



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](http://www.dav.org)

***STATEMENT OF  
ADRIAN M. ATIZADO  
DAV DEPUTY NATIONAL LEGISLATIVE DIRECTOR  
COMMITTEE ON VETERANS' AFFAIRS  
UNITED STATES SENATE  
MAY 17, 2017***

Chairman Isakson, Ranking Member Tester, and Members of the Committee:

Thank you for inviting DAV (Disabled American Veterans) to present our views on the bills under consideration at today's hearing. As you know, DAV is a non-profit veterans service organization comprised of nearly 1.3 million wartime service-disabled veterans. DAV is dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity.

**S. 23, Biological Implant Tracking and Veteran Safety Act of 2017**

This bill would require the Department of Veterans Affairs (VA) to establish a biological implant inventory identification and management system with the same features and requirements of an existing system in use by the Food and Drug Administration to regulate origin, movement, surgical implantation, and recall (if necessary) of any such biological material.

The term biological implant would be defined as any "animal or human cell, tissue, or cellular or tissue-based product," and would tie that definition to the existing regulatory definition under the Federal Food, Drug, and Cosmetic Act.

The bill would set a number of milestone and deadline dates for implementation, and would require VA to submit a series of reports to document its progress in implementation of this system. Procurement of biological implants would be restricted to vendors who meet certain conditions laid out in the bill, and would sanction any VA procurement employee involved in the procurement of biological implants who acted with intent to avoid, or with reckless disregard of the requirements of the bill.

A January 2015 report by the Government Accountability Office discussed weaknesses in procedures and compliance of those procedures on the purchase and tracking of surgical implants at VA facilities. Since the report was issued, we understand VA's ability to identify veterans who received an implant that is being recalled by the manufacturer or the Food and Drug Administration has been sufficiently strengthened, but that the compliance and requirements for purchasing surgical implants remains a concern.

VA Medical Centers (VAMC) or the Veterans Health Administration's (VHA) regional network contracting offices (NCO) can purchase, from the open market, a specific surgical implant requested by a clinician with appropriate clinical justification, rather than purchasing a similar item through a VA-negotiated competitive contract.

However, not recording the serial number or lot number for a surgical implant makes it difficult to systematically determine which veteran received an implant subject to a subsequent manufacturer or Food and Drug Administration recall. VHA policy stipulates that all open-market purchases of non-biological implants require a waiver approved by the VAMC Chief of Staff when a comparable item would have been available through a VA-negotiated national committed-use contract.

DAV has received no resolution from our membership that deals with the specific topic of surgical implants. However, DAV's Resolution No. 244 calls for VA to provide a comprehensive health care service for all enrolled veterans. Better control of the origins, movement, surgical implantation and recall, if necessary, of implantable biological material would be in keeping with the intent of our resolution. Therefore, DAV supports the intent of this bill.

As a technical matter, we recommend the bill language be amended to add a new section "§7330C," including subsequent references to this new section rather than the currently referenced "§7330B," which has already been added by Public Law 114-315, title VI, §612(a) on December 16, 2016.

**S. 112 – to amend title 38, United States Code to authorize per diem payments under comprehensive service program for homeless veterans to furnish care to dependents of homeless veterans**

Many community housing and supportive service programs available for homeless veterans do not have appropriate and safe accommodations to serve single-parent families. According to the National Coalition for Homeless Veterans, many organizations with Grant Per-Diem (GPD) programs do not have sufficient resources to provide housing for the children of veterans, or have major restrictions on the services they can provide, including age limits and the number of children per veteran they can accept. If enacted, this bill would authorize per diem payments under comprehensive service programs for homeless veterans to provide services and housing to dependents of homeless veterans funded by the VA GPD program.

According to the United States Housing and Urban Development Annual Homeless Assessment Report (AHAR) in 2016, about 9 percent (39,471) adults are homeless veterans and 3 percent (1,131) of these veterans are homeless and part of a family. Several factors related to military service can contribute to an increased risk of being homeless, such as having a mental health diagnosis and combat or wartime service. For women veterans these factors are increased. Over 300,000 women service members served in Iraq or Afghanistan—some with multiple tours that exposed them to combat and other hazardous situations during deployment. Research finds that women veterans are more likely to have experienced sexual trauma than women in the general population, and are more likely than male veterans to be single parents.

According to the Department of Defense (DOD), more than 30,000, of the women who served in the wars of Iraq and Afghanistan, were single parents and sole providers of dependent children. In its 2014 Sourcebook, VA reported about 46 percent of its women patients who served in Operations Enduring and Iraqi Freedom and Operation New Dawn had a mental health or substance use disorder diagnosis. Overall, it is estimated that women veterans are between two and four times as likely to be homeless as their non-veteran counterparts (according to a Congressional Research Service report dated November 6, 2015).

DAV is pleased to support S. 112. This measure is consistent with DAV Resolution No. 139, which calls for support of sustained and sufficient funding to improve services for homeless veterans, including homeless veterans with children.

### **S. 324, State Veterans Home Adult Day Health Care Improvement Act of 2017**

If enacted, this bill would authorize the Secretary to enter into new agreements with state veterans homes who provide medical supervision model adult day health care (ADHC) for veterans who are eligible for, but do not receive, skilled nursing home care under section 1745(a) of title 38, United States Code. Eligible veterans are those who require such care due to a service-connected disability, or who have a VA disability rating of 70 percent or greater and are in need of such care. Under this new authority, the payment to a state home for medical supervision model ADHC would be at the rate of 65 percent of the amount payable to the state home if the veteran were an inpatient for skilled nursing care, and payment by VA would be considered payment in full to the state home.

Viewed as a more cost-effective option than institutional services, adult day services today provided in elderly and adult day centers include day care, day health, and respite for family caregivers, which allows patients requiring long-term services and support to remain in their homes near family and friends, and delays institutionalization in nursing homes.

Adult day services have been divided into three models of care: social, medical, or combined. Social models tend to focus on socialization and prevention services, while medical models include skilled assessment, treatment, and rehabilitation goals, and combined models cover all areas. The distinction among these models has become increasingly unclear as these models have evolved into a dynamic, comprehensive model of care. Additionally, access to these centers is a challenge and transportation costs of patients must be considered.

The state veterans home ADHC medical model program is designed not just to promote socialization, stimulation, and maximize independence while enhancing quality of life, but also to ensure veterans have access to comprehensive medical, nursing, and personal care services. In addition, veterans have access to a full array of clinical and rehabilitative services during their day visits, equivalent to what is offered to full time nursing home residents. Currently, VA's per diem rate for state home ADHC is financially inadequate for most states to operate a medical supervision model program, of which there are only three in the nation at present. This legislation, which is based on the same concept as the existing "full cost of care" skilled nursing care program for severely disabled veterans, would measurably support the creation of more such

programs, and thereby provide more veterans, and their families, with options to avoid full-time institutionalization.

As this Committee is aware, there are many factors that impact the sustainability of adult day centers, including state regulatory requirements, staffing requirements and wages within a service area. DAV is pleased to support S. 324 based on DAV Resolution No. 142. In calling for enhancing VA's comprehensive program of long-term services and supports for service-connected disabled veterans irrespective of their disability ratings, this resolution also recognizes the need for VA to optimize its relationship with State Veterans Homes to ensure veterans in need of institutional and alternative forms of long-term services and supports may avail themselves of state home facilities to consider all options for their provision.

In addition, DAV understands that VA is close to finally releasing long overdue regulations that may create separate per diem rates for social and medical supervision model ADHC programs. Should such regulations be implemented, Congress should consider expanding this legislation to offer a "full cost of care" per diem rate for medical, social and combined models of Adult Day Services programs for severely disabled veterans.

#### **S. 543, the Performance Accountability and Contractor Transparency Act of 2017**

This measure would require entities entering into service contracts with VA to include performance metrics on cost, schedule and fulfillment of contract requirements. It further requires that the Secretary to ensure that contracts set forth plans and milestones for delivering specified services. For the largest contracts it requires use of VA IT systems to ensure that contractors are fulfilling their obligations and maintaining at least a threshold level of quality in services rendered. DAV has no resolution on this legislation, but does not object to its intent.

#### **S. 591 – the Military and Veteran Caregivers Services Improvement Act of 2017**

DAV strongly supports S. 591, the Military and Veteran Caregivers Services Improvement Act of 2017. This measure would allow severely ill and injured veteran from all eras who meet the requisite clinical eligibility criteria to be permitted to participate in VA's Program of Comprehensive Assistance for Family Caregivers. To ensure the program's integrity, the measure would phasing in veterans based on need, allowing VA to manage the new workload, while keeping service quality high. It would add a greater emphasis on mental health injuries and traumatic brain injury (TBI), and remove certain restrictions in current law on those eligible to become caregivers.

The bill would also make improvements to the VA caregiver program by including child care programs. Many family caregivers and veterans with young children are unable to receive VA supports and services they need without such a program. VA would also be authorized to provide caregivers financial advice and legal counseling. Improvements would be made in the DOD's Special Compensation for Assistance with Activities of Daily Living (SCAADL) including aligning the eligibility with that of the VA caregivers program, as well as making caregivers of service members receiving SCAADL eligible for a range of critical supportive services provided by VA.

We support this bill based on DAV Resolution No. 131, which calls for legislation that to provide comprehensive caregiver support services, including but not limited to financial support, health and homemaker services, respite, education and training, and other necessary relief to caregivers of veterans from all eras of military service.

VA's comprehensive caregiver program had been operating for over three years when Congress held a hearing late last year on how best to expand eligibility for the services and benefits of this program to severely ill and injured veterans of all eras. During the hearing, concerns were expressed about the program, and assertions were made that improvements should be made to the existing program prior to its further expansion.

We believe it is unconscionable to deny comprehensive caregiver supports and services to family caregivers who clearly need help today after decades of having cared for our nation's severely ill and injured veterans. Further, we believe that program improvements can be made while expanding eligibility to the Program of Comprehensive Assistance for Family Caregivers.

This is why DAV is bringing to bear our over 90 years of experience assisting veterans, their caregiver, families and survivors as we are working with the veteran community, VA, and Congress to address concerns about the program's operation, communication, transparency and fair treatment to ensure caregivers of severely disabled veterans today and in the future will receive comprehensive supports and services they need.

DAV recognizes the greatest obstacle to expanding this program is the cost for enacting legislation that would provide comprehensive caregiver support to all severely disabled veterans; nevertheless, we must acknowledge the cost of deploying service members to war. Caregivers of veterans severely ill and injured before September 11, 2001, have borne that cost for years, with little recognition or services for their sacrifices.

The years of sacrifices made by family caregivers has saved taxpayer money by reducing reliance on and delaying admission to nursing home facilities. The average cost per veteran per year in VA's comprehensive program is \$36,770 as compared to \$332,756 VA pays per veteran per year in a VA nursing home; \$88,571 in a community nursing home; and \$45,085 in per diem payments in a State Veterans Home.

Research has also shown well-supported caregivers of aging patients—such as World War II, Korea and Vietnam veterans—reduce overall health care costs by minimizing medical complications, lowering the number of hospital admissions and delaying admission into nursing homes. The business case to expand the comprehensive caregiver program has also been made in the report *Hidden Heroes: America's Military Caregivers*, by the RAND Corporation. The loving assistance provided by family caregivers saves taxpayers billions of dollars each year in health care costs, and enables severely disabled veterans to live at home rather than in institutions. DAV believes it is time for Congress to act to improve the Program of Comprehensive Assistance for Family Caregivers extend these supports and services to caregivers of severely ill and injured veterans of all eras.

## **S. 609, the Chiropractic Care Available to All Veterans Act of 2017**

DAV supports S. 609, the Chiropractic Care Available to All Veterans Act of 2017. This bill would require VA to offer chiropractic care at 75 VA medical centers by the end of 2018 and at every VA medical center by the end of 2020. DAV is pleased to support this measure, which is in line with DAV Resolution No. 244, calling for veterans' access to a "full continuum of care, from preventive through hospice services, including alternative and complementary care such as yoga, massage, acupuncture, chiropractic and other nontraditional therapies."

Veterans with chronic pain and other conditions that do not respond well to medical interventions are seeking alternative treatment options that do not involve use of opioids or other traditional pharmaceutical solutions. One study estimates that up to 40 percent of veterans from Iraq and Afghanistan may use complementary or alternative care practices. In the past decade, as access to chiropractic in VA has grown, veterans' use of chiropractic services has grown dramatically. VA currently offers chiropractic services as part of its medical benefits package and VA indicates that about 65 VA medical centers have chiropractors who are integrated into primary care, rehabilitation and other specialized care teams.

We caution that while some VISN and local VAMC policies restrict access to chiropractic services, VA must ensure such policies do not subvert congressional intent. This measure would ensure incremental expansion of chiropractic services at all VA facilities over the next four years, so veterans who want access to this type of care can easily access it in a VA health care setting.

## **S. 681 – the Deborah Sampson Act**

Women veterans are a rapidly increasing component of today's military, yet represent only a small part of the total force. The same is true within the veterans' population, which poses a significant challenge in delivering necessary health care, and providing supportive services to them. S. 681, the Deborah Sampson Act, would seek to address several issues women veterans face by resolving some of the barriers to care and services. Many women report feeling isolated as they transition from military service back into their roles within their family and the community. Combat exposure leading to post-traumatic stress disorder (PTSD) and other mental health conditions may further complicate reintegration.

DAV's report, *Women Veterans: The Long Journey Home* recommended the establishment of peer support networks in VA, to ease transition, isolation, and assist with readjustment problems. The enactment of a three-year, peer-to-peer pilot program under Section 101 would help many women readjust back into their communities by providing them assistance from a peer who can relate to their military service and understand the unique issues women face during deployment and reintegration. In addition, a peer counselor would offer pragmatic assistance in identifying and coordinating the many benefits and services administered by VA and other government agencies available to best meet their individual needs.

This program would place emphasis on women who have been exposed to military sexual trauma, have PTSD or other mental health conditions or who are at risk of homelessness. Peer

counseling is an evidence-based practice and VA is using peer specialists within many of its programs. In addition, Section 103 of S. 681 would expand the types of services and counseling available at peer retreats to include financial and occupational counseling, and information on conflict resolution and stress management to assist veterans with reintegration into family, employment and the community. DAV supports these provisions and the increased utilization of peer specialists.

DAV's report highlights the need for legal assistance and support for disability law, family law, employment law and criminal law. VA does not provide legal services and Section 201 would establish a partnership between VA and at least one nonprofit organization to address legal issues for which homeless women veterans have identified a high need. DAV supports this provision as a means of providing comprehensive support, not only to homeless women, but to all veterans at risk of homelessness due to legal issues affecting stable income, employment and housing.

DAV's report calls for enhanced housing support particularly for women with dependent children. Section 202 would earmark funding for grants to support homeless grant and per diem providers committed to providing assistance to women veterans and their families. Although DAV does not have a specific resolution addressing this issue we support the intent of this provision which would authorize VA to provide incentives to community grant and per diem providers to adapt and modify facilities and programs to support women veterans and their dependents. Women veterans frequently identify the need for child care and housing as a barrier to accessing needed care and services. Reports over the past few years indicate an increase in the number of homeless women veterans. Many of these women are single parents, and the sole providers for their dependent children. A recent DOD report noted that more than 30,000 single mothers deployed to Iraq and Afghanistan. Women of the most current deployments are more likely to become homeless than their male peers or women in the general population. Final Salute, an organization that provides women veterans with housing, indicated that over 70 percent of the women they have helped were single mothers. Homelessness creates a crisis, not just for the veteran, but for their dependent family members as well.

While we are mindful that certain issues disproportionately affect women veterans, the top 10 needs identified in the 2015 CHALENG survey for all homeless veterans include the need for legal assistance in areas such as housing, child support, restoration of driver's license and outstanding warrants and fines. For these reasons, we recommend these services be made available to both male and female veterans in need of them.

Section 301 of the Act would authorize VA to extend its coverage of newborn care from a maximum of 7 to 14 days. Section 302 would authorize VA to cover transportation of a newborn of a woman veteran, for the purpose of obtaining medically necessary care at another health care facility. DAV supports both of these provisions as a means of ensuring women veterans' access to medically necessary care. These additions would create a more robust VHA maternity care benefit for women veterans. A significant portion of the women returning from recent deployments are still in their childbearing years—VHA indicates 42 percent of its women patients are between 18-44 years of age. Improving the VA's maternity care benefit better assures their continued access to comprehensive and coordinated care developed to meet

veterans' needs. Additionally, women of recent deployments—especially those using VA health care—are likely to be service connected and many of their service-connected conditions, such as PTSD, are known to put them at risk of adverse pregnancy outcomes. VA must assure these women's care continues to be carefully managed during this vulnerable time and eliminate the likelihood of women choosing another source of care if this basic need is not met satisfactorily.

Title IV of the Deborah Sampson Act seeks to eliminate identified barriers to care for women veterans. DAV supports the provisions within this title. Between fiscal years 2003 and 2012, the number of women veterans using VA services grew from 200,000 to more than 362,000—an 80 percent increase within less than a decade. By 2020, women will comprise 11 percent of the veteran population and VA projects continued growth in the portion of the veteran population comprised of women over the next decades. Given this significant and rapid growth, VHA has been challenged to adapt its programs to successfully meet women's needs—particularly for gender-specific and sensitive care.

Section 401 would authorize \$20 million to retrofit VA facilities to address deficiencies in environment of care standards critical to ensuring the safety, privacy and dignity of women veteran patients. VA must modify its medical facilities to serve not only a higher volume of women, but also manage their specific health care needs. Safety, privacy, and additional needs for gender-specific capital equipment should all be taken into consideration in modifying facilities and in any new infrastructure designs or capital acquisitions.

In a December 2016 report, the Government Accountability Office found that about 27 percent of VA medical centers and health care systems lacked an onsite gynecologist and about 18 percent of VA facilities providing primary care lacked a women's health primary care provider. Section 402 would seek to ensure that women veterans have access to competent women's health providers by requiring that VA have a full or part-time women's health primary care provider at every VA medical facility and specifies that this individual would be involved in training others to meet women's needs. While not every VA medical center has the critical mass to necessitate having an onsite gynecologist, it is imperative that all facilities without a qualified gynecologist, establish a plan or have contracts in place to immediately address the needs of women presenting for this type of care. In addition, Section 404 would appropriate funds to continue VA's Mini Residency program for primary care, and emergency care physicians to learn more about treating women veterans' primary care needs.

Section 403 would establish the role of a Women Veteran Program Ombudsman at each VA medical center. Because women's health care needs cannot always be met at every VA facility, the role of the Women's Veteran Program Manager (WVPM) is essential to ensuring sources of gender-specific and veteran-specific health care is available to female veterans. WVPMs are responsible for establishing, coordinating, and integrating health care services for women veterans within VA medical facilities. Often, WVPMs are overburdened by their wide range of duties and responsibilities which makes it difficult for them to advocate on behalf of the women they serve. This bill provides an Ombudsman to aid the WVPM in addressing women's access to needed care and services. An ombudsman would also be able to assist with outreach and awareness which are often important in creating critical mass to initiate or maintain programs and services for women veterans. Because of the disparity in access for women



veterans to VA benefits and services, DAV agrees that a Women Veteran Program Ombudsman would be beneficial. We urge the Committee to work with VA to ensure that this position is integrated within the Veterans Experience Office.

Title V of the bill describes data collection and various required reports. Section 501 would require VA to submit and publish a report that includes information on the sex and minority status of each participant of each program operated by the Department. DAV supports this provision, but believes that the focus of such a report should be narrowed to incorporate those programs and services of most relevance to the House and Senate Veterans' Affairs Committees. DAV believes narrowing the scope of the report would yield higher quality data that was more meaningful to the Committees. In addition, the Committees could add programs required to report this data over time as necessary. Data on women veterans would allow VA to readily identify programs that underserve these gender and minority populations in relation to the proportion of the veteran population they represent. This information would be helpful in planning outreach or determining the ongoing need and demand for the program.

Section 502 would require the Secretary to report upon the availability of prosthetics made for women, including at each VA medical center. DAV supports the intent of this measure and believes that VA should expand the survey of all veterans using prosthetics, oversampling women to ensure their adequate representation, to determine their satisfaction with the prosthetic device(s) they obtain from the VA and the process used to obtain them. Prosthetics are not made available through uniform channels in VA—some are manufactured in house and some are purchased from private manufacturers.

There are special considerations in adapting prosthetics to meet women's needs such as using appropriately sized hands and feet and having accommodations to address weight fluctuations to ensure fit and comfort throughout the month and during pregnancy. Rehabilitation facilities throughout VA are accredited by the Commission for Accreditation of Rehabilitation Facilities and are required to use measures of patient satisfaction to assure full accreditation. Yet it is unclear if veterans have been asked about their satisfaction with prosthetic limb devices purchased or manufactured by VA, or with any training they might be given to properly use and care for the device. This information might be valuable to VA in identifying whether veterans prefer prosthetics made in VA or by private manufacturers, and whether subgroups of veterans such as women or younger veterans are more or less satisfied with their prosthetics than other veterans. DAV urges the Committee to look beyond just availability and use patient satisfaction with timeliness, comfort, durability, usability, and appearance as a finer gauge to determine the overall success of the VA prosthetics program.

Section 503 would require VA to create a centralized internet database for all VA women's resources, including staff contact information, available within the location in which the veteran is seeking services.

Section 504 would provide a sense of the Congress encouraging VA to adopt a more inclusive motto. DAV does not have a resolution on this provision and takes no position on this section.

DAV is pleased to support this comprehensive legislation, as it is consistent with many recommendations made in our report, *Women Veterans: The Long Journey Home*, and also with DAV Resolutions Nos. 129, calling for the support of enhanced medical services and benefits for women veterans, and 244, calling for support of the provision for comprehensive health care services to all enrolled veterans.

### **S. 764, the Veterans Education Priority Enrollment Act of 2017**

This measure, introduced by Senator Sherrod Rep Brown (D-OH) and cosponsored by Sen Thom Tillis (R-NC), would extend priority enrollment for college courses to veterans, service members, and eligible dependents who are utilizing GI education benefits. Expanding priority enrollment allows those individuals covered to plan purposefully so that they can finish their degrees before their benefits expire.

Many public colleges and universities currently extend priority registration to veterans when signing up for classes. This bill would expand this practice nationwide and would also include private schools with existing priority registration programs. The bill would not require colleges or universities to change their existing priority enrollment systems.

S. 764 would amend educational programs authorized under title 38, United States Code. If enacted into law, the Secretary or a State approving agency may not approve a program of education offered by such institution unless the institution allows a covered individual to enroll in courses at the earliest possible time pursuant to each priority enrollment system, if the educational institutions have a priority enrollment system for some students.

Covered individuals subject to S. 764 are those eligible for an educational assistance program provided for in chapter 30, 31, 32, 33, or 35 of title 38, United States Code, or chapter 1606 or 1607 of title 10, United States Code.

Our nation needs to support our veterans as they transition from military to civilian life. Congress, as well as VA and its partner agencies, have an obligation to ensure veterans not only enroll in college, but that they succeed when they get there. Education benefits provided to ill and injured veterans, their dependents, and survivors are essential for a veteran's successful transition. This legislation reveals a commitment to those who served by allowing covered individuals priority enrollment in courses. While DAV does not have a resolution from our membership on this particular issue, we would not oppose passage of this bill.

### **S. 784, Veterans' Compensation Cost-of-Living Adjustment Act of 2017**

This bill would provide a cost-of-living adjustment (COLA) in the rates of disability compensation for veterans with service-connected disabilities and in the rates of additional compensation for dependents, clothing allowance, and in dependency and indemnity compensation for survivors of certain service-connected disabled veterans. DAV supports annual COLA adjustments to account for the effects of inflation and other rising costs that veterans must bear, and therefore supports S. 784. However, we remain concerned that the current COLA formula is not always sufficient to account for such increases.

Congress customarily determines COLAs in parity with Social Security recipients, but it is important to note there have been years in which there were no COLA increases, or such as in 2017 when the COLA increase was quite small, only 0.3 percent. In many instances, veterans and their families rely on disability compensation as their sole source of income. In years when recipients receive no COLA increase, or when the increase is minuscule, it simultaneously erodes the value of their disability compensation benefits, and jeopardizes the ability of injured and ill veterans to maintain an adequate standard of living.

DAV supports legislation that provides veterans with a COLA increase in accordance with DAV Resolution No. 013, and recommends discussion and consideration of other methodologies for determining annual COLA adjustments that might provide a more realistic cost-of-living allowance for our nation's disabled veterans, their dependents and survivors. Compensation rates must bring the standard of living in line with that which they would have enjoyed had they not suffered their service-connected disabilities.

### **S. 804 – Women Veterans Access to Quality Care Act of 2017**

This measure would seek to improve VA health care facilities to better accommodate the needs of women veterans. Section 2 of the measure would direct the VA Secretary to establish standards to ensure that all medical facilities have the structural features necessary to sufficiently meet the gender-specific health care needs of veterans, including those for privacy, safety, and dignity. The bill would also require the Secretary to revise VA's prioritization methodology for funding construction projects to include these projects. Finally, it would require the Secretary to report to the House and Senate Veterans' Affairs Committees with a list of facilities that fail to meet such standards and the cost for renovations or repairs necessary to meet them.

DAV's report *Women Veterans: The Long Journey Home* points out that because of VA's aging infrastructure, many facilities are lacking inpatient and residential care for women veterans with separate, secured sleeping accommodations. In addition, VA medical centers must to provide women veterans primary care with gender-specific equipment like mammography units and other diagnostic or treatment equipment that is exclusive in the care of women at its medical facilities.

VHA policy dictates that women veterans will have exclusive space—space that is a separate physical location for the delivery of comprehensive primary care to women and is not shared by other clinics providing care to male veterans (VHA Directive 1330.07). VHA has made progress in developing such sites, but needs to assure all clinics have basic features such as privacy curtains and examination tables faced away from doors to assure the environment is conducive to patient treatment for all veterans.

Section 3 would require the Secretary to establish policies for environment of care (EOC) inspections, including the frequency of inspections and the roles and responsibilities of staff in performing inspections and complying with standards.

VHA's EOC requirements are set in place to protect the privacy, safety, and dignity of women veterans when they receive care. In December of 2016, The Government Accounting Office (GAO) released a report illustrating areas of concern in compliance with VHA's EOC requirements. A range of oversight deficits has occurred, including in the EOC rounds inspections process, weakness in policies and guidance, and variability in methods of data collection by facility staff and selection of information to report to VHA Central Office. In addition, when noncompliance is noted, guidelines to address the issues are not clearly delegated, nor is there follow up by VHA to verify the information received from its facilities.

VA must ensure its environment of care inspections process is aligned with its women's health handbook to ensure clarity, and uniformity throughout its facilities. VHA must also clarify roles and responsibility of medical staff responsible for identifying and addressing noncompliance of the environment of care rounds, and also follow up with its facilities to verify the accuracy of the information received, and to see that the deficient areas have been corrected.

Section 4 would require the Secretary to evaluate the performance of VA medical center directors by using health outcomes for women veterans who use VA medical services. The VA would be required to publish health outcomes for women veterans on a publicly available website including comparisons of the data to male veterans' health outcomes, and explanatory information for members of the public to easily understand the differences.

While it is imperative for VA leadership to ensure all personnel comply with laws, policy and directives, it is equally important to ensure the measuring criteria are clearly understood, the goal is obtainable, and that adequate resources are supplied. Administrators have control over ensuring that policies are disseminated and followed throughout their facilities, but they cannot necessarily control health outcomes which are a byproduct of patient genetics, patient behavior and physicians' care. To attach health outcomes as a performance measure of the directors, then, does not appear to be appropriate.

A more suitable measure would be to hold the directors responsible for compliance and non-compliance of VHA law, directives, and policies within their facilities. Policy compliance can be verified through inspections and audits and used to evaluate administrative performance. Adherence to policy seems a better measure to ensure that administrators are adequately performing within their span of control.

Section 5 would ensure that every VA medical center employs a full-time obstetrician/gynecologist, and mandates a pilot program to increase the number of residency program positions and graduate medical education positions for obstetricians/gynecologists at VA medical facilities, in at least three Veterans Integrated Service Networks.

Women veterans should be able to receive a basic level of treatment and (or) care at any facility of the Department from a knowledgeable women's health provider. It is noted that VHA primary care providers specially trained in women's health care services, such as breast exams—increased by 3 percent and 15 percent respectively, from fiscal year 2014 through fiscal year 2015. However, according to GAO, 27 percent of VA medical centers lack an onsite gynecologist, and 18 percent of VA's facilities providing primary care lacked a women's health

primary care provider. All facilities may not have the patient volume to merit an onsite gynecologist, but any facility without the ability to provide this specialized care should have a seamless process to refer women for necessary gender-specific care without delay. DAV supports this section; however, we want to ensure that facilities have the sufficient volume of women veteran patients to support a full-time obstetrician/gynecologist and the residency pilot program .

Section 6 would require the development of procedures to electronically share veterans' military service and separation data; email address; telephone number; and mailing address with State veterans' agencies in order to facilitate the assistance of benefits veterans may need. Under the bill, veterans would retain the option of not participating in this information exchange. Sharing of this information would make it easier to verify veterans' status and enable State agencies to respond more quickly to the needs of eligible veterans.

Section 7 would instruct the Government Accountability Office to examine whether VA medical centers are able to meet the health care needs of women veterans across a number of specific dimensions of care, including access, specialization, outcome differences, outreach and other key elements. Such a report would be valuable in determining which facilities require assistance to ensure consistency in making high-quality care available to women veterans.

The intent of this bill is consistent with DAV's 2014 Report, *Women Veterans: The Long Journey Home*; thus, the bill carries DAV's full support. The bill is also consistent with DAV Resolution No. 129 to support enhanced medical services and benefits for women veterans, passed by the delegates to our most recent National Convention.

It is in line with DAV Resolution Nos. 129, calling for the support of enhanced medical services and benefits for women veterans, and 244, calling for support of the provision of comprehensive VA health care services to enrolled veterans.

### **S. 1024 - Veterans Appeals Improvement and Modernization Act of 2017**

As this Committee knows, over the past year a remarkable workgroup comprised of the Veterans Benefits Administration (VBA), the Board of Veterans Appeals (Board) and a group of stakeholders who represent veterans, including DAV, spent significant time developing a new framework to modernize and streamline the appeals system. Through further consultation and collaboration with this Committee and others in Congress, we now have bipartisan appeals reform legislation, S. 1024, that DAV strongly supports. A similar bipartisan House bill, H.R. 2288, was also recently introduced, and we look forward to swiftly moving a final version of the appeals reform legislation through Congress and onto the President's desk to sign into law.

It is important to begin with the understanding that the pending and growing appeals inventory was primarily an unfortunate, yet foreseeable consequence of a long-term lack of adequate resources for both VBA and the Board. Over the past five years, there was a clear shift of focus and resources inside VBA to bringing down the claims backlog, thereby neglecting the appeals processing at VA Regional Offices (VARO) and resulting in today's staggering appeals

backlog. Moving forward, adequate resources will be critical to the success of appeals reforms, as well as continuing progress on the claims backlog.

The new appeals framework developed by the workgroup, and embodied within this legislation, would protect the due process rights of veterans while creating multiple options for them to receive their decisions in a more judicious manner. The critical core of the new framework would allow veterans to have multiple options to reconcile unfavorable claims' decisions, introduce new evidence new evidence at both the Board and VBA, and protect their earliest effective dates without having to be locked into the current long and arduous formal appeals process at the Board.

In general, the new framework offers three main options for veterans who are unsatisfied with their claims decision. First, there will be an option for a local, higher-level review of the original claim decision based on the evidence of record at the time of the claim decision. Second, there will be an option for readjudication and supplemental claims when new and relevant evidence is presented or a hearing requested. Third, there will be an option to pursue an appeal to the Board – with or without new evidence or a hearing.

The central dynamic of this new system is that a veteran who receives an unfavorable decision from one of these three main options may then pursue one of the other two appeals options. As long as the veteran continuously pursues a new appeals option within one year of the last decision, they would be able to preserve their earliest effective date, if the facts so warrant. Each of these options, or “lanes” as some call them, have different advantages that allow veterans to elect what they and their representatives believe will provide the quickest and most accurate decision.

For the higher-level review option, the veteran could choose to have the review done at the same local VARO that made the claim decision, or at another VARO, which would be facilitated by VBA's electronic claims files and the National Work Queue's ability to instantly distribute work to any VARO. The veteran would not have the option to introduce any new evidence, nor have a hearing with the higher-level reviewer, although VBA has indicated it may allow veterans' representatives to have informal conferences with the reviewer in order for them to point out errors of fact or law. The review and decision would be “de novo” and a simple “difference of opinion” by the higher-level reviewer would be enough to overturn the decision in question. If the veteran was not satisfied with the new decision, they could then elect one of two options.

In addition, for this higher-level review, VA's duty to assist (DTA) would not apply since it is limited to the evidence of record used to make the original claims decision. If a DTA error is discovered that occurred prior to the original decision, unless the claim can be granted in full, the claim would be sent back to the VARO to correct any errors and readjudicate the claim. If the veteran was not satisfied with that new decision, they would still elect the other appeal options. It is critical that relevant information be captured relative to decisions that have been overturned by a higher-level reviewer, the number of decisions upheld, and the number of decisions sent back to the VAROs to correct DTA violations. This information is needed to correct any claims processing errors that may be taking place within VAROs.

For the readjudication/supplemental claims option, veterans would be able to request a hearing and present new evidence that would be considered in the first instance at the VARO. VA's full DTA would apply during readjudication, to include development of both public and private evidence. The readjudication would be a de novo review of all the evidence presented both prior to and subsequent to the claims decisions until the readjudication decision was issued. As with a higher-level review, if the veteran was not satisfied with the new decision, they could then elect one of two options to continue redress of any contested issues. These first two options take place inside VAROs and cover much of the work that is currently done in the current Decision Review Officer (DRO) process, although it would be divided between two different lanes: one with and one without new evidence or hearings.

For the third option, a notice of disagreement (NOD) would be filed to initiate Board review, triggering the formal appeal process. The Board would operate two separate dockets, one that does not allow hearings and new evidence to be introduced; and a second that allows both new evidence and hearings. The Board would have no DTA obligation to develop any new evidence presented. For both of these dockets, appeals would be routed directly to the Board and there would no longer be Statements of the Case (SOCs), Supplemental Statements of the Case (SSOCs) or any VA Form 8s or 9s to be completed by VBA or the veteran. The workgroup had established a goal of having "no hearing/no evidence" appeals resolved within one year, but there was no similar goal discussed for the more traditional appeals docket. While eliminating introduction of evidence and hearings would naturally make the Board's review quicker, it is important that sufficient resources be allocated to the traditional appeal lane at the Board to ensure a sense of equity between both dockets.

For appeals that request hearings before the Board, veterans could choose either a video conference hearing or an in-person hearing at the Board's Washington, DC offices; there would no longer be travel hearing options offered to veterans. New evidence would be allowed, but limited to specific timeframes: if a hearing is elected, new evidence could be presented at the hearing or for 90 days following the hearing; if no hearing is elected, new evidence could be presented with the filing of the NOD or for 90 days thereafter. If the veteran was not satisfied with the Board's decision, they could elect one of the other two VBA options, and if filed within one year of the Board's decision, they would continue to preserve their earliest effective date. The new framework would impose no limits on the number of times a veteran could choose one of these three options, and as long as they properly elected a new one within a year of the prior decision, they would continue to protect their earliest effective date.

If the Board discovers that a DTA error was made prior to the original claims decision, unless the claim can be granted in full, the Board would remand the case back to VBA for them to correct the errors and readjudicate the claim. Again, if the veteran was not satisfied with the new claim decision, they could choose from one of the three appeals options available to them, and as long as they properly made that NOD election within one year of the decision, they would continue to preserve their earliest effective date.

## **Improving Claims Decision Notification**

While the workgroup was initially focused on ways to improve the Board's ability and capacity to process appeals, from the outset we realized that appeals reforms could not be fully successful unless we simultaneously looked at improving the front end of the process, beginning with strengthening claims' decisions. A clear and complete explanation of why a claim was denied is the key to veterans making sound choices about if and how to appeal an adverse decision. Therefore, a fundamental feature of the new appeals process must include ensuring that claims' decision notification letters are adequate to properly inform the veteran.

Under the new framework, the contents of the notification letter must be clear, easy to understand and easy to navigate. The notice must convey not only VA's rationale for reaching its determination, but also the options available to claimants after receipt of the decision. The bill includes this provision to require that in addition to an explanation for how the veteran can have a claim decision reviewed or appealed, all decision notification letters must contain the following information to help them in determining whether, when, where and how to appeal an adverse decision:

- (1) Identification of the issues adjudicated;
- (2) A summary of the evidence considered by the Secretary;
- (3) A summary of applicable laws and regulations;
- (4) Identification of findings favorable to the claimant;
- (5) In the case of a denial, identification of elements not satisfied leading to the denial;
- (6) An explanation of how to obtain or access evidence used in making the decision; and
- (7) If applicable, identification of the criteria that must be satisfied to grant service connection or the next higher level of compensation.

Overall, the new framework which is embodied in the legislation would provide veterans with multiple options and paths to resolve their disagreements more quickly, while preserving their earliest effective dates to receive their full entitlement to benefits. The structure would allow veterans quicker "closed record" reviews at both VBA and the Board, but if they believe that additional evidence is needed to satisfy their claim, they retain the right to introduce new evidence, or request a hearing at either VBA or the Board. If implemented and administered as envisioned by the workgroup, this new appeals system could be more flexible and responsive to the unique circumstances of each veteran's claim and appeal, leading to better outcomes for many veterans.

## **Significant Improvements to the Appeals Framework in this Legislation**

Although this bill embodies the appeals modernization framework agreed to by the workgroup last year, it also includes some significant improvements.

First, the legislation would enhance effective date protections for claimants that choose to file appeals with the Court of Appeals for Veterans Claims (Court). Claimants could preserve their effective dates for continuously pursued claims, if they choose to file a supplemental claim within one year following a decision from these courts. This is a fair and equitable approach to



provide claimants with the option to exercise their full appellate rights, without having to potentially jeopardize their effective date.

Second, under this proposal, claimants with legacy appeals would be permitted to enter into the new system at certain junctures. In instances when a SOC or SSOC is issued, claimants would have the opportunity to opt into the new processing system. In addition, the legislation would allow veterans who file a NOD within one year of the new system becoming effective to have the option to enter into the new system rather than being forced to undergo processing in the legacy system. These changes were proposed by VBA and the Board, and DAV supports them. Allowing claimants to make well informed decisions on the type of processing that is in their best interest would not only help to reduce the number of legacy claims, but provide these claimants with options best suited for their individual circumstances.

Third, in order to provide greater assurance that VBA and the Board are prepared to make this major transition to a new appeals system, the legislation would require the Secretary to submit a detailed transition and implementation plan, and then require the Secretary to certify that all elements are in place to efficiently process legacy claims and run the new modernized system. Furthermore, VSO collaboration is required along with this certification, a provision that serves everyone's best interests. DAV looks forward to continuing to work with VBA, the Board and Congress to ensure the transition and implementation is as smooth as possible.

Lastly, the legislation contains detailed reporting requirements, along with oversight to be performed by the Government Accountability Office (GAO). It is essential to have continuous real-time data concerning elements of both the legacy system and modernized system. In order to measure VA's progress, these metrics will assess where modifications would be needed in order to improve processing within either system. The oversight performed by GAO is another effective way of ensuring these changes produce a positive outcome for claimants within the legacy and modernized systems.

## **RECOMMENDATIONS**

### **Options Following decision by the Agency of Original Jurisdiction**

Section 2(h)(1) of this bill sets forth the options available to a claimant once a decision has been made, which include, but are not limited to, filing a supplemental claim, requesting a higher level review, or filing a notice of disagreement.

Within this provision, there is some uncertainty how the word "claim" would be interpreted. Today a single claim can contain one issue, or multiple issues. The intention is to allow a claimant to choose any of the three options noted above separately for each "issue" contained within a claim in order to avoid any unintended consequences that would disadvantage a claimant. For example, a veteran seeking an increased rating for hearing loss should be able to choose to file a supplemental claim for that issue, while also filing their notice of disagreement to the Board for the denial of service connection for a left knee disability. Allowing each issue to flow through the most appropriate "lane" will not only result in more timely decisions for the veteran, it will also make more efficient use of both VBA and Board resources.

DAV recommends:

- The legislation clarifies that claimants can elect different appeals options for individual issues decided within a claim.

### **Appeals to the Board**

The manner in which evidence would be handled by the Board, particularly, as it pertains to their DTA requirements would fundamentally change under this proposal. The legislation would require the Board to establish at least two separate dockets, while providing them with the ability to create additional dockets.

For cases before the Board wherein no hearing is elected on the NOD, and where there is no request to submit additional evidence, the evidence considered by the Board would be limited to the evidence of record at the time of the agency of original jurisdiction decision.

For cases with no hearing request, but a claimant elects to have new evidence considered by the Board in the first instance, that evidence must be submitted by the appellant, or his or her representative, if any, with the NOD and within 90 days following receipt of the NOD.

For cases wherein a hearing is requested, new evidence would be limited to evidence submitted by the appellant, and his or her representative, if any, at the Board hearing and within 90 days following the Board hearing. In this instance, the legislation does not make clear whether evidence presented with the NOD or 90 days thereafter would be accepted, returned or ignored. Would the Board really ignore evidence that arrived one day prior to a hearing?

DAV is pleased to see the inclusion of robust reporting requirements in the bill, particularly as it pertains to appeals processing metrics for each separate docket. Furthermore, we are pleased to see the inclusion of a provision requiring the Board to send written notice to claimants when new evidence they submit is not considered in making the decision because the evidence was not received within the established timeframes. The notice would also contain information on a claimant's option to have the evidence considered by VA following the decision through another one of the lanes.

DAV recommends:

- That claimants electing a Board hearing, with the option to supply evidence, should be permitted to introduce this evidence from the filing of the NOD until 90 days after the hearing. Evidence presented prior to a hearing should simply be made part of the record and considered in conjunction with the appellate issues before the Board. Since the Board no longer would have any DTA obligations, all new evidence would be considered at the same time after the hearing.
- The legislation would also provide the Board with the authority to screen cases in order determine if further development is required earlier in the process, rather than waiting

longer to accomplish the same thing. To assure this authority is properly utilized, DAV recommends:

- The Board be required to report on all screened cases, delineated by:
  - The number of issues found to require additional development;
  - The types of issues that required additional development, i.e., issues involving service connection, or issues involving increased ratings;
  - The number of claimants that chose to opt into the new system following remand;
  - The number of claimants that chose to remain in the legacy system following remand;
  - The number and types issues that were granted based on screening;
  - The number of cases containing multiple decisions, including how many of the issues were remanded, denied, or allowed.

The legislation mandates the creation of at least two dockets discussed above, and also provides authority for the Board to create additional dockets, subject to notifying the Senate and House Veterans' Affairs Committees with justification. The Board might consider creating a third docket in order to separate appeals that will include new evidence, but do not request a hearing. As it stands now, veterans who submit new evidence, but do not request a hearing, could be forced to wait months or even years behind veterans who request a hearing. A third docket could avoid such unnecessary delays for veterans, allow greater oversight and make more efficient use of Board resources.

### **“New and Relevant” Evidence**

The legislation would replace the standard for reopening claims, changing “new and material” to “new and relevant.” In the current system, the “new and material” standard has not effectively functioned as intended to focus VBA and Board resources on adjudicating the substance of claims and appeals.

In order to monitor whether the “new and relevant” standard will be more effective in this regard, while continuing to protect veterans' rights, DAV recommends:

- VBA and the Board should regularly report on the number and outcome of “new and relevant” decisions, including –
  - The number of supplemental claims denied because no “new and relevant” evidence had been received;
  - The number of higher level reviews filed with respect the issue of no “new and relevant” evidence, and the disposition of these higher level reviews;
  - The number of appeals filed with respect to the issue of no “new and relevant” evidence, which Board docket or options were used, and the outcome of the Board's determination, i.e., decisions upheld, decisions overturned, cases remanded for DTA violations.

## **Stakeholder Transition and Implementation Advisory Committee**

Since March of 2016, DAV, Congress, VA, the Board and other stakeholders have worked very closely to develop and refine the appeals modernization proposal. This partnership has been integral to making sure a modernized system will benefit our nation's injured and ill veterans, without compromising their due process rights and keeping VA's non-adversarial roll intact.

We are appreciative of the provision contained within this bill requiring the Secretary to collaborate and consult with veterans' service organizations and other stakeholders considered appropriate by the Secretary, as part of the certification required to begin operating the new appeals system, and expect that our continued partnership with VA will benefit both veterans and the VA. However, the hard work of implementing and operating this new system will continue for many years, and VSOs and other stakeholders can and must continue to play an integral role supporting this effort.

To ensure this partnership continues on throughout all phases of the implementation process, DAV recommends:

- The legislation include a provision to create a "Stakeholder Transition and Implementation Advisory Committee" to engage with VBA and the Board during implementation, transition and operation of the new system. This advisory committee should be composed of at least the three largest VSOs in terms of the number of claimants they represent before VBA and the Board, as well as other major stakeholders who represent veterans at VBA or the Board, as determined by the Secretary.

## **Planning, Oversight and Public Reporting**

The bill includes a number of new planning, reporting and certification requirements that are appropriate for legislation embodying such a significant reform. This level of reporting is critical to allow Congress and other stakeholders to help identify and offer solutions to unintended consequences and problems that may arise.

To strengthen this oversight, DAV recommends:

- The legislation requires that all VA plans, metrics and reports provided to Congress also be made immediately available to the public.

## **Temporary Staffing Increases**

Finally, as mentioned above, the most critical factor in the rise of the current backlog of pending appeals was the lack of sufficient resources to adequately manage the workload. Similarly, unless VBA and the Board request and are provided adequate resources to meet staffing, infrastructure and IT requirements, no new appeals reform will be successful in the long

run. As VBA's productivity continues to increase, the volume of processed claims will also continue to rise, which has historically been steady at a rate of 10 to 11 percent of claims decisions. In addition, the new claims and appeals framework will likely increase the number of supplemental claims filed significantly.

We are encouraged that VA has indicated a need for greater resources for both VBA and the Board in order to make this new appeals system successful; however, too often in the past funding for new initiatives has waned over time. We would urge the Committee to ensure that proper funding levels are determined and appropriated as this legislation moves forward.

Over the past few years, DAV and our *Independent Budget* partners have recommended that Congress consider providing VBA with the temporary authority and resources to hire two-year temporary employees. In the past, VBA used such an authority to hire several thousand employees for a temporary two-year term. At the end of those two years, many of the best that were hired on a temporary basis transitioned into permanent positions that became open due to attrition. VBA not only had additional surge resources to work on the claims backlog during the first two-years, but VBA also benefited by creating a pool of trained, qualified candidates to choose from as replacements for full-time employees leaving VBA.

The bill recognizes the need to address personnel requirements within the VBA and the Board as they implement and administer the modernized appeals system, as well as address the legacy appeals. In order to provide a surge capacity to address both appeals and claims, DAV recommends:

- VBA and the Board are provided additional authority and resources to hire two-year temporary employees, with the goal of eventually converting the best of the temporary employees into permanent employees based on the future and continuing personnel requirements of VBA and the Board.

This legislation represents a true collaboration between VA, VSOs, other key stakeholders and Congress in order to reform and modernize the appeals process. We are confident this bill, with the additional improvements recommended by DAV and others, could provide veterans with quicker favorable outcomes, while fully protecting their due process rights.

### **S. 1094 – Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017**

This legislation seeks to enhance accountability for VA managers and employees, strengthen protections for whistleblowers and enhance VA's ability to hire certain senior health care director positions. The bill would codify and strengthen the Office of Accountability and Whistleblower Protection recently created by Executive Order, in order to manage and investigate whistleblower disclosures, train staff about protecting whistleblowers and to report upon methods that might be used to retaliate against them. The bill would also lower the administrative burden for firing, demoting or taking other adverse personnel actions against VA senior executives and employees who are poor performers or who have engaged in misconduct, including criminal activity.

As detailed in DAV Resolution 068, we support meaningful accountability measures as long as they include appropriate due process protections for VA employees. Legislation that changes existing employment protections in VA must strike a balance between holding all civil servants fully accountable for their professional conduct and job performance, while enabling VA to become an employer of choice in order to engage the best and brightest employees to care for our ill and injured veterans.

The bill would provide the Secretary with new authorities to hold senior managers and employees accountable by streamlining, standardizing and shortening certain timelines and processes used to implement personnel actions, including reprimands, suspensions, demotions or firings. We agree that it is critical that the Secretary be given adequate tools to quickly discipline or remove employees who endanger veterans health or welfare, commit a felony, engage in misconduct, abuse their positions of trust or otherwise fail to adequately perform their jobs. However we must also remain cognizant that applying different accountability standards with fewer job protections to just one federal agency could have unintended consequences on recruitment and retention, particularly in highly competitive fields, such as health care and information technology, which already have critical professional staff shortages. For some potential VA employees, job stability and due process in employment matters are attractive features of federal employment that help mitigate against others including lower pay, benefits or career advancement possibilities.

The legislation also makes a significant change to the evidentiary burden imposed on VA when exercising the new authority to reprimand, suspend, reassign, demote, or remove employees. Currently, personnel actions taken for any reason other than performance, such as for misconduct, require that a “preponderance of the evidence” standard be satisfied, which is generally interpreted to mean greater than 50 percent of the evidence. This legislation, however, would lower the burden to “substantial evidence”, which the Supreme Court has interpreted to mean “more than a mere scintilla” of evidence. This significant reduction in evidentiary burden would certainly have the effect of making personnel actions against employees, up to and including firing, substantially easier for VA to implement, however it is unclear how such a change would affect the important balance between accountability and due process. For example, it could theoretically be possible under this new standard that a “preponderance of evidence” supports an employee’s defense, yet they could still be removed from their job as long as there is “more than a mere scintilla” of evidence produced by VA—that is, there may be some relevant evidence as reasonable minds might accept as adequate to support VA’s action to remove an employee even if it is possible to draw a contrary conclusion from the evidence. We have concerns about whether this new standard might have unintended consequences in terms of making VA a less desirable choice for potential employees, especially in comparison to other federal agencies that are bound by the higher evidentiary standard.

In light of these concerns, we support Sections 210 and 211, which would assess the effect of the enactment of the provisions on accountability of senior executives, supervisors, and other employees. We are hopeful these reports will provide valid and meaningful outcome data to help determine whether Title II of this bill is achieving its intended purpose.

Much more important in our view than the evidentiary standard is the practical reality that no accountability measure can or will be successful unless leaders properly train and hold managers accountable for documenting the performance and conduct of employees, and ensure administrative procedures required are fully and properly carried out to initiate personnel actions. We note Section 209 requires VA to provide periodic training to supervisors on, among other things, how to effectively manage employees who are performing at unacceptable levels. We believe this section is critically important and support its inclusion. In our opinion, true accountability relies more on the actions of VA leaders and managers than on any underlying laws or evidentiary standards.

DAV supports enactment of the Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017. We applaud the bipartisan effort to ensure greater accountability and strengthened whistleblower protections within VA and thank Senators Rubio, Tester and Isakson for working with DAV to ensure VA is able to enforce accountability standards to attract, hire and retain the brightest and best employees our nation has to offer to care for ill and injured veterans.

### **Draft bill – Serving Our Rural Veterans Act of 2017**

This bill directs the VA to establish an eight-year medical residency training program in conjunction with the Indian Health Service to train medical residents and interns at “covered facilities,” which are defined as facilities operated by an Indian tribe or the Indian Health Service (IHS).

Additionally, it amends section 7406 of title 38, United States Code, by replacing the term “department facility” with “covered facility.” In this instance, covered facility is defined as any department facility or one of the four types of newly added covered facilities; IHS facilities, Indian tribe facilities, federally qualified health centers, and community health centers. VA would reimburse covered facilities for their participation in the program and require any participating medical resident to enter into an agreement for a period of obligated service of one year for each year served in the medical residency training program.

DAV Resolution No. 055 supports fulfilling the rights and benefits earned by service-connected Native American and Alaska Native veterans and urges Congress to ensure that the five mutual goals recognized by the current memorandum of understanding between the VA and the IHS is fully implemented so that these veterans can receive the benefits and services they have earned and deserve. In light of our resolution, DAV supports the intent of this bill and urges the Committee strengthen certain provisions.

The reimbursement requirements laid out in the bill goes well beyond salary and benefit reimbursement for the participating residents. Given the defined and already limited resources of the VA, Congress must appropriate additional funding for the VA Office of Academic Affiliations to ensure existing residency programs are not adversely impacted due to the substantial cost of developing, standing up, and administering, as well as recruiting for the pilot program. We recommend authority for this program be subject to specific appropriated funds.

Furthermore, because it is uncommon for the service obligation to exist in other medical programs generally available to most medical students seeking a residency, we urge the Committee work with VA and other appropriate entities to address the period of obligated service required by the bill, which could act as a disincentive to recruiting top candidates in the medical field.

DAV thanks Senator Sullivan and the committee for its support of Native American and Alaska Native veterans, and ask that you confer with the VA Office of Academic Affiliations and the Association of American Medical Colleges to ensure that the intentions of the bill most fully meet the needs of this veteran community.

### **Draft Bill – Veteran Partners’ Efforts to Enhance Reintegration or “Veteran PEER Act”**

Enactment of the Veteran PEER Act would require VA to establish a program that includes peer specialists within patient aligned care teams (PACT) in medical centers of the VA to promote better integration of mental health services into the primary care setting. VA would have to carry out this program in at least 10 VA medical centers within the first 180 days of the Act passing and in no less than 25 locations after two years of the enactment of the bill, including within VA’s five polytrauma center locations.

The bill also would require VA to consider the feasibility of locating peer specialists in rural areas and other locations that are underserved by the Department. VA would be required to ensure that the unique needs of women veterans are considered and that female peer specialists are included in the program. The measure includes requirements for routine reporting to include findings and conclusions with respect to the program and recommendations related to the feasibility of expanding the program.

Veterans must have the ability to easily access to mental health services especially during a crisis. However, even when in crisis, many veterans are reluctant to reach out for help and seek the care they need. Since 2012, VA has hired over 1,000 Peer Specialists, and some mental health providers indicate that peer-to-peer interactions have been extremely helpful to both patients and clinicians. The Center for Medicare and Medicaid recognized Peer Support as an evidence-based practice a decade ago. Studies have found use of peer specialists is associated with better treatment satisfaction, more treatment engagement, less inpatient care utilization and more engagement in patients’ communities. However, a recent study published in the *Journal of Behavioral Health Services and Research* found that VA is still struggling with identifying appropriate supervision and training for these individuals and has been hesitant to fully include them as part of the patient care team. The Veteran PEER Act would assist with ensuring better utilization and inclusion of these professionals and could help to improve efficiency of VA peer specialists and ultimately health outcomes for veterans.

We are pleased the bill also includes provisions that would require VA to address the needs of women veterans. Findings show that when women return from deployment, the camaraderie and support from their male peers is often short-lived, resulting in isolation for many. Studies have shown that peer support is important to a successful transition, but women often report they cannot find a network of women who can relate to their military or wartime



service. Including the requirement of hiring female peer specialists in this measure helps ensure that women veterans will have a peer they can relate to and someone that understands their unique needs. Their ability to relate to other veterans because of their shared military experiences and mental health recovery is a key element of the program.

DAV is pleased to support the Veteran PEER Act, which is consistent with the following DAV Resolutions: No. 250, which calls for program improvements for VA mental health services to include increased staffing levels, improved outreach to veterans with a focus on reducing stigma when seeking post-deployment readjustment and other mental health services; and No. 129, which calls for enhanced medical services for women veterans as well as additional methods to address barriers to care. Finally, the bill is consistent with recommendations in DAV's 2014 report, *Women Veterans: The Long Journey Home* that notes the use of peer specialists can help reduce stigma and increase the acceptability of mental health care for veterans who need it and improve recovery.

### **Draft Bill – Department of Veterans Affairs Veteran Transition Improvement Act**

The Wounded Warriors Federal Leave Act of 2015 (Public Law 114-75), enacted in 2015, provides a separate new leave category, to be known as “disabled veteran leave,” of 104 hours to any new<sup>1</sup> Federal employee who is a veteran with a service-connected disability rated at 30 percent or more for purposes of undergoing medical treatment for such disability for which sick leave could regularly be used.

Subsequently, because disabled veterans who work for the Federal Aviation Administration (FAA) and Transportation Security Administration (TSA) did not have access to additional leave to treat service-related injuries, legislative relief in the form of Senator Hirono's bipartisan Federal Aviation Administration Veteran Transition Improvement Act was enacted into law in October 2016. It ensures that disabled veteran new hired employees at the FAA and TSA have access to the sick leave benefit during their first year on the job just as their counterparts in other agencies receive.

Notably, there are other categories of federal employees not covered by the both the Wounded Warrior Federal Leave Act and the FAA Veterans Transition Improvement Act including: employees of the United States Postal Service or the Postal Regulatory Commission, since they are covered by regulations issued by the Postmaster General; employees not covered under title 5, United States Code, section 2105 (such as employees of DOD non-appropriated fund instrumentalities); and employees not covered by a leave system (such as those with intermittent work schedules or leave-exempt Presidential appointees).

It appears disabled veterans employed under title 38 have a separate and distinct leave system than that under title 5 and therefore are unable to access the benefits provided under the Wounded Warriors Federal Leave Act of 2015.

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<sup>1</sup> Federal employee newly hired on or after November 5, 2016, with no previous Federal service, reappointed with at least a 90-day break in service, or military reservists or members of the National Guard who return to duty in their civilian positions after a period of military service.

We support the intent of this measure as contemplated under DAV Resolution 260, urging Congress to extend protection under the Family and Medical Leave Act (FMLA) to encompass the medical care needs of veterans with service-connected disabilities. We recognize in addition to FMLA, there are a variety of leave options and workplace flexibilities available to take time off from work to receive medical treatment for a veteran's disability, such as annual leave, sick leave, advanced annual leave or advanced sick leave, donated leave under the voluntary leave transfer program, alternative work schedules, credit hours under flexible work schedules, compensatory time off and telework and voluntary leave bank program.

This concludes my testimony, Mr. Chairman. DAV would be pleased to respond for the record to any questions from you or the Committee Members concerning our views on these bills.