



National Service & Legislative Headquarters  
807 Maine Avenue, S.W.  
Washington, D.C. 20024-2410  
Phone (202) 554-3501  
Fax (202) 554-3581  
www.dav.org

**STATEMENT OF  
SHURHONDA Y. LOVE  
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR  
BEFORE THE  
COMMITTEE ON VETERANS' AFFAIRS  
SUBCOMMITTEE ON HEALTH  
UNITED STATES HOUSE OF REPRESENTATIVES  
SEPTEMBER 26, 2017**

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 implementation 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 standard 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.