek opportunities for collaboration and efficiency if there is not a clear understanding of how they are supposed to work together to care for veterans? We need all the rowers in the boat paddling in the same direction - not beating each other over the heads.

I introduced the VA Management Alignment Act to make sure we follow through on the GAO findings. This bill simply requests the Secretary of VA to provide a report to Congress within 180 days on the organizational structure of the VA. Specifically, the bill would require the Secretary to outline the roles, responsibilities, and accountability measures of senior leaders and branches of the VA informed by existing recommendations on the matter, and to provide Congress with a series of legislative options to assist the Secretary in realizing positive change.

Before coming to Congress, I worked as a management consultant to large private sector companies and for a county wide economic development agency. My experience in both roles led me to understand that good management requires clarity from the top. To do that we need to better measure outcomes. We need to work collaboratively with the administration to set an environment for success. This bipartisan bill, which was drafted in consultation with GAO, meets both of those tests.

It is also important to note that the VA Management Alignment Act is supported by the American Legion and the American Federation of Government Employees. I am grateful that the largest veterans' service organization and the federal employee union have joined me in this effort.

As this is a legislative hearing and not a markup, I request that we continue to work together to move this policy forward. I am with you in the effort to improve the VA and turn our words into deeds.

Again, I appreciate the opportunity to join you here today and look forward to working with you honor the service and sacrifices of our nation's veterans.

Prepared Statement of Honorable Steve King

Good Morning Chairman Wenstrup, Ranking Member Brownley, and Members of the Committee. I am Congressman Steve King. I represent the Fourth District of Iowa, and I am truly honored to testify before you today in support of my bill, H.R. 1943, the Restoring Maximum Mobility to Our Nation's Veterans Act of 2017. This critical legislation aims to ensure that our nation's veterans with service-connected disabilities are not simply afforded a wheelchair, but are equipped with the very best wheelchair-one that affords maximum achievable mobility and function in the activities of daily life.

The ability to pursue life to the fullest possible degree, even in the face of disability, is critical to ensuring that our nation's veterans are as healthy as possible-in body, mind, emotions and spirit. And the statistics prove the truth of that statement. Statistics demonstrate that an average of 20 veterans die by suicide each day in our nation. Six of each 20 are recent users of Veterans Health Administration (VHA) services in the two preceding years leading up to the tragic decision to commit suicide. In my home state of Iowa, there were 75 veteran suicides in 2014 alone. We mourn these precious lives that were lost unnecessarily, and find it unthinkable that these trends should continue. We must do more, and we must provide better services, care and support that our nation's veterans need and deserve.

According to current practice, when determining which wheelchair is best equipped for a particular veteran, a VA clinician will take into account medical diagnoses, prognosis, functional abilities, limitations, goals, and ambitions. Evaluation of mobility assesses musculoskeletal, neuromuscular, pulmonary, and cardiovascular capacities and response, effort, quality and speed of mobility, and overall function. However, the VHA recommendations clarify that "Motorized and power equipment or equipment for personal mobility intended solely for a recreational leisure activity should not be provided.Motorized and power equipment designed for recreational leisure activities do not typically support a rehabilitative goal."

In view of suicide rates among our nation's veterans, how can motorized and power equipment designed for recreational leisure activities not support a rehabilitative goal? According to a study made available by the National Center for Biotechnology Information, which operates under the National Institutes of Health (NIH), ".leisure activities are defined as preferred and enjoyable activities participated in during one's free time, and characterized as representing freedom and providing intrinsic satisfaction. Individuals can recover from stress; restore social and physical resources through leisure activities. Leisure activities with others may provide social support and, in turn, mediate the stress-health relationship, enrich meaning of life, recovery from stress, and restoration of social and physical resources."

This description will sound accurate to anyone who has found rest, solace and rejuvenation in a preferred recreational activity. As someone who enjoys the outdoors, hunting, fishing and travel, I certainly can appreciate the importance of recreation to a healthy life. And as this reality affects our nation's disabled veterans, I have seen first-hand the benefit of recreation to their health. I have had the honor of hunting with my friend, Army Specialist Jack Zimmerman. Jack is a remarkable man and decorated veteran who lost both of his legs as a result of life-altering injuries caused by an improvised explosive device. After his injury, Jack had a long rehabilitation in front him. And he had to deal with trials that he simply should not have had to during that time, including the VA issuing multiple inadequate wheel-

chairs to him. As an outdoorsman, Jack needed a chair that could navigate uneven terrain without the risk of tipping over. Jack was made aware of an off-road powered-track wheelchair that could offer a heightened level of normalcy and enjoyment to his life. He contacted the VA to acquire one and waited months without success.

Jack's wife ultimately was able to procure a powered-track wheelchair from an outside organization called the Independence Fund, which provides resources and tools that enable veterans to work through their physical, mental and emotional wounds and regain their independence. I am grateful for the Independence Fund and other organizations that make it their mission to provide for our veterans. But our veterans should not have to rely on such groups to do for them what their nation should. They fought for this nation and they should be cared for by this nation.

In the aftermath of Iraq and Afghanistan, we have strived in Congress to halt veteran suicide. We have worked to ensure that every veteran has access to the health care and services they need. Sadly, the somber statistics demonstrate that we have far to go to adequately take care of our veterans. That's why I champion H.R. 1943, which amends Section 1701 of Title 38 of the United Code to ensure wheelchairs provided to our veterans include "enhanced power wheelchairs, multi-environmental wheelchairs, track wheelchairs, stair-climbing wheelchairs, and other power-driven mobility devices." This legislation ensures that the Secretary of Veterans Affairs may provide a wheelchair to a veteran because the wheelchair restores an ability that relates exclusively to participation in a recreational activity.

Prepared Statement of Honorable Lloyd Smucker

Chairman Wenstrup, Ranking Member Brownley, and Members of the Subcommittee, I thank you for the opportunity to testify before the committee on my legislation, the VA Billing Accountability Act.

On August 9, 2017, the Veterans Affairs Office of Inspector General reported that in Fiscal Year 2015, of roughly 15.4 million bills the Veterans Health Administration issued during 2015 approximately 1.7 million were improper bills for the treatment of service-connected conditions. To put this into perspective, the Veterans Health Administration collected a staggering $13.9 million from our nation's veterans inappropriately. This is simply unacceptable.

Our service men and women should not have to pay for errors or delays by the Department of Veterans Affairs (VA). For more than a decade, the Department of Veterans Affairs has failed to address its broken medical-billing system that leaves our nation's veterans to pick up an inaccurate and expensive bill. That is why I introduced the bipartisan VA Billing Accountability Act to relieve veterans of financial burdens caused by delays at the VA.

My congressional district is home to more than 38,000 veterans—all of them deserve the highest quality medical care and the assurance from the VA that they will not be forced to foot the bill for the mistakes made by VA bureaucrats.

To address this ongoing issue, my bill authorizes the VA to waive veterans' co-payments if a veteran received a co-payment bill more than 120 days after they received care at the VA or 18 months after they received care at a non-VA facility.

The VA Billing Accountability Act also holds the VA accountable by giving the Secretary of the VA the authority to get rid of the requirement that veterans make a co-payment if the VA does not abide by the billing timing mandates.

To ensure accountability my bill requires the Secretary of Veterans Affairs to review the agency's copayment billing controls and notification systems to see if there are solutions that can better monitor and prevent erroneous bills within 180 days after enactment of this legislation. It is imperative that the Department of Veterans Affairs prioritizes improving its internal billing procedures.

Our nation's veterans and their families have sacrificed so much in defense of our nation. We should be making it easier, not harder, for them to transition to post-military life. That starts with making sure that the VA not only delivers quality health care, but also timely bills that our veterans can count on.

Thank you again for the opportunity to testify before the committee today, and for all the work that the members of this committee do to ensure quality and affordable care for our nation's veterans.

I yield back.

Prepared Statement of Honorable Steve Stivers

Testimony Before the House Committee on Veterans' Affairs, Subcommittee on Health: Veterans Dog Training Therapy Act

Thank you Chairman Wenstrup and Ranking Member Brownley for holding this hearing today, and for giving me the opportunity to testify on behalf of my bill, the Veterans Dog Training Therapy Act. I also want to thank the co-sponsor of this bill, Congressman Tim Walz (D–MN), for his support.

We face a devastating mental health crisis in this country - one that has particularly affected our veterans' community. When veterans return home, many struggle with visible, physical wounds. However, the invisible wounds our veterans suffer with are often overlooked. This is includes Posttraumatic Stress Disorder (PTSD), depression, and other mental health related issues from their service. It is just as important that we find ways to help veterans address mental health related issues, as it is their physical wounds.

Today, I want to discuss a few of the ways that this bipartisan bill can help our nation's veterans in a unique way, and build on the already proven benefits therapy dogs can be to veterans.

Therapy Dogs Work

First and foremost, therapy dogs work. Anyone who has a dog as a pet knows how much of a calming presence they can be. For veterans struggling with service-connected mental health issues, having this presence can make all of the difference.

In fact, research by Kaiser Permanente has shown that veterans who have these companion dogs show fewer symptoms of PTSD, depression, anxiety, have better interpersonal relationships, a lowered risk of substance abuse, and better overall mental health. Therapy dogs can clearly make a difference, and as we are losing veterans every day to suicide, it is critical we pursue any strategy to help more veterans receive the help they need and deserve.

The Pilot Program

The Veterans Dog Therapy Training Act would establish a pilot program at the Department of Veterans Affairs (VA) in which the Secretary will contract with local therapeutic dog training organizations, and help veterans seeking treatment to learn the art and science of dog training. Upon completion, the program will graduate the animal to go home with their veteran.

The Compassionate Innovation office at the Veterans Health Administration will be responsible for managing the program and ensuring that only the best organizations who are certified and specialize in companion animal training receive contracts. This bill also establishes a director of therapeutic service dog training who has a background in social services, experience in teaching others to train companion dogs, and at least one year of experience working with veterans or service members dealing with PTSD.

Additionally, this legislation will receive oversight from Congress. The Secretary of the VA will be required to collect data on the program to determine the effectiveness for those participating and their mental health outcomes and report back to Congress.

Veterans Helping Veterans

A unique part of this legislation is it will help facilitate veterans to help other veterans who are struggling. We know how valuable, veteran on veteran engagement is to assisting our service men and women and, my legislation adds a preference to the pilot program for contracting with veterans who have graduated from PTSD treatment programs and companion dog training certifications to conduct the training. Only other veterans truly understand the struggles of returning home, and the benefits a companion dog can provide. This is just one more way we can help veterans coping with PTSD make connections to other veterans who are in need.

I believe therapy dogs can make a real difference in the lives of veterans struggling with service-related mental health issues. The Veterans Dog Training Therapy Act is bipartisan, establishes a program to measure the real outcomes of connecting veterans to therapy dogs, and gives veterans the opportunity to help other veterans. This bill has the support of organizations such as the Paralyzed Veterans of America, Iraq and Afghanistan Veterans of America (IAVA), Veterans of Foreign Wars (VFW), and Disabled American Veterans (DAV). Moreover, this legislation is proven to have support - the Veterans Dog Training Therapy Act passed the House of Representatives during the 114th Congress.

I want to thank the Committee again for inviting me to testify today, and I encourage all of the Members of the Committee to consider this legislation.

Prepared Statement of Honorable Ron DeSantis

Chairman Wenstrup, Ranking Member Brownley, thank you for the opportunity to testify this morning. I request that my statement be accepted for the record.

Addressing service-connected disabilities is a critical part of the United States' commitment to the men and women who risk their lives through military service. Honoring our commitment includes safeguarding mental health, yet far too often combat wounds that go beyond the physical go ignored.

According to the most recent Department of Veterans Affairs (VA) analysis of veteran suicide, "Suicide Among Veterans and Other Americans," an average of 20 veterans died by suicide each day.

The VA must be more effective in its treatment of our soldiers who struggle with mental health disorders, including post-traumatic stress disorder (PTS), to reduce the veteran suicide rate.

For this reason, I reintroduced HR 2327, the Puppies Assisting Wounded Servicemembers (PAWS) Act, to direct the Secretary of the VA to carry out a 5-year pilot program to provide grants to select organizations that pair veterans suffering from severe PTS with the service dogs critical to their recovery.

In order to be eligible for a VA grant for a service dog pairing, the organization must either be an Assistance Dog International accredited organization that also meets specific criteria listed in the measure, or meet the Association of Service Dog Providers for Military Veterans Service Dog Agency Standards, which cater to the needs of veterans with PTS.

To be eligible for participation in the pilot, the veteran must have completed traditional therapies for PTS and remain symptomatic. A VA medical provider or clinical team must determine that the veteran is an appropriate candidate for the program, and the veteran shall see the VA medical provider at least every 6 months to remain eligible.

The pilot is capped at $10,000,000 for the 5-year period covering 2018–2023 and entirely offset with funds from the VA Office of Human Resources and Administration, which has demonstrated inappropriate conference planning and spending in the past.

Prior to reintroduction, my staff and I worked with House Committee on Veterans' Affairs Committee staff, as well as U.S. Department of Veterans Affairs personnel who would be involved with implementing the pilot once it launches and U.S. Government Accountability Office employees who would evaluate its success, to improve language from last Congress. We appreciate the Committee's willingness to work with us to revise language and the support from outside organizations to help move this measure.

An ongoing study conducted by a Purdue University research team revealed in February 2017 that service dogs contribute significantly to emotional and psychosocial well-being. Furthermore, on March 7, 2017, Veterans Affairs Secretary David Shulkin testified at a House hearing on the use of service dogs for veterans who have PTS or other emotional disorders, stating, "[I] think it's common sense that service dogs help.we hear it every day from veterans.I'm not willing to wait because there are people out there today suffering."

I am not willing to wait either. The urgency of veteran suicide rates demands that we immediately explore the option of pairing service dogs with veterans suffering from mental health disorders.

I look forward to continuing to work with the Committee to accomplish this goal.

Thank you again for the opportunity to testify. I welcome your questions.

Prepared Statement of Honorable Mike Coffman

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

While many veterans successfully readjust and transition back to civilian life after their military service, unfortunately, some do not. Often due to undiagnosed or untreated issues related to their service, veterans find themselves involved in the criminal justice system.

My bill, H.R. 2147 - the Veterans Treatment Court Improvement Act, builds upon an existing and successful program that works with criminal justice involved veterans and connects them with the services they need.

Mr. Chairman, Veterans Treatment Courts (VTCs) were created to be dedicated to veteran offenders specifically. These specialty, diversionary courts take veterans out from the regular criminal justice process to address the underlying issues, such as post-traumatic stress disorder (PTSD) or substance abuse.

The VA provides Veteran Justice Outreach (VJO) Specialists who are licensed social workers operating through VA Medical Centers as part of the VJO Program. These VJO Specialists link veterans to available VA services and treatment, and monitor the veteran's progress in the Veteran Treatment Courts.

This successful model avoids the unnecessary incarceration of veterans with mental illness, assesses their health and social needs, and then helps develop a rehabilitation treatment program specific to the veteran's needs.

In my district, the 18th Judicial Veterans Treatment Court has a 74% success rate for those who have participated in their program. Clearly, this program works.

Mr. Chairman, there are more than 260 VJO Specialists in 167 VA Medical Centers nationwide. However, the VA currently lacks a sufficient number of VJO Specialists to meet the demand for their services. This means numerous veterans cannot avail themselves of the opportunity to enter the Veteran Treatment Courts and succeed in rehabilitating themselves.

My bill, H.R. 2147, will help the VA to better meet the demands of the program and to serve many more veterans by authorizing the VA Secretary to hire 50 additional VJO Specialists. H.R. 2147 also requires the VA Secretary to identify an offset, and requires the VA and GAO to report to Congress on the implementation of this bill.

Mr. Chairman, our veterans have served us - now let us serve those veterans who need our help. As a Marine Combat Veteran, I like to live by the rule that we never leave anyone behind, and the Veterans Treatment Court Improvement Act makes sure that we do not forget those who bravely served our country in their time of need.

Mr. Chairman, thank you for allowing me to testify today on behalf of my legislation and I yield back the remainder of my time.

Prepared Statement of Honorable John Rutherford

DRAFT LEGISLATION TO IMPROVE THE VA HEALTH PROFESSIONALS EDUCATIONAL ASSISTANCE PROGRAM

Chairman Wenstrup, Ranking Member Brownley, fellow members of the Subcommittee - thank you for the opportunity to speak on behalf of this draft legislation that would improve the Health Professional Educational Assistance Program at the VA.

This Subcommittee has frequently heard testimony regarding the high number of physician vacancies at the VA and the negative impact this has on the care of our nation's veterans. Currently, the VA has several programs to address recruitment in their profession ranks, including the Education Debt Repayment Program (RDRP) and the Health Professions Scholarship Program (HPSP). While these programs have improved recruitment, "physician" remains the top VA mission critical shortage, with the current estimate for physician vacancies to be 3,500. One way to ensure that the VA is long term staffed with qualified providers is to recruit those who are currently in medical school or are in residency and assist in their education expenses in exchange for their service within the VA system.

As we as a Congress work with our partners in the Administration and in our communities to improve care and decrease wait times, I believe it is critical that the VA has the tools to recruit and retain providers in areas that are desperately needed throughout the system.

This draft legislation makes three primary improvements to these programs.

First, it requires the VA to provide a minimum total of fifty 2 to 4 year scholarships annually for students studying to become physicians or dentists while the shortage of these professions is 500 or greater. These students will then be obligated to provide clinical service at a VA facility for 18 months for each year of scholarship support.

Second, this legislation requires the VA to create a pilot program to fund two scholarships at each of the five Teague-Cranston Act medical schools for veterans who qualify for admission to those medical schools. The schools that participate in this program will each reserve two seats in each class for the veteran recipients of these scholarships. The veterans are obligated to provide clinical service at a VA facility for a minimum of 4 years in exchange for the scholarship.

Third, it standardizes and increases the VA loan repayment program for newly graduated medical students or those currently in residency who will be training in specialties deemed as shortages in VHA. The loan payments will be a maximum of $40,000 per year with a maximum total of $160,000. Following completion of residency training, the loan recipients will be obligated to provide clinical service at a VA facility for a year for each $40,000 of loan repayment, but in no case fewer than two years. The current program varies among the VISNs and is not adequately competitive.

The VA has made many impactful changes in recent years, but it is important that we consider ways the VA can attract talent on the front end to improve the system long term. A key part of this is attracting young talent that will come into the system and compete with the private sector.

In closing, I would like to thank the Chairman, the Ranking Member, my colleagues on the Committee, and the Subcommittee staff for their commitment to this and the other pieces of legislation under consideration today that would continue to improve the VA health system.

Congressman John Rutherford represents the 4th Congressional district of Florida. Prior to being elected in 2016, Congressman Rutherford served as the Sheriff of Duval County for 12 years where he led initiatives to reduce crime in Jacksonville to a 40-year low. He serves on the House Committee on Homeland Security, the House Judiciary Committee, and the House Committee on Veterans' Affairs.

Prepared Statement of Keronica Richardson

Section	Title	Page	Position
H.R. 93	To amend title 38, United States Code, to provide for increased access to Department of Veterans Affairs medical care for women veterans.		Support
H.R. 501	VA Transparency Enhancement Act of 2017		Support
H.R. 1063	Veteran Prescription Continuity Act		Support
H.R. 1066	VA Management Alignment Act of 2017		Support
H.R. 1972	VA Billing Accountability Act		Support
H.R. 2147	Veterans Treatment Court Improvement Act of 2017		Support
H.R. 2225	Veterans Dog Training Therapy Act		Support
H.R.2327 DRAFT BILL	PAWS Act of 2017 To amend title 38, United States Code, to make certain improvements in the Health Professionals Educational Assistance Program of the Department of Veterans Affairs, and for other purposes.		Support No Position

Chairman Wenstrup, Ranking Member Brownley and distinguished members of the Subcommittee on Health; on behalf of National Commander Denise H. Rohan and The American Legion, the country's largest patriotic wartime service organization for veterans, comprising over 2 million members and serving every man and woman who has worn the uniform for this country, we thank you for the opportunity to testify on behalf of The American Legion's positions on the following pending and draft legislation.

H.R. 93

To amend title 38, United States Code, to provide for increased access to Department of Veterans Affairs medical care for women veterans.

According to the Department of Veterans Affairs (VA), the female veteran population accounts for 10 percent of U.S. veterans, and that number is expected to grow to 15 percent by 2030. This population experiences distinctive challenges such as ac-

cess to female-specific medical care, the greater likelihood for homelessness, and higher unemployment rates than male veterans. [1]

In 2013, The American Legion conducted fifteen "System Worth Saving" site visits focusing on women veterans healthcare. Based on these visits, the following key findings were identified: [2]

- Women veterans do not identify themselves as veterans and/or do not know what benefits they are eligible to receive;
- VA medical center facilities do not have a baseline, one-year, two-year, or five-year plan to close the gap between the catchment area, enrollment numbers, and actual users among women veterans;
- Additional research is needed to determine the purpose, goals, and effectiveness of the three VA women models of care on overall outreach;
- Communication and coordination of women veterans health services are substandard;
- Women veterans do not receive their mammogram results in a timely manner;
- Many VA facilities do not offer inpatient/residential mental health programs for women veterans; and
- VA's legislative authority for the child care pilot program is due to expire by the end of September 2017.

If enacted, H.R. 93 will require the VA to meet the healthcare needs of women veterans across the VA healthcare system. When the VA is unable to meet their needs, the Secretary may enter into contracts with third-party organizations to provide the services required.

Using resolution 147, Women Veterans, The American Legion supports any legislation that provides full comprehensive health services for women veterans department-wide, including, but not limited to: increasing treatment areas and diagnostic capabilities for female veteran health issues, improved coordination of maternity care, and increase the availability of female therapists/female group therapy to better enable treatment of Post-Traumatic Stress Disorder from combat and MST in women veterans. [3]

The American Legion Supports H.R. 93

H.R. 501 - VA Transparency Enhancement Act of 2017

To require increased reporting regarding certain surgeries scheduled at medical facilities of the Department of Veterans Affairs, and for other purposes.

During a study by the Environment of Care and Safety Review of the operating room at the Edward Hines Jr. VA Hospital in Hines, IL, the Department of Veterans Affairs (VA) Office of Inspector General (OIG) found that surgery infections are often caused by improper temperature and humidity control in the emergency room [4]suite. [5]

The Association of periOperative Registered Nurses recommends a temperature range in an operating room between 68&degF and 73°F. This is to prevent hyperthermia, surgical site infections, longer hospital stays, and other negative outcomes. Additionally, the recommended humidity range in an operating room is 20 percent to 60 percent. This is to reduce infections and prevent the development of mold and mildew in anesthetizing locations.

H.R. 501 would require the VA to track and submit findings regarding complications due to surgery infections to the Secretary of VA. The American Legion knows that it is pertinent to the safety of future veterans utilizing these hospitals for the VA to track specific outcomes regarding surgeries. This legislation would require these outcomes be made public so that individuals can make the best-informed decision regarding their medical treatments at different VA locations. These metrics will also help Congress and veteran service organizations understand which VA hospitals are having more problems with surgery infection complications and find ways to address these issues.

Using resolution 377, Support Veterans Quality of life, The American Legion supports any legislation that will enhance, promote, restore or preserve benefits for veterans and their dependents, including, but not limited to the following: timely access to quality VA health care, timely decisions on claims and receipt of earned benefits,

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[1] http://www.blogs.va.gov/VAntage/40134/
[2] https:// www.legion.org/sites/ legion.org/files/legion/ publications/ 2013–SWS–Report-WEB.pdf
[3] The American Legion Resolution No. 147 (2016): Women Veterans
[4] https://www.va.gov/oig/pubs/VAOIG–13–02315–332.pdf
[5] https://www.va.gov/oig/pubs/VAOIG–13–02315–332.pdf

and final resting places in national shrines and with lasting tributes that commemorates their service. [6]

The American Legion Supports H.R. 501

H.R. 1063 - Veteran Prescription Continuity Act

To ensure that an individual who is transitioning from receiving medical treatment furnished by the Secretary of Defense to medical treatment furnished by the Secretary of Veterans Affairs receives the pharmaceutical agents required for such transition.

In late 2014, the Department of Veterans Affairs (VA) conducted an evaluation of medical prescriptions for 2,000 Department of Defense (DoD) servicemembers entering the VA system for the first time. The study included individuals taking mental health or pain medication. The goal of the assessment was to evaluate the extent to which mental health medications and opioid analgesics active at the time of DoD separation were changed versus continued unchanged upon entering the VA system, as well as the reason for any changes (clinical vs. administrative). [7]

The study found that some veterans had their medication switched due to differences between the VA and DoD drug formularies. The current prescription drug formularies used by the DoD and VA have several differences, meaning that certain prescription drugs are unavailable to transitioning servicemembers once they start receiving care from the VA. As a result, there are occasions when transitioning servicemembers are forced to abruptly change their prescription drug regimen during an already arduous transition period.

This legislation would require the VA to continue supplying medications prescribed by a DoD healthcare provider when the DoD healthcare provider determines that such pharmaceutical agent is critical for such transition.

Using Resolution 377, Support Veterans Quality of Life Resolution, The American Legion supports any legislation that will enhance, promote, restore or preserve benefits for veterans and their dependents, including, but not limited to, the following: timely access to quality VA health care, timely decisions on claims and receipt of earned benefits, and final resting places in national shrines and with lasting tributes that commemorates their service. [8]

The American Legion Supports H.R. 1063

H.R. 1066 - VA Management Alignment Act of 2017

To direct the Secretary of Veterans Affairs to submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report regarding the organizational structure of the Department of Veterans Affairs, and for other purposes.

The American Legion has been at the forefront of efforts to both increase accountability at Department of Veterans Affairs and improve timely access to quality VA health care for veterans. We have been rightly critical of past management failures and recognize the need to assist VA, Congress, and other stakeholders to address these problems.

In 2015, VA health care was added to the Government Accountability Office (GAO) high-risk list because of concerns about VA's ability to ensure the timeliness, cost-effectiveness, quality, and safety of veterans' health care. In testimony delivered to the Senate Veterans Affairs Committee on March 15, 2017, GAO stated that insufficient progress has been made to address the concerns that led to high-risk designation. [9]

In May 2017, VA Secretary Shulkin delivered his diagnosis of the department noting a long road toward recovery. He offered an assessment on the "State of VA," outlining 13 areas where the department needs to improve and the legislative and administrative fixes it needs in order to see progress. Shulkin reiterated his belief that the department's central office is too large and unwieldy.

Another GAO report released in September 2016 found that the VA has been slow to make changes after the 2014 wait-time scandal and that VA does not have a process for following through with the recommendations that it receives or to effectively

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[6] The American Legion Resolution No. 377 (2016): Support Veterans Quality of Life Resolution

[7] https://www.pbm.va.gov/vacenterformedicationsafety/ othervasafetyprojects/ DoD—VA—Medication—Continuation—Report.pdf

[8] The American Legion Resolution No. 377 (2016): Support Veterans Quality of Life Resolution

[9] https://www.gao.gov/assets/690/683381.pdf

make changes [10]. The report also states that without a process, there is "little assurance" the delivery of health care will improve. It goes on to say the VA cannot confirm that it is holding leaders accountable for making improvements. [11]

The VA Management Alignment Act was introduced in response to this report to help address the issue. The measure would require the VA secretary to submit plans to the House and Senate veterans committees within 180 days after the bill goes into effect, detailing the roles and responsibilities of VA executives and spelling out how they would improve veterans' access to treatment.

The American Legion Resolution No. 3: Department of Veterans Affairs Accountability urges Congress to pass legislation to improve accountability at VA. [12] The VA Management Alignment Act of 2017 would provide the agency and Congress with a new perspective on how to address VA's management challenges and is consistent with ongoing efforts to improve VA's ability to ensure the timeliness, cost-effectiveness, quality, and safety of veterans' health care.

The American Legion supports H.R. 1066

H.R. 1972 - VA Billing Accountability Act

To amend title 38, United States Code, to authorize the Secretary of Veterans Affairs to waive the requirement of certain veterans to make copayments for hospital care and medical services in the case of an error by the Department of Veterans Affairs, and for other purposes.

While many veterans qualify for free healthcare services based on a Department of Veterans Affairs compensable service-connected condition or other special eligibilities, most veterans are required to complete a financial assessment or means test at the time of enrollment to determine if they qualify for free health care services. Veterans whose income exceeds VA income limits, as well as those who choose not to complete the financial assessment at the time of enrollment, must agree to pay required copays for health care services to become eligible for VA healthcare services. VA is also authorized to recover the reasonable cost of medical care furnished to a veteran for the treatment of a non-service-connected (NSC) disability or condition when the veteran or VA is eligible to receive payment for such treatment from a third-party.

After enrollment, if a veteran's medical care appears to qualify for billing under reimbursable insurance and co-payment, the charges for co-payments will be placed on hold for 90 days, pending payment from the third-party payer. If no payment is received within 90 days, the charges will automatically be released and a statement generated to the veteran. VA will provide sufficient information about first party co-payment debts to veteran patients reminding them of their responsibilities to pay their share of debts created as a result of medical services rendered as inpatient, outpatient, extended care, or medication. VA will follow up with the debtor until the debt is resolved.

VA currently has multiple options available to help make copay charges more affordable, or to eliminate them:

- Repayment Plan: A veteran has the right to establish a monthly repayment plan at any time during their enrollment in VA health care if they cannot pay their debt in full.
- Waiver Request: A veteran also has the right to request a waiver of part or all of the debt. If the waiver is granted the veteran is not required to pay the amount waived.
- Compromise: A veteran has the right to request a compromise. A compromise means a veteran proposes a lesser amount as full settlement of the debt.

H.R. 1972 would authorize the VA to waive the requirement that a veteran makes copayments for medications, hospital care, nursing home care, and medical services if:

- An error committed by the VA or a VA employee was the cause of delaying copayment notification to the veteran, and
- The veteran received such notification later than 120 days (18 months in the case of a non-VA facility) after the date on which the veteran received the care or services.

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[10] https://www.gao.gov/mobile/products/GAO–16–803

[11] http://www.gao.gov/assets/690/680054.pdf

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

In requiring a veteran to make a copayment for care or services provided at a VA or a non-VA medical facility, this bill would require VA to notify the veteran not later than 120 days (18 months in the case of a non-VA facility) after the date on which the veteran received the care or services. If the VA does not provide notification by such date, it may not collect the payment, including through a third-party entity, unless the veteran is provided with:

- information about applying for a waiver and establishing a payment plan with the VA, and
- an opportunity to make a waiver or establish a payment plan.

Finally, H.R. 1972 would require the VA to review and improve its copayment billing internal controls and notification procedures.

The VA Billing Accountability Act of 2017, by setting forth specific and immediate billing requirements, so our nation's veterans are not receiving unbilled co-payments for VA care in an untimely manner, sometimes from years past, will help bring more stability and financial security to their post-military lives.

Through Resolution No. 377: Support for Veteran Quality of Life, The American Legion supports any legislative proposal that urges Congress and the Department of Veterans Affairs to enact legislation and programs within the VA that will enhance, promote, restore or preserve benefits for veterans and their dependents, including, but not limited to the following: timely access to quality VA health care; timely decisions on claims and receipt of earned benefits; and final resting places in national shrines and with lasting tributes that commemorate their service. [13]

The American Legion supports H.R. 1972

H.R. 2147 - Veterans Treatment Court Improvement Act of 2017

To require the Secretary of Veterans Affairs to hire additional Veterans Justice Outreach Specialists to provide treatment court services to justice-involved veterans, and for other purposes.

The Veterans Court Improvement Act of 2017 recognizes the importance of Veteran Justice Outreach Specialists providing services to veterans as well as the importance of Veteran Treatment Courts. This legislation would assure our nation's veterans, who are in the criminal justice system, have access to services and resources they need to be productive members of society. With this bill, Congress validates that this unique population will be best served within their communities by providing sufficient resources to these courts.

When veterans return from combat, some turn to drugs or alcohol to cope with mental health issues related to Post Traumatic Stress Disorder (PTSD) and/or Traumatic Brain Injury (TBI). Thus, many returning veterans are entering the criminal justice system to face charges stemming from these issues. In 2008, a judge in Buffalo, NY, created the first Veterans Treatment Court after seeing an increase in veterans' hearings on his dockets. Veteran Treatment Courts are a hybrid of drug and mental health courts. They have evolved out of the growing need for a treatment court model designed specifically for justice-involved veterans to maximize efficiency and economize resources while making use of the distinct military culture consistent among veterans.

Through Resolution No. 145: Veterans Treatment Courts, The American Legion supports any legislation that establishes a separate program office within Department of Veterans Affairs Central Office with an increased program budget and hiring of staff to expand the Veterans Justice Outreach program and policies. [14] The resolution specifically calls for continuing to fund and expand Veterans Treatment Courts and hire more staff to expand the Veterans Justice Outreach program and policies.

The American Legion supports H.R. 2147

H.R. 2225 - Veterans Dog Training Therapy Act

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

Since 1991, the United States has been at war, and as a result, thousands of soldiers have returned home with mental and physical injuries. In 2009, Congress

[13] The American Legion Resolution No. 377 (2016): Support for Veteran Quality of Life
[14] The American Legion Resolution No. 145 (2016): Veteran Treatment Courts

amended Title 38, United States Code § 1714 by authorizing the Department of Veteran Affairs to extend benefits for the upkeep of service dogs used primarily for the aid of persons with physical disabilities and psychological wounds.

This bill directs the VA to carry out a five-year pilot program to assess the effectiveness of addressing veterans' post-deployment mental health and post-traumatic stress disorder symptoms through the therapeutic medium of training service dogs for veterans with disabilities.

Through Resolution No. 160: Complementary and Alternative Medicine, The American Legion supports any legislation that provides oversight and funding to the Department of Veterans Affairs for innovative, evidence-based, complementary and alternative medicine (CAM) in treating various illnesses and disabilities. [15]

The American Legion supports H.R. 2225

H.R.2327 - PAWS Act of 2017

To direct the Secretary of Veterans Affairs to make grants to eligible organizations to provide service dogs to veterans with severe post-traumatic stress disorder, and for other purposes.

The Puppies Assisting Wounded Servicemembers Act of 2017 (PAWS Act) makes service dogs accessible to veterans wanting an alternative post-traumatic stress disorder (PTSD) treatment option possible for veterans open to this type of treatment. Currently, the Department of Veterans Affairs does not fund service dogs or recognize the use of therapy service dogs as a possible method to treat veterans suffering from PTSD. There have been multiple studies proving that service dogs can provide many different forms of mental healing to veterans suffering from physically invisible wounds of war.

H.R. 2327 would create a five-year $10 million pilot program that pairs veterans who served on active duty in the Armed Forces on or after September 11, 2001, with eligible therapy service dogs if they have been diagnosed with PTSD severe enough to warrant treatment. Eligible veterans must have also completed an evidence-based treatment program and remain significantly symptomatic by clinical standards.

The American Legion supports this legislation because it allows for an alternative form of treatment to injured veterans returning home from war with Traumatic Brain Injury (TBI) and PTSD. Service dogs can act as an effective complementary therapy treatment component, especially for those veterans who suffer on a daily basis from the physical and psychological wounds of war. PTSD has become an epidemic, and the VA has estimated that between 11 and 20 percent of veterans who served in Afghanistan or Iraq have PTSD [16]. While the VA continues to stall with their dog-based therapy studies, veterans are being denied alternative forms of treatment. As the VA is continually accused of over-prescribing veterans, and as veteran continue to complain about overprescription, it is time that the VA, and the Federal government, look at alternative options. [17]

Through Resolution No. 160: Complementary and Alternative Medicine, The American Legion supports any legislation that provides oversight and funding to the Department of Veterans Affairs for innovative, evidence-based, complementary and alternative medicine (CAM) in treating various illnesses and disabilities. [18]

The American Legion supports H.R. 2327.

DRAFT BILL

To amend title 38, United States Code, to make certain improvements in the Health Professionals Educational Assistance Program of the Department of Veterans Affairs, and for other purposes.

The provisions of this draft bill fall outside the scope of established resolutions of The American Legion. As a large, grassroots organization, The American Legion takes positions on legislation based on resolutions passed by our membership. With no resolutions addressing the provisions of the legislation, The American Legion is researching the material and working with our membership to determine the course of action that best serves veterans.

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[15] The American Legion Resolution No. 160 (2016): Complementary and Alternative Medicine

[16] https://medlineplus.gov/magazine/issues/winter09/articles/winter09pg10–14.html

[17] http://www.npr.org/sections/health-shots/2014/07/11/330178170/veterans-kick-the-prescription-pill-habit-against-doctors-orders

[18] The American Legion Resolution No. 160 (2016): Complementary and Alternative Medicine

The American Legion has no current position on this Draft Bill.

Conclusion

As always, The American Legion thanks this subcommittee for the opportunity to elucidate the position of the over 2 million veteran members of this organization. For additional information regarding this testimony, please contact The American Legion Deputy Director of the Legislative Division, Derek Fronabarger, at (202) 861–2700 or dfronabarger@legion.org.

Prepared Statement of Amy Webb

On

"Pending Health Care Legislation"

H.R. 93 to Provide Increased Access to Department of Veterans Affairs Medical Care for Women Veterans	Support
H.R. 501 VA Transparency Enhancement Act of 2017	Support
H.R. 1063 Veteran Prescription Continuity Act	Support
H.R. 1066 VA Management Alignment Act of 2017	Support
H.R. 1943 Restoring Maximum Mobility to Our Nation's Veterans Act of 2017	Support
H.R. 1972 VA Billing Accountability Act	Support
H.R. 2147 Veterans Treatment Court Improvement Act of 2017	Support
H.R. 2225 Veterans Dog Training Therapy Act	Support
H.R. 2327 PAWS Act of 2017	Support
Draft to Make Certain Improvements to VA's HPEAP	Support

Chairman Wenstrup, Ranking Member Brownley, and all members of the committee; thank you for the opportunity to testify on behalf of AMVETS' 250,000 members. We are particularly thankful for your efforts to address some of the most challenging and longstanding veteran health care issues. We appreciate the dedication of your staff members who are working diligently to formulate policies that ensure we are taking care of our Nation's veterans.

H.R. 93: Provide Increased Access to Department of Veterans Affairs Medical Care for Women Veterans

AMVETS supports H.R. 93

H.R. 93 ensures that gender specific services are continuously available at every VA medical center and community based outpatient clinic.

This bill is strongly aligned with our National Resolution on Women Veterans Health care which states, in part, that AMVETS urges DoD and VA to enhance their programs to ensure that women veterans receive high-quality, comprehensive primary and mental health care services in a safe and sensitive environment at every VA health care facility.

H.R. 501 VA Transparency Enhancement Act of 2017

AMVETS supports H.R. 501

This bill increases reporting requirements from VA medical facilities regarding post-surgical infections, and cancelled or transferred surgeries.

AMVETS has a National Resolution on VA Accountability, and we believe that transparency is equally important. Any measure which seeks to improve the health care and health outcomes of veterans is something that we not only support, but advocate for as part of our organizational mission.

H.R. 1063 Veteran Prescription Continuity Act

AMVETS supports H.R. 1063

H.R. 1063 improves the care of individuals transferring from receiving treatment from the Department of Defense to the Department of Veterans Affairs by ensuring that any pharmaceuticals the patient is taking at the time of transfer that are not listed on the Joint Uniform Formulary for Transition of Care would be able to still be prescribed until such point where it was deemed they were no longer needed.

AMVETS believes it is imperative to offer servicemembers transitioning into veteran status the continuity of care that medical professionals believe is in their best interest. Allowing the continuation of needed medication, whether or not it is listed in the Joint Uniform Formulary, is something that is important and we urge passage of this bill.

H.R. 1066 VA Management Alignment Act of 2017

AMVETS supports H.R. 1066

H.R. 1066 increases the reporting requirements of the Department of Veterans Affairs related to the roles, responsibilities and accountability of the departments and its key leaders and staff.

This bill falls well under our National Resolution on VA Accountability. As VA works to ensure that those in all levels of employment are upholding their commitments and dedication to serving veterans, we encourage this type of reporting so that the different roles of different departments can be adjusted and enhanced to better serve those who have stood up to serve this country. This is VA's purported mission and we support all levels of improved excellence.

H.R. 1943 Restoring Maximum Mobility to Our Nation's Veterans Act of 2017

AMVETS supports H.R. 1943

This bill ensures that veterans with a service-connected disability may be furnished a wheelchair to restore an ability to participate in recreational activities and clarifies that wheelchairs furnished to these veterans should be intended to help the veteran achieve mobility and function in the activities of daily life and employment in addition to recreation.

AMVETS supports this bill as it falls in line with our National Resolution on Prosthetics and Sensory Aids, and we also support in the spirit of encouraging veterans of all abilities to be as active as they are able. From VA's sports clinics to its wheelchair games, it is quite evident that when veterans realize that they are capable of participation and involvement in actives they were not sure was possible after being injured or wounded, that it improves their physical and mental health.

H.R. 1972 VA Billing Accountability Act

AMVETS supports H.R. 1972

H.R. 1972 waives the requirement of certain veterans to make copayments for VA medical care, and prescriptions if the Department made errors in properly notifying the veteran that a payment was required, and if the notification was received more than three months after the date of service. It will be required that the veteran is given information on how to apply for a waiver, or to establish a payment plan. For medical care received outside of VA, the veteran must be notified of a payment due within 18 months of service.

AMVETS supports this protective measure of veterans, who should not be held liable if VA is not properly billing its patients, whether they receive care within or outside of the VA health care system.

H.R. 2147 Veterans Treatment Court Improvement Act of 2017

AMVETS supports H.R. 2147

H.R. 2147 would require the Secretary of VA to hire additional Veterans Justice Outreach (VJO) Specialists, and AMVETS enthusiastically supports this bill. Many veterans have specific needs and challenges related to their military service. AMVETS has been involved with veteran treatment courts since their inception - starting with our then Commander J.P. Brown who worked with Judge Russell in Buffalo New York who in January of 2008 created and began presiding over the nation's first Veterans Treatment Court. Commander Brown took that knowledge and spearheaded the creation of a veteran treatment court in his home state of Ohio where about 100 veterans have since gone through the system. Of those, only four have had to leave due to noncompliance. The 96 others have completed two years of treatment which combines VA services, Social Services, veteran and family counseling, and four mental health agencies. The veteran is also paired with a mentor. The court itself acts just like a regular court, and if the veteran client pleads guilty and completes the 2-year program, then the charges are dropped. It is a key legislative priority of ours to see these courts expanded and we appreciate that the bill would add more VJO Specialists. There are many solid systems in place to help veterans, but they will not properly function without adequate staffing.

H.R. 2225 Veterans Dog Training Therapy Act

AMVETS supports H.R. 2225

H.R. 2225 creates a five-year pilot program to study the effectiveness of treating post-deployment mental health symptoms by having eligible veterans learn how to train service dogs through the VHA's Center for Compassionate Innovation's Recreation Therapy Service. VA would be required to establish and hire a director of therapeutic service dog training who has a background in social services; experience teaching others to train service dogs in a vocational setting; and a minimum of a year working in a clinical setting with veterans or those on active duty with PTSD. In choosing dog training instructors, there would be preference given to veterans who have graduated from PTSD or other residential treatment programs and who are certified in service dog training.

Veterans participating in the pilot would do so in conjunction with VA's vocational rehabilitation Compensated Work Therapy program. Non-governmental entities would be contracted to perform the assessments of the pilot which include how stigma is reduced, improvements to emotional regulation and patience, reintegrating into the community, improving sleep patterns and instilling a sense of purpose.

The intent of this bill is in line with our National Resolution on VA mental health care that strongly recommends Congress appropriate more dedicated funding for mental health care and related programs and services. AMVETS is also a strong proponent of the benefits of service dogs, and believes that veterans in this pilot program would benefit by being in the leadership position to help train these canines that can change and better the lives of the fellow veterans they end up being paired with.

H.R. 2327 PAWS Act of 2017

AMVETS Supports H.R. 2327

The Puppies Assisting Wounded Servicemembers Act creates a five-year pilot program assessing the benefits of pairing a service dog with veterans suffering from severe PTSD, in an effort to reduce the concerning veteran suicide rate. The VA would provide $25,000 to eligible organizations for the procurement and training of each service dog paired with a veteran in addition to any necessary hardware, travel expenses for the veteran to obtain the service dog, or any potential replacement service dog, and a veterinary health insurance policy for the life of the dog.

In order for a veteran to be eligible for the pilot they must be enrolled in VA healthcare and have completed an established evidence-based treatment for PTSD without suitable improvement so as they still remain diagnosed under the PTSD checklist (PCL–5) and their mental health care provider determines that they may potentially benefit from a service dog. Once accepted into the pilot, in order to re-

main eligible the veteran needs to maintain their relationship with their mental health care provider, and have office visits at least every six months to determine whether the veteran is benefitting from being paired with a service dog. If it is determined that the veteran is not benefitting than the eligible organization that provided the dog will decide how best to ensure the safety of the dog and the veteran.

While the VA does not compensate veterans for the care of service dogs that assist veterans with PTSD as they do for some other conditions, they remain in the midst of a $12-million-dollar study to measure the cost and mental health benefits of pairing well-trained service dogs with veterans diagnosed with PTSD. The study also aims to compare service dogs and emotional support dogs in how they assist veterans with PTSD. Unfortunately, the study has been beset by many setbacks, including improper pairing of poorly trained dogs with veterans, and for being slow in acquiring and pairing dogs with veterans. After undergoing a pause and reorganization, the VA study picked back up in 2015 and according to the VA's Office of Research and Development website, "VA researchers are studying whether Veterans with PTSD can benefit from the use of service dogs or emotional support dogs. The study, being overseen by VA's Cooperative Studies Program, is enrolling 230 Veterans with PTSD from Atlanta, Iowa City, and Portland. To date, there is ample evidence on the benefits of service dogs for people with physical disabilities, but very little such evidence in the area of mental health." This particular study is set to be complete in 2018.

AMVETS has long seen the importance of well-trained and well-paired service dogs, and the impact this relationship has on individuals and veterans with physical and emotional illnesses or wounds. Service dogs can perform specific tasks to assist with the symptoms of PTSD such as learning commands to help secure space, turn on lights, sweep a room prior to a veteran entering and bark if anyone is present, to wake them up during a nightmare, remind them to take medication, and pick up on stress cues and offer calming support.

The AMVETS Ladies Auxiliary has worked with ADI accredited "Paws with a Cause" as its National Community Service program for nearly thirty years in a consistent effort to help veterans with visible and invisible wounds obtain a service dog to enhance their daily functioning. Through this partnership, AMVETS has seen firsthand the marked benefits to a veteran's quality of life when paired with a well-trained service dog.

The intent of this bill is in line with our National Resolution on VA mental health care that strongly recommends Congress appropriate more dedicated funding for mental health care and related programs and services. While AMVETS supports passage of the PAWS Act, it is with the stipulation that great care, consult, and oversight occur when awarding a contract to an organization that trains the service dogs; in choosing veterans who are able to manage the continued care and training the dog will require; in closely following those who are part of the pilot program; and in setting expectations for how quickly the veteran can obtain a dog. Fully trained service dogs are quite rarely immediately available, but once paired with a receptive and willing owner, the benefits can be extraordinarily rewarding. AMVETS looks forward to providing any assistance needed to properly choose organizations that provide trained animals that can effectively support veterans with PTSD.

Discussion Draft: Make Certain Improvements to VA's HPEAP

AMVETS supports the discussion draft

This measure will improve the VA's Health Professionals Educational Assistance Program (HPEAP) by offering additional scholarships to those seeking to become a physician or dentist, and stipulates varying degrees of commitment to working full time at a VA medical facility in return for the scholarship, in addition to repayment parameters should the individual not meet the requirements of the scholarship.

In addition this measure would create a VA Specialty Loan Repayment Program in order to repay the loans of certain VHA physicians who are eligible to be board certified in areas that are deemed to be most needed in the areas of recruitment and retention.

Lastly, it would establish a veterans healing veterans pilot program to fund the educations of ten eligible veterans who have separated from the military within ten years, and who are not eligible for other educational assistance. They must apply for admission to one of five Teague-Cranston medical schools for 2019 and would be chosen for being veterans with the highest admissions rankings. If each of the five schools do not receive or award the two scholarships, then another school may award an additional scholarship in order for ten total scholarships to be awarded.

Quality recruitment and retention of high performing physicians and dentists at VA has been a longstanding and complex challenge. We believe that this measures offers offer some excellent solutions to this issue, albeit rather short term with the repayment in the form of time committed to working in VA rather short-term. We hope that in the interim VA is able to strengthen its ability to retain physicians long-term in the way of comparable compensation to the private sector, and internal organizational processes across the board that speak to VA's stated core values of: Integrity, Commitment, Advocacy, Respect, Excellence ("I CARE").

Prepared Statement of Harold Kudler, M.D.

Good morning, Chairman Wenstrup, Ranking Member Brownley, and Members of the Subcommittee. Thank you for inviting us here today to present our views on several bills that would affect the Department of Veterans Affairs' (VA or Department) programs and services. Joining me today is Ms. Catherine Biggs-Silvers, Executive Director, for Mission, Planning, and Analysis, Human Resources and Administration. Due to the timing of the hearing, VA is unable to provide views on the draft bill, to make certain improvement in the Health Professionals Educational Assistance Program of the Department of Veterans Affairs. These views are currently being drafted and we will forward them to you as soon as they are available.

H.R 93 Medical Services for Women Veterans

H.R. 93 would add section 1720H to Title 38, United States Code (U.S.C.), requiring the Secretary to ensure that gender specific services are continuously available at every VA medical center (VAMC) and community-based outpatient clinic (CBOC). It also would allow the Secretary to employ appropriate staff and enter into such contracts as may be needed to meet current and expected future demand for these services.

We appreciate the intent of this proposal and would like to work with the Committee to further clarify the scope of this bill. We strongly believe that every Veteran should receive care specific to his or her needs, but we caution that the language as written could be broader than intended. For example, the term "gender specific services" is undefined, and could apply to both men and women Veterans. It is also unclear if this is intended to refer to gender-specific primary care services for women or more advanced services such as obstetrics and gynecology (for women) or urology (for men). We also note that the bill as written would require these services be continuously available at every VAMC and CBOC. This could potentially have significant resource implications depending upon the intended effect. We would greatly appreciate the opportunity to meet with the Committee further to discuss these and other issues to improve this legislation.

Given the unclear scope of the legislation, we are unable to provide a cost estimate for this bill at this time but note that it could have significant resource implications depending on the intended effect.

H.R 501 VA Transparency Enhancement Act of 2017

H.R. 501 would impose new reporting requirements on medical center directors and the Secretary. It would require each VAMC Director to file a quarterly report to the Secretary providing specific data related to surgical infections and cancelled or transferred surgeries. Within 60 days of the end of each calendar quarter, the Secretary would be required to report to Congress and publish online the reports submitted by the VAMC Directors and a summary on those reports.

We do not support this bill because portions of it are unnecessary and others would be burdensome to implement. Currently, each facility collects data on surgical infections locally, but this information is not gathered nationally. The VA Surgical Quality Improvement Program (VASQIP) examines a portion of all surgeries (approximately 30 percent) completed within VA to identify surgical infections, and nationally, approximately 1.5 percent of VASQIP assessed surgeries result in infections within 30 days of the procedure. Examining all surgeries could significantly increase our demand for resources without generating an appreciable improvement in quality.

We are concerned about the intended result of the summaries of surgical infections, which could implicate patient privacy information. We would appreciate the opportunity to discuss this further with the Committee to resolve these concerns while ensuring the Committee has the information it needs to perform its oversight functions.

We currently collect information on cancelled surgeries (including both the number and the reasons for such cancellations) and can provide this information as needed, both locally and nationally. It would be more difficult to gather information on transferred surgeries, as our systems do not collect this information now. We note that section 2(a)(2)(C) directs VA to provide information on the number of additional days each such patient had to wait for surgery because of cancellation or transfer, but we caution that there are a number of reasons for cancellations and transfers, some of which are patient-driven and others that may be clinically necessary, and that this information would therefore not necessarily be helpful. Some surgeries may be cancelled and never performed, either because they were elective or because of intervening circumstances. We would also like to discuss this provision further with the Committee to see if currently available information may satisfy the objective of this provision.

VA estimates the cost of the legislation would be $18 million in fiscal year (FY) 2018, $97 million over five years, and $209 million over 10 years.

H.R 1063 Veteran Prescription Continuity Act

H.R. 1063 would amend Section 715 of the National Defense Authorization Act for Fiscal Year 2016 (Public Law 114–92) by adding a new subsection (c). The Secretary would be required to provide any pharmaceutical agent not included in the joint uniform formulary for VA and the Department of Defense (DoD) to an individual who is transitioning from receiving treatment from DoD to receiving treatment from VA, if a DoD health care provider determines that such pharmaceutical agent is critical for such a transition. VA would be required to furnish these pharmaceutical agents beginning on the date on which the individual enrolls in the VA health care system and ending on the date on which a VA provider determines the agent is no longer required by the individual.

We do not support this bill. When filling prescriptions, the Veteran's medical necessity drives the utilization of medications, not the formulary status of a medication. Fundamentally, we are concerned that the legislation would usurp a prescriber's professional responsibility to ensure a medication, whether a controlled substance or not, started by another provider continues to be safe and effective.

We have a long-standing practice of continuing medications that are clinically needed for transitioning Servicemembers, and we have strengthened this further with a policy articulating this requirement in 2015 (VHA Directive 2014–02, issued January 20, 2015). Further, as required by Congress, VA and DoD have developed a process for annually reviewing the Continuity of Care Drug List, and we recently completed this review earlier this summer. VA's Center for Medication Safety has collaborated with DoD and performed two studies that have validated that our policies are working and that transitioning Servicemembers and new Veterans are receiving the medications they clinically need. The VA Center for Medication Safety is assessing the financial impact of the Continuity of Care Drug List, as required by Congress.

DoD has no requirements in law to address the opioid crisis currently affecting the country. While section 715 required a joint formulary, there is no requirement for VA and DoD to adhere to the same protections and metrics for opioid prescriptions. We recommend that if Congress is interested in legislating in this area, this is an area that could produce significant improvements in the safety and well-being of Veterans and Servicemembers alike. We would be happy to work with the Committee on this initiative. We also recommend that Congress enact legislation requiring DoD to notify VA immediately for any patients on high-risk medications who are transitioning out of military service. There currently is no mechanism for sharing this information, which introduces the potential for gaps in clinical care and patient safety.

The bill is intended to ensure that patients maintain continuity of their prescription medications as they transition from DoD to VA, but as written, this legislation could obligate providers and pharmacists to furnish medications in ways that could violate other provisions of law or professional responsibility. For example, if a Servicemember received a prescription for a controlled substance, and such a prescription requires either routine monitoring or additional screening, a VA pharmacist or provider could be forced to decide which law to comply with and which to violate. As another example, if a Servicemember received a prescription for a controlled substance, then sought additional prescriptions for the same substance from several private providers, a VA pharmacist would know this by checking the Prescription Drug Monitoring Program; ordinarily, VA pharmacists would not fill that prescription, but this bill could require them to do so. VA providers and pharmacists are trained to review prescriptions carefully to ensure that patient safety is the top

priority, and we are concerned that this legislation, while well-intended, could impede that objective.

We note as a technical manner that, as written, proposed section 715(c)(2)(B) would require a VA health care provider to determine that the Veteran does not require a pharmaceutical agent. This would preclude a non-Department provider authorized to furnish care and services to Veterans from making this determination. Given the continuing discussion regarding the future of Care in the Community, we note this language may affect some Veterans differently based upon who furnishes their care.

We are unable to provide a cost estimate for this bill given the uncertainty regarding how many transitioning Servicemembers would be affected, which medications VA would have to provide, how much those medications would cost, and how long it would take for VA to make a clinical determination regarding the continued need for that medication.

H.R. 1066 VA Management Alignment Act of 2017

H.R. 1066 would require, within 180 days of enactment of this Act, the Secretary to report to Congress on the roles, responsibility, and accountability of elements and individuals within VA. In creating the report, the Secretary would be required to utilize the results of the Independent Assessment of the Health Care Delivery Systems and Management Process established by section 201 of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113–146), any study or report by the Commission on Care established by section 202 of Public Law 113–146, and other studies or reports. The Secretary's report to Congress would also have to specify clearly delineated roles and responsibilities to optimize the organizational effectiveness and accountability of each administration, staff office, or staff organization, their subordinate organizations, and key leaders of the Department.

VA supports the intent of this bill. The Secretary has made improving accountability within VA, including ensuring that the Department is well-organized and well-functioning, one of his highest priorities, and our current efforts are achieving the intended results of this legislation. We are not waiting for legislation to improve VA's organizational structure and internal management-we are taking aggressive steps now to ensure that VA is responsive to Veterans' needs while being a good steward of taxpayer dollars.

We do not expect this legislation would result in any appreciable costs.

H.R 1943 Restoring Maximum Mobility to Our Nation's Veterans Act of 2017

H.R. 1943 would amend 38 U.S.C. § 1701 by adding a new paragraph (11) defining the term "wheelchair". This term would include enhanced power wheelchairs, multi-environmental wheelchairs, track wheelchairs, stair-climbing wheelchairs, and other power-driven mobility devices. It would also add a new subparagraph (2) to 38 U.S.C. § 1712(c) to require the Secretary to ensure that each wheelchair provided under this title to a Veteran because of a service-connected disability restores the maximum achievable mobility and function in the activities of daily life, employment, and recreation for the Veteran. The Secretary would be authorized to furnish a wheelchair in order to restore an ability that relates exclusively to participation in a recreational activity.

We generally support the proposed changes to section 1701, but have concerns with a few of the types of wheelchairs identified. For example, track wheelchairs and stair-climbing wheelchairs are not currently cleared by the Food and Drug Administration (FDA) for use, and as a result, we do not believe it is appropriate to prescribe or furnish such equipment to Veterans. We currently furnish FDA-cleared wheelchairs, and in the event that other wheelchairs are cleared by FDA in the future, we would be able to furnish such wheelchairs at that time. Similarly, we are concerned about the breadth of the term "other power-driven mobility devices", which could include any number of items that have no valid medical necessity.

Regarding the proposed changes to section 1712, we note that the language would limit eligibility to Veterans who are furnished a wheelchair because of a service-connected disability. VA currently provides wheelchairs to Veterans, regardless of their service-connected status, as long as they are enrolled in VA health care and the wheelchair is determined to be medically necessary. We do not distinguish between Veterans with service-connected disabilities and those without when making determinations regarding which prosthetic devices the Veteran needs; we only consider their medical necessity. In this context, we do not believe these amendments are needed because we already furnish these services. We recommend that the language requiring the Secretary to ensure that each wheelchair restores the maximum achievable mobility and function in the activities of "employment" and "recreation" be removed, as this could potentially create an open-ended obligation. We believe

it is sufficient for a Veteran's clinical needs that the wheelchair restore the maximum achievable mobility and function in the activities of daily life.

We note there is some ambiguity in terms of the intent and effect of the second sentence in proposed 1712(c)(2), and we would appreciate the opportunity to discuss this further with the Committee to provide any technical assistance that may be required.

Because the intended scope of the certain provisions of the bill is unclear, we cannot estimate the cost of this legislation to the Department but note that it could have significant resource implications.

H.R 1972 VA Billing Accountability Act

H.R. 1972 would amend sections 1710(f)(3) and 1722A, and add a new section 1709C to title 38, U.S.C., that would require VA to notify Veterans of their copayment requirements no later than 120 days after the date of care or services provided at VA medical facilities, and no later than 18 months after the date of care or services provided at non-VA facilities. If VA does not provide such notice, VA could not collect the copayment, including through a third-party entity, unless VA provided the Veteran: (1) information on applying for a waiver and establishing a payment plan, and (2) an opportunity to make a waiver or establish a payment plan. The Secretary would be authorized to waive the copayment requirement in cases where notification to the Veteran was delayed because of an error committed by VA, a VA employee, or a non-VA facility (if applicable), and the Veteran received notification beyond the specified timeframes. H.R. 1972 would also require VA, no later than 180 days after enactment, to review and improve its copayment billing internal controls and notification procedures, including pursuant to the provisions of the bill.

VA supports the intent of H.R. 1972 to prevent delays in the release of copayment charges due to operational error, avoid undue burden to Veterans, and improve VA's copayment billing procedures. However, we are concerned that the 120-day time period proposed in the bill could adversely affect some Veterans. Further, it is not clear what specific copayment billing issues the bill would address.

We note that copayments are automatically generated by VA's integrated billing system. Moreover, VA ensures that every Veteran is given the notice of rights and the opportunity to request a waiver or compromise, and to establish a repayment plan for copayment charges. This information is included with every copayment billing statement that VA sends to a Veteran. As a service to Veterans, VA holds copayment bills until a Veteran's other health insurance (OHI) is billed and either pays or denies the claim. This allows VA potentially to offset the Veteran's copayment charges with payment received from the OHI, reducing the Veteran's liability. When a Veteran has OHI, the copayment charge is placed on hold for 90 days while the OHI is billed. If no payment is received within 90 days, the charges will automatically be released and a statement generated to the Veteran. If a balance remains after an OHI payment is applied to the copayment debt, the bill for the remaining balance is released to the Veteran and he or she receives it within a variable timeframe that ranges from 70 to 150 days depending on when the OHI payment is made - a timeframe that can exceed the proposed 120-day standard in H.R. 1972. Requiring all copayment bills to be issued within 120 days could adversely affect some Veterans whose OHI payments are delayed, as they would be notified of a copayment and billed when they would ordinarily not incur any personal liability. We note that less than 10 percent of copayment bills currently are submitted more than 120 days from the date of service, but in these cases, requiring copayment bills be issued could produce confusion among Veterans, result in greater out-of-pocket costs for these Veterans, and increase VA's administrative burden in implementing this change. VA financial policy for medical care debts specifies that Veterans who do not have OHI should have the opportunity to satisfy copayment obligations at the Agent Cashier's office prior to leaving the medical facility. Otherwise, the record of service is prepared and the copayment is released for billing on the Veteran's next scheduled monthly billing statement, which is normally received anywhere from 14 to 42 days after the date of service. The timeliness of OHI payments to VA is one of the biggest factors affecting the timeliness of copayment bills issued by VA to Veterans.

Copayment bills may also be generated following income verification under 38 U.S.C. § 5317, which authorizes VA to validate certain Veterans' reported income with the Internal Revenue Service (IRS) and Social Security Administration information. This validation begins 18 months after the calendar year in which that income is reported due to receipt of data, upon completion of tax processing, from the IRS. If VA identifies unreported income, VA has authority to generate copayment billings as a result of this verification process. VA also refunds copayments, when appropriate, as a result of this income verification process. The timeframe associ-

ated with this process exceeds the 120-day standard proposed in H.R. 1972. We also note that private sector billing industry standards allow for billing up to 12 to 18 months after services are rendered - also exceeding the proposed 120-day timeframe.

H.R. 1972 does not specify what constitutes an error, what would justify a waiver, and whether the waivers and payment plans authorized under the bill would differ from those currently authorized in applicable statutes and regulations. VA has existing procedures under 38 U.S.C. § 5302 to waive collection in cases where the Secretary determines that recovery would be against equity and good conscience. In these instances, an application for relief must generally be made 180 days from the date of notification of the indebtedness.

We note that VA copayment requirements under 38 U.S.C. § 1710(f)-(g), 38 U.S.C. § 1722A, and 38 U.S.C. § 1710B (which is not referenced in H.R. 1972, but requires copayments of certain Veterans for extended care services) apply regardless of whether the care or services was provided in a VA facility or authorized by VA in a non-VA facility. Therefore, the 120-day timeframe that would be added in section 1710(f)(3)(G)(ii) and section 1722A(c)(2) by the bill may be read as applying to care or services in both VA and non-VA facilities.

We note that the Department is close to submitting its plan for the future of community care, the Veteran Coordinated Access & Rewarding Experiences (CARE) Act, which will include proposed amendments to its practices concerning the recovery or collection of reasonable charges from other parties for certain care and services. We recommend the Subcommittee forbear further consideration of HR 1972 until VA has submitted the Veteran CARE Act and the Subcommittee can consider how this bill would be affected by the Department's proposal.

If copayment billings delayed beyond 120 days from date of service are waived, VA estimates a 5-year revenue loss of $282 million and a 10-year revenue loss of $562.8 million from the First Party Inpatient/Outpatient and Pharmacy Medical Care Collection Fund.

H.R 2147 Veterans Treatment Court Improvement Act of 2017

H.R. 2147 would require VA to hire additional Veterans Justice Outreach (VJO) Specialists to provide treatment court services to justice-involved Veterans. Specifically, H.R. 2147 would require that VA hire not less than 50 VJO Specialists and place each such VJO Specialist at an eligible VA medical center (VAMC). The bill would require that the total number of VJO Specialists employed by the Department not be less than the sum of (a) the VJO Specialists employed on the day before the enactment of this provision; and (b) the number of VJO Specialists to be hired under this bill. The bill would require that the Secretary prioritize placement of the VJO Specialists at facilities that will create an affiliation with a Veterans treatment court that is established on or after the date of enactment of the bill, or one that was established prior to enactment but is not fully staffed with VJO Specialists. The bill would require the Secretary to submit a report to Congress on the progress and effects of implementing these provisions within one year, with new reports submitted annually after that. The bill would also require the Comptroller General to submit to Congress a report on the implementation of this authority and the effectiveness of the VJO Program. The bill would authorize to be appropriated $5.5 million for each of fiscal years 2017 through 2027, and would require the Secretary to submit to Congress a report that identifies such legislative or administrative actions that would result in reduction in expenditures by the Department that are equal to or greater than the amounts authorized to be appropriated.

VA supports the intent of this bill and is already working to hire more than the 50 additional VJO Specialists within the next year. However, the bill could ultimately result in a reduction of $5.5 million in funding to other programs (including possibly programs for homeless Veterans). Because of this potential reduction in funding, VA does not support the legislation as drafted. Demand for VJO Specialists has grown considerably over the past several years, partly as a result of the adoption of the Veterans Treatment Court model in new jurisdictions. Limited VJO staff resources have affected VA's ability to partner effectively with Veterans Treatment Courts, especially those newly established.

We note that provisions of section 2(e) of the bill concerning the authorization of appropriations may not accomplish the intended objective. We understand this provision is intended to ensure that the Secretary identifies offsets to fund the program required by this bill. However, this provision would violate the Recommendations Clause, U.S. Const. art. II, § 3, by requiring the Secretary to recommend legislative actions regardless of whether the Secretary judges such legislation "necessary and expedient." To comply with the Constitution, such recommendations should be discretionary rather than mandatory. Moreover, the bill only requires the Secretary to report to Congress on legislative or administrative actions that would result in a

reduction of expenditures equal to or greater than $5.5 million. To the extent that the Secretary identifies legislative actions that would result in a reduction of expenditures, there is no guarantee that Congress would take such actions. We further note that the offsets would likely affect adversely VA's ability to implement and run other programs, which could result in delays in the provision of benefits, healthcare, and other critical services to Veterans and other beneficiaries. Ultimately, we do not believe this is an appropriate mechanism for funding the program required by this section.

We also note that the definition of "local criminal justice system" in section 2(f)(3) of the bill would not include Federal courts. We understand there are some Federal district courts that have Veterans treatment courts, and these would not be supported under this bill.

While we estimate the hiring of 50 additional VJO Specialists would cost $5.5 million in FY 2018, because the bill would require VA to identify offsets, we believe the ultimate cost would be $0 in FY 2018 and over both 5 and 10 years, if these offsets, some of which may require legislation, can be implemented. We again caution that the costs for implementation would involve reductions to other VA programs.

H.R 2225 Veterans Dog Training Therapy Act

H.R. 2225 would require the Secretary, within 120 days of enactment, to commence a 5-year pilot program under which the Secretary enters into a contract with one or more non-government entities for the purpose of assessing the effectiveness of addressing post-deployment mental health and post-traumatic stress disorder (PTSD) symptoms through a therapeutic medium of training service dogs for Veterans with disabilities. The bill would require the Secretary to enter into contracts with non-government entities located in close proximity to a minimum of three and not more than five VA medical centers. The bill requires that the non-government entities be certified in the training and handling of service dogs and have a training area that meets certain enumerated specifications.

The bill would require each pilot program site to employ at least one person with clinical experience related to mental health, and to have certified service dog training instructors with preference given to Veterans who have graduated from a residential treatment program and are adequately certified in service dog training. In addition, the bill would require VA to collect data to determine how effectively the program assists Veterans in various areas such as reducing stigma associated with PTSD, improving emotional regulation, and improving patience. Not later than one year after the date of commencement of the pilot program and annually thereafter, VA would be required to submit to Congress a report regarding the number of participating Veterans, a description of the services carried out by the pilot program, the effects of pilot program participation in various areas relating to the participating Veterans' health and well-being, and recommendations with respect to extension or expansion of the pilot program.

VA supports the identification of effective treatment modalities to address PTSD and other post-deployment mental health symptoms; however, VA does not support the specific provisions in H.R. 2225 because VA has significant concerns about the proposed legislation. Although anecdotal evidence has been offered to show the benefits of participating in such a dog training therapy program, there is no published scientific evidence to date that shows that such a program benefits PTSD patients specifically or that such a resource-intensive program is any better than other therapies known to be effective in alleviating PTSD symptoms. By propagating a yet unproven therapy, the bill may result in unintended and negative consequences for the Veterans who would be participating in this unsubstantiated treatment regime. Also, the pilot program would be duplicative of a DoD study of this same therapy program at the Uniformed Services University of Health Sciences. In addition, the service dog training therapy program currently in place at the Palo Alto VAMC is organized as part of an integrated set of services provided for their in-patient Trauma Recovery Program and is not offered as a stand-alone program or as an outpatient service. VA has no prior experience in offering or managing such a program as an outpatient program.

We note the bill would require this program be carried out through the Center for Compassionate Innovation of the Veterans Health Administration (VHA) of the Department of Veterans Affairs. We recommend against including such specific language identifying a particular organization as the lead for implementation, particularly given the nature of this work and the involvement of multiple offices within VHA.

The bill would require that each contract entered into under subsection (a) shall provide that the nongovernmental entity shall employ at least one person with clin-

ical experience related to mental health. It is unclear what role this person is intended to fill.

The bill would also make a number of restrictive stipulations regarding the structure and operation of the pilot program. For instance, contractor service dog trainers would be required to be certified, but there is currently no national certification program for service dog trainers. The bill would require the contractor to preferentially hire Veterans who have graduated from a PTSD or other residential treatment program and received "adequate certification in service dog training." However, programs at the Palo Alto VAMC and DoD sites do not provide adequate training to qualify a Veteran as a dog trainer, and they focus on basic commands rather than the advance tasks required by service dogs. The legislation would also require establishing a VA director of therapeutic service dog training who is experienced in teaching others to train service dogs in a vocational setting, has a background in social services, and has at least one year of experience working with Veterans or active duty military members with PTSD in a clinical setting. These criteria would severely reduce the number of eligible candidates.

VA also notes that, if any service dogs successfully trained through the program for Veterans with disabilities are to be eligible to participate in VA's service dog medical benefit program, the non-government entities chosen would have to be accredited by Assistance Dog International. Thus, the number of potential non-government entity partners who could produce dogs eligible for VA's service dog medical benefit program would be relatively limited.

VA estimates this bill would cost $3 million in FY 2018 and $14 million over five years.

H.R 2327 PAWS Act of 2017

H.R. 2327 would require the Secretary to carry out a pilot program under which the Secretary provides a $25,000 grant to an eligible organization for each Veteran referred to that organization for a service dog pairing. Grantees would be required to provide for each participating Veteran and service dog coverage of a commercially available veterinary health insurance policy; hardware, or repairs or replacements for hardware, that are clinically determined to be required by the dog to perform the tasks necessary to assist the Veteran with the diagnosed disorder of the Veteran; and payments for travel expenses for the Veteran to obtain the dog. If the Veteran is required to replace a service dog provided pursuant to a grant, the Secretary would be required to pay the travel expenses for the Veteran to obtain a new service dog, regardless of any other benefits the Veteran is receiving for the first service dog.

To be eligible to receive a grant, an applicant would have to be a nonprofit organization certified by Assistance Dogs International (ADI), provide one-on-one training for each service dog and recipient for 30 hours or more over 90 days or more, provide wellness verifications from licensed veterinarians, ensure all service dogs pass the American Kennel Club Community Canine test and the ADI Public Access test prior to permanent placement, while also meeting other requirements. VA would review and approve Veterans to participate in this program based upon their application, and VA would have 90 days to make an approval determination. Veterans would have to: be enrolled in the VA health care system; have been treated and have completed an established evidence-based treatment for PTSD; receive the recommendation of a VA provider or team that the Veteran may potentially benefit from a service dog; and agree to successfully complete training provided by an eligible organization. Veterans would have to see their provider at least every six months to determine, based on a clinical evaluation of efficacy, whether they continue to benefit from a service dog. Any improvement in symptoms as a result of participation in the pilot program could not affect the eligibility of the Veteran for any other benefit under the laws administered by the Secretary.

The Secretary would be required to develop metrics and other appropriate measurements to determine the efficacy of the program. Within one year of enactment, the Comptroller General would be required to brief Congress on the methodology established for the pilot program. Ten million dollars ($10,000,000) would be authorized to be appropriated for the period of FY 2018 through FY 2023 to carry out the pilot program, and the amounts otherwise authorized to be appropriated for VA's Office of Human Resources and Administration would be reduced by the same amount over the same time period. The pilot program would terminate on the date that is 5 years after the date of the enactment of this Act, and any eligible Veteran in possession of a service dog furnished under the pilot program as of the termination of the pilot program may keep the service dog after the termination of the program for the life of the dog.

As we previously stated, VA supports the identification of effective treatment modalities to address PTSD and other post-deployment mental health symptoms; however, we do not support the specific provisions in H.R. 2327 because VA has significant concerns about the proposed legislation. Again, there is no published scientific evidence to date that shows that such a program benefits PTSD patients specifically, or that such a resource-intensive program is any better than other therapies known to be effective in alleviating PTSD symptoms. By propagating a yet unproven therapy, the bill may result in unintended and negative consequences for the Veterans who would be participating in this unsubstantiated treatment regime. Also, the pilot program would be duplicative of an existing VA research study on the effectiveness of service dogs and emotional support dogs for Veterans with PTSD.

We have several other concerns with this legislation. We note that the bill refers in certain places to "severe" PTSD, but there are no established diagnostic criteria to distinguish levels of severity of PTSD.

In section 2 of the bill, Congressional findings are presented concerning Veteran suicide, mental health disorders, and substance use disorders. However, we note that there is no evidence to support that the presence or possession of a service dog would result in the reduction of any of these conditions or events. VA strongly agrees with the need to focus on reducing Veteran suicide and in treating Veteran's mental health conditions, but we do not believe the proposed bill would be the best use of resources to that end. VA is aggressively pursuing efforts to end Veteran suicide, but we cannot rely on the assumption that service dogs will ensure the well-being of Veterans.

Under section 3(a) of the bill, grantees would receive $25,000 for each Veteran referred to that organization for a service dog pairing. We note that it is possible some organizations may be able to furnish these services for less than $25,000. We recommend the language be revised to state that grants may not exceed $25,000 to ensure that Federal resources are not wasted. We would appreciate the opportunity to conduct a cost analysis to ensure that we are the best stewards of taxpayer dollars and that we maximize the potential use of our resources.

Section 3(c)(1)(A)(ii) of the bill would require an organization to provide, on average, one-on-one training for each service dog and recipient for 30 hours or more over 90 days or more. If this refers only to the pairing, this may be an appropriate amount of time, but if this is intended to cover all of the training of the dog, this would be inadequate.

The 90-day approval period for VA to determine a Veteran's eligibility under section 3(d)(1) could present challenges in implementation given the number of consultations or clinical visits that may be required for some Veterans.

We are concerned about section 3(d)(2)(A), which could provide an incentive for failing treatment and could interfere with other forms or guidelines for evidence-based mental health treatment. Regarding section 3(d)(2)(B), there is no clinical basis in existence for providers to make a determination about whether a Veteran may benefit from a service dog. This could make implementation more difficult and result in variation across the system. We have similar concerns about the requirement in section 3(d)(3) for the ongoing evaluation every 6 months to determine the clinical efficacy of whether the Veteran continues to benefit from a service dog, as there are no recognized means for making such determinations. In section 3(d)(4), the bill clarifies what happens if the Veteran is no longer able or willing to care for the service dog, but does not address what would happen if the service dog were no longer able to fulfill its function.

We strongly oppose section 3(i) of this bill, which would reduce the amounts authorized to be appropriated for VA's Office of Human Resources and Administration (HRA) by $10 million between FY 2018 and FY 2023. This reduction would have a devastating impact on our mission. HRA's budget funds missions that are statutorily driven. A reduction of this nature would have a cascading impact on all of the organizations in VA, including health care delivery. HRA's budget funds staff office rent for 10 buildings, security, U.S. mail, and other operational costs for VA's Central Office campus. These are non-negotiable fixed costs, and account for roughly half of the funds allocated to HRA as part of the General Administration appropriation. The remaining funds are allocated to payroll. Most of the services HRA provides to VA are provided through Federal employees. VA has already conducted a comprehensive review of HRA's organizational functions to reduce or eliminate activities not required by law, and as a result, there are no further programs that could be stopped based on a further reduction in funds.

Under section 3(j), the authority to operate the program would end 5 years from the date of enactment. This length of time would further limit the efficacy of this program. VA would be required to publish regulations for this program (see 38 U.S.C. § 501(d)), and in addition, it takes on average approximately 18–24 months

to train a service dog. This would result in very little time in which Veterans could receive service dogs and would likely not produce very many service dogs that could be provided to Veterans.

We estimate the bill would cost $2 million in FY 2018 and $14 million over 5 years, but note that certain provisions in this legislation could result in continuing costs beyond that time period.

Mr. Chairman, this concludes my prepared statement. My colleagues and I would be pleased to answer any questions you or other members of the Subcommittee may have.

Prepared Statement of Rick Weidman

Good morning, Chairman Wenstrup and other distinguished members of the subcommittee. Vietnam Veterans of America (VVA) is pleased to have the opportunity to appear here today to share our views concerning pending legislation before this subcommittee.

H.R.501 - VA Transparency Enhancement Act of 2017, introduced by Congresswoman Debbie Dingell, (D–MI–12). This bill requires increased reporting regarding certain surgeries scheduled at medical facilities of the Department of Veterans Affairs.

We have no objections to this bill.

H.R.93 - Introduced by Congresswoman Julia Brownley, (D–CA–26), would provide for increased access to VA medical care for women veterans.

VVA has always championed quality health care for women veterans. We continue our advocacy to secure appropriate facilities and resources for the diagnosis, care, and treatment of women veterans throughout the health care system. While the Department has made many improvements and advancements over the past several years, some concerns remain. Specifically, every woman veteran should have access to a VA primary care provider who meets all her primary care needs, including gender-specific care.

We support Ms. Brownley's bill as it addresses the need for such gender-specific services at every VA Medical Center and Community-Based Outpatient Clinic.

H.R.1063 - Veteran Prescription Continuity Act, introduced by Congressman Beto O'Rourke (D–TX–16). This bill would ensure that an individual who is transitioning from receiving medical treatment furnished by the Department of Defense to medical treatment at a VA facility receives a "seamless transition" of the pharmaceutical agents provided by DoD yet may not be on the VA drug formulary.

The transition process is not necessarily as robust as it should be. While VA and the DoD have collaborated for many years to improve the transitioning process, gaps still remain, and too many veterans still fall through the bureaucratic cracks. Oftentimes we hear of veterans who have transitioned from the military health care system to the VA health care system, not receiving the same medications, a situation very much the case with mental health drugs. We believe that every measure should be taken to ensure veterans have a safe, transparent, and hassle-free transition.

VVA supports enactment of this bill.

H.R.1066 - VA Management Alignment Act of 2017, introduced by Congressman Derek Kilmer (D–WA–6), which would direct the Secretary of Veterans Affairs to submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report regarding the organizational structure of the Department of Veterans Affairs.

VA's organizational structure seems to undergo changes whenever there is a change in leadership. This often leads to unnecessary confusion, as well as questions as to who has responsibility and accountability for a given task or program. Numerous studies and reports on what an effective organizational structure might look like have been developed, yet they wind up languishing on the shelf and forgotten. Mr. Kilmer's bill directs the VA to utilize the results of several recent reports to accomplish a restructuring and management realignment. We believe this process should be as transparent as possible.

VVA supports this bill.

H.R.1943 - Restoring Maximum Mobility to Our Nation's Veterans Act of 2017, introduced by Congressman Steve King, (R–IA–4), would require the Secretary of Veterans Affairs to ensure that each wheelchair furnished to a veteran because of a service-connected disability restores the maximum achievable mobility in the activities of daily life, employment, and recreation.

Restoring independence and mobility to a severely injured person speeds his/her recovery mentally as well as physically. The Department has many professional occupational and recreational therapists who assist veterans every day to bring them closer to achieving those goals. In fact, the Department has an adaptive sports program that is very popular with the veteran community. In 2017 there were six events for veterans to participate in. Similarly, DoD hosts the Wounded Warrior Games, and veterans can participate in the Invictus Games and Paralympics.

This bill would authorize the Secretary to furnish a wheelchair to a veteran because the wheelchair restores an ability that relates exclusively to participation in a recreational activity.

VVA supports this bill.

H.R.1972 - VA Billing Accountability Act, introduced by Congressman Lloyd Smucker (R–PA–16), would authorize the VA Secretary to waive the requirement that certain veterans make copayments for hospital care and medical services in the case of an error by the Department.

The VA has a history of billing problems. Veterans should not be held responsible for making a payment due to the fault of the Department. VVA supports the opportunity for veterans to apply for a waiver or establish a payment plan for the purposes of paying copayments as laid out in the legislation.

VVA has no objection to this bill.

H.R. 2147 - Veterans Treatment Court Improvement Act of 2017, introduced by Congressman Mike Coffman (R–CO–6), would require the Secretary of Veterans Affairs to hire 50 additional Veterans Justice Outreach specialists to assist justice-involved veterans.

Today there are more than 360 Veterans Treatment Courts in jurisdictions across the country, with scores more in various stages of planning and implementation. The role of VJOs is critical to the effective functioning of these courts. So, too, are VJOs key in assisting veterans incarcerated in jails as well as prisons, arranging for services and health care upon their release from confinement, providing invaluable aid in helping eligible veterans find housing and employment.

While it is a chronic complaint among many in government that they are overworked, the reality is that the VA's VJOs are spread really thin, considering all the treatment courts and correctional facilities where their services are vitally needed. Considering that Mr. Coffman's bill would appropriate $5,500,000 to hire additional VJOs not only for FY'17 but for the next nine federal fiscal years as well, enactment of this bill is certainly a step in the proverbial right direction. It is also in essence companion legislation to Senator Jeff Flake's S. 946.

VVA applauds Congressman Coffman for introducing this legislation.

H.R. 2225 - Veterans Dog Training Therapy Act, introduced by Congressman Steve Stivers (R–OH–15), would direct the Secretary of Veterans Affairs to carry out a pilot program on dog training therapy.

VVA has always recognized the importance of guide dogs trained to assist visually impaired veterans and service dogs trained to assist hearing impaired veterans or veterans with a spinal cord injury or dysfunction or other chronic impairment that substantially limits mobility.

Recognizing the expansion of alternative treatments for mental health issues, Congress gave VA the authority in 2009 to provide service dogs for the aid of veterans with mental illness. However, we would like to emphasize that instead of a pilot program, or in conjunction with the pilot program, what is really needed for dog therapy and other alternative treatments is evidence-based epidemiological research studies that would determine the efficacy of a certain treatment. Currently, research is scarce on these types of treatments and a well-designed study conducted by professionals could be used to inform treatment protocols that are validated through such research.

Still, VVA has no objection to the bill.

H.R. 2327 - PAWS Act of 2017, introduced by Congressman Ron DeSantis (R–FL–6th). This bill would direct the VA Secretary to make grants to eligible organizations to provide service dogs to veterans with severe PTSD.

While our comments regarding H.R. 2225 apply as well to this bill, we must object, however, to the offset in this bill that would take $10 million from the Office of Human Resources and Administration. It is widely known that VA's HR office is understaffed and in need of training. They can hardly afford to have that funding taken away from them. It has been our long-standing argument that you do not take funding from one program for veterans to fund another: you do not rob Peter to pay Paul. If Congress cannot provide for the funding for PAWS, VVA cannot support its enactment.

Draft bill: introduced by Congressman John Rutherford (R–FL–4), to make improvements in the VA's Health Professional Educational Assistance Program (HPEAP).

Section 2 of this bill would authorize the Secretary to award no less than 50 scholarships to individuals who are enrolled in a program to become a physician or dentist until the staffing shortage of physicians and dentists in the Department is less than 500. In return, the participant agrees to serve in the Veterans Health Administration as a full-time employee. It further extends HPEAP to December 31, 2033.

Section 3 establishes the Specialty Education Loan Repayment Program. In general, to be eligible an individual must have recently graduated from an accredited medical or osteopathic school and matched to a residency program in a certain medical specialty described in title 38, owe money, and be a physician in training. In return, the participant incurs an obligation to serve for a specified number of years as a full-time clinical practice employee of VHA. The Secretary may give preference to veteran applicants.

This legislation also authorizes the establishment of a pilot program in which the VA funds the medical education of 10 eligible veterans enrolled in the Teague-Cranston medical schools. The veterans must have been discharged under honorable conditions in order to be eligible for this program. In return, the veteran agrees to serve as a full-time clinical practice employee in the VHA for four years.

VVA is well aware of the shortages in clinical staff throughout the VA health system. This is a good first step in trying to alleviate that shortage. However, this will take some time to implement and offers no immediate succor for an increasingly serious staffing situation.

Also, we believe the VA would be well-served if they opened the doors of service to veterans with an administratively rendered OTH discharge. If a "veteran" is defined as one who is discharged under other than dishonorable conditions, then OTH vets should not be excluded from this program unless they were discharged for medical malpractice, crimes involving patients, or other reasons that call into question their integrity and hence, their ability to be the type of employee valued by the VA and the veterans it serves.

The VHA - and Congress - must come to grips with the underlying causes of the so-called access scandal that rocked the VA in 2014 (even though the practice that was called into question had been going on for decades): the serious shortage of qualified medical personnel willing and able to work for the VA, and making less money than they might otherwise earn in private practice. If a veteran with "bad paper" goes on to a career in medicine and is otherwise qualified, s/he should be granted the opportunity to participate in this program.

VVA thanks you for this opportunity to present our views here today. We will be pleased to respond to any questions you might care to put to us.

Statements For The Record

DAVID J. SHULKIN, M.D.

The Honorable Brad Wenstrup
Chairman
House Committee on Veterans' Affairs
Subcommittee on health
United State House of Representatives

Washington, DC 20510

Dear Mr. Chairman:

The agenda for the House Committee on Veterans' Affairs' Subcommittee on Health September 26, 2017, legislative hearing included the draft bill to make certain improvements in VA's Health Professionals Educational Assistance Act, for which the Department of Veterans Affairs (VA) was unable to provide views in our testimony. We are aware of the Committee's interest in receiving this information. The enclosure expresses VA's views on this legislative initiative.

We appreciate the opportunity to comment on this legislation and look forward to working with you and the other Committee Members on these important legislative issues.

Sincerely,

David J. Shulkin, M.D.

Enclosure

Draft Bill, to amend title 38, United States, Code, to make certain improvements in the Health Professional Educational Assistance Program of the Department of Veterans Affairs, and for other purposes

Section 2 of the draft bill, would require the VA to offer 50 scholarships to physicians and dentists in return for a service obligation to practice at a VA facility.

Section 3, would amend the Health Educational Assistance Programs to include the Specialty Education Loan Repayment Program (SLERP), an education loan repayment program to attract physicians who are eligible for board certification in medical specialties that are difficult for recruitment and retention for employment in the VA.

Section 4, would require the VA to offer 10 additional scholarships to Veterans attending a Teague Cranston Medical School in return for a service obligation to practice at a VA facility.

VA supports sections 2 and 4, subject to the availability of funds, as this is an excellent opportunity to recruit providers to fill critical vacancies throughout the VA. VA estimates the cost for sections 2 and 4 would be $45 million over five years and $98 million over ten years.

VA supports the intent of section 3, but would like to work with the Committee to further clarify the scope to enhance existing programs and develop new programs to meet the hiring needs of VA. As written, the language infers that only recent medical school graduates or those in their initial year of residency who will not have declared a subspecialty would be eligible, limiting VA's ability to attract more experienced providers who would be eligible sooner. Furthermore, the maximum award amount exceeds the maximum award amount authorized under the Education Debt Reduction Program (EDRP), 38 U.S.C. § 7683, which limits education debt reductions payments to$24,000/year, not to exceed $120,000). This creates disparity between physicians currently employed within the VA or those eligible for permanent appointment and recent medical school graduates or residents with less experience, giving those with fewer qualifications a larger reimbursement.

VA is unclear regarding the eligibility requirement of "[who are eligible to be board-certified]" and the requirement that program candidates be ".hired under section 7401." as individuals who have recently completed medical school or are in the first year of residency would not necessarily be a permanent VA employee.

Given the existing loan repayment authority for the EDRP, VA recommends an alternative approach, such as a stipend program, to attract medical residents and fellows with declared specialties (i.e., those in the final two years of residency or fellowship) to better meet the recruitment and retention needs of VA.

As written, VA is unable to estimate the costs of this section and would welcome the opportunity to discuss further. VA agrees with the intent of the draft legislation, however as written this will not fulfill the intent of the Committee. VA requests the opportunity to have a discussion with the Committee to develop a stipend or other program that will meet the intent of the legislation.

VA appreciates, through the proposed legislation, the opportunity to recruit providers to fill critical vacancies throughout the VA.

BLINDED VETERANS ASSOCIATION (BVA)

Introduction

Thank you, Chairman Wenstrup, Ranking Member Brownley and members of the Health Subcommittee, for the opportunity to participate in this hearing. The com-

ments that follow are submitted on behalf of the Blinded Veterans Association, (BVA) the only Congressionally chartered veteran service organization (VSO) exclusively dedicated to serving the needs of blinded veterans and their families. There are several significant pieces of legislation under consideration at this hearing, and we appreciate the opportunity to comment on them. Our comments will focus on three bills in particular: H.R.93; H.R.2225; and H.R.2327.

H.R. 93

Approximately 400 of BVA's current members are female veterans. Most of these veterans are enrolled in the VA healthcare system. Many of them have reported experiencing significant hardships due to the lack of gender-specific medical services at the clinic where they receive their healthcare. These veterans sometimes face insurmountable barriers due to the lack of transportation options that would enable them to get to an alternate facility where gender-specific treatment is available. We, therefore, applaud the introduction of H.R. 93 and would welcome the assistance it could bring to some of our female members.

H.R.2225

Many members and staff of the Blinded Veterans Association, including this writer, have experienced firsthand the benefits a well-trained dog can provide to a person with a disability. Those benefits can be life changing. Therefore, we welcome efforts that will give veterans with other disabilities opportunities to experience similar benefits. Although we believe the sponsors of H.R.2225 intended to design a program that could provide such opportunities to veterans who struggle with PTSD, we are concerned that the effectiveness of the pilot it seeks to establish could be undermined by numerous shortcomings in the program's design. There are a number of questions crucial to the effectiveness of this program that this legislation leaves unanswered. First, although the bill directs the Secretary to enter into contracts with entities "certified in the training and handling of service dogs," it does not specify what certification will be acceptable. We believe this is an important oversight that should be clarified. Working with quality training entities from the beginning will give this program a greater chance for success. Since other programs administered by the VA to support service dogs and their handlers require that the dogs be trained by entities with ADI or IGDF certification, we would be much more favorable to this legislation if it further specified that the entities participating in this program must be ADI certified. Alternatively, standards could be specified related to the training methodologies, facilities, and dog care practices expected of the contracting entities. This would give the VA some criteria by which to evaluate entities seeking to participate in the program, and determine whether they are likely to produce the desired results.

Another key aspect of this pilot that this bill fails to consider adequately involves the dogs. It seems to us that one of the criteria contractors should be evaluated on is their ability to provide dogs that are likely to be successfully trained to assist veterans appropriately. The formal training is only one factor in determining that success. How will the dogs be prepared for participation in this program? For that matter, this legislation does not even discuss provision of the dogs. Is it assumed that contractors will provide dogs ready and available for training?

With regard to the training itself, there is no mention of what tasks veterans will train dogs to do, or what tasks the dogs will be trained to perform, by participating veterans, as part of their therapy. This is a crucial omission, if the intended result is to have trained dogs that could be placed with other veterans as working service dogs. Activities that can provide veterans with high quality therapy may not necessarily also produce well-trained dogs that can be placed with other veterans and serve them as service dogs. We believe that all of these issues should be addressed in order to provide the VA with the greatest chance of designing a successful program. The training itself should be designed in a manner that minimizes obstacles and maximizes its chances of success. To do this, guidelines as to what the VA should look for in training entities should be provided. The VA is not currently involved in service dog training, so leaving such matters unspecified creates risk of unintended consequences, missteps by the VA and ultimately, design flaws that undermine the program's ability to achieve its goal of serving veterans. It also undermines the department's ability to assess the effectiveness of the program in mitigating the veterans' disabilities.

It is also unclear whether this legislation anticipates that the veterans who receive training will then be utilized as trainers by the contracting entity during the pilot, or whether it anticipates an additional phase of the program, established in the future, to give these veterans an opportunity to utilize their newly-acquired skill. Further there are no criteria here for the placement of dogs with other vet-

erans, and the nature and scope of follow-up services that will be provided to them in order to insure their long-term success after training.

The premise behind this bill, that giving veterans a practical means of helping other veterans could restore the mental health of the helpers, while assisting additional veterans, is laudable. However, we are concerned that the program, as currently designed, is fraught with myriad opportunities for things to go wrong that could undermine the program's chances for success. It will also be difficult for VA to assess the effectiveness of this program. We applaud the intent to get help to veterans as quickly as possible in order to try to avert crises that could otherwise occur, and we acknowledge the possibility that this help could come in the form of a partnership with an animal begun through a program such as this, we worry that the concern for creating those partnerships as soon as possible could undermine the success of those partnerships long-term. That being said, we would welcome an opportunity to work with the offices of Rep. Stivers and Rep. Walz, and other co-sponsors of this legislation, to address these issues. It is our hope that the concerns that we believe currently undermine the effectiveness of this bill can be remedied, so that a program that gives additional veterans access to the benefits of partnership with service dogs will follow.

H.R. 2327

There are many aspects of this bill that the Blinded Veterans Association both welcomes and supports. However, once again, we have several questions and serious concerns about the feasibility of the project, as set forth in this legislation.

First, the general concern we have is with the offset being proposed to fund this pilot. It is our understanding that VA's Office of Human Resources is currently under staffed. Additionally, Secretary Shulkin has been talking about department-wide efforts to ramp up recruitment of personnel to deal with shortages of medical personnel throughout the VA healthcare system, particularly within the mental health field, whose professionals provide much-needed services to the same veterans the authors of this bill are trying to help. We wonder what impact reductions in funding for the VA Office of Human Resources will have on that office's ability to provide administrative support to VA's recruitment efforts.

The design of the pilot program itself looks reasonable. It is our position that good training for both dogs and their users is essential to the success of their partnership. We are not certain how well developed the best practices are for training of dogs to assist people who have PTSD, but there are well established standards of dog behavior that should be included in any service dog training curriculum and we are pleased to see them included in the requirements for covered facilities here. The rush to get people paired with dogs as quickly as possible, in hopes of mitigating their disability's negative impact on quality of life is laudable and, we believe, generally well intentioned. But we hope this will not be done at the expense of careful and thorough training for both the dogs and their recipients. To compromise here could add significantly to, rather than relieve an individual's stress. It can and has also caused injuries to veterans, dogs, and members of the public who inadvertently get caught up in situations involving misbehaving, frightened or aggressive dogs.

Finally, we have some concerns about whether VA has the capacity to administer a program of dog training and placement, such as the one called for in this legislation. We worry that the process of determining whether a facility and/or a veteran, is eligible to participate in this program might be more involved than this legislation appears to anticipate. It could easily require more than making sure all the boxes are checked and all the right documents are attached to the applications. Does the VA have staff with the expertise to make these determinations beginning in 2018? Do the bill's authors envision that some of the monies appropriated for this program would be used to hire additional staff with the expertise to process these applications? To make certain facilities are what and who they claim to be? If someone falls short and doesn't follow through, will VA have the capability of tracking and trying to redress the situation?

I raise the questions above because VA is already having trouble communicating and consistently enforcing the policies they have in place with regard to service dog access. We have received numerous reports over the past couple of years of incidents involving apparently untrained, or poorly trained dogs on VA property who act aggressively toward VA employees, veterans who accidentally get too close to the dog, or the service dogs of veterans with disabilities. Several of our members have reported to us that they have been forced by repeated encounters with aggressive dogs at VA medical centers to leave their service dogs at home when they must go to those facilities for care. Unfortunately, many of these dogs are presented to VA personnel as service dogs who are needed by the person bringing them to the facility to mitigate PTSD. Frequently, front line personnel are not equipped to, or don't feel

that they can, make a judgment as to whether an animal's behavior is sufficiently inappropriate to deny access. Security and law enforcement personnel who are called in response to incidents of dog misbehavior commonly ignore it or claim there's nothing they can do. Nobody wants to be the "bad guy" and risk wrongfully denying access to a service dog, even though both the VA policy and the ADA regulations clearly give agency and business operators the authority to remove out-of-control or disruptive animals from their premises. We met with Dr. Alaigh and other VHA leaders last month to discuss this growing trend and ask the under-secretary to initiate a review of both the current department policies and the means by which those policies are communicated to VA personnel. We hope this will encourage the VA to take action to clarify the access rights of service animal users, regardless of disability, as well as the enforcement tools available to security personnel who have reason to believe that a dog is being fraudulently presented as a service animal or who encounter a dog that is not under the control of its handler and poses a danger to other people on the premises. This should include the standards of good public behavior that the law allows the VA to expect as well as the enforcement options that can be exercised when animals, or their handlers, do not comply with those standards.

In summary, while we appreciate the intent of this legislation, and we believe this program is a good one, we are not convinced that the VA has the capacity to carry out this program in the manner prescribed, or the funds to cover the cost of the program, within the time frame set forth in the bill.

Conclusion

Each piece of legislation discussed above seeks to address critical issues faced by a significant number of veterans today. We appreciate the efforts of the bills' sponsors to address these critical issues, and we appreciate the opportunity to discuss these issues with the members of the Health Subcommittee. We hope this is the beginning of continuing dialogue on this legislation, and will look forward to working with committee members and staff to further address these issues and help the VA find innovative ways to provide critical assistance to veterans who have PTSD and post-deployment mental health conditions.

DISABLED AMERICAN VETERANS (DAV)

SHURHONDA Y. LOVE

ASSISTANT NATIONAL LEGISLATIVE DIRECTOR

Mr. Chairman and Members of the Subcommittee:

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

H.R. 93, a bill to provide increased access to VA care for women veterans

This bill seeks to improve access to Department of Veterans Affairs (VA) medical care for women veterans by ensuring that gender-specific health care services are available at every medical center and community-based outpatient clinic of the Department. It provides that the Secretary, in consideration of women veterans' increased demand for services and the projected growth in the population, may employ personnel, or enter into such contracts as necessary to ensure comprehensive gender-specific care is available to women veterans in accordance with Veterans Health Administration (VHA) quality standards.

The number of women serving within the United States military continues to rapidly increase. Women now comprise 15.5 percent of active duty military, and 19.0 percent of the National Guard and Reserves. As more women serve within the military, the number of women seeking care from VHA will also grow. From 2005 to 2015, the number of women enrolled in VA health care increased by 83.9 percent, translating into more than 400,000 users of VHA care. With more than two million women represented within the total veteran population, and the women veterans' population projected to grow by 18,000 per year for the next 10 years, it is vitally

important that VA is prepared to meet their unique health care needs now and in the future.

Currently women veterans between the ages of 18 and 44 make up approximately 42 percent of women users of VHA. This age group represents a population of women within child bearing years that may require maternity care. Women require routine breast care and gynecological services throughout their lives; therefore, it is important that VA is prepared to care for these women now and as they age. Yet, in a recent Government Accounting Office report (GAO–17–52), VHA data from fiscal year (FY) 2014 and 2015 shows about 27 percent of VA medical centers and health care systems lacked an onsite gynecologist.

DAV understands that some facilities may not have enough women veterans seeking care to warrant a full time gynecologist onsite, but it must have policies and procedures in place to ensure women seeking care are able to receive the gender-specific services they need from a qualified health care provider either in VA or in the community.

In addition to ensuring women veterans have access to gender-specific care, like gynecology and other specialty services, women veterans must also have access to primary care physicians that have expertise in women's health. VHA Directive 1330.01, states that each VA medical facility must ensure eligible women veterans have access to high-quality, equitable, comprehensive medical care that includes but is not limited to primary care. However, GAO points out 18 percent of VA facilities are unable to provide women with a primary care provider who is specially trained in the care of women.

In cases where VA is unable to provide health care services to women veterans, the Veterans Choice Program is used to purchase care in the community. Based on data contained in the GAO report, women veterans utilize more non-VA outpatient care than men, which is consistent with the inability to obtain basic gender-specific care, forcing them out of VA to receive care in the community. However, whenever possible we want women veterans to have the opportunity to get their care in VA so they are afforded access to VA's specialized services for veterans such as treatment for post-traumatic stress disorder (PTSD), sexual trauma, and war-related injuries. Veterans using VA care are frequently asked if they need supportive services for homelessness or post-deployment mental health challenges such as substance use disorder (SUD) or suicidal ideation. We want to ensure women veterans also have access to this unique and specialized care whenever possible. If care must be obtained from community providers, there must be a plan to provide a seamless transition for that care.

DAV is pleased to support H.R. 93, which is consistent with DAV resolutions 128 and 225, adopted at our most recent National Convention. These resolutions call on VA to furnish quality primary health care and gender-specific services necessary to meet the needs of a growing population of women veterans, and to ensure that the provision of health care services and specialized programs are inclusive of gender-specific services. These services must be provided to the same degree and extent that services are provided to eligible male veterans.

H.R. 501, VA Transparency Enhancement Act of 2017

This measure would require increased reporting regarding certain surgeries scheduled at VA medical facilities.

We note VA is not exempt from reporting hospital-acquired infections in VA hospitals in its annual Facility Quality and Safety Report. The first of such reports containing details at the VA facility level was issued in 2008. Moreover, subsequent to this bill's introduction, VA made available to the public through its website those measures, analysis and comparison on those aspects of health care quality and patient safety this bill requires and many other quality of care measures applicable for all its VA facilities.

More specifically, the results of Healthcare Associated Infection measures and Surgical Complications based on Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators (PSIs) for VA facilities can be found here: http://www.accesstocare.va.gov/Healthcare/HospitalCompareData. As an example, information for Ann Arbor VA Medical Center is here: http://www.accesstocare.va.gov/Healthcare/HospitalData/506

While DAV has no resolution to support the particular approach proposed by this legislation, we urge the Subcommittee to consider focusing the resources and efforts that would otherwise be needed to meet these reporting requirements towards directly addressing veterans medical care needs as well as identifying and correcting known deficiencies at VA facilities.

H.R. 1063, Veteran Prescription Continuity Act

This measure would amend the FY 2016 National Defense Authorization Act (NDAA) to direct VA to furnish an individual, who is transitioning care settings from the Department of Defense (DoD) to VA, any pharmaceutical agent not included in the joint uniform formulary if a DoD health care provider determines that the pharmaceutical agent is critical for the transition.

We urge the Subcommittee to strengthen this bill with regards to section (c)(2)(B). Specifically, the proposed language does not recognize or provide for consideration of a holistic, patient-centered approach for changing or discontinuing medications.

DAV recognizes chronic and severe pain as one of the most prevalent reasons individuals, including wounded, injured and ill veterans, seek health care and that chronic pain is closely linked with depression and other mental health challenges, including suicidal ideation.

The delegates to our most recent National Convention adopted Resolution No. 116, which highlights the failure of some VA providers to adhere to Department's own Pain Management Opioid Safety Guide. This guide calls for certain resources such as "[i]ncreased options for monthly (or more) face to face and/or Telehealth visits, case management and a structured communication between primary care (or whoever is tapering the opioids) and mental health or SUD clinicians" be in place when a VA clinician decides to taper or discontinue opioids.

All too often we hear from veterans these supportive resources are not offered or provided to veteran patients when their pain medication is significantly reduced or abruptly discontinued. This paternalistic approach that harms severely ill and injured DAV members as well as the patient-provider relationship may be reinforced by section (c)(2)(B) of this bill or the lack of a provision requiring a patient-centered holistic approach.

For example, in VA's Pain Management Opioid Safety Guide, healthcare providers are cautioned when "[a] decision is [made] to taper opioids, the pace of opioid taper should be individualized with a risk benefit analysis."

Our resolution calls for, among other things, pain management that ensures severely disabled veterans with chronic pain who have used prescribed pain medications over long periods be managed in a patient-centered environment, with balanced regard for both patient safety and humane alternatives to the use and reduction of controlled substances, and while under VA care receive their prescribed medications in a timely fashion.

Mr. Chairman, DAV supports H.R. 1063 as it will be beneficial for veterans who have an effective, established medical regimen for treatment of psychiatric, pain or sleep issues and for transitioning service members whose medications are effective for them. We recommend the bill be amended to address medications such as benzodiazepines, stimulants and opioids that can be effective in the short-term, but detrimental if continued to be taken in the long-term. We believe VA providers should have the option of initiative tapers or changing these medications when appropriate but the bill should also propose a balanced decision-making process between the clinician and the patient when determining which pharmaceutical agent is deemed "critical for such transition" in a manner that mitigates harm at a vulnerable point in the patient's treatment-the space between care settings.

H.R. 1066, VA Management Alignment Act of 2017

This bill would require the VA to prepare and submit a report to the Senate and House Committees on Veterans' Affairs that details the roles, responsibilities and accountability requirements for key leaders and offices within the Department. In producing this report, VA would utilize the results of the Independent Assessment mandated by the Choice Act, the final report of the Commission on Care, and other relevant reports related to improving VA's organization and governance. The report should also include recommendations for any legislation VA considers necessary and appropriate to strengthen its organization, management and governance structure.

DAV does not have a resolution from our membership specific to this bill but recognizing that better organization and management of VA could improve the delivery of benefits and services to veterans, we have no objection to its enactment.

H.R. 1943, Restoring Maximum Mobility to Our Nation's Veterans Act of 2017

This bill seeks to expand the term "wheelchair" to include enhanced power wheelchairs, multi-environmental wheelchairs, track wheelchairs, and other power-driven mobility devices. It further seeks to ensure that a veteran prescribed a wheelchair under the provisions of this bill due to a service connected disability receive any

chair that restores the maximum achievable mobility and function in their activities of daily life, employment, and recreation.

VHA provides care to thousands of veterans who require wheelchairs due to disabilities, age or infirmity. For these veterans, wheelchairs are an extension of the body that restore functionality, enhance independence, and even allow them to engage in preferred recreational activities. VA research and clinical experience show that physical activity is important to maintaining good health, speeding recovery and improving overall quality of life. Wheelchairs, for persons with disabilities who have lost the ability to ambulate on their own, allow many veterans to freely participate and engage actively with their families and in their communities, and are critical to overall wellbeing.

Younger veterans, and veterans that are active in rehabilitative sports, or outdoor activities may require the use of more than one type of wheelchair to maintain or enhance their quality of life. These veterans should have every opportunity to receive the type of wheelchair appropriate for the activities in which they participate. Some veterans may require multiple chairs in order to navigate different terrain such as beaches or wooded areas, just as veterans with lower limb amputations may require different prosthetic devices to shower, swim or run. The preventive and therapeutic value of sports, fitness and recreation, are key factors in VA's extensive rehabilitation program. Participation in recreational activities is also beneficial to veterans helping many to overcome or mitigate the physical and emotional impact of severe disabilities.

H.R. 1943 is in line with DAV Resolution No. 178, which calls for VA to deliver high quality cutting-edge prosthetic items to help injured, ill and wounded veterans recover, regain mobility and achieve maximum independence, to the extent possible, in all areas of their life. While assuring veterans of the highest quality wheelchairs and prosthetics in accord with their individual needs, VA must also access and assure veterans' safety. We believe that all specialized devices should meet appropriate and similar standards and criteria for FDA-approved wheelchairs. There may be some instances in which a veteran requests a wheelchair that has not been FDA approved. The request for prescriptions for such wheelchairs should be determined on a case-by-case basis.

H.R. 1972, VA Billing Accountability Act

This measure would require VA waive a veteran's copay requirement if, due to an error by the Department, its copayment notification was received by the veteran after 120 days from the date the veteran received VA medications, hospital care, nursing home care, or medical services.

As the Subcommittee is aware, VA's antiquated systems supporting collections for first-party copayments and third-party reimbursements requires manual intervention making the process prone to human error. VA's Consolidated Patient Account Centers must rectify these mistakes and subsequently bill co-payments weeks to months after veterans receive care.

We support the intent of this legislation based on DAV Resolution No. 115, which calls for legislation to eliminate or reduce VA health care out-of-pocket costs for service-connected disabled veterans.

In addition, we urge the Subcommittee to further strengthen this important bill by including a provision to extend the waiver to VA-furnished extended care services under title 38, United States Code, Section 1710B.

H.R. 2147, Veterans Treatment Court Improvement Act of 2017

This measure requires the VA to hire additional Veterans Justice Outreach (VJO) specialists to ensure veterans have greater access to effective and tailored treatment. VA created the VJO program to engage justice-involved veterans in specialty treatment courts and provide timely access to VA's specialized services. The veterans' treatment court model removes veterans from the regular criminal justice process and helps to address conditions that are prevalent among veterans, including traumatic brain injury, PTSD, and SUDs. In a veterans' treatment court, the presiding judge works alongside the veteran and the VJO specialist to establish a structured rehabilitation program that is tailored to the specific needs of that veteran.

The bill would authorize $5.5 million for each fiscal year beginning in FY 2017 through 2027 to hire a minimum of 50 additional VJO Specialists. Funding priority would be given to VA facilities that work with newly established or existing but understaffed veterans' treatment courts. VA would be required to annually report on the implementation of the bill and its effect on the VJO program. The Government Accountability Office is also required to review and report on the implementa-

tion of the bill and the overall effectiveness of the VJO program for justice-involved veterans.

DAV supports H.R. 2147 based on DAV Resolution No. 105, calling for the continued growth of veterans' treatment courts. We recognize the importance of this unique program as years of experience from the veterans' courts now in existence nationwide has produced a statistically significant reduction of recidivism rates among veterans compared to persons in other treatment courts and individuals not involved in any sort of alternative or diversionary treatment options. We also recognize that veterans in general deeply value their military experiences and share a unique bond with their peers. In our opinion, veterans' treatment courts build upon this bond by enabling veterans to proceed through the treatment court process with people who are similarly situated and by pairing veterans with veteran mentors. We are pleased to inform you that DAV members across the country strongly support this program and many volunteer to serve as mentors.

We hope this measure receives favorable consideration, and ask the Subcommittee to further strengthen this bill. We join with other organizations who have voiced concern for section 2(e) of the bill that calls for the identification of offsets to fund the increase in VJOs. We believe that Congress should appropriate new funds rather than reallocate funds that may adversely affect other programs and/or benefits currently utilized by ill and injured veterans.

Further, the DAV has concerns with section 2(f)(3) of the bill that defines the "local criminal justice system" as law enforcement, jails, and state and local courts. This limits the scope of the bill and precludes Federal Courts such as the Judicial District Veterans Courts. These Federal court cases make up 2.2 percent of the overall veteran cases in our justice system. Therefore, we ask that the bill be amended to include Federal courts so that all justice-involved veterans can be served by the program.

Finally, we urge that a provision be added in section 2(d)(2)(B) of this bill, which currently directs the Government Accountability Office to submit to Congress a report on the implementation of this section and the effectiveness of the Veterans Justice Outreach Program. We suggest the report should include an evaluation of the sufficiency of VJO staffing levels in meeting current demand and the impact of existing staffing levels on the effectiveness of the program.

DAV thanks the bill sponsor for his strong advocacy on behalf of justice-involved veterans and we are committed to working with all interested parties to enact this important measure.

H.R. 2225, Veterans Dog Training Therapy Act

This bill would require the Secretary of Veterans Affairs to establish a five-year dog training therapy pilot program, with one or more non-governmental entities certified in the training and handling of service dogs. The pilot would assess the effectiveness of addressing post-deployment mental health and PTSD symptoms through the training of service dogs for veterans with disabilities.

The Center for Compassionate Innovation, in collaboration with Recreation Therapy Services of the Department, under the direction of a certified recreational therapist with sufficient administrative experience, would help oversee the program. It would also establish a new director of therapeutic service dog training.

The measure mandates the pilot program be located in close proximity to at least three but not more than five medical centers of the Department. The Secretary would provide, to the one or more non-government entities entering into contract, access to a training area in VA that is appropriate for educating veterans with mental health conditions, in-service dog training and handling through lecture and hands-on experience. Each contract awardee would be required to: employ at least one person with clinical experience related to mental health; ensure participating veterans receive training from certified service dog training instructors; include practical hands-on training and grooming of service dogs; and ensure that each service dog participating in the training pilot program is taught all essential commands for service dogs. In hiring dog trainers, awardees would give preference to veterans who have successfully completed PTSD treatment and who are certified in service dog training.

Pilot program participants could include veterans who are enrolled in VA's Compensated Work Therapy (CWT) program and the Secretary would be required to determine if veterans would be selected or volunteer for participation in the dog training pilot program.

Additionally, the Secretary would be required to collect data to determine the effectiveness of the program by assessing the reduction of stress associated with a veteran's PTSD, including the improvement of emotional regulation, and other stand-

ard measures. VA would also be required to submit a report to Congress not later than one year after the commencement of the pilot program, and each year thereafter, to include information about the number of veterans participating in the program; services provided in the program; and measures to demonstrate effectiveness of program in improving participants' PTSD symptomatology, family dynamics, pain management, and general wellbeing. In addition, the Secretary would be required to make a recommendation to Congress about extending or expanding the pilot program.

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 many veterans report that service animals have immensely improved their quality of life by promoting their recovery, helping them reestablish their independence and assisting them to better cope with stressful situations and facilitate reintegration into their communities. For these reasons, we have no objection to the passage of this bill.

However, VA's Cooperative Studies Program is currently overseeing comprehensive multi-site research on the benefits of service dogs, to determine the efficacy of the types of therapy in improving activity and quality of life for veterans with PTSD. We understand this research is due to be completed in April of 2020. While we would like to ensure the effectiveness of trained therapy dogs for veterans with mental health conditions before VA makes significant investments in training or acquiring and maintaining service dogs for veterans, DAV is supportive of innovative non-traditional therapies and expanded mental health treatment options for veterans in accordance with DAV Resolution Nos. 019, 128 and 245.

H.R. 2327, Puppies Assisting Wounded Servicemembers Act of 2017 (PAWS Act of 2017)

If enacted, this bill would create a five-year pilot program and pair eligible veterans suffering from the most severe levels of PTSD with service dogs. Participants would be required to be enrolled in the VHA and have a medical determination by a Department health care provider, indicating that the veteran may benefit from having a service dog. Participants must have completed a course of evidence-based treatment for PTSD, yet remain significantly symptomatic prior to entering the program. Once approved for participation in the pilot, veterans would then be referred to an accredited dog assistance organization to be paired with a service dog.

Service dogs must pass the American Kennel Club Community Canine Test and the Assistance Dogs International (ADI) Public Access Test prior to placement with the veteran. Follow-up support service for the life of the dog, to include a contact plan, should be offered to the veteran. If at any point the veteran is no longer able or willing to care for the service dog, the organization providing the dog, and the veteran shall determine the appropriate course of action.

Organizations participating in the pilot must be nonprofit organizations that provide trained service dogs, certified by ADI. They must be able to provide one-on-one training, provide a wellness verification from a licensed veterinarian for each dog, and provide an in-house residential facility or other accommodations where the veteran may stay while receiving training with their new service dog. Participating organizations would be provided a grant in the amount of $25,000 for each veteran referred to that organization for service dog pairing. Offsets from the VA's office of Human Resources and Administration (HR), will be reduced for FY 2018 through 2023, by $10 million per year in support of this pilot program.

At the conclusion of the five-year program, the Comptroller of the United States shall provide Congress a briefing on the methodology established for the pilot program, and a report on the results of the pilot program.

While DAV supports the intent of this bill, and recognizes that trained guide dogs and other trained service dogs can play a significant role in maintaining functionality and promoting maximal independence for individuals with disabilities, we are concerned with the $10 million proposed offset for FY 2018–2023 from VA's HR department. This department is already facing significant difficulties in filling critical employee vacancies, and this offset would likely impede VA's ability to attract, hire and retain high quality personnel necessary to fulfill VA's primary mission; the provision of high quality health care and benefits services to veterans.

Furthermore, as noted above, such a significant investment of resources, and funds in a program that has not yet been shown to be an efficacious intervention in the treatment of veterans with PTSD may not prove to be an investment in the best interest of the veterans it seeks to aid. We understand that VA is currently conducting a legislatively mandated study at its Palo Alto facility, the Paws for Purple Hearts study to determine the efficacy of the use this nontraditional application

of service dogs, acting as companions to veterans with PTSD. DAV encourages VA to complete its current research, and resolve the overarching question of whether service dogs are an efficacious therapy intervention for veterans with PTSD.

Finally, DAV notes that only providing service dogs to veterans with PTSD, while excluding veterans with other severe mental health conditions raises questions of equity to this benefit. DAV's resolution 019, adopted at our most recent National Convention, calls for VA to complete its plan to conduct research and expansion of ongoing model programs to determine the most efficacious use of guide and service dogs in defined populations; in particular, veterans with mental health conditions. While we support the intent of this bill, and have no objection to its passage, we do again note our concerns with the proposed offset in the legislation.

Discussion Draft, to make certain improvements in the Health Professionals Educational Assistance Program of the VA

Mr. Chairman, we were also asked to make any comments on a draft bill to improve the Health Professionals Educational Assistance Program (HPEAP). DAV recently approved two resolutions that allow us to support this draft measure. DAV Resolution 177 specifically supports scholarships for mental health practitioners who practice in VHA facilities and DAV Resolution 228, which supports effective recruitment, retention and development of the VA health care system workforce.

Section 2 of this bill would amend the HPEAP and require the Secretary to offer not less than 50 scholarships for physicians and dentists when VHA reports staff shortages of at least 500 positions. In years in which VHA reports fewer than 500 unfilled physician and dentist positions, the Secretary would offer scholarships representing at least 10 percent of the vacancies. Professionals awarded these scholarships would be required to serve in VHA for 18 months for each school year the scholarship was awarded. The Secretary would be authorized to give preference to veterans in awarding scholarships. In addition, the HPEAP would be extended from December 31, 2019 until December 31, 2033.

Section 3 of the bill would create a new program under Chapter 76-the Specialty Education Loan Repayment Program. This program would be specifically targeted at medical specialties that the Secretary determines VHA has difficulty recruiting or retaining providers and could be used alone or in tandem with the HPEAP or other tools. The program would authorize the Secretary to provide up to $40,000 annually, for no more than four years, for a total of no more than $160,000 per provider to assist with tuition, educational expenses and reasonable living expenses. In return it would require the health professional to serve in VHA for 12 months for each $40,000 VHA provides under the program.

Section 4 of the bill would establish a pilot program-Veterans Healing Veterans Medical Access and Scholarship Program. This program would require the Secretary to select two veterans to whom VA would award scholarships at each of the five Teague-Cranston medical schools. Veterans selected must have been honorably discharged from the military within the past decade and be able to meet the requirements for medical school admission.

VA has identified staffing shortages for physicians for many years. DAV is aware that VHA requires new recruitment tools to meet increasing demand for care as well as quality and timeliness standards. Many VHA facilities serve in areas the Health Resources and Services Administration has designated as "health professional shortage areas" or medically underserved areas. VHA medical professional shortages will be exacerbated by the estimated 40 percent of the VHA workforce expected to retire in the next few years and the national shortage of physicians overall. In addition, the federal government has not been successful in recruiting younger employees. The recent Commission on Care noted that individuals younger than thirty years old accounted for only six percent of the federal government's employees as opposed to 23 percent of the civilian workforce.

The efficiency of talent management processes in VHA programs has also been called into question. VHA loses approximately 13 percent of its applicants in the hiring process, which many reports, including the Independent Assessment required under the Veterans Access Choice and Accountability Act of 2014, have found are slow and cumbersome compared to the processes used by many private health care organizations today. In addition, government pay rates are often not competitive with the private sector.

There are many reasons VHA struggles with quickly filling critical health professional staff positions and all of these issues must be addressed if VA is to become the employer of choice. This draft bill would provide a way for the Department to attract professionals entering into medical careers at the beginning of the production pipeline, rather than the end when individuals with highly sought after skills

have many more options. Use of these tools also requires the Secretary and VHA to determine and assess future workforce needs more systemically. DAV supports this draft measure, which we believe would assist VHA in becoming a more competitive employer of physicians and dentists, particularly for providers in scarce medical specialties ultimately leading to more timely care of our nation's ill and injured veterans.

Mr. Chairman, this concludes my testimony. DAV would be pleased to respond to any questions from you or Subcommittee members concerning our views on the bills under consideration today.

JUSTICE FOR VETS

H.R. 2147 VETERANS TREATMENT COURT IMPROVEMENT ACT OF 2017

Statement of Judge Robert Russell, Buffalo, New York

To Chairman Wenstrup, Ranking Member Brownley, and distinguished Members of the Subcommittee, I am honored to have the opportunity to submit my testimony in support of H.R. 2147 Veterans Treatment Court Improvement Act of 2017 and respectfully request my statement be entered into the record.

In 2007, while serving as presiding judge over the drug court and mental health court in Buffalo, New York, I began to see an increase in the number of veterans appearing on our dockets struggling with substance use disorders, mental health disorders and trauma. Drug court is the most successful justice intervention for offenders with a substance use disorder and is proven to significantly reduce drug abuse and crime while saving money. Mental health courts were established in the mid-nineties to apply the drug court model to cases involving individuals with an underlying mental health condition. Despite the proven success of these interventions, I became concerned that not enough was being done to connect veterans in crisis with the appropriate treatment and services.

One day during our mental health court docket, I called the case of a Vietnam veteran who, to that point, had not been progressing in his treatment or with the help being offered by the court, and who struggled to communicate with the court team. In a moment of exasperation, I asked one member of my staff and a county employee, both Vietnam veterans, to go out in the hall and talk to him. The three Vietnam veterans met for over thirty minutes. The next time I called the case, the man walked up to the bench, stood at parade rest, and held his head high. I asked him if he had any comments, and he looked me in the eye and said yes, he would try harder and would work with the court and treatment.

This profound experience became the inspiration for what would become the first veterans treatment court in the nation. It helped us recognize two things. First, the camaraderie that exists between men and women who served in the military can be motivational and therapeutic. Surrounding veterans with other veterans is crucial to breaking through the warrior mentality that can make accepting help difficult. Second, it is critical to link veterans with the specific resources they earned through their service and which are uniquely suited for their individual needs.

Together, my staff and I decided that more must be done to serve our justice-involved veterans. I went to our local VA medical hospital and asked the director if they would allow a staff person to come to our court so they could immediately engage with veterans coming through the program. I told him our program could refer veterans to treatment at the hospital, and ensure compliance with said treatment through regular court appearances and supervision. He agreed. This became the impetus for the Veterans Justice Outreach (VJO) program.

Veterans Treatment Courts

In January 2008, we launched the Buffalo Veterans Treatment Court. This veterans-only docket is an alternative to incarceration for veterans whose involvement in the justice system is rooted in a substance use or mental health disorder, often both. While maintaining the traditional partnerships and practices of our highly successful drug court - judge, prosecutor, defense, probation, law enforcement, case manager - the veterans treatment court interdisciplinary team includes representatives from the Department of Veterans Affairs - including the Veterans Health Administration and the Veterans Benefit Administration - as well as State Department/Commission of Veterans Affairs, Vet Centers, community mental health and substance use treatment providers, veterans service organizations, and volunteer veteran mentors.

Veterans in the program receive structure, supervision, and treatment surrounded by other veterans and being connected to veteran specific local, state and federal resources.

Almost immediately after launching our program, we became inundated with requests from other jurisdictions seeing the same increases of justice-involved veterans. This was the beginning of a movement that has grown to include today more than 350 operational veterans treatment court programs serving approximately 15,000 justice-involved veterans a year.

Veterans treatment courts are now considered the most innovative and successful intervention for justice-involved veterans diagnosed with substance use and/or mental health disorders. Through a coordinated effort that promotes accountability, structure, and treatment, veterans treatment courts connect veterans in crisis with the benefits and services they earned. This approach saves money, reduces future crime, and ensures that veterans have the opportunity for freedom and recovery.

The Role of the VJO

Veterans treatment courts simply could not exist without the VA's Veterans Justice Outreach program. Approximately 80 percent of veterans in the Buffalo Veterans Treatment Court qualify for VA benefits. This is consistent with other programs across the country. The VJO representative in court helps determine eligibility, assists with expediting or following up on the status of a VA Veteran Health Identification Card, provides necessary information for placement, educates enrolled participants about services that are available, provides ongoing support in connecting enrolled participants to treatment in the VA healthcare system and/or other community health systems and communicates directly with the court to ensure treatment referral and engagement - two of the most important indicators of treatment success.

For example, a Marine combat veteran (one-tour Afghanistan/one-tour Iraq) enters veterans treatment court after becoming addicted to prescription drugs to cope with undiagnosed PTSD. The veteran is unemployed and sleeping on friends' couches because his wife has left him. He has only been out of the military for eight months and is not enrolled in the VA.

During his first session in veterans treatment court, the VJO confirms his eligibility and enrolls the veteran in the VA. The VJO schedules the veteran to receive therapy for PTSD and coordinates with the court to secure inpatient treatment for his substance use disorder. While it ordinarily might take weeks or months for this veteran to receive treatment, he is getting help within days. The VJO monitors the veteran's progress in treatment and reports back to treatment court team weekly. The VJO helps the veteran explore other benefits offered through the VA. The veteran receives a service-connection disability rating from the VA that helps pay for living expenses. The veteran then applies and qualifies for VA's Vocational Rehabilitation and Employment (VR&E) and enrolls in college.

This example is not unique, it is the type of success occurring in veterans treatment courts across the country; success that would not be possible without the presence of the VA in court.

Since 2008, I have travelled the country as faculty for Justice For Vets, a division of the non-profit National Association of Drug Court Professionals dedicated to the training and expansion of veterans treatment courts. Justice For Vets has trained more than 227 of the more than 350 operational programs nationwide. The comprehensive Justice For Vets training brings together all stakeholders necessary to implement and sustain a veterans treatment court, including VJO and other VA personnel.

The most common issue we encounter from jurisdictions seeking to establish a program is not knowing how to liaise with the VA. In my experience, the inability of a jurisdiction to coordinate directly with a VJO is the most significant mitigating factor in efforts to create a veterans treatment court.

These concerns are alleviated by the presence of a VJO. Unfortunately, many communities do not have access to a VJO, or the VJO assigned to their region cannot fully engage with the court due to the large area they cover; one VJO in Upstate New York is responsible for eight counties alone. The VJO program has been crucial to the growth and success of veterans treatment courts and is also one of most effective programs at VA.

The VJO program has one of the highest rates of treatment referral and engagement in the VA. A 2014 study of the program states, "among veterans who had a mental health or substance use disorder, 97% entered mental health or substance use disorder outpatient or residential treatment or received pharmacotherapy for alcohol or opioid use disorders.[T]he rate of treatment engagement, defined as six or more mental health outpatient visits, or six or more substance use disorder out-

patient visits, or any mental health or substance use disorder residential treatment, was 79%."

In 2016, the Government Accountability Office recommended the VA expand the VJO program to help keep up with demand, which is precisely what this bill aims to do.

Justice-Involved Veterans

It is important to note veterans are incarcerated at significantly lower rates than non-veterans, and the number of veterans in jails and prisons decreased between 2004 and 2012 (Bureau of Justice Statistics [BJS], 2015). But there is a startling lack of data on the intersection of veterans and the justice system and too often veterans are not identified upon entry to the system or reentry to their community. What we do know suggests substance use disorders and mental health disorders are a significant factor in justice involvement.

In March 2014, The Washington Post released a report finding that more than half of the 2.6 million American veterans of the wars in Iraq and Afghanistan struggle with physical or mental health problems stemming from their service, and feel disconnected from civilian life (Chandrasekaren, 2014). The RAND Center estimates about 1 in 5 veterans of the wars in Iraq and Afghanistan has post traumatic stress disorder (PTSD) or significant mental health needs (Tanielian & Jaycox, 2008). The Substance Abuse and Mental Health Services Administration (SAMHSA) estimates 1 in 15 veterans had a substance use disorder in 2014 (SAMHSA, 2015).

Left untreated, these issues put veterans at significant risk for involvement with the justice system. Historically, there is no comprehensive effort to ensure the justice system responds sufficiently to the unique clinical needs some veterans face. Justice-involved veterans are scattered throughout the justice system, making it difficult to coordinate effective treatment interventions. Until veterans treatment courts, the VA had little to no contact with justice-involved veterans.

Veterans Treatment Courts: Unprecedented Success

Veterans treatment courts are now considered the most successful intervention for veterans in our justice system. In Buffalo, we have 'graduated' 240 veterans, with less than 10 percent recidivism rate amongst these graduates.

Nationally, the numbers are just as impressive. Recently, Community Mental Health Journal released the first published study on veterans treatment courts and concluded participating veterans experienced significant improvement with depression, PTSD, and substance use, as well as with critical social issues including housing, emotional well-being, relationships, and overall functioning. The study further concluded that veterans who receive trauma-specific treatment and mentoring not only experienced better clinical outcomes, they reported feeling more socially connected (Knudsen & Wingenfeld, 2016). Much of this success can be attributed to the VJO program. A national study of more than 22,000 veterans in the VJO program found that veterans treatment court participants had better housing and employment outcomes as compared to other justice-involved veterans.

These outcomes are crucial for ensuring long-term success.

The Future

Veterans treatment courts continue to be the fastest growing treatment court model in the United States. Thanks to the rise of veterans treatment courts and the role and engagement of VJOs in local justice systems, jurisdictions from coast to coast learned the importance of identifying veterans at the earliest possible contact with the justice system, assessing them for substance use or mental health disorders and diverting them to evidence-based treatment. The progress is monumental but in order to ensure existing programs remain faithful to the veterans treatment court model—and new programs are established with the proper policies and procedures in place—training and VJO involvement is absolutely necessary.

Veterans treatment courts combine criminal justice and the VA in a way that has never been done. Programs that launch without proper training or coordination with the VA run the risk of doing more harm than good. Justice For Vets is doing all it can to meet the urgent and growing need for training but more support is needed.

The men and women of the United States military safeguard our freedom. It is this nation's collective responsibility to treat the wounds-visible and invisible-of those who suffer as a result of their service.

The Veterans Treatment Court Improvement Act of 2017 is a critical step in meeting the urgent and growing need, and ensuring out nation delivers its promise to our veterans. I want to thank Chairman Wenstrup and Ranking Member Brownley for conducting a hearing on this important piece of legislation, and urge the swift passage of the bill.

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MAKE A DIFFERENCE AMERICA

Wisdom, courage and compassion.

These three words describe unique attributes of the men and women that are and have been members of the armed services of the United States of America.

America's military is the greatest protective force in the world. There are many elements that contribute to making our military the best including leading edge technology, seasoned leadership and dedicated personnel. However, I believe that the overwhelming reason for our success is the manner in which we conduct ourselves.

As American citizens and as Americans in the military, we care deeply about the people of the world. No matter what their country, origin, culture or tradition, we care. America will never be defeated with a military like ours that conducts itself with wisdom, courage and compassion. Our military also serves as an ambassador to the people of the world. Average citizens in foreign countries learn about America through their interaction with our service members. For this reason America and its citizens are respected around the world; whether or not their leaders agree.

As citizens, knowing what our military does for us, we want to be confident that America is ensuring that our veterans are receiving the care that they have earned. Our men and women in the military have protected us and when necessary, sacrificed for us. It is our obligation to address their concerns even if they say they will "tough it out and not complain".

HR1943 was initiated by an average citizen that asked the question, "Why are organizations like the Gary Sinise Foundation, Independence Fund and Wounded Warriors providing track wheelchairs to our veterans with private funds? Shouldn't the VA be providing them?".

After talking to members of the House and Senate, it was determined that Congress thought that the VA was providing the track wheelchairs to our veterans. That conclusion prompted us to commission a research project to determine if the VA actually had the authority to provide powered track wheelchairs to service-disabled veterans for recreational purposes. The research found a statement in the VHA Prosthetic Clinical Management Program (PCMP) which states that "Motorized and power equipment or equipment for personal mobility intended solely for a recreational leisure activity should not be provided."

Now knowing the "root cause" for service-disabled veterans being denied powered mobility devices for recreational purposes by the VA, we had the credibility to approach members of Congress with the facts. Once we had the research information organized in a digestible form, it wasn't long before Congressman Steve King (IA), a long time veteran supporter, agreed that the regulations needed changing and offered to introduce our initiative as a bill.

On April 05, 2017, HR 1943 was introduced by Congressman King. This was a great day for our country. HR1943 is not just a bill, it is a bill that came about the way our Founding Fathers intended, by citizens of our country using the legislative tools we were provided to make changes in the law.

Of course, we are only at the beginning of the process; taking little steps at a time. However, it has been a pleasurable experience so far and has shown that one citizen can make a difference and together there is nothing we cannot change.

I want to thank the Veterans Affairs Committee for selecting HR1943 as one of the bills to be reviewed at the hearing scheduled for September 26, 2017. This will be one more important step in the process of providing changes to our laws that will make the lives of our disabled-veterans as whole as possible.

Dave Meister

PARALYZED VETERANS OF AMERICA (PVA)

CONCERNING

PENDING LEGISLATION

Chairman Wenstrup, Ranking Member Brownley, and members of the Subcommittee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to present our views on the broad array of pending legislation impacting the Department of Veterans Affairs (VA) that is before the Subcommittee. No group of veterans understand the full scope of care provided by the VA better than PVA's members-veterans who have incurred a spinal cord injury or disease. Most PVA members depend on VA for 100 percent of their care and are the most vulnerable when access to health care, and other challenges, impact quality of care. These important bills will help ensure that veterans receive timely, quality health care and benefits services.

H.R. 93, "to amend title 38, United States Code, to provide for increased access to Department of Veterans Affairs medical care for women veterans"

PVA supports H.R. 93, to amend title 38, United States Code, to provide for increased access to Department of Veterans Affairs (VA) medical care for women veterans. The bill would ensure gender specific services are continuously available at every VA medical center and community based outpatient clinic.

As of 2016, women comprise nearly 10 percent of the total veteran population. That percentage is expected to rise. VA has made strides in recent years to meet the needs of women veterans, by providing basic reproductive health services, preventative screenings and provider training on women's health issues. However, nearly a third of VA medical centers still lack providers for gynecological services and refer women veterans to community providers.

The great advantage for a patient of the VA health care system over other networks in the United States is the care coordination provided amongst its comprehensive services. For too many women veterans, their care is fractured between their VA medical center, and a bevy of community care providers. They have to worry about record sharing, prescription data, and if VA will pay the provider on time before receiving a bill themselves. For most male veterans at VA, these basic health services are quickly and readily available. All veterans deserve to benefit from the hallmark of the VA system. The number of women enrolling at VA continues to rise. VA must have systems and providers in place to address their unique needs. This legislation would require VA facilities hire or contract with the needed providers.

H.R. 501, the VA Transparency Enhancement Act of 2017

PVA generally supports H.R. 501, the "VA Transparency Enhancement Act of 2017." The bill seeks to increase availability of information regarding the prevalence of surgical infections, cancellations, and transfers. The bill would require quarterly reports to the Committees on Veterans' Affairs of the House and Senate, and a public release on VA's website. Currently, VA provides the monthly completed and pending appointment data from local VA medical facilities. VA does not publically release data on rates of infection or cancelled or transferred surgeries. Hospitals that receive reimbursement from the Centers for Medicare and Medicaid Services (CMS) must report a variety of quality measures to the National Healthcare Safety Network, including surgical infections. This legislation will bring VA in line to be qualitatively compared to the private sector.

H.R. 1063, the "Veteran Prescription Continuity Act"

PVA supports H.R. 1063, the "Veteran Prescription Continuity Act." This bill would ensure a service member transitioning from Department of Defense to Department of Veterans Affairs while receiving medical treatment is able to maintain their prescription regimen if not included in the joint uniform formulary.

Currently, there is no guarantee a patient transitioning to VA can be prescribed the same drug as prescribed by DOD. The only exception is medication for post-traumatic stress or chronic pain. This bill would have VA offer what DOD prescribed until the veteran's provider determines it is no longer necessary. This is a logical accommodation for a service member in transition. Ensuring there is a seamless handoff between systems is of the utmost importance.

H.R. 1066, the "VA Management Alignment Act of 2017″

PVA supports H.R. 1066, the "VA Management Alignment Act of 2017." This legislation would direct VA to submit to Congress a report on the organizational structure of VA and the means to improve such structure to improve access to quality care. GAO reports have revealed VA has not implemented the recommendations for managerial and structural improvement. The report required by this bill would spell out the roles and responsibilities for senior staff and organizational units within VA and how they work together to promote efficiency and accountability, as well as any legislative recommendations to improve access to care.

H.R. 1943, the "Restoring Maximum Mobility to Our Nation's Veterans Act of 2017″

PVA generally supports H.R. 1943, the "Restoring Maximum Mobility to Our Nation's Veterans Act of 2017." The bill would amend title 38, USC, to require VA to ensure each wheelchair, furnished to a veteran with a service connected disability restores the maximum achievable mobility in activities of daily living, employment,

and recreation. The bill would amend 'wheelchair' to include 'enhanced power wheelchairs, multi-environmental wheelchairs, track wheelchairs, stair-climbing wheelchairs, and other power-driven devices.' The bill would allow the Secretary to furnish a wheelchair to a veteran because the wheelchair restores an ability that relates exclusively to participation in a recreational activity.

PVA supports this bill provided such wheelchairs meet all International Organization for Standardization (ISO) criteria and FDA requirements for wheelchairs. The existing regulations and standards will ensure the veteran is using equipment that has been rigidly tested to meet all safety, mechanical and software parameters. This is a difficult standard for many of the mentioned devices, such as tracked vehicles. Our primary concern is the veteran's safety and well-being. We would not encourage VA to furnish veterans with spinal cord injuries an off road "wheelchair" that could roll over. And there are general safety concerns for these recreational vehicles and the operation of gasoline motors.

H.R. 1972, the "VA Billing Accountability Act"

PVA supports H.R. 1972, the "VA Billing Accountability Act." This bill would authorize the Secretary of Veterans Affairs to waive the requirement of certain veterans to make copayments for hospital care and medical services in the case of an error by the VA. Many VA Medical Centers struggle to send billing statements for co-payments to veterans in a timely manner. For some veterans this means being sent a bill years after the service. H.R. 1972 would mandate that a veteran receive their bill within 120 days from receiving care at a VA Medical Center and within 18 months if seen at a non-VA facility. Further, the bill grants the Secretary the authority to waive the co-payment altogether if these billing timelines are not adhered to. If the bill is sent after the required time VA must notify the veteran of the option to receive a waiver or create a payment plan before the payment can be collected. Veterans and their families should not be burdened with unknown debts resulting from mistakes in VA's own processes.

H.R. 2147, the "Veterans Treatment Court Improvement Act of 2017″

PVA firmly believes in the rule of law and that anyone convicted of a crime should be held accountable. Our criminal justice system, though, has long recognized the existence of aggravating and mitigating circumstances that play an important role in influencing the administration of penalties. While advocacy before a sentencing judge following conviction is critical, prosecutorial discretion is also vast. Veterans Justice Outreach Specialists can help veterans use their honorable service, as well as mitigating circumstances arising from that service, to ensure both the prosecutor and judge see more than just a rap sheet when making decisions.

If the specialist demonstrates that the veteran is entitled to health care or disability benefits, the judge or prosecutor might be able to fashion a sentence or plea offer that incorporates utilization of these services in lieu of imposing solely punitive sanctions. It could also lead to an outright deferment of prosecution conditioned on the veteran exploring and obtaining all services available to him or her. This scenario is especially enticing to the judicial system given the constant struggle to find resources, particularly for in-patient substance abuse rehabilitation programs and mental health care.

For some veterans, this path might help them avoid being permanently stigmatized with a criminal conviction. For others, it might be the ticket that lifts them out of homelessness and the corresponding criminal recidivism, specifically with petty and/or vagrancy crimes. It is no secret that some veterans go years before realizing they were entitled to certain benefits that might have helped them avoid poverty and dejection. A court order pointing the veteran to the Department of Veterans Affairs can sometimes turn into a life-changing event. At the least, more veterans touched by this program will re-engage productively with society. That is a goal worth pursuing.

H.R. 2225, the "Veterans Dog Training Therapy Act"

PVA supports H.R. 2225, the "Veterans Dog Training Therapy Act." This legislation would require the Department of Veterans Affairs (VA) to contract with certified non-government entities to test the effectiveness of addressing veterans' post-deployment mental health and post-traumatic stress disorder (PTSD) symptoms through training service dogs for fellow veterans with disabilities.

PVA knows that service animals provide tremendous benefits for many veterans living with disabilities. The benefits of service animals are multi-faceted. Service animals promote independence for veterans with disabilities and help them to break

down barriers in their communities. Many PVA members have personally experienced these benefits.

"The Veterans Dog Training Therapy Act" will allow VA to explore potential therapies for veterans with certain mental health issues to include training of service animals. Not only could this provide additional treatment options for veterans living with PTSD and other similar conditions but it will provide highly trained service animals for veterans living with disabilities. This pilot program would be located at VA medical centers and administered by VA's Center for Compassionate Innovation. We believe that this construct will provide the conditions that lead to effectively trained service animals for veterans with disabilities.

H.R. 2327, the "Puppies Assisting Wounded Servicemembers (PAWS) Act of 2017"

PVA generally supports H.R. 2327, the "Puppies Assisting Wounded Servicemembers (PAWS) Act of 2017," to provide service animals to veterans who need them. If enacted, this legislation would direct the VA to carry out a pilot program to provide service dogs to certain veterans with severe post-traumatic stress disorder (PTSD). Service animals provide crucial assistance to many veterans living with catastrophic disabilities. The benefits of using a service animal are multi-faceted. Service animals promote independence and help to break down societal barriers. Many members of Paralyzed Veterans have personally experienced these benefits.

Through the PAWS Act, VA will provide grants to service animal organizations to assist veterans referred by VA who have PTSD. This pilot program will provide service dogs to veterans with PTSD who have completed evidence-based treatment for PTSD but who continue to have a PTSD diagnosis. We support efforts to increase access to service animals for veterans with disabilities. It is our hope that this program will be funded. However, we strongly discourage it be done by offsetting resources for VA's Office of Human Resources and Administration, which could derail VA's efforts to hire and retain qualified personnel.

Additionally, the bill as written does not appropriately reflect the fact that the VA currently does not provide service animals to any veteran directly. Service animals are provided to veterans by organizations responsible for the training and provision of service animals, not the VA. The VA currently bares no direct cost when it comes to providing service animals. As it is, we are not aware of a demonstrated need for VA to be the procurer of service animals. Additionally, this bill would have the VA provide service dogs only to veterans with PTSD, excluding veterans with other mental health conditions and physical disabilities who would also benefit.

VA provides veterinary health insurance and other ancillary benefits to service animals used for veterans with physical disabilities. While this bill would make PTSD service dogs eligible for existing benefits, (something VA currently has the authority to do) it goes a step beyond by charging VA with procuring a trained, capable dog. We are concerned that creating a new process to place service dogs with veterans with PTSD confuses the process among veterans with other needs.

Draft legislation to "make certain improvements in VA's Health Professionals Educational Assistance Program"

PVA supports the draft legislation to make certain improvements in VA's Health Professionals Educational Assistance Program. The bill would designate at least fifty scholarships to medical or dental students. The goal is to award such scholarships until the Secretary determines the staffing shortage of these providers is less than 500. The recipient of the scholarship agrees to serve as a full-time employee in VHA for a period of obligated service of 18 months of each school year or part thereof that the scholarship was provided. The bill would also establish within VA a Specialty Education Loan Repayment Program. The purpose is to incentivize medical residents to work at VHA, particularly in specialties where recruitment and retention have proven difficult. This bill would allow for the Secretary to waive maximum loan repayment caps established under the Specialty Education Loan Repayment Program and pay the total amount of the principal and interest on a participant's loan. The participant's obligated service would be determined on a scale of the amounts repaid. Additionally, Section 4 of the bill would establish a pilot program to fund the medical education of ten eligible veterans throughout the Teague-Cranston medical schools.

Given the critical shortage of health care providers VA must be able to pursue the means to recruit and retain new residents. The majority of providers at VA and throughout the United States will soon retire and there are not enough poised to

take their place. And with an aging patient population and uncertain healthcare landscape, these challenges require quick action

That potential health care students are reluctant to commit to medical school, or new residents are hesitant to take a post in an underserved community, should come as no surprise. The cost burden of their education and training is an overwhelming prospect and debt is all but guaranteed. No matter how eager to serve, or desirous of giving back to veterans a new resident may be, a career at an understaffed VA may not be a tenable choice. By providing scholarships to cover the cost of medical school or paying off loans, in exchange for a period of service, VA would become an obvious choice. Removing the financial barriers encourages the best and the brightest to make their mark at VA. Additionally, such programs would cultivate a culture of commitment by those unburdened by debt and revive areas too long stressed by continuous shortages. VA must be given the resources to address this current and looming crisis. The health and wellbeing of our nation's veterans depend on it.

VETERANS OF FOREIGN WARS OF THE UNITED STATES (VFW)

KAYDA KELEHER, ASSOCIATE DIRECTOR

NATIONAL LEGISLATIVE SERVICE

Chairman Wenstrup, Ranking Member Brownley and members of the Subcommittee, on behalf of the women and men of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, thank you for the opportunity to provide our remarks on legislation pending before this subcommittee.

H.R. 93, to provide for increased access to Department of Veterans Affairs medical care for women veterans.

The VFW supports this legislation which would ensure gender-specific health care services maintain continuous availability within Department of Veterans Affairs (VA). It would also authorize VA to provide women veterans community care options when VA is unable to provide gender-specific care at its medical facilities.

Estimated to grow to the size of the entire active duty military by the year 2030, women veterans are the fastest growing cohort of the veterans' community. It is absolutely imperative that VA provides necessary access and employ personnel trained to provide gender-specific health care.

H.R. 501, VA Transparency Enhancement Act of 2017

The VFW agrees with the intent of this legislation, but has concerns with some of its requirements. The VFW firmly believes VA must maintain agency transparency and be held accountable when necessary. Yet Congress must not put undue burdens on VA. The VFW does not believe it necessary to overstretch the already scarce resources it is given, which are intended for delivering health care and service to veterans, on superfluous reporting requirements.

Health care associated infections are currently tracked by the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN). More than 17,000 medical facilities within the United States currently submit surgical site infections data for public reporting to CDC NHSN for patients who are 18 years old or older. Most of this data is transferred by the medical facilities electronic health record systems directly to CDC.

With this in mind, the VFW has concerns with this legislation that would require a quarterly report of surgical site infections, as well as cancelled or transferred surgeries. First, a quarterly report is unnecessarily frequent and unusual when compared to other health care systems. Aside from the logistics of preparing a quarterly report—disseminating and analyzing it—any report made publicly available should be posted alongside similar reports of other non-VA facilities. This would help keep the information organized and easily comparable to the rest of America's health care sector. Also, a report strictly showcasing the number of surgical site infections without a comparison to the number of total surgeries per surgical site would be unusable, except for promoting unintended concern and distrust of VA.

H.R. 1063, Veteran Prescription Continuity Act

The VFW supports this legislation which would ensure veterans transitioning from the Department of Defense (DOD) to VA have access to the same medical care and treatment, specifically pharmaceuticals, as they did before transitioning out of

DOD. Making sure pharmaceuticals that are medically necessary and have a crucial effect on the quality of veterans' lives are available is an absolute must. Both DOD and VA must ensure their formularies match for medications of high prevalence and necessity for service members and veterans. This is particularly true for pharmaceuticals specific to both chronic pain and mental health.

H.R. 1066, VA Management Alignment Act of 2017

The VFW agrees with the intent of this legislation, but does not support it. This bill would require the Secretary of VA to submit a report outlining the current organizational structure within VA, and how it should strive to work together between different offices and departments.

VA has developed the Functional Organization Manual, which was updated this year. This manual covers VA's organizational structure, missions, functions, activities and authorities. This legislation would require the Secretary to use VA resources for an independent assessment striving for the same results, while also specifying how each office should work with other offices within VA. This legislation is also unclear as to whether it would require VA to evaluate all 300,000 positions within VA or specifically VA's Central Office. While it is of utmost importance that VA continues striving to improve structural organization and working relationships within the department, it is increasingly redundant to continue demanding reports on already conducted studies.

H.R. 1943, Restoring Maximum Mobility to Our Nation's Veterans Act of 2017

The VFW supports the intent of this legislation, but has concerns as currently written.

Members of the VFW have vocalized concerns and barriers faced in trying to receive the prosthetics necessary to live functional, high quality lives. Whether they need an additional prosthetic limb for recreational activities or cultural purposes, veterans have earned them. While it may not be rampant, some members who have been fortunate enough not to lose a limb still need the assistance of a wheelchair.

We believe all service-connected veterans in need of wheelchairs deserve one from VA. Mobility and functionality are crucial for the mental well-being of our nation's veterans. With this said, VA must work to ensure all veterans in need of a wheelchair have one which meets the requirements of both the International Organization for Standardization criteria, as well as the U.S. Food and Drug Administration. These regulations standardize requirements to ensure veterans are using wheelchairs that have been tested for safety, and mechanical and software perimeters.

While technology keeps improving, it must also continue to meet industry standards for the safety of our veterans who are bound to wheelchairs. Many new models of wheelchairs do not meet these standards and can cost more than a car. Congress must ensure VA resources are spent smartly on safe medical equipment.

H.R. 1972, VA Billing Accountability Act

The VFW supports this legislation to provide the Secretary of VA with the authority to waive certain veterans from copayment requirements for hospital care and medical services in the case of an error by VA.

At this time, VA has the authority to waive copayment requirements for hospital and medical services both inside and outside VA. This legislation would codify that authority. While authorizing VA to waive debts if VA employees fail to provide timely notice to veterans is a step toward the right direction, the VFW would urge the subcommittee to require VA to waive debts for veterans when VA is unable to provide timely notice. Veterans must hot be held liable because VA sent them untimely bills that do not contain information for waivers or payment plans.

H.R. 2147, Veterans Treatment Court Improvement Act of 2017

The VFW strongly supports this legislation which would require VA to hire more Veterans Justice Outreach Specialists to provide treatment court services to justice-involved veterans.

According to the most recent data from the Bureau of Justice statistics, over 130,000 veterans are incarcerated in state and federal prisons, representing approximately eight percent of the total prison population. While the VFW realizes veterans who are convicted of crimes must suffer the consequences, we also recognize that having veteran advocates or individuals to represent them before sentencing and act in their best interests is invaluable.

Increasing the amount of Veterans Justice Outreach Specialists will help our justice-involved veterans navigate the legal system, and hopefully attain outcomes that are best suited for each individual veteran. Also, by providing veterans struggling

with legal issues, it allows VA and the justice system to more directly assist veterans struggling with substance abuse issues related to mental health conditions from their service.

H.R. 2225, Veterans Dog Training Therapy Act

The VFW supports this legislation which would carry out a pilot program for dog training therapy at several VA facilities.

With such a high ratio of veterans who have defended our nation being diagnosed with post-traumatic stress disorder (PTSD), VA must provide veterans mental health care options that work best for them. Recent studies show service dogs provide positive health care outcomes in veterans with PTSD. Such studies illustrate a reduction in symptoms from the PTSD Checklist, lowered effects of anxiety and depression disorders, as well as a reduced need for psychopharmaceutical prescriptions. Veterans who have service dogs also experience an increased participation in social settings, as well as overall satisfaction with life. The VFW supports continued efforts to evaluate the efficacy of using service dogs to treat PTSD and other mental health conditions. Currently, VA in Oregon has already developed the program on which this legislation is modeled. Basing legislation on a currently functioning program ensures an easy transition and proper implementation of the pilot program in more VA facilities.

For more than a decade, research into the benefits of providing service dogs to veterans struggling with their mental health has garnered attention. Given promising research in both the private sector as well as VA, VFW members have consistently reported on the benefits they experienced from having a service dog.

This legislation would ensure more veterans are provided the opportunity to receive a service dog for combat-related mental health conditions. This opportunity would be provided at a VA medical center, administered by VA's Center for Compassionate Innovation, with experienced and qualified staff training the dogs and veterans. Veterans would not need to travel for this benefit, and they would have access to VA's veterinary insurance. It would also have the potential to advance and positively affect ongoing studies of service dogs by collecting essential data. Many studies and anecdotal notes have found veterans with service dogs decrease their use of medications such as opioids for chronic pain linked to PTSD. This collection of data would be invaluable in knowing the likelihood of medication decreases, emotional well-being and improvements of service dog owners as well as sleep patterns.

H.R. 2327, Puppies Assisting Wounded Servicemembers Act of 2017

The VFW supports the intent of this legislation. This legislation would provide grants to eligible private sector organizations to provide service dogs to veterans with severe PTSD.

Studying the benefits of providing service dogs to veterans struggling with mental health disorders after the military is absolutely crucial. With that said, the VFW knows that not all combat veterans return home with PTSD. There is a wide range of behavioral health issues veterans may struggle with, from mental illness to psychosocial disorders. This pilot program would limit access to service dogs only for veterans with severe PTSD. These veterans would have to travel for their service dog training, which would be reimbursed by VA. While this is not always a barrier, travel outside VA may be a barrier to some veterans. Legislating that the pilot must be performed by private organizations outside VA adds a possible barrier to veterans in need. This legislation would also only require one report within nine months of the pilot program ending. This would limit the ability of VA and Congress to oversee the progress and benefits of the outcomes for participating veterans. Also, with more than 40,000 employment vacancies within VA, the VFW is concerned this legislation's offset could have unintended consequences for VA's Human Resources trying to fill those much needed positions.

The VFW strongly supports the continuance of care this legislation would require to maintain eligibility of canine health insurance. Continuance of care is crucial to successfully overcoming any illness, whether it is physical or mental. With VA only maintaining coverage of the service dogs if the veteran continues to see their physician or mental health care provider at least once a quarter—unlike other service dog bills—this legislation would ensure more consistent and open communication between the medical provider and veteran.

Draft Bill, to make certain improvements in VA's Health Professionals Educational Assistance Program.

The VFW Supports the draft legislation and has recommendations to improve it, which we hope the subcommittee considers before advancing it.

This legislation would make improvements to scholarship and educational assistance programs provided by VA in an attempt to address provider shortages within the department. These position vacancies in VA must be properly addressed, and the VFW supports the idea of providing education incentives to attract more high quality VA employees. Section 2 of this draft bill is specific in designating scholarships specifically for physicians and dentists. There is zero doubt VA needs physicians and dentists, but this section must include scholarship opportunities for psychologists and students working toward their Master of Social Work. The entire country has a shortage of mental health care providers, and psychiatrists are not the ones providing talk therapy and the majority of mental health testing/screening for patients. By not including psychologists and therapists in section 2, this legislation would be proving a disservice to VA in the form of not addressing veterans' mental health needs and access to care.

The second alarming issue the VFW has concerns with is in Section 4. This section would provide a full-ride scholarship to certain veterans who qualify and choose to attend a Teague-Cranston medical school. This scholarship is not tied to any other education benefit eligibility for title 38 or title 10 of the United States Code. Yet this legislation specifically shuns certain veterans with bad paper discharges. Eligible veterans would only include those discharged not more than 10 years before they apply, and only those with an honorable or a general discharge. The VFW firmly believes this criteria must be more open and inclusive.

Mr. Chairman, Ranking Member, this concludes my testimony. The Veterans of Foreign Wars sincerely appreciates the opportunity to provide views on these important bills, and I am prepared to take any questions you or the subcommittee members may have.