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STATEMENT OF  
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OF THE  
DISABLED AMERICAN VETERANS  
BEFORE THE  
COMMITTEE ON VETERANS' AFFAIRS  
UNITED STATES SENATE  
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Chairman Murray, Ranking Member Burr and Members of the Committee:

On behalf of the Disabled American Veterans (DAV) and our 1.2 million members, all of whom are wartime disabled veterans, I am pleased to present our views on the 23 legislative bills and two draft measures under consideration today.

S. 1264, Veteran Voting Support Act of 2011

The Veteran Voting Support Act of 2011 would require the Secretary of Veterans Affairs to permit facilities of the Department to be designated as voter registration agencies and expand assistance to veterans in registering to vote and voting. Section 3 of the bill directs the Department of Veterans Affairs (VA) to provide mail voter registration application forms to each veteran who seeks to enroll in the VA health care system; and is already enrolled in such system when there is a change in the veteran's enrollment status or when there is a change in the veteran's address.

It also requires the Secretary to accept completed voter application forms and transmit them to appropriate state election officials and requires forms accepted at VA medical centers, community living centers, community-based outpatient centers, and domiciliarys be transmitted within ten days of acceptance, unless a completed form is accepted within five days before the last day for registration to vote in an election, in which case it must be transmitted within five days of acceptance.

Section 4 requires each director of a VA community living center, domiciliary, or medical center to provide assistance in voting by absentee ballot to resident veterans, and requires such assistance to include: 1) providing information relating to the opportunity to request an absentee ballot; 2) making available absentee ballot applications upon request, as well as assisting in completing such applications and ballots; and 3) working with local election administration officials to ensure the proper transmission of the applications and ballots.

Section 5 requires the Secretary to permit nonpartisan organizations to provide voter registration information and assistance at facilities of the VA health care system.

Section 6 prohibits the Secretary from banning any election administration official, whether state or local, party-affiliated or non-party affiliated, or elected or appointed, from providing voting information to veterans at any VA facility. It also directs the Secretary to provide reasonable access to facilities of the VA health care system to state and local election officials for the purpose of providing nonpartisan voter registration services to individuals.

Although DAV has a long-standing resolution encouraging disabled veterans to register to vote and to vote—and initially provided our support for S. 1556, the Veteran Voting Support Act of 2009—at this time we have reconsidered our position on the bill due to concerns about the overall negative impact this bill would have on the Veterans Health Administration (VHA) and

the fact that VA is currently providing voter registration to veterans when requested. Currently, VHA Directive 2008-053 defines VA's policy for assisting patients who seek information on voter registration and voting. Based on the policy, VA does not solicit voter registration but provides assistance to veterans who are inpatients under VA's care; residents of VA community living centers and domiciliaries who want to get registered to vote or vote in an election. Additionally, state and local election officials, as well as non-partisan groups are invited into VA health care facilities and those visits are coordinated to ensure there are no disruptions in patient care services. Finally, flyers and information on the voting assistance program are posted throughout facilities and volunteers have been specifically recruited in the past to help with these efforts. Based on this policy, it appears that much of the bill would be duplicative of VA's current efforts and therefore unnecessary. Likewise, we are confident that the policy and existing Federal Regulations under title 38, subsection 17.33, ensure veteran patients the opportunity to exercise their voting privilege.

#### S. 1391

S. 1391 would change the standard of proof required to establish service connection for veterans with post-traumatic stress disorder (PTSD) resulting from military service, and for veterans suffering from certain mental health conditions, including PTSD, resulting from military sexual trauma that occurred in service.

Essentially, S. 1391 would eliminate the requirement of an in-service, verifiable stressor in conjunction with claims for PTSD. Under this change, VA would now be able to award entitlement to service connection for PTSD even when there is no official record of such incurrence or aggravation in service, provided there is a confirmed diagnosis of PTSD coupled with the veteran's written testimony that the PTSD is the result of an incident that occurred during military service, and a medical opinion supporting a nexus between the two.

In November 2010, VA modified its prior standard of proof for PTSD related to combat veterans by relaxing the evidentiary standards for establishing in-service stressors if it was related to a veteran's "fear of hostile military or terroristic activity." S. 1391 would build upon that same concept and expands it to cover all environments in which a veteran experiences a stressor that can reasonably result in PTSD, regardless of whether it occurred in a combat zone, as long as it occurred when the veteran had been on active duty or active duty for training. The legislation would also remove the current requirement that the diagnosis and nexus opinion come only from VA or VA-contracted mental health professionals, but would instead allow any qualified mental health professional.

S. 1391 would also allow VA to award entitlement to service connection for certain mental health conditions, including PTSD, anxiety and depression, which a veteran claims was incurred or aggravated by military sexual trauma experienced in service, even in the absence of any official record of the claimed trauma. Similar to the evidentiary standard above for PTSD, the veteran must have a diagnosis of the covered mental health condition together with a written testimony by the veteran that the claimed trauma was incurred during military service. Further, the veteran must have a medical opinion from a mental health professional indicating that the claimed mental health condition is reasonably related to military sexual trauma, which would include a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment while the veteran was serving on active duty or active duty for training.

DAV supports S. 1391, which is consistent with DAV Resolutions 59 and 171. DAV Resolution 171 states that, "establishing a causal relationship between injury and later disability can be daunting due to lack of records or certain human factors that obscure or prevent documentation

of even basic investigation of such incidents after they occur..." and that, "... an absence of documentation of military sexual trauma in the personnel or military unit records of injured individuals prevents or obstructs adjudication of claims for disabilities for this deserving group of veterans injured during their service, and may prevent their care by VA once they become veterans..." Further, DAV Resolution 59 states that, "... proof of a causal relationship may often be difficult or impossible..." and that, "...current law equitably alleviates the onerous burden of establishing performance of duty or other causal connection as a prerequisite for service connection..." Enactment of S. 1391 would provide a commonsense standard of proof for veterans who have experienced serious mental and physical traumas in environments that make it difficult to establish exact causal connections.

#### S. 1631

S. 1631 would authorize the Secretary of Veterans Affairs to establish a center for technical assistance for non-Department health care providers who furnish care to veterans in rural areas. This bill makes the head of such center the Director of the Rural Veterans Health Care Technical Assistance Center. It also requires the Secretary, in selecting the center's location, to give preference to a location that, among other things, has a high number of veterans in rural and highly rural areas, and is near one or more entities carrying out programs and activities relating to health care for rural populations.

The purpose of the center would be to develop and disseminate information, educational materials, training programs, technical assistance and materials and other tools to improve access to health care for veterans living in rural areas. It would also help to establish and maintain Internet-based information such as best practice models, research results and other appropriate information.

VHA's Office of Rural Health's (ORH) mission is to improve access and quality of care for enrolled rural and highly rural veterans by developing evidence-based policies and innovative practices to support their unique needs. ORH includes information on its website about the three Veterans Rural Health Resource Centers (VRHRC) that have been established. The Western Region center in Salt Lake City focuses on outreach, access issues and the special needs of Native Americans (American Indian, Alaska Native, Native Hawaiian, Pacific Islander) and aging veterans. The Central Region center in Iowa City, Iowa focuses on evaluating rural health programs and piloting new strategies to help veterans overcome barriers to access and quality. The Eastern Region center located in Gainesville, Florida focuses on developing models to deliver specialty care services to rural areas, training VA and non-VA service providers caring for rural veterans and bringing specialty care to community-based clinics via tele-health technology. DAV Resolution No. 203 supports the mission of the VA's Office of Rural Health and improvements to VA coordinated health care services for veterans living in rural areas. DAV originally supported S. 1631 when it was introduced in September of 2011. It is unclear from the information we have available to us if any of the VRHRCs are in fact devoting resources toward the intent of this bill, which is to aid non-VA providers who furnish care to veterans in rural areas with technical assistance. We urge the Committee to ask VA to provide specific details in this regard. In the event that VA is not working towards this goal, we continue to support this bill and taking other actions to help medical providers better deliver much-needed health care to veterans in rural areas.

#### S. 1705

Introduced by Chairman Murray, this bill would designate the VA Medical Center in Spokane, Washington, as the “Mann-Grandstaff Department of Veterans Affairs Medical Center.” DAV has no resolution on this issue and has no national position on this bill.

#### S. 1707, Veterans Second Amendment Protection Act

Introduced by Senator Burr, this bill would amend title 38, United States Code, to clarify the conditions under which certain persons may be treated as adjudicated mentally incompetent for certain purposes. DAV has no resolution on this issue and has no position on this bill.

#### S. 1755

S. 1755 would provide for coverage under VA's beneficiary travel program disabled veterans with vision impairment, a spinal cord injury, or multiple amputations for travel related to in-patient care in a special disabilities rehabilitation program. Currently, VA is authorized to pay the actual necessary expense of travel (including lodging and subsistence), or in lieu thereof an allowance based upon mileage, to eligible veterans traveling to and from a VA medical facility for examination, treatment, or care. According to title 38, United States Code, Section 111(b)(1), eligible veterans include those with a service-connected rating of 30 percent or more; receiving treatment for a service-connected condition; in receipt of VA pension; whose income does not exceed the maximum annual VA pension rate, or; traveling for a scheduled compensation or pension examination.

Notably, the VA Secretary has the discretionary authority under section 111(b)(2), to make payments for beneficiary travel to or for any person not currently eligible for travel by such person for examination, treatment, or care.

DAV has no resolution on this issue and has no position on this bill. However, we would note that while the intended recipients of this expanded eligibility criteria would certainly benefit, we would urge the Committee to consider a more equitable approach rather than one based on the specific impairments of a disabled veteran. Further, we ask that if the Committee does favorably consider this measure, it also take appropriate actions to ensure that sufficient additional funding be provided to VA to cover the cost of the expanded program.

#### S. 1799, Access to Appropriate Immunizations for Veterans Act of 2011

This measure would require the Secretary of Veterans Affairs to make available periodic immunizations against certain infectious diseases as adjudged necessary by the Secretary of Health and Human Services through the recommended adult immunization schedule established by the Advisory Committee on Immunization Practices. The bill would include such immunizations within the authorized preventative health services available for VA-enrolled veterans. The bill would establish publicly reported performance and quality measures consistent with the required program of immunizations authorized by the bill. The bill would require annual reports to Congress by the Secretary confirming the existence, compliance and performance of the immunization program authorized by the bill.

Although DAV has no adopted resolution from our membership dealing specifically with this matter of immunizations for infectious diseases, DAV Resolution No. 193 calls on VA to maintain a comprehensive, high quality, and fully funded health care system for the nation's sick and disabled veterans, specifically including preventative health services. Preventative health services are an important component of the maintenance of general health, especially in elderly and disabled populations with compromised immune systems. If carried out sufficiently, the intent of this bill could also contribute to significant cost avoidance in health care by reducing the spread of infectious diseases and obviating the need for health interventions in acute illnesses of

those without such immunizations. For these reasons, DAV supports this bill and urges its enactment.

S. 1806

S. 1806 would amend the Internal Revenue Code of 1986 to allow taxpayers to designate overpayments of tax as contributions to the homeless veterans assistance fund. DAV has no resolution on this issue and has no position on this bill.

S. 1838

S. 1838 would require the Secretary of Veterans Affairs to carry out a pilot program on service dog training therapy. If enacted, this measure would require the Department to conduct a pilot program to assess the feasibility and advisability of using service dog training activities as part of an integrated post-deployment mental health program. The purpose of the pilot program is for VA to produce specially trained service dogs for veterans; to determine how effectively the program would assist veterans with post-traumatic stress disorder (PTSD) and the feasibility of extending or expanding the pilot program.

DAV has no resolution on this issue and has no position on this bill. However, we are looking forward to the receipt of findings from VA's ongoing research project to determine the efficacy of service dog usage by veterans challenged by mental illness and post-deployment mental health conditions related to combat, including PTSD. We recognize that trained service animals can play an important role in maintaining functionality and promoting maximum independence and improved quality of life for persons with disabilities—and that pilot programs such as the one proposed could be of benefit to certain veterans. However, we do have a concern about VA's experience with advanced training methods for the many varieties of highly specialized service dogs.

S. 1849, Rural Veterans Health Care Improvement Act

S. 1849, the Rural Veterans Health Care Improvement Act, would require VA to develop a five-year strategic plan for ORH for improving access to, and the quality of, health care services for veterans in rural areas.

DAV supports the intention of S.1849 in accordance with DAV Resolution No. 203. However, we note that the VA's ORH has made available its "Strategic Plan Refresh" for Fiscal Years 2012-2014 with six specific goals and a number of initiatives to achieve those goals. The VA's Strategic Plan on rural health care is comprehensive and seems to cover many of the provisions listed in S. 1849; however, we would like to see additional information on the use of mobile clinics and coordination of care for women veterans living in rural areas. We ask VA to provide an update on the use of mobile clinics in rural areas and the provisions in the bill that would require a survey of each VA facility that serves rural and highly rural areas concerning the provision for and coordination of care for women veterans—including options for fee-basis care and specialty care. DAV is interested in hearing VA's testimony on these topics, and in the event that their current two-year plan does not address those specific provisions outlined in S. 1849, we would support passage of an amended version of this bill related to those specific provisions or any others that are missing from VA's plan.

S. 2045

S. 2045 would require judges of the United States Court of Appeals for Veterans Claims to reside within 50 miles of the District of Columbia. DAV has no resolution on this issue and has no position on this bill.

S. 2244, Veterans Missing in America Act of 2012

This bill would direct the Secretary of Veterans Affairs to cooperate with veterans service organizations and other groups in assisting the identification of unclaimed and abandoned human remains. The VA would also be required to determine if any such remains are eligible for burial in a national cemetery. The VA would cover the burial cost if the remains are determined to be that of an eligible veteran who does not have a next of kin or other person claiming the remains, and there are no available resources to cover burial and funeral expenses. In addition, the bill calls on the VA to establish a public database of the veterans identified in this project. DAV has no resolution on this issue and has no position on this bill.

S. 2259, Veterans' Compensation Cost-of-Living Adjustment Act of 2012

S. 2259 would provide for a cost-of-living adjustment (COLA), effective December 1, 2012, in the rates of compensation for veterans with service-connected disabilities and the rates of dependency and indemnity compensation for the survivors of certain disabled veterans based on the Social Security COLA. DAV generally supports this legislation; however, consistent with DAV Resolution 172, we oppose rounding down the adjusted rates to the next lower whole dollar.

S. 2320, Remembering America's Forgotten Veterans Cemetery Act of 2012

S. 2320 would direct the American Battle Monuments Commission to provide for the ongoing maintenance of Clark Veterans Cemetery in the Republic of the Philippines, and for other purposes. DAV has no resolution on this issue and has no position on this bill.

S. 3049

S. 3049 would expand the definition of homeless veteran for purposes of benefits under the laws administered by the Secretary of Veterans Affairs. DAV has no resolution on this issue and has no position on this bill.

S. 3052

S. 3052 would require the Secretary of Veterans Affairs to notify veterans who electronically file claims for benefits that they may be able to receive assistance from veterans service organizations (VSOs), and to provide contact information for such VSOs. DAV Resolution 001 states that, "... our first duty as an organization is to assist the service-connected disabled, their surviving spouses and dependents...", and the inclusion of information explaining the availability of VSO assistance and VSO contact information on electronic claims applications would likely increase our ability to do exactly that. In fact, DAV has made this exact request to the Veterans Benefits Administration as they have been developing a new electronic paperless claims system, and it is our understanding that just as VSO contact information is provided to veterans who file paper claims, it will similarly be provided to those who file electronic claims. As such, while enactment of statutory language may not be necessary, we are not opposed to the favorable consideration of this bill.

S. 3084, VISN Reorganization Act of 2012

S. 3084, the VISN Reorganization Act of 2012, would require the Secretary of Veterans Affairs to restructure and realign VHA's 21 current Veterans Integrated Service Networks (VISNs) as well as set personnel limits for VISNs.

Section 2 of the bill would place a limitation on the number of VISN management units at 12, down from the current 21, and would lay out the missions, policies, budgets, procedures and other responsibilities of these integrated regional VISNs, including alliances with other agencies, health care organizations and governments in conducting their work. It would also specify that each network's VISN headquarters be restricted to not exceed employment of more than 65 full-time employee equivalents, including contractors, and would require VA to submit reports to

Congress annually on VISN employment; budget and other benchmarks. This section would also prescribe a consolidation of the existing 21 VISNs in a specified pattern and direct the Secretary to choose one of the existing VISN offices consolidated as sites of the new combined VISN headquarters, including dealing with leased space in commercial buildings, relocation of employees and reemployment assistance for those displaced.

Section 3 of the bill would establish four VISN regional support centers whose main purpose would be to evaluate the effectiveness and efficiency of the new VISNs, across a number of parameters, with a preference that these support centers be established in existing VA medical center locations.

Section 4 of the bill would clarify that this reorganization of VISNs would not require any change to existing direct care at VA sites, including medical centers, CBOCs, or Vet Centers. DAV has no resolution concerning the organizational alignment of the VHA, or of the VISNs; thus, DAV has no position on this bill. However, last year, DAV, along with other national VSOs, put forward a set of nine recommendations to eliminate waste, duplication and inefficiency within VA, one of which dealt with the size of VISN bureaucracy versus its original mandate as outlined in VA's "Vision for Change" report that led to the creation of the current VISN structure. We would also note that the VA Office of Inspector General recently completed two reports on VHA's VISNs, with a particular concern about the size of their staffing. Results of these reviews were inconclusive, but strongly suggested that VISNs have expanded their permanent staffing allocations significantly compared to the levels in 1995, rather than relying on using "temporary" task forces and working groups pulled from medical centers and other facilities as envisioned in the original plan. In addition, a number of coordinator positions covering a variety of subjects (OEF/OIF; suicide; quality; credentialing of professionals; and FRC, etc.) have been imposed by Congress or VA Central Office over the years, further adding to their staffing totals. Also, pressures on acquisition, human resources and financial management have dictated establishment of consolidated functions for the activities at the VISN level leading to additional personnel. In our recommendations, DAV and the other VSOs urged Congress to examine VISN staffing and functions by contracting with the National Academy of Sciences, Institution of Medicine (IOM), to conduct an independent study of the VISNs, including their staffing levels, and to submit recommendations to Congress about whether and how these functions should be reorganized. We believe such a study is necessary before setting specific limitation on either the number of VISNs (12) or FTEE per VISN (65). Therefore, we recommend that the Committee ask IOM to conduct such a study, with appropriate protections for the many benefits the structure has brought to VA health care, before taking any legislative action to restructure or reorganize VHA's VISN system.

S. 3202, Dignified Burial of Veterans Act of 2012

S. 3202, the Dignified Burial of Veterans Act of 2012, would authorize VA to furnish a casket or urn to a deceased veteran when VA is unable to identify the veteran's next-of-kin and determines that sufficient resources are not otherwise available to furnish a casket or urn for burial in a national cemetery. The bill would further require that VA report back to Congress on the industry standard for urns and caskets and whether burials at VA's national cemeteries are meeting that standard. Under current law, VA is not authorized to purchase a casket or urn for veterans who do not have a next-of-kin to provide one, or the resources to be buried in an appropriate manner. DAV has no resolution on this issue and has no position on this bill. However, if it is to be favorably considered by the Committee, we urge additional resources be provided to VA to

ensure that implementation of this discretionary authority does not result in a reduction of funding for other authorized programs.

S. 3206

S. 3206 would extend from 2013 to 2018 the authorization of appropriations under title 38, United States Code, section 322, allowing VA pay a monthly assistance allowance to disabled veterans training or competing for the Paralympic Team. It would similarly extend the authorization of appropriation under section 521A for VA to provide assistance to United States Paralympics, Inc.

The DAV has testified previously on sections 521A and 322 before and after enactment of Public Law 110-389. Specifically, while the intent of Public Law 110-389 is laudable, our concern was and remains the impact it may have on the National Disabled Veterans Winter Sports Clinic, which is a rehabilitation event and not a training ground for future Olympians.

In addition, the same paragraph allows for individuals with disabilities who are not veterans or members of the Armed Forces to participate in sports programs that receive funds originating from VA grants. As an organization devoted to improving the lives of our nation's wartime disabled veterans, we are concerned about any shift of VA's mission, personnel, and resources away from disabled veterans, their families and survivors.

Unfortunately, our concern was appropriate based on issues surrounding the implementation, oversight and accountability for the first year of the grant program authorized under section 521A. As you may be aware, VA and U.S. Paralympics, a division of the United States Olympic Committee (USOC), signed its Memorandum of Understanding at the beginning of fiscal year 2010, announced the Olympic Opportunity Fund and subsequently sought proposals. It was in this first year that it became apparent to DAV there was a lack of VA oversight and accountability on the implementation of the grant program and grant recipients, as well as a lack of accountability to ensure adherence by certain grant recipients to the intent of the law.

We note, however, that a number of improvements have been and continue to be made since the consolidation of VA's Office of National Programs and Special Events, which managed VA's National Rehabilitation Special Events, with the Office of National Veterans Sports Programs and Special Events, and additional staff and resources were provided to this office. Furthermore, we look forward to the actions VA will take to address the findings and recommendations of the Government Accountability Office's investigation of this grant program.

In an effort to ensure limited VA resources are wisely spent directly, rather than incidentally, on disabled veterans and disabled members of the Armed Forces to participate in recreation and sport activities, we urge this Committee, if this measure is favorably considered, to include a future mandatory review of this grant program by the Government Accountability Office (GAO). We also urge this Committee to conduct oversight of this grant program subsequent to the release of GAO's upcoming and future reports.

S. 3238

S. 3238 would designate the VA community-based outpatient clinic in Mansfield, Ohio, as the David F. Winder Department of Veterans Affairs Community Based Outpatient Clinic. DAV has no resolution on this issue and has no national position on this bill.

S. 3270

S. 3270 would require the Secretary of Veterans Affairs to consider the resources of individuals applying for pension that were recently disposed of by the individuals for less than fair market value when determining the eligibility of such individuals for such pension. DAV has no resolution on this issue and has no position on this bill.

### S. 3309, Homeless Veterans Assistance Improvement Act of 2012

S. 3309, the Homeless Veterans Assistance Improvement Act of 2012, is a comprehensive bill that focuses on improving services for homeless veterans.

Sections 2, 3 and 4 of the bill require that recipients of VA grants for comprehensive service programs for homeless veterans meet physical privacy, safety, and security needs of such veterans; modify the authority of the Department to provide capital improvement grants for comprehensive service programs that assist homeless veterans by not only establishing but maintaining such programs; and provide funding for furnishing legal services to very low-income veteran families in permanent housing.

Section 5 modifies the requirements relating to per diem payments for services furnished to homeless veterans allowing such payments to include furnishing care for a dependent of a homeless veteran who is under the care of that veteran while he or she receives services from the grant recipient (or entity).

Section 6 authorizes grants by VA to centers that provide services to homeless veterans to be used for operational expenses. The aggregate amount of all grants awarded in any fiscal year may not exceed \$500,000.

Section 7 expands the authority of VA to provide dental care to eligible homeless veterans who are enrolled for care for a period of 60 consecutive days, and who are receiving assistance under section 8(o) of the United States Housing Act of 1937 (42 U.S.C. 17 1437f(o)); or receiving care (directly or by contract) in any of the following settings; a domiciliary; therapeutic residence; community residential care coordinated by the Secretary; or a setting for which the Secretary provides funds for a grant and per diem provider.

Section 8 of this measure extends the dates, authorities and resources affecting homeless veterans for the following programs in title 38, United States Code:

- Comprehensive programs
- Homeless veterans reintegration programs
- Outreach, care, treatment, rehabilitation and therapeutic transitional housing for veterans suffering from serious mental illness
- Program to expand and improve provision of benefits and services by VA to homeless veterans
- Housing assistance for homeless veterans
- Financial assistance for supportive services for very low-income veteran families in permanent housing
- Grant program for homeless veterans with special needs; and
- The Advisory Committee on Homeless Veterans

DAV is pleased to support S. 3309, the Homeless Veterans Assistance Improvement Act of 2012, as it is in line with DAV Resolution No. 205, which calls for us to support sustained and sufficient funding to improve services for homeless veterans. This resolution approved by our membership also urges Congress to strengthen the capacity of VA's programs to end homelessness among veterans and to provide health care and other specialized services for mental health, including dental care.

### S. 3313, Women Veterans and Other Health Care Improvements Act of 2012

S. 3313, the Women Veterans and Other Health Care Improvements Act of 2012, contains a number of important enhancements to women veterans health care programs.

Section 2 of the bill instructs the Secretary of Veterans Affairs to facilitate reproductive and infertility research conducted collaboratively by the Secretary of Defense and the Director of the National Institutes of Health to find ways to meet the long-term reproductive health care needs of

veterans who have a service-connected genitourinary disability or a condition that was incurred or aggravated while serving on active duty, such as spinal cord injury, that affects their ability to reproduce.

The Secretary of Veterans Affairs would ensure that any information produced by the research deemed useful for other activities of the VHA be disseminated throughout the VHA. Within three years after the date of enactment, the Secretary will report to Congress on the research activities conducted.

Section 3 of the measure clarifies that fertility counseling and treatments, including treatment using assisted reproductive technology, are medical services the Secretary may furnish to veterans.

Section 4 of this bill requires the Secretary to furnish reproductive treatment and care for spouses and surrogates of veterans by allowing the Secretary to furnish fertility counseling and treatment, including the use of assisted reproductive technology, to a spouse or surrogate of a severely wounded veteran who has an infertility condition incurred or aggravated while on active duty and who is enrolled in the health care system established under section 1705(a) 25 of title 38, United States Code, if the spouse and the veteran apply jointly for such counseling and treatment through a process prescribed by the Secretary.

In the case of a spouse or surrogate of a veteran not described who is seeking fertility counseling and treatment, the Secretary may refer such spouse or surrogate to a qualified clinician and would be required to prescribe regulations to carry this out no later than one year after enactment.

While DAV has no specific resolution from our membership related to reproductive and infertility research and fertility counseling and treatment, this section of the bill is focused on improving the Departments' ability to meet the long-term reproductive health care needs of veterans who have a service-connected condition that affects the veteran's ability to reproduce. For these reasons DAV has no objection to the passage of these sections of the bill, with the exception of subsection (b) of section 4 of the measure: DAV has no position on that particular subsection.

Section 5 of this bill requires that the Secretary of Veterans Affairs enhance the capabilities of the VA women veterans call center by responding to requests by women veterans for assistance with accessing health care and benefits and by referring such veterans to community resources to obtain assistance with services not furnished by VA.

Sections 6 and 7 of the bill seek to modify the pilot program of counseling women veterans newly separated from active duty in retreat settings by increasing the number of locations from three to fourteen and by extending the time of the pilot program from two years to four years; and to modify the duration of the established child care pilot programs for certain veterans receiving VA health care under Public Law 111-163 to note that the pilot program may operate until the date that is two years after the date on which the pilot program is established in the third VISN.

Section 7 of the measure would also require a child care pilot program in at least three Readjustment Counseling Service Regions for certain veterans receiving readjustment counseling and related mental health services. It requests the Secretary of Veterans Affairs to carry out a pilot program to assess the feasibility and advisability of providing assistance to qualified veterans to obtain child care so that such veterans can receive readjustment counseling and related mental health services.

Child care assistance under this subsection may include: stipends for the payment of child care offered by licensed child care centers either directly or through a voucher program; payments to private child care agencies; collaboration with facilities or programs of other Federal departments or agencies; or other forms of assistance as the Secretary considers appropriate. When the child care assistance under this subsection is provided as a stipend, it must cover the full cost of such child care.

No later than 180 days after the completion of the pilot program, the Secretary shall submit to Congress a report on the pilot program. The report shall include the findings and conclusions of the Secretary as a result of the pilot program, and shall include such recommendations for the continuation or expansion of the pilot program as the Secretary considers appropriate. There is authorized to be appropriated to the Secretary of Veterans Affairs to carry out the pilot program \$1,000,000 for each of fiscal years 2014 and 2015.

We thank the Chairman for her continued efforts on improving VA's women veterans health programs and services and are pleased to support this draft measure. DAV has heard positive feedback related to the pilot program of counseling women veterans newly separated from active duty in retreat settings and the childcare pilots established in Public Law 111-163. We supported the original provisions for these program pilots and are pleased to support the proposal to expand them. Likewise, we are supportive of the provisions in section 5 of the bill that require VA to enhance the capabilities of the Department's women veterans call center related to assistance with accessing health care and benefits and referrals to community resources to obtain assistance with services not furnished by VA.

Draft bill to establish and name outpatient clinic in Hawaii

Introduced by Senator Inouye, this bill would authorize the Secretary of Veterans Affairs to carry out a major medical facility project lease for a VA outpatient clinic at Ewa Plain, Oahu, Hawaii and designate such clinic as the Daniel Kahikina Akaka Department of Veterans Affairs Clinic. DAV has no resolution on this issue and has no national position on this bill.

Draft Bill on Mental Health ACCESS Act of 2012

This draft measure, the Mental Health Access to Continued Care and Enhancement of Support Services Act of 2012, or the Mental Health ACCESS Act of 2012, is a comprehensive bill focused on improving and enhancing the programs and activities of the Department of Defense (DoD) and VA related to suicide prevention and resilience and behavioral health disorders of members of the Armed Forces and veterans.

All of the sections in Title I of this bill are related to DoD matters with the exception of sections 105, 106 and 109. These provisions require collaboration between the two agencies with respect to improving sharing of patient records and information under the medical tracking system/ electronic health record shared between DoD and VA; participation of members of the Armed Forces in peer support counseling programs of VA; and compliance of DoD with requirements for use of VA's Schedule for Rating Disabilities in determinations of disability of members of the Armed Forces. DAV recognizes the need for the both Departments to collaborate on certain mental health matters and we are supportive of these specific sections in accordance with DAV Resolution No. 200, approved by our membership. This resolution supports program improvements and enhanced resources to support readjustment services for the post-deployment mental health needs of war veterans. Further, DAV Resolution No. 177 calls for improved collaboration between VA and DoD in making disability determinations. As for the remaining sections in Title I of the measure, however, DAV takes no formal position on the issues that fall exclusively under the jurisdiction of DoD.

Sections in Title II of the measure deal with VA mental health matters. Section 201 would instruct the Secretary of Veterans Affairs to develop and implement a comprehensive set of measures to assess mental health care services VA is providing. The provisions would require VA to specifically assess the timeliness of the furnishing of mental health care; the satisfaction of patients who receive it; VA's current capacity to furnish mental health care; and the availability and furnishing of evidence-based therapies.

The section also would require that the Secretary develop and implement guidelines and productivity standards for providers of mental health care for the staffing of general and specialty mental health care services, including those resident in community-based outpatient clinics. The bill would require the Secretary to enter into a contract with the National Academy of Sciences Institute of Medicine (IOM) to create a study committee to assess and provide an analysis and recommendations on the state of VA's mental health services. The study committee would also be responsible for assessing barriers to accessing mental health care by Operation Enduring Freedom, Operation Iraqi Freedom, or Operation New Dawn (OEF/OIF/OND) veterans as well as the quality of mental health care they are receiving.

We are especially pleased that the bill would require VA to provide detailed recommendations for overcoming observed barriers, and to improve access to timely, effective mental health care at VA health care facilities and that the Secretary and IOM would be required to include at least one former VHA official and at least two former VA employees who were providers of mental health care as members of the study committee. Likewise, we are pleased the bill includes provisions to ensure transparency in the process—specifically that the measures and guidelines developed and implemented as well as an assessment of the performance of VA using such measures and guidelines are to be made available to the public on a VA website and must be updated quarterly at a minimum.

Given the previous hearings held by this Committee on mental health matters and the findings from various informal surveys and official reports on timeliness of VA mental health care and ongoing staffing shortages, DAV fully supports the aforementioned provisions. These requirements are in line with a mandate from our membership contained in DAV Resolution No. 200.

Section 202 would expand the Vet Center mandate established in Public Law 111-163 to include Readjustment Counseling Service (RCS) furnishing counseling to certain members of the Armed Forces and their family members. This language would authorize limited eligibility for family members to receive counseling separately from a given service member when those family members are dealing with combat-related deployment problems. Under this section, counseling furnished could include a comprehensive assessment of the veteran's or family member's psychological, social, and other characteristics to ascertain whether they are experiencing difficulties associated with coping with the deployment of a member, or readjustment of the family to civilian life of a veteran or service member following a deployment.

The RCS provides an optimal model of psychological counseling for a veteran's family to assist with recovery and post-deployment mental health challenges. Therefore, we believe this provision is fully consistent with the RCS's mission and goals to help combat veterans recover from that unique experience. Public Law 111-163 provided VA a new authority for active duty personnel to receive Vet Center services outside their military chains of command, as well as a number of other, novel authorities enabling family caregivers of severely injured veterans to receive direct VA services. Historically, Vet Centers have been counseling family members in certain circumstances when such counseling is helpful to keep families intact, to deal with

survivors' grieving of a lost service member or veteran, to deal with separation anxieties and depression, and to aid family members in coping with a number of deployment-related stresses. Therefore, we see these new provisions as consistent with the RCS mission to continue as a non-medical source of healing and recovery for this young population. We believe this is an important, but incremental improvement in the RCS mandate. Therefore, DAV fully endorses this provision in accordance with DAV Resolution No. 189 that supports a comprehensive Vet Center Program for combat veterans of all eras.

Section 203 establishes authority for the Secretary of Veterans Affairs to furnish mental health care through facilities other than Vet Centers to immediate family members of Armed Forces personnel deployed in connection with a contingency operation; this authority would be subject to the availability of appropriations for this purpose. We support this provision, also on the strength of Resolution No. 189.

Section 204 stipulates the organization of the RCS in the VA and notes that it is a distinct organizational element within the VHA that provides counseling and other important health and psychological services. This measure would require the Chief Officer of the Readjustment Counseling Service to report directly to the Under Secretary for Health with no intervening supervisory layers between them. The provision would also specify qualifications of an individual for holding this sensitive post.

For the past 35 years, the RCS has served as a quasi-independent source of psychological counseling for combat veterans and family members. In fact, the Committee may recall that the original charter for the RCS was modeled on a novel readjustment counseling service initiated independently by DAV following the Vietnam War when it became apparent to our predecessors that VA was not addressing the urgent counseling and readjustment needs of a number of Vietnam veterans. As intended by Congress in establishing its original mandate in 1979, the RCS was to be an independent, non-medical, non-psychiatric source of care for certain veterans who did not want to be labeled "mentally ill" by VA, but who were in need of services to aid them in readjusting from the sacrifices they endured in military combat environments. The RCS succeeded all expectations in playing that role. Today's combat veterans have made it clear to DAV and others that they desire a similar, non-stigmatizing service to aid them, and have found the Vet Centers to be welcoming, non-judgmental places to receive that help.

Without notice to this community and without any consultation beforehand, the VHA journalized the RCS under its medical professional arm. The RCS office now reports through, and is thus restrained by, a gauntlet of bureaucracies led by VA physicians and those working for VA physicians in VA Central Office. Reporting to physicians is wholly inconsistent with the non-medical, psychological and pastoral mission of RCS, and detracts from its historic role as planner, budgeter, staffer and operator of all RCS programs in 300 Vet Centers in every State and most major cities. No other VA medical professional service in the current VHA configuration possesses this level of combined responsibility or accountability as does the RCS. We cannot see any advantage having been accrued to VHA as a consequence of this realignment (except perhaps to promote medical and psychiatric traditionalism), but many disadvantages have become apparent.

With these views in mind, we strongly endorse this section that would return RCS to its traditional state of independence from medical and psychiatric supervision in a VA bureaucracy. The section also would require funding for the activities of the Readjustment Counseling Service, including the operations of Vet Centers, to be derived from amounts appropriated for the VHA for medical services and not through the Veterans Equitable Resource Allocation system

that funds most other VA clinical care. The section would also require the budget request for the RCS to be segregated from other funding needs for VHA. We fully support these provisions on the same basis that we support RCS being maintained as a separate entity in VHA's organization, reporting only to the Under Secretary for Health. If funding for RCS is routed through VERA, it is subject to the overall needs of each VISN. This would give each VISN office the opportunity to parse RCS funding to other needs deemed more urgent or higher priority. We do not support this concept. RCS funding should be maintained and justified by RCS only, exclusive of interference by outside interests.

The section also requires that, not later than March 15 of each year, the Secretary shall submit a report to the Committee on Veterans' Affairs of the Senate and the House of Representatives on the activities of the RCS during the preceding calendar year. Each report would include for each period covered: 1) a summary of the activities of the RCS, including its Vet Centers; 2) a description of the workload and additional treatment capacity of the Vet Centers, including, for each Vet Center, the ratio of the number of full-time equivalent employees and the number of individuals who received services or assistance; 3) a detailed analysis of demand for and unmet need for readjustment counseling services; and 4) the Secretary's plan for meeting any such unmet needs. We support this provision.

Section 205 would instruct the Secretary of Veterans Affairs to carry out a national program of outreach to societies, community organizations, and government entities in order to recruit mental health providers, who meet the quality standards and requirements of the VA to provide mental health services for the Department on a part-time, without-compensation basis. In carrying out this program the Secretary could partner with a community entity or assist in the development of a community entity, including by entering into an agreement that would provide strategic coordination of the societies, community organizations, and government entities in order to maximize the availability and efficient delivery of mental health services to veterans. The Secretary would be required to provide training to mental health providers to ensure that clinicians who provided mental health services under this authority gain sufficient understanding of military and service specific culture, combat experience, and other factors that are unique to the experience of OEF/OIF/OND veterans.

DAV is pleased to support this comprehensive draft measure and we appreciate the Chairman's continued efforts on improving mental health programs and services for our nation's service members, veterans and their families. We are especially appreciative of your recognition of the importance of the RCS's role in restoring new veterans to society and family life following their strenuous deployments to Afghanistan and Iraq, over this decade-long war. We particularly appreciate those provisions in this bill.

DAV would again like to thank the Committee for the opportunity to submit our views on the numerous legislative measures under consideration at this hearing. Much of the proposed legislation would significantly improve VA benefits and services for our nation's service members, veterans and their families.

This concludes my testimony. I am happy to answer any questions Committee Members may have related to my statement.