S. HRG. 117–501

# HEARING TO CONSIDER PENDING LEGISLATION

## HEARING

BEFORE THE

## COMMITTEE ON VETERANS' AFFAIRS
## UNITED STATES SENATE

ONE HUNDRED SEVENTEENTH CONGRESS

FIRST SESSION

OCTOBER 20, 2021

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# C O N T E N T S

OCTOBER 20, 2021

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# HEARING TO CONSIDER PENDING LEGISLATION

**WEDNESDAY, OCTOBER 20, 2021**

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
*Washington, DC.*

The Committee met, pursuant to notice, at 3 p.m., via Webex and in Room SR-418, Russell Senate Office Building, Hon. Jon Tester, Chairman of the Committee, presiding.

Present: Senators Tester, Murray, Sanders, Brown, Hirono, Manchin, Sinema, Hassan, Moran, Tillis, Sullivan, Blackburn, and Tuberville.

## OPENING STATEMENT OF CHAIRMAN TESTER

Chairman TESTER. I call the Committee on Veterans' Affairs to order.

Good afternoon to everybody. I want to thank you for joining us here to hear the views from the VA and the Veterans Service Organizations on 18 pending bills before this Committee.

In the wake of the U.S. withdrawal from Afghanistan this summer, the Veterans Crisis Line saw a sharp increase in calls, texts, and chats to hotlines. To the hotline, I mean. The Veterans Crisis Line provides a valuable service to veterans in crisis or distress and can be a lifeline not only for emergency response but for connecting veterans to VA healthcare.

Due to this increased VCL use and recent disturbing oversight reports, today we are going to consider the REACH for Veterans Act, a bill that I worked on with Senator Moran, to strengthen the Veterans Crisis Line and ensure every veteran who calls receives the best possible service. This bill will bolster the VCL's staff training, management, and response to high risk veteran callers that are at risk of suicide.

October is Breast Cancer Awareness Month and a good reminder that we must provide access to high quality mammography and breast cancer care for our veterans. On our agenda today is the MAMMO for Veterans Act, a bill I introduced with Senator Boozman, Hirono, and Collins. This legislation will help improve veterans' access to breast cancer screening at the VA and in their communities. It will strengthen veterans' access to clinical trials and care through partnerships with the National Cancer Institute and the Department of Defense.

Lastly, I want to talk about the military sexual trauma and highlight the importance of another bill of mine, the Servicemembers and Veterans Empowerment and Support Act, which is also on the

agenda today. For years, we have been hearing from veterans and MST survivors who have not received fair consideration from the VBA and are being denied the benefits and care they deserve.

An IG report released this summer found VBA's handling of MST claims has actually worsened in recent years. The IG found out about 57 percent of denied MST claims were not being processed correctly in 2019, and that is an increase from 49 percent in the 2018 report. That means veterans and MST survivors remain at risk of not receiving the benefits and care to which they are entitled and of being retraumatized when their claims are improperly handled or denied. This is an issue that I have worked on in the Senate for almost a decade now, with legislation originally titled as the Ruth Moore Act. It is long past due for MST survivors to get the benefits and the care that they need and that they deserve.

I want to thank the witnesses. When we get up to the table, I will thank you again.

And with that, I will turn it over to Senator Moran.

[The pending bills referred to by Chairman Tester appear on page 35 of the Appendix.]

**OPENING STATEMENT OF SENATOR MORAN**

Senator MORAN. Good afternoon, Chairman, and good afternoon to Dr. Brill, Dr. Carroll, and to Mrs. Pierce and our VSO witnesses here today. I look forward to this hearing, and I am glad to see the Committee is moving forward with additional pieces of legislation important to members of this Committee but important to the veterans that we serve.

Mr. Chairman, I would tell you that yesterday, Monday in fact, I was at a number of memorials to veterans here in Washington, DC. And a week ago, another honor flight was here that I met at the World War II Memorial, and I was explaining to them that this Committee continues to do its work. There is a Chairman that is a Democrat and a Ranking Member that is a Republican. We have served in opposite capacities in the past. And this place continues to be one of the few remaining places in which Republicans and Democrats continue to work together on behalf of the veterans that I and others were honoring at the various memorials across Kansas.

So I want to thank you for the continued working relationship that puts veterans above party politics, and I am grateful that today is another example of that.

We have 18 bills that members of this Committee and others in Congress are interested in pursuing. It seems as if this Committee has, over the last several years, been able to work our way through things that are beneficial to veterans. And today, I have no doubt, will continue to be a continuation of that bipartisan effort to find good results for those who served our Nation.

I will mention a couple of bills that are important to me, and I am anxious to hear comments about all of them. One of those includes the Veterans' Prostate Cancer Treatment and Research Act, which you, Mr. Chairman, and I are sponsors of, the lead sponsors of. This bill creates a standardized system of care from early detection to successful treatment for the most commonly diagnosed cancers within the VA, affecting over 489,000 veterans.

Among the remaining items on today's agenda are such critical topics as veteran peer specialists, shared medical facilities between the VA and the Department of Defense, and the VA's capacity to provide mammography services.

I am also pleased to join you, Mr. Chairman, in co sponsoring the REACH for Veterans Act you mentioned, which will build upon our work to improve VA mental health services by directing the VA to implement key recommendations of the Office of Inspector General, including improved Veterans Crisis Line staffing, training, extend the safety planning pilot program, and a smooth transition to 988 as the national 3-digit suicide crisis hotline for veterans comes into play.

Mr. Chairman, I was not exactly sure what you said. I should have been listening more closely, but I would indicate that now is a time in which we cannot turn our backs on those veterans suffering from mental health issues or those who are contemplating suicide. With the most recent developments in Afghanistan, I think the demand for the appropriate services is increasing, and I want to make sure that we do everything to minimize and to eliminate any death by suicide and improve the mental health of our men and women who have served our Nation.

I look forward to today's testimony. I appreciate, as I said earlier, the partnership and working with you and the other colleagues on this Committee, again, significantly different in many instances than many other committees we all serve on, and I am grateful for that.

I thank you, Mr. Chairman, and I yield back.

Chairman TESTER. I want to let our first witness panel get settled. Dr. Elizabeth Brill, Dr. David Carroll, and Ms. Lawrencia Pierce, you can go sit.

I just want to say this to the Ranking Member and my good friend, Senator Moran. I have had the incredible privilege on this Committee of working with some really good people: Johnny Isakson and you, Johnny as Chair of this Committee and myself as Ranking Member and now you. And I will tell you that I think what allows this Committee to work is respect and respect for our opinions even when we differ. And I just want to say thanks, it has been a pleasure, and I hope it continues for a good number of years, to be able to work with you in this way.

Senator MORAN. Mr. Chairman, I would only point out it would work better if you differed with me less often.

Chairman TESTER. Oh, that is true, but you know, what the heck. That is life.

One, two, three, four, five, six, seven, eight, nine.

UNIDENTIFIED SPEAKER. We have nine.

Chairman TESTER. We need 10. Brown?

UNIDENTIFIED SPEAKER. Ten.

Chairman TESTER. Oh, that is good. So with that, I want to recess this hearing momentarily.

[Recess.]

Chairman TESTER. We will go back to our hearing that we had started, and I want to express my appreciation for everybody that was here so we could get this done to get these folks into the VA.

Yes?

Senator MANCHIN. Mr. Chairman, there is a vote going on so we can just come right back [off microphone.]

Chairman TESTER. Yes, we are going to let everybody speak but you, Joe. We are just kidding. No, go vote. You come back. We are going to be here for the next—it depends on how boisterous Dr. Brill is, and then we are going to have another panel of VSOs. So we have got—we are going to be here for another hour at least. We have had one vote.

UNIDENTIFIED SPEAKER. Did you vote on the first one?

Senator MORAN. We had two votes at the beginning.

Chairman TESTER. We had a nom, and then we had a vote on the legislation. So . . . Okay? We welcome you back when you get back. Everybody.

So I want to welcome our panel: Dr. Elizabeth Brill, who is the Deputy Assistant Under Secretary for Health for Clinical Services and the Deputy Chief Medical Officer. She will provide the statement on behalf of the VA. She is accompanied by Dr. David Carroll, Executive Director, Office of Mental Health and Suicide Prevention, VHA, and Ms. Lawrencia Pierce, who is Assistant Director, Office of Outreach, Transition, and Economic Development of VBA.

Dr. Brill, welcome, and you may begin.

## PANEL I

### STATEMENT OF ELIZABETH BRILL ACCOMPANIED BY DAVID CARROLL AND LAWRENCIA PIERCE

Dr. BRILL. Thank you. Chairman Tester and Ranking Member Moran and other members of the Committee, thank you for inviting us here today to present our views on several bills that would affect VA programs and services.

VA's views are provided on all the bills in detail in written statement, but I will not be able to speak about every bill in my opening statement. Therefore, I will only highlight some of the bills on the agenda, but please be assured that by doing so there is no intent to minimize the importance of any bills today.

VA supports, contingent on funding, the Veterans Preventive Health Coverage Fairness Act that would eliminate copayments to VA for hospital care, medical services, and medications related to preventative healthcare services.

We are also glad to support a draft bill regarding State Veterans Homes that would require State Veterans Homes to have a governing body to be responsible for numerous management and oversight responsibilities as well as buttress their programs for prevention of infections. We believe these changes are in the right direction, and VA's written testimony includes other suggestions to buttress standardization and expertise in the management of State homes.

We are also glad to support two of the bills today that will help VA address its infrastructure needs: the fiscal year 2022 VA Major Medical Facility Authorization Act and a bill designed to facilitate shared medical projects between VA and the Department of Defense. We greatly appreciate the Committee's interest in this area.

We also support, with some technical suggestions, the Long Term Care Veterans Choice Act. Medical Foster Homes are a way to provide veterans, when medically appropriate, with an alternative to traditional institutional care that allows them to be in the more home-like, less restrictive environment of what are called Medical Foster Homes. The bill also actually yields net savings to our medical program when traditional nursing home care can be avoided while still providing safe, quality care for the veteran.

We are also glad to endorse the draft bill making changes regarding VA podiatrists, which includes a pay adjustment and certain organizational changes.

Mr. Chairman, there are other bills on the agenda where we wholeheartedly endorse the goals of the bills but cannot offer our support on every provision because we believe they duplicate current VA efforts and have other technical issues that would, in our opinion, make implementation of the bills in their current form impractical or counterproductive. One bill in that category is the MAMMO for Veterans Act, where there are a number of instances of duplication or other issues in carrying out the bill as written. We are finalizing the strategic plan that we believe meets the spirit of the bill by driving toward excellent access and quality in mammography for veterans across the Nation.

Similarly, VA cannot endorse the VA Prostate Cancer Treatment and Research Act, which would codify requirements for numerous VA actions on early detection, treatment, and research. We are very much aligned with the bill's focus on prostate cancer, but we believe it is overly prescriptive on the details of program implementation, including the internal structure of VA and the prostate cancer clinical pathway.

There are several bills on the agenda that deal with critical issues of mental health and suicide prevention and military sexual trauma, including the REACH for Veterans Act, which concerns the Veterans Crisis Line, and the Servicemembers and Veterans Empowerment and Support Act. We support a provision in the latter that addresses gaps in health care for victims of MST who serve in the Guard and Reserves, with some adjustments. VA enthusiastically agrees with the overall goals of both pieces of legislation. However, for a number of provisions in those multi-part bills, we have serious concerns on possible unintended consequences, duplication of existing efforts, and other impediments to implementation.

We welcome further discussion with the Committee on these important topics.

[The prepared statement of Dr. Brill appears on page 39 of the Appendix.]

Chairman TESTER. Appreciate your testimony and we will hear questions from the Senators now. I am going to yield my time to Senator Hassan.

**SENATOR MARGARET WOOD HASSAN**

Senator HASSAN. Well, I am very appreciative of that, Mr. Chairman and Ranking Member Moran. Thank you as well for this hear-

ing and thank you to all of the folks here from the VA for your excellent work. We really appreciate it.

Dr. Brill, I did want to follow up with you on something. New Hampshire is home to two VA vet centers, and I often hear from veterans about how they wish they could have connected to these mental health resources sooner to support their adjustment to civilian life. So as I think you know, I have a bipartisan bill with Senator Cramer that would require VA vet centers to contact recently separated veterans to raise awareness about the services available to them. So could you please discuss the range of mental health and counseling services that VA vet centers offer and why it can benefit veterans to learn about these services quickly after separating from service.

Dr. BRILL. I will turn to my colleague.

Senator HASSAN. Sure. Thank you.

Ms. PIERCE. Thank you, ma'am. With regards to early notification or awareness of the Vet Centers and what they offer, that information is robustly covered in the Transition Assistance Program, as well as the TAP MLCs. With respect to what is covered——

Senator HASSAN. Okay. Can we just start by why is it a benefit for veterans to learn about this early?

Ms. PIERCE. Yes. It is a benefit because the Vet Centers provide free counseling and support services even while they are on active duty, and then they have wraparound care as well once the member separates. It is confidential, it is free, and it is a community integrator.

Senator HASSAN. And is it fair to say that as veterans transition from military to civilian life often they find that they may need additional support during that time because it is a considerable change?

Ms. PIERCE. Absolutely. Within the first 365 days of separation, a critical time period, the Vet Center provides support tools along with the services that VHA provides.

Senator HASSAN. Well, thank you for that. I then wanted to follow up to get a little bit more specific about the VA's position on the bill, and that may be what you were beginning to talk about.

So the bill that Senator Cramer and I have requires the VA to electronically alert the vet center nearest to where a veteran resides that a veteran has separated from the military. And we filed this bill because folks from the VA came and asked us to because they said they had difficulty getting information from the Department of Defense about when somebody was separating and they wanted to be able to do specific outreach. And the bill actually not only says DOD has to provide the VA this information but then also says that the vet centers have to reach out to the veteran within a particular amount of time.

And I was pleased to get testimony, written testimony, from all of you that said you share the goals, but now it seems that you are saying you think you can get the information. So I just would like to kind of clarify the position of the VA on the bill and what we need to do to make sure not only that vet centers can get the information in a timely way but that vet centers do the outreach in a timely way, too.

Ms. PIERCE. VA's position on the bill, we support the intent, but we do feel that with the regulations and the processes that are in place currently, there is no need for additional legislation. We would be happy to present any complications or barriers to accommodating the data sharing with the Vet Centers if we approach such. But currently, our current process and the data that we get from DOD, we feel that we can meet the letter of the law with regards to this bill.

Senator HASSAN. With those guidelines in place right now from the DOD and VA, you all can do it. But those could change; right? One of the things I am concerned about is different administrations, different leadership, different policymakers in executive agencies can change the way things work. And I am just really wanting to make sure that we all are walking together to make sure that VA vet centers can get this information in a timely way from DOD so that we are reaching out to veterans and then that they know they have an obligation to reach out to veterans in a specific amount of time. And are you saying that all of the policies and procedures in place achieve that goal?

Ms. PIERCE. I would say, yes. Within the TAP, or the Transition Assistance Program, governance structure, we have work groups and we have the communication with our DOD partner as well as VHA to meet the letter of the law.

There is one item that we would look to have leniency, and that would be respect to the seven-day requirement to transfer that data over to the Vet Center. We would ask that the seven days would begin from the date we receive the data from DOD versus once the servicemember separates.

Senator HASSAN. Well, and how long does it take DOD to get you the information because if it takes DOD weeks or months that is not helpful; right? And then we may need to have this law passed to say you have got to get the information to the VA and then the vet center.

I mean, what I am concerned about is the bill also says that you all, the vet center, will reach out to the veteran within 14 days. And are you telling me that that is a goal you currently achieve?

Ms. PIERCE. We can achieve that, yes, ma'am.

Senator HASSAN. Do you currently achieve that?

Ms. PIERCE. So currently, the data transfer requirement that is in this bill is not in implementation yet. We receive the data from DOD, but the transfer to the Vet Center is the part that we are working on. It is in the development phase, and we do believe that we can accomplish the same with the current infrastructure and the processes that we have in place.

Senator HASSAN. Well, I look forward to following up with you. I think I may still think that this legislation is necessary because what I would like to do is make sure that this is an obligation that you all are required by law to follow rather than too much flexibility because, at the end of the day, this is about getting veterans the support they need and saving lives. Thanks.

Ms. PIERCE. Thank you.

Chairman TESTER. Senator Moran.

Senator MORAN. Chairman, thank you.

Dr. Brill, my staff and I are confused when we read the Department's testimony on S. 2720, the Veterans' Prostate Cancer Treatment and Research Act. I know that my Committee staff, as well as staff on the House Veterans Affairs' Committee, had multiple conversations with relevant program offices within the Department and the Office ofCongressional and Legislative Affairs to work out issues on the original draft text of this bill before it was ever filed. Committee staff made several substantial changes to accommodate the Department's view. Now we read in your testimony that the VA does not support the bill because "it is overly prescriptive in detail of program implementation."

Again, we worked out our differences with the VA, and then your testimony does not reflect that result. That is confusing to us.

While the VA did develop an initial clinical pathway for treatment of prostate cancer, can we all agree that a more integrated and streamlined approach, which includes a diagnostic component and more collaboration with research institutions, would be better care for our veterans? Perhaps I will let you respond, and then I may have a few comments to respond to your response.

Dr. BRILL. Yes, thank you, sir. So I suspect that what occurred is that in the conversations that the entities with whom you worked with were talking about the substance of the clinical initiatives that they have. And I believe that the National Surgery Office and the other interdisciplinary services in VA that address prostate cancer do not feel that legislation per se is needed in order to achieve these goals because they are achieving these goals through the normal clinical pathways.

So in 2021, this year, the VA published a new prostate clinical pathway, so already accomplishing that goal, in which they worked with DOD experts, interdisciplinary services within VA. And they update this regularly, and they are already working to integrate this clinical pathway with the new Cerner Millennium IT system for EHRM.

Secondly, in 2019, the Precision Oncology Initiative, which is a high reliability, organization-type initiative with a learning healthcare model, worked with the Office of Research and Development to further cutting-edge and high quality technology in order to give veterans the best prostate cancer care that is available.

We also have other services such as genomic profiling, tele-oncology, and the availability of decentralized trials for veterans to participate in even if they are not immediately local to where the trial is being run.

So fundamentally, I believe that the National Surgery Office and the rest of the multidisciplinary team believes that they are meeting all of the desires in this Act and do not believe that legislation is necessary in order for them to provide that level of high quality care.

Senator MORAN. Despite the fact they spent a significant amount of time working with us to get the legislation drafted in a way that they found acceptable.

Dr. Carroll, similar to that frustration, it happened again in the Department's testimony on S. 2283, the REACH for Veterans Act, co-sponsored—both of these bills co-sponsored by Chairman Tester and me. This legislation was developed after the Office of Inspector

General delivered two reports to Congress detailing how inadequacies in the Veterans Crisis Line resulted in tragic outcomes, including a veteran homicide and a veteran suicide. The OIG report also contained recommendations for improving these adequacies.

The testimony submitted by the VA claims that the provisions contained within the bill are not necessary because "the Department already has sufficient authority in this area." However, would you agree there were issues with the Veterans Crisis Line that resulted in these tragic outcomes despite you having sufficient authority in this area and significant tragedies for the veterans and their families?

We understand the VA already has certain policies in place. However, I think the main point of this legislation is that the Veterans Crisis Line was not adequately following those policies. Considering this, why would the Department not want to work with Congress to address these issues to ensure that these tragic outcomes do not happen again?

Dr. CARROLL. Thank you, Senator. We wholeheartedly agree with the intent of this legislation, with the concern of you and Chairman Tester. It is a concern that we share, to ensure the integrity and high quality of the operations of the Veterans Crisis Line. And we appreciate the OIG's report of the recent recommendations. All of them have been closed by the OIG, except one that requires a few additional months of data collection, because we have met or exceeded what they asked us to do.

Our concern with the legislation is not at all about intent. We very much appreciate it and take this very seriously, but we do not want to be limited by what is written into law because we are already meeting and exceeding. We have improved several things over the last few months in terms of policies, procedures that are put in place, staff training, consultation with other organizations. We have seen an increase in call and text and chat volume. At the same time, we have seen a decrease in our rollover rates. We have accreditation by external bodies already.

We do not want to be—we want to continue to innovate and to move forward with our quality improvement process, and we are simply asking to be able to do that without being bound by what is written in legislation.

Senator MORAN. Dr. Carroll, you said something that I would just follow up on. Can you quantify that increase in calls?

Dr. CARROLL. Over the last year, there was about a 2.2 percent increase in call volume and roughly a 25 percent increase, give or take a little, in both chat and text volume.

Senator MORAN. Thank you.

Dr. CARROLL. We are also preparing for the 988 implementation, which was mentioned earlier, and with additional staff at the Veterans Crisis Line.

Senator MORAN. I may come back to process again before the hearing is over. Thank you.

Chairman TESTER. Senator Brown.

**SENATOR SHERROD BROWN**

Senator BROWN. Thank you, Chairman Tester and Ranking Member Moran.

Dr. Brill, early in the pandemic, we saw how susceptible patients are to infectious diseases in nursing homes and State Veterans Homes. In Ohio, as you know, we have two veterans homes, one in Georgetown near where you used to live, the other in Sandusky in the other end of the State. Too many individuals contracted the virus. Too many died. We know the importance of public health programs and making sure we have standardization of care.

Senator Warnock has a bill on today's agenda that would make improvements to prevent the outbreaks we saw in so many State Veterans Homes over the last year. Your testimony has some recommendations related to the reporting requirements and emergency plan. Walk through for us, if you would, Dr. Brill, why hiring infection preventionists and standardizing the emergency plan to respond are so important?

Dr. BRILL. Yes, thank you, Senator Brown. So, yes, as you know, we fully support this bill and the provisions of providing a governing body, infection preventionists, and an emergency plan.

So as you mentioned with the pandemic, you know, many were caught off guard with a disease that we had not seen before. We did not realize just how virulent it was and in the early days what was needed to prevent spread. Obviously, those living in nursing homes are highly susceptible to any number of infectious diseases, and this has really raised awareness of the importance of infection prevention as a full-time role in those facilities.

And so we believe not only should there be an infection prevention person in each of those facilities, but there should be some standardization around that role so that we can have the same standards expected in all of the facilities.

The same thing with the emergency plan. And the emergency plan could deal with things such as pandemics but could also deal with the natural disasters of which we have seen, unfortunately, far too many this year.

An infection prevention committee is another recommendation that we have, and you know, always in these types of, you know, uncertain environments many heads are better than one. And so having a committee around infection prevention, treatment, mitigation factors, a committee would be very valuable.

Additionally, we had two other recommendations that all of these committees undergo CMS certification, and we recommend that the report change from the requirement of annually to quarterly, which we believe would allow a better sort of finger on the pulse of what is going on in those facilities.

Senator BROWN. Okay. Thank you.

Ms. Pierce, a question for you. I had a meeting discussion today with an Ohio State professor, Ms. Sheftall, and she is—we talked about suicide rates, and she has issued a paper and done a really important study on the alarming increase in young black girls, young women, females up to the age of 18, and the increasing suicide rates. We are also, of course, seeing rates far too high among veterans.

We have the part of the—you know, where we want to look with the Transition Assistance Program is veterans do not really know because nobody really knows until they are in that situation. They

do not know enough about VA services. They do not know enough about where they can go if they are having thoughts of suicide.

There is legislation. The Daniel Harvey and Adam Lambert Improving Servicemember Transition to Reduce Veterans Suicide Act—somebody could have come up with a shorter title than that has been introduced. The modified version is included in the House bill, in the House version of NDAA. Discuss the importance of that, particularly in light of suicide, how we do better with transitioning with veterans through these programs.

Ms. PIERCE. Thank you, sir. So with regards to suicide prevention or awareness of the resources that VA and community partners provide, the Transition Assistance Program has again revamped its curriculum to include information along the transition journey. And we define that to be 365 days pre separation; for retirees, it is two years. And within that window, we make sure that there is information about the resources that are available to the servicemember that is transitioning.

That can include the crisis hotline. That also includes VA Solid Start. If you are not aware, what happens is right after the servicemember separates, they receive strategic calls to check in with them, and VA Solid Start representatives are trained to recognize or handle a crisis with regards to transferring them to our VHA partners, to get them expedited help in that event of a crisis.

So I would say that the Transition Assistance Program, along with our robust partnership with our VHA partners and DOD, is at the ready and provides sufficient resources, information, and awareness for those servicemembers who may need assistance during that critical transition.

Senator BROWN. It may be at the ready, but it is not working as well as it should. But, thank you.

Ms. PIERCE. And that is something that we are looking at and will continue to look at. We look at our curriculum on an annual basis so that it is ready, and based on servicemembers' feedback we make sure that we update accordingly. But we will take that for action. Thank you, sir.

Chairman TESTER. Senator Sullivan.

## SENATOR DAN SULLIVAN

Senator SULLIVAN. Thank you, Mr. Chairman.

And I want to thank the witnesses, sincerely thank the witnesses, Dr. Brill and your team. You know, you guys come in here; you take a lot of incoming in these hearings. And we know that your heart is in the right place in terms of taking care of our veterans, and that is a noble service. So thank you for that.

Now I am going to give you a lot of incoming. No, I am just kidding. Actually, I want to thank you.

S. 2526, which, Dr. Brill, you mentioned in your written statement—in your opening statement, is a bill that I have been working on with a number of Senators, what I think is a really commonsense bill because it would do things that you do not often see in the Federal Government. It would save money. It would help train our active duty, DOD, and VA medical professionals. It would expand services for medical services to our vets. It would increase the

readiness of our military. And it would apply to all kinds of states that have this opportunity.

In essence, Mr. Chairman and Senator Moran, this is the bill that authorizes the Secretary of Defense and the Secretary of the VA to enter into agreements for the planning, design, construction of facilities to be operated at a shared medical facility.

So, Dr. Brill, I am glad that you have endorsed this. Part of the reason, I am sure, is because we worked really closely with you and your staff on it in addition to the Pentagon. But can you expand more on why this kind of collaboration between VHA, DHA, and this joint planning would be a good thing?

Some of the things I listed in terms of cost savings, but this is really about service to veterans in addition to training up our DOD docs. I would like a little more detail because this is a top priority of mine. I think it should be a top priority of the Committee's. It is already having success on the DOD SASC side, but I would like to get your more detailed views.

Dr. BRILL. Yes, thank you, Senator. So as you noted, we fully support this bill, and as you mentioned, there are certainly cost savings and ease of planning.

I can share my personal experience of when I was training as a resident at William Beaumont Hospital in El Paso, Texas, in the Army. The VA facility was co-located with us, and so it gave us the ability to sort of wheel a patient across the hall——

Senator SULLIVAN. Oh.

Dr. BRILL [continuing]. And to take them directly to VA.

Senator SULLIVAN. Oh, so you have actually experienced this idea.

Dr. BRILL. Experienced it, yes, sir.

Senator SULLIVAN. And you were an active duty doc at the time?

Dr. BRILL. Yes.

Senator SULLIVAN. Great. So you got to work on, say for example, you know, elderly patients that you would not see in the active force.

Dr. BRILL. Correct.

Senator SULLIVAN. One example.

Dr. BRILL. I think, you know, even more so today, you know, as we saw with the pandemic and you never know where you are going to see peaks and valleys of need, the ability to share staff, to share facilities, to share equipment across geographies and then across the DOD and VA is very helpful. And then of course, also in times of conflict, when our, you know, DOD counterparts are deployed, then again you know, the ability of VA and DOD to work collaboratively back here in the States allows us to give great care to our patients.

Senator SULLIVAN. So the surge capacity on either side, depending on where the demand signal is, is obviously enhanced.

Dr. BRILL. Correct.

Senator SULLIVAN. What about service to veterans themselves, which of course, is of high priority to this Committee?

Dr. BRILL. So, service to veterans. So first of all, again from a geographical perspective, not every facility is in every geography. And so by having more facilities available net-net, I think that gives veterans more options of where to receive care. And it does—

also, as we move much more into telemedicine and teleconsultation, it allows tapping into experts that may be in one geography but not another. And so really, the more that we can collaborate across VA and DOD, the more options we have to serve our veterans.

Senator SULLIVAN. Good. Well, Mr. Chairman, you know, this is a bill I think that makes sense whether you are from Alabama, North Carolina, Montana, Alaska, because we all have significant vet populations, significant DOD centers. This is very important for my State. As you know, we do not even have a full-service VA hospital in the whole State and we are, you know, six times bigger than Montana; right?

So I hope that we can move this in a bipartisan way because for all the reasons Dr. Brill mentioned and it saves money, and there is not a lot of legislation that comes out of this Committee that we know is going to save money. So I appreciate the VA's support, and I look forward to working with the Committee on moving this. Thank you.

Chairman TESTER. Thank you, Senator Sullivan. Just so you know, we are working to annex North Dakota, South Dakota, Wyoming, Nebraska, Iowa, Arkansas, and Louisiana.

Senator SULLIVAN. I am sorry.

Chairman TESTER. It is all right. This is an ongoing thing.

So first of all, I want to thank all three of you to be here today. I will tell you that I feel a little beat up this afternoon. I mean, the bills that the good Ranking Member and Chairman have on this docket are not exactly embraced, and so I want to flesh that out a little more if I might because I think if I got the list right from you, Dr. Brill, at the very end of your testimony, you had problems with the MAMMO Act, you had problems with the Prostate Cancer Act, you had problems with the REACH for Veterans Act, the MST bill. Is that pretty accurate?

Dr. BRILL [No audible response.]

Chairman TESTER. Okay. So I am just going to ask right off the top, kind of going off of Senator Moran's questions, and I think it goes to you, Dr. Carroll. You said that you are taking care of the problem. You are taking care of the problem that the REACH Act is trying to address with the Veterans Crisis Line already and that, I believe your words were—and do not let me put words in your mouth—that if we pass legislation that would kind of limit your ability to do stuff.

Dr. CARROLL. That was not my intention, sir, at all.

Chairman TESTER. So tell me what you said.

Dr. CARROLL. I said that we did not want to be held to a lower standard in legislation than we are already meeting, and that was——

Chairman TESTER. Okay. So what you are saying is you think that the REACH Act is a step backward from where you are at now?

Dr. CARROLL. We think we are meeting what is in the REACH Act right now.

Chairman TESTER. So you have data to show that you are meeting or exceeding the expectations in the volume, including the increased volume?

Dr. CARROLL. We would be happy to go through the data with you, sir.

Chairman TESTER. Do you have it?

Dr. CARROLL. We do. I think we can talk through our training standards.

Chairman TESTER. Yes.

Dr. CARROLL. The legislation talks about two monitors per month. We are already doing three.

Chairman TESTER. I am going to task my staff——

Dr. CARROLL. Okay.

Chairman TESTER [continuing]. And the Ranking Member's staff, too, if they so choose, to go over that information with you.

Dr. CARROLL. Sure.

Chairman TESTER. And I will tell you why this kind of concerns me. I want to work with the Department to make sure we have a bill that is workable. If it is not workable, you cannot implement it, and it is unfair to do that.

On the same side of the coin, our job is to make sure there is oversight that you are doing the job. And I could be wrong on this, but I can tell you that we can have oversight over rules that you guys pass; we also can have oversight over the legislation, much more direct oversight. In fact, we do in every meeting almost.

And so the goal here—and it is the same goal you have, Dr. Carroll—is to make sure that if a vet is in crisis that stuff happens and that it happens and we do not lose these people. I do not need to tell you the statistics; you should be able to repeat them to me, about how many veterans we are losing per day. It is not acceptable. It has been that way since I have been on this Committee.

And so when the IG report comes out with a report and says, you know, your Veterans Crisis Line, which is pretty foundational to healthcare, is not doing the job, then you guys are going to have to show us the data that shows you are doing the job now because if you are not we are going to bring you back up and we are going to do it again.

Now let us talk about the Prostate Cancer Act that Senator Moran also talked about, and the question I have for you, Dr. Brill, is that: We worked with the VA, but we did not work with the right people in the VA; is that what you were saying?

Dr. BRILL. Sorry. I am not sure if that would be the right answer, and I will be happy to circle back with those that you worked with to see what kind of communication they had with your team. I think, you know, if their feeling was that what we are doing clinically through our development of guidelines, through our development of relationships, through our development of, you know, cutting-edge technologies, using telemedicine, tele-oncology, et cetera, precluded the need for legislation, then I think that they should have been more forthcoming of that opinion during the working sessions that they had with your team.

Chairman TESTER. So this is basically the same thought as with the REACH Act, that you were already meeting the needs and you do not need legislation to do it? I do not want to put words in your mouth. I am just kind of repeating what I heard.

Dr. BRILL. Well, so yes and no. I would say, yes, but also because the nature of medicine and development of clinical guidelines and

keeping up to date, as you could certainly see from the pandemic, can be sometimes slow-moving but sometimes very rapidly moving. And when the clinical community comes together through research, collaboration, work with academic affiliations, you know, they should be able to move as quickly as they need to, to respond clinically to a——

Chairman TESTER. And do you think that they have moved as quickly as they have needed to, to address prostate cancer?

Dr. BRILL. Well, I do believe that prostate cancer is very high on the VA's list because of the number of veterans that we have that fall into the age group and gender that are impacted by prostate, and it is a very high priority.

Chairman TESTER. I think that is true, as veteran suicide is a very high priority, but we have not found out what we need to do to solve that yet either.

And so what I would say is this: We are going to take another run at this on all five or six of these bills, and I will tell you—and I did not even get into military sexual trauma, which is—I mean, it is a massive issue within the VA. Okay? It is.

And I will tell you that I worked with the members on this Committee, including the Ranking Member, on all these bills. And if they put you in a bad situation, where it is going to limit your ability to provide benefits to veterans, we do not want to do that. What we do want to do, though, is hold you accountable so you make sure that you are going to continue to be the leader in healthcare for veterans in this Nation. No ifs, ands, or buts, about it.

And if you are not, then we are going to bring you in front of the Committee and Tillis is going to rail on you. Okay? Or I am going to rail on you, or somebody is going to rail on you. Okay?

So we will go back. We will have a discussion about these bills. We tend to—I will just be honest with you. We tend to do what the VSOs ask us to do in this Committee, and I do not think these bills came about because of my staff working in a vacuum. So we will continue to work with that.

With that, I will turn it over to Senator Tuberville unless you were second to Tillis, which I can certainly make a mistake on that.

Senator TUBERVILLE. I was courteous. I did not elbow him when we were in the doors.

Chairman TESTER. Oh, well, in that case, look—no, it is age before beauty, Tuberville.

Senator Tillis.

**SENATOR THOM TILLIS**

Senator TILLIS. Thank you, Senator Tuberville,

Chairman, Ranking Member. And I want to thank you all for being here. We made a comment about bipartisan collaboration among the members. But I have been here for six and a half years, and I have seen transitions of Democrat and Republican administrations, and I think there has been a smooth transition there. So, look forward to working with you all and the work that you have done in the past.

I want to get to Senator Sanders's bill. I think it is a well-intentioned bill. However, in your opening testimony, I think one of the

statements you made, VA's existing resources to provide dental care are at or near full capacity, and then you say, with regional variances. In North Carolina, in our VA—or I am sorry, our Fayetteville service area, we are only meeting the needs of about 20 percent of the currently eligible population. And we are adding dental treatment rooms, but I do not believe that the additional dental treatment rooms will be sufficient for current capacity. And we are talking about a State that has got one of the fastest growing populations.

And so Senator Tester, in reference to another bill, made the comment, it is not workable if you cannot implement it. I think if we were to implement this until we were able to fully achieve, across all regions, capacity for those currently eligible, that it would not be workable and put us further away from providing quality care for those who have it. So, not opposed to the intent, but I do think it could create a lot of disruptions.

So with that said, do you support—I know that you, in your opening testimony, made reference to a couple of sessions. But do you support the bill? I mean, can it be made right now given the challenges you have with the current unmet need?

Dr. BRILL. So, Senator Tillis, you bring up a very good point, and what we noticed—so before I was in this role, I was the Chief Medical Officer for the Office of Community Care. And so what we noticed with the MISSION Act is when eligibility was increased in terms of distance and wait time that there was a tremendous upsurge in the seeking of dental care in the community, which showed that even for the eligible veterans, which is only 15 percent of our veteran population, even for those eligible veterans, we were not meeting their needs. And so the cost went up significantly for community care. But what it does signify is that were we to increase eligibility to all veterans, you know, it is such a far road to travel from 15 percent to 100 percent.

A few things that make it challenging in particular is, as you point out, we do not have the infrastructure to handle it internally at all. So, immediately would have to go the community, which would be okay except the way that the dental benefit is written it is very comprehensive and does not have a lot of sort of guard rails around it and could be really prohibitive from a cost perspective. The projection for five years is $34 billion. Billion.

And so I think conversations that——

Senator TILLIS. I saw a 10-year projection of $109 billion.

Dr. BRILL. Yes. Correct.

Senator TILLIS. Yes.

Dr. BRILL. And that is because over that period of time that would be when we would be building more dental clinics, hiring more staff, and the early days would really just be paying for community care.

So one of the things I think we need to consider, collectively, is: Should the coverage be so comprehensive? You know, should we cover all people perhaps with fewer benefits rather than fewer people with more benefits?

So I think that would be one thing to consider in order to limit the total cost and then really plan a stepped-out approach to the segueing from community care, which would be our first—you

know, sort of our first step, and then really timing out the building of facilities and recruitment of dentists. And there is some concern from the Office of Dentistry as to the availability of dental providers throughout the country to recruit.

So I think we could do it, but it will be very expensive, and it needs to be very carefully stepped out over time.

Senator TILLIS. Yes, I think your point over the—I think it was in the past, just when related to Sections 3 and 4 of the bill, that even if you built it, not enough dentists or dental professionals would come because this is not only a problem in our VA population in North Carolina, where half of our State is rural, but we are struggling to find basic dental services for the broader population.

So again, I think I would rather our focus be on the immediate challenge, which is not serving the population who already is eligible, dealing with the geographic disparities, and then figure out how we can incrementally build a wider net and, as you said, maybe fewer services to more people or whatever mix makes sense. So I think for that reason I share, I think word for word, your concerns that were expressed in the bill.

Thank you, Mr. Chair.

Chairman TESTER. Senator Tuberville.

**SENATOR TOMMY TUBERVILLE**

Senator TUBERVILLE. Thank you, Mr. Chairman.

Thank you all for what you all do for our veterans. It is a hard job, going to get harder. That is the reason we are here, to help.

Ms. Pierce, I want to follow up on Senator Hassan's question on Vet Centers earlier. Can you talk about S. 1944, the Vet Center Improvement Act, especially the requirements of productivity evaluation of counselors. What are vet centers doing to support transitioning veterans, and how can productivity evaluations bring more assistance to veterans in crisis?

Dr. BRILL. So I will take that one if that is okay with you, Senator.

Senator TUBERVILLE. Go ahead.

Dr. BRILL. So essentially, there was a GAO report in 2021 which identified some issues with productivity, with staffing, and recommended feedback from vet center counselors, from staff, and from veterans, et cetera, some standardization around position descriptions, some hiring—you know, some hiring initiatives.

So I think with regards to the bill itself the vet centers are achieving all of the goals that were stated for them from the GAO report, and the VA's position is that the bill is not necessary because they are already taking those actions to address those issues.

I would focus on Section 8, which relates to food, and just quickly say that we do support the issue of dealing with food insecurity and veterans and that portion of the bill we would like to have some more conversation about as to how we can do that more comprehensively. We do not have an appropriation to purchase food for veterans at this point in time, and so we would like to explore ways of how we can help with food insecurity.

We would ask, though—the GAO is doing a review of food insecurity for VA and also for USDA. So we would like to ask that after

that review is completed then looking at what the recommendation are.

And I would say that, differentiating the recommendations around food versus the recommendations around staffing and productivity, we have the internal capacity, and have already addressed the staffing and productivity issues. That is within our bailiwick, if you will. But the food piece, particularly the ability to purchase food, they may need other appropriations or certain things that could only be legislated in order for us to support the food insecurity piece. And so we would like to work with you on that.

Senator TUBERVILLE. Thank you. I am going to ask you this one, too, Dr. Brill. S. 2386, the Veteran Peer Specialist Act, would require the VA to expand the Peer Specialist Support Program at 25 VA medical centers. Can you describe, you know, how the expansion would be implemented, number one, and what benefits this expansion would bring to our veterans?

Dr. BRILL. So I am going to defer that one over to Dr. Carroll.

Senator TUBERVILLE. Nobody likes my questions. Go ahead.

Dr. CARROLL. Thank you, Senator, and thanks, Dr. Brill. The peer support within VA has been one of the most transformative things that has happened with the support of Congress, this Committee, over the last several years, and it makes an incredible difference for veterans to connect with other veterans who can help them connect to resources in the community, help walk them through mental health treatment. And we are continually looking for ways to expand peer support within our own structure. We currently have almost 1,200 peer support specialists employed in VA right now and are looking to expand that and also working with our community partners around Peer Support.

This legislation would ask us to move forward on additional peer support specialists within our primary care clinics in particular. We have had good experience with that. We feel we are ready to do that. We have the technical assistance, the lessons learned from a previous implementation, that we are very ready to share with facilities that want to do this.

We feel that they need to look at their staffing within primary care and have the flexibility to, you know, perhaps this month they could hire a peer specialist, but maybe the next opportunity they need to look at provider staffing or nurse staffing within their primary care clinic. So we think having—allowing facilities to flexibly hire is important.

This year, we are looking to—we are expanding peer support in our substance use disorder clinics, in our women's mental health programs as well.

And so I think it is a constant area for us, but we feel that we currently have the authorities necessary to move forward with this.

Senator TUBERVILLE. Are you asking for volunteers, or how are you doing this selection process for the 25?

Dr. CARROLL. We would ask for volunteers to move forward with it. So . . .

Senator TUBERVILLE. Okay. Thank you all. Thank you for your support. Thank you.

Thank you, Mr. Chairman.

Chairman TESTER. I believe we have Senator Blackburn, virtually. Senator Blackburn, you are up.

**SENATOR MARSHA BLACKBURN**

Senator BLACKBURN. Yes, Mr. Chairman. Thank you so much and thank you for this hearing and for allowing us to come in virtually when we are trying to do too many things at one time. So I appreciate that.

Dr. Brill, I would like to come to you if I may. I am a big believer in veterans deserve choice, flexibility. They want options when it comes to how they use the benefits that they have earned.

We have a lot of veterans in Tennessee. Tennessee does not have a State income tax. We have a lot of people that have served for Fort Campbell, or they have been at Arnold Engineering, or they have been at the naval station in Millington over by Memphis, and they choose to retire in Tennessee. So we do have very high numbers of veterans that live there, and having more flexibility, not less, is what they are looking for.

This is why Senator Sinema and I did the Long-Term Care Act, and we are grateful that this was on the markup calendar for today because it increases access to Medical Foster Homes as an alternative to nursing homes. That is the kind of thing that veterans are wanting to see.

And I also hear from veterans in Tennessee that they prefer to get their care in the community, that local community where they live, seeing a doctor there in that community, many times going to a hospital there in their local community. And I have concerns that the VA has begun to restrict access to community care. And the press release that the VA sent out October 5th announced that they were decommissioning the Office of Community Care and noted that VHA conducted a functional assessment in the fall of 2020 to reach this decision.

So, Dr. Brill, you may not be able to speak directly on this issue, but I want to get your commitment that the VA will work with my office and work with this Committee to provide answers so that we can continue to conduct proper oversight. And can you please provide the Committee and my office a copy of that functional assessment report?

Dr. BRILL. Senator Blackburn, thank you. I will address both of the issues that you brought up. So first of all, VA is very supportive of the Long-Term Care Veterans Choice Act. Medical Foster Home, as you know, provides an option for veterans to be in a non-institutional environment, in someone's home as a Medical Foster Home. And right now they have to pay out of their own pocket to be in those settings, and this bill would allow some subsidizing of those veterans so that they would not necessarily need to pay for that setting. So we are very supportive of that. It would be a net savings to our program. So it really benefits everyone, not just the veterans, but also the VA. And so that is what I will say about Medical Foster Home.

And then as far as the Office of Community Care, so first of all, I was a chief medical officer for the Office of Community Care right before taking this role. And what I will tell you is, first of all, the MISSION Act standards have not changed at all. Those are by

statute. And so the wait times, the travel distances, et cetera, the lack of facilities in a State, those sort of statutes, they still hold, and the eligibility is in no way changed because of this kind of bringing together of the Office of Access for Care and the Office of Community Care.

So I will just explain the goal of that joining of those two offices. So the Office of Community Care was stood up in short order due to Choice Act and other legislation that increased choice for veterans to be seen in a community with less hassle, less wait, and less travel time. The Office of Access for Care is working on access inside of the VA facilities to make sure that clinics are available and, if not, that patients are getting sent to the community.

What veterans were then experiencing is this bifurcated relationship with their healthcare providers. These offices were not always working completely in synchrony, and really, the veteran should have a seamless experience. If they want care, it should not really matter how we are working behind the scenes making the sausage for them to get care. They should be able to get the kind of care that they want, that they are eligible for. And so by bringing these two offices together, we are attacking access, quality, and service collaboratively and uniformly, whether or not the patient goes to the community or stays in VA.

And we will be happy to provide those documents to your office.

Senator BLACKBURN. Thank you. I know I am out of time, but I would also like for you to provide me a list of completed appointments through community care, those community care completed appointments in 2019, '20, and '21, so that we can see how many have been completed, not scheduled, but completed. That would be helpful.

I have a couple of other questions for you that I will submit for the record, but thank you so much for your time.

Chairman TESTER. Senator Moran.

Senator MORAN. Chairman, thank you. Just a couple of things to wrap up. I do not think there is a question here but just a statement on my part.

First of all, legislation, in my view, should not be opposed because you are exceeding its requirements. It is appropriate for us to establish legislation. We often look at what the VA is doing now and put into statute that standard so that you do not ever go beneath what you are already doing. And so the idea that a bill is less demanding of what you are already doing, I hope that you always look for ways to do better than what even the statute or the law says. And so I do not know that is a good explanation for opposition to a bill. Creating a floor, not a ceiling, is what I think we are all about.

And then I wanted to highlight the Veterans Health Care Act of 1992. I have indicated this to the Secretary, and I indicate it again to you to make certain that it is heard within the VA leadership. That Act, 1992, unequivocally prohibited the VA from performing and providing abortions. However, after writing to the Secretary to remind him of this prohibition, he responded by describing the VA's prohibition as a policy decision, quote unquote, rather than a statutory one. This is a departure from the VA's previous position that

it cannot, by law, provide abortion services. That is what the VA has said publically on its website.

I raise this today not because any bill that we are considering on the agenda touches upon on this issue, specifically, but because the VA's argument is that despite congressional authorization and prohibitions on what it can and cannot do it has generally treatment authority to override those decisions made by Congress.

I would like to use this as an opportunity based upon the discussion that we have had regarding a number of the bills that Senator Tester and I have sponsored. I would like to reiterate to our witnesses here today that we do not hold hearings like this before passing legislation just so that those laws will ultimately end up being mere suggestions to the VA on how they operate. We expect, I expect, the VA to abide by these laws, including the statutory prohibition on abortion.

Mr. Chairman, thank you.

Chairman TESTER. Thank you, Senator Moran. I would just tell you there is 18 bills on the [off microphone.] In the end, I want you guys on board or tell us why you cannot get on board. Okay?

Thank you for that. The first panel is released.

And we will hear from the second panel which are our veterans' advocates. We have Marquis Barefield, who is Assistant National Legislative Director for the Disabled American Veterans. And we have Tom Porter, and Tom is the Executive Vice President, Government Affairs of the Iraq and Afghanistan Veterans of America. We will get you guys seated, and then we will hear your testimony and then open up for questions and answers. So take your seats if you might.

Welcome, gentlemen. It is great to have you back in front of the Committee, and we will start with you, Mr. Barefield.

## PANEL II

### STATEMENT OF MARQUIS BAREFIELD

Mr. BAREFIELD. Thank you, Mr. Chairman. Chairman Tester, Ranking Member Moran, and members of the Committee, DAV is pleased to offer our views on the bills that impact service-disabled veterans and the programs administered by the VA that are under consideration by the Committee. My full written statement covers all the legislation, but I would just highlight a few bills in my oral remarks.

DAV strongly supports the Servicemembers and Veterans Empowerment and Support Act of 2021. This legislation would address existing shortfalls in the military sexual trauma claims process to help ensure that veterans are aware of, and have adequate access to, care and services for conditions related to their trauma and that they do not face unnecessary hardships throughout the claims process. This bill stands as a much needed compilation of provisions that address many of the longstanding issues DAV has noted within the claims process for MST-related conditions.

We support changing the evidentiary standard for MST cases more closely in line with what is currently required for combat vet-

erans. It is also important to protect the integrity of the claims process and prioritize the best interest of veterans by putting accuracy before speed. We strongly recommend veterans complete the full claims development process prior to undergoing any exams to ensure they are presenting the strongest and most thorough for VA evaluations and adjudication. It is very important to get this first step right to avoid possible premature denials and putting veterans in the position of undue emotional stress.

We support automatic written communications providing information on resources for MST coordinators in both VBA and VHA. DAV believes this is a positive step forward in synchronizing efforts between the two administrations and keeping the veterans more informed.

DAV also supports studies on staff training for claims processors and studies on access to inpatient mental health care and the pilot program on interim access to more intensive outpatient care. This bill will help ensure that all MST survivors gain access to specialized treatment programs and services they need to fully recover and that VA conducts vigorous oversight of claims adjudication personnel and review of data to ensure the policies for processing claims for conditions due to MST are standardized in all VA regional offices.

DAV also strongly supports the Veterans Dental Care Eligibility Expansion and Enhancement Act. The bill would authorize dental services in a phased approach beginning with veterans that are service-connected at 30 percent or greater. We believe the phase-in implementation outlined in the bill would allow VA the appropriate time to develop program capacity, to include the hiring of dental staff or to contract with community dentists for such services.

Oral health is integral to overall general health and well being. Veterans who are medically compromised or who have chronic disabilities can be at greater risk for oral diseases, which has the potential to jeopardize the overall health and quality of life. DAV supports this draft legislation which recognizes the importance of oral health as part of basic healthcare and authorizes VA to provide comprehensive dental care to all enrolled veterans.

DAV is also pleased to support the following bills:

S. 2283, the REACH Act for Veterans, which would improve training protocols for Veterans Crisis Line responders, including enhanced guidance for managing callers with substance use disorder or at risk of overdosing, which would strengthen the overall quality of the program.

S. 2386, the Veteran Peer Specialist Act of 2021, which seeks to expand the peer specialist program. DAV recommends the Committee work closely with the VA to address some of the concerns it raised in testimony about its companion bill about implementing this program.

Finally, DAV is pleased to support both vet center bills, S. 1944, the Vet Center Improvement Act of 2021, and S. 2924, the Vet Center Outreach Act of 2021. Vet centers have proven to be an effective resource to assist veterans of all eras, who seek care for issues associated with exposure to traumatic combat situations, military

sexual trauma, and challenges reintegrating into families and communities.

Mr. Chairman, this concludes my remarks, and I welcome any questions that you or members of the Committee may have.

[The prepared statement of Mr. Barefield appears on page 80 of the Appendix.]

Chairman TESTER. Thank you, Mr. Barefield.

Mr. Porter.

**STATEMENT OF THOMAS PORTER**

Mr. PORTER. Thank you, Mr. Chairman, Ranking Member Moran, and members of the Committee for having us here to provide our views. Our full testimony is submitted for the record. I will highlight a few of the bills that we have here today.

I am glad you brought up the military sexual trauma issues. It is an issue that is really, really important to us. It is a near crisis situation, and IAVA is attacking this from all angles. So we actually support—and it is a big priority of ours—legislation on the front end on DOD, with Senator Gillibrand and Senator Ernst over on the DOD side. And I am glad that we are doing this on the VA side as well because, as you probably know, 1 in 4 women veterans and 1 in 100 males report experiencing military sexual trauma.

For years, the claims process has been criticized for the lengths veterans must endure to approve their MST claims. And in August, the VA OIG reported the VA potentially denied thousands of veterans benefits related to their MST claims due to errors in processing. The report also found the VA failed to implement recommendations made by OIG back in 2018 that resulted in similar issues. The lack of implementation resulted in an increase from 49 percent of claims being improperly processed to 57 percent. The VA must make veterans feel safe as they embark on the difficult process of filing their claim.

So IAVA strongly supports Senator Tester's draft Servicemembers and Veterans Empowerment and Support Act to improve the MST claims process and adjust the standard of proof a veteran has to provide, lessening the potential for retraumatizing veterans.

Suicide prevention is always a top IAVA priority. In the last year, IAVA worked to pass legislation to establish a national suicide hotline, 988, to ensure that all Americans, including veterans, have easier access in times of crisis and mental health and suicide prevention resources.

The VCL is invaluable resource, but it is not without fault. The data has shown, when the VA OIG reported last year, that VCL mishandled several high risk callers. That is why IAVA supports the Revising and Expediting Actions for the Crisis Hotline, the REACH Act. This bill would implement many OIG recommendations, as you know, such as retraining for VCL employees and other improvements. It also would have the VCL consult with VSOs in implementing the new 988 number, so we appreciate that.

Veterans, as you know, have been very, very stressed over the last few weeks, couple months, during the withdrawal from Afghanistan. Our data has shown that in the amount of veterans that

have called in for help from us. So this is a timely discussion on this bill. So, appreciate it.

There is much uncertainty around the decision to leave the military, and according to a Pew Research study veterans are at highest risk for dying by suicide in the first three months after their transition. And vet centers offer a community-based touch point that could be used to proactively reach out to veterans soon after they separate from the military. So vet centers are very, very valuable to us and to our community. They are an innovative response to a lot of needs and emerging needs in the veteran community.

So for these reasons, we support both of the vet center bills, Senator Tester, the one you have with Chairman Reed, the Vet Center Improvement Act, and then Senators Hassan and Cramer have the Vet Center Outreach Act. So those are both bills that we support.

The MISSION Act established a peer support program that empowers veteran peer specialists to apply their own experiences to help others navigate the VA system and access services while teaching them about positive, health-reaffirming behaviors. The Veteran Peer Specialist Act expands the successful peer specialist program to all VA medical centers, and it would prioritize expansion to rural areas and ensure peer specialists reflect population diversity.

We know there is a connection between Agent Orange and prostate cancer. There has been research to back that up. So we support the Veterans' Prostate Cancer Treatment and Research Act. That is important to us to be able to improve ways to treat it.

And then our women veterans are always a top priority for us. They are the fastest growing segment of the military veteran population. Veterans' services have improved greatly in recent years at the VA. There is still more work to do. One of the piece of legislation that highlights—that we want to focus on is the MAMMO for Veterans Act. I think the more that we can improve the ability, especially in rural areas where women veterans and all veterans lack a lot of services, that we can deliver mammogram services, upgrading their abilities to seek treatment.

So thank you for having us here today. Happy to answer any questions, Mr. Chairman.

[The prepared statement of Mr. Porter appears on page 95 of the Appendix.]

Chairman TESTER. Appreciate you both being here. Appreciate your testimony. This question is for both of you. Have either you or your organizations had a chance to look at all 18 bills?

Mr. PORTER. I can say, Mr. Chairman, not in as much detail as we would like. We noted the ones that I have testified on today in my oral statement that we dug a bit deeper on, but we have taken a look at almost all of them. A couple of the offices did not respond, so we could not look at all of them.

Chairman TESTER. Okay.

Mr. PORTER. But . . .

Chairman TESTER. Mr. Barefield?

Mr. BAREFIELD. Yes, we have had an opportunity to review all 18 bills.

Chairman TESTER. And we will go with you, Mr. Barefield. Are there any of the bills that you oppose of the 18?

Mr. BAREFIELD. Of the 18, there are 5 bills that we do not have a position on based on the fact there are no resolutions that the Disabled American Veterans have for those particular pieces of legislation.

Chairman TESTER. Okay. Mr. Porter?

Mr. PORTER. Mr. Chairman, the legislation on the chaplains, to reorganize that, it seems to make sense on the front end to us, but we would like to hear more from the VA to see what their reaction is, want to see what there is more to do discuss on this, hear more about that.

I think that the National Green Alert Act, we cannot support that bill at this time. There is still a stigma in seeking out help on this issue. I have concerns about some privacy, possible privacy concerns about this, and I want to hear what VA and proponents of the legislation have to say about that.

Chairman TESTER. Okay. So as I requested of the VA, I will make the same request of you guys. If there are ways we can work with you to make sure we address those concerns, I think that is critically important moving forward. And if there is information that you need that you cannot get that you want, we will do our best to get it for you. And so that is where we are at.

I want to talk a little bit about where you left off, Tom, and that is with the breast cancer screening and care, especially as it applies to rural and remote areas and the challenges accessing healthcare there. Almost the entire Mountain West and Pacific Northwest do not have an onsite VA mammography, and there is a lot of rural veterans in that region that do not live near a National Cancer Institute-designated cancer center.

So, Mr. Barefield, can you speak to the necessity of assessing mammography and coordinating cancer care for veterans, especially in the rural areas?

Mr. BAREFIELD. Thank you for the question, Chairman. Yes, it is very important, very important that women's health is put in the forefront. And when it comes to the mammography bill, since as you mentioned in your area there is not enough or there is a lack of VA facilities to be able to provide those services, then that is where the relationship in the community should be looked to and grown. That way, the needs of women veterans, especially for mammography services, can be sent out to community providers to help fill in the gap that the VA cannot fill.

Chairman TESTER. Okay. Thank you.

Mr. Porter, I do not need to explain to you that the women's population I believe it continues to be the fastest growing population within the VA for services. Can you talk about the importance of the VA establishing a strategic plan when it comes to mammography?

Mr. PORTER. Well, that can go for treating women veterans, Mr. Chairman.

Chairman TESTER. That is true.

Mr. PORTER. And that is why we helped develop the Deborah Sampson Act with you, and that is one of our top priorities, is seeing that implemented. And that goes a long way to look at it strate-

gically, to look at all services. There is a lot more that we can do. So, yes, we need to look at the more targeted approaches on mammograms and getting rural veterans access to those, but we want to keep going and look at everything that we could possibly do.

Chairman TESTER. Appreciate that. Look, the Veterans Crisis Line was brought up with the last panel. You guys were here. You heard the conversation around it. I mean, from a veteran's standpoint, Tom, can you explain the importance of the Veterans Crisis Line as a resource to veterans?

Mr. PORTER. Well, as we all know, suicide amongst the veteran and military community remains a crisis. And we keep saying that over and over and over again, but it remains to be true. But at no time have we felt it more critical—and I cannot underscore it enough—than over the last couple of months as we withdrew from Afghanistan.

I knew veterans, military members around the clock like desperate to get people they knew out of Afghanistan or that felt that their service suddenly did not matter anymore. The deployments over the last 20 years, why did we go? Spouses saying, why do we do this?

And so we surveyed our members. The survey is out right now, but we have preliminary data that is out that shows exactly how it impacts the community. And this has not been released yet, publically yet, but 63 percent of our members supported withdrawing troops from Afghanistan, but 56 percent strongly disagreed with the way that the administration withdrew the troops. Another 10 percent agreed, simply agreed. So about 66 percent disagree with the way they were withdrawn. And then even greater, 85 percent, that more should have been done to help our Afghan partners get out.

So that just proves that there is an enormous amount of stress in the community, and then that goes to the 80 percent increase of callers to our call center that we maintain that refer for mental health referral. So, 80 percent increase just in August.

Chairman TESTER. Okay.

Mr. PORTER. So there is an answer just from our community.

Chairman TESTER. Yes. Thank you.

I am way out of time or I would have asked you the same question, Marquis, but we will go down that line a bit later.

Senator Moran.

Senator MORAN. Thank you, Chairman.

Tell me, Mr. Porter, about 988. What is the status of its implementation, and what, if anything, still needs to be accomplished to see that it is functioning well?

Mr. PORTER. Well, I have not talked to VA about the exact state of it, but I know from working with the House and Senate energy committees in developing it, it is a lot more complicated than people think. They think we just establish the three numbers, and then you implement it. You have to go to each of the States, and you have to get all of the right, qualified personnel. You have to get the funding, the authorizations. There is a lot to do. We are here to help, but I have not heard anything that needs our help at this point.

Senator MORAN. Okay. Your testimony, Mr. Porter, about S. 2720, the Veterans' Prostate Cancer Treatment Act, what do you regard as important in this legislation? What outcome will we achieve with its passage and rightful implementation?

Mr. PORTER. Well, I think, first off, it is always a priority for us to address the broader picture of toxic exposures, and Agent Orange is something that we have worked with the older groups to address. And we know that there is a tie to, because of research, from Agent Orange to prostate cancer. So if we would know more about the disease, we would know more about how to address that, and then we could address it better. And then that also tells us that we need to address the broader issue of toxic exposures.

Senator MORAN. Thank you.

Mr. Barefield, DOD and VA constantly communicate, yet still have difficulties in forecasting and planning future medical facility needs. The passage of 2526, Senate Bill 2526, that we are having a hearing on today, how does it allow the departments to behave differently or to get a better result?

Mr. BAREFIELD. Thank you for the question. This particular bill would allow the two departments to get along and be able to have facilities that they can coexist in. And hopefully, as they coexist in these facilities, they would be able to develop relationships where not only the clients that they serve can have better quality service and healthcare, but they can see that these two organizations can work together. And as it was mentioned earlier during the questioning of the first panel, anything that can save money would be a very integral thing.

Senator MORAN. Thank you for that answer.

Mr. Porter, let me come back to you for my final question. Women veterans' health. What do you think the priority should be, and how do the bills that we are talking about today address those priorities?

Mr. PORTER. Well, I mean, all of these affect women veterans. But women veterans also want equal care, and sometimes that means there are gaps in care that we need to fill. And so that does not mean that we are providing special treatment for women veterans. So when veterans need mammograms in rural areas and they cannot get to them, we need to be able to fill those gaps and get them what they need.

Senator MORAN. Let me ask this question. Would you consider that the MISSION Act and community care that is authorized by the MISSION Act, in fact, required by the MISSION Act, would be a further step in meeting the needs of particularly women veterans, rural or otherwise?

Mr. PORTER. Absolutely. IAVA was a supporter of the MISSION Act because the VA cannot be everywhere. So the private sector has a role in that, that VA cannot be everywhere the veterans are. So that is why we supported that is because especially in the rural areas where you cannot have an appointment as quickly as you would like to, if the private sector can fill that gap, then that is what they are there for, and we support that.

Senator MORAN. I agree with that. I would say that in addition to that, I mean in addition to the community care, the MISSION Act community care providing needs for rural veterans, women are

a larger percentage of the population than they are of the VA at the moment. That number continues to grow. The percentage of women who are veterans. And we know that women are being treated in our medical communities, in communities, in community care, in the places they would normally go.

So my point is that there would be availability of care for women more readily perhaps outside the VA until we catch up with the general medical care provided in a community; right? I mean, so community care becomes more important as the VA works to get more care for women. We are not there yet?

Mr. PORTER. Absolutely. No, I would be happy to work with you.

Senator MORAN. I did not say that very well, but I think that the concept is right. Women are being provided care in the normal healthcare setting outside the VA. This gives the VA a chance to provide those services in the community while the VA continues to increase the availability of care for women today.

Mr. PORTER. Right.

Senator MORAN. Makes sense?

Mr. PORTER. Yep. Absolutely, sir.

Senator MORAN. Okay. Chairman, thank you.

Chairman TESTER. Yep. Senator Tuberville.

Senator TUBERVILLE. Thank you, Mr. Chairman.

Thanks for being here. Off the subject a little bit, how are veterans dealing with COVID that you know of?

Mr. PORTER. We see a lot of veterans, sir, that really are taking advantage of the vaccine, and we encourage them all to get vaccine. And we are actually partnering with some other VSOs to encourage veterans and servicemembers to go out there and get it. We support efforts by DOD to require that amongst the Services. Seeing a lot of great results on that. We just think we need to do more.

Senator TUBERVILLE. Yes. Our DAVs, with COVID, how are we doing?

Mr. BAREFIELD. Our position is that we are encouraging veterans to go out and get vaccinated. A lot of our membership, of course, are over the age of 50. So of course, we are pushing to make sure that they know about where they go and get the vaccines, and vaccine shots are available to them.

I, myself being a veteran, of course, myself and my wife were able to get vaccinated at our local community-based outpatient clinic. So as soon as the shots were available, we signed up, and we went right ahead and got our vaccine.

So we are doing what we can to help spread the word that it is very important to become vaccinated.

Senator TUBERVILLE. Yes. I hope the boosters are available soon. Have you all seen any availability yet for our veterans? The boosters?

Mr. PORTER. They are available for everybody that is suggested that they get it.

Senator TUBERVILLE. Yes.

Mr. PORTER. At the right amount of time.

Senator TUBERVILLE. Yes. Okay. Mr. Barefield, many of the bills on today's agenda address mental health and wellness of veterans. What VA resources, such as vet centers, have you found the DAV members leverage the most?

Mr. BAREFIELD. Our membership, they respect and use all of the services, so to include the vet centers and the mental health services that are at the VA medical centers as well. We understand that the VA has high quality care when it comes down to mental health services. So we encourage our members to make sure that if there are issues that they have, that they seek out going to their closest either VA medical center or vet center, if they meet the qualifications to go to the vet center, to make sure that they go there and get the required mental health services that they need.

Senator TUBERVILLE. Did you see anything in this legislation, our list here, that you would most emphasize?

Mr. BAREFIELD. Well, I think all of the bills that deal with the mental health and suicide prevention efforts that are on discussion today are important. So I would not say singling out one more than another. But if I did have to pick one, the Servicemembers and Veterans Empowerment and Support Act is very key because along with just the regular mental health services that it discusses it also talks about the MST and being—and offering available mental health services for those veterans who suffer from MST incidents.

Senator TUBERVILLE. Yes. Thank you.

Mr. Porter, in your testimony, you mentioned that based on some preliminary data from a recent Iraq and Afghanistan Veterans of America survey 77 percent of members had some or many challenges upon transitioning from active duty to the civilian world; 34 percent stated they were not prepared to manage their finances immediately after the military. Based off your experience, can you ballpark what percentage of transitioning servicemembers have leveraged VA resources, you know, to get through this situation?

Mr. PORTER. I do not have the numbers in front of me, but a great deal, a vast majority of our members, I believe around three-quarters at least of our members are enrolled with the VA.

Senator TUBERVILLE. Really?

Mr. PORTER. So they are heavily invested in the VA. They depend on the VA. They need VA to work better for them. So they are pleased with it.

Senator TUBERVILLE. Do you find they are successful? Are they successful?

Mr. PORTER. There is a big challenge a lot of times with veterans trying to get into the care, but the studies that we have seen show that once they are actually in then they highly value the VA care once they get in.

Senator TUBERVILLE. So how do you foresee legislation such as S. 2924, the Vet Center Outreach Act, complementing the opportunity for, you know, people to use all of our resources? Have you looked at that one?

Mr. PORTER. I looked at both of the bills that deal with the vet centers. They both add to the capability of the vet centers and enable them to be more—be supportive of the community, like the one with the outreach that requires them on a timeline to reach out to veterans when they leave the service, when they transition. Those are all good. I mean, these reforms are good. They increase the capabilities of the vet centers.

Senator TUBERVILLE. Thank you.

Thank you, Mr. Chairman.

Chairman TESTER. Thank you, Senator Tuberville.

I want to thank you fellows for your testimony. I want to thank you for being here and representing the organizations you represent. Very thankful for having you folks at the table.

And I want to thank the VA for coming in and testifying. I want to also thank the VA for sticking around for the second panel. I think that is really important, and so thank you.

I think both panels today shared valuable insight, and we will use that insight as we move forward on these 18 bills.

We will keep the record open for a week, and with that, this hearing is adjourned.

[Whereupon, at 4:33 p.m., the Committee was adjourned.]

# A P P E N D I X

# Hearing Agenda

**UNITED STATES SENATE**
**COMMITTEE ON VETERANS' AFFAIRS**

**Hearing: Pending Legislation**

**October 20, 2021, 3:00 p.m.**
**Russell Senate Office Building, Room 418**

1. S. 1342 (Hassan), National Green Alert Act of 2021
2. S. 1779 (Duckworth), Veterans Preventive Health Coverage Fairness Act
3. S. 1937 (Booker), DOULA for VA Act of 2021
4. S. 1944 (Reed/Tester), Vet Center Improvement Act of 2021
5. S. 2283 (Tester/Moran), REACH for Veterans Act
6. S. 2386 (Blumenthal), Veteran Peer Specialist Act of 2021
7. S. 2526 (Sullivan), A bill to authorize the Secretary of Defense and the Secretary of Veterans Affairs to enter into agreements for the planning, design, and construction of facilities to be operated as shared medical facilities, and for other purposes
8. S. 2533 (Tester/Boozman/Hirono), MAMMO for Veterans Act
9. S. 2624 (Tester/Moran), FY2022 Veterans Affairs Major Medical Facility Authorization Act
10. S. 2720 (Moran/Tester), Veterans' Prostate Cancer Treatment and Research Act
11. S. 2787 (Cassidy/Sinema), A bill to amend title 38, United States Code, to clarify the role of doctors of podiatric medicine in the Department of Veterans Affairs, and for other purposes.
12. S. 2852 (Sinema/Blackburn), Long-Term Care Veterans Choice Act
13. S. 2924 (Hassan/Cramer), Vet Center Outreach Act of 2021
14. S. XXXX (Tester), Servicemembers and Veterans Empowerment and Support Act of 2021
15. S. XXXX (Warnock), A bill to amend title 38, United States Code, to establish new requirements for State homes for veterans that receive per diem from the Secretary of Veterans Affairs, and for other purposes.
16. S. XXXX (Sanders), Veterans Dental Care Eligibility Expansion and Enhancement Act
17. S. XXXX (Sanders), Veterans State Eligibility Standardization Act
18. S. XXXX (Lankford), A bill to amend title 38, United States Code, to reorganize the Chaplain Service of the Department of Veterans Affairs, and for other purposes

# Prepared Statements

**STATEMENT OF**
**DR. ELIZABETH BRILL**
**ASSISTANT UNDER SECRETARY FOR HEALTH FOR CLINICAL SERVICES AND**
**DEPUTY CHIEF MEDICAL OFFICER**
**VETERANS HEALTH ADMINISTRATION**
**DEPARTMENT OF VETERANS AFFAIRS (VA)**
**BEFORE THE**
**SENATE COMMITTEE ON VETERANS' AFFAIRS**

**October 20, 2021**

Chairman Tester, Ranking Member Moran, and other Members of the Committee: thank you for inviting us here today to present our views on several bills that would affect VA programs and services. Joining me today is Dr. David Carroll, Executive Director, Office of Mental Health and Suicide Prevention, Veterans Health Administration (VHA), and Dr. Lawrencia Pierce, Assistant Director, Office of Outreach, Transition, and Economic Development (OTED), Veterans Benefits Administration.

**S. 1342 National Green Alert Act**

S. 1342 would establish a Green Alert System Advisory and Support Committee, comprised of interagency Federal and private sector personnel, empaneled to outline best practices and provide technical assistance to States for establishing State "Green Alert" systems that would be activated when a Veteran with a history of mental health issues, including neurocognitive disorders, suicide attempts or impulses, or substance use disorders (SUD), goes missing.

VA does not support this bill because we believe the proposed legislation may further stigmatize Veterans with mental health conditions and jeopardize their rights to privacy and confidentiality. Alert systems for missing individuals with cognitive impairment already exist in many jurisdictions, while these systems do not label someone as a veteran, systems exist that could be used to report missing individuals. All missing Veterans, regardless of a physical or mental health condition, may be at risk of harm. For example, a Veteran who requires daily insulin injections, could be at significant risk of health consequences if they were unable to receive or administer those injections as needed; this risk could easily be greater than the risk a Veteran who received treatment for SUD 30 years ago. Further, the bill's focus on mental health issues would mean that any such alert would immediately disclose to the non-medical community the name of a specific Veteran who has a mental health condition. This disclosure raises concerns regarding privacy and autonomy. In addition, VA has concerns regarding the medical ethics associated with disclosure and non-disclosure of information under this authority, as it would involve the disclosure of the fact that a Veteran had a history of mental health issues. The criteria in the bill regarding disclosure are ill-defined and would likely be situational.

**S. 1779 Veterans Preventive Health Coverage Fairness Act**

The Veterans Preventive Health Coverage Fairness Act would amend 38 U.S.C. §§ 1710 and 1722A(a)(3) to eliminate copayments to VA for hospital care, medical services and medications related to preventive health services. The proposed legislation also would amend 38 U.S.C. § 1701(9) to expand the definition of "preventive health services."

VA supports this bill subject to the availability of additional appropriations to replace lost revenue from the elimination of these copayments. The proposed legislation does not appear to impact VA's authority to assess a copayment when an outpatient visit includes services beyond preventive health services or VA's authority to recover reasonable charges from a third-party under 38 U.S.C. § 1729. VA notes that under existing regulatory provisions at 38 C.F.R. § 17.108, outpatient visits solely consisting of preventive screening and immunizations and laboratory services; flat film radiology services; and electrocardiograms are not subject to copayment requirements and, pursuant to existing 38 C.F.R. § 17.4600(d)(2), an eligible Veteran who receives urgent care consisting solely of an immunization against influenza is not subject to a copayment.

If this bill is enacted, VA would incur a loss of revenues impacting first party pharmacy and outpatient copayment collections. VA estimates that approximately 3% of all outpatient copayments are from services that are included in the expanded definition for preventive health services. This 3% was applied to the 10-year outpatient copayment collections amounts and resulted in a 5-year impact of $24.2 million and a 10-year impact of $49.1 million. For medication copayments, VA estimates the 5-year revenue impact on pharmacy collections would be $193 million and the 10-year impact would be $399 million. The total MCCF collections impact would range from a 5-year impact of $218 million to a 10-year impact of $448 million.

**S. 1937 DOULA for VA Act**

S. 1937 would require VA to establish, not later than 1 year after the date of enactment, a 5-year pilot program to provide doula services to covered Veterans through eligible entities by expanding VA's Whole Health model. The pilot program would measure the impact that doula support services have on birth and mental health outcomes of pregnant Veterans. The pilot program would have to be carried out in the three Veterans Integrated Service Networks (VISN) that have the highest percentage of female Veteran enrollees and the three VISNs that have the lowest percentage of female Veteran enrollees.

VA is committed to improving maternal and neonatal outcomes among the Veterans it serves. The population of Veterans VA serves with maternity benefits has risk factors for poor maternal and infant outcomes, is racially diverse, has significant rates of mental health comorbidities, and is older when compared to the general population of pregnant people in the United States (see, e.g., Mattocks, K. M. et al. (2010). Pregnancy and

mental health among women Veterans returning from Iraq and Afghanistan. *Journal of Women's Health*, 19(12), 2159-2166. doi:10.1089/jwh.2009.1892; and Combellick, J. L., et al. (2020). Severe Maternal Morbidity Among a Cohort of Post-9/11 Women Veterans. *Journal of Women's Health*, 29(4), 577-584).

VA has established a robust Maternity Care Coordination program with maternity care coordination at every VA facility. Maternity Care Coordinators (MCC) serve as a support and resource to pregnant and postpartum Veterans. MCCs help Veterans navigate health care services inside and outside of VA, access care for their other physical and mental health conditions, connect to community resources, cope with pregnancy loss, connect to needed care after delivery and answer questions about billing for pregnancy care. A key component of the role of MCCs is to screen pregnant Veterans for mental health conditions such as postpartum depression and to provide universal education about intimate partner violence; MCCs also ensure the Veteran is connected to needed resources outside and within VA.

Regarding the bill itself, VA does not support the proposed legislation due to technical concerns with how it is currently written. First, we have several concerns with the timeframes identified in the bill. For example, the bill would only provide 1 year from the date of enactment to establish the program, but we believe this would be a complex process that would take at least 18-24 months to ensure the program is well-designed. That time is necessary to develop a doula pilot program that is best positioned to improve maternal outcomes; we would appreciate the opportunity to discuss these concerns with the Committee in the hope that we might identify ways of improving this bill. VA would conduct a review of the current evidence on benefits of doula care specifically as it may apply to the Veteran population and engage with key stakeholders including established community-based doula programs, female Veterans, reproductive mental health experts and birth workers to establish the characteristics of a successful doula pilot program. VA would need to develop and plan the program, select pilot site and select pregnant women Veterans for participation. Because there may not be a mechanism to pay non-licensed providers through current VA provider structure, VA would have to work to determine the most feasible way to fairly compensate doulas for their work. A hurried implementation schedule would likely result in a poorly designed program that would reduce the likelihood of its success. We also are concerned about the 5-year duration of the pilot program. A shorter pilot would seem to be better from a Veterans' benefit perspective. If the pilot program is successful, then we would like to be able to offer doula support to all Veterans using VA's maternity benefit, and if it is not successful, then there should be no reason to continue a program that is not producing benefits.

Second, we also are concerned about the requirement to include six VISNs in the pilot program, as this would potentially account for one-third of all women Veterans of child-bearing age. Pilot programs generally involve only a handful of facilities to allow them to be developed more quickly and to ensure VA is prudently using its resources in implementing these authorities. For a pilot program, this requirement would involve a significant commitment of human capital and funding to support.

There are other aspects of the bill that make it difficult for us to support as written. The bill would require VA to establish a Doula Service Coordinator within the functions of the MCCs at each site where the pilot programs are implemented to facilitate care between doulas and Veterans. MCCs already are managing significant care coordination activities, and this bill would add to their workload for support of a pilot program, prior to a demonstrated benefit for this program.

VA does not have a cost estimate for this bill. We remain available to provide technical support for proposed legislation to further support pregnant and postpartum Veterans.

**S. 1944 Vet Center Improvement Act of 2021**

Section 3 of S. 1944 would require VA, not later than 1 year after the date of the enactment of this legislation, to evaluate productivity expectations for readjustment counselors at Vet Centers. Not later than 90 days after the date of the completion of the evaluation of productivity expectations, VA would be required to implement any needed changes to the productivity expectations to ensure the quality of care and access to care for Veterans and the welfare of readjustment counselors. It would further require VA to make every effort to ensure that all Vet Center readjustment counselors are given the opportunity to fully provide feedback on Vet Center operations and productivity expectations to a working group established under section 5 of the bill. Not less frequently than once every year during the 5-year period beginning on the date of enactment, the Comptroller General would be required to audit the feedback obtained from Vet Center readjustment counselors. Not later than 1 year after the date of enactment, VA would be required to develop and implement a plan for reassessing the productivity expectations for Vet Center readjustment counselors and implement any needed changes to such expectations. VA would be required to conduct a reassessment not less frequently than once each year.

Section 4 of the bill would require VA, not later than 1 year after the date of enactment, to develop and implement a staffing model for Vet Centers that incorporates key practices in the design of such staffing model. In developing the staffing model, VA would have to involve key stakeholders, incorporate key work activities, ensure the data used in the model is high quality and incorporate various factors. Not later than 1 year after the date of enactment, VA would have to develop a plan for assessing and updating the staffing model not less frequently than once every 4 years and implementing any needed changes to such model.

Section 5 of the bill would require VA to establish a working group to support the efforts in sections 3 and 4 of the bill. This group would be composed of readjustment counselors, outreach specialists and Vet Center directors. The working group would provide to VA feedback from readjustment counselors, outreach specialists, and Vet Center directors and recommendations on how to improve quality of and access to care for Veterans and the welfare of Vet Center staff.

Section 6 of the bill would require VA, not later than 1 year after the date of enactment, to standardize descriptions of position responsibilities at Vet Centers. In the next two annual reports required by 38, U.S.C. § 7309(e), VA would be required to include a description of VA's actions in this regard. This section of the bill also would amend 38 U.S.C. § 7309(e)(2) to also require a description of actions taken by VA to reduce vacancies in Vet Center counselor positions and the time it takes to hire such counselors.

VA does not support sections 1-6; while we are in agreement with the goals of these sections, we do not believe they are necessary. VA already has the authority to carry out these requirements and has been working to address the issues raised in these sections based on the findings of the September 2020, Government Accountability Office (GAO) Report, "VA Vet Centers: Evaluations Needed of Expectations for Counselor Productivity and Centers' Staffing" (GAO 20-652). VA has developed an action plan to meet these requirements and is on track to complete the actions outlined in GAO's recommendations in accordance with timelines established by VA and accepted by GAO.

Section 7 of the bill would require the Comptroller General to submit to Congress a report, not later than 1 year after the date of enactment, on the physical infrastructure and future investments with respect to Vet Centers. VA defers to the Comptroller General on this section.

Section 8 of the bill would require VA, not later than 1 year after the date of enactment, to establish a pilot program to award grants to eligible entities to support partnerships that address food insecurity among Veterans and their families who receive services through Vet Centers. Eligible entities would include nonprofit organizations, VSOs, public agencies, community-based organizations or an institution of higher education. An eligible entity seeking a grant would have to submit an application for such a grant. VA would have to select applicants using a competitive process taking into account various factors.

VA would have to ensure, to the extent practicable, an equitable geographic distribution of grants under this section. Grants would have to be used to carry out a collaboration between one or more eligible entities and VA for 5 years, to increase participation in nutrition counseling programs and provide educational materials and counseling to Veterans and their families, and to increase access to and enrollment in Federal and other assistance programs. Grantees would have to provide information to VA, at least once each year during the duration of the grant, on the number of Veterans and family members screened for, and enrolled in, education, counseling and assistance programs, as well as other services provided by the grantee to Veterans and their families using grant funds.

Not later than 180 days after the date of enactment, VA would have to submit to Congress a report on the status of the implementation of this section. Not later than 1 year after the date on which the pilot program terminates, the Comptroller General

would have to submit a report to Congress evaluating the effectiveness of the activities carried out under this section in reducing food insecurity among Veterans and their families. This section would authorize to be appropriated $50 million for each fiscal year in which the program is carried out, and not more than 5% of that authorized amount could be used for VA's administrative expenses associated with administering grants.

We support section 8, assuming appropriations are provided for this purpose and some amendments are made to the text. VA currently is unable to offer direct support for Veterans facing food insecurity because appropriated funds cannot be used to purchase groceries or other means of subsistence for Veterans. Food may only be provided concurrent with the provision of medical care or therapy. In addition, VA programs are able to assist only those Veterans who come to VA for care, so there may be Veterans facing food insecurity who could receive support through this section.

We appreciate the Committee's interest in addressing food insecurity among Veterans and their families. For the last 5 years, VA has been working to collaborate with government and nonprofit agencies to focus on the issue of food insecurity. VA has developed and deployed a food insecurity screening tool as part of the regular screenings that occur during VA primary care visits; all Veterans are screened annually unless they reside at a nursing home or long-term care facility. If the Veteran is screened positive for food insecurity, the Veteran is subsequently screened every 3 months thereafter. Veterans who screen positive are offered a referral to a social worker and a dietitian, and VA further assesses the Veteran for clinical risk and complications. Since July 2017, VA has completed more than 10 million screenings. VA social workers can provide information about Supplemental Nutrition Assistance Program (SNAP) eligibility and help Veterans complete a SNAP application. They can also address possible root causes of food insecurity and connect Veterans with community resources. We would welcome the opportunity to meet with the Committee to discuss our current efforts to address Veteran food insecurity.

GAO is currently conducting a review of VA's and USDA's programs regarding food insecurity among Veterans. It may be advisable for the Committee to forbear action on this proposal and in this policy area until that review has been completed. We believe it would be prudent to have GAO's recommendations prior to implementing new programs or authorities to ensure we are using our resources to their greatest effect.

We do note a few technical issues with the bill text. We do not believe 1 year would be enough time to establish a new grant program. VA would need to issue regulations for this new authority, which generally takes between 18 and 24 months. VA also would need funding and staffing to develop the necessary resources to implement this program. Furthermore, this section does not define the duration of the pilot program. Section 8(f)(1) requires grants be used to carry out collaborations "for five years," but grants are typically awarded year-by-year and the length of time for the collaboration may not be the same as the duration of the pilot program. We also note concerns that the language in the bill appears to envision multi-year grants. VA currently awards grants annually, which ensures funding is available and grantees are using funds

responsibly. Particularly for a new program like this, VA recommends adopting this same structure for the proposed grant program. We would be happy to work with the Committee to address these and any other technical issues.

VA developed several potential cost estimates depending upon the size of the program. VA is providing a cost estimate under these scenarios for a 7-year period because this would allow for preparation (in the first year), implementation of a 5-year pilot program (assuming the reference noted previously to 5 years is the limit on the program), and post-program analysis and evaluation (in the final year). On a smaller scale, if we are providing approximately 3.5 million meals during the pilot period, then we estimate this section would cost $0.24 million in FY 2022, $58.25 million over 5 years and $73.41 million over 7 years. On a medium scale, if we are providing approximately 4.9 million meals during the pilot period, then we estimate this section would cost $0.33 million in FY 2022, $81.64 million over 5 years and $102.88 million over 7 years. On the largest scale, if we are providing approximately 6.3 million meals during the pilot period, then we estimate this section would cost $0.43 million in FY 2022, $105.03 million over 5 years and $132.35 million over 7 years. While the bill would authorize up to $50 million per fiscal year for the program, we are uncertain whether obligating that amount would be logistically feasible or advisable given that this program would be a new program with which VA has no relevant experience.

**S. 2283 REACH for Veterans Act**

Section 101 of S. 2283 would require VA to enter into an agreement with an organization outside VA, such as the American Association of Suicidology (AAS), to review the training for call responders for the Veterans Crisis Line (VCL) on assisting callers in crisis. This review would have to be completed not later than 1 year after the date of the enactment of this legislation. This review would have to consist of a review of the training provided by VA on subjects including risk assessment; lethal means assessment; substance use and overdose risk assessment; safety planning; referrals to care; supervisory consultation; and emergency dispatch. If any deficiencies in the training for VCL call responders are found, then VA would have to update such training and associated standards of practice to correct those deficiencies not later than 1 year after the completion of the review.

VA agrees with the goals of this section but does not believe it is necessary because we already have sufficient authority in this area and our current efforts exceed the requirements of the legislation. Rather than reviewing VCL training standards according to baseline accreditation requirements, VA recommends incorporating a consultative review by the Rocky Mountain Mental Illness Research Education and Clinical Center (MIRECC) for Suicide Prevention to provide recommendations for ongoing training enhancements from the latest research evidence base while we await the next revision of the VA/DOD Clinical Practice Guideline for The Assessment and Management of Patients at Risk for Suicide (2019). Currently, VCL maintains accreditation with the AAS, the Commission on Accreditation of Rehabilitation Facilities, and the International Customer Management Institute. VA currently exceeds the requirements this bill would

impose; for example, AAS expectations are for a minimum of 6 days in precepting, but, on average, VCL responders complete over 85 days of training and precepting before being released for independent work. VA's training for VCL responders include subjects such as military culture; posttraumatic stress disorder (PTSD) and moral injury; military sexual trauma; suicide risk assessment; violence risk assessment; lethal means safety; substance use and overdose risk; crisis intervention; and police perspective.

Section 102 of the bill would require VA, not later than 1 year after the date of enactment, to develop guidelines on retraining and quality management for when a VCL call responder has an adverse event or when a quality review check by a supervisor of such a call responder denotes that the call responder needs improvement. These guidelines would have to specify the subjects and quantity of retraining recommended and how supervisors should implement increased use of silent monitoring or other performance review mechanisms.

VA does not support this section because its requirements would be redundant to current policy. VA already requires supervisor to conduct investigation and oversight after critical incidents or any scenario in which responders need quality review. VA uses data to inform training initiatives through a continuous quality improvement cycle that includes data collection, analysis, feedback and training.

Section 111 of the bill would direct VA to require that no fewer than two calls per month for each VCL call responder be subject to supervisory silent monitoring. VA would have to establish benchmarks for requirements and performance of VCL call responders on supervisory silent monitored calls. Not less frequently than quarterly, VA would have to submit to the Office of Mental Health and Suicide Prevention a report on occurrence and outcomes of supervisory silent monitoring of calls on the VCL.

VA does not support this section because it is unnecessary; we already have sufficient authority in this area, and we do not believe it is prudent to legislate specific methods for quality measurement, as this could limit VA's ability to adopt innovative approaches in the future. VA already has in place three monitors (one performance and two quality assurance) per responder per month, so adding a second supervisory performance monitor is unnecessary. VCL quality assurance monitoring, which includes coaching sessions, is done by quality assurance staff and examines overall VCL quality. VCL performance monitoring is performed by supervisors and can result directly in performance or conduct actions. This section would also direct that quarterly monitoring reports be prepared, but VCL currently generates monthly reports on quality monitoring targets and supervisory monitoring data.

Section 112 of the bill would require that, not later than 1 year after the date of enactment, the leadership of the VCL establish quality management processes and expectations for VCL staff, including reporting of adverse events and close calls.

VA does not support this section because it is unnecessary. In August 2021, VA issued a new policy and standard operating procedures (SOP) that establish the overall policy of reporting adverse events and close calls, as well as expectations for responders, supervisors, quality management staff and others. VCL is monitoring training of all staff in this new SOP with 97.2% of staff completing the training to date. This new SOP has also been incorporated into our new employee orientation. VCL quality assurance is monitoring daily reporting with monthly reviews by VCL leadership to ensure ongoing implementation and adherence.

Section 113 of the bill would require VA, not less than annually, to perform a common cause analysis for all identified callers to the VCL who died by suicide during the 1-year period preceding the conduct of the analysis before the caller received contact with emergency services and in which the VCL was the last point of contact. VA would submit the results of each analysis to the Office of Mental Health and Suicide Prevention. VA would be required to apply any themes or lessons learned under an analysis to update training and standards of practice for VCL staff.

VA does not support this section because it is unnecessary; we already have sufficient authority in this area, and we do not believe it is prudent to legislate specific methods of analysis, as this could limit VA's ability to adopt innovative approaches in the future. The policy VA issued in August 2021 defines the aggregate analysis process that VCL will conduct to identify themes and determine any necessary actions to address quality, continuous improvement or technological solutions.

Section 121 of the bill would require VA, not later than 1 year after the date of enactment, in consultation with VA national experts on SUD and overdose, to (1) develop enhanced guidance and procedures to respond to calls to the VCL related to SUD and overdose risk, (2) update training materials for VCL staff in response to such enhanced guidance and procedures and (3) update criteria for monitoring compliance with such enhanced guidance and procedures.

VA does not support this section because it is unnecessary given VA's actions to implement OIG's recommendations. OIG recommended that VA update SUD and overdose risk policies and staff-wide training; lethal means assessment training and job aides; and communication between staff regarding emergency dispatch and disconnected callers. VA has taken actions in each of these areas. VA's enhanced guidance and training was informed based on consultation with mental health and SUD experts, and consultations occur with Poison Control Centers of America to provide real-time management of potential overdose cases. VA has also developed enhanced criteria for monitoring staff in this area, with coaching completed by silent monitoring staff; VA will be tracking these criteria and will be reporting monitoring data as it becomes available.

Section 122 of the bill would require VA, not later than 1 year after the date of enactment, to review the current emergency dispatch SOPs of the VCL to identify any additions to such procedure to strengthen communication regarding emergency

dispatch for disconnected callers and the role of social service assistants in requesting emergency dispatch and recording such dispatches. VA also would have to update such procedure to include the additions identified previously. VA would be required to ensure that all VCL staff are trained on all updates to VCL's emergency dispatch SOP.

VA does not support this section because it is unnecessary as we already have sufficient authority in this area. VA updated its SOPs for emergency dispatch in June 2021 to include additional steps for responders to take when conducting emergency dispatch requests with VCL customers. Responders are required to communicate status updates with Social Service Assistant (SSA) staff when a call disconnects. The new process also provides guidance to responders to ascertain customer status through VCL resources, such as reviewing incoming calls through caller ID. VA is further evaluating outcomes of VCL emergency dispatches and facility transport plans, and these findings may inform additional process improvements.

Section 131 of the bill would require VA, not later than 1 year after the date of enactment, to establish oversight mechanisms to ensure that SSAs and supervisory SSAs working with the VCL are trained appropriately and implementing VA guidance regarding the VCL. VA also would be required to refine SOPs to delineate rules and responsibilities for all levels of supervisory SSAs working with the VCL.

VA does not support this section because it is unnecessary, as VA has already delivered enhanced training on SSA roles and responsibilities to all SSAs, supervisors and support staff. New SOPs will be released soon for SSA responsibilities regarding facility transportation plans, consult check-ins and carryovers.

Section 201 of the bill would require VA, not later than 180 days after the date of enactment, to carry out a pilot program to determine whether a lengthier, templated safety plan used in clinical settings could be applied in VCL call centers. Not later than 2 years after the date of enactment, VA would be required to brief Congress on its findings, including such recommendations as VA may have for continuation or discontinuation of the pilot program.

VA does not support this section because it is unnecessary as VA has sufficient authority in this area and is already nearing completion of a pilot program where a select group of responders have been trained in implementing VA's standardized six-part safety plans. VCL responders are attempting to complete these plans with any Veteran caller when they identify a need for risk mitigation. VA will review the results of this pilot program to determine next steps for any broader implementation. We would be happy to share the results with the Committee when they are available.

Section 202 of the bill would require VA, not later than 1 year after the date of enactment, to carry out a pilot program on the use of crisis line facilitations to increase use of the VCL among high-risk Veterans. Not later than 2 years after the date of enactment, VA would be required to brief Congress on its findings, including such recommendations as VA may have for continuation or discontinuation of the pilot program.

VA does not support this section because it is unnecessary, as VA completed a pilot study on crisis line facilitation in 2019 and is already considering the possibility of a broader pilot or staged implementation. We would be happy to report to the Committee on this pilot upon request.

Section 211 of the bill would authorize to be appropriated $5 million for VA's Mental Illness Research, Education, and Clinical Centers (MIRECC) to conduct research on the effectiveness of the VCL and areas for improvement for the VCL.

VA does not support this section because it is not needed at this time. Instead, we recommend that Congress could consider appropriating funds to VA to implement recommendations, including ongoing program evaluation projects with the Rocky Mountain MIRECC, and implementing a five-year program evaluation plan with the VA Partnered Evidence-Based Policy Resource Center.

Section 301 of the bill would require VA to solicit feedback from VSOs on how to conduct outreach to members of the Armed Forces, Veterans, their family members and other members of the military and Veterans community on the new, national three-digit suicide and mental health crisis hotline, 988, to minimize confusion and ensure Veterans are aware of their options for reaching the VCL. The Federal Advisory Committee Act (5 U.S.C. App.) would not apply to any feedback solicited under this section.

VA supports the goal of this section, but it is unnecessary because VA's current efforts already meet the requirements of the bill. VA is briefing and soliciting feedback on VA's 988 Communication Plan with federally chartered VSOs during monthly meetings.

For the above reasons, VA does not support this bill as most of the goals of this legislation are already being met. VA would be happy to provide briefings and other details on existing quality assurance measures to the Committee as needed.

**S. 2386 Veterans Peer Specialist Act**

S. 2386 would amend section 506 of the VA MISSION Act of 2018 (P.L. 115-182; 38 U.S.C. § 1701 note) to insert a new subsection (d) to make permanent and expand the peer specialist program required by section 506. VA would be required to add an additional 25 VA medical centers (VAMC) each year for the 5-year period following the date of the enactment of this legislation until the program is carried out at each VAMC. In selecting additional medical centers, VA would be required to prioritize VAMC's in

rural and underserved areas that are not close to an active-duty military installation, and areas representing different geographic locations, such as census tracts established by the Bureau of the Census.

We support the goals of this proposed legislation, but we do not believe it is necessary because VA already has the authority to appoint peer specialists at VA medical centers. In implementing section 506 of the VA MISSION Act of 2018 (P.L. 115-182), VA found that expanding peer specialist services in patient-aligned care teams benefited Veterans and was associated with increased participation and engagement in care. VA also found that Veterans valued these services. As stated in VA's final report to Congress on its implementation of section 506 of the VA MISSION Act of 2018, peer specialists were highly beneficial to Veterans. They delivered services through individual and group-based interactions that were in-person, over the phone, or by other telehealth technology. Early interactions with Veterans yielded lasting, positive relationships between Veterans and peer specialists with many benefits. Anecdotally, VA heard from family members who expressed their gratitude for the peer services that were provided. Peer specialists provided emotional, tangible, and personalized services. Veterans shared that peer specialists enhance engagement in mental health and other types of care. Peer specialists can bridge gaps between clinical care and behavioral health support outside the clinic as well, while helping Veterans engage with community resources such as food pantries, interfaith and community centers, community colleges, and clothing, housing, and transportation services. VA's Office of Mental Health and Suicide Prevention (OMHSP) and the Center for Integrated Healthcare (CIH) are prepared to share the lessons learned through implementation of section 506 with VA facilities who elect to adapt existing peer support programs or expand such programs through hiring additional peer specialists specifically for work in patient-aligned care teams (PACT). As of the end of August 2021, VA has more than 1,200 peer specialists working in mental health programs across the Nation.

VA's final report to Congress on this authority in November 2020 found that dedicated and sustained funding was essential to ensuring implementation of these specialists at VA facilities. We believe that funding each position for a period of three years is necessary to cover costs and ensure positions are fully functioning prior to the costs for these employees being assumed by the facility or Veterans Integrated Service Networks (VISN). As such, this would require extending the bill's proposed timeline from five years to seven years (to allow a full three years of support for the final phase of peer specialists added in year five). Without additional appropriated funds to support these efforts, we believe VA's current authority, which allows facilities to opt to provide peer specialists, is a better approach. Peer specialists require initial and ongoing training, as well as supervisory support. A program of the scale in the bill would require implementation support and evaluation, which would increase the associated budgetary needs. We do not believe the $5 million authorized for each fiscal year (FY) between FY 2022 and FY 2027 would be sufficient to implement the bill's requirements.

**S. 2526 Authorizing VA-Department of Defense Shared Medical Facilities**

S. 2526 would allow the transfer of funds between VA and the Department of Defense (DoD) for the planning, designing and constructing of shared medical facilities.

VA supports this bill, which would enable both Departments to realize savings through using existing available capacity at the other's facilities; acquiring and operating a single facility rather than two that are separate; and resulting from a more rapid planning and project execution timetable. The Department designated as lead for a particular project would provide the capital assets (real property) to the other Department and would then be compensated for those assets. The bill would require engagement at the facility level between VA and DoD for the ownership, governance, terms and funding.

**S. 2533 MAMMO for Veterans Act**

S. 2533 seeks to improve mammography services furnished by VA. We share the Committee's goal of ensuring all Veterans have access to high-quality breast imaging services. We currently are finalizing a strategic plan that will address many of the provisions in this bill, and we believe this plan will further VA's goal to provide excellent access and quality in mammography for Veterans across the Nation.

Section 101 of S. 2533 would require VA, within 1 year of the enactment of this legislation, to submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a strategic plan for improving breast imaging services for Veterans. The plan would have to cover the evolving needs of women Veterans; address geographic disparities of breast imaging furnished at VA facilities and the use of breast imaging through non-VA providers; address the use of digital breast tomosynthesis (DBT-3D breast imaging); address the needs of male Veterans who require breast cancer screening services; and provide recommendations on potential expansion of breast imaging services furnished at VA facilities (including infrastructure and staffing needs), on the use of DBT-3D breast imaging, on the use of mobile mammography, and on other access and equity improvements for breast imaging.

We support the goals of this section, but we do not believe it is necessary because VA is already finalizing a strategic plan for the provision of breast imaging services for Veterans. We are already in the process of finalizing a breast imaging strategic plan that addresses the critical elements of this section. We would be happy to brief the Committee when the strategic plan is complete.

Section 102 of the bill would require VA, within 1 year of the date of enactment, to carry out a 3-year pilot program to provide telemammography services for Veterans who live in States where VA does not offer breast imaging services at a VA facility or locations where access to breast imaging services at a VA facility is difficult or not feasible. The pilot program could use community-based outpatient clinics (CBOC), mobile mammography, federally qualified health centers, rural health clinics, critical access hospitals, clinics of the Indian Health Service and other sites as VA determines feasible

to provide mammograms. Under the pilot program, mammography images generated would be sent to VA's centralized telemammography center for interpretation by expert radiologists and results would be shared with the Veteran and their primary care provider. Within 1 year of the conclusion of the pilot program, VA would be required to submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report evaluating the pilot program, including an assessment of the quality of mammography provided; feedback from Veterans and providers participating in the pilot program; and a recommendation on the continuation or discontinuation of the pilot program.

While VA supports the goals of this section, we do not support this section as written. VA shares the Committee's goal of ensuring all Veterans have access to high-quality breast imaging services. To this end, VA has established a robust network of community mammography centers to augment services provided by our in-house mammography programs. Independent third-party metrics confirm that women Veterans are more likely to receive timely breast cancer screening than women covered by a commercial health management organization or a preferred provider organization, or by Medicare or Medicaid benefits. We would be happy to brief the Committee or share this research at your request.

Tele-screening mammography (that is, remote electronic interpretation of a screening mammogram by a specially trained physician breast radiologist) may be useful in certain circumstances, but this would be only one component of a comprehensive breast imaging service. For many women, a screening mammogram may be sufficient to exclude breast cancer. However, when an area of concern is identified on a screening exam, additional diagnostic workup (e.g., additional mammogram views, ultrasound, MRI, etc.) is clinically indicated. For optimal patient care, a diagnostic exam (as opposed to a screening exam) requires the physical presence of a breast radiologist to personally direct the workup, perform a physical examination if needed, correlate findings and to counsel the patient. Tele-screening mammography is only useful in areas where referral sites are readily available to provide appropriate follow-up diagnostic imaging care, which may limit the use of the proposed pilot in rural or underserved areas, as these referral sites may not be accessible. Even in areas where diagnostic services are accessible in the community, coordination with a full-service breast imaging center presents challenges to ensuring continuity of care.

Fundamentally, the proposed scope of this section is too broad for a pilot program for logistical reasons. Sustaining high-quality breast imaging services requires enough women Veterans to maintain technical proficiency. Many of the sites VA would be able to select under this section would not meet these minimum requirements. Identifying specific locations where VA in-house mammography programs have limited breast radiologist support could be a useful starting point, and in this regard, a pilot program may identify additional use cases. Mobile screening mammography with remote interpretation may be a consideration in selected areas, specifically where supporting diagnostic and interventional services are available, although mobile screening's utility as a comprehensive service in remote areas is limited. Another barrier for tele-

screening mammography would be the difficulty in obtaining prior mammography examinations for comparison from other imaging centers. Comparison images are helpful to limit patient recalls for follow-up imaging of otherwise indeterminate findings. The section also proposes screening mammography performed by community imaging centers with centralized interpretation by VA providers. While this may prove a viable long-term solution, we are concerned that the technical and cybersecurity requirements may not be feasible within the time constraints of a pilot study. Additionally, we are concerned the proposed one-year timeframe may prove insufficient to implement a pilot. If this section were to become law, we would need to balance the requirements of accreditation, certification and professional competence with the section's requirements to offer these services at additional locations. This could limit the number of sites where the pilot could be implemented.

We would like to discuss our current efforts with the Committee before further actions is taken on this section at this time, and we look forward to working with you to provide the highest quality care for our Veterans.

Section 103 of the bill would require VA, within 2 years of the date of enactment, to upgrade all mammography services at VA facilities that provide such services to use DBT-3D and to submit a report to the Committees on Veterans' Affairs of the House of Representatives and the Senate indicating that the upgrade has been completed and listing the facilities or other VA locations at which DBT-3D is used.

We support the goals of this section, which is consistent with VA's current plans, but we do not believe this section is necessary because we already have sufficient authority in this area. Currently, 62 of the 68 VA mammography programs offer DBT-3D. The six sites that do not offer this technology are in the process of conducting market research or are reviewing construction options to upgrade to the latest technology. We are concerned that the proposed timeline may not be realistic, or could result in additional expenses to VA, as procurement and construction could take longer than this time period. Two years may be inadequate to upgrade all mammography sites without DBT-3D.

Section 104 of the bill would require VA to conduct a study on the availability of access to testing for the breast cancer gene for Veterans diagnosed with breast cancer, as recommended by the guidelines set forth by the National Comprehensive Cancer Network. In conducting the study, VA would have to examine (1) the feasibility of expanding VA's "Joint Medicine Service" to provide genetic testing and counseling for Veterans with breast cancer and (2) access to such testing and counseling for Veterans living in rural or highly rural areas. Section 104 also would require VA to update guidelines or institute new guidelines to increase the use of testing for the breast cancer gene and genetic counseling for Veterans diagnosed with breast cancer; VA could develop clinical decision support tools to facilitate delivery of breast cancer care that is in line with national cancer guidelines. Not later than 2 years after the date of the enactment of this legislation, VA would be required to submit a report to the Committees on Veterans' Affairs of the House of Representatives and the Senate on the results of

the study, any updates to guidelines or new guidelines instituted, and any progress by VA in improving access to and usage of testing for the breast cancer gene among Veterans diagnosed with breast cancer, including Veterans in rural or highly rural areas.

We agree with the goal of this section, but we believe our current efforts are already increasing the availability of access to genetic testing. If VA were required to conduct a study as well, VA would require additional resources (funding for both VA health care and information technology requirements, as well as personnel) beyond those VA has already planned to use to implement improved testing and care. In terms of developing guidelines to increase the use of testing and clinical decision support tools, we anticipate these could be completed with some additional financial support. We note as a technical matter that the bill refers to VA's Joint Medicine Service, but we believe this should instead be to VA's Genomic Medicine Service.

Section 105 would require VA to conduct a study on the accessibility of breast imaging services at VA facilities for Veterans with paralysis; spinal cord injury or disorder (SCI/D); or another disability. The study would have to assess the accessibility of the physical infrastructure at VA breast cancer imaging facilities, including the imaging equipment, transfer assistance and the room in which services will be provided, as well as the adherence to best practices for screening and treating Veterans with SCI/D. The study would have to include a measurement of breast cancer screening rates for Veterans with SCI/D during the 2-year period before the commencement of the study, including a breakout of the screening rates for such Veterans living in rural or highly rural areas. Not later than 2 years after the date of the enactment of this legislation, VA would be required to submit a report to the Committees on Veterans' Affairs of the House of Representatives and the Senate on the findings of the study, including the rates of screening among Veterans with SCI/D, including Veterans living in rural or highly rural areas. Furthermore, VA would be required to update VA policies and directives to ensure that, in referring a Veteran with SCI/D for care from a non-VA provider, the Secretary confirms with the provider the accessibility of the breast imaging site, including the imaging equipment, transfer assistance and the room in which the services will be provided, and provide additional information to the provider on best practices for screening and treating Veterans with SCI/D.

We support the goal of this section, but we do not support it as written. VA can assess the physical infrastructure for providing in-house mammography services to paralyzed Veterans or those with SCI/D and other disabilities. We would like to discuss our current efforts and plans with the Committee to determine where we can work together in this regard.

Section 106 would require the VA Inspector General to submit a report to the Committees on Veterans' Affairs of the House of Representatives and the Senate on mammography services furnished by VA. The report would be required to include an assessment of the access of Veterans to mammography screenings, including any VA staffing concerns in providing such screenings, the quality of such screenings and reading of the images from such screenings, the communication of the results of such

screening, the performance of VA's Women's Breast Oncology System of Excellence (the System) and the access of Veterans diagnosed with breast cancer to a VA comprehensive breast cancer care team. The System will be comprised of research and partnerships that include precision oncology and tele-oncology that will provide women Veteran oncology patients with cutting edge care and access to potentially lifesaving clinical trials. Within 180 days of the submittal of this report, the Secretary would be required to submit a plan to the Committees on Veterans' Affairs of the House of Representatives and the Senate to address the deficiencies identified in the report.

While VA defers to OIG on this provision, we note that VA's Women's Breast Oncology System of Excellence is focused on care delivery and not mammography screening; additionally, the Center will be implemented in FY 2022 and FY 2023. Consequently, we believe asking the OIG to assess the performance of this Center at this time would be premature.

Section 201 would require VA to enter into partnerships with one or more cancer centers of the National Cancer Institute (NCI) centers in VISN to expand access to high quality cancer care for women Veterans. In carrying out these partnerships, VA would have to ensure that Veterans with breast cancer who reside in rural areas or States without a cancer center in such a partnership with VA are able to receive care through such a partnership via telehealth. Not later than 180 days after the date of the enactment of this legislation, VA would be required to submit a report to the Committees on Veterans' Affairs of the House of Representatives and the Senate on how VA will ensure that the advancements made through the existing partnership between VA and the NCI to provide Veterans with access to clinical cancer research trials are permanently implemented and VA's determination whether expansion of such partnership to more than the original 12 VA facilities that were selected is feasible. Not later than 3 years after the date of enactment, and every 3 years thereafter, VA would be required to submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report assessing how the partnerships have impacted access by Veterans to cancer centers of the NCI, including an assessment of the telehealth options made available and used pursuant to such partnerships. The report also would need to describe the advancements made with respect to access by Veterans to clinical cancer research trials through these partnerships, including how many of those Veterans were women Veterans, minority Veterans and rural Veterans, as well as identifying opportunities for further innovation.

VA supports the general goal of this section, but we do not believe it is necessary because we already have sufficient authority in this area, and we have some concerns with it as written. There are nearly 50 NCI-Designated Cancer Centers that have academic affiliations already with a VA facility or are near one, and many of these already support breast cancer care at the affiliated VAMC. VA's Breast Cancer System of Excellence plans to use telehealth to expand access to expert breast cancer care using staff from NCI-Designated Cancer Centers to provide care to Veterans in every VISN, but these experts will not necessarily be located in each VISN. By using tele-oncology, VA can ensure coverage for patients no matter where they live while also

ensuring access to experts that may not be available in specific communities. Cancer treatment is highly specialized, so having a center or an agreement is no guarantee that the center has the expertise to address a particular patient's clinical needs. The System of Excellence being developed by VA will bring this expertise to every community.

Additionally, we have some concerns with the technical language of this section. For example, we note that this section would direct VA to enter into partnerships with cancer centers, but these centers are private entities, and VA cannot compel them to enter into a partnership or agreement. We would be pleased to work with the Committee to address these concerns.

Section 202 would require VA, not later than 180 days after the date of the enactment of this legislation, in collaboration with DoD, to submit to Congress a report on all current research and health care collaborations between VA and DoD on treating Veterans and members of the Armed Forces with breast cancer. The report would have to include a description of potential opportunities for further interagency collaboration between VA and DoD with respect to treating and researching breast cancer and may include a focus on (1) transitions to VA of women members of the Armed Forces who are undergoing screening for breast cancer, (2) collaborative breast cancer research opportunities between VA and DoD, (3) access to clinical trials and (4) such other matters as VA and DoD consider appropriate.

VA is pleased to share information regarding its work and collaborations with DoD, but we do not believe this section is necessary because we already have sufficient authority in this area. VA currently reports regularly on various collaborations, including the Applied Proteogenomics Organizational Learning and Outcomes Network. These collaborations have been useful, and VA and DoD are working closely on several efforts. We would be pleased to brief the Committee on this work in general or any specific projects upon your request.

**S. 2624 FY 2022 VA Major Medical Facility Authorization Act**

S. 2624 would authorize 12 major construction projects requested in the President's FY 2022 Budget through the available funding provided in this request and in previous years.

VA supports this bill.

**S. 2720 Veterans' Prostate Cancer Treatment and Research Act**

Section 3 of S. 2720 would require VA, not later than 365 days after the date of enactment, to establish an interdisciplinary clinical pathway for all stages of prostate cancer, from early detection to end of life care. The pathway would be established in the National Surgery Office, which would include a Program Office for Urology in VA's National Surgery Office in close collaboration with the National Program Office of Oncology, the Office of Research and Development (ORD) and other relevant entities in VA.

The national clinical pathway would have to include a diagnosis pathway for prostate cancer that includes early screening and diagnosis protocol; a treatment pathway that details the respective role of each VA office that will interact with Veterans receiving prostate cancer care; treatment recommendations for all stages of prostate cancer that reflect nationally recognized standards for oncology, including the National Comprehensive Cancer Network guidelines; a suggested protocol timeframe for each point of care based on severity and stage of cancer; and a plan that includes, as appropriate, VA and community-based facilities and providers and research centers specializing in prostate cancer. In establishing the clinical pathway, VA could collaborate and coordinate with the National Institutes of Health, NCI, the National Institute on Minority Health and Health Disparities, the Centers for Disease Control and Prevention, the Centers for Medicare and Medicaid Services, the Patient-Centered Outcomes Research Institute, the Food and Drug Administration, DoD and other institutes or centers.

VA would have to consult with, and incorporate feedback from Veterans who have received prostate cancer care at VA medical facilities, as well as experts in multi-disciplinary cancer care and clinical research. VA would have to publish the clinical pathway on an internal website and update the pathway as needed by review of the medical literature and available evidence-based guidelines at least annually.

Not later than 180 days after the date of enactment, VA would have to submit to Congress a plan to establish a prostate cancer program using the comprehensive clinical pathway VA would be required to develop. The comprehensive program would receive direct oversight from the Deputy Under Secretary for Health; include a yearly program implementation evaluation; be metric-drive and include the development of biannual reports on the quality of prostate cancer care; and include an education plan for patients and providers.

VA would be required to establish a program evaluation tool to learn best practices and to inform VA and Congress regarding further use of the disease specific model of care delivery. VA would be required to submit to Congress a plan that provides for continual funding through ORD for supporting prostate cancer research designed to position VA as a national resource for prostate cancer detection and treatment. Finally, VA would be required to submit to Congress a report on the barriers and challenges associated with creating a national prostate cancer registry.

This report would include recommendations for centralizing data about Veterans with prostate cancer for the purpose of improving outcomes and serving as a resource for providers.

VA does not support this bill. While the intent of the draft bill is well aligned with existing VA activities, it is overly prescriptive in details of program implementation, including the internal structure of VA and the prostate cancer clinical pathway. The requirements in the draft bill are not aligned with the current implementation structure and unintentionally risk disrupting progress toward our shared goal of creating a system of excellence for prostate cancer care in VA.

In 2021, VA designed, tested, published and implemented a new prostate clinical pathway. VA's National Oncology Program Office worked with a multidisciplinary team of VA physicians in addition to community-based academic experts and DoD to develop this clinical pathway, which is in use today and is capturing data that are used for monitoring and measuring program performance, pathway utilization, molecular testing and treatment selection that is most clinically appropriate for the Veteran. Key program office collaborators included experts from the VA's National Surgery Office, Pathology and Laboratory Medicine, Pharmacy, Clinical Genetics, Medical Oncology and Radiation Oncology.

Pathway updates are based upon new clinical evidence and occur at least annually, but more frequent updates are considered for major practice changing information. Such management is intended to reduce disparities in health care delivery to Veterans with prostate cancer and is already a part of the current pathway implementation plan. Pathways are published and accessible by VA physicians within the electronic health record as well as on a National Oncology Program internal resource page. A new pathway, as prescribed in the bill, would disrupt patient care and would represent a step backwards in providing high quality prostate cancer care for Veterans. Furthermore, VA already has begun work to enable pathways to be compatible with Cerner to ensure smooth implementation. We are concerned this bill, if enacted, would jeopardize progress toward implementation.

In December 2019, VA announced the launch of an expanded Precision Oncology Initiative with the mission of improving the lives of Veterans with cancer through precision medicine. The initiative is grounded in high reliability principles and a learning health care model in which new knowledge is rapidly transitioned to clinical practice and learning from clinical practice is maximized. This initiative is made possible due to close collaboration among clinical program offices and ORD, facilitated by the Office of Healthcare Transformation.

Key components of the Precision Oncology Initiative are centered around the delivery of cutting edge, high quality, accessible care to Veterans diagnosed with prostate cancer. Clinical Pathways across cancer types are a key component of this effort.

The National Precision Oncology Program (NPOP), which launched in 2016, has implemented national infrastructure in the form of a national contract and metrics around comprehensive genomic profiling using next generation sequencing for all Veterans with metastatic prostate cancer.

In May 2021, national guidelines were implemented, and access to a nationally funded contract made germline testing in metastatic prostate cancer available to VAMCs. Prostate Cancer Foundation funding for Centers of Excellence, which was initiated in 2016, led to the establishment of the Precision Oncology Program for Cancer of the Prostate (POPCaP), and ORD funding for genitourinary sites, which was initiated in 2021, is further expanding these best practices more broadly across VA to provide Veterans with access to precision clinical trials and research across an entire System of Excellence in prostate cancer care.

The National TeleOncology service, which was initiated in 2018, provides access to specialized oncology care providers for Veterans in rural and underserved areas through a virtual model and is also a planned foundational infrastructure component to bring decentralized trials to VA. Decentralized trials would allow Veterans to enroll in clinical trials previously inaccessible due to geographical location, which expands access by bringing the trial to the Veteran within VA rather than Veterans to the trial elsewhere.

We appreciate the goals of the legislation and are grateful for the attention that is being given to ensure that our Veterans have access to the highest standard of care for prostate cancer. This area is a high priority for VA, and activities are occurring at an accelerated pace. We would appreciate the opportunity to further discuss prostate cancer related precision oncology initiatives with the Committee.

We do not have a cost estimate for this bill.

**S. 2787 Clarifying the Role of VA Podiatrists**

S. 2787 would amend 38 U.S.C. § 7306 to establish that the Office of the Under Secretary for Health would include a Podiatric Medical Director who would be a qualified doctor of podiatric medicine and who would be responsible to the Under Secretary for Health for the operation of the Podiatric Service. This change would rename the current role of the Director of Podiatric Service, which is currently included among other Directors in that section of law. It also would provide that for the Assistant Under Secretaries for Health appointed under section 7306(a)(3), not more than two of them may be persons qualified in the administration of health services who are not Doctors of Medicine, podiatric medicine, dental surgery or dental medicines. The bill also would also amend section 7306 to provide that the Secretary's appointment of the Podiatric Medical Director would be made upon the recommendation of the Under Secretary for Health.

The bill also would amend 38 U.S.C. § 7404 to provide that the pay of podiatrists (along with physicians and dentists) serving in positions to which an Executive Order applies under 38 U.S.C. § 7404(a)(1) would be determined under subchapter III of chapter 74 of title 38, United States Code instead of by such Executive Order. The bill also would make a clarifying edit to the table in section 7404(b) to add "(DPM)" to indicate doctors of podiatric medicine.

VA supports S. 2787, though if enacted, implementation will take some time. The bill would allow the Director of Podiatric Medicine to be paid like other podiatrists in the Veterans Health Administration (VHA). Notably, if enacted, this bill would affect the way Senior Executive Service (SES)-Equivalent podiatrists are paid. Podiatrists appointed under sections 7306 and 7401(4) would receive pay under section 7431, just as physicians and dentists do, because of the changes the bill would make to section 7404(a)(2). Currently, the basic pay of podiatrists appointed under sections 7306 and 7401(4) is set as if it was SES, but market pay assessments and pay for performance would be included in the total compensation of those positions. Of note, 38 U.S.C. § 7404(c) would no longer apply to podiatrists appointed under section 7306.

We estimate the bill would cost $15,000 in FY 2022, approximately $78,000 over 5 years and approximately $163,000 over 10 years.

**S. 2852 Long-Term Care Veterans Choice Act**

Section 2(a) of the Long-Term Care Veterans Choice Act would amend section 1720 to add a new subsection (h) providing authority for a 5-year period for the Secretary to pay for long-term care for certain Veterans in Medical Foster Homes (MFH) that meet Department standards. Specifically, the bill would allow Veterans, for whom VA is required by law to offer to purchase or provide nursing home care, to be offered placement in homes designed to provide non-institutional long-term supportive care for Veterans who are unable to live independently and prefer to live in a family setting. VA would pay MFH expenses by a contract, agreement or other arrangement with the home. VA could pay for care for a Veteran in an MFH before the date of enactment, if the home meets VA standards, pursuant to a contract, agreement or other arrangement between VA and the MFH. Veterans on whose behalf VA pays for care in an MFH would agree, as a condition of payment, to accept home health services furnished by VA under section 1717. In any year, not more than a daily average of 900 Veterans could receive care in an MFH. The limitations in section 1730(b)(3), which provide that payment of the charges of a community residential care facility to a Veteran whom VA has referred to that facility is not the responsibility of the United States or VA, would not apply. The changes made by this subsection would take effect 90 days after the date of enactment.

VA endorses the concept of using MFHs for Veterans who meet the appropriateness criteria to receive such care in a more personal home setting. VA endorsed this idea in its FY 2018, 2019 and 2020 budget submissions and appreciates the Committee's

consideration of this concept. Our experience has shown that VA-approved MFHs can offer safe, highly Veteran-centric care that is preferred by many Veterans at a lower cost than traditional nursing home care. VA currently manages the MFH program at over two-thirds of our VAMCs, partnering with homes in the community to provide care to nearly 1,000 Veterans every day. However, Veterans are solely responsible for the expenses associated with MFH care today. Of the nearly 800 Veterans in MFHs currently, nearly 200 would be eligible for care at the MFH at VA expense under this bill. Our experience also shows that MFHs can be used to increase access and promote Veteran choice-of-care options. We are concerned with the short period of time to implement this new authority; we believe 1 year would be more appropriate than 90 days to ensure contracts or agreements are in place, and that policies and regulations, if needed, are in effect.

While VA fully supports the MFH concept, we would look forward to working with you to resolve a few technical issues in this bill. For example, the limitation in proposed subsection (h)(3), regarding a limit "in any year" of a "daily average" of 900 or fewer Veterans receiving care, is ambiguous. It is unclear how the limitation to a given year qualifies the daily average and how VA could operationalize this concept effectively. VA would like to work with the Committee to ensure VA can effectively incorporate MFHs into the continuum of authorized long-term services and support available to Veterans. We are happy to provide the Committee with technical assistance on this matter and are available for further discussion.

Section 2(b) of the bill would require VA to create a system to monitor and assess VA's workload in carrying out this new authority by tracking requests by Veterans to be placed in an MFH; denials of such requests and the reasons for such denials; the total number of MFHs applying to participate (disaggregated by those approved and those denied); Veterans receiving care in an MFH at VA expense; and Veterans receiving care at an MFH at their own expense. VA would be required to identify and report to Congress on such modifications to implementing the new authority as VA considers necessary to ensure the authority is functioning as intended and care is provided to Veterans as intended.

To implement the requirements of section 2(b) and to meet potential demand nationwide VA would have to expand operations and oversight of the existing MFH program to ensure timely placement and payments for Veterans requesting placement. Requirements associated with additional monitoring and data tracking would necessitate additional staff and information technology support.

Section 2(c) of the bill would require the Comptroller General, not later than 3 years and 6 years after the date of enactment, to report to Congress assessing the implementation of the amendments made by this bill; assessing the impact of the monitoring and modifications under subsection (b) on care provided under section 1720(h), as amended; and setting forth recommendations for improvements to the implementation of such section as the Comptroller General considers appropriate.

VA defers to the Comptroller General on this subsection.

We estimate the new costs associated with section 2(b) would be $1.19 million in FY 2022 and $19.10 million over 5 years. We estimate the cost savings of section 2(a), due to the diversion of Veterans from nursing home care to MFHs, would be $15.32 million in FY 2022 and $165.32 million over 5 years. We estimate the total cost savings resulting from the bill, after factoring out the additional costs, would be $14.14 million in FY 2022 and $146.22 million over 5 years.

**S. XXXX Vet Center Outreach Act**

Section 2 of the draft bill would create a new section, 1730D, in title 38, United States Code, regarding transmittal of information on Veterans transitioning from the Armed Forces to Vet Centers. Specifically, section 1730D would require VA, in consultation with DoD if necessary, to transmit not later than 7 days after the date on which a Veteran separates from the Armed Forces certain information to the personnel of the Vet Center nearest where the Veteran intends to reside permanently after such separation. This information would include the Veteran's name, branch of service, physical address, email address, phone number, service record, marital status and such other information as VA considers relevant. The information would be transmitted electronically in the form of an orderly and easily understood list. Information transmitted would be received and processed by the Readjustment Counseling Service. This information would be available for use to contact members and former members of the Armed Forces transitioning from service to civilian life not more than 14 days after receipt of the information. If it is found, after personnel of a Vet Center contact a Veteran, that another Vet Center is closer to where the Veteran lives, the personnel who initially contacted the Veteran would, only with the consent of the Veteran, directly connect the Veteran to the relevant personnel of the other Vet Center.

VA supports the goals of this section but believes that legislation may be unnecessary. VA currently is working to ensure that Vet Centers have access to this information, currently recorded in the VA-DoD Identity Repository (VADIR), through a data sharing agreement with DoD's Defense Manpower Data Center. We ask that the Committee allow these administrative steps to proceed. If we identify any barriers that would require legislation, we can notify the Committee and recommend action on the bill at that time. VA notes that if the legislation were to move forward, we recommend that the 7-day requirement be modified to the date on which the information is received from DoD. While this information is received within 7 days for many Service members, there are delays in some situations, particularly for members of the Guard and Reserve.

Section 3 of the draft bill would require VA, as part of the Transition Assistance Program (TAP) provided under 10 U.S.C. §§ 1142 and 1144 to provide members of the Armed Forces with information on how to locate Vet Centers and an explanation of how to use Vet Center services. VA would provide this information during instructor-led classroom and virtual courses.

VA supports the provision of information about Vet Centers to transitioning Service members through TAP; however, we do not believe that we require new statutory authority to do this. VA currently discusses Vet Centers in detail as part of the VA Benefits and Services course of TAP. VA redesigned the VA Benefits and Services course in response to section 552 of the National Defense Authorization Act for Fiscal Year 2019 (NDAA FY 2019, P.L. 115-232), which mandated improvements to TAP including providing 1 day of instruction on VA benefits. Through increased interactivity, real-life examples and customizable resources such as checklists and contact lists, the VA Benefits and Services course now provides greater access to information and resources about available VA benefits and services, including VA testimonial videos about Vet Centers. Vet Centers also are discussed in detail during the "Maintaining Your Health" module, which provides instructions on how to locate Vet Centers, describes eligibility requirements and explains how to use Vet Center services.

VA also has launched a Military Life Cycle (MLC) module focused on Vet Centers, which is a voluntary information session available in-person or online at TAPevents.org/courses, available for Service members, Veterans and their families. MLC modules are available at any time throughout a Service member's career. The existing Vet Center MLC module provides information on how to connect with local Vet Centers, on eligibility for Vet Centers and on how Service members, Veterans and their families can use Vet Centers as a free resource. The MLC module emphasizes that Vet Centers are community-based counseling centers that provide a wide range of social, emotional and mental health services for active-duty Service members, members of the reserve components and Veterans and their family members. It notes that all services are confidential and free. It also highlights the Vet Center Call Center, which is an around-the-clock confidential call center where a Service member, Veteran or family member can call to talk about their military experiences or any other issue they may be facing.

VA acknowledges Vet Centers as a valuable resource for Service members, Veterans and their families, and VA plans to continue providing information about Vet Centers under TAP. We ask that the Committee allow VA to take the necessary steps to meet the requirements of this section. If we identify any statutory barriers, we will notify the Committee and recommend action on the bill at that time.

We do not believe this draft bill would require additional resources to implement if enacted.

**S. XXXX Reorganizing the Chaplain Service**

The draft bill would add a new section, 324, to title 38, United States Code, establishing within VA a Chaplain Service for the provision of spiritual or religious pastoral services. The Chief of Chaplain Services would be appointed by and directly report to the Secretary. The Chief would oversee the Chaplain Service and be the proponent for, and coordinate with the Secretary on, all guidance pertaining to spiritual or religious pastoral services, faith-based programs and instruction and any policy or guidance pertaining to

religion or religious accommodation. The Secretary would have to ensure that all appropriate VA offices coordinate with the Chief on best practices to implement guidance or policy pertaining to religion or religious accommodation. The Chaplain Service would be collocated with VA Central Office. The Chaplain Service would provide and facilitate spiritual or religious pastoral service across VA as a whole in coordination with the Secretary and VA's three Under Secretaries. Spiritual or religious pastoral services would include the broad facilitation of the free exercise of religion and could include assessment, individual counseling and group counseling. VA would be prohibited from requiring any Chaplain to perform a rite, ritual or ceremony if the Chaplain objects based on the conscience, moral principles or religious beliefs of the Chaplain or the ecclesiastical organization that endorses the Chaplain. VA would be required to promulgate regulations to carry out this section. The bill also would make conforming amendments to 38 U.S.C. §§ 7306 and 7401.

VA does not support this draft bill. In September 2020, VA converted Chaplains from the title 5 excepted service to the hybrid-title 38 excepted service personnel system. It is unclear if the draft bill is intended to provide an additional hybrid-title 38 authority or a separate title 38 authority; we understand this could affect other agencies that also employ chaplains, and we recommend the Committee consult with the Office of Personnel Management regarding these potential effects. The draft addition of a 38 U.S.C. § 7401(5) indicates direct appointments made in VHA, though, as read with the other changes, the intent is unclear, especially as to the proposed Chief of Chaplain Services. If the intent is for all Chaplains to be aligned under the Secretary and not in VHA then further statutory changes would be needed for any pay to be available under Chapter 74 of title 38,United States Code. If Chaplains are aligned under the Secretary, they would have to be covered by the title 5 personnel system absent additional statutory changes. However, to continue to be recognized as clinical providers, Chaplains would need to remain under the hybrid-title 38 authority, which is critical to ensuring that the Chaplains' clinical workload continues to align with the three approved Centers for Medicare and Medicaid Services Healthcare Common Procedural Coding System codes, as implemented in October 2020. Clinical workload for the Chaplain Service also is reported already through the Veterans Equitable Resource Allocation model, which informs VA's budget requests. The bill would require the Chaplain Service to be collocated with VA Central Office, but a memorandum in January 2020 already established that the Director of the National Chaplain Service is physically located in VA Central Office. The current status and placement of Chaplains allows them access across the Department, including in the Veterans Benefits Administration (VBA) and the National Cemetery Administration.

VA also notes as a technical matter that the amendment striking 38 U.S.C. § 7306(e) does not have a corresponding amendment to 38 U.S.C. § 7306(d), which references that paragraph.

**S. XXXX Dental Care Expansion and Enhancement Act**

Sections 3 and 4 of the draft bill would require VA to provide dental care in the same manner as medical services in the VA medical benefits package phased in by priority group over an 8-year period following enactment, thereby requiring that VA provide all necessary dental services to any Veteran enrolled in VA health care. The changes made by section 3 would take effect on the date that is 1 year after the date of the enactment of this legislation.

These sections are aligned with the mission of VA Dentistry, which is to honor America's Veterans by contributing to whole health through the provision of exceptional oral health care. Veterans who are ineligible for dental care through VA may purchase dental insurance at a reduced cost through the VA Dental Insurance Program or may be eligible to participate in the Community Provider Collaborations for Veterans Pilot Program.

If these sections were enacted, VA expects an initial surge in demand for dental care that would stabilize over time. Only 1.35 million Veterans of the 9.28 million Veterans enrolled for VA health care are currently eligible for dental care. This bill would increase the number of eligible Veterans by 678%, which would create a significant spike in the need for resources to meet the increased demand. While we would expect that demand would level off after this initial spike, the sheer number of newly eligible Veterans would mean that a tremendous increase in the number of available resources would be needed in the long-term as well. Current statutes and regulations do not define any limitations to dental benefits for those eligible for them. The proposed bill defines the dental benefit as comprehensive and, as such, would have no limitations. VA's existing resources to provide dental care are at or near full capacity, with some regional variation. As a result, VA does not believe it could provide all this care internally, even with the phased implementation period. Therefore, VA would require an increased use of community resources, which would have associated administrative costs, as well as the direct cost of paying community providers to provide dental care to all enrolled Veterans. We also believe an expansion of this magnitude would require building new dental clinics and hiring new staff to meet demand.

VA estimates that in the first year of implementation (FY 2023), the cost of expanding dental care would be more than $4.1 billion. Our estimated costs only reflect the additional costs associated with purchased care ($3.77 billion) and costs to the dental program within VA, but we note that this expansion would also increase VA's costs for associated services like sterile processing. We have not had an opportunity to calculate those costs. The cost for VA's dental program and community care over 5 years is estimated to be more than $34 billion, and the cost to VA's dental program and community care over 10 years would be more than $109.3 billion. Given these estimates, VA does not believe that it would have the necessary resources to successfully complete the expansion required by the bill and, therefore, does not support these sections of the bill.

Section 5 of the draft bill would require VA to ensure that each State has a VA dental clinic to meet the needs of the Veterans within that State. This section would take effect on the date that is 1 year after the date of enactment.

We support the intent of this section, but we do not believe it is necessary. There is currently only one State, Vermont, that does not have a dental clinic, but VA is planning to include such a clinic in a new CBOC location.

Section 6 would require VA to carry out a program of education to promote dental health for enrolled Veterans. The program would need to include specific information on various matters. These materials would have to be provided through a variety of mechanisms. This section would take effect on the date that is 1 year after the date of enactment.

We support the intent of this requirement, but we do not believe this is necessary because VA already provides and promotes dental health education information for enrolled Veterans, including options for obtaining access to dental care. We would be happy to brief the Committee on these efforts.

Section 7 would require VA to ensure that it has sufficient staff to provide dental services to Veterans by implementing a loan reimbursement program for qualified dentists, dental hygienists and oral surgeons who agree to work at VA for a period of not less than 5 years. VA could not reimburse more than $75,000 for each participating dentist, $10,000 for each participating dental hygienist and $20,000 for each oral surgeon. VA would have to monitor demand among Veterans for dental care and require participants in the loan reimbursement program to choose from VA dental clinics with the greatest need for dentists, dental hygienists or oral surgeons according to facility enrollment and patient demand.

We appreciate the intent of this section, but we do not support this section as written. We believe the amounts specified in this draft section would not provide an incentive for dentists, dental hygienists and oral surgeons given the average student loan obligations of graduates in these professions. VA has not had a challenge in hiring these specialties to meet current demand. If sections 3 and 4 of the bill were enacted, VA would need significantly more staff, but we would be unable to hire for these positions, simply because there would be insufficient supply.

Section 8 would require VA to enter into educational and training partnerships with dental schools to provide training and employment opportunities for dentists, dental hygienists and oral surgeons.

We support the goal of section 8, but we do not believe this is necessary. VA currently maintains a robust network of partnerships with dental schools. We currently have 360 dental resident positions authorized around the country. We would be happy to brief the Committee on these efforts.

Section 9 would authorize to be appropriated such sums as necessary to carry out this legislation. The amount authorized to be appropriated would be available for obligation for the 8-year period beginning on the date that is 1 year after the date of enactment.

As noted previously, we believe the total costs of this bill would be prohibitive.

**S. XXXX Veterans State Eligibility Standardization Act**

This draft bill would require VA to modify the areas in which Veterans reside as specified for purposes of determining whether Veterans qualify for treatment as low-income families for enrollment in VA health care. VA would have to modify these areas so that any area so specified would be within only one State, and any area so specified would be coextensive with one or more counties (or similar political subdivisions) in the State concerned. VA also would have to modify the thresholds for income for determining eligibility for enrollment so that there would be one income threshold for each State, which would be equal to 100%t of the highest threshold among the counties or metropolitan statistical area within each State and any metropolitan statistical area that encompasses territory of such State and one or more States. The calculation of the highest income threshold would be consistent with the calculation used for section 3(b) of the United States Housing Act of 1937 (42 U.S.C. § 1437a(b)). The timing and methodology for implementing these changes would be determined by VA in such a manner as to permit VA to build capacity for enrolling such additional Veterans in the patient enrollment system as they become eligible based on these changes, except that all required modifications would have to be completed not later than 5 years after the date of the enactment of this legislation.

VA appreciates the Committee's interest in considering updates to eligibility criteria, but as is the case with any proposals to changes affecting enrollment for care, VA is concerned about potential adverse or inequitable consequences that might result from this legislation. We have not had an opportunity to conduct a full State-by-State analysis, but the draft bill would have very different results across States. In States with diverse economic statuses that include both lower income areas and cities with much higher median incomes, there could be a significant change in the geographic means-test threshold for those in lower income areas. In States with more homogenous income levels, not as many Veterans may be affected by this legislation. This variance could introduce unintentional inequities across the Nation, as Veterans in States with even a single high-income area would benefit more. We also are concerned about the potential effect this legislation could have on Veterans who reside in one State but regularly receive services in another State; because the bill limits eligibility based on income to State borders, Veterans living near these borders could be uniquely affected. We would welcome the opportunity to discuss this proposal in greater detail with the Committee.

We have not had an opportunity to develop a cost estimate for this draft bill.

**S. XXXX Servicemembers and Veterans Empowerment and Support Act**

Section 101 of the draft bill would require VA within 1 year of the date of enactment to begin to revise its regulations for the definition of military sexual trauma (MST) for purposes of access to VA health care and compensation. VA would have to ensure that its revised regulations include matters relating to technological abuse (further defined in the draft bill) to reflect sexual harassment in the digital age. VA would be required to collaborate with DoD and to consult with VSOs, military service organizations and other stakeholders. Not later than 1 year after the date of enactment, VA would have to submit to Congress a report on its progress in revising its regulations. Final regulations would have to be issued within 2 years of the date of enactment, and VA would have to update training aids, manuals and information materials to reflect these changes.

VA recognizes the unique challenges and difficulties that Veterans may experience because of technological abuse, and we commend the Committee for looking at this issue. We welcome further discussion given that the goals of section 101 are commendable. However, there are several complexities that make it difficult for us to support the bill as written, and we would welcome the opportunity to discuss these further with the Committee.

Initially, for benefits purposes, many of the examples of technological abuse in this section do not appear to require a sexual component or context, and it is unclear that the definition of MST should be expanded in this way. The bill language suggests, but does not specifically state, that the "private information, photographs, or videos" must be of a sexual nature. If that is the intent, VA believes that its current authority accounts for these actions as sexual harassment, and we support Congress' intent to ensure eligibility for benefits and health care for Veterans who experienced MST consisting of (1) technology-facilitated sexual harassment, (2) online sexual abuse and harassment form an intimate partner (as defined in the Uniform Code of Military Justice Article 117a), (3) online retaliation related to a sexual assault, or (4) violation of a military protection order via sexual threats or non-consensual distribution of intimate digital images and DoD sexual harassment policies. Similarly, the existing definition of MST in 38 U.S.C. § 1166(c)(2), which includes sexual harassment, does not preclude that harassment occurring through technological means. VA is concerned that becoming overly specific in defining specific behaviors that establish eligibility for benefits could be problematic if it ultimately becomes more limiting than inclusive by omitting (likely inadvertently) circumstances that should be included. We also have some reservations about our ability to implement this authority in a consistent and fair way for claims processing, and we would be happy to discuss these in detail with the Committee.

From the health care perspective, the concern about the concept of "technological abuse" is reasonable and experiences of this sort can affect victims' health and well-being. However, we are concerned that the proposed changes in section 101 may not be necessary and may result in regulations that are ambiguous and difficult to implement.

VA's authority to provide MST-related treatment already includes a broad definition of "sexual harassment" in 38 U.S.C. § 1720D(f). Any verbal contact (spoken or online) of a sexual nature that is unsolicited and threatening in character is qualifying for health care. VA already is taking steps to call more attention to technology-based harassment. For example, the sexual harassment question used in VA's universal MST screening program currently is being updated to include "sexual texts and online messages" as one of the examples offered to patients. Also, for purposes of health care, VA has adopted an expansive evidentiary policy: MST survivors are not required to provide documentation or otherwise prove that their harassment experiences meet specific legal criteria to gain access to care.

Furthermore, efforts to regulate access to MST-related care using rules that include all behaviors listed in section 101 would likely result in legal difficulties and definitional conflicts that would complicate, rather than facilitate, greater access. VA's treatment authority under 38 U.S.C. § 1720D(a) is specific to conditions that resulted from physical assault of a sexual nature, battery of a sexual nature or sexual harassment. Several behaviors listed in section 101 do not have a clear sexual nature, but to provide care, VA would be obligated to develop regulatory criteria defining when these behaviors do and do not have a sexual nature. VA providers and staff would, in turn, be obligated to attempt to apply these criteria to decide eligibility in individual cases. We note that if Congress intends for VA to treat conditions related to technology-based harassment that is not clearly of a sexual nature, the remedy is to grant additional authority through legislation; VA cannot on its own regulate more expansive access to care than what its statutory authorities permit. As noted before, we support Congress' intent to ensure Veterans who experienced MST consisting of those four categories identified above are able to access benefits and health care. We would welcome the opportunity to discuss where our statutes could be clarified to recognize qualifying online behavior and technology-facilitated behavior to support victims of MST.

We are aware that Congress has an interest in expanding health care eligibility to include experiences such as those which were part of the Marines United scandal in 2017, where explicit photos taken of women Service members were later posted on Facebook. VA concurs with this intent but notes that VA's authority under 38 U.S.C. § 1720D is specific to sexual harassment experienced while a former Service member was serving on duty. The regulations prescribed by section 101 would not and could not authorize care for sexual harassment experienced after leaving the military (such as in the Marines United case), even if the content of the abuse is related to the individual's military service. As noted previously, if Congress intends for VA to provide care related to these types of circumstances, additional legislative change to VA's statutory authorities would be required. Again, we would welcome the opportunity to discuss specific areas of concern with the Committee.

We estimate section 101 would result in mandatory costs of $12.7 million in FY 2022, $192.3 million over 5 years and $716.4 million over 10 years. We also estimate this section would result in discretionary costs of $7.0 million in FY 2022, $23.4 million over 5 years and $51.0 million over 10 years.

We believe a robust discussion of how this section might affect Veterans and VA would be appropriate to ensure that any changes made preserve VA's ability to furnish care and services to MST survivors while also supporting their applications for compensation benefits.

Section 201 would adopt the definition of military sexual trauma set forth in 38 U.S.C. § 1167(j), as added by section 203(a) of this legislation, for purposes of sections 201-207 of this draft bill.

VA has no objection to this section.

Section 202 would amend 38 U.S.C. § 1166(c) to adopt the definitions of covered mental health condition and military sexual trauma set forth in section 1167(j), as added by section 203(a) of this legislation.

VA has no objection to this section.

Section 203 would add a new section, 1167, to title 38, United States Code, to accept as sufficient proof of service connection a diagnosis of a covered mental health condition by a mental health professional together with satisfactory lay or other evidence for claims that a covered mental health condition was based on MST that was incurred in or aggravated by active military, naval or air service. This acceptance would be required notwithstanding the fact that there is no official record of such incurrence or aggravation in such service, and VA would be required to resolve every reasonable doubt in favor of the Veteran. Service connection of such covered mental health conditions could be rebutted by clear and convincing evidence to the contrary.

VA would be required to ensure that if a disability compensation claim is received for a covered mental health condition based on MST, evidence from sources other than DoD's official records regarding the Veteran's service or evidence of a behavior change following the MST event may be considered to corroborate the Veteran's account of the trauma. VA would be prohibited from denying an MST-related disability compensation claim for a covered mental health condition without first advising the Veteran about evidence that may constitute credible corroborating evidence of MST and allowing the Veteran an opportunity to furnish such evidence or advise VA of potential sources of such evidence. In a case where non-military sources of evidence or evidence of behavior changes are unavailable, and the only evidence of the occurrence of MST is the Veteran's own lay statement, VA would have to accept a lay statement that was consistent with the places, types and circumstances of the Veteran's service as credible evidence the event occurred, which would lower the evidentiary standard in contrast to the evidentiary standard for other PTSD claims

In reviewing claims for compensation for covered mental health conditions, VA would have to submit evidence to appropriate medical or mental health professionals to obtain a nexus opinion whether it is at least as likely as not there is a nexus between the MST

and any diagnosed covered mental health condition. If a Veteran submitted a lay statement describing the MST, the Veteran would have to be provided with a medical examination and opinion, without delay to request records from the Veteran. VA would have to request records regarding non-military sources of evidence and evidence of behavior changes if the medical examination and opinion do not result in a diagnosis of a covered mental health condition and a positive opinion that the MST was related to the diagnosis. VA would be required to provide a subsequent medical examination and opinion following receipt of evidence. The bill also would require VA to ensure that each document provided to a Veteran related to an MST-related disability compensation claim includes contact information for an appropriate point of contact within VA. Furthermore, VA would have to ensure that all MST-related disability compensation claims are reviewed and processed by a specialized team established under section 1166. Finally, within 180 days of the date of the enactment of this legislation, VA, with input from the Veteran community, would have to implement an informative outreach program for Veterans regarding the standard of proof for evaluation of MST-related claims.

Section 203 of the bill would include a rule of construction prohibiting VA from construing this section as supplanting the standard of proof or evidence required for claims for PTSD based on non-sexual personal assault. Covered mental health conditions would include PTSD, anxiety, depression or other mental health diagnoses described in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association that VA determines to be related to MST and which may be service connected. Military sexual trauma would be defined to mean, with respect to a Veteran, a physical assault of a sexual nature, battery of a sexual nature or sexual harassment that occurred while the Veteran was serving in the active military, naval or air service.

VA cannot support section 203 unless certain provisions in proposed section 1167 are removed.

VA does not object to the expansion of the lowered evidentiary standard contained in current regulations to cover mental health conditions listed in proposed section 1167. However, VA opposes provisions in proposed section 1167 that would further lower the evidentiary threshold for MST claims. VA is concerned the bill's language would require VA to accept for benefits purposes all allegations of an MST stressor and potentially award service connection based on a single lay statement from the Veteran without any other evidence verifying the existence of the stressor. VA acknowledges that the circumstances of service make the claimed MST stressor more difficult to corroborate, and to that end, VA has promulgated regulations at 38 C.F.R. §§ 3.303 and 3.304(f)(5), which establish equitable standards of proof and provide examples of the types of evidence that may corroborate an in-service injury, disease or event for purposes of service connection.

Proposed section 1167, as written, would substantively create new standards for verifying a stressor and establishing a nexus between a claimed mental health condition and a claimed MST stressor when adjudicating a claim for service connection for MST-related conditions. VA believes some level of corroboration is necessary to maintain the integrity of the claims process. The bill would essentially require VA to award service connection if there is a current diagnosis of a covered mental health condition and a mental health professional is willing to speculate that the claimant's symptoms are related to an event in military service reported by the Veteran. This situation would occur in the absence of corroborating evidence to substantiate the occurrence of the stressor.

To be clear, VA does not object to the codification of certain MST evidentiary standards that are already included in VA regulations that necessarily lower the evidentiary threshold based on the sensitive and challenging nature of MST claims. This method allows adjudicators to process MST claims in a fair and equitable manner, for example, by considering alternative sources of evidence (i.e., non-military evidence and markers) to corroborate the Veteran's account of the stressor incident.

In addition to these concerns, VA has several technical comments and concerns with section 203, and we would appreciate the opportunity to discuss these with the Committee. For example, we are concerned about the definition of "covered mental health conditions", which would include mental health diagnoses described in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), as VA establishes service connection for disabilities using the VA Schedule for Rating Disabilities, and not every DSM-V disability is in the Schedule for Rating Disabilities.

We estimate this section would result in mandatory costs of $323.6 million in FY 2022, $4.2 billion over 5 years and $11.4 billion over 10 years. We also estimate this section would result in discretionary costs of $38.5 million in FY 2022, $215.1 million over 5 years and $447.4 million over 10 years.

Section 204 would amend 38 U.S.C. § 1165 to require VA to ensure that Veterans who require a medical examination in support of a disability compensation claim for a mental or physical health condition that resulted from a physical assault of a sexual nature, battery of a sexual nature or sexual harassment may request the medical examination take place at a VA facility of choice and be performed by a qualified VA employee. VA would be required to grant any such request and could not issue a decision on such a claim before the requested examination is completed.

VA would support this section if amended to state that Veterans requiring a medical examination may request such an examination take place at a facility within 100 miles of the Veteran, which is consistent with VA's current contractual requirements for specialist examinations or diagnostics. In addition, we recommend that the references to "a facility of the Department" be revised to "a medical facility of the Department" and that the reference to "a qualified employee of the Department" be removed.

We do not believe this provision, if amended as we recommend, would result in any additional costs to VA.

Section 205 would require VA to establish a board to review correspondence relating to MST. The board would have to include experts in MST and mental health, including VA mental health providers, experts on sexual assault and sexual harassment and MST coordinators from VHA and VBA. The board would be responsible for the review of all standard correspondence and other materials, as well as outreach materials and Veteran-facing website content from VA to survivors of MST for sensitivity and to ensure that communications treat survivors with dignity and respect while not re-traumatizing survivors. VA would have to ensure that any written communication to an MST survivor includes contact information for VBA and VHA MST coordinators, the Veterans Crisis Line and the VA health care facility closest to where the survivor resides.

Although VA supports ensuring that communications and care for MST survivors is sensitive and appropriate, we do not believe this section is necessary. VA already prioritizes ensuring that the entire environment of care, including correspondence, outreach and staff interactions, as well as health care delivery, communicates respect and safeguards the dignity and autonomy of MST survivors. This emphasis has been a driving factor in VA's outreach and staff awareness training efforts for many years. We are concerned with the specific requirements in subsection (b) that any written communication to an MST survivor must include certain information, such as the nearest facility and that facility's MST Coordinator. This requirement could create confusion and miscommunication. For example, VA can provide MST-related care to certain former Service members who are pending eligibility determinations, but if such a person were found ineligible based on further review, VA would need to correspond with that person to state they are no longer eligible. While VA has taken steps to ensure this correspondence is sensitive and respectful, including contact information may suggest that the person is eligible for services from these facilities. Further, VA sends out broad communications to many Veterans, some of whom are MST survivors and some of whom are not. The requirement that "any" written communication from VA to an MST survivor must include certain information would complicate VA's general outreach efforts and could require two separate sets of information and documents be prepared and shared. This requirement would increase costs to VA and increase the likelihood for errors in distribution. It is also unclear how broad-based online communication through social medial or email distribution lists would comply with these requirements. There also is no guarantee that, even with extra measures taken, some Veterans will not experience re-traumatization. We note that some may find the term "survivor" troublesome and object to its use, so adoption of an alternative with a less sensitive connotation might be appropriate. Finally, we recommend that the review board established under section 205 also include representatives from the Board of Veterans' Appeals.

Section 206 would require VA to conduct a study on the quality of training provided to VA personnel who review MST-related disability compensation claims and the quality of VA's procedures for reviewing the accuracy of the processing of such claims. VA would have to submit to Congress a report detailing its findings with respect to this study not later than one year after the date of enactment.

VA has no objection to this section.

Section 207 would require the Under Secretary for Benefits to conduct annually a special focus review on the accuracy of the processing of MST-related disability compensation claims. If the Under Secretary found, pursuant to the review, that an error had been made with respect to a Veteran's entitlement to a benefit, VA would return the claim to the appropriate regional office for reprocessing to ensure the Veteran receives an accurate decision. If the Under Secretary found, pursuant to a special focus review, that the accuracy rate was less than 90%, VA would conduct a review of each MST-related claim filed during the fiscal year preceding the fiscal year in which the report was submitted. Finally, section 207 would amend section 5501 of P.L. 116-315 to include as a requirement in the report required by that section the findings of the most recent special focus review.

VA has no objection to section 207.

Section 301 would amend 38 U.S.C. § 1720D, to expand the population of eligible persons to include former members of the Armed Forces who served on active-duty, active duty for training or inactive duty training, and who were discharged or released therefrom under any condition that is not a discharge by court-martial or a discharge subject to a bar to benefits under 38 U.S.C. § 5303. It would also define the term "military sexual trauma" to mean, with respect to a former member of the Armed Forces, a physical assault of a sexual nature, battery of a sexual nature or sexual harassment which occurred while the former member of the Armed Forces was serving on duty, regardless of duty status or line of duty determination.

VA would support section 301 if amended. Former members of the National Guard and Reserve face additional barriers to accessing MST-related care relative to the active-duty components. Under current authority, VA is authorized only to provide this care to former Service members who served on "active military, naval, or air service", which is defined in 38 U.S.C. § 101(24) as inclusive of active duty and any period of reservist duty where the individual incurred a service-connected disability. Former National Guard and Reserve members could satisfy only the active-duty component if they served in active duty before entering the Guard or Reserve or were federally activated under 10 U.S.C. § 12301, and most members do not meet these requirements. Former members of the Guard and Reserve who are ineligible for VA care may have few to no alternatives to access comparable care in their communities. VA providers have unique clinical expertise in MST and other health concerns specific to Veterans. MST survivors often face both physical and mental health effects from their experiences and benefit from VA's ability to coordinate care seamlessly across multiple specialties.

VA also supports defining military sexual trauma in 38 U.S.C. § 1720D(f), as this health care-oriented definition would facilitate future rulemaking, avoid technical implementation issues, and improve the clarity and conciseness of communication materials on the topic. We do have one technical concern with the definition, as it would not apply to VA's authority to provide care to current members of the Armed Forces under section 1720D(a)(2). VA historically has referred to care provided under sections 1720D(a)(1) and (a)(2) as "MST-related care", but having that term limited in statute to one patient cohort (Veterans) and not the other (current Service members) would be counterproductive. We recommend the proposed definition of military sexual trauma be inclusive of former and current members of the Armed Forces, and we further recommend that subsection (a)(1) be amended to refer to this definition.

VA estimates this section would cost $2.97 million in FY 2022, $28.82 million over 5 years and $82.26 million over 10 years.

Section 302 would require VA, not later than 14 days after the date on which a Veteran submits an MST-related disability compensation claim, to send a communication to the Veteran with contact information for the nearest VBA and VHA MST coordinator, the types of services that MST survivors may receive from VA, contact information for the Veterans Crisis Line and other such information VA considers appropriate.

VA supports the intent of section 302, but we do not believe it is necessary because our current authority is sufficient. Timely, consistent and comprehensive communication with the goal of connecting claimants to key points of contact is critical to supporting Veterans during the claims process. Furthermore, we note as a technical matter that the section, as written, would apply only for claims related to sexual assault or sexual harassment experienced during "active military, naval, or air service" under section 101(24). This point would exclude certain former members of Reserve components, who are eligible to file a disability claim.

Section 303 would require VA conduct a study on access to inpatient mental health care for current and former members of the Armed Forces who are MST survivors. The study would have to assess several factors, and VA would be required to submit a report to Congress, not later than 1 year after the date of enactment, detailing the findings of the study.

VA supports in principle efforts to better understand access to care for MST survivors, but we do not support this section because it is unnecessary as VA already has authority to carry out such a study. Further, we are concerned that the references in this section (as well as in sections 304 and 305) to "inpatient" programs should instead refer to "residential" programs. VA's inpatient mental health units treat Veterans with severe and acute treatment needs, such as suicidal behavior, and the focus is on crisis stabilization. These are not considered residential treatment programs.

We also are concerned about the reference to current Service members in section 303(a). To protect privacy and confidentiality related to DoD open health care record sharing, current Service members receiving treatment at VA are not screened for experiences of MST, and VA cannot reliably identify whether current Service members receiving VA mental health residential rehabilitation treatment have experienced MST.

In addition, due to the COVID-19 pandemic, mental health residential treatment programs have seen significant reductions in utilization and capacity. We are concerned that a study at this moment would not reflect the typical care provided by these residential treatment programs; in particular, we believe the satisfaction data may be adversely affected by the COVID-19 pandemic and necessary requirements for mitigation of the virus and related reductions in services. If Congress intends to move forward with such a requirement, we believe commencing the study at a later point in time, after the COVID-19 pandemic, and for a longer period, such as 3 years, would be appropriate.

Further, no VA mental health residential rehabilitation treatment programs are officially designated as MST-treatment programs, although there are a small number of such programs that only serve Veterans who have experienced MST. It would seem more appropriate to instead focus on the needs of all Veterans who have experienced MST who require residential treatment. VA does not capture the level of detail in the proposed legislation at the national level from Veterans receiving care in a mental health residential treatment program, so to complete the study as written would require significant time to develop and implement a means of capturing such information.

We estimate section 303 would cost more than $156,000 in FY 2022, $1.55 million over 5 years and $3.6 million over 10 years.

Section 304 would require VA commence, not later than 1 year after the date of enactment, a 3-year pilot program to provide intensive outpatient mental health care to current and former members of the Armed Forces who are MST survivors when the wait times for inpatient mental health care from VA are more than 14 days. VA would be required to carry out the pilot program at not fewer than four VISNs, and VA would have to select locations that have the longest wait times for inpatient mental health care, particularly for MST survivors. VA would be required to notify Congress of the locations selected for the pilot program before commencing the program. VA could provide services, subject to the preference of the participant, through telehealth or at a VA community-based outpatient clinic. Participation in the pilot program would be during the period in which the survivor is waiting for an inpatient bed opening and would not disqualify the survivor from receiving inpatient mental health care following their participation in the pilot program. Decisions about participation in the pilot program would be made by the survivor and their health care provider. Not later than 180 days after the conclusion of the pilot program, VA would be required to submit a report to Congress on participation in the pilot program, clinical outcomes under the pilot program and recommendations for the continuation or termination of the program, along with recommendations for legislative or administrative action.

While VA appreciates the intent of this section, we do not support it because the implementation of a pilot program to develop an intensive outpatient program to provide interim services for Veterans pending residential admission is not warranted. VA currently provides a broad continuum of mental health services that include intensive outpatient services for mental health and SUD concerns. These services are available in-person and by telehealth. VA policy requires support for Veterans pending residential admission including at a minimum weekly contact with a focus on ensuring all emergent needs are met. We also are concerned about the reference to "inpatient" programs instead of residential programs, as noted in our discussion of section 303.

More significantly, we are concerned that the proposed program may not be aligned with existing programs that have self-identified as providing specific treatment related to MST. Intensive outpatient treatment programs represent a level of care distinct from residential treatment, and an intensive outpatient program may not be beneficial to all Veterans who would benefit from residential services. Even more concerning, participation in an intensive outpatient program could result in further delays in care as Veterans may not be willing to stop treatment mid-course and may bypass an available residential treatment bed.

Section 305 would require the Comptroller General to conduct a study on access to mental health care for MST survivors at VA facilities. Not later than 2 years after the date of enactment, the Comptroller General would be required to submit to Congress a report on the findings of this study.

VA defers to the Comptroller General on this section. However, we do note that the proposed study overlaps with, and may be partially redundant with, other GAO investigations, such as "Review of Servicemember Trauma and Experiences with Unwanted Sexual Behavior". Also, as previously noted, we are concerned with the references to "inpatient" care as opposed to residential treatment programs. Finally, we note that one of the required elements, assessing the role of VHA MST coordinators in coordinating and providing care for MST survivors at VA facilities, may be inapplicable, as these positions are administrative by design. Although MST coordinators may provide care to MST survivors as part of other job roles, there is no designated responsibility or expectation these coordinators be involved in care delivery.

**S. XXXX State Veterans Home Requirements**

This draft bill would add a new section, 1741A, to title 38, United States Code, establishing conditions on the receipt of per diem payments to State Veterans Homes (SVHs) under subchapter V of chapter 17, title 38, United States Code. These conditions would require SVHs to have a governing body that is legally responsible for establishing and implementing policies regarding the management and operation of the SVH, consists of more than one person, and appoints an administrator or deputy superintendent who is licensed by the State (if required by State law) and who meets standards established by the Secretary of Health and Human Services under sections 1819(f)(4) and 1919(f)(4) of the Social Security Act (42 U.S.C. §§ 1395i-3(f)(4) and 1396r(f)(4)).

SVH also would have to employ an infection preventionist and include in the annual report to VA the name of this preventionist and an emergency plan, updated annually, in case of a public health emergency or other disaster. The draft bill also would add a new section, 1744A, requiring VA to make payments to States for assisting SVHs in the hiring and retention of infection preventionists. Payment to SVHs would be made, subject to submission of an application, to any State that during the fiscal year receives per diem payments under this subchapter. Payments under this section could not be used to provide more than 50% of the salary or wages for an infection preventionist for a fiscal year.

Payments could only be made upon an application submitted by the State seeking such payment. Each such application would have to describe the salary or wages of the infection preventionist. Payments under this section would be made as part of the disbursement of payments under section 1741. VA would have to require, as a condition of any payment under this section, that in any case in which the SVH receives a refund payment made by an employee in breach of the terms of an agreement for employee assistance that used funds provided under this section, the payment must be returned to the incentive program account for the SVH and credited as a non-Federal funding source.

Any SVH receiving a payment under this section would be required to provide VA with a report setting forth in detail the use of funds received through the payment. VA would be required to prescribe regulations necessary to carry out this authority, including the establishment of criteria for the award of payments under this section.

VA would support the draft bill if amended and subject to the availability of appropriations. In terms of our recommended changes, first, we recommend the bill be revised to require that all SVHs hire a licensed Nursing Home Administrator, as this would establish a core knowledge level for such persons. Second, we recommend the role of the infection preventionist be standardized for all SVHs. We would be happy to share specific elements or requirements of this position we think might be appropriate. We further recommend the emergency plan in case of a public health emergency or other disaster have standardized components across all SVHs. Areas of the plan should

focus on the prevention, control and monitoring of infectious disease outbreaks. We also recommend establishment of infection prevention committees and members be standardized across the SVHs. We also recommend the annual reporting requirement for SVHs to the Secretary be updated to a quarterly report, and we further recommend submission of these reports be a condition of receiving payments under this section. Finally, we recommend that all SVHs be required to obtain CMS certification and be held to the current edition of the State Operations Manual.

We estimate this bill would cost $23.47 million in FY 2022, $124.60 million over 5 years and $266.53 million over 10 years.

**Conclusion**

This concludes my statement. We would be happy to answer any questions you or other Members of the Committee may have.

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***STATEMENT OF***
***MARQUIS D. BAREFIELD***
***DAV ASSISTANT NATIONAL LEGISLATIVE DIRECTOR***
***BEFORE THE***
***COMMITTEE ON VETERANS' AFFAIRS***
***UNITED STATES SENATE***
***OCTOBER 20, 2021***

Chairman Tester, Ranking Member Moran and members of the Committee:

Thank you for inviting DAV (Disabled American Veterans) to testify at this legislative hearing of the Senate Veterans' Affairs Committee. As you are aware, DAV is a non-profit veterans service organization (VSO) comprised of one million wartime service-disabled veterans and dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity.

We are pleased to offer our views on the bills that impact service-disabled veterans, their caregivers and families and the programs administered by the Department of Veterans Affairs (VA) that are under consideration by the Committee.

**S. 1342, National Green Alert Act of 2021**

S. 1342,the National Green Alert Act of 2021, would establish an interagency advisory and support committee for the development of a green alert system that would be activated when a veteran with a known history of mental health issues—to include suicide attempts or impulses, substance use disorder or neurocognitive disorders—goes missing.

The purpose of the committee would be to establish guidelines and best practices to assist states with the development of systems known as "green alerts," ensuring they adhere to applicable federal and state privacy laws. No later than two years following the enactment of the bill, the committee would be required to provide a report to the president and Congress that contains a detailed statement of its findings, conclusions and recommendations with respect to its charge.

DAV does not have a resolution specific to the proposal outlined in S. 1342 and takes no position on the bill.

**S. 1779, Veterans Preventative Health Coverage Fairness Act**

S. 1779, the Veterans Preventative Health Coverage Fairness Act, would add preventative medications and services to the list of no-fee treatments that VA covers

and eliminate copayments for such items and services including immunizations, cancer screenings, vitamin supplements and tobacco cessation products, well-woman visits and other potentially life-saving assessments recommended by the U.S. Preventive Services Task Force. These same medications and services are provided free of charge to service members, military retirees and many civilians, including those with private insurance plans under the Affordable Care Act.

While service-connected disabled veterans rated higher than 50% do not incur costs for medications, those with lower disability compensation ratings using VA for their health care are currently required to pay out-of-pocket for many of the prescription drugs, preventative health medications and health screenings they need.

DAV supports S. 1779, in accordance with DAV Resolution No. 019, which calls for the elimination or reduction of VA co-payments for service-disabled veterans.

**S. 1937, DOULA for VA Act**

The DOULA for VA Act would establish a pilot program within the Veterans Health Administration to provide pregnant and post-partum women veterans access to doula services in an effort to foster better child and maternal health outcomes. Pregnancy, labor and delivery, and the early days of motherhood can be difficult in the best of circumstances, but for women veterans, they can be further complicated by physical and mental health conditions related to military service—this includes anxiety, depression, PTSD due to combat or military sexual trauma, musculoskeletal problems and neurological issues.

Doulas act as advocates before, during and after pregnancy, helping expectant and new mothers navigate their birth experience and empowering them to self-advocate for their care, which can be especially important in instances where health care needs are profound or where veterans do not have strong, established support networks.

This legislation would enhance support services for pregnant women veterans by providing access to doula care within pilot facilities, which is vital as the demand for maternity care services continues to trend upward within VA. By establishing Doula Service Coordinators, this legislation would also help aid in the effort to coordinate care between VA and community providers. In addition, with a focus on health equity, the establishment of the pilot program would be important to addressing poorer maternal health outcomes among minority veteran groups.

We are pleased to support S. 1937, which is consistent with DAV Resolution No. 015, to support enhanced medical services and benefits for women veterans.

**S. 1944, Vet Center Improvement Act of 2021**

This bill requires the VA to evaluate productivity expectations for counselors of VHA's Readjustment Counseling Service (RCS) Vet Centers. The mandated evaluation

is required to include feedback from counselors regarding the potential effects of productivity expectations on client care, any effect of productivity expectations on the recruitment, retention and welfare of readjustment counselors, and whether productivity expectations provide incentives or add pressure on counselors to inaccurately report client visits. This bill also requires VA to develop and implement a staffing model for Vet Centers, and to standardize position descriptions of Vet Center staff.

In addition, this legislation directs VA to establish a pilot grant program to address food insecurity among veterans and family members of veterans who receive services through Vet Centers or other VA facilities.

According to VA, there was a 90 percent increase in the number of veterans receiving mental health care between 2006 and 2019. As a result, there have been mental health provider staffing shortages within VA and some veterans face challenges in accessing timely mental health services.[1] According to GAO (Government Accounting Office) Report 20-652, shortages of mental health staff within VHA coupled with the increasing veteran demand for mental health services highlight the critical importance of ensuring appropriate Vet Center staffing.[2]

VHA's RCS Office has set expectations for counselor productivity at Vet Centers however, GAO notes that although most Vet Center counselors met the productivity expectations in fiscal year 2019, some counselors indicated those expectations led them to change work practices in ways that could negatively affect client care.

DAV supports this legislation in accordance with DAV Resolution No. 118, which calls for program improvements VA mental health services and suicide prevention programs.

DAV believes the goal of staffing models and productivity expectations for every VA mental health program must be recovery-oriented and focused on providing veterans the services they need for a positive mental health outcome. Mental health treatment must be patient-centered and tailored to meet the needs and goals of the individual veteran. Therefore, we urge Congress to work in partnership with VHA's RCS Office to create the appropriate statutory mandates that ensure Vet Centers are able to accomplish the mission for which they were established and fully meet the needs of the veterans they serve.

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[1] See, GAO, VA Mental Health: Clearer Guidance on Access Policies and Wait-Time Data Needed, GAO-16-24 (Washington, D.C.: Oct. 28, 2015); and VA Mental Health: Number of Veterans Receiving Care, Barriers Faced, and Efforts to Increase Access, GAO-12-12 (Washington, D.C.: Oct. 14, 2011). See also Department of Veterans Affairs Office of Inspector General, Office of Healthcare Inspections, Veterans Health Administration: OIG Determination of Occupational Staffing Shortages FY2019, #19-00346-241 (Washington, D.C.: Sept. 30, 2019).

[2] See, GAO, VA VET CENTERS: Evaluations Needed of Expectations for Counselor Productivity and Centers' Staffing, GAO-20-652 (Washington, D.C.: Sept, 2020).

**S. 2283, REACH for Veterans Act**

The Revising and Expediting Actions for the Crisis Hotline (REACH) for Veterans Act would require a review of training protocols for Veterans Crisis Line (VCL) responders to improve quality management processes. The VA would be required to implement or enhance quality management by: improving staff training; issuing re-training guidelines for call responders who have experienced an adverse event or low performance ratings; establishing monitoring and performance benchmarks for quality review management; ensuring adverse events and close calls are reported; and requiring adequate investigations into VCL callers who die by suicide.

The Act would also require enhanced guidance for managing callers with substance use disorders at risk of overdosing, review of VCL standards for emergency dispatch, and consideration of adapting safety planning for VCL call responders' use. Finally, the bill requires the VA establish a pilot program on the use of crisis line facilitation for the purpose of increasing use of the VCL among veterans at high-risk for suicide and to conduct research on the effectiveness of the VCL and areas for improvement.

Over the past decade, Congress, the VA and the Department of Defense (DOD) have been steadily working to improve prevention efforts to address the epidemic of suicide among service members and veterans. The VCL has proven to be effective and a true lifeline to hundreds of thousands of veterans at risk of self-directed violence. The crisis line takes approximately 650,000 calls a year, but after the expected deployment of the new national 9-8-8 hotline in July 2022, it anticipates a doubling or even tripling of its call volume. While the VCL is an incredibly important resource for veterans who are struggling and has helped hundreds of thousands of veterans access mental health services and mitigate suicide risk—there have been some lapses in quality that led to adverse events for veterans that this legislation could help to resolve.

DAV supports S. 2283 in accordance with DAV Resolution No. 118, which calls for improvement of mental health and suicide prevention programs for veterans and enhanced resources to support increased demand for these critical services.

**S. 2386, Veteran Peer Specialist Act of 2021**

S. 2386, the Veteran Peer Specialist Act of 2021 would require the VA to make permanent and expand the Veteran Peer Specialist Support program to all medical centers. The bill would require each medical center to have, at a minimum, two peer specialists and expansion of the program would take place over a five-year period including 25 VA medical centers each year until all medical centers have implemented the program. VA would be required to prioritize medical centers in rural and other areas that are underserved by the VA; areas that are not in close proximity to a military base; and areas representing a variety of geographic locations. In hiring peer specialists the bill requires VA to consider women to assist other women veterans treated at the medical center and candidates representing the racial and ethnic groups composing the community the medical center serves.

The bills also requires VA to submit an annual report to Congress for the five-year period of the program containing the following information: an assessment of the benefits of the program to veterans and family members of the veterans; an assessment of the effectiveness of the peer specialists engaging with health care providers in the community; the location of where the new peer specialists were hired; the number of new peer specialists at each medical center and the total number of peer specialists hired overall in the VA; and finally, an assessment of any barriers related to recruitment, training and retention of peer specialists. Once the program has been implemented at all medical centers, the VA would be required to submit a final report on the progress of the program.

Peer specialists have been an important addition to VA's programs. This bill helps to ensure that underrepresented veterans including women and ethnic and racial minorities have a point of contact in a system that may seem bureaucratic and unresponsive to their individualized needs. Peer specialists can personalize veterans' care experience helping them establish goals for recovery and increasing their knowledge and engagement in their care. They also help by sharing their own experiences and serving as role models for veterans recovering from similar conditions and help them navigate the complex array of services and benefits that may be available to them. They can also add the cultural and gender sensitivity the VA health care system may lack.

In testimony on October 13, 2021, before the House Veterans' Affairs Committee Subcommittee on Health, VA noted that expanding peer specialist services in patient-aligned care teams benefited veterans and was associated with increased participation and engagement in care and that their early interactions with veterans yielded lasting, positive relationships with many benefits. VA further noted that peer specialists require initial and ongoing training, supervisory support and dedicated and sustained funding to ensure successful implementation of these positions. VA suggested that a program as outlined in the bill would require extending the bills proposed reporting time-line from 5 to 7 years and additional resources.

DAV supports the expanded use of peer support specialists proposed in S. 2386, in accordance with DAV Resolution No. 028, which calls for a full continuum of health care services to ensure barriers to care for veterans in ethnic, racial and sexual minority groups are addressed, including staff expertise in addressing these groups' needs with sensitivity and gender-specific services necessary to meet the needs of a growing population of women veterans.

**S. 2526, a bill to authorize the Secretary of Defense and the Secretary of Veterans Affairs to enter into agreements for the planning, design, and construction of facilities to be operated as shared medical facilities**

This legislation would provide broad and consistent authority to the VA and the Department of Defense (DOD) to plan, design and construct shared medical facilities,

which could be a building, multiple buildings or a medical campus. Under the proposed legislation, a shared medical facility could be located either on a military installation or on VA property. The bill would specifically allow both departments to transfer and receive funds from the other and merge those funds into a single account to use for shared major or minor construction projects that have been authorized by Congress.

Given the commonality between the populations served by the VA and DOD health care systems, DAV has long supported efforts to expand the use of shared medical facilities to improve access and better utilize resources for veteran's health care. Unfortunately, longstanding regulatory and bureaucratic obstacles have hindered efforts to undertake and complete joint VA-DOD construction projects. This legislation would provide broad authority for shared medical facility projects and hopefully incentivize leadership in both departments to prioritize such efforts.

DAV supports this legislation in accordance with DAV Resolution No. 115, which calls for modernization of VHA's health care infrastructure, and calls on Congress to examine new models of funding to accomplish this goal.

**S. 2533, MAMMO for Veterans Act**

S. 2533, the Making Advances in Mammography and Medical Options for Veterans (MAMMO) Act would improve mammography services in the VA by requiring the Secretary to develop a strategic plan for breast imaging services and establishing a tele-mammography pilot program in states without VA mammography services and in locations in which provision of such services is not feasible. The bill would also require VA to upgrade current mammography equipment to three-dimensional imaging and to study the availability of genetic testing for the breast cancer gene to veterans.

In addition, the bill would require that VA determine the accessibility of its mammography services for veterans with disabilities such as spinal cord injuries and dysfunction and collect data on rates at which such veterans receive mammograms. VA would also be required to identify best practices for making these services accessible, assuring that community referral sites are accessible and sharing best practices in accessible breast imagery care with community providers.

The bill would also require that the Inspector General study veterans' access to mammography services in VA or the community, the quality of such services and the documented communication to patients about the results of images. The IG would also assess the performance of the Women's Breast Oncology System of Excellence and the access of veterans diagnosed with breast cancer to a comprehensive breast cancer care team.

Finally, the bill would require VA to enter into an agreement with the National Cancer Institute which would provide access for veterans to services in at least one designated center in each Veterans Integrated Service Network to report on how VA will leverage this agreement to assure women veterans have access to care provided in

clinical trials. In addition, VA would report on additional opportunities to collaborate on breast imagery services with the Department of Defense.

DAV understands that women veterans are a small, but rapidly growing, part of the veterans' population. Because women do not necessarily reside near VA resources, VA does not always have sufficient numbers of women in the population to operate efficient and high quality services to meet their needs, including basic breast health. In many locations, VA has had to rely upon community partners for gender-specific health services—this leads to women veterans using community care at significantly higher rates than male peers.[3] VA reports that in FY 2020 a third of all gender-specific cancer treatment and screening took place in the community and VA does not expect that proportion of care to change in the near future.[4] Anecdotal research indicates that women receiving care in the community are often dissatisfied with communication about scheduling and results of diagnostic work.[5]

One of every eight women will have invasive breast cancer during her lifetime. Breast health is as essential to women's health as prostate health is to men's, yet VA is often operating without providing adequate access to these vital services. There is no doubt that VA continues to make progress with women's health, still, according to the VA's most recent budget summary fewer than half of VA's women patients received gender-specific care in fiscal year 2020—these numbers are particularly low (13%) for the oldest cohort of women veterans who are at the highest risk of breast cancer.[6] In addition, only about 79% of VA's medical centers had a full or part time breast health coordinator which could hamper access to community care for mammography.[7]

These numbers suggest the need for a more strenuous breast health effort in VA and DAV is pleased to support S. 2533 in accordance with DAV Resolution No. 015, which calls for enhanced medical services and benefits for women veterans.

**S. 2624, FY 2022 Veterans Major Medical Facility Authorization Act**

This legislation would authorize 12 major construction projects for VA health care facilities for which VA requested funding in its FY 2022 budget submission. The projects authorized include two new spinal cord injury centers in Texas and California; a new research facility in California; a new long-term care community living center (CLC) in New York; and the construction, renovation or repair of medical facilities in California, Kentucky, Mississippi, Missouri, Oklahoma, Texas and Oregon.

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[3] Vol 4. Sourcebook: Women Veterans in the Veterans Health Administration. P.49.
[4] Vol. 2 Department of Veterans Affairs Budget Submission, p. VHA-289
[5] Mattocks, K.M., et al. Examining Women Veterans' Experiences, Perceptions, and Challenges With the Veterans Choice Program, Med Care, 2018; 56: 557-560.
[6] Vol. 2 Department of Veterans Affairs Budget Submission, p. VHA-283
[7] Vol. 2 Department of Veterans Affairs Budget Submission, p. VHA-286

DAV supports this legislation in accordance with DAV Resolution No. 115, which supports modernization of VA's health care infrastructure and urges VA to request, and Congress to approve sufficient funding to achieve this goal.

We also note that DAV and our partners in *The Independent Budget* (IB) have called for significantly greater funding levels for major and minor construction than VA requested in the FY 2022 budget. According to VA's internal Strategic Capital Investment Planning (SCIP) methodology, it would take at least $66 billion over the next ten years to meet VA's infrastructure needs, which is a far greater level of funding than has been requested by VA or approved by Congress in recent years. For this reason, DAV also supports the inclusion of $18 billion for VA health care facilities as part of infrastructure proposals currently being considered by Congress.

**S. 2720, Veterans' Prostate Cancer Treatment and Research Act**

S. 2720 would require VA to develop, in collaboration with knowledgeable federal stakeholders and partners, a clinical pathway to diagnose and treat prostate cancer at each stage of the disease. Importantly, in creating these pathways, it would require that VA consult with veterans who have received VA care for prostate cancer in addition to multi-disciplinary cancer care providers and clinical researchers. Not later than 180 days after enactment of the legislation, the Secretary would be required to submit a plan for implementing the pathway in its clinical programs which includes a plan for oversight and data-driven program evaluation and describes an educational plan for patients and providers. The plan will also describe means of identifying best practices and bolstering funding to support VA's prostate cancer research efforts.

Prostate cancer is the most common cancer (after skin cancer) among men—one in eight men will be diagnosed with it in their lifetime. Early identification and treatment of the disease is often the key to full recovery. It is particularly important for those veterans at highest risk for the disease, including veterans who may have been exposed to carcinogenic or other toxic materials during military service.

We are pleased to support S. 2720, in accordance with DAV Resolution No. 028, which calls on VA to provide high-quality, responsive, comprehensive health care to all enrolled veterans. Developing a clinical pathway for the treatment of prostate cancer is an important first step in ensuring VA provides best-in-class diagnosis and treatment for this common, often service-related and fatal, disease. This legislation is also in accord with DAV Resolution No. 256, which supports VA's medical research program for the purpose of helping wounded, injured and ill veterans recover and rehabilitate from health conditions related to their military service.

**S. 2787, a bill to clarify the role of doctors of podiatric medicine in the VA**

S. 2787 aims to clarify the role of doctors of podiatric medicine in the VA and would amend title 38, United States Code, to ensure that directors of the podiatric service are filled by doctors of podiatric medicine and that these professionals are

included in the Veterans Health Administration (VHA) pay scales with doctors of medicine.

Podiatrists or a podiatric physician DPM (doctor of podiatric medicine) is a medical professional who treats disorders of the foot, ankle, and related structures of the leg. While Podiatrists are doctors they do not generally attend a traditional medical school. In the U.S., podiatrists are licensed and regulated by states.

While we understand the important role DPMs play in ensuring the full continuum of health care services are available to serve the needs of service-disabled veterans—DAV has no resolution on the role of podiatrists in VHA as outlined in the bill and takes no position on S. 2787.

**S. 2852, Long-Term Care Veterans Choice Act**

S. 2852, the Long-Term Care Veterans Choice Act, would provide VA with a new authority to place and pay for veterans in medical foster homes, which are small group homes offering veterans long-term care in more family- and community-oriented settings. Veterans who have a service-connected disability rated at 70% or greater, or who need nursing home care due to a service-connected disability, would be able to request placement into a medical foster home; however, it would remain a discretionary program. The bill would place a limit on the program of 900 veterans based on the annual average daily total.

Medical foster homes can provide a long-term care alternative for veterans who want to have greater independence and remain closer to their families and communities, while receiving a higher level of care than could be sustained in their homes. In VA's fiscal year 2022 budget proposal, the Department requested this legislative authority because VA believes that medical foster homes have "...proven to be safe, preferable to Veterans, highly Veteran-centric..." and cost less than traditional nursing home care.

DAV supports this legislation in accordance with DAV Resolution No. 022, which notes that VA lacks sufficient non-institutional long-term care alternatives, such as medical foster homes, and calls for VA to provide veterans access to a wider range of options to this type of care.

We also note that the proposed legislation provides VA with broad authority to develop regulations to oversee the operation of privately-run medical foster homes, and VA must take special care to ensure these homes all meet strict health and safety standards. In particular, the challenges that every type of long-term care facility faced trying to prevent and mitigate COVID-19 during the pandemic make it especially critical that VA health and safety standards are consistent across all care settings. Veterans and their loved ones should have confidence that all long-term care options offered by VA are safe and offer high quality services.

**S. 2924, Vet Center Outreach Act of 2021**

S. 2924, the Vet Center Outreach Act of 2021 would require information on members of the Armed Forces who are transitioning to civilian life to be sent to the VA Vet Center nearest to where a veteran resides within seven days of that veteran separating from the military. That information would be used to contact former service members and inform them of the various readjustment services provided through Vet Centers to include, counseling for PTSD and other readjustment challenges, suicide prevention, crisis intervention, marriage and family counseling, and family bereavement counseling. VA would also be required to provide information on how to access such services and how to locate other Vet Center locations if they relocate.

Vet Centers have proven to be an effective resource to assist veterans of all eras who seek care for readjustment issues associated with exposure to combat, military sexual trauma and reintegration challenges with families and communities. DAV supports this legislation in accordance with DAV Resolution No. 106, which encourages Vet Center outreach to inform eligible veterans about these critical community-based readjustment services.

**Draft bill, Servicemembers and Veterans Empowerment and Support Act of 2021**

The draft Servicemembers and Veterans Empowerment Act addresses existing shortfalls in the military sexual trauma (MST) claims process to help ensure veterans are aware of and have adequate access to care and services for conditions related to their trauma, and that they do not face unnecessary hardships throughout the claims process. Specifically, this law would expand the definition of MST to include more technologically modern forms of harassment and abuse; codify evidentiary standards and requirements within the review process; enhance outreach and communication with veterans regarding the claims process for MST-related conditions; mandate studies on the quality of both training and procedures of Veterans Benefits Administration (VBA) staff responsible for reviewing and processing these cases; access to inpatient mental health care for MST survivors; and authorize a pilot program to provide intensive outpatient mental health care services for MST survivors unable to access inpatient mental health care at VA medical center within a 14-day window.

This bill stands as a much-needed compilation of provisions that address many of the long-standing issues DAV has noted within the claims process for MST-related conditions. In fact, many of the recommendations DAV made at the hearing before this Committee on May 12 of this year are reflected in this bill, and we appreciate the dedication shown to listening directly to MST survivors and those who advocate for them, and incorporating their feedback into this proposed legislation.

One such recommendation was to relax the evidentiary standards for “stressor” requirements in claims for conditions related to MST. For many survivors, establishing service connection for mental and/or physical injuries caused by MST represents personal validation as well as recognition of and gratitude for their honorable service.

DAV supports lessening the evidentiary burden for MST cases, more closely in line with what is currently required for combat veterans—as this bill seeks to do through the addition of provisions outlined in Section 1167.

As we address this long-standing issue, DAV believes it is also important to protect the integrity of the claims process and to prioritize the best interest of veterans by putting accuracy before speed. The proposed new section—Section 1167, Evaluation of claims involving military sexual trauma, Subsection (f), Paragraphs (2) and (3)—calls for a veterans' lay statement (a personal statement of the event, for example) to be considered adequate for VA to provide both an exam and medical opinion, without waiting for other evidence to be presented. While we believe this provision is well-intentioned, the bill text indicates there may be times in which this results in the veteran not receiving a supporting medical opinion for diagnosis of a covered mental health condition linked to the MST. In such cases, VA would need to request additional evidence and order a new exam. Enduring unnecessary exams throughout this process can be re-traumatizing for MST survivors. As such, DAV strongly recommends veterans complete the full claims development process (in such instances where evidence exists and stressors can be documented) prior to undergoing any exam to ensure they are presenting the strongest and most thorough case to the VA for evaluation and adjudication. It is important to get this first step right to avoid possible premature denials and putting veterans in the position of undue emotional stress.

Beginning in 1992, with the enactment of Public Law 102-585 and in the years since, VHA began offering veterans counseling and services to address physical and mental health issues related to MST, without requiring a service-connected rating or proof of the event. However, a lack of consistent coordination between VBA and VHA often results in MST survivors filing for disability claims without any guidance on the immediate health services available to them through VA. This bill includes provisions that would initiate automatic written communications—guided by experts and mental health professionals—to MST claimants, providing information on resources and contact information for MST coordinators in both VBA and VHA. DAV believes this is a positive step forward in synchronizing efforts to serve the same veteran between the two administrations. We would further recommend VA consider requiring its MST coordinators provide initial outreach by phone once a claim has been filed, something that has shown to be beneficial in making pregnant women veterans aware of available VA services through maternity care coordinators.

Additionally, DAV appreciates the inclusion of provisions to allow MST survivors the opportunity to request their compensation and pension exam be done at a VA facility by a VA provider. However, based on the unique nature of these cases, the often-complex health needs of survivors and the expertise within VA regarding veterans' mental health and impacts of trauma, DAV recommends all original mental health claims be handled by VA providers, rather than directed to the community.

Caring for disabled veterans, and specifically MST survivors, must begin at the very beginning of the claims process. This type of trauma is uniquely personal and

sensitive, and the approach to address it cannot always be standardized. An August 2021 VA Office of Inspector General (OIG) report, showed clear challenges remaining in the MST claims process. The report's concerning findings make the bill's provisions for studies on VA staff training and processing of claims particularly important moving forward, especially as VBA effectively creates MST rating specialists across a limited number of regional offices to handle the entire volume of these cases. DAV is also in favor of the bill's provisions for studies on access to inpatient mental health care and the pilot program on interim access to more intensive outpatient care, which could help to ensure care is available to veterans when they need it.

DAV supports the draft Servicemembers and Veterans Empowerment Act in accordance with DAV Resolution Nos. 116 and 074, which call for ensuring that all MST survivors gain access to the specialized treatment programs and services they need to fully recover and that VA conducts rigorous oversight of claims adjudication personnel and review of data to ensure the policies for processing claims for conditions due to MST is being faithfully followed and standardized in all VA regional offices.

**Draft bill, State Veterans Homes**

This draft legislation would establish several new requirements that State Veterans Homes (SVHs) must meet to remain eligible to receive VA per diem payments for the provision of long-term care to eligible veterans. Specifically, the legislation would require every SVH to have a governing body consisting of two or more people that would be legally responsible for establishing and implementing policies regarding the management and operation of the SVH. Under current VA regulations, a SVH can have either a governing body or a "designated person functioning as a governing body," such as a state director of veterans affairs. It is unclear whether this legislation would prohibit a state from having a director of veterans affairs or similar state official be responsible for overseeing its SVHs.

The draft bill would also require SVHs to have an administrator or deputy superintendent who is licensed by the State or meets federal standards, and to employ an infection preventionist with appropriate education, training and licensing. Currently, most SVHs meet these requirements. Finally, the bill would create a VA program to provide up to 50% of the salary or wages for the infection preventionist to help with recruitment and retention for this position.

The State Veterans Homes program is a partnership between the federal government and state governments. SVHs receive per diem payments from VA for providing skilled nursing care, domiciliary care, and adult day health care (ADHC) to eligible veterans. VA also provides State Home Construction Grants, covering up to 65% of the cost to build, renovate and maintain SVHs. Although VA has significant regulatory and oversight authority for State Veteran Homes, each state is responsible for the operation and management of its homes.

Although DAV Resolution No. 017 supports the State Veteran Homes program and calls for sufficient funding, we have no specific resolution concerning changes to the management or oversight of SVHs proposed in this draft bill and take position on the legislation.

**Draft bill, Veterans Dental Care Eligibility Expansion and Enhancement Act**

This discussion draft, the Veterans Dental Care Eligibility Expansion and Enhancement Act, would include dental care as currently provided to certain veterans under title 38, United States Code (USC), Section 1712 in the definition of medical services. Currently, VA is only authorized to provide outpatient dental services to a limited number of veterans. Specifically veterans rated 100% service connected, veterans who were held prisoner-of-war or to those who have sustained dental trauma in performance of military service and in some cases to other veterans the Secretary determines require such care to provide effective preventative health care.

The bill would phase in provision of dental services to all enrolled veterans starting with veterans with service-connected conditions rated at least 30% or greater (priority groups 1 and 2 under title 38 USC, Section 1705(a)) at locations including VA medical centers with existing dental clinics; at least four military treatment facilities with dental clinics as agreed upon with the Secretary of Defense; at least four community based outpatient clinics with space available; at least four federally qualified health centers; and at least four Indian Health Service facilities with dental clinics. In choosing locations for participation in phase 1, VA must consider locations in rural areas; those distant from military treatment facilities and those from different geographic areas. The Secretary could also consider mobile clinics and home services for care delivery. The VA Secretary must increase the sites of dental services at each phase of implementation commensurate with the growth in the eligible veterans' population.

- Phase 1 would begin one year after the date of enactment and continue for two years;
- Phase 2 would begin 90 days after the completion of Phase 1 and continue for two years;
- Phase 2 would include veterans from Phase 1 in addition to veterans in enrollment priority groups 3 and 4;
- Phase 3 would begin 90 days after completion of Phase 2 and continue for two years, including veterans authorized for care in Phases 1 and 2 and adding veterans in priority groups 5 and 6;
- Phase 4 would begin 90 days after completion of Phase 3 for a duration of two years and include all other enrolled veterans.

DAV believes that the long phased in implementation schedule outlined in the bill would allow VA the appropriate time to develop program capacity, obtain the necessary resources to hire dental staff or contract with dentists in the community for such services, and make any adjustments necessary to support this new proposed dental benefit for veterans using VA care.

Oral health is integral to overall general health and well-being and is part of comprehensive health care coverage for most private, federal and state health care plans. Veterans who are medically compromised or who have chronic disabilities can be at greater risk for oral diseases which has the potential to jeopardize their overall health, compromise their ability to work and significantly diminish their quality of life. A recent study of Medicaid beneficiaries with a high burden of disease indicated that, for this large cohort of publicly insured individuals in New York State, preventive dental care was associated with better health care outcomes, most notably for the rates and costs of inpatient medical care admissions.[8] Certain associations with poor nutrition, diabetes, obesity and other chronic health conditions have also been made.

We support this draft legislation in accordance with DAV Resolution No. 018, which recognizes the importance of oral health as part of basic health care and calls on VA to provide comprehensive dental care to all enrolled service-connected veterans.

**Draft bill, Veterans State Eligibility Standardization Act**

This draft legislation would change the methodology that VA uses to calculate low-income thresholds for the purpose of providing veterans eligibility to VA health care under Priority Group 5. Currently, VA uses geographic low-income limits calculated by the Department of Housing and Urban Development (HUD) based upon metropolitan statistical areas (MSAs), which can consist of one or more contiguous cities or counties located in one or more states. As a result, veterans living in a state can be subject to different income thresholds depending on what part of the state they reside in.

This draft legislation would require that VA establish one single income threshold for all veterans residing throughout the entire state, which would be based on the highest of the HUD low-income thresholds for any city or county in the state. As a result, more veterans would become eligible for VA health care under Priority Group 5 based on their income levels.

DAV does not have a specific resolution that addresses changes to Priority Group 5 eligibility requirements for low-income thresholds and takes no position on the draft legislation.

**Draft bill to reorganize the Chaplain Service of the VA**

This bill would reorganize and establish a Department-wide Chaplain Service in the VA, to provide guidance and spiritual or religious pastoral services to all 3 administrations within the Department—VHA, VBA and the National Cemetery Administration. This service would be overseen by a new Chief of Chaplain Services appointed by the Secretary and report directly to the Secretary. Currently, Chaplain

[8] Lamster IB, Malloy KP, DiMura PM, et al. Dental Services and Health Outcomes in the New York State Medicaid Program. Journal of Dental Research. 2021;100(9):928-934. doi:10.1177/00220345211007448.

services are overseen by the National Director of VA Chaplain Service who reports directly to the Under Secretary for Health.

DAV does not have a resolution that pertains to this legislation and takes no position on this draft bill.

Mr. Chairman, again thank you for inviting DAV to provide testimony on the bills under consideration and I am happy to address any questions you or members of the Committee may have.

**Statement of Tom Porter**
**Executive Vice President, Government Affairs**
*of*
**Iraq and Afghanistan Veterans Of America**
*before the*
**Senate Veterans Affairs Committee**

**October 20, 2021**

Chairman Tester, Ranking Member Moran, and Members of the Committee, on behalf of Iraq and Afghanistan Veterans of America's (IAVA) more than 425,000 members, thank you for the opportunity to share our views, data, and experiences on the legislation before you today.

IAVA appreciates the Committee for bringing forward legislation that touches on a few of our priorities for 2021, which are: Combatting Suicide, Modernizing Government to Support Today's Veterans, Burn Pits, and Women Veterans.

**Modernizing Government to Support Today's Veterans**

The VA reports that about 1 in 4 women veterans and 1 in 100 male veterans report experiencing sexual trauma (MST) while serving in the military. For years, the claims process has received a fair amount of criticism due to the gruesome process a veteran must go through to prove their experienced MST. This past August 5, the VA OIG released a glaring report detailing that VA potentially denied thousands of veterans benefits related to their MST claims due to errors during claims processing. The report also found that VA failed to implement recommendations made by OIG back in 2018 that had resulted in similar issues. The lack of implementation resulted in an increase from 49% of claims being improperly processed to 57%.

Additionally, VA's claims process for MST is already a difficult road for a survivor. It is imperative that VA does not further traumatize and instead make veterans feel safe and secure as they embark on the difficult process of filing their claim.

IAVA strongly supports Chairman Tester's draft *Servicemembers and Veterans Empowerment and Support Act* that will greatly improve the MST claims process and adjust the standard of proof a veteran has to provide, lessening the potential for re-traumatizing any veteran. It also would require VA to review the claims process yearly to ensure accuracy. Finally, the legislation would require VA to study the training and accuracy of VBA's disability claims process for MST.

In recent years, VA has made incredible strides to modernize its internal and external operating systems. The implementation of new interoperable electronic health records is underway, allowing VA and DoD clinicians to share health data, ensuring continuity of care for transitioning servicemembers. Additionally, VA has updated its website to be more interactive and intuitive, allowing veterans to quickly find the information they need. These are major accomplishments and a system slowly but surely moving to the 21st century is a win for all veterans.

Each generation of veterans, including the post-9/11 generation, relies on VA for health care and benefits, and an agile system capable of accommodating them is critical. About 49% of all veterans are enrolled in VA health care. Among IAVA Member Survey respondents, 84% are enrolled in VA health care; of those, 85% rated their experience at VA as average or above average. IAVA members have been clear that access to VA care can be challenging, but once in the system, they are satisfied with their treatment. Further independent reviews of VA health care show that the quality often exceeds the private sector.

Providing today's veterans with a system willing to adapt to them will take the full coordination of the executive branch, Congress, state and local government, and stakeholders in the private and nonprofit sectors. We need a system that leverages the use of new technologies to streamline processes and enables the VA to take a more dynamic approach to respond to the needs of today's veterans. Even so, the best technology will not save a system if it is built upon outdated structures. The VA must connect its internal departments and work with DoD to streamline services.

Currently, in civilian and active-duty military health care systems, preventative medicines, such as aspirin and vitamin supplements, are provided at no cost to the patient. This is not the case for those receiving VA care. Preventative medicines can drastically cut the cost of medical bills and government spending later on. For these reasons, IAVA supports the *Veterans Preventative Health Coverage Fairness Act* (S. 1779).

Year after year, the concern grows surrounding the health impacts of toxic exposures like burn pits in recent conflicts. Burn pits were a common way to get rid of waste at military sites in Iraq and Afghanistan. The effect of burn pits is not just the chemicals in the smoke, but the particulate matter and pollution these men and women breathed in from many sources. According to IAVA's Member Survey, 86% say they were exposed to burn pits and/or airborne toxic materials, and 88% of those report they are experiencing related symptoms.

A study conducted by the Portland VA Medical Center in collaboration with the Oregon Health and Science University in 2013 discovered that veterans exposed to Agent Orange were at higher risk of prostate cancer. They were also more likely to have aggressive forms of cancer.

The list of conditions related to burn pits exposure continues to grow, which is why IAVA supports the *Veterans' Prostate Cancer Treatment and Research Act* (S. 2720). It is important to further research how prostate cancer is affecting veterans and how best to treat it.

The process of enrolling at VA is not an easy task for any veteran and this process can become further complex with the over 3,000 different geographic income eligibility thresholds. Currently, most state insurance has a standard income threshold for the entire state. IAVA supports the draft *Veterans State Eligibility Standardization Act*, which would limit the number of geographic regions to one per state and set the income eligibility threshold in each state to the most generous in that state.

In 2019, IAVA advocated creating a pilot program that would expand dental care to veterans that have certain chronic conditions. Timely dental care has been proven to increase overall health and reduce health care costs. IAVA supports Sen. Sanders' draft bill to require VA to provide dental care in the same manner as any other medical service. IAVA believes that proper health care includes dental care.

VHA's Medical Foster Home program (MFH), provides a non-institutional long-term care alternative for eligible veterans. However, while VA provides care team support to MFHs, it does not have the authority to pay for the cost of MFHs. As a result, veterans must use personal or other funding sources should they choose this alternative rather than nursing homes. The *Long Term Care Veterans Choice Act* (S. 2852) would change this and allow veterans to have more options when choosing their long-term care by authorizing VA to cover the cost of MFHs. IAVA supports this legislation.

IAVA also supports the *Veterans Affairs Major Medical Facility Authorization Act* (S.2624) by Chairman Tester and Ranking Member Moran, to allow already funded major construction projects of VA to continue to proceed.

IAVA does not yet have a position on Sen. Lankford's draft legislation regarding VA Chaplains. While we can see how restructuring the office to reside under the secretary rather than VHA could be an effective change, we would like to view VA's position on the legislation, as well as the opinions of stakeholder organizations.

**Combatting Suicide**

Suicide prevention has been IAVA's number one policy priority for many years. In the last year, IAVA celebrated passage of the *Commander John Scott Hannon Veterans Mental Health Care Improvement Act* and the *Deborah Sampson Act,* two landmark bills we worked hard to enact. Additionally, we worked with the House Energy and Commerce Committee to pass legislation last year to establish a national suicide prevention hotline, 9-8-8, to ensure that all Americans, including veterans, have easier access in times of crisis to lifesaving mental health and suicide prevention resources.

The Veterans Crisis Line (VCL) is an invaluable resource providing free, confidential support for veterans experiencing a crisis. While this tool is unparalleled, it is not without fault and that was shown when the VA OIG released two reports within the past year detailing how the VCL mishandled several high-risk callers, one resulting in the death of a veteran. This cannot be overlooked and is why IAVA strongly supports the *Revising and Expediting Actions for the Crisis Hotline (REACH) for Veterans Act* (S. 2283) by Chairman Tester and Ranking Member Moran. This bill would implement many of the recommendations made by the OIG in the reports, such as re-training for VCL employees, increasing silent monitoring, and more. The bill would also aid VCL with the transition to the new 9-8-8 number by requiring VA to utilize the knowledge of VSOs on how to best inform the veteran community about the new number.

In the past 10 years, VA and DoD have invested millions of dollars to better understand suicide and improve prevention efforts. While our community is in a much better position today, there is still more work to be done. About half of all deaths by suicide involve a mental health diagnosis. For the other half, environmental factors such as relationship stress, financial problems, or a crisis event can lead to a moment of crisis. And while we have invested in the understanding and treatment of mental health injuries, we must broaden the aperture and include community-based solutions, and continue to understand the factors impacting suicide.

IAVA regularly surveys our veteran members to gauge what issues are important to them and what needs to be improved upon to help veterans. Our most recent survey opened on September 8. While it is still underway, we have been able to gather preliminary data from the responses we have received.

Preliminary data shows that 21% of our members had difficulty covering monthly expenses with their income. For this reason, IAVA strongly supports the *Vet Center Improvement Act* (S. 1944) which would establish a grant program to combat food insecurity and provide essential heating assistance for veterans and their families.

The *MISSION Act* established a peer support program that empowers veteran peer specialists to apply their own lived experiences to help other veterans navigate the VA health system and access services while also teaching them about positive health-affirming behaviors. The *Veteran Peer Specialist Act* (S. 2386) would expand the highly successful peer specialist program to all VA medical centers and it would prioritize expansion to rural areas and ensure that peer specialists reflect the diversity of the veteran population. IAVA believes this legislation would further aid VA in the fight against veteran suicide and is proud to support.

Transitioning from active duty into the civilian world is terrifying for many veterans. According to preliminary data from our current survey, 77 % of IAVA members had some or many challenges upon transition. 34% also stated they were not prepared to manage their finances immediately after leaving the military.

There is much uncertainty around the decision to leave the military. The first year after leaving the military is often the hardest, and according to a 2019 study by Pew Research, veterans are at the highest risk for dying by suicide in the first three months of transition. Vet Centers offer a community-based touchpoint that could be used to proactively reach out to veterans soon after they separate from the military. For this reason, IAVA supports the *Vet Center Outreach Act* (S.2924) to require VA to notify the closest Vet Center within seven days of a servicemember's separation. It would also require the Vet Center to reach out to the transitioning veteran within 14 days of receiving the notification.

Knowing where and how to access available resources is instrumental to a successful transition. This legislation could help to reduce the approximately two-thirds of veterans that die by suicide each day not utilizing VA healthcare.

While IAVA supports the spirit of the *National Green Alert Act* (S. 1342), we cannot fully support the legislation as it is currently written. Many veterans are very private about their struggles with mental health and despite years of work, there is still a stigma around those that seek mental healthcare services. We want to make sure that our veterans are safe, but exposing a veteran's medical background due to them being missing could have catastrophic effects.

**Women Veterans**

Women are the fastest-growing population in both the military and veteran communities, and their numbers have been growing steadily since the 1970s. While more women are joining the military, veteran services and benefits often fall behind those offered in the civilian world. While the past few years have been encouraging in the display of growing interest in ensuring health

care accessibility for women at VA, increasing support for women veterans, and expanding services, there is still much work to be done.

As more women transition from the military, it will be paramount that DoD and VA are able and ready to support them. Part of that care means ensuring proper reproductive care and support for women veterans and their spouses.

Maternal mortality in the U.S. is a public health crisis. According to a 2020 report by the Commonwealth Fund, the U.S. has the highest maternal mortality rate among 11 other developed countries. Pregnancy and birth is already a stressful time, which is compounded with the unique healthcare conditions veterans can be faced with and can increase the amount of stress a veteran feels during birth. Doulas act as an advocate for a new mother before, during, and after giving birth. A Journal of Perinatal Education study from 2013 found that those mothers paired with a doula during pregnancy and birth were two times less likely to experience a birth complication involving themselves or their baby. The mothers paired with doulas also generally had better birth outcomes than those without. More women veterans are choosing to use the VA for their healthcare. VA must be prepared to take on that increase and offer safe and effective options. IAVA supports the *Delivering Optimally Urgent Labor Access (DOULA) for VA Act* (S. 1937) which would create a pilot program at six VISNs offering the use of doulas to support pregnant veterans and provide VA with data on how doulas can impact childbirth for veterans.

According to preliminary survey data, 23% of IAVA members live in rural areas and have to drive long distances for healthcare appointments. It can already be a struggle for women veterans to access high-quality mammography and breast cancer care even without a long-distance commute. IAVA is proud to support the *Making Advances in Mammography and Medical Options (MAMMO) for Veterans Act* (S. 2533), which would not only help ensure that veterans living in remote areas have access to mammogram services but also upgrade all VA in-house breast imaging to use the superior 3D digital mammography.

Members of the Committee, thank you again for the opportunity to share IAVA's views on these issues today. I look forward to working with the Committee in the future and answering any questions you may have.




**Biography of Tom Porter**

Tom Porter, Executive Vice President for Government Affairs, has served with IAVA since 2015. In this role, Tom leads IAVA's government relations team and national advocacy for our nation's veterans, while also serving as a media spokesman for IAVA priorities. Prior to joining IAVA, Porter was Vice President at Morgan Meguire, LLC since 2004. He was successful in achieving goals on behalf of a nationwide client base through aggressive and bi-partisan advocacy before Congress and federal agencies. He also served nine years on the staff of three Members of Congress. Porter serves in the U.S. Navy Reserve with 25 years of reserve and active service, including deployments to Afghanistan and the Arabian Gulf.

## Statements for the Record

Statement for the Record
Senate Veterans Affairs Committee
"Hearing to Consider Pending Legislation
Wednesday October 20, 2021
Senator Kyrsten Sinema

Thank you to our witnesses for being here today to share their views on the veterans' health care legislation being considered.

I'd also like to thank all of our witnesses, and the caregivers, doctors, nurses, and advocates for the tireless work you are doing throughout the pandemic to keep our veterans safe and supported.

This is especially important for our aging veterans and those with complex health needs who may no longer be able to live independently without access to additional long-term care services. It is critical that our veterans have access to a wide range of long-term care options.

The VA's Medical Foster Home program offers veterans a long-term care option where they can live and receive supportive services in a family-like setting. These homes can help elderly veterans remain as independent as possible while under the care of supported, compassionate caregivers. These environments often promote increased health outcomes. However, currently veterans often must pay out-of-pocket to reside in a medical foster home. While the costs are often half what it would cost the VA for nursing home care, for too many veterans, this alternative care option remains out of reach because of cost.

That is why I was proud to join with Senator Marsha Blackburn of Tennessee and Congressman Clay Higgins of Louisiana to introduce the Long-Term Care Veterans Choice Act to expand the VA's Medical Foster Home program and authorize the VA to cover the costs for qualified veterans. For many veterans, a family-like setting could be a welcome alternative to entering into a traditional nursing home where they are one of many residents.

I'd like to thank the VA and veteran serving organizations who worked with our office to make improvements to the bill since we introduced it last Congress, and for expressing your support of the legislation in your submitted testimony.

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**WOUNDED WARRIOR PROJECT**
**STATEMENT FOR THE RECORD**

**COMMITTEE ON VETERANS' AFFAIRS**
**UNITED STATES SENATE**

**LEGISLATIVE HEARING**
**ON**
**S. 1342, National Green Alert Act of 2021; S. 1779, Veterans Preventive Health Coverage Fairness Act; S. 1937, DOULA for VA Act of 2021; S. 1944, Vet Center Improvement Act of 2021; S. 2283, REACH for Veterans Act; S. 2386, Veteran Peer Specialist Act of 2021; S. 2533, MAMMO for Veterans Act; S. 2720, Veterans' Prostate Cancer Treatment and Research Act; S. 2787, A bill to amend title 38, United States Code, to clarify the role of doctors of podiatric medicine in the Department of Veterans Affairs, and for other purposes; S. 2852, Long-Term Care Veterans Choice Act; Servicemembers and Veterans Empowerment and Support Act of 2021 (discussion draft)**

**OCTOBER 20, 2021**

Chairman Tester, Ranking Member Moran, and distinguished members of the Senate Committee on Veterans' Affairs – thank you for allowing Wounded Warrior Project (WWP) to submit this written statement. We are grateful for the opportunity to highlight WWP's positions on key issues and legislation before the Committee.

Wounded Warrior Project was founded to connect, serve, and empower our nation's wounded, ill, and injured veterans, Service members, and their families and caregivers. We are fulfilling this mission by providing more than 20 life-changing programs and services to over 200,000 registered post-9/11 warriors and family members, continually engaging with those we serve, and capturing an informed assessment of the challenges this community faces. We are pleased to share that perspective for this hearing on pending legislation. Over the next several months, we are hopeful that we can assist your work to improve the lives of veterans and their families during the 117th Congress.

**S. 1342, the *National Green Alert Act of 2021***

Public safety and concern for at-risk individuals are the cornerstones for alert systems that serve a range of purposes from awareness to protection. AMBER Alert systems have been established in all 50 states to assist locating missing children, and 37 states have created Silver Alert systems to help mobilize the public to find elderly individuals with Alzheimer's disease, dementia, or a mental disability. A growing number of states – 36 as of June 2019 – have launched Blue Alert systems to help law enforcement speed up the apprehension of violent criminals who kill or seriously injure local, state, or federal law enforcement officers.

In this context, states including Wisconsin, Delaware, and Texas have extended similar efforts to help locate veterans and Service members who have gone missing. The *National Green Alert Act of 2021* would help provide federal guidance to states interested in implementing similar systems by establishing a federal committee to develop best practices and provide technical assistance to states to establish Green Alert systems. These systems would be activated when a veteran with a history of mental health issues, including neurocognitive disorders, suicide attempts or impulses, or substance use disorder goes missing. Key stakeholders from federal agencies including the Department of Justice, Department of Health and Human Services, the Department of Veterans Affairs (VA), and the Department of Transportation would be represented on the committee, as would veterans and veteran service organizations.

Wounded Warrior Project is pleased to support the *National Green Alert Act of 2021*, but that support is grounded in facts not seen in the legislation. States are permitted to establish Green Alert systems with or without federal support or guidance, and we believe that the development of best practices would be beneficial to those systems already in existence and those that may come in the future. The broad range of perspectives invited to serve on the committee will help ensure well-rounded consideration of issues such as how to file a missing persons report, what criteria should be considered for activating an alert, what mechanisms should be used to disseminate an alert, what audiences should be targeted, and how long alerts should last. Veteran and Service member privacy concerns should also be considered.

Our support for the *National Green Alert Act of 2021* should not, however, be construed as support for a national Green Alert system. An important issue to consider is the effect that such a system – or even prolific growth in state alert systems – would have on public perception of veterans. A recent report published by Cohen Veterans Network revealed that many Americans still hold misconceptions about the prevalence of PTSD in the veteran community.[1] This study showed that two-thirds (67%) of Americans believe the majority of veterans experience PTSD, while three in four (74%) believe the majority of combat veterans experience PTSD. One in four believes most people with PTSD are violent or dangerous. Broadcasting the

[1] Press Release: "From Symptoms to Treatment, New Survey Reveals Americans' Strong Misconceptions About PTSD." *Cohen Veterans Network.* (June 3, 2021), available at https://www.cohenveteransnetwork.org/wp-content/uploads/2021/06/Press-Release-Americas-Mental-Health-Pulse-Survey-PTSD-FINAL-1.pdf.

experience of veterans – and not others – who may be suffering mental health challenges to the public could deepen these perceptions if they are not handled appropriately.

Protecting veterans who may be at risk for suicide after disconnecting from their family and friends is a laudable goal, but WWP recommends that the *National Green Alert Act of 2021* – or the committee it seeks to establish – takes due care to ensure that public perception of veterans' mental health is considered in the best practices and guidance that may be provided to states in the future. Preventing suicide and other mental health crises remains a top priority for WWP and others, but we believe that legislation like this with conceivably broad public application should take steps to preserve and expand work being done on stigma reduction, education, and awareness. We thank Senator Maggie Hassan for introducing the *National Green Alert Act of 2021* and look forward to continuing our advocacy to support connecting veterans to the mental health care and support they need

**S. 1779, the *Veterans Preventive Health Coverage Fairness Act***

High-quality preventative health care can prevent or delay the onset of disease, foster better overall health and well-being, and help reduce health care costs. Yet, despite these benefits, many veterans face financial barriers to accessing preventative health care. Veterans receiving health care from VA often pay more in out-of-pocket costs for essential preventative health medications, services, and hospital care than those who use private insurance. Preventative health medications include vitamin supplements, certain breast cancer prevention medicines, and products to quit smoking, while preventative services encompass immunizations, cancer screenings, mental health screenings, screening for intimate partner violence, behavioral counseling, and breastfeeding support and supplies.

Although preventative prescription medications and services are covered without cost sharing by nearly all private insurance companies after the *Affordable Care Act* (P.L. 111–148), veterans receiving health care through VA are required to make copayments for many of these same essential health services. Under current law, veterans are required to pay for each 30-day supply of medication furnished on an outpatient basis for the treatment of a non-service-connected disability or condition. In addition, with the exception of certain home health services and education on the use of opioid antagonists, veterans are liable to pay for medical services and hospital care as determined by VA.

The *Veterans Preventive Health Coverage Fairness Act* seeks to address this by amending 38 U.S.C. § 1722(a)(3) to eliminate copayments for medication that is part of a preventative health service and amending 38 U.S.C. § 1710 to eliminate copayments for hospital and medical care related to preventive health services provided by VA. This legislation would also amend 38 U.S.C. § 1701(9) to expand the definition of preventative health services to include any items listed with a grade of "A" or "B" by the United States Preventive Services Task Force, such as breast, lung, and colon cancer screenings; screenings for diabetes and high

blood pressure; screening for vitamin deficiencies during pregnancy; screening for depression; and tobacco cessation counseling. It would also expand the definition to cover a set of standard vaccines recommended by the Advisory Committee on Immunization Practices and preventive care and screenings for women as provided in the most recent version of the Health Resources and Services Administration Preventive Services Guidelines.

Wounded Warrior Project supports the *Veterans Preventive Health Coverage Fairness Act*. By eliminating copayments for preventative medication, services, and hospital care, this legislation would make health care more affordable for veterans and bring it into alignment with what is offered through most private insurance options. Lowering costs will also increase access to preventative medications and services, which will help safeguard veterans against serious illness and disease. Veterans deserve access to high-quality health care at an affordable rate that provides equal coverage as those using private insurance. WWP thanks Senator Tammy Duckworth for her work on this topic.

**S. 1937, the *DOULA for VA Act of 2021***

While the experience is unique for each woman, pregnancy undoubtedly brings about changes in physical, emotional, and mental health for all who choose to become mothers. This consideration is particularly important for women veterans who show high rates of mental health conditions like anxiety, depression, and PTSD.[2] Studies have shown that PTSD symptoms are predictors of adverse pregnancy outcomes like preterm births, postpartum depression, and the perception of a difficult pregnancy.[3] In dealing with these and other pregnancy-related issues, some turn to doulas for additional assistance.

The role of a doula is to provide continuous physical and emotional support to women during pregnancy, childbirth, and the postpartum period. Doulas have been associated with better pregnancy and birthing outcomes, an effect which is largely attributed to findings that the uninterrupted "emotional, physical, and informational support doulas give to women during the birthing process [account] for the reduced need for clinical procedures during labor and birth, fewer birth complications, and more satisfying experiences during labor, birth, and postpartum."[4]

While doula services are not currently covered uniformly across federal insurers like Medicaid and TRICARE, benefits for these services are becoming more common. States including Minnesota, Oregon, Indiana, New Jersey, and Wisconsin, and Nebraska all cover doula services in some respect through state Medicaid programs. In addition, TRICARE is

[2] The 2020 *Annual Warrior Survey* found that 86 percent of women veterans report anxiety, 83 percent report depression, and 80 percent report PTSD; survey available for download and review at https://www.woundedwarriorproject.org/mission/annual-warrior-survey.
[3] Nillni, Yael I., et al. "The Impact of Posttraumatic Stress Disorder and Moral Injury on Women Veterans' Perinatal Outcomes Following Separation From Military Service." JOURNAL OF TRAUMATIC STRESS, vol. 33, no. 3, 2020, pp. 248–56. Crossref, doi:10.1002/jts.22509.
[4] Gruber, Kenneth J., et al. "Impact of Doulas on Healthy Birth Outcomes." THE JOURNAL OF PERINATAL EDUCATION, vol. 22, no. 1, 2013, pp. 49–58. Crossref, doi:10.1891/1058-1243.22.1.49.

undertaking a pilot program to offer access to doulas, as directed by Section 746 of the *National Defense Authorization Act for Fiscal Year 2021* (P.L. 116-283).

Wounded Warrior Project supports the *DOULA for VA Act*, a bill to pilot the expansion of VA's Whole Health program to measure the impact of doula support services on birth and mental health outcomes of pregnant veterans. In our own programming, WWP utilizes a total wellness framework, providing support to veterans in all aspects of their lives through by integrating both clinical and non-clinical services. We understand that effective care and support can come from many sources and seek to maximize each. In a similar fashion, we believe that integrating doulas into a holistic health care team may help women veterans to maintain their physical, emotional, and mental health during pregnancy. WWP thanks Senator Cory Booker for his work on this important matter concerning the health of women veterans.

**S. 1944, the *Vet Center Improvement Act of 2021***

In 2017, the Veteran Health Administration's (VHA) Readjustment Counseling Service (RCS) implemented new counselor productivity expectations governing time management and visit volume. Under these new expectations, counselors are expected to spend 50 percent of their work time with clients, directly providing services, and are expected to achieve an average of 1.5 visits for each hour they provide direct services. VHA RCS officials have also commenced efforts to implement a staffing model that will provide criteria for assessing Vet Center staffing needs, including whether additional counselors are needed.

In September 2020, the Government Accountability Office (GAO) published a report[5] assessing these changes and identified several areas of concern. GAO found that, due to new expectations, counselors at several Vet Centers now spend less time with clients and see clients less frequently. Additionally, counselors are incentivized to conduct more group counseling sessions, for which some clients may not be ready. GAO also found RCS's planned staffing model to be lacking; specifically, GAO identified that the model did not involve key stakeholders in the development process; narrowly focuses on the workload of counselors, excluding directors' needs; includes incomplete data; and does not adjust for factors which may impact counselors' bandwidth, such as large geographic responsibilities. Based on these findings, GAO provided recommendations, including that the VHA evaluate the new Vet Center productivity expectations for counselors and develop and implement a staffing model that incorporates key practices and is responsive to changing veterans' needs.

In response to GAO's recommendations, the *Vet Center Improvement Act* provides directives that VA solicit feedback regarding any potential effects of the productivity expectations – both positive and negative – on client care, that GAO audit this feedback at least once each year, and that VA implement needed changes accordingly. Further, this legislation

[5] U.S. GOV'T ACCOUNTABILITY OFFICE, Report on "VA Vet Centers: Evaluations Needed of Expectations for Counselor Productivity and Centers' Staffing" (September 2020), available at https://www.gao.gov/assets/gao-20-652.pdf

requires that VA develop and implement a Vet Center staffing model which adheres to GAO's key practices and develop a plan to continuously assess and update this staffing model. In addition to directly addressing all of GAO's recommendations, the *Vet Center Improvement Act* includes additional provisions for improvement. These include: creating a working group to assess the quality of care and access to care for veterans; standardizing descriptions of Vet Center position responsibilities; reviewing Vet Center infrastructure to examine what future investments are needed; and creating a pilot program to provide grants to combat food insecurity and provide necessary heating and cooling assistance to veterans and their families.

In fiscal year 2019, RCS's 300 Vet Centers provided approximately 1.9 million visits to more than 300,000 individuals. These Vet Centers provide crucial mental health services, including readjustment counseling. Therefore, productivity expectations for counselors and the Vet Center staffing model must be designed accordingly to best serve veterans' needs. Wounded Warrior Project supports the *Vet Center Improvement Act* and thanks Senator Jack Reed for championing this effort.

**S. 2283, the *Revising and Expediting Actions for the Crisis Hotline (REACH) for Veterans Act*, or the *REACH for Veterans Act***

On September 8, 2021, VA released its annual report on veteran suicide prevention. This report revealed that in 2019, there were 6,261 veteran suicide deaths.[6] Despite a 7.2 percent overall decrease in the age- and sex-adjusted veteran suicide mortality rate from 2018 to 2019, the suicide rate among veterans in 2019 was 52.3 percent higher than for non-veteran U.S. adults. In response, VA has pledged to continue prioritizing suicide prevention and implementing its ten-year vision to end veteran suicide. The agency's strategic plan contains many initiatives and efforts, including increasing awareness of the role of the Veterans Crisis Line in providing services and support to veterans in crisis.[7]

The Veterans Crisis Line (VCL) serves as a lifeline for all veterans, Service members, National Guard and Reserve members, and their family and friends. Following two incidents in 2018 and 2019 that resulted in a veteran suicide and a veteran homicide, respectively, the VA Office of Inspector General (OIG) conducted health care inspections to evaluate allegations regarding delayed and insufficient VCL responses to these two callers. VA OIG published

[6] OFF. OF MENTAL HEALTH AND SUICIDE PREVENTION, U.S. DEP'T OF VET. AFFAIRS, *2021 National Veteran Suicide Prevention Annual Report* (September 2021), available at https://www.mentalhealth.va.gov/docs/data-sheets/2021/2021-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-9-8-21.pdf

[7] OFF. OF MENTAL HEALTH AND SUICIDE PREVENTION, U.S. DEP'T OF VET. AFFAIRS, *National Strategy for Preventing Veteran Suicide 2018–2028*, available at https://www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf

corresponding reports in November 2020[8] and April 2021[9], which contain a total of 19 recommendations related to their findings.

The *REACH for Veterans Act* would codify several of the key recommendations from these two OIG reports through several VA requirements related to staff training, quality review and management, and responder guidance for high-risk calls. In addition, it would establish an extended safety planning pilot program at the VCL, establish a Crisis Line Facilitation pilot program to make veterans more comfortable utilizing VCL services, and authorize funding for the VA Mental Illness, Research, Education, and Clinical Centers (MIRECC) to conduct research on the VCL's effectiveness and areas for growth. Lastly, this bill requires VA to solicit feedback from veterans service organizations (VSOs) on how to alert members of the Armed Forces, veterans, and their family members about the upcoming transition to 9-8-8 as the new, national three-digit suicide hotline, in order to ensure that members of the military and veterans community are aware of and prepared for the change, which is expected to take effect by July 2022.

VA's forecasting modeling projects that the transition to 9-8-8 will increase VCL call volume significantly. The VCL has begun preparing for this increased demand by adding 460 new positions to its organizational chart and beginning the hiring process for these positions.[10] As new hires are onboarded, the *REACH for Veterans Act* contains timely provisions to improve and strengthen the VCL by requiring that VA contract with an external organization to review the training for VCL staff on assisting callers in crisis; increasing the use of silent monitoring to two calls per responder per month and establishing benchmarks for staff performance; mandating an annual root cause analysis study for all VCL callers who died by suicide; and requiring VA to develop enhanced guidance for VCL callers with substance use disorders and at risk for overdose.

The *REACH for Veterans Act* will not only help shore up VCL weaknesses, but also ensure that the crisis line is prepared for the sharp increase in call volume which is expected to occur following 9-8-8 implementation. WWP supports this comprehensive suicide prevention legislation, and thanks Chairman Jon Tester and Ranking Member Jerry Moran for their leadership to help ensure that the VCL is poised to provide quality care in a timely manner for veterans in crisis.

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[8] OFFICE OF INSPECTOR GENERAL, U.S. DEP'T OF VET. AFFAIRS, *Deficiencies in the Veterans Crisis Line Response to a Veteran Caller Who Died* (November 2020), available at https://www.va.gov/oig/pubs/VAOIG-19-08542-11.pdf

[9] OFFICE OF INSPECTOR GENERAL, U.S. DEP'T OF VET. AFFAIRS, *Insufficient Veterans Crisis Line Management of Two Callers with Homicidal Ideation, and an Inadequate Primary Care Assessment at the Montana VA Health Care System in Fort Harrison* (April 2021), available at https://www.va.gov/oig/pubs/VAOIG-20-00545-115.pdf

[10] *2021 National Veteran Suicide Prevention Annual Report,* 15.

**S. 2386, the *Veteran Peer Specialist Act of 2021***

Peer Specialists are VA employees in recovery from mental illnesses and substance abuse disorders who help other veterans to engage in mental health and substance use treatment. Veteran peer specialists use their own experiences with recovery to help and support the mental health needs of their fellow veterans. Peer support services can encourage veterans to share their experiences and discuss coping skills, improve veterans' relationships with their health care provider, and strengthen veterans' engagement with their course of treatment.[11]

In 2018, Section 506 of the *VA MISSION Act* expanded the peer specialist program to 30 primary care sites nationwide. In that time, VA peer specialists in patient-aligned care teams have been associated with increased participation and engagement in care. The *Veteran Peer Specialist Act of 2021*, would amend the *VA MISSION Act* and expand the peer specialist program to all VA medical centers. During the five-year period following enactment of this bill, the program would be initiated at an additional 25 medical centers per year until the program is carried out at each medical center of the Department. Two peer specialists would be assigned at each facility, and facilities in rural and underserved areas would receive first priority. This legislation would also ensure that female peer specialists are hired and made available to support female veterans and prioritizes diversity by striving to hire peer specialists in demographic percentages that reflect the racial and ethnic demographic percentages of the overall veteran population. Annual reports to Congress by VA will include an assessment of the benefits of the program as well as an assessment of the effectiveness of peer specialists in engaging with health care providers in the community.

Wounded Warrior Project has witnessed the value of peer support firsthand; our Alumni Program and peer support groups help combat veteran isolation by fostering connection. Although different in nature than VA's peer specialist program's clinical context, WWP's Alumni Program has facilitated more than 160,000 engagements through more than 14,000 events and programs designed to build connection and camaraderie among those we serve. We believe these engagements are a key reason why so many warriors believe that there are people they can depend on to help if they really need it (79.9%) despite often feeling isolated from others (37% versus 63% who hardly ever or sometimes feel isolated).

As many veterans still struggle to access appropriate mental health resources, WWP supports the *Veteran Peer Specialist Ac*t so that all veterans can benefit from the support and strength a peer specialist provides. Following VA's October 13, 2021, testimony on House companion legislation before the House Committee on Veterans' Affairs, Subcommittee on Health, our only recommendation is to increase the funding authorization in Section (2)(b). WWP thanks Senator Richard Blumenthal for his work on this issue.

[11] Matthew Chinman, Kevin Henze & Patricia Sweeney, *Peer Specialist Toolkit: Implementing Peer Support Servicers in VHA*, U.S. DEP'T OF VET. AFFAIRS, available at https://www.mirecc.va.gov/visn4/docs/Peer_Specialist_Toolkit_FINAL.pdf

**S. 2533, the *Making Advances in Mammography and Medical Options for Veterans Act*, or the *MAMMO for Veterans Act***

One in eight women veterans in the VA health care system develop breast cancer in their lifetimes.[12] Mammograms are the best tools available for providing early detection of breast cancer, sometimes three years before it can be felt.[13] Despite the potential life-saving capability that mammograms provide, WWP has found that many women veterans in rural locations face difficulty accessing mammograms due to a lack of Community Care Network providers and VA equipment. This issue was brought to light during WWP's Women Warriors Initiative roundtable discussions, with rural women veterans relaying that distance to a mammography facility was their primary reason for not receiving an annual mammogram.[14]

The *MAMMO for Veterans Act* would broadly improve access to and quality of mammography for women veterans, with a specific focus on rural women veterans. Among its key provisions are the development of a strategic plan to enhance breast cancer screening services, a pilot program to provide telemammography to primarily-rural veterans, and a VA OIG report on the quality and accessibility of VA's current mammography options. This strategic plan for Mammography Services would include information on the evolving needs of women veterans, geographic disparities in access to mammography, the use of digital breast tomosynthesis (3D imaging), and the needs of male veterans who require breast cancer screenings. The pilot program would provide telemammography services for veterans living in states where VA does not offer in-house services; under this provision, women veterans would be able to receive mammograms at a number of federal health care facilities, such as rural health clinics, Federally Qualified Health Centers, community-based outpatient clinics, etc., and then have their images sent to a centralized VA telemammography center for interpretation by expert radiologists. The VA OIG report would study accessibility of mammography screenings through VA and the Community Care Network, quality of screenings and the use of 3D mammography, timeliness of results, and the performance of the VA Women's Breast Oncology System of Excellence.

The *MAMMO for Veterans Act* includes additional provisions to improve VA's mammography services. This comprehensive legislation mandates that VA upgrade all mammography equipment for the use of 3D breast imaging; conduct a study on the usage and accessibility of mammography services for veterans with physical disabilities, including paralysis and spinal cord injuries; and conduct a study on the availability of BRCA genetic testing for veterans diagnosed with breast cancer to align BRCA gene testing best practices with those utilized by national cancer centers. In addition, the *MAMMO for Veterans Act* would establish a partnership between VA and the National Institutes of Health's (NIH's) National

[12] OFFICE OF INSPECTOR GENERAL, U.S. DEP'T OF VET. AFFAIRS, "VA creates National Women Veterans Oncology System of Excellence in fight against breast cancer" (October 2020), available at https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5549
[13] "What Is a Mammogram?", Breast Cancer, U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION, (September 20, 2021), available at https://www.cdc.gov/cancer/breast/basic_info/mammograms.htm
[14] *Women Warriors Initiative Report*, Wounded Warrior Project, (2021), available at https://www.woundedwarriorproject.org/media/tt0ftq4a/wwp-women-warriors-initiative-report-2021.pdf

Cancer Institute to increase veteran participation in clinical research trials and generate a joint VA-Department of Defense (DoD) report focused on ongoing research and health care collaborations between the agencies, particularly breast cancer-related partnerships.

Wounded Warrior Project supports the *MAMMO for Veterans Act.* This legislation is well-aligned with WWP's women veteran priorities, particularly with respect to expanding access to gender-specific care and optimizing telehealth. As this Committee knows well, rural veterans often struggle to reach timely and convenient health care. As the number of women veterans continues to grow, VA must be prepared to adapt its offerings to meet the health care needs of this population, especially those in underserved or hard-to-reach areas. This population is deserving of the most innovative and effective research, treatment, and prevention opportunities, and proximity to services must not negatively impact the decision to seek care. The *MAMMO for Veterans Act* would help ensure that these warriors have access to quality health care and would identify additional accessibility challenges through its reporting components. Wounded Warrior Project thanks Chairman Tester and Senator John Boozman for championing this vital effort to improve access to lifesaving care for women veterans.

**S. 2720, the *Veterans' Prostate Cancer Treatment and Research Act***

Each year, VA diagnoses and treats approximately 50,000 veterans for cancer. Of those, 41 percent are for prostate cancer, making it the most commonly diagnosed cancer at VA.[15] In 1996, the National Academies of Science, Engineering, and Medicine found an association between prostate cancer and Agent Orange exposure, and veterans who suffered this exposure are considered to be at high risk for developing the disease. More research is needed to determine whether a scientific link exists between prostate cancer and other military toxic exposures, such as burn pits and high doses of radiation that military pilots and certain other occupations may experience.

The *Veterans' Prostate Cancer Treatment and Research Act* would make improvements to prostate cancer care at VA by requiring the establishment of an interdisciplinary clinical pathway for all stages of the disease, from early detection to end of life care. The bill defines a clinical pathway as, "a health care management tool designed around research and evidence-backed practices that provides direction for the clinical care and treatment of a specific episode of a condition or ailment." The clinical pathway would be organized under the VA National Surgery Office, in consultation with the VA National Program Offices of Oncology, Research and Development, and Primary Care. VA would be authorized to collaborate with other federal agencies as well, to include the National Institutes of Health, the Centers for Disease Control and Prevention, the Food and Drug Administration, the Department of Defense, and others. VA would also incorporate feedback from veterans who were treated for prostate cancer at VA facilities as well as experts in multi-disciplinary cancer care and clinical research. The bill also

[15] U.S. DEP'T OF VET. AFFAIRS, *Shoulder to Shoulder: Defeating Cancer, National Oncology Program*, available at https://www.cancer.va.gov/CANCER/docs/NOP_Brochure_vFinal_DIGITAL.pdf

requires VA to submit a plan to Congress to provide continuous funding to the VA Office of Research and Development to support prostate cancer research designed to position VA as a national resource for prostate cancer detection and treatment.

Prostate cancer is a serious disease that significantly impacts the veterans' population, and WWP believes that the establishment of a collaborative clinical pathway would improve the detection and treatment of this condition at VA. We support the *Veterans' Prostate Cancer Treatment and Research Act* and thank Ranking Member Moran and Chairman Tester for their leadership on the matter.

**S. 2787, A bill to amend title 38, United States Code, to clarify the role of doctors of podiatric medicine in the Department of Veterans Affairs, and for other purposes.**

Section 502 of the *VA MISSION Act of 2018* (P.L. 115-182) improved pay and leadership opportunities for VA podiatrists to remedy inequalities between lower-extremity specialists and other specialty care physicians, provide equity with the private sector, and address VA's podiatrist shortage. While the *VA MISSION Act* elevated VA podiatrists to the level of other medical doctors, VA's Office of the Under Secretary for Health still only includes a Director of Podiatric Service, a position on par with the Director of Pharmacy Service and Director of Dietetic Service.

Senator Bill Cassidy's legislation would address this issue by requiring that the Office of the Under Secretary for Health replace the role of Director of Podiatric Service with a Podiatric Medical Director. Anyone who fills this position must be a qualified podiatric medicine doctor and must be paid in the same category as physicians and dentists. WWP supports this legislation to clarify the role of podiatric doctors and thanks Senator Cassidy for his work on this matter.

**S. 2852, the *Long-Term Care Veterans Choice Act***

Through years of service to severely wounded warriors, WWP has learned that provision of personalized care and support options, including at home and in the surrounding community, can be critical to maintaining better quality of life. One alternative to traditional nursing homes is VA's Medical Foster Home (MFH) program. This program provides non-institutional, long-term, supportive care for veterans who are unable to live independently and prefer a family setting; in MFHs, caregivers provide daily assistance to a small group of individuals, both veterans and non-veterans.

While this program ultimately combines the provision of nursing-home level care and supervision in a homelike setting, the cost of participating can be a limiting factor for many. Conventional nursing homes are covered under VA benefits for eligible veterans, but veterans in MFHs need to pay out of pocket for housing and parts of their care, often totaling between

$2,500 and $3,000 per month[16]. Many veterans can apply various benefits to help cover the cost, but federal legislation to eliminate that burden would make this a more attractive option.

The *Long-Term Care Veterans Choice Act* would amend 38 U.S.C. § 1720 to authorize VA to enter into contracts and agreements with medical foster homes to expand veterans' access to the MFH program. If enacted, VA would cover the cost of care of the MFH program for up to 900 veterans per day. This legislation also requires that VA create a system to monitor and assess how many veterans request to be placed in an MFH, how many are denied, and how many veterans receiving care at a medical foster home pay at their own expense. VA will submit a report on its findings to examine the impact of changes to the MFH program and ensure that care is being provided to veterans as intended.

In addition to helping to ensure that eligible veterans may utilize MFHs without being deterred due to cost, this program provides cost-saving potential for VA as well. Through the *Long-Term Care Veterans Choice Act*, more veterans may elect to receive their care at MFHs; the cost of these non-institutional MFH services is significantly lower than the price of traditional nursing home services, which are approximately $7,000 per month. While nursing homes will continue to a better option for some, the *Long-Term Care Veterans Choice Act* provides a cost-saving mechanism without reducing care and support to the veteran.

WWP supports the *Long-Term Care Veterans Choice Act* to provide VA more flexibility to better meet veterans' needs in a clinically appropriate and veteran-centric setting. We would like to thank Senator Krysten Sinema for introducing this important bill, which offers an attractive option for younger veterans who prefer not to live at nursing home facilities that may not feel age appropriate. Providing necessary long term support services (LTSS), to include sufficient amounts of those services, to veterans who are relying on them earlier in life is a WWP priority. WWP is meeting that priority through services like our Independence Program, and we would offer two key facts for the Committee to consider as it continues to drive critical improvements, such as those provisions within the *Long-Term Care Veterans Choice Act,* to VA LTSS.

First, veterans under the age of 65 are using VHA's Geriatrics and Extended Care (GEC) programs at a high and increasing rate. In 2020, 27 percent of GEC program users were veterans under the age of 65.[17] That figure represents a 10 percent increase over 2019, when veterans under age 65 accounted for 16.7 percent of GEC program users.[18] Across all VA long term programs from fiscal year 2014 through 2018, the number of veterans who served on or after

[16] Mitch Mirkin, "No Place Like Home: Studies on VA Medical Foster Homes Show Good Outcomes for Vets," OFFICE OF RESEARCH & DEVELOPMENT, U.S. DEP'T OF VET. AFFAIRS (Oct. 3, 2019), available at www.research.va.gov/currents/1019-Studies-on-VA-medical-foster-homes-show-good-outcomes-for-Vets.cfm

[17] U.S. DEP'T OF VET. AFFAIRS, FISCAL YEAR 2022 BUDGET SUBMISSION, Medical Programs and Information Technology Programs at VHA-187, available at https://www.va.gov/budget/docs/summary/fy2022VAbudgetVolumeIsupplementalInformationAndAppendices.pdf (last visited July 12, 2021).

[18] U.S. DEP'T OF VET. AFFAIRS, FISCAL YEAR 2021 BUDGET SUBMISSION, Medical Programs and Information Technology Programs at VHA-92, available at https://www.va.gov/budget/docs/summary/archive/FY-2021-VA-BudgetSubmission.zip (last visited July 12, 2021).

9/11 and received long-term care has increased at a faster rate than the overall number of veterans who received this care.[19]

Second, veterans under the age of 65 are more likely to have been the beneficiaries of modern life-saving military medicine and technology during their time in service. Improvements in combat casualty care including better use of tourniquets, quicker blood transfusions, and faster prehospital transport times have saved the lives of many who would have been lost in previous wars, including those most critically injured, who experienced a three-fold increase in survival rates from 2001 to 2017.[20] Many of those who survived due to these advances in medical technology and battlefield care were very seriously wounded and will be challenged by lifelong physical disabilities or mental health conditions. Thus, this increased survival rate will continue to contribute to the need for LTSS services that are responsive to a community of younger veterans who will require more intensive care and case coordination over a longer period.[21] WWP again thanks the Committee for its consideration of the needs of this population.

**Discussion Draft, the *Servicemembers and Veterans Empowerment and Support Act***

In recent years, VA has made impressive strides to expand its services catered to Military Sexual Trauma (MST) survivors and improve accessibility of care to all who experienced sexual trauma during military service, regardless of service-connection or other limiting factors. However, the complex nature of MST requires VA to consistently modernize and expand its treatment options for veterans in need of support. As this legislation recognizes, more can be done to ease access to benefits and care for MST survivors.

The *Servicemembers and Veterans Empowerment and Support Act* proposes a number of reforms intended to reduce the emotional and evidentiary burden of VBA's claims process, improve the accuracy and efficiency of such process, streamline communication between VHA and VBA, and enhance treatment options for MST survivors. WWP is pleased to see the Committee take a comprehensive approach to this issue, and we are confident that many of the proposals in this legislation will make real and lasting change. In our statement today, however, WWP will focus our comments and recommendations on the provisions which most closely reflect our priorities and expertise.

Sections 206 and 207 of this draft legislation would take steps to improve the quality of VBA training and accuracy of MST-related claims processing by requiring reviews on both topics, the latter of which to be performed annually. The discussion around these measures occurs at a timely moment. A report from the VA Office of Inspector General (OIG) identified

[19] U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-20-84, VA Health Care: "Veterans' Use of Long-Term Care Is Increasing, and VA Faces Challenges in Meeting the Demand" (2020).
[20] JT Howard, RS Kotwal, CA Stern, et al. *Use of Combat Casualty Care Data to Assess the US Military Trauma System During the Afghanistan and Iraq Conflicts, 2001-2017*. Surgery. Published online 2019, *available at* https://jamanetwork.com/journals/jamasurgery/article-abstract/2729451.
[21] Ben Barry, *Battlefield Medicine: Improving Survival Rates and 'The Golden Hour,'* INT'L INST. FOR STRATEGIC STUDIES, (Apr. 16, 2019) available at www.iiss.org/blogs/military-balance/2019/04/battlefield-medicine.

that, despite supposed implementation of previous recommendations, accuracy of MST-related claims determinations worsened since 2018. This report found that 57 percent of denied MST-related claims from October 1 – December 31, 2019, were not properly processed. This error rate represents more than a failure of VBA governance, it directly impacts the emotional and financial health of MST survivors.

Thus, WWP supports the annual review process that this legislation would implement for MST-relation claims. We make one minor suggestion: Section 207 requires a full review of all MST-related claims submitted in the year prior when the accuracy rate is found to be under 90 percent. WWP recommends that any such review prioritize MST-related claims that were previously denied ensuring any subsequent remediations are focused on veterans in greatest need.

Under Section 302 of the *Servicemembers and Veterans Empowerment and Support Act*, VA would be required to send a communication to a veteran who submits an MST-related claim with information on VHA and VBA MST Coordinators, the types of services MST survivors may be eligible for, and information to reach the Veterans Crisis Line. This provision is intended to improve veterans' awareness and access to support services – namely, mental health support – during the claims process. This is a concept for which WWP strongly supports.

We understand that the benefits process may trigger an emotional response for many veterans; its thorough nature requires veterans to reiterate traumatizing experiences, often to multiple providers or representatives. While filing a benefits claim may be emotionally challenging, it also represents an opportunity to connect veterans to meaningful mental health care. In FY 2021, WWP's Benefits team provided over 300 referrals to our suite of mental health programming, illustrating how WWP works to integrate emotional and mental health support into the claims process. We recognize that the intent of Section 302 is aligned with this goal and offer the following as context and recommendation for improvement.

Section 302 language only requires VA to send a "communication" to a veteran who submits an MST-related claim. WWP recommends enhancing this effort to reflect a more personalized model, such as wellness checks via phone. Doing so may allow VA to reach MST survivors in a timelier manner and provide referrals or recommendations to services that meet their individual needs. Written communication, on the other hand, puts an additional burden on MST survivors to find their own resources during a time when they may be under emotional stress.

In addition, WWP recommends that the scope of Section 302 be expanded to cover additional pain points along the claims timeline. The submission of a claim is, indeed, a critical moment. However, other potentially re-traumatizing events include: writing a personal statement describing the trauma; the phone screening prior to a medical examination; the compensation and pension examination; the day a decision is rendered, regardless of the outcome; the Board of Veterans' Appeals (BVA) hearing, and any subsequent examinations it

requires. While we recognize that it may not be feasible to conduct outreach after each of these events, we include them to illustrate the importance of maintaining an ongoing dialogue with MST survivors. For the purposes of this draft legislation, WWP recommends that personalized outreach be conducted after compensation and pension examinations and after BVA hearings.

Section 304 of the *Servicemembers and Veterans Empowerment and Support Act* would create a pilot program to provide intensive outpatient mental health care to MST survivors who face wait times for inpatient mental health care longer than 14 days.

Wounded Warrior Project has been connecting veterans with intensive outpatient treatment since 2015 through our Warrior Care Network program. We have witnessed firsthand the significant impact that this type of care can have on veterans. In the two-to-three week treatment programs WWP facilitates through four Academic Medical Center partners across the country, participating warriors receive more than 70 hours of direct PTSD treatment in addition to complementary alternative therapies. Originally designed to address symptoms of moderate to severe PTSD and/or TBI, Warrior Care Network expanded to incorporate curriculums tailored to MST. MST-specific cohorts are delivered through Rush University Medical Center and help survivors to connect with their veteran peers, develop resiliency, and ultimately heal from past trauma. VA has personnel on site as well to help facilitate any necessary care coordination, record transfers, or provide education on resources in the veteran's home area.

If enacted, WWP offers our full support to VA in developing an effective intensive outpatient treatment program for MST survivors. We are grateful to the Committee for recognizing the potential of this treatment pathway to improve timeliness and effectiveness of mental health care delivery, and WWP is pleased to offer our expertise as this initiative develops.

While we have provided comments on only a few of the provisions included in the *Servicemembers and Veterans Empowerment and Support*, WWP would like to endorse this legislation as a whole. We thank Chairman Tester for acting as a champion for MST survivors, and for supporting these crucial reforms to VA benefits and services.

**CONCLUSION**

Wounded Warrior Project thanks the Committee and its distinguished members for allowing our organization to submit this statement. We are grateful for and inspired by this Committee's proven dedication to our shared purpose to honor and empower our nation's warriors. Your efforts to provide interventions to meet the growing needs of veterans and support quality mental health care will certainly have a strong impact on the post-9/11 generation. We are proud of all of the work that has been done and look forward to continuing to partner on these issues and any others that may arise.

**STATEMENT FOR THE RECORD**
**PARALYZED VETERANS OF AMERICA**
**FOR THE**
**SENATE COMMITTEE ON VETERANS' AFFAIRS**
**ON PENDING LEGISLATION**
**OCTOBER 20, 2021**

Chairman Tester, Ranking Member Moran, and members of the Committee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to submit our views on pending legislation impacting the Department of Veterans Affairs (VA) that is before the Committee. No group of veterans understand the full scope of benefits and care provided by VA better than PVA members—veterans who have incurred a spinal cord injury or disorder (SCI/D). PVA provides comment on the following bills included in today's hearing.

**S. 1779, the Veterans Preventive Health Coverage Fairness Act**
PVA supports this legislation which would eliminate copayments for medications, hospital care, and medical services when services received are considered preventive care services. PVA believes eliminating copayments for preventive care services is long overdue and is consistent with preventive care services provided at community health care facilities and the provisions authorized under the Affordable Care Act (P.L. 111-148).

**S. 2283, the REACH for Veterans Act**
Since its launch in 2007, the Veterans Crisis Line (VCL) has served as an important tool for veterans in crisis or families seeking information. PVA supports the REACH for Veterans Act which directs improvements in staff training and management of the hotline and helps facilitate the VCL's transition to 9-8-8 as part of the national suicide prevention hotline. This legislation would help to ensure that veterans are receiving the top-quality mental health crisis resources they deserve.

**S. 2386, the Veteran Peer Specialist Act of 2021**
Peer specialists are VA employees who provide support and assistance to help fellow veterans in recovery to successfully engage in mental health and substance use treatment. These specialists support and boost veterans' recovery by helping them navigate the VA health care system; learn coping skills; and develop positive, health-affirming behaviors. PVA supports this bill which requires VA to work with its Inspector General to conduct an in-depth analysis of its current staffing plan for peer specialists who are women and to report to Congress about their geographic distribution. It would also direct VA to examine how that data matches up with the population and geographic distribution of women veterans, what the specified responsibilities are for peer specialists,

and what percentage of these specialists focus on mental health and/or suicide prevention. Because the mental health challenges that can accompany disabilities like an SCI/D are often overlooked, we believe that the study should also examine the demographics of existing peer specialists to determine if there are any who have catastrophic disabilities that could work with women veterans with similar injuries or illnesses.

**S. 2526, to authorize the Secretary of Defense and the Secretary of Veterans Affairs to enter into agreements for the planning, design, and construction of facilities to be operated as shared medical facilities, and for other purposes**

PVA supports this bill which authorizes VA and the Department of Defense (DOD) to enter into agreements with one another for planning, designing, constructing, and leasing shared medical facilities. In addition to saving taxpayer dollars, shared facilities can help increase patient access to medical services and promote improved efficiency by reducing the duplication of services.

**S. 2533, the MAMMO for Veterans Act**

Ensuring access to breast imaging services for SCI/D veterans is a critical part of providing proper health care for our members. Women veterans who live with SCI/D often face barriers that can limit effective breast screening. Exam rooms may not be able to accommodate wheelchairs or may not have lifts. Screening equipment may also be inaccessible. Consequently, too many SCI/D veterans receive inadequate screenings. Thus, we strongly support the MAMMO for Veterans Act. We are especially pleased with the provisions related to the screening accessibility for veterans living with paralysis and other disabilities. These provisions would help increase mammography accessibility for paralyzed and disabled veterans by requiring a study on the accessibility of breast imaging services within VA. The study would also provide critical data such as cancer rates among veterans with SCI/D, as well as information on our rural veteran population and their access to breast screening health care. In addition, the legislation would require VA to update its policies and directives to ensure that community care settings are accessible and have information on best practices for screening paralyzed and disabled veterans.

**S. 2624, the FY2022 Veterans Affairs Major Medical Facility Authorization Act**

PVA strongly supports this legislation which would authorize funding for VA medical facility construction projects for fiscal year 2022. Most VA facilities were built during the 1940s and require extensive upgrades. This legislation would allow VA to move forward with critical construction projects such as the construction of a spinal cord injury center in Dallas, Texas; construction and renovation of the Gulfport Hospital in Biloxi, Mississippi; construction of a community living center and renovation of domiciliary and outpatient facilities in Canandaigua, New York; and replacement of a VA medical center bed tower

and clinical building expansion in St. Louis, Missouri. This is just some of the projects this legislation would support and PVA urges Congress to pass this bill as soon as possible.

**S. 2720, the Veterans' Prostate Cancer Treatment and Research Act**
PVA supports this bill which would direct the VA Secretary to establish an interdisciplinary clinical pathway for all stages of prostate cancer, from early detection to end of life care. Among U.S. veterans, prostate cancer is the most frequently diagnosed cancer, accounting for roughly one-third of VA's present cancer cases.[1] Currently, it is the Veterans Health Administration's (VHA) largest oncology burden with nearly 500,000 veterans undergoing treatment for the disease. Establishing a comprehensive, multi-disciplinary prostate cancer clinical pathway within VA will optimize treatment options and likely result in improved outcomes for these patients.

**S. 2852, the Long-Term Care Veterans Choice Act**
PVA supports this legislation which would authorize VA to pay for the care of a veteran placed in a medical foster home. The bill also requires, as a condition of such payment, that the veteran agree to accept home health services furnished by VA under Title 38 United States Code, section 1717. Like most veterans, our members prefer receiving care in a home-like environment and being placed in a nursing home only when other home and community-based services (HCBS) would not meet their health care needs. Thus, expanding access to HCBS, including medical foster homes, is a key priority for PVA.

**S. 2924, the Vet Center Outreach Act of 2021**
PVA supports this legislation which would require VA to send an alert to a local VA Vet Center nearest to where a veteran resides within seven days of that veteran separating from the military, along with information that can help the VA Vet Center engage in personalized outreach to the veteran. The local Vet Center would then have two weeks to reach out to the veteran within two weeks of getting that information. Reaching out to veterans earlier in their transition back to private life may help reduce rates of suicide and would ensure they have more immediate access to the high-quality readjustment counseling they need and have earned.

**Senate Discussion Draft, the Servicemembers and Veterans Empowerment and Support Act of 2021**
PVA supports the Servicemember and Veterans Empowerment and Support Act which expands the definition of MST to ensure servicemembers and veterans who experience online sexual harassment can access VA counseling and benefits. It also codifies a lower burden of proof, which would expand eligibility to essential counseling and treatment for survivors of MST, even if they did not feel comfortable reporting the event to their chain of command while in service. We feel this legislation, which includes additional

[1] The Prostate Cancer Foundation-VA partnership

improvements for MST survivors, would help ensure their claims are fairly adjudicated so they can address the life-long physical and emotional impact that sexual trauma can have.

**Senate Discussion Draft, the Veterans Dental Care Eligibility Expansion and Enhancement Act**

VA currently provides dental care services to about 490,000 of the 9 million veterans who are enrolled in the VHA system. They include veterans with a service-connected disability rated at 100 percent; veterans with a service-connected dental condition; former prisoners of war; homeless veterans; and those who have a dental condition that aggravates a service-connected condition or complicates treatment of that condition. Another 80,000 veterans purchase limited dental care coverage through VA's Dental Insurance Program, which is set to expire at the end of 2021. This means most veterans are obtaining coverage for dental care elsewhere or forgoing care altogether because they cannot afford it.

Recent studies have illuminated the positive impact that oral health has on the overall health, medical costs, and quality of life for an individual. That, coupled with the lack of access many veterans have to dental care coverage, prompt PVA to support this bill, which would expand eligibility for VA dental care to all veterans receiving VHA health care. It also incentivizes dental school enrolment and service to our nation's veterans through a loan reimbursement program and requires VA to educate veterans on their eligibility for dental care and the importance of dental hygiene for an individual's overall health. Each of these changes stands to improve VA's provision of dental care to veterans.

PVA would once again like to thank the Committee for the opportunity to submit our views on some of the legislation being considered today. We look forward to working with the Committee on this legislation and would be happy to take any questions for the record.

# Questions for the Record

**Department of Veterans Affairs (VA)**
**Questions for the Record**
**Committee on Veterans' Affairs**
**United States Senate**
**Hearing on Pending Legislation**

**October 20, 2021**

Questions for the Record from Senator Tester

**QUESTION 1: Are all former Guard and Reservists currently eligible for MSTrelated health care and counseling at VA, if they experienced MST?**

Response: VA provides Military Sexual Trauma (MST)-related care under its authority at 38 U.S.C. § 1720D. Under this statute as written, not all former National Guard or Reserve (NG/R) members are eligible to receive MST-related care even if they experienced sexual assault or sexual harassment that qualifies as MST.

In order to qualify for care under §1720D currently, a former Service member must have experienced a sexual trauma as described under §1720D(a) and must meet the definition of "former member of the Armed Forces" given under §1720D(g). To meet the latter definition, an individual must either:

1. Qualify as a "Veteran" as defined by 38 U.S.C. § 101(2); or
2. Meet all criteria described under 38 U.S.C. § 1720I(b).

Both above require the individual to have served on active military, naval, air, or space service (as defined by 38 U.S.C. § 101(24)), which includes Federal active duty and any period of Federal reservist duty during which the individual was disabled from an injury incurred or aggravated in the line of duty.

Therefore, to be eligible for MST-related care, a former NG/R member must meet at least one of the following criteria:

1. Full-time Federal active-duty service, other than for training—either in an activeduty component prior to entering the NG/R or as part of a Federal activation under 10 U.S.C. § 12301(a); or
2. Service-connected by VA for a disability incurred during reservist duty (the disability does not itself need to be MST-related).

We know from past inquiries that this is an area of interest for Senator Tester's office and were pleased to see Section 301 of the draft Service members and Veterans Empowerment and Support Act bill discussed in this hearing, as it would close this

eligibility gap. As noted in VA's testimony for this hearing, Section 301 of the draft Service members and Veterans Empowerment and Support Act bill would close this eligibility gap by removing the current requirement for active military, naval, air, or space service. All former NG/R members who served on Federal active duty or Federal reservist duty (without any need for service connection) would be eligible for MSTrelated care, provided they meet discharge requirements. As with all former Service members, former NG/R members would also need to have been discharged or released from Federal duty under any condition that is not a discharge by court-martial or subject to a bar to VA benefits under 38 U.S.C. § 5303.

VA estimates this section would cost $2.97 million in FY 2022, $28.82 million over 5 years and $82.26 million over 10 years. Subject to the availability of appropriations, VA supports the draft Section 301, with some technical concerns and suggested revisions to the other amendment prescribed by the section, which would newly define the term "military sexual trauma" under §1720D. We suggested the Committee consider amending the definition to be inclusive of both current and former Service members and amending current §1720D(a) so as to refer explicitly to the new definition.

**QUESTION 2: What percentage of MST-related claims are processed by a specialized team at VBA?**

Response: All identified MST claims are now being handled by specialized teams at the Veterans Benefits Administration (VBA). Beginning in May 2021, the VBA consolidated MST-related claims to five Regional Offices (Hartford, New York, Lincoln, Columbia and Portland) to provide tighter control and oversight for these claims.

**QUESTION 3: What steps is VA taking to respond to the IG reports and improve the accuracy of claims processing for MST survivors?**

Response: VA is committed to supporting Veterans who suffer from chronic mental health conditions and other disabilities due to MST. VBA has made significant changes and improvements since the Office of Inspector General (OIG) report in August 2018. VBA implemented several actions to effectively improve claims processing, resulting in higher grant rates. The MST claims grant rate increased from 57% in fiscal year (FY) 2018 to 74% in FY 2021. In November 2018, VBA mandated that only specialized groups of trained Veterans Service Representatives and Rating Veterans Service Representatives who have demonstrated high-quality standards process these high priority and complex claims. VBA continues to highlight the importance of MST claims processing during national training, as well as business line and leadership conferences. VBA made improvements in MST-related claims processing including eliminating the requirement for potentially unnecessary phone calls that could retraumatize Veterans, improving training for MST claims processors and continuing quality reviews of MST cases through special focused quality reviews, which are used to develop annual training.

In May 2021, VBA centralized this important work to five ROs to further improve benefits delivery to Veterans who file MST-related claims by enhancing efficiency, accuracy and timeliness by placing these cases in the hands of well-trained, experienced employees. VBA improved claims processor training and hosted two virtual MST Training Symposia for MST Coordinators and MST claims processors in FY 2021. Additionally, in July 2021, VBA added clarity to the Procedures Adjudication Manual to better guide the claims processor in making accurate decisions on complex MST-related claims.

**QUESTION 4: When does VA expect to publish the strategic plan for breast imaging?**

Response: The current timeline is for the Veterans Health Administration (VHA) National Radiology Program to submit the draft strategic plan for breast imaging for leadership review by the end of the second quarter of FY 2022. While the goal is to publish the strategic plan by the end of FY 2022, the actual publication date will depend on the time required to complete the review and concurrence process.

**QUESTION 5: What partnerships does VA currently have with the National Cancer Institute and Department of Defense to improve veterans' access to clinical trials and high-quality breast cancer care? How could these partnerships be strengthened?**

Response: For high-quality breast cancer care, VA partners with the Department of Defense (DoD) in two areas: (1) DoD expert clinicians are members of VA's workgroup for development and maintenance of breast cancer clinical pathways; and (2) VA and DoD are partnering to converge on a single configuration of Electronic Health Record (EHR), which includes chemotherapy order sets (PowerPlans) and other tools for care of patients with breast cancer. There are also several medical facilities that have colocation of DoD and VA beneficiaries receiving breast cancer care from the same providers in the same clinic.

For access to clinical trials, VA partners with the National Cancer Institute (NCI) in the NCI and VA Interagency Group to Accelerate Trials Enrollment program to increase access to clinical trials. VA providers can also refer patients to the National Institutes of Health Clinical Center for clinical trials.

**QUESTION 6: What is VA's plan to revise productivity expectations for Vet Center/RCS staff? How will these expectations incorporate the challenges of providing care in rural areas?**

Response: VHA believes that assessing the impact of current productivity standards is essential to ensuring the best outcomes for the Veterans we serve. We are currently assessing the counselor productivity elements in their performance plans,

including the development of questionnaires to collect feedback directly from Readjustment Counseling Services (RCS) counselors on both the positive and potentially negative effects of current productivity standards on client care. This assessment is expected to be completed in quarter two o FY 2022. VHA RCS continues to review these standards to ensure they encompass all service areas and modalities, to include rural areas.

**QUESTION 7: Does VA plan to develop a staffing model for Vet Centers? And if so, when will it be ready?**

Response: VHA through RCS has created and implemented an interactive Staffing Tool to assist leadership in effective and efficient counseling staff allocation within Vet Centers. RCS is currently working with VA's Workforce Resource Team to develop a Staffing Model for implementation in FY 2022.

**QUESTION 8: Does the RCS/Vet Center program have the capacity to provide care to additional servicemembers, veterans, and their families, beyond current eligibility? If not, what are the main considerations for such expansions (e.g. workforce, physical infrastructure)?**

Response: RCS has existing capacity to begin providing services for newly eligible individuals related to recent eligibility expansions in Public Law (P.L.) 116-176, the Vet Center Eligibility Expansion Act. RCS anticipates continued growth in demand for services and has requested additional budget allocations for FY 2023 to accommodate further eligibility expansion for reserve component members resulting from the implementation of section 762 of P.L. 116-283, the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 (NDAA), which becomes effective January 1, 2022, and continued growth related to P.L. 116-176. Additional expansions in eligibility beyond those previously mentioned would require further budgetary allocations to allow for growth in staffing and physical infrastructure to provide adequate service levels in direct correlation to the increase in eligible individuals.

**QUESTION 9: What is the current status of the implementation of the CARE for Reservists expansion of Vet Center eligibility to former Guard/Reserve?**

Response: Section 762 of the NDAA for FY 2021 (P.L. 116-283), allows VA, in consultation with DoD, to furnish counseling to assist eligible persons in readjusting to civilian life; eligible persons are any member of the reserve components of the Armed Forces who has a behavioral health condition or psychological trauma. This law became effective January 1, 2022. VA will move forward with implementation of this new eligibility while concurrently engaging in rulemaking to revise 38 C.F.R. 17.2000; VA also has consulted with DoD regarding the scope of this discretionary authority. VA met the January 1, 2022, implementation date in accordance with the statute.

**QUESTION 10: Please provide the data documenting any improvements in VCL service quality over the past year to two years. This should include measures of responsiveness, caller safety, referrals to care, etc. (not just volume of calls/texts/chats).**

Response: In FY 2021, VHA's Veterans Crisis Line (VCL) engaged approximately 1,819 calls per day, saw an additional 373 contacts through chat and text programs and submitted approximately 444 referrals per day to local VA Suicide Prevention Coordinators who contact Veterans to ensure continuity of care with local VA providers. VCL met its performance targets, answering 93.2% of calls in 20 seconds or less with an average speed of 9 seconds, and had a rollover rate of 0.096%. Regarding responsiveness, VCL saw a 31.53% reduction in rollover rate to the backup center, despite a 2.26% increase in average daily calls offered, a 27.91% increase in average daily text interactions and a 25.38% increase in average daily chat interactions. VCL also saw a 23.33% reduction in abandonment rate as compared to FY 2020. VCL saw a 6.55% reduction in average time to answer, meaning callers were waiting less time to receive service.

*Improvements in Caller Safety*

VCL consulted with substance use disorder experts from VA's Office of Mental Health and Suicide Prevention (OMHSP) and VA's Center of Excellence in Substance Addiction Treatment and Education to develop enhanced guidance and training for responders regarding substance use and overdose risk. VCL developed and provided staff updated training on the assessment of overdose risk as well as suicide risk in the context of substance use disorder, with a post-test requirement to ensure assessment of competency. In addition, VCL has developed enhanced criteria for monitoring staff on this subject, with coaching completed by silent monitoring staff to frontline responders. Consultations are also occurring with Poison Control Centers of America regarding realtime management of potential overdose cases.

Additionally, VCL updated its Standard Operating Procedure (SOP) for Emergency Dispatch in June 2021, to include additional action steps for responders when conducting emergency dispatch requests with VCL customers. The SOP update provided strengthened guidance for responders to ascertain customer status through the use of VCL resources such as reviewing incoming calls through VCL caller ID. Responders are mandated to discuss with supervisors before discontinuing outreach. SOP updates were communicated via all-staff training, with training compliance tracked in VA's Talent Management System. VCL is also currently evaluating outcomes of VCL emergency dispatches and facility transport plans, and these findings may inform additional process improvements.

Related to improvements in caller safety, in coordination with VHA's National Center for Public Safety, VCL implemented a new policy for Managing Critical Incidents and Near Misses, strengthening methods of addressing critical incidents and deaths by suicide. This policy implements an aggregate analysis process that VCL conducts to identify themes and determine any necessary actions to address quality, continuous improvement, or technological solutions in line with High Reliability Organization principles. In FY 2020, VCL also provided an intensive 8-hour training to Responders to educate and reinforce best-practices in critical areas including engagement using principles of Motivational Interviewing, violence risk assessment and lethal means safety. Additionally, in FY 2021 VCL developed a new "Information Only" Suicide Prevention Coordinator Consult for Abuse, Neglect, Exploitation and concurrent SOP released to the VHA field to better respond to callers reporting these concerns and provide appropriate follow-up and reporting.

As part of ensuring fidelity to VCL policy and quality assurance, VCL provides three silent monitors per month: two through quality monitors through the quality assurance team, and one by clinical supervisors. In FY 2021, VCL Quality Assurance Team monitored 9,254 crisis calls, 933 crisis chats and 1,191 crisis texts. The VCL Quality Assurance Team also completed 1,293 Social Services Assistant Monitors. In addition to quality assurance monitoring, supervisors also conduct monthly monitoring. In FY 2021, Crisis Supervisors met monthly goals of meeting with staff 1:1 and completing performance monitors.

In addition to these areas of expansion, VCL has developed a set of evidence-based interventions to support Veterans both during and after their call to VCL. The Caring Letters project was launched in June 2020. The intervention reached over 100,000 Veterans in the first 12 months after their call to the VCL, sending over 530,000 caring letters by July 2021. The Caring Letters intervention have been found to reduce the rate of suicide death, attempts and ideation for individuals receiving the communications.

VCL also launched a Peer Support Outreach Call Center in 2021. The Peer Support Outreach Call Center is an outbound call center focused on contacting and supporting Veterans at high-risk for suicide. This Center is staffed by trained Veteran peers who provide support through shared life experiences.

VCL also implemented a pilot program where a select group of responders has been trained in implementation of VHA standardized six-part safety plans. The pilot launched April 1, 2021 and is intended to run for 6 months or when 300 safety plans have been completed. Once compete, VCL will review results with senior leadership to determine next steps with regard to any broader implementation based on outcome data from the evaluation.

VCL also continues its strong commitment to program evaluation. This has included collaborating with VA Health Services Research and Development, Center of

Excellence (CoE) for Suicide Prevention and Serious Mental Illness Treatment Resource and Evaluation Center (SMITREC) to evaluate its effectiveness across multiple outcomes, including:

1. Proximal outcomes of the calls themselves including reduced caller distress, suicidality, and acceptance of a referral;
2. Intermediate outcomes such as successful linkage and engagement in local mental health care; and
3. Distal outcomes including reduced risk for suicide attempts and suicide.

The CoE for Suicide Prevention at the VA Finger Lakes Healthcare System and colleagues designed a VCL effectiveness evaluation project that aimed to examine changes in distress, suicidal ideation and suicidal urgency during VCL calls; link those calls with VHA medical records to examine changes in treatment utilization following VCL calls (including treatment contact and engagement in any VA health care and VA mental health care); and examine associations with changes in distress on health care utilization. This is the first evaluation to examine immediate outcomes of VCL calls and to link immediate outcomes with treatment contact and engagement.

To date, findings show that Veterans who call the VCL and provide identifying information are less distressed and have less suicidal ideation at the end of the call than at the beginning (Britton et al., under review). Additionally, Veterans who called the VCL and could be linked to medical records were more likely to make contact and/or engage in any health care and mental health care in the month following the call than in the month preceding the call (Britton et al., under review). Reductions in distress were associated with more days of mental health care in the month following the call. Reductions in suicidal ideation were associated with more days of any health care in the months following the call (Britton et al., under review). Ongoing evaluation is presently examining the association of immediate outcomes and treatment contact and engagement on risk for suicidal behavior.

The SMITREC looked at patient outcomes following calls to the VCL. Researchers analyzed VCL call data over a 5-year period and reported rates of mortality and suicidal behavior within 12 months following the initial call. They found that callers to the VCL may be at increased risk of death by suicide, with a suicide rate several times higher than the general Veteran population (Hannemann et al., 2020). The results also indicated that callers classified as moderate-to-high or high risk had significantly higher rates of suicide mortality and suicide behavior over the following 12-month period than those whose risk was moderate-to-low.

In addition to these studies looking at suicidal behaviors, VCL has invested in growing program evaluation efforts in collaboration with VA researchers, which also assesses other areas of importance to VCL ongoing improvements (e.g., treatment engagement, distress reduction and awareness and perception of VCL services). For example, in a

sample of VCL callers that agreed to a referral to a suicide prevention coordinator, approximately 83% of callers reported feeling better following their call (Rasmussen et al., 2017). Tsai and colleagues (2020) surveyed a nationally representative sample of 1,002 Veterans and found that the majority of Veterans surveyed were aware of the VCL service. Veterans calling the crisis line are more likely to engage in care after receiving a Suicide Prevention Coordinator consult (Britton et al., 2020). In another study, the majority of VCL users interviewed (81.6%) found the VCL to be helpful, and for those that were suicidal at the time of their VCL call, more than four out of five (84.6%) reported the VCL helped them not kill themselves (Johnson et al., 2021). In addition to these current program evaluation efforts, VCL is coordinating with the VA Partnered Evidence-Based Policy Resource Center in implementation of a 5-year VCL Program Evaluation plan. VCL looks forward to the ongoing growth of its program evaluation efforts to move forward its mission of providing the highest-quality services to Veterans and Service members.

Senator Sanders

**QUESTION 1: Of the 1.4 million veterans that are eligible for VA dental care, how many receive dental care through VA?**

Response: During FY 2021, VA managed the dental care of 450,446 of the 1.379 million Veterans eligible for comprehensive dental care. In-house care was provided to 407,678 Veterans, and 141,863 received dental care in the community. In addition to the 450,446 Veterans provided comprehensive dental care, 89,810 received care on a limited or focused basis due to a compelling medical condition or special program authority such as vocational rehabilitation or homelessness (61,337 in-house and 33,473 through community care). Please note that some Veterans receive care through both in-house and community care providers, so the addition of in-house and community care will not equal the total value.

**QUESTION 2: How many veterans purchase dental insurance through the VA Dental Insurance Program (VADIP)?**

Response: Through September 2021, 133,022 Veterans and Civilian Health and Medical Program of VA beneficiaries have purchased VADIP policies.

**QUESTION 3: What are the average rates paid by veterans for insurance policies through the VADIP?**

Response: The average monthly rate is $42.12.

**QUESTION 4: How many veterans receive dental care through the VA Dental Pilot Program?**

Response: Since pilot program implementation on July 1, 2021, 966 unique Veterans have received care and over 3,221 procedures have been performed.

**QUESTION 5: What types of partner organizations and facilities is VA working with to implement this program?**

Response: VA is connecting enrolled Veterans who are not eligible for VA dental services with partnering community Dental Care Providers (DCP) who provide pro bono or discounted services (e.g., federally qualified health centers and dental schools). The initial pilot program includes four partnerships with community DCP organizations: New York University School of Dentistry (NYU), CompleteCare Health Network, Rutgers School of Dentistry and Zufall Health Center. VA is exploring opportunities for expanded pilot implementation through similar partnerships with DCPs in additional geographic locations. Strategic partnerships to help facilitate pilot implementation and expansion

include the American Dental Association and National Association of Community Health Centers.

**QUESTION 6: How many dental facilities participate in the VA Dental Pilot Program?**

Response: The initial pilot includes four DCP organizations consisting of 18 sites of care and a mobile dental van.

**QUESTION 7: Can you describe some of the positive health outcomes that have resulted from the VA Dental Pilot Program?**

Response: VA is analyzing the sites' patient satisfaction surveys and working to create a VETSmile Survey. VA is also working to establish a partnership with CareQuest to help identify outcome measures that can be used to measure program impact on health outcomes and to demonstrate a positive whole health correlation.

**QUESTION 8: Would you say that the VA Dental Pilot Program has contributed positively to the overall well-being of its patients?**

Response: Early Veteran feedback, including a testimonial video filmed by partnering DCP NYU that features a Veteran participant, demonstrates that Veterans are positively impacted by the VETSmile program. As the program expands, we are beginning to understand the positive effects of dental care for Veterans, e.g., reengaging Veterans with VA services, improving nutrition for Veterans, improving Veteran's employability and improving access to care for rural Veterans. The initial months of the VETSmile pilot program have been focused on implementation and early collection of utilization data, but as the program matures, VA is working to measure and evaluate clinical outcome and quality data.

The testimonial video is publicly available and can be accessed using the following link: https://youtu.be/dRwlvcWPHyU.

Senator Blumenthal

**QUESTION 1: Dr. Brill (VA): The VA spoke highly of the Peer Specialist Program in its testimony. May you share the positive impacts you expect the Peer Specialist Program to achieve for our veterans?**

Response: VHA Peer Specialists work in a variety of different health care programs which include outpatient, inpatient and residential mental health programs, homelessness programs, primary care patient-aligned care teams (PACT) and also the national VCL's new Peer Support Outreach Call Center, where they provide outreach calls to offer short-term telephone-based peer support services to Veterans who recently called VCL. In all of these programs, peer specialists work alongside other health care professionals and bring a unique perspective to the interdisciplinary treatment teams as they work toward the teams' shared goals to provide quality health care services as Veterans use the services of the programs where the peer specialists are assigned.

The expertise of peer specialists is founded in their personal experiences of overcoming challenges with their mental health and wellness, resulting in them successfully living in recovery in their daily lives. Peer specialists meet with Veterans individually, in groups, or both, and they have been trained to use their personal lived experiences with recovery to promote hope and assist Veterans to identify and achieve self-determined goals for recovery and personal wellness. They assist Veterans with personal goal setting and problem solving. They help Veterans identify their strengths, resources and skills that support their personal goals. Peer specialists use a host of recovery tools to help Veterans learn new coping strategies to improve their self-management over their mental health conditions. They assist Veterans with navigating VA's health care system, teach self-advocacy skills and empower Veterans to reconnect with others and find a sense of belonging and purpose both in VA and in their communities.

Similar to other health care professions, it can be challenging to point to peer specialists' specific impacts on program outcomes and health care outcomes for Veterans because Veterans' health care services are delivered by interdisciplinary treatment teams in the VA health care system. Programs' outcomes and Veterans' health care outcomes are impacted by the contributions of each member of the interdisciplinary treatment team, including the peer specialists. Research studies are working to try to provide some answers to questions about peer specialists' impacts on health care outcomes.

Research evidence about the positive impacts of peer specialists' services on patient outcomes is still in the early stages of development in and outside of VHA due to variability in both research design and how studies have defined peer support services. Despite this, overall, there is a positive signal that there are benefits for individuals who

receive peer support services as part of their treatment services for mental health and substance use conditions. Studies have found improvements in mental health treatment engagement, treatment retention, reduction in symptoms of mental illness, improvements in abstinence from addictive substances and improvements on quality-oflife measures for individuals who received peer support services as part of their mental health care services. There are reported benefits specifically for Veterans in working with peer specialists in the VA health care system, including increased hopefulness, increased treatment engagement, reduced isolation, reduced symptoms of mental illness, improved functioning and increased community integration. An additional benefit reported for Veterans in their work with peer specialists is that the peer specialists have personal understanding of the Veterans' unique experiences in a military context. For Veterans, being aware that they are working with a fellow Veteran who has had similar military experiences and post-military personal struggles builds trust in the peer specialist as someone who can help because the peer specialist "has been there, too." Peer specialists also facilitate opportunities for Veterans to reduce their isolation and socially connect with fellow Veterans in their communities, which has additionally been seen as a benefit for Veterans who receive peer support services in the VA health care system. As an additional example of the impacts that peer specialists have on Veterans' outcomes, VHA's final report to Congress regarding the implementation of section 506 of the VA MISSION Act of 2018 (P.L. 115-182) found that implementation of peer specialists in primary care PACT was highly beneficial for Veterans and was associated with Veterans' increased participation and engagement in care. VHA also found that Veterans valued the peer specialists' services in PACT, and that dedicated and sustained funded was essential to optimize successful implementation of peer specialists in PACT at VHA facilities.

The Peer Support Services Section of OMHSP serves as an operational partner for several VA research investigators who are studying the implementation of peer specialists in a variety of different mental health care settings, and they are looking at the benefits of peer support services for Veterans' health care outcomes. If the studies' results demonstrate the efficacy of peer specialists' services, the Peer Support Services Section will assist with dissemination of the outcomes through the Section's wellestablished communication systems (webinars, email groups, quarterly national newsletter) to encourage leadership at VHA facilities to view working with peer specialists as beneficial for Veterans' health care outcomes and the VA health care system so that the facilities' leaders will keep peer specialists in mind as they determine funding allocations for new staff positions.

**QUESTION 2: Dr. Brill (VA): How do you plan on implementing a strategic recruitment initiative to include more Peer Specialists into the program that will reflect the racial and ethnic demographics of the veteran population?**

Response: Tables 1 and 2 (below) include the reported racial and ethnic demographic data of VHA's current peer specialist workforce as well as the most current

racial and ethnic demographic data available about Veterans who used VHA's services across FY 2020. As shown in both Table 1 and Table 2, the VHA peer specialist workforce generally represents a greater range of diverse racial and ethnic backgrounds as compared to Veterans who use VHA services. There are proportionally fewer white peer specialists (45.1%) than white Veteran VHA service users (63.5%). There are significantly more black peer specialists (43.6%) than black Veteran VHA service users (16.7%). There are more Hispanic peer specialists (7.3%) and more American Indian/Native American peer specialists (1.2%) than Veteran VHA service users in either of those demographic categories. Although the total number and percentage of FY 2020 Native Hawaiian and Pacific Island Veteran VHA service users is unknown, 0.6% of the current peer specialist workforce identify in this demographic category as compared to 0.21% of the FY 2020 total U.S. Veteran population. The Asian demographic category is the only one, besides the "Other" demographic category, where Asian peer specialists (1%) are proportionally fewer than Asian VHA Veteran user service users (1.9%). However, this difference between Asian peer specialists and Asian Veteran VHA service users is minor.

**Table 1. FY 2020 Racial and Ethnic Demographic Data about Peer Specialists and Veterans**

| | White | | Black | | Hispanic | | Asian | |
|---|---|---|---|---|---|---|---|---|
| | **Number** | **%** | **Number** | **%** | **Number** | **%** | **Number** | **%** |
| **Peer Specialists** | 540 | 45.1% | 522 | 43.6% | 87 | 7.3% | 12 | 1.0% |
| **Veterans** | 3,933,494 | 63.5% | 1,033,428 | 16.7% | 411,972 | 6.65% | 117,709 | 1.9% |

**Table 2. FY 2020 Racial and Ethnic Demographic Data about Peer Specialists and Veterans (Continued)**

| | Native Hawaiian/ Pacific Islander | | American Indian/ Native American | | Other** | | Total Number |
|---|---|---|---|---|---|---|---|
| **Peer Specialists** | **Number** | **%** | **Number** | **%** | **Number** | **%** | |
| | 7 | 0.6% | 14 | 1.2% | 15 | 1.3% | 1,197 |
| **Veterans** | Not available* | Not available* | 39,547 | 0.6% | 124,935 | 2.02% | 6,192,031 |

*FY 2020 data about Veteran VHA service users did not include specific demographic data about Veterans who identify as Native Hawaiian and Other Pacific Islander. Information about the Native Hawaiian and Other Pacific Island Veterans was likely

captured in the "Other" category. However, according to FY 2021 VA data about minority Veteran statistics, Veterans who identify as Native American and Other Pacific Islander were estimated to be 0.21% of the total Veteran population in the United States. (Retrieved from https://www.va.gov/HEALTHEQUITY/dataviz/minorityVeterans.html.)

** The "Other" Category included peer specialists and Veterans whose racial and ethnic background was not indicated in available VHA records.
OMHSP collaborates with the VHA Office of Workforce Management and Consulting to provide guidance to VHA medical centers' Human Resources leaders and facility management teams regarding policies on peer specialist certification requirements, hiring and promotions for peer specialists. To support hiring Veterans as new peer support staff members, OMHSP provides funding for the required peer specialist certification, which GS-5 Peer Support Apprentices access during a 1-year term appointment that also allows them to obtain supervised, on-the-job experience, thus making them eligible for open peer specialist staff positions at the VHA facilities. Additionally, VHA's OMHSP has informed Veterans Service Organizations and nonprofit peer specialist certification training organizations about the qualification standards requirements, peer specialist certification requirements and roles for peer specialists in the VA health care system. Available peer specialist positions are posted on USAJOBS, and VHA facilities use locally available resources for sharing announcements with eligible Veterans regarding available peer specialist positions. VHA facilities commonly recruit and hire peer specialists from within the same communities where Veterans who use the local VHA facility's services live.

The VHA peer specialist workforce represents all branches of U.S. military service, and the peer specialists usually reside in the same communities as the Veterans they serve at the local VHA facilities. As seen from the demographic data on the previous page, VHA's recruitment and hiring efforts thus far have been successful in hiring a racially and ethnically diverse peer specialist workforce that reflects the Veteran populations served in the VA health care system. VHA will continue its consistent efforts to recruit and hire knowledgeable and highly skilled peer specialists and provide peer specialists with ongoing training to enhance their technical skills and their cultural competency to provide culturally responsive peer support services to all Veterans they serve in their daily work.

**QUESTION 3: Dr. Carroll (VA): I understand the suicide rate among our younger veterans and Native American are staggeringly high, so may you share how these populations, respectively, have engaged with the Peer Specialist Program in the past?**

Response: Our most recent data show that suicide rates are rising among younger and Native American Veterans, and that younger Native American Veterans may be at particular risk. For this reason, we are working to improve VA suicide

prevention efforts for Native American Veterans in partnership with other key VA offices, such as the Office of Rural Health and OMHSP. This includes supporting suicide prevention outreach and engagement with tribal communities through community-based suicide prevention.

**Question 3a: How will you look to improve this over the course of the next five years?**

Response: As stated in response to Question 1, OMHSP provides oversight over the peer specialist profession, but the approximately 1,200 current peer specialists do not all work in one specific program. There is not a VA Peer Specialist Program. Instead, similar to colleagues from other health care professions, the peer specialists work in a variety of different mental health care programs throughout the VA health care system.

Peer specialists can be an asset in supporting the mental health recovery of younger Veterans, Native American Veterans and other Veterans who are at risk for suicide. As part of their peer specialist certification training and expected scope of practice for their work in VHA, peer specialists are trained how to use their personal recovery stories to provide support to be of benefit to fellow Veterans who are struggling with issues with their health, functioning and quality of life. Peer specialists are expected to be effective communicators and active listeners, assist Veterans in exploring their personal recovery and wellness goals, support Veterans in learning and using healthy self-help coping skills and practices and empower Veterans to advocate for themselves. The peer specialists function as role models by exhibiting competency in personal recovery and use of coping skills. The peer specialists assist Veterans in treatment, based on the principles of recovery, wellness and resiliency, by promoting self-determination, personal responsibility and the empowerment inherent in self-directed recovery. By inspiring hope that recovery, wellness and resiliency are achievable goals, the peer specialists can empower Veterans with mental health conditions to achieve their personal recovery goals.

Regarding Veterans' access to peer support services by VHA Directive 1163, the need for peer support services must be documented in the Veteran's treatment plan. The treatment plan documentation must include the referral of a Veteran to a peer specialist by the Veteran's clinical treatment provider and specify how the peer support services will be delivered, in what context, for what duration and what the goals of the intervention are. Peer support services do not occur in isolation but are a component of the overall services offered by the programs in which they exist. Peer specialists provide individual and group-based peer support services to Veterans who are using the health care services of the specific programs where the peer specialists are assigned. These programs include outpatient, inpatient, and residential mental health programs, homelessness programs, primary care PACT and the national VCL's new Peer Support Outreach Call Center, where the peer specialists on staff provide outreach calls to offer

short-term telephone-based peer support services to Veterans who recently called the Veterans Crisis Line. Peer specialists are integrated members of the interdisciplinary treatment teams in all these programs, and they bring a unique perspective to the treatment teams as they work with colleagues toward the teams' shared goals to provide quality health care services to the Veterans who use the services of the programs.

Senator Sinema

**QUESTION 1: The VA states in its submitted testimony that to implement the requirements of section 2(b) S. 2852, the Long-Term Care Veterans Choice Act, the VA "would have to expand operations and of the existing MFH program to ensure timely placement and payments for Veterans requesting placement. Requirements associated with additional monitoring and data tracking would necessitate additional staff and information technology support." Given this legislation would expand an already existing program, does the VA anticipate that the needed information technology support will be an expansion of the current system, or a new platform? If the latter, please explain why the current platform cannot be used?**

Response: The reporting requirements in the legislation would create requirements for additional data capabilities. VA would need an additional full-time Program Administrator and full-time Data Analyst to (a) procure, implement and sustain the new data system(s); (b) align and enhance any currently available systems; and (c) sustain monitoring for expected reporting. To monitor and track the 900-bed capacity, a system for tracking the patient census will need to be procured and implemented for VA to track bed capacity. VA is currently expanding its Medical Foster Home (MFH) program but given the 900-bed limit in the legislation, we would meet that limit with an addition of only a few (2 or 3) patients at each facility. At that point, the program would be at maximum capacity, which is why an accurate, real-time bed-tracking system would be critical to ensure that these limited resources are not under-utilized. There is not any national data system for tracking the MFH bed capacity, and any bed tracking is currently done only at a local level without a central report. In addition, current capture of MFH reporting, being integrated with VA's VISTA system, will not translate to the new EHR platform because MFH program data are not considered "patient data." Additional information technology support is needed to support MFH, and further support would be required if the bill became law.

**QUESTION 2: The VA testimony estimated the new costs associated with section 2(b) would be $1.19 million in FY 2022 and $19.10 million over 5 years. The VA also estimates a cost savings from section 2(a) would be $15.32 million in FY 2022 and $146.22 million over 5 years. Please explain further why it is that this legislation will ultimately save the VA money.**

Response: The average cost of Community Nursing Home is more expensive than the average cost for VA to provide MFH care. As Veterans use the proposed MFH program in lieu of Community Nursing Home Care, the cost difference should reduce VA's need for appropriated resources for this purpose. Cost savings figures were based on an FY 2022 (October 1, 2021) start. Estimates would need to be recalculated based on the timing of potential enactment and an identified implementation date. We are

concerned with the short period of time that would be provided by the bill to implement this new authority if it were enacted; we believe 1 year would be more appropriate than 90 days to ensure that contracts or agreements are in place, and that policies and regulations, where applicable, are in effect.

**QUESTION 3: What type of savings could an individual veteran in Arizona see if they are currently paying out-of-pocket for their care in a Medical Foster Home now and would qualify for VA covered-care under this bill?**

Response: **VHA has active Medical Foster Home (MFH) programs operating in Tucson and Prescott. These MFH programs in Arizona provide self-reported data to the National GEC Office average monthly costs of MFH care. As such, current costs are reported to be $3000-$3100/month per Veteran. VA-covered MFH care under this bill should therefore translate to annual cost savings of approximately $37,000 per Veteran.**

Senator Blackburn

**VA's press release on October 5, 2021, announced that they were decommissioning the Office of Community Care, and noted that VHA conducted a functional assessment in the fall of 2020 to reach this decision.**

**QUESTION 1: Can you please provide the committee and my office a copy of the functional assessment report?**

Response: A copy of the Functional Assessment report is attached below. This document was prepared by a non-VA entity, and while VA concurs in the general approach recommended and is acting in accordance with that approach, the specific views and statements expressed within the document do not necessarily reflect the views or opinions of the Department

IVC Functional Assessment Report_FI

**QUESTION 2: Can you please provide the committee and my office a copy of data around how many community care appointments the VA has completed per month in 2019, 2020, and 2021?**

**Question 2a: Not referrals to community care but appointments in the community.**

Response to Q2 and Q2a: The attached spreadsheet below includes appointment data for FY 2019, 2020, and 2021. The 2nd half of FY 2021 includes an additional estimated number of appointments that occurred but are yet to be reported as VA has not received all community care claims from that duration.

SVAC Legislative Member QFR's 11.12

**QUESTION 3: Can you provide to the committee and my office how many veterans were eligible for community care under the VA MISSION Act in 2020 and 2021?**

**Question 3a: Of those veterans, how many were offered community care and how many elected to receive community care?**

Response to Q3 and Q3a: VA does not have a complete dataset that would enable precise answers to these questions. Our systems do not allow for full capture and reporting of all Veterans eligible for community care (CC) nor do the systems consistently or automatically capture those eligible Veterans who opt-out of CC. Currently, VA staff must manually document Veteran CC eligibility using the consult toolbox and the Veteran's choice to opt-in or out of CC. This manual work is not done consistently limiting the availability of the requested data. Additionally, it is important to note that CC eligibility is specific to an episode of care; eligibility depends on an individual Veteran's specific care needs, distance to the specific type of care needed, system availability at the time care is requested and other criteria set forth in statute. Although VA does not currently have the ability to capture the total number of CC eligible Veterans, nor the episodes of care for which they were eligible, VA continues to evaluate methods of capturing this information through future upgrades to our systems. Due to the system limitations discussed above, VA is unable to capture the total number of Veterans eligible for CC and how many of those Veterans were offered CC. In terms of Veterans who elected to receive CC, the information on Veterans with an active or completed referral is included below:

- Fiscal Year 2020 - 1,759,056 Veterans
- Fiscal Year 2021 – 1,884,822 Veterans
  **This excludes Veterans with emergency care, beneficiary travel, and Geriatrics and Extended Care referrals.*

**QUESTION 4: When the VA cancels a veteran's appointment without their permission, like they did during COVID, does this reset the wait time clock for eligibility for community care?**

VA Response: No, there is no reset in wait time when appointments are deferred or canceled**.** VA calculates wait time eligibility, for purposes of determining whether VA can offer an appointment within the designated access standards established under 38 C.F.R. 17.4040, based on the date of request for an appointment, unless a later date has been agreed to by the Veteran in consultation with the VA health care provider. The wait time is not "reset" when VA cancels a Veteran's appointment. When an appointment is cancelled by VA, the original date of the request determines if the Veteran is eligible for CC based on the designated wait time access standards.

**Department of Veterans Affairs**
**February 2022**

# Integrated Veteran Care Functional Assessment

## Final Report

## Veterans Health Administration (VHA)

Department of Veterans Affairs

December 17, 2020
Version 2.0

## Executive Summary

The Veterans Health Administration (VHA) established a multidisciplinary Integrated Project Team (IPT) to perform a functional review focused on improving the process of how VHA manages Veterans' access to care through clinical, administrative and financial operations. The assessment methodology employed in this work was derived from the Government Accountability Office's (GAO's) program evaluation guide, *Fragmentation, Overlap, and Duplication: An Evaluation and Management Guide*. The IPT produced recommendations and courses of action (COAs) based on the assessment findings to streamline coordination of roles related to direct care and community care.

The assessment team conducted 70 interviews, including 12 with VHA Central Office Program Offices, 6 with Office of Veterans Access to Care (OVAC), 18 Veterans Integrated Service Network (VISN) leadership teams, 21 with Office of Community Care (OCC), and 9 with VHA Finance Program Offices. The team also interviewed leaders of four external health systems to provide industry best practices among core operational functions.

The assessment team findings:

> ***Finding 1***: Fragmented finance and access functions within VHA Office of Finance, OVAC, OCC and VISNs
>
> ***Finding 2***: Disjointed care coordination system between direct and community care
>
> ***Finding 3***: Lack of common tools and resources to effectively manage care delivered to Veterans across the enterprise
>
> ***Finding 4***: Opportunity to enhance access by optimizing direct care
>
> ***Finding 5***: Duplicative or overlapping administrative, financial and operational functions within the OCC

The following recommendations and associated recommended actions were developed to address these findings with focus on the needs and interests of the Veteran, ensuring seamless care at the right place, at the right time and by the right provider. These recommendations are directly tied to address findings discovered during assessment team interviews. They are:

| | Finding Addressed | | | | |
|---|---|---|---|---|---|
| **Recommendation** | 1 | 2 | 3 | 4 | 5 |
| Integrate finance functions across VHA[1] | X | | | | X |
| Establish an Assistant Under Secretary for Health-Integrated Veteran Care[2] | X | X | X | | |
| Design enterprise Integrated Veteran Care model[3] | X | X | X | X | X |
| Establish Network Directors (NDs) as operational leaders | X | X | X | X | |

This assessment proposes a notional timeline for full implementation of the recommendations to begin January 1, 2021 and conclude by September 30, 2021.

[1] May require Congressional notification and/or Congressional approval
[2] May require Congressional notification and/or Congressional approval
[3] May require Congressional notification and/or Congressional approval

# Table of Contents

# 1. Introduction

The Department of Veterans Affairs (VA) Veterans Health Administration (VHA) implemented two monumental pieces of legislation (Veterans' Access to Care through Accountability, Choice and Transparency Act (VACAA) of 2017 and VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018) to transform the VHA health system, while proactively initiating a modernization journey of multiple, continuous improvement initiatives to better achieve its critical missions. VHA initiated this assessment to advance the modernization journey and continue efforts toward key transformation principles aimed to reduce inadvertent overlap and duplication of core organizational access and financial functions.

**Key Transformation Principles**

- Operate as a high reliability, Veteran-centric organization, with a commitment to Zero Harm
- Establish regional/market operations as the "effector arm" and catalysts for change
- Establish clear accountabilities and authorities, pushing decision rights as close to the point of care as feasible
- Align operations at local, VISN and Central Office. Consolidate shared administrative services and create service-level agreement

VHA established a multidisciplinary Integrated Project Team (IPT) to perform a functional review focused on improving the process of how VHA manages Veterans access to care through clinical, administrative and financial operations. The IPT was co-chaired by the Acting Deputy Under Secretary of Health (ADUSH) and the Assistant Under Secretary for Health for Operations (AUSH-Operations). The IPT focused primarily in two main areas, finance and access, and was comprised of four Network Directors (NDs), the VHA Chief Financial Officer (CFO), the Deputy CFO, the AUSH-Community Care and the VHA Office of Veterans Access to Care (OVAC) Executive Director.

VHA commenced this effort to evaluate the current state of access and finance functions. The objectives were:

- Determine business functions and capabilities supported by program offices in Community Care, Finance and Access
- Identify fragmentation, overlap and duplication of program office activities
- Map interlinkages of program office functions with Veterans Integrated Service Networks (VISNs)
- Assess program office alignment with VA/VHA Strategy
- Develop Courses of Action (COAs) to optimize functional alignment to advance integrated Veteran care

The IPT was charged to provide findings and recommendations to VHA leadership by December 18, 2020.

# 2. Methodology

The Functional Assessment applied the methodology used in the VHA Modernization Functional Assessment Review in 2017 to streamline VHA Central Office. The methodology is derived from

the Government Accountability Office's (GAO) program evaluation guide, *Fragmentation, Overlap, and Duplication: An Evaluation and Management Guide*:

1. Identify program fragmentation, overlap and duplication
2. Identify the effects of program fragmentation, overlap and duplication
3. Validate effects and assess and compare programs
4. Identify options to increase efficiency or reduce or better manage fragmentation, overlap or duplication

Figure 1 depicts GAO's recommended four steps and related tasks.


*Figure 1. Fragmentation, Overlap, and Duplication: An Evaluation and Management Guide Methodology*

VHA's Functional Assessment seeks to validate negative outcomes and compare the functions of VHA programs. Outputs of this Functional Assessment identify options and support decision-making for increased efficiency or reduced fragmentation, overlap and duplication.

In focusing this assessment on access to care and financial management, the IPT defined specific access and finance functions using VHA's Business Function Framework (BFF). VHA's Functional Assessment conducted employee interview sessions as part of ongoing efforts to minimize duplication between program offices and VISNs and encourage uniform collaboration to meet VHA's strategic goals. The interview sessions provided a perspective of VISN and program office staff roles and responsibilities as well as identification of opportunities for consolidation between organizations. Interview sessions were conducted virtually (i.e., web and telephone conference calls), as the most convenient and efficient means of collecting information.

Over 70 interview sessions (see Appendix A for list of interviews) were conducted over the course of approximately three weeks, with each session lasting at least 60 minutes. The interview sessions were conducted to obtain staff input across the enterprise. Interview sessions used structured and semi-structured techniques through virtual discussions. The purpose of hosting many individual interviews was to gather different opinions as they pertained to each office's role in access to care for Veterans. Participants shared their experiences, insights and recommendations to functional collaboration and consolidation.

The interviews were the primary means to provide the IPT the information upon which to analyze organizational roles and responsibilities, limitations/barriers and opportunities for improvement. A consistent set of questions was used regarding the functions defined in the BFF to objectively gain understanding and perspective from both program offices and VISNs as to their roles in executing access and finance functions. While the 2017 VHA Modernization Functional Assessment included a data call to all program offices to collect ancillary data, due to the focused scope of this assessment and sensitivity to operations during COVID-19, a parallel data call for this effort was not conducted. In some cases, the assessment team did ask for additional information to clarify interview responses. This assessment is scoped specifically around access and finance functions.

# 3. Findings

Review of the observations and recommendations from the interviews, informed by analysis of the Functional Assessment Team and discussions with the IPT, led to the following findings:

## 3.1 Fragmented Finance and Access Functions within VHA Office of Finance, Office of Veterans Access to Care (OVAC), Office of Community Care (OCC) and VISNs

Multiple program offices, the OVAC, the OCC and the VISNs are all responsible for a portion of access care coordination. This results in inconsistent guidance sent from VHA Central Office to the VISNs and VA Medical Centers (VAMCs) on how to execute access care coordination, contradictory messages on when to use direct care versus community care, fragmented management of the direct and community care appropriation and duplication of efforts across the enterprise.

## 3.2 Disjointed Care Coordination System Between Direct and Community Care

There are multiple access care coordination models currently within VHA, supporting direct care and community care. The end-to-end business process for consults, referrals, authorization, budget execution and claims payment has become fragmented based on where the Veteran seeks care. As a result, there exists varying customer experiences and timeliness of care for the Veteran between the direct care and Community Care Network (CCN).

## 3.3 Lack of Common Tools and Resources to Effectively Manage Care Delivered to Veterans Across the Enterprise

VHA Central Office, VISNs, VAMCs, the OCC and other program offices lack consistent and timely records, claims, data and outcomes from community providers on care received outside of the direct care system. As a result, each entity may create its own tools and dashboards to try to determine financial and patient information for community services. This results in inconsistent data and presents challenges for the system to accurately plan annual budgets, decide on staffing and resourcing and make decisions on the best care for Veterans.

## 3.4 Opportunity to Enhance Access by Leveraging Direct Care

Each VISN and VAMC has unique geographic, population and regional needs and challenges in delivering direct care and utilizing community care. The current application of the community care standards does not provide flexibility in determining if direct care is a better solution for the Veteran based on the expertise in the local and regional market versus the community, and the

timeliness of receiving the care in the community. As a result, the decision to use community care may not provide the best outcomes to the Veteran.

### 3.5 Duplicative or Overlapping Administrative, Financial and Operational Functions within the OCC

To meet the Choice Act and MISSION Act requirements, the OCC developed administrative and operational functions critical for implementation success. As a result, there exists duplication and an opportunity to streamline VHA in many areas, including financial management, policy and planning, communications, data analytics and resource management.

## 4. Recommendations

The following steps should be considered to ensure Veterans' care focuses on the needs and interests of the Veteran and occurs at the right place, at the right time, by the right provider and is seamless across providers and settings. For these recommendations to be successfully executed, they will need to be resourced appropriately with finance and staffing at the VAMC, VISN and VHA Central Office level. These recommendations should be implemented in a phased approach to maximize adoption of the recommendations and sustainment of these changes.

### 4.1 Integrate Finance Functions across VHA (Addresses Findings 3.1 and 3.5)[4]

Streamlining and consolidating Community Care functions, such as financial management, revenue operations and resource management within the Office of Finance at VHA Central Office will provide operational efficiencies and effectiveness and reduce the duplication across the enterprise. The summarized consolidation of functions is as follows:

1. The Office of Finance will assume responsibility for OCC Financial Management functions, Resource Management and Revenue Operations.

The following functions are recommended to be consolidated under the purview of the identified offices below:

| Consolidated Organization/Office | OCC Functions To-Be Consolidated |
|---|---|
| Office of Finance | Revenue Operations, Financial Management, Resource Management |

As noted in the findings, significant fragmentation, overlap and duplication exists today in access and finance functions. Resourcing the new operating model through the realignment of existing resources should be prioritized and should consider recent and/or current initiatives (e.g., Referral Coordination Initiative, Finance Working Group, Enterprise Data team). The implementation plan to achieve the new functional alignment should include detailed organizational design to ensure the proper operational effectiveness of the realigned functions.

[4] May require Congressional notification and/or Congressional approval

## 4.2 Establish an AUSH for Integrated Veteran Care[5] (Addresses Findings 3.1, 3.2, and 3.3)

An AUSH for Integrated Veteran Care (AUSH-IVC) will more effectively deliver a unified enterprise strategy on access care coordination, direct roles and responsibilities at VHA Central Office for access care coordination, coordinate enterprise access functions spanning direct and community care and report on access performance.

This executive-level office will provide clear and consistent guidance on the use of direct care and community care, provide VISN and VAMCs one set of tools to support the execution of access functions, and provide a unified Veteran-centric access management strategy and performance management framework (to include telehealth and other new modalities, and timeliness) that is uniformly applied to direct and community care. This will allow for seamless services for the Veteran.

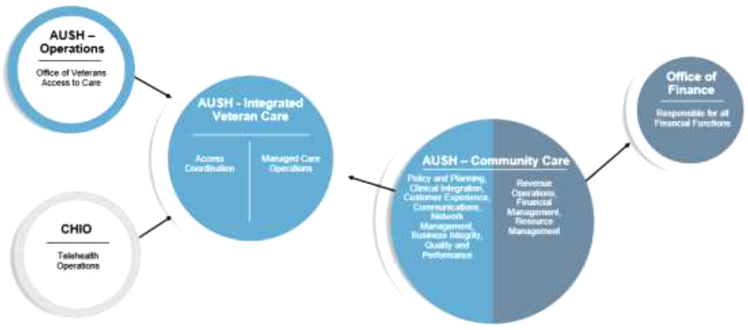



*Figure 2 Proposed Notional Future State Concept Diagram*

The AUSH-IVC will be the single point of coordination of supporting functions to the VISNs in executing the new access operating model. A formal request will be sent to Congress to establish an AUSH-IVC.

| Recommended Actions |
| --- |
| ▪ Develop charge memo to communicate the creation of this position with the conditions for Initial Operating Capability and Full Operating Capability of this office.<br>▪ Establish and execute change management plan in conjunction with the design and implementation of a new enterprise access operating model (recommendation 3) |

[5] May require Congressional notification and/or Congressional approval

## 4.3 Design Enterprise Integrated Veteran Care Model[6] (Addresses Findings 3.1, 3.2, 3.3 and 3.5)

A common enterprise access care coordination model (as depicted in Figure 3, to include virtual care and other modalities) applied in each VISN spanning direct and community care is needed to provide Veterans with seamless care at the right place, at the right time and by the right provider.

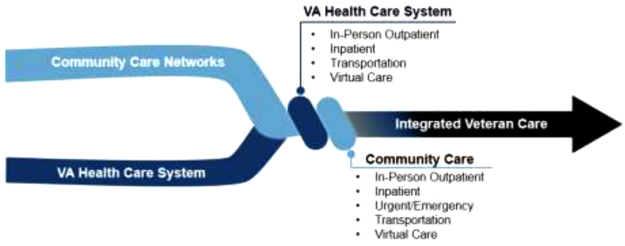



*Figure 3 Integrated Veteran Care Model*

To successfully design and implement this model, VHA requires a unified information view for care coordination (patient and cost data) with views at every level of the organization. This will provide VAMCs and VISNs appropriate data to make decisions on delivering the best care possible to the Veteran while efficiently aligning support from program offices and other supporting entities.

The design effort will make recommendations as to which functions should be consolidated and integrated. The effort will be scoped to include:

1. Integration of OVAC and OCC access care coordination functions under the AUSH-IVC.
2. Reassignment of the OCC managed care operations (eg. CCN, CHAMPVA) to the AUSH-IVC.
3. Assignment of accountability for the current functions of care coordination activities related to access to AUSH-IVC and definition of levels of support required from other program offices to meet enterprise outcomes for Access.

As noted in the findings, significant fragmentation, overlap and duplication exists today in access and finance functions. Resourcing the new operating model through the realignment of existing resources should be prioritized and consider recent and/or current initiatives (e.g., Referral Coordination Initiative, Finance Working Group, Enterprise Data Team). The implementation plan to achieve the new functional alignment should include detailed organizational design to ensure the proper operational effectiveness of the realigned functions.

[6] May require Congressional notification and/or Congressional approval

| Recommended Action |
| --- |
| ▪ Direct Modernization Access Lane of Effort to conduct organizational design to integrate access care coordination functions |

### 4.4 Assign NDs Roles as Operational Leaders (Addresses Findings 3.1, 3.2, 3.3 and 3.4)

NDs are the operational arm of the care delivery system and they have a holistic view of their network and its unique needs for an access care coordination model. By assigning NDs as the accountable party, they can create operational strategies to supplement the direct care system with community networks based on regional needs. To execute the strategies, NDs need input into and transparent view of direct and community care budgets for their region, flexibility to shift funds in coordination with Finance to best cover care costs within direct and community care, and drive critical make/buy decisions for services provided to Veterans. NDs are the supported accountable entity for executing access operations in their respective regions. They are empowered to make decisions on the use of direct care and community care to best meet the needs and interests of Veterans entrusted in their care. NDs have operational authority over budget resources and staff performing access care coordination functions within their region. The enterprise can consistently align supporting functions around the NDs to support operational decision-making and care delivery operations across the health system.

The NDs will report through the AUSH-Operations to maintain consistent operations for access care coordination and ensure best practices are distributed throughout VHA. As the accountable officials for access operations, NDs should oversee the development the operational model for integrated Veteran care to ensure it is resourced with necessary clinical and administrative staff reporting through the NDs. Supporting functions within the networks that do not report through the NDs should have formally defined levels of support to achieve the operational outcomes set by the NDs.

| Recommended Action |
| --- |
| ▪ Develop charge memo to communicate this intent with the conditions for Initial Operating Capability and Full Operating Capability of this office.<br>▪ Establish implementation plan that includes detailed organizational design and analysis; the implementation plan may consider a phased approach to properly assess, design, and implement the to-be organization. |

## 5. Notional Timeline

To implement these recommendations, VHA should begin these initiatives concurrently based on the interdependencies to execute each recommendation as shown in Figure 4.

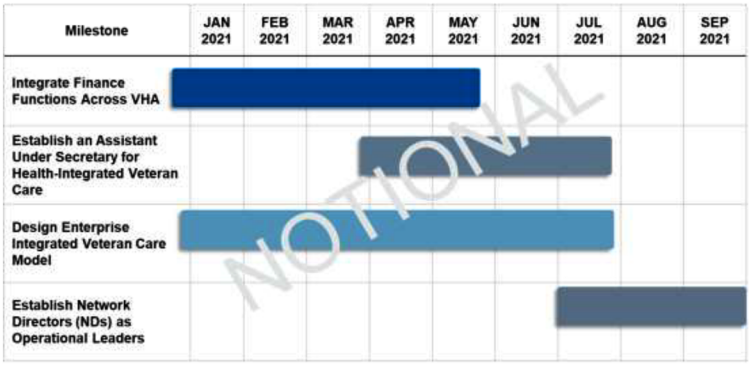



*Figure 4 Recommended Notional Implementation Timeline*

## 6. Conclusion

This Functional Assessment identified the opportunity for VHA to define and create an access care coordination model with clear business functions and capabilities supported by VISNs, AUSH-IVC and Office of Finance. The four recommendations presented address specific areas to focus on the needs and interests of the Veteran and ensures care occurs at the right place, at the right time, by the right provider and is seamless.

These findings allow VHA to continue its modernization journey and transformation to operate as a high reliability, Veteran-centric organization with clear accountabilities and authorities by pushing decision rights as close to the point of care as feasible.

## Appendix A: Interview Participants

| | Offices Interviewed | |
|---|---|---|
| 1 | OCC | Acting Deputy Under Secretary of Health (DUSH) for Community Care |
| 2 | OCC | Business Operations and Administration (10D1A) |
| 3 | OCC | Policy and Planning |
| 4 | OCC | Financial Management |
| 5 | OCC | Communications |
| 6 | OCC | BOA Operations |
| 7 | OCC | BOA PAL |
| 8 | OCC | Business Integrity and Compliance |
| 9 | OCC | Delivery Operations (10D1B) |
| 10 | OCC | Payment Operations and Management |
| 11 | OCC | Resource Management |
| 12 | OCC | Customer Experience |
| 13 | OCC | Revenue Operations (10D1C) |
| 14 | OCC | Payer Relations and Services |
| 15 | OCC | Quality and Performance |
| 16 | OCC | eBusiness |
| 17 | OCC | Operations |
| 18 | OCC | Clinical Network and Management |
| 19 | OCC | Network Management |
| 20 | OCC | Performance Improvement and Reporting (CHIO) |
| 21 | OCC | Informatics/Data Analytics |
| 22 | Finance | Resource Management Office |
| 23 | Finance | Financial Management & Accounting |
| 24 | Finance | Accounting Policy (104A) Oversight |
| 25 | Finance | Accounting Policy (104A) Payment Integrity |
| 26 | Finance | Budget Formulation/Execution (104B) Leadership |
| 27 | Finance | Budget Formulation/Execution (104B) Team (90 min) |
| 28 | Finance | Policy (104C) |
| 29 | Finance | Managerial Cost Accounting (104D) Leadership |
| 30 | Finance | Managerial Cost Accounting (104D) Team (90 min) |
| 31 | OVAC | OVAC Strategy Leadership Group |
| 32 | OVAC | OVAC Clinic Practice Management |
| 33 | OVAC | OVAC Field Support |
| 34 | OVAC | OVAC Emerging Technology |
| 35 | OVAC | OVAC Governance |
| 36 | OVAC | OVAC Clinic Contact Centers |
| 37 | Program Offices | Primary Care |
| 38 | Program Offices | Mental Health and Suicide Prevention |
| 39 | Program Offices | National Surgery Office |
| 40 | Program Offices | Specialty Care |
| 41 | Program Offices | Care Management and Social Work |
| 42 | Program Offices | Emergency Medicine |
| 43 | Program Offices | Pharmacy |
| 44 | Program Offices | Dental |
| 45 | Program Offices | Strategy |
| 46 | Program Offices | Telehealth |
| 47 | Program Offices | Office of Nursing Services |
| 48 | Program Offices | GEC |
| 49 | VISN | VISN 1 |
| 50 | VISN | VISN 2 |

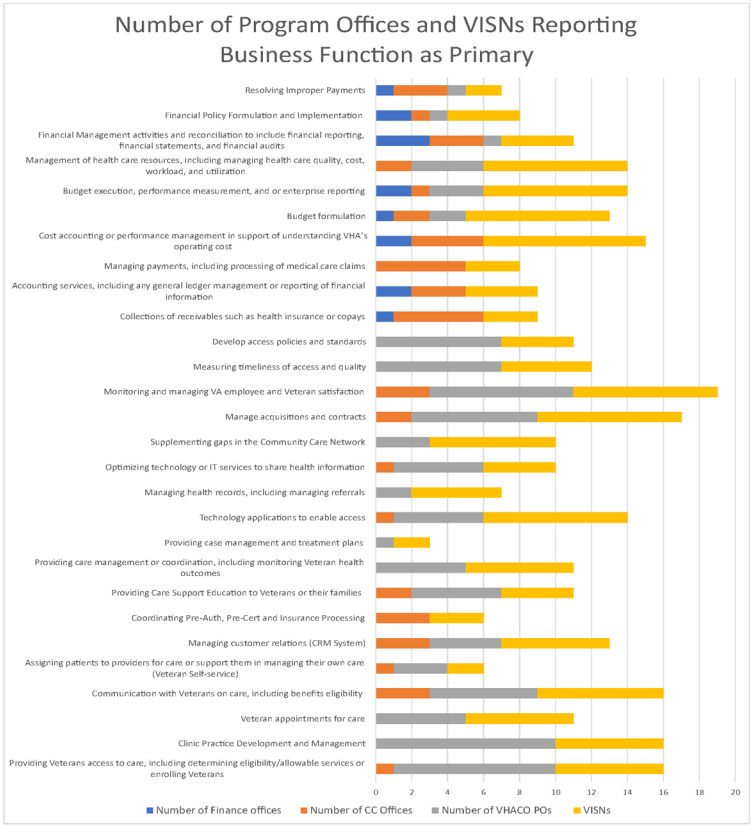
| | Offices Interviewed | |
|---|---|---|
| 51 | VISN | VISN 4 |
| 52 | VISN | VISN 5 |
| 53 | VISN | VISN 6 |
| 54 | VISN | VISN 7 |
| 55 | VISN | VISN 8 |
| 56 | VISN | VISN 9 |
| 57 | VISN | VISN 10 |
| 58 | VISN | VISN 12 |
| 59 | VISN | VISN 15 |
| 60 | VISN | VISN 16 |
| 61 | VISN | VISN 17 |
| 62 | VISN | VISN 19 |
| 63 | VISN | VISN 20 |
| 64 | VISN | VISN 21 |
| 65 | VISN | VISN 22 |
| 66 | VISN | VISN 23 |
| 67 | External | Former Kaiser Permanente Leadership |
| 68 | External | Marshfield Clinic |
| 69 | External | Geisinger Medical Group |
| 70 | External | Sutter Health |

## Appendix B: Business Function Framework

| Access Business Functions |
|---|
| a. Providing Veterans access to care, including determining eligibility/allowable services and authorizing care |
| b. Clinic practice design and management |
| c. Veteran appointments for care |
| d. Communication with Veterans on care, including benefits eligibility |
| e. Assigning patients to providers for care or support them in managing their own care (Veteran Self-service) |
| f. Managing customer relations (Customer Relationship Management (CRM) System) |
| g. Coordinating Pre-Auth, Pre-Cert and Insurance Processing |
| h. Providing Care Support Education to Veterans or their families |
| i. Providing care management or coordination, including monitoring health outcomes |
| j. Providing case management and treatment plans |
| k. Technology applications to enable access |
| l. Managing health records, including managing referrals |
| m. Optimizing technology or IT services to share health information |
| n. Supplementing the Community Care Network (CCN) |
| o. Manage acquisitions and contracts |
| p. Monitoring and managing VA employee and Veteran satisfaction |
| q. Measuring timeliness of access and quality |
| r. Develop access policies and standards |

| Finance Business Functions |
|---|
| a. Collections of receivables such as health insurance or copays |
| b. Accounting services, including any general ledger management or reporting of financial information |
| c. Managing payments, including processing of medical care claims |
| d. Cost accounting or performance management in support of understanding VHA's operating cost |
| e. Budget formulation |
| f. Budget execution, performance measurement and/or enterprise reporting |
| g. Management of health care resources, including managing health care quality, cost, workload, make vs. buy decisions and utilization |
| h. Financial Management activities and reconciliation to include financial reporting, financial statements and financial audits |
| i. Financial policy formulation and implementation |
| j. Resolving improper payments |

# Appendix C: Overlapping Functions



## Appendix D: List of Acronyms

| Acronyms | |
|---|---|
| **ADUSH** | Acting Deputy Under Secretary of Health |
| **AUSH** | Assistant Under Secretary for Health |
| **BFF** | Business Function Framework |
| **BOA** | Business Operations and Administration |
| **CCN** | Community Care Network |
| **CFO** | Chief Financial Officer |
| **CHIO** | Chief Health Informatics Officer |
| **COA** | Course of Action |
| **COVID** | Coronavirus Disease |
| **CRM** | Customer Relationship Management |
| **DUSH** | Deputy Under Secretary of Health |
| **FSC** | Financial Service Center |
| **GAO** | Government Accountability Office |
| **GEC** | Geriatrics and Extended Care |
| **IPT** | Integrated Project Team |
| **IT** | Information Technology |
| **MISSION Act** | Maintaining Internal Systems and Strengthening Integrated Outside Networks Act |
| **ND** | Network Director |
| **OCC** | Office of Community Care |
| **OVAC** | Office of Veterans Access to Care |
| **TPA** | Third Party Administrators |
| **VA** | Department of Veterans Affairs |
| **VACAA** | Veterans' Access to Care through Accountability, Choice and Transparency Act |
| **VAMC** | Veteran Affairs Medical Center |
| **VHA** | Veterans Health Administration |
| **VISN** | Veterans Integrated Service Networks |

Notes:

- Appointments derived from claims submitted by community providers
- Appointment month based on treatment date
- Limited to outpatient services with inpatient care excluded
- For FY21, highlighted months also include additional estimated appointments, based on prior month averages, as VA has not received all claims for treatment rendered.

| Fiscal Year | # of Appt by month |
|---|---|
| **2019** | **31,808,219** |
| OCT | 2,601,438 |
| NOV | 2,472,697 |
| DEC | 2,412,180 |
| JAN | 2,673,913 |
| FEB | 2,427,580 |
| MAR | 2,601,690 |
| APR | 2,736,451 |
| MAY | 2,869,645 |
| JUN | 2,531,594 |
| JUL | 2,813,410 |
| AUG | 2,883,118 |
| SEPT | 2,784,503 |
| **2020** | **32,861,543** |
| OCT | 3,010,136 |
| NOV | 2,738,955 |
| DEC | 2,823,968 |
| JAN | 3,019,312 |
| FEB | 2,823,648 |
| MAR | 2,721,093 |
| APR | 2,257,642 |
| MAY | 2,443,657 |
| JUN | 2,692,824 |
| JUL | 2,803,791 |
| AUG | 2,741,340 |
| SEPT | 2,785,177 |
| **2021** | **33,053,752** |
| OCT | 2,810,674 |
| NOV | 2,620,968 |
| DEC | 2,763,114 |
| JAN | 2,669,690 |
| FEB | 2,522,168 |
| MAR | 3,004,747 |
| APR | 2,852,099 |
| MAY | 2,718,097 |
| JUN | 2,696,015 |
| JUL | 2,715,544 |
| AUG | 2,885,028 |
| SEPT | 2,795,608 |

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**Senate Veterans' Affairs Committee**
**October 20, 2021 Hearing to Consider Pending Legislation**
**Follow-Up Questions for the Record from Senator Kyrsten Sinema**

**Questions for Marquis Barefield, DAV Assistant National Legislative Director**

RE: S. 2852, the Long-Term Care Veterans Choice Act

***Question:***

DAV has long been a proponent for VA programs that provide veterans access to a wider range of long-term care options and has expressed support for S. 2852, Long-Term Veterans Choice Act. Why is the Medical Foster Home program so important as an alternative long-term care option for veterans and how would it improve care for older veterans?

***Response:***

Medical foster homes can provide a long-term care alternative to institutional care for veterans who want greater independence and a family-like environment that allows them to remain involved with their communities while receiving a higher level of care than could be sustained in their homes. In addition, the Department of Veterans Affairs believes that medical foster homes have "…proven to be safe, preferable to Veterans, highly Veteran-centric…" and cost less than traditional nursing home care.

Veterans who receive care in medical foster homes must be eligible for nursing home care, but medical foster homes may not be appropriate placements for all eligible veterans including those with traumatic brain injury (TBI), significant cognitive impairments or neurobehavioral issues that cause them to wander or veterans with very complex medical needs, for example.

***Question:***

Programs like the Medical Foster Home cannot be successful if veterans and their families don't know about them. Do veterans in need of long-term care and their families know what options are available to them? What can the VA, veteran serving organizations, and Congress do to improve efforts to share this information with veterans who benefit from programs like the Medical Foster Home?

***Response:***

DAV believes having a variety of long-term care options is beneficial for veterans. But for the full potential to be realized veterans must know that these alternative programs and services exist. VA should ensure that educational materials and training are provided to VA social workers, health care providers and clinical staff. Providers can help guide veterans to make the best decision based on their unique circumstances and identify appropriate long-term care services and supports. Currently, to find out about alternatives to institutional care veterans or family members must do their own research, and navigate the Department of Veterans Affairs

website. Knowledgeable care navigators should be available to assist older veterans and veterans with TBI and cognitive issues to ensure they understand their options and make informed decisions that best meet their needs.

***Question:***

One of the benefits of the Medical Foster Home program is in the long-run it will save the VA money while providing a caring, therapeutic environment for older veterans. This bill takes the cost of such care away from the veteran and puts it on the VA. How do you think that will impact the veterans who are deciding between a nursing homes versus alternative settings like a medical foster home?

***Response:***

The benefit to VA is having a placement for an eligible veteran that is significantly lower cost than a nursing home bed in a VA-operated community living center (CLC) or in a community nursing home. Veterans who are compelled to self-pay for medical foster care rather than nursing home care may select nursing home care if only to avoid the significant cost of medical foster home care for themselves or their families. If both settings were paid for by VA, veterans would be able to choose the most appropriate care for them which, in many cases, may be a medical foster home resulting in a significant savings for VA compared with the cost of caring for that veteran in a CLC nursing home bed.