S. HRG. 116–179

# HEARING ON PENDING LEGISLATION

## HEARING

BEFORE THE

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

ONE HUNDRED SIXTEENTH CONGRESS

FIRST SESSION

MAY 22, 2019

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# C O N T E N T S

MAY 22, 2019

## SENATORS



## WITNESSES



## APPENDIX

# HEARING ON PENDING LEGISLATION

**WEDNESDAY, MAY 22, 2019**

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

The Committee met, pursuant to notice, at 2:28 p.m., in room 418, Russell Senate Office Building, Senator John Boozman, presiding.

Present: Senators Moran, Boozman, Tester, Murray, Brown, Blumenthal, and Sinema.

## HON. JOHN BOOZMAN, ACTING CHAIRMAN, U.S. SENATOR FROM ARKANSAS

Senator BOOZMAN. The hearing will come to order. We are pleased to have some of our colleagues here to talk about some important pieces of legislation. So, we will begin with Senator Casey of Pennsylvania. He is going to speak in support of S. 746, the Department of Veterans Affairs Website Accessibility Act of 2019.

Senator Casey.

## STATEMENT OF HON. BOB CASEY, U.S. SENATOR FROM PENNSYLVANIA

Senator CASEY. Thanks so much, Senator Boozman. I am not allowed to call you Mr. Chairman today, or you are the acting chair?

Senator BOOZMAN. John.

Senator CASEY. Senator Boozman, thanks so much. I want to thank you and thank the Ranking Member, Senator Tester, for this opportunity and for inviting me to speak as well as our colleagues.

As you mentioned, I am here to discuss the VA Website Accessibility Act, which is Senate Bill 746, which I introduced with my colleague, Senator Moran, who, of course, is a Member of this distinguished Committee. I want to thank Senator Moran for his partnership on this legislation which aims to help disabled veterans. We look forward to continuing our work in the future to help those who have served our Nation.

I also want to acknowledge our colleagues in the House for advancing similar bipartisan legislation under the leadership of Representative Elaine Luria.

The VA Website Accountability Act—Accessibility Act, I should say—seeks to ensure that all veterans have access to electronic and information technology provided by the Department of Veterans Affairs, including those who are blind. This should not be a controversial idea, of course. In fact, it is already required by law. In the 1990s, Congress amended the Rehabilitation Act to include Section

508, which requires Federal agencies, including the VA, to make their electronic and information technology accessible to people with disabilities.

Unfortunately, the VA has faltered in its compliance with Section 508. The Blinded Veterans Association reports that all too frequently the VA releases new websites or apps that cannot be easily used by the blind. This often occurs after the agency promises, at the initial developmental stages, that the technology will be accessible. This, I know for everyone in the room, is unacceptable.

The act that we have introduced will promote a common-sense approach to solve the problem. It will require the VA to examine its websites, web-based applications, and VA medical facility kiosks to determine if they are accessible. The bill also requires the VA to report to this Committee and its House counterpart detailing which technology is not accessible. For technology that is identified as not accessible, the VA must develop and provide a plan for bringing that technology into compliance with Section 508.

We have an abiding duty to provide for the brave men and women who have served our country. As President Lincoln said, when he outlined a very basic test or standard, he said, it is our obligation to, "care for him who shall have borne the battle and for his widow and his orphan." We have to live up to that standard in everything that we do as it relates to the VA and veterans.

This legislation takes a small, but important, step in ensuring that we meet our abiding obligation to serve and help every veteran, including those who are blind.

I want to thank the Committee under the leadership of Chairman Isakson and Ranking Member Tester, and Senator Boozman today, for examining this important piece of legislation. Thank you very much.

Senator BOOZMAN. Thank you, Senator Casey, and again, thank you for being with us today.

Next we are going to hear from Senator Gardner of Colorado. He is going to talk about the two pieces of legislation, S. 221, the Department of Veterans Affairs Provider Accountability Act, and S. 450, the Veterans Improved Access and Care Act of 2019.

Senator Gardner.

## STATEMENT OF HON. CORY GARDNER, U.S. SENATOR FROM COLORADO

Senator GARDNER. Thank you, Senator Boozman. Thank you, as well, Ranking Member Tester, for allowing me this opportunity to talk about Senate Bill 450 and Senate Bill 221, to improve the VA hiring process and strengthen accountability at the VA. I would like to thank the Colorado veterans who helped us get this legislation to where it is today, and the many providers and VSOs that helped provide guidance.

When meeting with veterans across Colorado, I often hear concerns about the amount of time it takes to get in to see a VA provider. In order to reduce wait times and provide timely care to our veterans, we have to address the root problem at many VA facilities in Colorado and across the country—staffing and staffing shortages.

As the Wounded Warrior Project notes in their testimony today, there are over 24,000 medical or dental shortages in the VHA. Many VA hospitals continue to experience long wait times and staffing shortages as a result of lengthy hiring processes. The primary driver of this protracted hiring process is the onboarding process for licensed medical providers. According to a recent study by McKinsey and Company, the VA hiring timeline spans between 4 to 8 months, while a typical private sector organization hires staff between 0.2 and 2 months.

This bipartisan legislation, Senate Bill 450, the Veterans Improved Access and Care Act, aims to address this problem by directing the VA to establish a pilot program to expedite the hiring of licensed medical professionals in locations where there are shortages of available providers. The bill also requires the VA Secretary to submit a report detailing a strategy on how to reduce the shortages and how to expedite the VA hiring process.

It is essential the Department of Veterans Affairs and Congress collaborate on ways to find innovative solutions to the bureaucracy and red tape that serves as a barrier to employment at a VA medical center, to ensure that veterans receive quality, timely care they deserve.

Another essential component of ensuring our Nation's heroes receive the highest quality care is accountability for medical errors that put patients in harm's way. The vast majority of VA employee and medical providers provide exceptional care to our veterans, and I am grateful for their service. So, there is no excuse for allowing certain medical providers with a history of committing major medical errors to continue putting other patients at risk.

A troubling GAO report from 2017 revealed an unacceptable trend of VA facilities failing to report providers who made major medical errors to the National Practitioner Data Bank and the relevant State licensing boards responsible for tracking dangerous practitioners. As a result, these practitioners can go into private practice or move across State lines without disclosing prior mistakes to patients or State regulators.

As we speak, the Comptroller General of the United States is testifying before the House Veterans' Affairs Committee, the Subcommittee on Oversight and Investigation, that since that 2017 GAO report, the VA has failed to implement recommendations regarding the appropriate reporting to State licensing boards.

Originally the VA indicated that they would take such steps by October 2018. It is now May 2019. We are no closer to ensuring the VA facilities are following advisable medical reporting standards.

The VA Provider Accountability Act would solve this problem by requiring the VA to inform the National Practitioner Data Bank and State licensing boards of major adverse actions committed by medical providers at the VA. Additionally, it would prevent the VA from signing settlements with fired employees to hide major medical mistakes in their personnel files.

We owe every single veteran the best possible care and we can only provide that care with increased accountability. My bipartisan bill will protect veterans and potential patients outside the VA system from mistakes by medical providers who have proven themselves to be dangerous.

I look forward to collaborating with our Nation's veterans, the Senate Veterans' Affairs Committee, the VA, and other stakeholders on furthering these critical solutions.

I ask for the Chairman's consent to allow the letters that I have with me to be submitted to the record in support from these organizations: the Federation of State Medical Boards; National Council of State Boards of Nursing; and the United Veterans Committee of Colorado.

Senator BOOZMAN. Without objection.

Senator GARDNER. Thank you.

[The letters appear in the Appendix.]

Senator BOOZMAN. Thank you, Senator Gardner.

Next we are going to hear from my fellow Senator from Arkansas, Senator Cotton. He is going to speak in support of S. 857, a bill to increase the Medal of Honor pensions. And, congratulations on your efforts chronicling the Old Guard and becoming truly an expert on Arlington.

## STATEMENT OF HON. TOM COTTON, U.S. SENATOR FROM ARKANSAS

Senator COTTON. Thank you. A great story that is available for purchase on Amazon right now. [Laughter.]

I want to thank the Committee, Chairman Isakson, and Ranking Member Tester for inviting me to speak at this hearing. I also want to thank my colleague from Arkansas, Senator Boozman, as well as Senator Blumenthal for cosponsoring Senate Bill 857, which would increase the special pension for Medal of Honor recipients.

Medal of Honor citations often read like Hollywood scripts, only the heroism is so amazing most people would not believe it really happened if it were a movie. But, it did happen, and Medal of Honor recipients who lived to tell their stories become public figures overnight. They are inundated with requests for speeches and appearances at schools, veterans' groups, and civic organizations. Many appear at as many as 200 events every year. They do this out of a sense of duty to the Nation and to their buddies who did not survive.

Our country, therefore, pays Medal of Honor recipients a special pension to defray the costs of their demanding travel schedules. The pension began at about $10 a month, more than a century ago. Congress has increased it periodically and it now stands at about $1,300 per month. That amount can no longer cover basic expenses, such as lodging, food, and transportation.

That is not right, so let's make it right. Our bill would increase the Medal of Honor pension to $3,000 per month. This is a modest change, and even more modest expense for our country. The pensions would cost barely $1 million a year out of our $4 trillion budget, but that money would go a long way to help these Medal of Honor recipients share their stories.

These are not the stories of celebrity or fame. They are stories of valor and patriotism. They give young men and women honorable examples to follow, indeed, inspiring many of them to enlist themselves. That is why Medal of Honor recipients are some of our military's best recruiters and Ambassadors. It is only fair we reimburse them for the job they do.

Time is of the essence. We once had hundreds of living recipients but now we are down to only 70. Just last week, we lost another Medal of Honor recipient, Robert Maxwell, who passed away at the age of 98. A generation of heroes is slowly passing from the scene, so let's act now to make sure their stories are shared as widely as possible.

Every Medal of Honor recipient has sacrificed for his country in the words of the citation "above and beyond the call of duty." That sacrifice continues well beyond the battlefield but it should not require financial sacrifice. So, let's give Medal of Honor recipients the raise they deserve.

Thank you.

Senator BOOZMAN. Thank you, Senator Cotton.

Senator Ernst, it is good to have you here. The senator from Iowa is going to be speaking in support of S. 123, the Ensuring Quality Care for Our Veterans Act, which is very important. We appreciate your leadership in this area, and we have had, you know, a great deal of pleasure in trying to help and play in a role, so thank you again.

**STATEMENT OF HON. JONI ERNST, U.S. SENATOR FROM IOWA**

Senator ERNST. Thank you. Senator Boozman and Ranking Member Tester, thank you so much for the invitation today so that I can advocate for S. 123, the Ensuring Quality Care for Our Veterans Act. I also want to thank you, Senator Boozman, as well, as a Member of this Committee and for also supporting S. 123, as well as Senator Grassley and Senator Coons. So, thank you very much for your support on this issue.

Today, folks, I want to share a story of Anthony, who is an Iowa veteran. In 2017, Anthony was experiencing headaches, so he went to the Iowa City VA medical center to get an MRI of his head and neck. Anthony's MRI results came back and they unfortunately indicated that he had a brain tumor.

Anthony was referred to Dr. John Schneider, a neurosurgeon at the Iowa City VA. Anthony was struck by Dr. Schneider's demeanor. He was personable and genuinely seemed to care about Anthony's well-being. Dr. Schneider was going to operate on Anthony with the goal of removing the tumor, and Anthony was confident he was in good hands.

After Anthony's surgery, Dr. Schneider proclaimed that he had removed all of the tumor—all of the tumor. In the weeks and months following the surgery, it became clear to Anthony that something was amiss. His health had not improved, and when Anthony would bring this up to Dr. Schneider, Schneider claimed that it would take at least a year for his symptoms to improve.

All of this changed on December 3, 2017. A disturbing report in *USA Today* found that the VA had knowingly hired providers with revoked medical licenses and who have a history of providing substandard care. One of those providers was Dr. Schneider.

After that report broke, Anthony immediately went to the VA and had another MRI. It turned out that Dr. Schneider had never removed the tumor.

Members of the Committee, Dr. Schneider never should have been hired to treat our veterans. While the VA reformed its hiring

practices—thank goodness—there are still veterans out there who were treated by physicians with revoked licenses, but who do not know if they received bad care. That is absolutely unacceptable.

Every veteran who was treated by a physician with a revoked license should have their medical care scrutinized by a neutral third party. That is exactly what my bill does. The Ensuring Quality Care for Our Veterans Act ensures that every provider who was hired with a revoked license will have their care scrutinized by a neutral third party. If that third party determines that the care was substandard, the veterans will be notified.

The VA conducted a review of all their providers and found a small number of providers who were hired with revoked licenses. This bill focuses on that small group of providers. It is a targeted oversight measure with minimal costs, that will give our veterans peace of mind.

I thank the Committee again for the opportunity to testify in front of you today, and I do urge the Committee to support this bill. Thank you.

Senator BOOZMAN. Thank you, Senator Ernst.

Senator Tester.

**OPENING STATEMENT OF HON. JON TESTER, RANKING MEMBER, U.S. SENATOR FROM MONTANA**

Senator TESTER. Thank you, Senator Boozman. I appreciate you filling in today for Chairman Isakson.

Yesterday I hosted a roundtable of veteran service organizations. I am very concerned that they are not being provided adequate information on implementation of the VA Mission Act.

These VSOs are essential figures in this process. They can help provide information to their members and answer questions when problems arise. But, what I heard yesterday is that the group lacked real opportunities for questions and answers.

In some instances, VA is requiring questions in advance so that no real dialog is occurring. In particular, the groups noted that they have not been provided information about what veterans do if they run into problems accessing care starting the 6th of June. VA needs to get this right. Congress gave the agency a full year to roll out this program. The agency absolutely needs to provide the VSOs with an opportunity for real back-and-forth within the next few days, given that this Mission Act will go live in 2 weeks.

As far as this hearing goes, I just want to say that we have got a fairly heavy load for this hearing and I greatly appreciate that you have included so many bills that I have on this agenda today. I want to briefly touch on a few bill that I have worked on, and we will get views on it today.

One of the main focuses in Congress is on mental health and suicide prevention. I want to thank all of my colleagues on this Committee for being such good partners in this effort, in particular, Senator Moran, for helping expand access to mental health care for our veterans and increasing oversight over VA mental health programs.

S. 785—this is the Commander John Scott Hannon Veterans Mental Health Care Improvement Act—does just that. It also eases transition for recently separated veterans, improves and expands

VA mental health infrastructure, increases community engagement through grants.

I also want to thank Senators Sullivan, Murray, Sanders, Blumenthal, Hirono, Manchin, and Sinema for their support of this bill.

S. 711, Care for Reservists, allows members of the National Guard and Reserve to receive care at Vet Centers, and includes them in VA suicide prevention planning. I worked with Senators Moran, once again, Sullivan, Cassidy, Tillis, Sanders, and Manchin to improve and expand care for our guardsmen and reservists.

Today's agenda also includes S. 514, the Deborah Sampson Act, which would eliminate barriers to care in services that many women veterans face and would expand services for women veterans most in need, such as those experiencing homelessness.

And, a very special thank you to the man to my left, Senator Boozman, who reintroduced this critical bill with me, as well as 32 other cosponsors, 7 of whom sit on this Committee.

Another bill that I worked on was S. 805, the Veteran Debt Fairness Act, which helps veterans by reducing VA's ability to recover overpayments from veterans that are caused by VA errors. Again, I want to thank Senators Boozman, Brown, and Blumenthal for being great partners in this legislation and assuming that the VA, not our veterans, are held accountable when it makes mistakes.

Finally, I have got a couple of bills that increase oversight and accountability of the VA. S. 1154, the Department of Veterans Affairs Electronic Health Record Advisory Committee Act, would create a panel of experts to oversee and give guidance to the VA as they embark on the $16 billion, 10-year Cerner electronic health record project. Thank you to Senator Blackburn for working together with me to ensure that this massive project gets rolled out correctly.

Last, but not least, S. 524, the Department of Veterans Affairs Tribal Advisory Committee Act, which would create an advisory committee made up of Tribal members from across the Nation to advise the Secretary on issues specific to Indian country. I want to thank Senators Sullivan, Cramer, and Sinema in pushing for greater representation of Indian country in VA policy at the highest level.

I look forward to hearing the rest of our witnesses here today's views on the bills as we look forward for a very productive hearing.

Thank you, Mr. Chairman.

Senator BOOZMAN. Well, thank you, and let's go ahead and hear from our panel. We will start with Dr. Teresa Boyd. She is accompanied by Dr. David Carroll and Beth Murphy. We do appreciate you being here.

Dr. Boyd.

**STATEMENT OF TERESA BOYD, DO, ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY DAVID CARROLL, Ph.D., EXECUTIVE DIRECTOR, MENTAL HEALTH AND SUICIDE PREVENTION, VETERANS HEALTH ADMINISTRATION; AND BETH MURPHY, EXECUTIVE DIRECTOR, COMPENSATION SERVICE, VETERANS BENEFITS ADMINISTRATION**

Dr. BOYD. Thank you. Good afternoon, Senator Boozman, Ranking Member Tester, and Members of the Committee. I appreciate this opportunity to be here to discuss the bills on today's agenda. I am accompanied today by Dr. David Carroll, Executive Director of the Office of Mental Health and Suicide Prevention, and Beth Murphy, who leads VBA's Compensation Service.

With just a few minutes for my introductory statement I can only highlight a few key points on some of the bills today, but I will cover as much territory as I can. Our written testimony goes into greater detail, and most importantly, after the hearing we are glad to bring subject matter experts to the Committee and work closely with you and your staff on any of the legislation you have brought forward today.

There are a few matters where we could not conclude views in time to include in our written testimony. We will be following up with those view for the record and provide them to the Committee as soon as possible.

Preventing veteran suicide is, of course, a serious topic the country is rightfully focused on now and it is reflected in the largest bill on the agenda today, S. 785. Suicide is a public health tragedy that affects communities across the country.

As we discuss suicide prevention legislation it is important to first place it in the context of what VA is doing now. VA's efforts are organized around the 2018 National Strategy for Prevention Veteran Suicide, which is a framework for identifying priorities, organizing efforts, and focusing community resources to prevent suicide among veterans.

There is much in S. 785 that keys in on what we believe are the right elements, including suicide prevention coordinators at every medical center, a grant program that taps into the resources of the local community, focused research projects and deployment of promising clinical approaches to suicide prevention, the use of complementary and integrative health care, outreach efforts to reach those veterans that are not in our system of care, and the use of joint clinical practice guidelines, among other features.

As we detail in our written testimony, some requirements found in the bill are already underway at VA. Even though we applaud the fact that VA initiatives are recognized as worthy in S. 785, we do urge caution in terms of prescribing those initiatives into detailed legislation, where the specifics of the bill requirements have the potential to work at cross purposes or not be flexible enough to allow VA to tailor its implementation to be most effective. Situations could arise where our public health experts decide that shifting resources from a mandated responsibility into a newly promising initiative will give us a better chance of success.

Our testimony also details instances where we believe a study or report would be duplicative or would be less effective and useful for public health purposes than intended. There are also provisions that would come on top of related requirements in the recently enacted MISSION and CARE Acts. We want to make sure that we help keep records and compliance mandates as streamlined as possible for the benefit of our veterans. That is why we especially value further discussion with the Committee where we can give our best advice on how we ensure any legislation will produce the outcomes we all want.

We especially want to work with you on Section 201, as we believe this kind of grant program shows a great deal of promise. Specifically, we would like to discuss how we could broaden the scope to include veterans who do not have a mental health diagnosis and allow grantees to provide more forms of assistance.

Both S. 785 and S. 711 address a critical component of our suicide prevention efforts, access to care. Recently, Congress and VA have acted to open VA access in a limited way for those who do not meet the standard definition of veteran eligibility because of their nature of discharge and for reservists who have simply not been federally activated.

But, VA wants to do more. While we do not endorse the eligibility changes in these bills as drafted, we are committed to working on these issues with the Committee so that we can better reach those individuals where VA could make a life-changing difference.

S. 514 and S. 318 address a topic that is also a big priority for VA, making sure our services meet the needs of women veterans whose use of VHA has tripled since 2000. As noted in our testimony, we support many provisions among the numerous initiatives in S. 514, including expanded newborn health care, convening retreats especially for women veterans, and standing up partnerships to provide legal services to women veterans. We would like to work with the Committee on some technical concerns with S. 318 regarding health-related transportation for newborns.

VA has not let up in our efforts to combat veteran homelessness, which is the subject of S. 980. We appreciate the recognition of legal services as an element of how we can help homeless and at-risk veterans. We welcome discussion on other provisions in that bill.

We also appreciate your support on VA's Highly Rural Transportation Grant Program, the subject of S. 850. We support that measure and, in fact, would be very pleased if Congress extend that authority through 2029.

I am glad to share the table today with Beth Murphy, who can speak to the bills that concern VBA programs. I will say, on her behalf now, that VA appreciates the inclusion of bills that will increase special pension benefits for Medal of Honor recipients, expand the types of professionals who can conduct disability examinations, and allow VA to continue payment of education benefits when a school is closed under certain emergency situations such as hurricanes. VA does support these bills.

S. 805 addresses a complicated subject, which is VA's management of debts that veterans may owe to VA. Committee staff has spent a lot of time with VA subject matter experts this year in ef-

forts to make changes to ensure fairness and reduce frustration for veterans. In this area, we run into some decentralization among different parts of VA, some inconsistencies simply because of the nature of a debt with VBA, perhaps resulting to an education benefit, is very much different than a debt to VHA, which could be over a copayment.

While we do not support the bill in its current form, we will keep working with the Committee on legislation that could improve matters while we continue to work on improving our own internal processes.

Finally, we appreciate and support S. 524, which would stand up a VA Tribal Advisory Committee to focus on issues important to Native American veterans and tribal organizations, as well as advise the Secretary on those issues. The special sovereign nature of Native American tribes and the unique needs of those veterans merit this kind of forum, which I know will result in ideas that will help VA better serve this population.

I will need to close without addressing some of the bills on the agenda, but before I do I want to thank you and the Committee for holding this important hearing. Our objective is to give our Nation's veterans the top quality of experience and care they have earned and deserve. We appreciate the continued support and encouragement from this Committee and our VSO partners here with us today as we identify challenges and find new ways to care for veterans.

This concludes my testimony. My colleagues and I are happy to respond to any questions you and the Committee may have.

[The prepared statement of Dr. Boyd follows:]

PREPARED STATEMENT OF TERESA BOYD, DO, ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION (VHA), U.S. DEPARTMENT OF VETERANS AFFAIRS (VA)

Good afternoon, Chairman Isakson, Ranking Member Tester, and Members of the Committee. Joining me today are Dr. David Carroll, Executive Director of Mental Health and Suicide Prevention, Veterans Health Administration, and Ms. Beth Murphy, Director of Compensation Service, Veterans Benefits Administration (VBA).

I want to thank the Committee for putting forward legislation on critical issues such as suicide prevention, mental health care, and the needs of women Veterans, among other important topics. In this testimony we are providing background information on many of our ongoing efforts and strategies for addressing these important issues, so that we can provide context for our analysis of the proposals before us today. I am confident that we can, in partnership with Congress, ensure VA has the tools to deliver the state-of-the-art health care and other benefits that Veterans deserve.

VA was not able to address the draft Janey Ensminger Act of 2019. We are also still analyzing sections 101(a) and (b) and section 104 of S. 785, and will provide views soon in a follow-up letter.

*Legislation Concerning Mental Health and Suicide Prevention*

Suicide is a national public health issue that affects all Americans, and the health and well-being of our Nation's Veterans is VA's top priority. On average, twenty Veterans, active-duty Servicemembers, and non-activated Guard or Reserve members die by suicide each day, and of those twenty, fourteen have not been in our care. That is why we are implementing broad, community-based prevention strategies, driven by data, to connect Veterans outside our system with care and support. The Department's Fiscal Year (FY) 2020 budget requests $9.4 billion for mental health services, a $471 million increase over 2019. VA's budget specifically invests $221.7 million for suicide prevention programming, a $15.6 million increase over the 2019 enacted level. The budget request funds over $5.4 billion to support mental health outpatient visits, an increase of nearly 78,000 visits over the 2019 estimate.

This builds on VA's current efforts. VA has hired more than 3,900 new mental health providers yielding a net increase in VA mental health staff of over 1,000 providers since July 2017. Nationally, in the first quarter of 2019, 90 percent of new patients completed an appointment in a mental health clinic within 30 days of scheduling an appointment, and 96.8 percent of established patients completed a mental health appointment within 30 days of the day they requested.

Preventing Veteran suicide requires closer collaboration between VA, the Department of Defense (DOD), and the Department of Homeland Security (DHS). On January 9, 2018, President Trump signed Executive Order (EO) 13822, Supporting Our Veterans During Their Transition from Uniformed Service to Civilian Life. The EO directs DOD, VA, and DHS to develop a Joint Action Plan that describes concrete actions to provide access to mental health treatment and suicide prevention resources for transitioning uniformed Servicemembers in the year following their discharge, separation, or retirement. On March 5, 2019, President Trump signed Executive Order 13861, National Roadmap to Empower Veterans and End Suicide, which creates a Veteran Wellness, Empowerment, and Suicide Prevention Task Force that is tasked with developing, within one year, a road map to empower Veterans to pursue an improved quality of life, prevent suicide, prioritize related research activities, and strengthen collaboration across the public and private sectors. This is an all-hands-on-deck approach to empower Veteran well-being with the goal of ending Veteran suicide.

For Servicemembers and Veterans alike, our collaboration with DOD and DHS is already increasing access to mental health and suicide prevention resources, due in large part to improved integration within VA, especially between VBA and VHA, which have worked in collaboration with DOD and DHS to engage Servicemembers earlier and more consistently than we have ever done in the past. This engagement includes support to members of the National Guard, Reserves, and Coast Guard.

VA's suicide prevention efforts are guided by our National Strategy for Preventing Veteran Suicide, a long-term plan published in the summer of 2018 that provides a framework for identifying priorities, organizing efforts, and focusing national attention and community resources to prevent suicide among Veterans. It also focuses on adopting a broad public health approach to prevention, with an emphasis on comprehensive, community-based engagement.

However, VA cannot do this alone, and suicide is not solely a mental health issue. As a national problem, Veteran suicide can only be reduced and mitigated through a nationwide community-level approach that begins to solve the problems Veterans face, such as loss of belonging, meaningful employment, and engagement with family, friends, and community.

The National Strategy for Preventing Veteran Suicide provides a blueprint for how the Nation can help to tackle the critical issue of Veteran suicide and outlines strategic directions and goals that involve implementation of programming across the public health spectrum, including, but not limited to:

- Integrating and coordinating Veteran Suicide Prevention across multiple sectors and settings;
- Developing public-private partnerships and enhancing collaborations across Federal agencies;
- Implementing research-informed communication efforts to prevent Veteran suicide by changing attitudes knowledge and behaviors;
- Promoting efforts to reduce access to lethal means;
- Implementation of clinical and professional practices for assessing and treating Veterans identified as being at risk for suicidal behaviors; and
- Improvement of the timeliness and usefulness of national surveillance systems relevant to preventing Veteran suicide.

Every day, more than 400 Suicide Prevention Coordinators and their teams—located at every VA medical center—connect Veterans with care and educate the community about suicide prevention programs and resources. Through innovative screening and assessment programs such as REACH VET (Recovery Engagement and Coordination for Health—Veterans Enhanced Treatment), VA identifies Veterans who may be at risk for suicide and who may benefit from enhanced care, which can include follow-ups for missed appointments, safety planning, and care plans.

With that background and foundation established, I will now turn to the suicide prevention and mental health-related bills on the agenda today.

S. 711

The CARE for Reservists Act of 2019 would authorize VA, in consultation with DOD, to furnish readjustment counseling, without a referral, to any member of the

Reserve Components of the Armed Forces with a behavioral condition or psychological trauma; outpatient services and mental health services would also be available. The bill would further allow VA to include members of the Reserve Components in VA's comprehensive program for suicide prevention and would also allow VA to provide care and services to such members who served in classified missions. Finally, the bill would require VA to submit a report to Congress on the use of certain VA services by members of the Armed Forces and the Reserve Components of the Armed Forces.

Although we support the principle of providing suicide prevention services to members of the Reserve Components, we do not support the expansion of VA's Readjustment Counseling Service (RCS) eligibility to any member of the Reserve Components as this bill is currently written, for reasons tied to the special role of Vet Centers as distinguished from medical care. We would emphasize that we are looking for ways to provide suicide prevention services to members of the Reserve Components in VA's mental health programs. We welcome the opportunity to discuss section 4 of the bill with the Committee to explore those ideas.

The RCS was created to help Veterans who experienced traumatic events or served in combat and are facing readjustment issues as a result. While the bill would focus on members of the Reserve who have a behavioral health condition or psychological trauma, Vet Center counselors are not prepared to treat serious mental illness because many cases of such care require prescription medications, and these Centers lack the infrastructure to support such care as this care is beyond the scope of what Vet Centers provide. While well-intentioned, we believe such an expansion could undermine this focus of the RCS and could compromise the quality of the services they provide to Veterans who are currently eligible. This would also blur the line to some extent between VA's Vet Centers and medical clinics. Concerning section 3 of the bill, which would permit VA to furnish mental health services to members of the Reserve Components, we are concerned this could have the unintended result of providing greater benefits to members of the Reserve Components than Veterans who meet statutory eligibility under other provisions of law. On a technical level, we are unsure whether the legislation is intended to permit DOD to reimburse VA for such care. We would appreciate the opportunity to discuss the intent of this provision with the Committee. Finally, we do not support section 5, which would require VA to submit an assessment to Congress on current and future utilization. We believe this would be redundant in some respects, as VA's RCS already submits an annual report on its workload, including services provided to members of the Armed Forces. We would like to work closely with the Committee on our efforts to augment the availability of VA services to those in Reserve Components.

S. 785

The Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019, is a sweeping bill that includes 35 different provisions. VA would like to discuss with the Committee in detail the abundance of ideas in the bill, so that any legislation Congress enacts will ensure VA can maintain a strong focus on suicide prevention, and not create overlapping initiatives that pose the risk of confusing duplication of programs and undue complications in our efforts.

Title I of S. 785 would expand eligibility for mental health care for Veterans, amend VA's statutory authority regarding the enrollment system for VA health care, require the Department of Labor (DOL) to promote information on VA benefits and issue grants to support transition assistance, require VA to enter into an agreement to compile a list of community-based programs, and modify VA's authority to furnish care to Veterans with other than honorable discharges.

VA defers to DOL on sections 101(c) and 102. VA does not support section 103 as VA is already implementing a similar provision enacted as section 401 of Public Law 115–407.

Title II is focused on suicide prevention. Section 201 would require VA to provide grants to eligible community entities to provide or coordinate the provision of mental health supportive services for Veterans with mental health conditions. VA strongly supports this concept as it supports recently-issued Executive Order 13861, National Roadmap to Empower Veterans and End Suicide, which requires the establishment of a grant program and aligns with a similar proposal in VA's FY 2020 budget request. We do have concerns with some aspects of the language of the section 201 grant program, as it may be too limiting as far as the Veterans the grantee entities could assist. There are also other technical issues we'd like to work with the Committee to resolve. We are eager to partner with you on a grant program that could truly make a difference for at-risk Veterans.

Title II would also require VA to designate one week per year to organize outreach events and educate Veterans on how to conduct peer wellness checks, or "Buddy Checks." It would also direct VA, in consultation with DOD and DHS, to enter into partnerships with non-profit mental health organizations to facilitate posttraumatic growth among Veterans who have experienced trauma, as well as develop metrics to track progress on each of the 14 goals and 43 objectives outlined in the National Strategy for Preventing Veteran Suicide. There are several associated reports included within these provisions. Similarly, VA would further be required to complete a study on the feasibility and advisability of providing complementary and integrative health (CIH) treatments at all VA facilities and would also be required to begin a program to provide CIH services to Veterans for the treatment of Post Traumatic Stress Disorder (PTSD), depression, anxiety, and other conditions. Finally, Title II would require the Comptroller General to report to the Committees on Veterans' Affairs on VA's efforts to manage Veterans at high risk of suicide.

Outreach, partnerships, studies and evaluation are a core part of the VA's current suicide prevention efforts. VA's current efforts address many of the elements of Title II, and as a result we believe those provisions are duplicative. For example, we believe the Buddy Check week provision is redundant, given other robust efforts to increase awareness and support. We do not believe it is advisable to pursue the posttraumatic growth (PTG) program required by this section, because currently there is little scientific evidence to support its effectiveness as a separate clinical intervention (Wagner et al, 2016; Zoellner et al, 2011). VA currently has a range of effective treatment approaches that promotes recovery and is well-grounded in the academic literature. Concerning CIH treatments, these treatments are already available at many VA facilities; we strongly support the use of CIH treatments within VA and are actively working to comply with the requirements of Subtitle C, Complementary and Integrative Health, from the Jason Simcakoski Memorial and Promise Act (Title IX of Public Law (P.L.) 114–198, the Comprehensive Addiction and Recovery Act of 2016). As a result, we do not believe further statutory requirements would be beneficial. We are also concerned that animal therapy, agritherapy, and outdoor sports therapy, as referenced in the bill, are not widely available, nor well studied as effective treatments (Strauss et al, 2011; Wehbeh et al., 2014). Further studies into these complementary therapies are underway and we hope to know more in coming years.

Title III of S. 785 would focus on programs, studies, and guidelines on mental health. Specifically, VA would be required to: (1) commence a program to assess the feasibility and advisability of using computerized cognitive behavioral therapy to treat eligible Veterans experiencing depression, anxiety, PTSD, military sexual trauma (MST), or substance use disorder (SUD) who are already receiving evidence-based therapy from VA; (2) conduct a study (which could be performed in part through a contract with academic institutions or other qualified entities) on the connection between living at high altitude and the risk of developing depression or dying by suicide among Veterans; (3) complete the development of clinical practice guidelines for the treatment of PTSD, MST, and Traumatic Brain Injury (TBI) that is comorbid with SUD or chronic pain; (4) issue an update to the VA/DOD Clinical Practice Guidelines for Assessment and Management of Patients at Risk for Suicide; and (5) develop and implement an initiative to identify and validate brain and mental health biomarkers among Veterans, with specific consideration for depression, anxiety, PTSD, TBI, and other mental health conditions.

In general, we do not believe these provisions are necessary, either because Veterans already have access to some services in the case of computerized cognitive behavioral therapy or because current efforts will satisfy these requirements, as in the case of the two provisions regarding clinical practice guidelines. For example, the topic of altitude related to hypoxia and suicide is already undergoing scientific investigation (see Reno et al, 2018; Riblet et al, 2019). Regarding the provision concerning biomarkers, the use of data collected must be specified in a research protocol and informed consent so that participating study enrollees may make an informed decision about what happens to their private health information. We generally do not believe the research studies that would be required by this Title are necessary either, given ongoing and completed work. VA has been actively engaged in biomarker research for numerous years, having highlighted numerous findings in precision medicine including blood tests that can predict which mental health patients will begin thinking about suicide or attempt it and apps developed to help patients monitor their mood and stressors (Le-Niculescu et al, 2013; Niculescu et al, 2015). In response to the provision on VA/DOD clinical practice guidelines for comorbid mental health conditions, we have concerns about the feasibility of implementing this section and believe it would be redundant to current efforts and there

are other concerns regarding implementation. VA and DOD are also updating the clinical practice guidelines on the assessment and management of patients at risk for suicide, and we expect this work to be completed soon.

Title IV is focused on oversight of mental health care and related services. It would require a number of reports and studies from VA or others (including the Comptroller General) on the effectiveness of VA's suicide prevention and mental health outreach materials and campaigns and on VA's progress in meeting the goals and objectives of EO 13822. VA also would be required to establish goals for its mental health and suicide prevention media outreach campaigns in raising awareness about these topics. The Comptroller General would be required to submit to the Committees on Veterans' Affairs a management review of VA's mental health and suicide prevention services, as well as a report on VA's efforts to integrate mental health care into VA primary care clinics. Finally, VA and DOD would be required to submit to Congress a report on VA mental health programs, DOD mental health programs, and joint programs of the Departments.

Similar to Title III, we believe many of these provisions would impose significant reporting requirements that would be burdensome to meet, could divert employees' attention from patient care and program management, and in our view would not produce significant additional value. Moreover, similar reporting requirements already exist for several areas, particularly concerning VA and DOD programs.

Title V is focused on improving VA's medical workforce. Title V would modify VA's appointment authority for psychologists, require a staffing plan to address shortages of psychiatrists and psychologists, require VA to develop an occupational series for licensed professional mental health counselors and marriage and family therapists, require VA to assess the capacity of women peer specialists in VA, establish a readjustment counseling service scholarship program, and require VA to ensure that each VA medical center is staffed with no less fewer than one suicide prevention coordinator. It would further direct the Comptroller General to submit to the Committees on Veterans' Affairs a report on VA's RCS, while also requiring VA to report on the resources required to meet unmet needs for VA's Vet Centers and to conduct a study on the attitudes of eligible Veterans toward VA offering appointments outside the usual operating hours of VA facilities. Title V would also establish direct hiring authority in Title 5 U.S.C. for certain VA health care positions.

We note generally that recruitment and retention of medical professionals are critical to ensuring that VA has the right doctors, nurses, clinicians, specialists and technicians to provide the care that Veterans need, and VA has placed a special focus on bringing the best mental health professionals into VA service. The FY 2020 budget strengthens VHA's workforce by providing funding for 342,647 full-time equivalent positions, an increase of 13,066 over 2019. VA is also actively implementing authorities enacted as part of Public Law 115–182, the Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act, which increased VA's ability to recruit and retain the best medical providers by expanding existing loan repayment and clinical scholarship programs; it also established the authority to create several new programs focused on medical school students and recent graduates. VA is also implementing additional initiatives to enhance VA's workforce, such as the expanded utilization of peer specialists and medical scribes.

With that background established, turning to the provisions of Title V, the Department does not object to section 509, requiring that the Secretary ensure that all VA medical centers have at least one suicide prevention coordinator. VA agrees with that policy, and in fact that goal is already being met. VA defers to the Government Accountability Office (GAO) on section 506, which would require a Comptroller General report regarding VA's RCS, though it is important to note that RCS already has similar reporting criteria as a part of the annual congressionally mandated report currently outlined in 38 U.S.C. 1712a. As noted above, the remainder of Title V includes numerous changes in personnel authorities, a new specialized scholarship program, and multiple reports and plans. Especially with the enactment of significant VHA workforce provisions in the MISSION Act in June 2017, which VA is now implementing, VA would like to discuss these provisions in detail with the Committee. Some we believe would be duplicative of ongoing efforts and planning. VA wants to be careful that layering new requirements in light of the multitude of ongoing programs in the same area could distract personnel and resources from VA's current efforts. In addition, there are technical issues with some of the provisions we would like to discuss with the Committee.

Title VI would seek to improve VA's telehealth services, which are an important means of expanding access to high quality care, by requiring VA to enter into partnerships and expand existing partnerships between VA and community entities to expand telehealth capabilities and the provision of telehealth services to Veterans

through grants. It would also require VA to assess current telehealth security protocols.

We are continuing to enhance our telehealth programs and appreciate the Committees' interest in bolstering VA's efforts. The first provision in Title VI includes provisions that are similar to VA's Advancing Telehealth Through Local Access Stations initiative. The bill would go farther, though, in also creating a grant program to support these efforts. We welcome the Committee's support of these efforts and would appreciate the opportunity to discuss this further with the Committee to ensure that any legislative action does not limit our existing efforts. There are some details included in the legislation that could present problems that we believe could be avoided. For example, the inspection requirement would be difficult to scale and, we believe, impossible to fully maintain and enforce. Concerning the latter part of Title VI, we believe the language in this bill is ambiguous, and VA is uncertain what exactly the intended effect of this language is. We believe that elements of section 602, particularly in the networks, equipment, operators, and organizations involved, are outside the scope of VA's mission and authorities. We are also concerned that attempting to undertake the requirements of Title VI could affect other critical efforts of VA. We believe it would be advisable to have further discussions with the Committee, along with the Federal Communications Commission, to discuss this provision in more detail.

*Legislation Concerning Women Veterans*

On our ongoing efforts to ensure the needs of women Veterans are met, VA has made significant progress. We now provide full services to women Veterans, including comprehensive primary care, gynecology care, maternity care, specialty care, and mental health services. The FY 2020 budget requests $547 million for gender specific women Veterans' health care, a $51 million increase over 2019.

The number of women Veterans using VHA services has tripled since 2000, growing from nearly 160,000 to over 500,000 today. To accommodate the rapid growth, VA has expanded services and sites of care across the country. VA now has at least two Women's Heath Primary Care Providers (WH-PCP) at all of VA's health care systems. In addition, 91 percent of community-based outpatient clinics have a WH-PCP in place. VA now has gynecologists on site at 133 sites and mammography on site at 65 locations. For severely injured Veterans, we also now offer in vitro fertilization services through care in the community and reimbursement of adoption costs.

VA is in the process of training additional providers, so every woman Veteran has an opportunity to receive primary care from a WH-PCP. Since 2008, 5,800 providers have been trained in women's health. In FY 2018, 968 Primary Care and Emergency Care Providers were trained in local and national trainings. VA has also developed a mobile women's health training for rural VA sites to better serve rural women Veterans, who make up 26 percent of women Veterans. This budget will also continue to support a full-time Women Veterans Program Manager at every VA health care system who is tasked with advocating for the health care needs of women Veterans.

VA is at the forefront of information technology for women's health and is redesigning its computerized patient record system to track breast and reproductive health care. Quality measures show that women Veterans who receive care from VA are more likely to receive breast cancer and cervical cancer screening than women in private sector health care. VA also tracks quality by gender and, unlike some other health care systems, has been able to reduce and eliminate gender disparities in important aspects of health screening, prevention, and chronic disease management. We are also factoring care for women Veterans into the design of new VA facilities and using new technologies, including social media, to reach women Veterans and their families. We are proud of our care for women Veterans and are working to increase the trust and knowledge of VA services of women Veterans, so they choose VA for benefits and services.

With that background and foundation, we will turn now to related bills on today's agenda.

S. 514

We appreciate the intent and focus of S. 514, the Deborah Sampson Act, which seeks to improve the benefits and services provided by VA to women Veterans in a variety of ways. For example, subject to the Congress appropriating additional funding to support implementation, the Administration can support authorization for VA to furnish counseling in group retreat settings to persons eligible for RCS from VA including retreats specifically for women Veterans, as well as extending, from 7 to 14 days, coverage of newborns of a woman Veteran receiving delivery care.

VA does not object to section 102, regarding Women Veterans Call Center, as we implemented the texting feature called for by the provision in April of this year. VA also agrees with the bill's intent to buttress the Women Veterans Health Care Mini-Residency Program by one million dollars annually, to provide more opportunities for participation by primary care and emergency care clinicians. We would like to discuss this provision with the Committee, however, as the ambiguous wording of the provision could have the unintended consequence of actually reducing the resources VA dedicates now to the program.

VA estimates the cost of these provisions to be:

- Approximately $505,000 to conduct six retreats in FY 2019, $2.7 million over 5 years, and $6.07 million over 10 years;
- $8.8 million in FY 2020, $46.6 million over 5 years, and $100.6 million over 10 years to provide extended coverage of newborns; and
- $1 million in FY 2019, $5 million over 5 years, and $10 million over 10 years to provide opportunities for participation in the Women Veterans Health Care Mini-Residency Program.

We also support, conditioned on the availability of additional appropriations, section 201 which would require VA to establish a partnership to provide legal service to women Veterans, and, again subject to the availability additional appropriations, section 202, which would authorize additional amounts for the Supportive Services for Veterans Families (SSVF) grant program to support organizations that have a focus on providing assistance to women Veterans and their families. Regarding section 201, we support this provision with modifications, specifically allowing such assistance to be available to male Veterans as well; we also have some further recommendations on improvements to this section as well. We do not believe the gap analysis required by section 203 is necessary. We estimate the authorization of additional amounts for the SSVF program would cost $60 million for FY 2020 through FY 2022.

Other provisions of the bill, though, present challenges that VA would appreciate the opportunity to discuss with the Committee. For example, we appreciate the intent of section 401, which would require VA to retrofit existing VA medical facilities with fixtures, materials, and other outfitting measures to support the provision of care to women Veterans at such facilities. VA currently has the authority, and has made it a priority, to renovate or improve its facilities to protect the privacy, safety, and dignity of women Veterans. We are concerned that subsection (a), for example, would legislate specific requirements that are better addressed through current construction standards. Other provisions, such as section 402, are unnecessary because VA already has authority to employee women's health primary care providers, resources permitting.

We also do not support other provisions of the bill, particularly those in Title V dealing with data collection and reporting. In general, we believe these requirements are too onerous and will provide too little benefit to justify the time and expense involved in collecting this information.

S. 318

S. 318 would expand the scope of benefits for newborn children of women Veterans by authorizing VA to furnish transportation necessary to receive covered health care services. The bill also would allow VA to furnish more than 7 days of health care services to a newborn child and to provide transportation necessary to receive such services, if such care is based on medical necessity, including cases of readmission.

VA supports in principle providing medically necessary transportation benefits for newborns. The bill presents, however, a few technical concerns, such that we do not support the bill in its current form. For example, it would allow VA to "waive" a debt that a beneficiary owes for medically necessary transportation provided for a newborn that was incurred prior to enactment of this Act. VA would generally have no ability to waive such a debt because the debt would not be owed to VA; further, VA would not have been a party to the transportation agreement or arrangement entered into by the beneficiary and a third party. In addition, the bill's exception to the otherwise applicable 7-day limitation on the duration of services is sweeping in scope. We would welcome the opportunity to discuss this to better understand the Committee's intent.

*Legislation on Health Care Quality and Access*

VA has been making a concerted effort to improve the quality of care we furnish and the ability of Veterans to access this care. Our efforts are paying dividends. Since 2014, the number of annual appointments for VA care has increased by 3.4

million, with over 58 million appointments in FY 2018. Simply put, more Veterans are choosing to receive their health care at VA. Patients' trust in VA care has risen steeply—currently at 87.7 percent—and a 2019 study in the Journal of the American Medical Association[1] shows that VA average wait times are shorter than those in the private sector in primary care and two of three specialty care areas reviewed. A 2018 Rand study[2] found that the VA health care system "generally delivers higher-quality care than other health providers," and a 2018 Dartmouth study[3] found that "Veterans Health Administration hospitals outperform non-Veterans Health Administration hospitals in most health care markets."

We appreciate Congress' support of our efforts and its interest in further improving the quality and accessibility of VA care. In addition to the telehealth provisions of S. 785, numerous bills address the provision of health care to Veterans.

S. 123

The Ensuring Quality Care for Our Veterans Act would require VA to enter into a contract or agreement with a non-Federal organization to conduct a clinical review for quality management of hospital care or medical services furnished by certain VA providers. We do not support S. 123, as VA already closely monitors the quality of care provided and uses peer review to further ensure we are delivering safe and effective care. We also have a strong institutional disclosure process and policy.

S. 450

The Veterans Improved Access and Care Act of 2019 is intended to improve access by requiring VA to conduct a pilot program to assess the feasibility and advisability of expediting the onboarding process for new medical providers and to submit to Congress a strategy to reduce the duration of the hiring process by half for licensed professional medical providers. The pilot program would have VA seek to reduce the time to onboard medical providers to no more than 60 days. While we appreciate the intent of this bill, we do not support S. 450 because VA can achieve the goals of the proposed pilot program with currently available approaches and strategies. We are glad to brief the Committee regarding this initiative.

S. 850

The Highly Rural Veteran Transportation Program Extension Act would allow VA to continue operating the Highly Rural Veteran Transportation Program through FY 2021; this program helps provide grantees greater flexibility to employ new approaches to serving such Veterans, resulting in improved service and health care access for Veterans. VA strongly supports S. 850, but VA would like to extend this authority through 2029, as requested in our FY 2020 budget request.

*Legislation Addressing Veteran Homelessness*

S. 980

The Homeless Veterans Protection Act would make a number of improvements to VA's authorities that VA generally supports, on the condition of the availability of additional resources. In particular, we support section 3, which would require VA to enter into partnerships with public or private entities to provide general legal services to Veterans who are homeless or at risk of homelessness. The language further specifies that VA is only authorized to fund a portion of the cost of legal services. VA supports the intent of section 3—this was a legislative proposal in VA's FY 2020 budget request. Legal services remain a crucial but largely unmet need for homeless and at-risk Veterans, but we respectfully recommend technical amendments to the bill language. We believe some additional changes could be made to other provisions to improve the bill and would welcome the opportunity to work with the Committee in this regard. We appreciate the intent of section 4, which would extend dental benefits to additional Veterans enrolled in the VA health care system.

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[1] Penn, M. (2019, January 18). Comparison of Wait Times for New Patients Between the Private Sector and VA medical centers. Retrieved April 17, 2019, from https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2720917

[2] Anhang Price, R., & Farmer, C. (2018, April 26). VA Health System Generally Delivers Higher-Quality Care Than Other Health Providers. Retrieved April 18, 2019, from https://www.rand.org/news/press/2018/04/26.html

[3] https://tdi.dartmouth.edu/news-events/veterans-health-administration-hospitals-outperform-non-vha-hospitals-most-healthcare-markets

However, because of likely very significant costs for section 4 we cannot support it absent a realistic prospect of future funding availability.

*Legislation Regarding Other Health Care Matters*

S. 221

This bill would require VA to report certain health care employees against whom a performance or conduct-based major adverse action was taken to the National Practitioner Data Bank (NPDB). VA would be prohibited from entering into settlement agreements with employees that conceal a serious medical error or purge a negative record from a VA employee's personnel file. While we certainly agree with the principles underlying this bill in terms of ensuring quality care, we do not support this legislation. NPDB reporting is for substandard care, professional misconduct, or professional incompetence. VA is in the process of rewriting policy and regulations related to reporting to NPDB to incorporate more comprehensive and stringent reporting requirements than those outlined in this bill. We also note that existing VA regulations and policy forbid any formal or implied agreement prohibiting the reporting of a licensed health care professional to a State licensing board or the NPDB.

S. 1154

S. 1154, the "Department of Veterans Affairs Electronic Health Record Advisory Committee Act," would establish an advisory committee to provide guidance to the Secretary and Congress on VA's implementation of and transition to an electronic health record system.

VA does not support S. 1154. We believe the Department, in concert with DOD, is already fulfilling the aims of the bill by its continuing collaboration with clinical, business, and information technology stakeholders and Veterans Service Organizations, as well as our work in partnership with the Congress to advance the best possible technology to support the best possible care for Veterans. We also believe there are already multiple avenues for robust Congressional oversight, including regular briefings and Congressional hearings on the progress of the Electronic Health Record Modernization (EHRM) effort, engagement with GAO, regular statutory reporting requirements, and responses to Congressional inquiries. We believe the additional layers of review by an 11-member advisory committee would not only be unnecessary given the above but would also be unduly complicated and distract attention and resources from our core EHRM efforts and partnerships.

We also believe the requirement to have meetings no less frequently than monthly for an 11-member advisory committee would be excessive. Moreover, that requirement will present what we believe would be unworkable conflicts with the Federal Advisory Committee Act (FACA), which would be applicable to the new EHRM Advisory Committee. FACA requires a detailed meeting notice of a meeting be published in the *Federal Register* no later than 15 days before the date of the meeting. In addition, should the Advisory Committee wish to close all or part of a meeting to the public, the Department would need to be accorded 30 days to respond to the request. We believe these requirements are incompatible with a monthly meeting schedule.

*VA Benefits Measures*

S. 857

S. 857 would amend 38 U.S.C. § 1562(a) to increase the amount of special pension for Medal of Honor recipients to $3000, effective 180 days after the date of enactment, but if this date is not the first day of a month, the first day of the first month beginning after the date that is 180 days after enactment. If the effective day is prior to December 1, 2019, the monthly rate of the pension would not be increased by the cost of living adjustment (COLA) for FY 2020, and the annual COLA would resume effective December 1, 2019. VA supports an increase in the pension for these heroes provided Congress can identify an offset for the mandatory benefit costs. Benefit costs are estimated to be $693,000 in the first year, $6.6 million over 5 years, and $14.7 million over 10 years. There are no additional full-time equivalent or general operating expense costs associated with the proposed legislation.

S. 1101

S. 1101, the "Better Examiner Standards and Transparency for Veterans Act of 2019" ("BEST for Vets Act of 2019"), would amend section 504(a) of the Veterans' Benefits Improvements Act of 1996 to authorize VA to contract with non-physician healthcare providers to conduct disability examinations. VA would have to report to

Congress no later than one year after the date of enactment of this Act and not less frequently than once each year thereafter, on the conduct of the program.

VA supports this bill with the clarification that VA will contract with licensed non-physician providers to perform medical disability examinations. Along with licensed physicians, VA has historically utilized VA physician assistants, audiologists, and nurse practitioners to perform disability examinations. These individuals have been medically trained and have demonstrated their competence to conduct examinations. Enabling licensed non-physicians to perform contract examinations would greatly increase the number of examiners available for this important segment of the disability claims process.

We believe that section 2(a)(2) of S. 1101 is not in fact a "prohibition" because section 2(d) of the bill expands the medical professionals authorized to provide exams from licensed contract physicians to licensed contract health care providers. VA would appreciate the opportunity to provide technical assistance to the Committee to streamline this bill.

There are no costs associated with this bill.

DRAFT BILL REGARDING CONTINUANCE OF EDUCATIONAL ASSISTANCE FOR TEMPORARY CLOSURE OF EDUCATIONAL INSTITUTIONS

The draft bill would extend the authority of the Secretary of Veterans Affairs to continue payments of educational assistance and subsistence allowances to eligible persons when educational institutions are temporarily closed until 8 weeks after the temporary closure. VA supports this bill because it would ensure that beneficiaries are not disadvantaged during emergency situations that are due to no fault of their own. Benefit costs associated with this bill are insignificant.

*Legislation on Other Matters*

S. 805

The Veteran Debt Fairness Act would (1) require VA to improve notice about debts that is provided to VA beneficiaries, (2) limit the authority of the Secretary of Veterans Affairs to recover overpayments made by the Department and other amounts owed by Veterans to the United States, and (3) makes changes regarding the adjudication of disputes over collections.

With respect to improving the processing of Veteran's benefits, VA continues to make progress in centrally tracking debts incurred by Veterans, to include providing more standardized electronic and standard mail notifications that would, to the fullest extent possible, and considering the limitations, consolidate the full scope of each Veteran's debt into one notification. The Office of Enterprise Integration is working with all internal VA stakeholders (i.e., Office of Management (OM), Veterans Experience Office, Office of Information Technology, VHA, and VBA) to establish an integrated program management plan and identify a lead office for implementation of our Veteran debt management efforts from an enterprise level.

While VA appreciates the intent of this bill and is continuing to work with Committee staff to address VA debt management, VA does not support the bill in its current form. We believe some provisions are duplicative of current efforts, while others present technical and implementation issues as detailed below. We pledge to continue to work with the Committee to improve our debt collection program.

Regarding the requirement in section 2(a) of the legislation that VA develop a method by which individuals may elect to receive notice of debt by electronic means in addition to standard mail, VHA is currently developing an electronic option to permit viewing of monthly Patient Medical Statements via the "My Healthevet" portal (https://www.myhealth.va.gov/mhv-portal-web/home). By July 2019, Veterans will be able to view or print their statements electronically via the portal. These statements are currently delivered by standard mail to Veterans who are required to make co-payments; the statements advise Veteran patients of their medical copayment debts, provide a description of those debts, and present all payment options available to them. VBA and OM are in the initial scoping and planning phases for electronic notification of VBA-related debts.

Some of the proposed amendments to 38 U.S.C. § 5314, set forth in section 3 of the legislation, are not consistent with other statutes outside of Title 38. For example, 31 U.S.C. § 3711, entitled "Collection and Compromise," provides that, "The head of an executive, judicial, or legislative agency shall try to collect a claim of the U.S. Government for money or property arising out of the activities of, or referred to, the agency." Pursuant to existing law and regulation, VA returned to our respective programs over $1.6 billion through debt collection in FY 2018, thereby allowing recovered funds to be reused for Veterans programs. Failure to collect any portion

of these funds would therefore increase the mandatory benefit budget request by that amount.

With respect to the due process notice periods set forth in the legislation, VA notes that in cases where a debt dispute is not submitted within 30 days from VA's initial notification of indebtedness, the Department will still have to comply with Public Law 104–134 and the Debt Collection Improvement Act (DCIA) of 1996 to refer the debt to the Department of the Treasury Offset Program (TOP) when the debt reaches 120 days. Not referring the debt to TOP timely would be a violation of the DCIA.

The prohibition in section 3 on recoupment of debt by offset more than 5 years after the date the debt was incurred is contrary to 31 U.S.C. § 3716, which does not place a time limit on VA's ability to collect via offset. Further, the prohibition on recoupment of debt by offset more than 5 years after the date the debt was incurred is also contrary to 28 U.S.C. § 2415(i), which does not impose any limitation on the time period for agencies of the United States to collect claims by means of administrative offset. Additionally, disputing and appealing a debt sometimes takes years, delaying collections significantly. Considering such appeals delays, particularly in cases where a debt is discovered after the fact and established retroactively, VA may end up not being able to collect some debts.

With respect to reforms intended to improve due process, VA appreciates the bill's recognition that different notice periods are appropriate for different benefit programs. For example, the 45-day notice period for debts incurred as a result of a person's participation in a program of educational assistance administered by the Secretary recognizes that, with education debts, there was a risk in extending the notice timeline to 90 days before a deduction may be made as there may not be an education benefit to offset after 90 days.

Another concern is that limiting VA's ability to recover debts through offset could impact agreements VA has with the Defense Finance and Accounting Service, which acts on behalf of DOD, to collect such debts. For example: VBA awards Dependent and Indemnity Compensation benefits to a surviving spouse, which results in an offset of DOD Survivor Benefit Plan benefits and a potential debt to DOD. VA would collect any potential debt by withholding it from any retroactive benefits and then reimburse DOD. However, this debt is not a result of any of the five elements of the proposed legislation and may go back more than 5 years.

Additionally, VA routinely creates debts in excess of $2,500. For example, VA's compensation program has over 150,000 such debts. All VA benefit debts currently have a dispute process in place for validation. A secondary review would impose a significant additional burden which would further delay the collection process, potentially causing non-compliance with the DCIA, which requires debt referral within 120 days.

Finally, with respect to the issue of correcting erroneous information submitted to consumer reporting agencies (CRA), it is important to note that VHA does not submit debt information to CRAs. However, pursuant to 31 U.S.C. 3711(g)(1), VHA is required to refer delinquent accounts to the Treasury Cross Servicing program. Notwithstanding the fact that VHA does not submit debt information directly to CRAs, the VA's Debt Management Center (DMC) does refer delinquencies to them for VBA debts. However, the DMC also corrects CRA reports when needed, either through the Online Solution for Complete and Accurate Reporting or when internal processing determines a negative remark needs to be corrected. An internal processing example would include if the DMC sent debt notification letters to a deployed reservist; DMC would remove the negative remark when the reservist advised DMC of the situation. VA also provides written notice to a debtor when a CRA referral is changed.

As noted above, VA has been working with the Committee staff on these and numerous other Veteran debt management issues and looks forward to continuing such work for the benefit of Veterans.

S. 524

S. 524, the "Department of Veterans Affairs Tribal Advisory Committee Act of 2019," would establish an advisory committee to provide advice and guidance to VA on matters relating to Indian tribes, tribal organizations, and Native American Veterans and to annually report to Congress on the Committee's recommendations.

VA supports this bill as an opportunity to strengthen and potentially expand opportunities for partnerships between the Department and tribal governments, provided Congress appropriates additional funds to support implementation. VA also supports this bill because it would provide a forum in which the Secretary and senior VA leadership could engage with tribal leadership on a scheduled, recurring

basis. Native American Veterans may sometimes be viewed as members of a minority group rather than citizens of political entities which should be consulted with and engaged on a government to government basis in regular discussion and partnership. However, many issues involving Native American Veterans are not related to Native American Veterans' minority status, and thus do not fall within the purview of the Advisory Committee on Minority Veterans. The Committee proposed by this bill would provide a forum for consideration of issues related to the relationship tribal governments have with the United States, such as opportunities for VA collaboration with the Indian Health Service and Tribal health programs and land tenure issues.

Costs for S. 524 would range between $45,000 and $60,000 annually for committee member travel reimbursement and compilation and distribution of an annual report.

S. 746

S. 746, the "Department of Veterans Affairs Website Accessibility Act of 2019," would require VA, within 180 days after enactment, to conduct a study on the accessibility of VA websites to individuals with disabilities in accordance with section 508 of the Rehabilitation Act of 1973 and to report to Congress within 90 days after completion of the study on the websites that are not accessible and a plan to bring such websites into compliance.

While VA agrees with the purpose of the bill, we believe it is unnecessary as system owners scan and remediate their websites as needed. Moreover, we have some concerns with the mandated schedule regarding conducting a review and developing a remediation plan. VA's Section 508 Office currently scans VA websites to identify non-compliant websites, files, and web-based applications. The results of these scans are shared with the Administrations and staff offices responsible for maintaining the Web sites. Furthermore, the inclusion of kiosks and file attachments in the definition of "Web site" significantly expands the scope of what are considered Web sites for VA's section–508 compliance regime. As an example, a file attachment could include any number of items that are not covered under section 508. Finally, we believe that, in practical terms, it would be unrealistic to conduct a universal review within 180 days. While VA does not support S. 746 in its current form, we wish to emphasize that VA system owners are scanning their systems and implementing remediation when necessary in accordance with section 508.

Mr. Chairman, this concludes my statement. Thank you for the opportunity to appear before you today. We would be pleased to respond to questions you or other Members may have.

## OPENING STATEMENT OF HON. JOHN BOOZMAN, ACTING CHAIRMAN, U.S. SENATOR FROM ARKANSAS

Senator BOOZMAN. Thank you so much, Dr. Boyd, and in the interest of time I am going to forego my opening statement.

We do appreciate you all being here very much.

We have 17 bills here that we are going to talk about. Last Congress, in a very, very bipartisan way—that is the hallmark of this Committee—we were able to pass several really significant pieces of legislation that are going to help veterans. We appreciate Secretary Wilkie and the staff that make these things happen, working so hard to actually get those into law, get them in place, so that our veterans will benefit from the legislation we have done.

As you know, this Committee is committed to working with the VA to end the tragic epidemic of veteran suicide. Your testimony mentions a need for an all-hands-on-deck approach to empower veterans' well-being with the goal of ending veteran suicide.

You know, we have talked about this ever since I have been in Congress and it seems like we still have essentially the same number and lots of resources. I guess the question is, what resources or assistance does VA need from Congress in order to move the needle so that we do not continue to talk about the same number year after year?

Mr. CARROLL. Thank you, Senator. I would be happy lead off on answering that. We appreciate your support. Suicide in America is a public health crisis at this point. It affects veterans, which is our focus, but it affects all of the American population. We know, from working with our colleagues in DOD, other Federal agencies, academic experts, that there is no single cause of suicide, in general, and certainly in the veteran population overall. We are working on bundled approaches, implementing the National Strategy for Preventing Veteran Suicide, which was published last year, which looks at care within the facility, and we appreciate your support in terms of advancing our mental health care.

We also know that suicide is not simply a mental health issue. It is not simply something that can be treated on the way forward. We need to support veterans in the communities where they live, work, and thrive. That is why the grant program would be very important to us; working with our State and community partners to make sure that veterans and their families feel supported and welcomed, have a sense of belonging, including in their work places. We need to get beyond the walls of VA. Mental health care is important but we need to get beyond simply the health care system and support these women and men where they live and work.

Senator BOOZMAN. I totally agree that this is something that really does stretch society. The reality, though, in Arkansas and I think throughout much of the country, is the incidence of veteran suicide is quite a bit higher than in the general population. So, you know, there is a problem, yet there is a greater problem in the VA, which we really need to figure out the source of. It is a difficult problem that we are spending lots of money, lots of resources on. So, hopefully we will have some metrics in place to go forward.

One of the things that seems to be working in Arkansas is the private entities. Tell us about public-private collaboration. What are we doing in that area?

Mr. CARROLL. We are working in several ways in that space. We have arrangements with over 60 organizations in partnership, supporting the work that they do. We are also working with VSO groups, including those who are here today with us, both on a national level and working with their local chapters to make sure that veterans and their families are supported in those spaces.

The effort which we have recently launched, in terms of Mayors' and Governors' challenges, is an important effort to get the local community involved. VA is providing the data and resources to help local communities look at the footprint of veterans within their community, look at perhaps the unique risk factors or groups of veterans in their communities that may be at risk for suicide, helping those communities, working with our SAMHSA partners to put together a plan that is tailored for their individual communities.

Senator BOOZMAN. I appreciate that. Thank you very much. In Arkansas, the suicide rate is 48 per 100,000, versus 22 per 100,000; so, there is a significant difference. Again, I think that we would find that throughout the rest of the country.

Your testimony expresses support for S. 980, Section 3, which would enable VA to enter into partnerships to provide legal services to homeless veterans. How would the ability to provide legal

services strengthen VA's efforts to combat veteran homelessness, which is another issue that we are actually making, I think, significant headway.

Dr. BOYD. Yes, we are. Thank you for recognizing that. In fact, overall homelessness has decreased about 49 percent since 2010. We are not there yet. We have a long way to go, but we are improving.

We do know that if we could address the many issues around homelessness, why folks get into a homelessness state, and many times that is a—there are legal issues there. There are legal roots to that. Likewise, the legal issues that maybe crop up and force someone into not having a roof, being homeless, actually then feeds into what we were talking earlier about, the increased risk for suicide and self-harm.

So, anything that we can do to help folks get on the right footing, housing first, work on those other supportive services, and I do believe that we will be in a much better place. We will start nicking away at the rest of that 51 percent.

Senator BOOZMAN. Senator Brown.

**HON. SHERROD BROWN, U.S. SENATOR FROM OHIO**

Senator BROWN. Thanks, Chair. Thank you, Senator Tester.

First I want to thank the two of you, Senator Boozman and Senator Tester, for the Veterans Debt Fairness Act. Many of my colleagues have had conversations with local veterans, with veterans in our States where this had been a problem. I would like to enter two letters in the record, one that came out of testimony from James Powers when we did a field hearing in Columbus, and then the other from John Moser, Master Sergeant John Moser, who read an article about the hearing and had a similar situation.

If I could ask for your consent.

Senator BOOZMAN. Yeah. Without objection.

Senator BROWN. Thank you, Mr. Chairman.

[The letters appear in the Appendix.]

Senator BROWN. I will not recount their stories except to say that he was overpaid a considerable amount—Mr. Powers, $26,000—and it caused him great hardship. He notified the VA a number of times. You know this story; it has happened far too many times. Veterans deal with enough stress. They should not have to deal with stress created by the VA and then the VA unwilling to accept its responsibility.

I have a series of questions about that, first for you, Ms. Murphy. You know, your testimony concerns of the bill, the VA is already working to provide notice for debt collecting activities, actions that this Committee required in a law passed last year. Wouldn't almost all the concerns, Ms. Murphy, that VA raised about the bill be addressed if the VA did a better job keeping track of its payments to veterans in the first place?

Ms. MURPHY. So, the debt issue is certainly a concerning one and no one wants to get a debt letter, and sometimes we acknowledge that those could be more clear, better written. So, we have been working with improving and modernizing the way that——

Senator BROWN. Well, no. It is not just more clear and better written. Acknowledge it was a—they are mistakes.

Ms. MURPHY. Well, and to understand what the root of the debt was, what did or did not happen. We have—we administer——

Senator BROWN. Wait, wait, wait. I know—I mean, you do not work at the White House. I know the White House has not admitted a mistake in 2 years, but the VA could admit a mistake when you one is made. If you overpaid, you made a mistake. I understand it is a huge—I think the VA does great work in CBOCs like Mansfield and the VA in Cleveland, but if you make a mistake, you make a mistake. Acknowledge it to the Committee and then work with veterans to fix this, right?

Ms. MURPHY. Certainly, we have a broad array of benefits that we administer. There is the health care side, the benefit side. I know that these have been worked in different systems, and I think we are taking one of the first efforts, holistically, across the enterprise in VA, at a department level, to look at how we approach debts, how that affects veterans, how we communicate, modernizing the way that we notify. It is a complicated issue——

Senator BROWN. I am sure it is.

Ms. MURPHY [continuing]. And we acknowledge that we need to do a better job.

Senator BROWN. OK. Thank you.

All right. You said that your debt collection allows you to fund other VA initiatives. What about the toll it takes on other—on veterans like James and John?

Ms. MURPHY. Well, sir, we acknowledge individual circumstances have to be addressed. We have provisions for if we need to make a different repayment plan, if it would affect someone. But, we also have to be good fiscal stewards and make sure that we are administering our programs responsibly.

Senator BROWN. When updating the bill language, working with Senators Boozman and Tester, we wanted to make sure that while a veteran is disputing a debt, VA could not take action to collect or reduce a benefit. We want to make sure the VA realized the burden should be on the Department. I understand you make mistakes. We all do. I understand that. But, the burden should be on the Department, not the veteran, understanding that this process could cause additional stress and hardship for a veteran or for the veterans' families.

My question, for Drs. Carroll and Boyd, is this. You work on mental health issues at VA. Do you consider financial hardships as a stressor or risk factor for suicide?

Mr. CARROLL. Yes, sir.

Senator BROWN. Dr. Boyd?

Dr. BOYD. Yes, sir.

Senator BROWN. OK. Do you think VA should have clear policies in place to limit additional stressors for veterans?

Mr. CARROLL. Yes.

Senator BROWN. OK. Dr. Boyd?

Dr. BOYD. Yes, sir.

Senator BROWN. Thank you. Certainly this is part of it. It is, of course, not everything, but these mistakes—if these mistakes ever contribute to a veteran's more likely taking her own or his own life then we obviously have a lot of work to do.

Thank you. Thanks, Mr. Chairman.

Senator BOOZMAN. Senator Murray.

**HON. PATTY MURRAY, U.S. SENATOR FROM WASHINGTON**

Senator MURRAY. Well, thank you. Thank you very much, Mr. Chairman. I am really glad to be here today and have an opportunity to talk about my legislation that will help clarify current law and provide relief and peace of mind to countless veteran moms and their newborns during the most critical moments after a child is born.

But, Mr. Chairman, before I say more about my proposal, I wanted to voice a very grave note of concern regarding the rash of veteran suicides that we have seen across our country. It is a crisis that impacts all of our communities, including my home State of Washington. Over the weekend we had another one of our veterans take their lives, this time at the VA hospital in American Lake.

Every case like this is a tragedy. It defies explanation. For any of our veterans or servicemembers, including those who survived combat in our service, to die by suicide, I believe we cannot just stand by while this epidemic claims more of our veterans. It crushes families and it is overwhelming our communities. I cannot just stand by.

I know the Chairman is not here today but if you and his staff just tell him that I really believe this Committee needs to hold some hearings and take some action to uphold our promise to our veterans, that we will have their back, and do what is necessary to get a handle on this really growing tragedy. I would appreciate it.

Now about today's topic, I am really glad to have a moment to talk about my legislation, to help make life easier for veteran moms and help them get the care that they need for their newborn infants in the event of a medical emergency. Under current law, veterans expecting a child are eligible to have that care covered by the VA, and in some cases, when there is an emergency, the veteran and the newborn may need to be transferred, often by a helicopter, to a hospital that can provide them a higher level of care in that emergency.

However, anecdotal reports from our veterans have unveiled that the VA often improperly refuses to pay the cost of transporting newborns to a more advanced facility and that leaves the veteran stuck with the thousands of dollars in surprise billing.

Now, as this Committee knows, current law clearly states that the VA can cover all post-delivery care services a newborn may need, but bizarrely, the VA so far has refused to pay for those expenses, not to mention current law limits care for newborns to only 7 days, which is a threshold, actually, that can be far too restrictive in certain cases, like premature births.

I know this is not how we, at Congress, intended for this to work for our veterans. So, the bill that I have, in my proposal, called the VA Newborn Emergency Treatment Act, makes clear Congress' intent in the law and makes sure that veterans and their newborns are getting the care they need while being treated with the dignity that they deserve.

The idea that transportation to get newborn infants emergency treatment, would not be covered by the VA is really shocking, and

it really is a needless gap in care. I firmly believe Congress must ensure that no veteran ever faces a surprise bill for benefits they have earned through their sacrifice to our country, especially new moms and babies dealing with emergency situations.

So, I hope colleagues from both sides of the aisle will join me in supporting this necessary fix and make sure we are doing right by our veteran moms and military families, and I look forward to the markup we will have on this.

Dr. Boyd, in my short time left I wanted to tell you I really appreciate the assistance the VA provided us in putting together the Newborn Emergency Treatment Act with working through our technical concerns. I have already incorporated a number of those recommendations you have made to help everyone understand the urgent need for this bill. I did want to ask you, can you describe for us some of the situations when a newborn would need to be moved to a higher-level facility and how urgent it is to get that child into care?

Dr. BOYD. Well, I am not a neonatologist or a pediatrician. However, I am a family doc and a mom. I can share with you that my youngest daughter, who is 28 years old, was born at 30 weeks, so I truly understand where you are coming from on this.

It could be anything from—especially in that 7-day time period, within the 7- to 14-day time period—it could be anything from injuries or issues at birth, through the actual birthing process, all the way to some very rare complications or rare disorders or diseases that manifest within that first time period. There are many things that it could be.

We all wish to have a normal birth and delivery, and all wish to have a healthy newborn. It is not always the case.

Senator MURRAY. Please speak to the 7-day requirement. Tell me when a newborn child would need care longer than 7 days, which is the current coverage.

Dr. BOYD. Again, I would need some SMEs on that for the 14, anything beyond 7, but just so you know we absolutely do support, within S. 514, the expansion of up to 14 days. So, we have no issue with that.

Senator MURRAY. OK. I have some questions about cost and how you came to your cost estimates. I will submit them in writing.

Dr. BOYD. Thank you.

Senator BOOZMAN. Senator Tester.

Senator TESTER. Thank you, Mr. Chairman, and I want to thank you all for being here.

Dr. Carroll, I think you got into the importance of incorporating community-based public health approach to veteran suicide prevention with Senator Boozman's question so I will skip that on mine.

For you, Dr. Boyd, I asked for technical assistance on 10 sections of the Command John Scott Hannon Mental Health Improvement Bill on February 28, and for the entire bill on March 26. It has been a while ago, quite frankly. I have not received any technical feedback. You guys were not fully enamored with the bill. That technical feedback is important. When can I expect it?

Dr. BOYD. First of all, you must know that it is at the utmost front line and center for the Secretary to be very responsive to Congress. So, my understanding is this, that the technical review had

begun on the first 10 provisions, that had been submitted, and then came the remainder, as you stated, later in March. As that was really getting kind of rolling—because some of these are very complex, have multiple decision points and authorities. Then we had the remaining initially 17 new bills that was whittled down to 16. So, it blanketly overtaxed some of our system to ensure that we had the entire agenda to speak from.

But, I do want you to know this. S. 785 is at the center of everything that we do. In fact, there is a lot that we are already doing, and we want to be extremely careful in the vision that you did have. We are at a better place than we were back in February or March. I think that we can move forward with this with continued discussion with the Committee.

Senator TESTER. That is good but I need that technical input. I am just telling you, I just flat need it.

Dr. BOYD. Absolutely.

Senator TESTER. If I do not have it then we are going to do what I think is best, without your input——

Dr. BOYD. I understand, sir.

Senator TESTER [continuing]. And that could be a problem.

S. 711 is another bill that we have got, the Care for Reservists bill, that I do not think the Department is too enamored with, quite frankly. I have got a bunch of questions to put you on the spot but I am not going to do that to you.

I am just going to tell you that everybody who spoke here, from Senator Boozman to Senator Brown to Senator Murray and now I, and quite frankly you guys too, have talked of the importance of reducing suicide. Senator Boozman put it most articulately, that we have done a lot of things which has not affected the numbers. It has not done it. It has not gotten us where we need to be. Not that one suicide is acceptable, but it has not even gotten us close to a point where we can say, "You know what? We have done some good stuff here and we have moved the ball."

We are using reservists in a way that we have never used them before in the past, and it did not start with this administration, by the way. It started in previous administrations. And these folks are coming back with pretty serious problems, that, quite frankly, we created for them. So, if we do not step it up for active duty and for Guard and Reserve, we should not be asking them to sign up to serve, and that is as simple as that.

So, we have got to do something in that area. And, as we look at whether it is S. 785 or S. 711, it is critically important that we figure out what we can do different to make a difference. If we are able to do that then we both can be much prouder of what is going on.

The last thing, then I will kick it back to the Chairman. To Senator Brown's questions on S. 805, he is right, this should not be on the veteran. This should be on the VA. If we do not look at it from that perspective, we are making a big mistake. I do not think you are going to find anybody on this Committee, either side of the aisle, that does not believe that.

So, we look forward to working with the Department to get that fixed too, amongst the other bills.

Thank you, Mr. Chairman.

Senator BOOZMAN. Well, thank you, Senator Tester. Let me just say a couple of things about two or three bills. First of all, I really enjoyed working with Senator Tester on the Deborah Sampson bill. We appreciate your leadership. There are 2 million women vets, 20,000 in Arkansas. As I go around the State, and I am sure Senator Tester, as he goes around Montana, very similar, rural States, I hear that we are blessed with some of the most progressive VA facilities in the country, through a lot of hard work from lots of individuals.

But, one of their top concerns is the inequality of health care between men and women. It is all kinds of things. It is shortage of primary care providers; the lack of respect sometimes shown to our women veterans in the sense of asking where their husbands are in the sense of thinking that they are the wife of a veteran; the gender-specific providers; and the list goes on and on. You all understand that. You are very, very familiar with it. I know you have got some problems with our bill, but certain data collection about where women veterans need their care is something that we can be doing. Some of them are things that you have the ability to do now, without legislation.

I hope that you will work with us. Our VSOs are on board and are doing a great job of pushing this forward. But, this is something unlike suicide, as Senator Tester talked about, the panel talked about, you talked about, which is something that involves all kinds of factors and is a difficult problem.

Inequality is not a difficult problem. This is something that we can solve. It is going to take some work. It is going to take a little bit of change of attitude in some cases, but we can do a better job of providing the resources that we need—privacy, I mean, just these basic things that with the significant increase in our veteran population of women, which is only going to grow substantially as we go forward, are necessary.

Again, I hope that we can work together in that regard.

The other bill that I would like to talk about is Senator Ernst's bill and the idea that you do not hire these practitioners that have had significant problems. You know, there is simply no excuse for that. We need to do a much, much better job in that. I would lump currently licensed, impaired in the past, all those things together. You know, there is simply no excuse for that.

Last, Senator Cotton's bill that increases the stipend for our Medal of Honor winners. I think that is something that we can be so proud of and looking at inflation, that is something else that we need to take care of.

Have you got any other things? Again, thank you all very, very much. We do appreciate your hard work and appreciate your testimony.

Dr. BOYD. Thank you to the Committee. Thank you.

Senator BOOZMAN. OK, Panel 2. Are you guys ready to jump up here and get seated? [Pause.]

Well, we want to welcome our panel. Thank you for taking the time. We do appreciate all of your hard work and all that you represent.

I have a list of organizations that have submitted written statements on today's hearing agenda. We have 4 represented here. We

have 19 others that have submitted data. So, without objection, that is so ordered.

[The statements appear in the Appendix.]

Senator BOOZMAN. Today we are blessed to have Ms. Melissa Bryant, Chief Policy Officer of Iraq and Afghanistan Veterans of America; Michael Richardson, Vice President of Independent Services and Mental Health, Sounded Warrior Project—again, it is great to have you here; Greg Nembhard, Deputy Director of Claims Services, The American Legion—thank you, Greg; Maj. Gen. (Ret.) Jeffrey Phillips, Executive Director, Reserve Officers Association.

We will start with you, Ms. Bryant.

## STATEMENT OF MELISSA BRYANT, CHIEF POLICY OFFICER, IRAQ AND AFGHANISTAN VETERANS OF AMERICA

Ms. BRYANT. Thank you, Senator Boozman, Ranking Member Tester, and to the distinguished Members of the Committee who could not be here at this moment. On behalf of Iraq and Afghanistan Veterans of America, or IAVA, and our more than 425,000 members worldwide, we thank you for the opportunity to share our views, data, and experiences on the legislation in front of the Committee today.

As you have heard me speak to in the past, I am not only the Chief Policy Officer for IAVA, but I am also a third-generation combat veteran. These bills we are discussing today are largely issues which impact me personally, especially as a woman veteran who has been exposed to burn pits, borne of a father who still suffers injuries that he was exposed to by Agent Orange in Vietnam.

I am here as a former Army officer who has lost soldiers to suicide and worked with several others who struggled with suicidal ideation for a variety of factors, ranging from financial stress to survivor's guilt. I am here as a student veteran who used her earned GI Bill benefit to obtain a master's degree in policy mid-career, which is what landed me here today as Chief Policy Officer for IAVA, and to give voice to the voiceless so they can get the support that they deserve from their government so they can live their lives to their fullest potential.

I am going to highlight just a few items here, but overall there are 16 bills contained within the legislation today that IAVA does support. Of our Big Six priorities for 2019, it remains number 1 to be the campaign to combat suicide among troops and veterans. Suicide rates over the past 10 years have been rising at a shocking rate. In 2016, the Centers for Disease Control reports that 45,000 Americans had died by suicide.

To clarify and reiterate what many others have said today, while suicide is an American epidemic and public health crisis, it is severely impacting the veteran population in particular. According to the most recent Department of Veterans Affairs data, 20 veterans and servicemembers die by suicide every day, which is over 7,000 per year. At-risk populations include women veterans, like myself, who are almost twice as likely to die by suicide than their civilian counterparts; and veterans aged 18 to 34, the post-9/11 generation, which IAVA represents, have the highest rate of suicide among any generation of veteran.

We have been watching this trend line for years. In our latest member survey, 59 percent of IAVA members reported knowing a post-9/11 veteran who died by suicide; 65 percent know a post-9/11 veteran who has attempted suicide. In 2014, these numbers were 40 percent and 47 percent, respectively.

More alarmingly, our newest data shows that 43 percent of IAVA members report having suicidal ideation since leaving the military, a 12 percent increase since 2014, showing that more and more veterans and servicemembers in IAVA's community are experiencing suicidal ideation, which is also a risk factor in and of itself for suicide.

This information tracks with the final report under the Clay Hunt SAV Act: the VA Mental Health Program and Suicide Prevention Services Independent Evaluation from 2018. The report shows that veterans ages 18 to 45, the post-9/11 generation, had the greatest proportion of suicidal behaviors, including suicidal attempts and ideation, among any age group and made up almost 40 percent of the overall suicidal behavior totals.

We believe the best next step in addressing this crisis is the passage of the Commander John Scott Hannon Veterans Mental Health Care Improvement Act, S. 785, as discussed earlier today. We thank you, Senator Tester and Senator Moran, who was here earlier. We believe that this bill will bring even greater attention to resources that the VA needs in order to combat the veteran suicide crisis, and IAVA is very pleased with the provisions in the bill to provide grants to organizations to provide mental health care services for veterans not receiving VA care, as well to organizations that provide transition assistance to veterans and their spouses. We were proud to stand with Commander Hannon's family, partner VSOs, and Senators Tester and Moran to introduce the Commander John Scott Hannon Veterans Mental Health Care Improvement Act, and it has IAVA's unqualified support going forward, sir.

We also support the Care and Readiness Enhancement for Reservists Act, otherwise known as CARE, because we do recognize that this is a gap where reservists and our National Guard men and women are not necessarily receiving the same amount of care due to the fact that they are in units that do not necessarily have the same continuum of care as if you were on active duty. We wholeheartedly support this effort as well to close this gap for their mental health as well.

In support for She Who has Borne the Battle, over the past few years there has been a groundswell of support for women veterans' issues. We made the bold choice to lead on this issue, going back, in 2017, when we launched our #SheWhoBorneTheBattle campaign. That is why this year we are wholeheartedly in support of S. 514, which is the reintroduction of the Deborah Sampson Act, which thank you both, gentlemen, in reintroducing this year. We strongly support the passage of that bill, along with the other provisions that have been updated for the version for the 116th Congress.

Again, there are 16 other bills that I could go on to. I am going to focus just on burn pits and toxic exposures. Knowing that we support both CONUS (Contiguous United States) and Camp Lejeune, we also support this bill, as well as defending the GI Bill,

which has always been a long-standing issue for IAVA, since we championed the post-9/11 GI Bill in 2008.

Thank you. I am happy to go through anything else that is within our testimony and to speak more to the support that we have for the 16 other bills that are within this hearing.

[The prepared statement of Ms. Bryant follows:]

PREPARED STATEMENT OF MELISSA BRYANT, CHIEF POLICY OFFICER, IRAQ AND AFGHANISTAN VETERANS OF AMERICA

CHAIRMAN ISAKSON, RANKING MEMBER TESTER, AND MEMBERS OF THE COMMITTEE, On behalf of Iraq and Afghanistan Veterans of America (IAVA) and our more than 425,000 members worldwide, thank you for the opportunity to share our views, data, and experiences on the legislation in front of the Committee today.

IAVA is pleased to see that much of the legislation in front of the Committee today addresses components of our Big Six Priorities for 2019 which are: the Campaign to Combat Suicide, Advocate for Government Reform, Support for Injuries from Burn Pits and Toxic Exposures, Defend Veterans Education Benefits, Support and Recognition of Women Veterans, and Support for Veteran Medicinal Cannabis Use.

As you've heard me speak to in the past, I am not only the Chief Policy Officer for IAVA, but also a third-generation combat veteran. The bills we're discussing today are largely issues which impact me personally—especially as a woman veteran who has been exposed to burn pits, borne of a father who was exposed to and still suffers injuries from Agent Orange. I'm here as a former Army officer who has lost Soldiers to suicide and worked with several others who struggled with suicidal ideation for a variety of factors ranging from financial stress to survivor's guilt. And I'm here as student veteran who used her earned GI Bill benefit to obtain a masters degree in policy mid-career, thus landing me here before you today to passionately advocate for the voiceless veterans worldwide who need the support of their government in so they can live to their lives' fullest potential.

CAMPAIGN TO COMBAT SUICIDE

IAVA's top Big Six priority for 2019 remains the Campaign to Combat Suicide Among Troops and Veterans. Suicide rates over the past 10 years have been rising at a shocking rate; in 2016, the Center for Disease Control reports that 45,000 Americans died by suicide. While suicide is an American epidemic and public health crisis, it is severely impacting the veteran population in particular. According to the most recent Department of Veterans Affairs data, 20 veterans and servicemembers die by suicide every day, which is over 7,000 every year. At risk populations include women veterans who are almost twice as likely to die by suicide than their civilian counterparts. And veterans aged 18 to 34, the post-9/11 generation, have the highest rate of suicide among any generation of veteran.

We've been watching this trendline for years. In our latest member survey, 59 percent of IAVA members reported knowing a post-9/11 veteran who died by suicide; 65 percent know a post-9/11 veteran who has attempted suicide. In 2014, these numbers were 40 percent and 47 percent respectively.

More alarmingly, our newest data shows that 43 percent of IAVA members report having suicidal ideation since leaving the military—a 12 percent increase since 2014; showing that more and more veterans and servicemembers in IAVA's community are experiencing suicidal ideation—a risk factor for suicide. This information tracks with the final report under the Clay Hunt SAV Act: The VA Mental Health Program and Suicide Prevention Services Independent Evaluation from 2018. The report shows that veterans ages 18 to 45—the post-9/11 generation—had the greatest proportion of suicidal behaviors, including suicidal attempts and ideation, among any age and made up almost 40 percent of the overall suicidal behavior totals.

We believe the best next step in addressing this crisis is passage of the Commander John Scott Hannon Veterans Mental Health Care Improvement Act (S. 785), introduced by Sens. Tester and Moran, which will bring even greater attention and resources to VA to combat the veteran suicide crisis. IAVA is very pleased with the provisions in the bill to provide grants to organizations that provide mental health care services for veterans not receiving VA care, as well to organizations that provide transition assistance to veterans and spouses. S. 785 also invests in a number of studies, including the link between elevation and suicide and an evaluation of Vet Centers' Readjustment Counselors efficacy; it also provides for an increased number of tracking metrics to ensure that VA is providing the best possible mental

health care possible. We were proud to stand with Commander Hannon's family, partner VSOs, and Sens. Tester and Moran to introduce the Commander John Scott Hannon Veterans Mental Health Care Improvement Act, and it has IAVA's unqualified support.

In addition to expansion of mental health care for our veterans, we must also focus on our military's Guard and Reserve components. Currently, members of the National Guard and Reserve undergo annual health assessments to identify medical issues that could impact their ability to deploy, but any follow-up care must almost always be pursued at their own expense. Though some National Guard units have worked to expand care, many of these efforts are funded with limited dollars that must also cover training and equipment expenses. The Care and Readiness Enhancement (CARE) for Reservists Act (S. 711) would allow Guardsmen and Reservists to access Vet Centers for mental health screening and counseling, employment assessments, education training, and other services to help them return to civilian life. Access to care for Guard and Reservists is a top concern for IAVA as almost 60 percent of our membership is either currently serving or has served in the Guard or Reserves. It is for those reasons that IAVA supports the passage of this legislation.

SUPPORT FOR SHE WHO HAS BORNE THE BATTLE

Over the past few years, there has been a groundswell of support for women veterans' issues. From health care access to reproductive health services to a seismic culture change within the veteran community, women veterans have rightly been focused on and elevated on Capitol Hill, inside VA, and nationally. In 2017, IAVA launched our groundbreaking campaign, #SheWhoBorneTheBattle, focused on recognizing the service of women veterans and closing gaps in care provided to us by VA.

IAVA made the bold choice to lead on an issue that was important to not just the 20% of our members who are women, but to our entire membership, the future of America's health care and national security. We continue to fight hard for top-down culture change in VA for the more than 700,000 that have served since 9/11, including 345,000 women who have deployed to Iraq or Afghanistan in support of the most recent wars.

This is why in 2017, IAVA worked with Congressional allies on both sides of the aisle and in both chambers to introduce the Deborah Sampson Act (S. 514). This bill called on the VA to modernize facilities to fit the needs of a changing veteran population, increasing newborn care, establishing new legal services for women veterans, and eliminating barriers faced by women who seek care at VA. This bill would also increase data tracking and reporting to ensure that women veterans are getting care on par with their male counterparts.

Although the Deborah Sampson Act, the centerpiece of IAVA's She Who Borne The Battle campaign, was not passed in the 115th Congress, IAVA is pleased with progress made overall in support of women veterans, with key provisions of the legislation passed or funded in the last two years. These hard-fought victories included funding to improve services for women veterans, such as research on and acquisition of prosthetics for female veterans, increased funds for gender-specific health care, women veterans' expanded access and use of VA benefits and services, improved access for mental health services, and for supportive services for low income veterans and families to address homelessness.

While we have seen greater awareness and progress toward improving services for women veterans, there is much more we can do. Toward this goal, IAVA strongly supports passage of the updated Deborah Sampson Act reintroduced by Sens. Tester and Boozman. Provisions of the new bill include expanded peer to peer services, such as the ability for women to receive reintegration counseling services with family members in group retreat settings, increased newborn care services, and an increase in spending in order to retrofit VA facilities to enhance the privacy and environment women are being treated in, including privacy curtains and door locks. It also provides for legal and support services to focus on unmet needs among women veterans, like prevention of eviction and foreclosure and child support issues. This must be the year that Congress passes the Deborah Sampson Act into law.

In addition to the increase in newborn care under the Deborah Sampson Act, IAVA is pleased to support another bill in front of the Committee today, the VA Newborn Emergency Treatment Act (S. 318). This legislation would allow VA to reimburse the cost of emergency transportation related to newborn care. Coupled with provisions in the Deborah Sampson Act this will finally allow VA to give greater care to veteran mothers.

BURN PITS & TOXIC EXPOSURES

Another Big Six priority for IAVA is Support for Burn Pits and Toxic Exposures. Unfortunately, the exposures our servicemembers face isn't only overseas in the wars in Iraq and Afghanistan, but for some it was back home as well. From 1953 to 1987 the drinking water in Marine Corps Base Camp Lejeune was contaminated with chemicals that caused a number of diseases. In 2012 the original Jane Ensminger Act was passed, which allowed those who were exposed to Camp Lejeune's contaminated water to access the treatment that they deserved. The Janey Ensminger Act of 2019 will allow additional research into the symptoms and diseases of those that were exposed to contaminated drinking water on Camp Lejeune. It is for those reasons that IAVA supports the bill in front of the Committee today.

DEFEND THE GI BILL

A temporary school closure can be a very stressful time for military-connected students, and losing their housing allowance adds an additional layer of stress to that situation. Allowing students to continue to receive their housing allowance is a needed fix for this problem. IAVA supports the draft bill in front of the Committee to allow military-connected students affected by temporary school closures to continue to receive their housing allowance during the temporary closure.

MODERNIZE GOVERNMENT TO SUPPORT TODAY'S VETERANS

As of August 2018, there were over 40,000 job vacancies within VHA. While these are difficult-to-fill positions, we need to do more to ensure that VA is capable of closing this employment gap. While closing this gap is critical, we must also guarantee that our Nation's veterans are receiving the best care that is available. It is with this in mind that IAVA supports three additional bills to improve VA hiring and employment practices; the Ensuring Quality Care for Our Veterans Act (S. 123), the VA Provider Accountability Act (S. 221), and the Veterans Improved Access and Care Act of 2019 (S. 450).

The VA Tribal Advisory Committee Act (S. 524) would improve VA outreach, health care, and benefits for Native American veterans through the establishment of a VA Advisory Committee on Tribal and Indian Affairs. Native American and Alaska Native servicemembers face unique challenges when accessing VA services and experience homelessness and health disparities at higher rates than other veterans. The bill aims to eliminate health disparities for Native American veterans by establishing a 15-member Committee comprised of a representative from each of the 12 regions of the Indian Health Service (IHS) and three at-large Native American members. This Committee would ensure greater collaboration between Tribal governments and VA, ensuring that our Native servicemembers are getting the benefits that they deserve. IAVA is proud to support this legislation.

IAVA is pleased to see the Committee take up the important issue of VA overpayments. Overpayments from the VA have been on the rise since 2013. In 2016 alone, the VA issued upwards of 200,000 overpayment notices to veterans, often recouping funds by withholding some or all of a veteran's monthly disability benefit payments. In many of these cases, the overpayment was caused by no fault of the veteran, which only increases frustration when payments are withheld. The Veteran Debt Fairness Act (S. 805) aims to fix this issue with common sense solutions, such as only allowing the VA to collect debts that occur as a result of an error or fraud on the part of a veteran, only allowing the VA to deduct 25 percent of a veteran's monthly payment, and preventing the VA from collecting debts incurred more than five years prior. These are common-sense solutions that will protect veterans from financial hardship caused by accounting errors at VA. IAVA fully supports the passage of this legislation.

The Highly Rural Veteran Transportation Program Extension Act (S. 850) would expand the ability of VA to make grants for qualifying VSOs to provide transportation to veterans in highly rural areas to VA facilities. Veterans that live in highly rural areas deserve the same care as veterans that may live close to a VA facility and this program will allow those veterans to seek that care at no cost to themselves. IAVA is pleased to support this legislation.

The VA Website Accessibility Act (S. 746) would require VA to review all of its websites to determine if they comply with requirements in current law that they be accessible to individuals with disabilities. The bill would require VA to report to the Congress on its findings, and describe its plans to bring its websites into compliance. IAVA supports this bill to ensure that VA's website is accessible to all veterans.

The Medal of Honor is the highest award for valor in action against an enemy force which can be bestowed upon an individual serving in the Armed Forces. Presented to its recipient by the President of the United States of America in the name of Congress. These American heroes often attend and speak at events about their military service at their own expense. While Medal of Honor recipients receive a modest pension, it has not been updated in 15 years. S. 857 would provide necessary funding to allow Medal of Honor recipients to share their personal stories in even more character development programs and speaking engagements, and has IAVA's support.

The VA is currently undertaking a decade-long transition to bring veterans' health records into the 21st century by ensuring that veterans can have access to a seamless electronic health record across the VA and Department of Defense (DOD) health systems. The VA Electronic Health Records Advisory Committee Act (S. 1154) would create another level of oversight on this important transition. The 11-member Committee would operate separately from VA and DOD and would be made up of medical professionals, Information Technology and interoperability specialists, and veterans currently receiving care from the VA. The Committee will analyze the VA's strategy for implementation, develop a risk management plan, and ensure that stakeholders across VA and DOD have a voice in the process. The Committee will meet with the VA Secretary at least twice a year on their analysis and recommendations for implementation. IAVA supports the spirit of this legislation and increased oversight over the electronic health records project, however we would like to see the Committee work with VA to implement systems that are effective and will not add unnecessary burden on the project.

The Better Examiner Standards and Transparency (BEST) for Veterans Act (S. 1101) ensures that only licensed health care providers are conducting medical disability examinations (MDEs) on behalf of VA. Last year, reports revealed that contract physicians with revoked medical licenses have been performing MDEs on behalf of the VA due to a loophole in current legislation. IAVA supports the closure of this loophole and ensures that veterans are only being treated and screened by health care providers that are licensed and qualified.

END VETERAN HOMELESSNESS

The number of homeless veterans has declined in the past decade, and in fact, has dropped nearly 50% since 2010. Despite the enormous advances made in recent years, there are still tens of thousands of veterans who remain homeless on a single night. VA cannot solve this challenge alone. Veterans who struggle with substance abuse or who have been previously incarcerated are often unable to be placed in housing programs. Even more struggle to maintain a permanent home. In our latest member survey, over 20 percent of IAVA members reported going without a home for over a year after they transitioned out of the military, and 84 percent reported couchsurfing temporarily. Housing and homelessness related referrals are among the services most requested through IAVA's RRRP; in 2018 alone, IAVA provided hundreds of veterans and family members with housing and homelessness related support. IAVA is pleased to support the Homeless Veterans Prevention Act (S. 980), which includes several important provisions to address veteran homelessness, such as an expansion of vouchers to dependents of homeless veterans, increased legal and financial services, and studies in order to track the effectiveness of these programs.

Thank you for allowing IAVA to share our views and we look forward to answering any questions you may have.

Senator BOOZMAN. Good. Thank you, Ms. Bryant.

Mr. Richardson.

## STATEMENT OF MICHAEL C. RICHARDSON, VICE PRESIDENT OF INDEPENDENCE SERVICES AND MENTAL HEALTH, WOUNDED WARRIOR PROJECT

Mr. RICHARDSON. Good afternoon, Senator Boozman, Ranking Member Tester, and distinguished Members. Thank you for the opportunity to testify at today's hearing and offer Wounded Warrior Project's perspective on legislation before the Committee.

My name is Mike Richardson and I serve as Vice President at Wounded Warrior Project for all mental and brain health program-

ming. I am a combat veteran and a military retiree, as is my wife. Together we have over 50 years of active duty service.

During my service I also commanded a warrior transition battalion in Europe, so I have not only observed but experienced firsthand the challenges that combat and transitioning cause our veterans.

Before moving our attention to how today's legislation can help address these challenges, I want to praise the Committee's focus on: improving programs and services for female veterans through S. 514; its effort to improve accountability and trust in the VA system through bills like S. 123, 221, and 1101; and its focus on strengthening transition and civilian readjustment with S. 711.

As our community works together to meet the needs of all veterans, these bills and others before the Committee are helping to enhance care and services and increase faith in the VA's ability to evolve with changing demographics and needs.

As I sit before you today, suicide prevention is VA's top clinical priority, as it should be. Wounded Warrior Project's largest program investment is in mental and brain health, and I am here to express our organization's support for the Committee's efforts to bring greater attention to the tragic trend of veteran suicide and its initiative to deliver legislative changes to improve access to care, drive research forward, keep the community accountable, and foster collaboration among stakeholders throughout the mental health spectrum.

As one of those community stakeholders I would like to use this opportunity to focus on mental health more generally so that the Committee can be informed of what we have learned as an organization that unifies programming, provides advocacy, and funds organizations that assist us in delivering our mission to honor and empower wounded warriors.

Our approach to mental health care is grounded in several core and scientifically supported beliefs. To that end we acknowledge that no one organization, no single agency, if you will, can fully meet all the veterans' needs, that empirically-supported mental health treatment absolutely works when it is available and when it is pursued, and that we will find the best results by embracing an integrated and comprehensive public health approach focused on increasing resiliency, psychological well-being, and an aggressive prevention strategy.

All of these concepts are embraced by the intent of the Commander John Scott Hannon Veteran's Mental Health Care Improvement Act, and we believe several proposals in the bill can help veterans not just survive, but really thrive in their communities by helping them create lives worth living, with a purpose.

This bill recognizes that networks of support already exist and new ones can be developed to help VA reach more veterans and enter more communities, and that VA is an indispensable partner in this process.

As an example, through our Warrior Care Network, Wounded Warrior Project is in partnership with four academic medical centers: Emory Healthcare, Massachusetts General Hospital, Rush University, and UCLA Health, who we directed to develop an innovative, 2- or 3-week intensive outpatient program that integrates

evidence-based treatments with wellness, mindfulness, nutrition, yoga, art, and family support.

Veterans are not required to be enrolled in VHA to participate in our Warrior Care Network, but every veteran, including active duty, National Guard, Reservists, and retirees who come through the program consults with an on-site VA employee who enrolls, provides education on essential VA resources, drives referrals to their systems back in the veteran's community before they leave the care of these academic medical centers, and helps create the trust in a VA system that is performing, as studies show, at the same level, or better, than other providers in some communities.

The Warrior Care Network fully incorporates complementary and alternative therapies for veterans while they are in our care, approaches that are embraced in Title II of S. 785.

Our network also drives veterans toward supportive organizations and services back in the home when they depart from us. Many of those organizations are funded through grants from Wounded Warrior Project. We understand that mental health and wellness goes beyond just clinical care.

Our approach to this type of partnership is focused on uniting resources, driving change through maximizing collective impact, serving as a force multiplier, and expanding the network of support. Looking at the Warrior Care Network as the sum of these parts, one of the most telling results is that after completing the intensive outpatient program over 96 percent of warriors are recommending the program to another warrior. This is an example of how we are normalizing the conversation and helping end the stigma around seeking mental health care.

In closing, just this past Monday I was in the great State of Georgia, in the beautiful city of Atlanta, at Emory University, where we had the grand opening of their newly expanded space named Wounded Warrior Project's Brain Health Suite. Because of our space expansion investment in Emory we increased access for the veterans to this life-saving care. Space was a barrier; it no longer is.

I am sure the leadership of Emory, the veterans' programs, and, of course, Wounded Warrior Project would love for the Chairman and any Member of this Committee to stop by for a visit the next time you are in Atlanta.

Again, thank you for allowing us to be part of this very important work as we care for and serve those that served our Nation. Thank you.

[The prepared statement of Mr. Richardson follows:]

PREPARED STATEMENT OF WOUNDED WARRIOR PROJECT

*S. 123, S. 221, S. 318, S. 450, S. 514, S. 524, S. 711, S. 746, S. 785, S. 805, S. 850, S. 857, S. 980, S. 1101, S. 1154, Draft Bill—Janey Ensminger Act of 2019, Draft Bill—A Bill to Amend Title 38, United States Code, to Extend the Authority of the Secretary of Veterans Affairs to Continue to Pay Educational Assistance or Subsistence Allowances to Eligible Persons When Educational Institutions are Temporarily Closed, and for Other Purposes.*

CHAIRMAN ISAKSON, RANKING MEMBER TESTER, AND DISTINGUISHED MEMBERS OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS, Thank you for inviting Wounded Warrior Project (WWP) to testify on these important issues.

Wounded Warrior Project's mission is to honor and empower wounded warriors. Through community partnerships and free direct programming, WWP is filling gaps

in government services that reflect the risks and sacrifices that our most recent generation of veterans faced while in service. Over the course of our 15-year history, we have grown to an organization of nearly 700 employees in more than 25 locations around the world, delivering over a dozen direct-service programs to warriors and families in need.

Through our direct-service programs, we connect these individuals with one another and their communities; we serve them by providing mental health support and clinical treatment, physical health and wellness programs, job placement services, and benefits claims help; and we empower them to succeed and thrive in their communities. We communicate with this community on a weekly basis and are constantly striving to be as effective and efficient as possible.

S. 123—ENSURING QUALITY CARE FOR OUR VETERANS ACT

According to the 2018 WWP Survey,[1] 68.4 percent of WWP's alumni reported using the Department of Veterans Affairs (VA) as their primary health care provider.[2] Additionally, through the delivery of direct services provided to over 125,000 registered alumni, WWP teammates frequently encourage warriors eligible for VA medical benefits to enroll in the Veterans Health Administration (VHA). In contrast, the 2018 WWP Survey also indicates that 43.7 percent of the warriors who chose not to utilize the VA as their primary care provider do so because there is a perception that higher quality care is available outside of the VA. This perception contradicts an April 2018 RAND study which stated:

> "VA hospitals performed on average the same as or significantly better than non-VA hospitals on all six measures of inpatient safety, all three inpatient mortality measures, and 12 inpatient effectiveness measures, but significantly worse than non-VA hospitals on three readmission measures and two effectiveness measures. The performance of VA facilities was significantly better than commercial HMOs and Medicaid HMOs for all 16 outpatient effectiveness measures and for Medicare HMOs, it was significantly better for 14 measures and did not differ for two measures. High variation across VA facilities in the performance of some quality measures was observed, although variation was even greater among non-VA facilities.[3]"

While we know via the recent RAND study that VA is performing on average at the same level or significantly better than non-VA hospitals, there are always ways to improve. One such improvement is to ensure that no medical providers are practicing with revoked licenses. The Ensuring Quality Care for Our Veterans Act aims at ensuring veterans seeking care at VA medical facilities are not being seen by providers who are practicing with a revoked license. It is our understanding that the VA has conducted a thorough review of all providers and has taken the appropriate human resource measures to ensure providers who have had their license revoked are no longer employed. Additionally, the VA has taken actions to address internal hiring practices in order to ensure providers with a revoked license are not considered for employment in accordance with VA policies. Furthermore, S. 123 requires the VA to contract with a non-Federal entity to conduct a third party-clinical review of the care provided by those who were found to be practicing with a revoked license. If any previously provided care is deemed to be substandard, VA would be required to notify the veteran. If such instance exists, WWP requests VA implement a process for patient notification of those deemed to have received substandard care and how, if appropriate, VA will address medical needs.

Wounded Warrior Project supports the intent of S. 123 and recommends VA submit a report to Congress providing the results of the original review. For VA providers found to have practiced with a revoked license, WWP supports a third party-clinical review to ensure veterans seen by these providers did not receive substandard care. This would help VA combat the narrative that VA care is substandard and reinforce their commitment to quality care.

S. 221—DEPARTMENT OF VETERANS AFFAIRS PROVIDER ACCOUNTABILITY ACT

The Department of Veterans Affairs Provider Accountability Act would require VA to report employees who had major adverse actions taken against them for conduct or performance to the National Practitioner Data Bank and the employee's applicable licensing board. Like S. 123, this bill proposes to hold VA health care providers

[1] The 2018 WWP survey is the tenth iteration of our organization's annual poll of registered warriors ("alumni"). The 2018 edition received over 33,000 completed surveys.

[2] https://www.woundedwarriorproject.org/media/183005/2018-wwp-annual-warrior-survey.pdf

[3] https://www.rand.org/news/press/2018/04/26.html

accountable for substandard care and substandard conduct, both of which negatively impact the veteran experience. VA would be required to report such actions 30 days after the date on which such major adverse action is carried out.

While WWP appreciates the intent of S. 221, what remains unclear is how VA providers' appeals will be considered, or how employment status will be affected by reports to the National Practitioner Data Bank. Additionally, WWP recommends expanding on the language "major adverse action" to clearly define when an employee should be reported. WWP recommends expanding on this piece of legislation to address these concerns.

Wounded Warrior Project supports S. 221.

S. 318—VA NEWBORN EMERGENCY TREATMENT ACT

The VA Newborn Emergency Treatment Act proposes to provide clear authority for VA to cover the costs of medically necessary emergency transportation services for newborn babies of certain women veterans. This bill would alleviate payment issues that arise when a female veteran mother does not travel with her newborn child.

As women continue to be one of the fastest-growing veteran populations, it is crucial to recognize that VA benefits must be aligned and be responsive to those who rely on VA for maternity care. Unlike their civilian counterparts, these women may have service-connected disabilities that place them at higher risk for pregnancy complications, including pre-term labor or low-birth weight newborns. In such situations, it is critical for VHA to be able to link these mothers and their children with specialized and intensive services when necessary—a step that can require emergency transportation if a particular VA facility cannot provide such care internally.

In order to address these concerns and a lack of clarity in current law, WWP supports the VA Newborn Emergency Treatment Act.

S. 450—VETERANS IMPROVED ACCESS AND CARE ACT OF 2019

During the February 27, 2019, House Veterans' Affairs Committee hearing on the future for the VA, Secretary Wilkie expressed concern with the 49,000 vacancies across the Department. Of these vacancies cited at that time, 42,790 were within the VA health care system, with 24,800 in the medical and dental fields. Secretary Wilkie indicated that the Department is prioritizing staffing efforts based on greatest needs, with particular effort focused on staffing primary care, mental health, and women's health. "Primary health because newer veterans are used to urgent care, mental health because suicide is an epidemic, and women's health because that demographic is growing.[4]"

S. 450 requires the VA to carry out a pilot program to assess the feasibility and advisability of expediting the process of the VHA for onboarding new medical providers with a goal to reduce the length of time it takes to onboard medical providers to no more than 60 days.

Wounded Warrior Project supports S. 450.

S. 514—DEBORAH SAMPSON ACT

The National Center for Veterans Analysis and Statistics predicts that over the next 25 years the total veteran population will decline by an average of 1.8 percent per year; however, that decline will be driven by declines in the male veteran population. Over that period, the female veteran population is estimated to grow by an average of 0.6 percent per year as the male population declines by 2.2 percent per year.[5] At a time when female veterans already represent 11.6 percent of OEF/OIF/OND veterans and approximately 10 percent of the current veteran population, the VHA system must evolve to meet the needs of a unique and growing demographic.

Nearly 16 percent of WWP registered alumni are women and we are acutely aware of the need for programs and services tailored to their needs. In FY 2018, female warriors registered with WWP had significantly higher participation rates than men in nearly all program areas, particularly WWP Talk[6] and our Physical Health & Wellness programming. In this context, WWP supports the Deborah

[4] 2019–02–27 Full Committee Hearing: VA 2030 A Vision for the Future of VA https://www.youtube.com/watch?v=aByF4NT_06k

[5] Source: https://www.va.gov/vetdata/docs/Demographics/VetPop_Infographic_2019.pdf

[6] WWP Talk is a helpline for WWP alumni, family members, and caregivers that provides emotional support over the telephone. Participants speak with the same helpline support member each week, developing an ongoing relationship and a safe, non-judgmental outlet to share thoughts, feelings, and experiences

Sampson Act's pursuit of female-specific services and its intent to eliminate barriers to care.

Wounded Warrior Project supports the S. 514 initiatives found in Section 101 (reintegration and readjustment services), Section 202 (financial assistance for housing), and Section 404 (female-veteran-specific training for community providers), among others; however, we would support a review of current VA initiatives for female veterans in order to ensure the necessity of new legislation. For example, VA has already implemented a text messaging capability for the Women Veterans Call Center (Section 102) and developed an internet website to provide information on services available to women veterans (Section 503).

Additionally, we wish to bring attention to Section 502 which requires VA to submit a report to Congress on the availability of prosthetics made for women veterans, including an assessment of the availability of such prosthetics at each VA medical facility. Although well intentioned, this section is extremely broad and may not be specific enough to meet congressional intent. VA Prosthetic and Sensory Aids Service (PSAS) is the largest and most comprehensive provider of prosthetic devices and sensory aids in the world.[7] According to VA lexicon, the term "prosthetic device" may suggest images of artificial limbs, but in actuality, it refers to any device that supports or replaces a body part or function. In order to get a true understanding of the scope of "prosthetic" devices for female veterans, WWP recommends a report include the following elements:

(1) list of all devices the VA classifies as prosthetic devices.
(2) once a list is compiled; identify whether each device is gender neutral or manufactured to be gender specific,
(3) for gender-neutral devices, identify whether adequate sizing is available for female veterans,
(4) assess whether all VA facilities are adequately resourced to meet the demand of female veteran needs,
(5) for facilities with low demand, identify what procedures are in place to expedite the acquisition or manufacture of devices for female veterans.

S. 524—DEPARTMENT OF VETERANS AFFAIRS TRIBAL ADVISORY COMMITTEE ACT OF 2019

The Department of Veterans Affairs Tribal Advisory Committee Act of 2019 proposes to give a voice to the American Indian Veteran population—a population that faces unique issues that are not always understood by the country—by establishing the Department of Veterans Advisory Committee on Tribal and Indian Affairs. This Committee would help VA identify evolving issues that are specific to American Indian veterans and communicate these issues directly to the Secretary of Veterans Affairs.

American Indians and Alaska Natives serve in the military at a higher rate than members of other racial groups. Due to the unique challenges they face in receiving VA medical and benefits assistance, it is necessary in allowing this group of veterans a voice in order to raise their concerns to the highest level of authority at the VA.

Given that 5.3 percent of WWP alumni identity as American Indian or Alaska Native, we recognize that this population has a different set of challenges in accessing care and benefits. At times, this population is located many miles from VA medical centers and often lack coordinated care for long-term treatment. A recent U.S. Government Accountability Office (GAO) report recommended that VA strengthen oversight and coordination of health care for this population.[8] The proposed Veterans Advisory Committee can help VA address all recommendations in the March 21, 2019, GAO study as well as any additional deficiencies yet to be discovered.

Wounded Warrior Project supports S. 524.

S. 711—CARE AND READINESS ENHANCEMENT (CARE) FOR RESERVISTS ACT OF 2019

The CARE for Reservists Act of 2019 proposes to extend VA mental health care resources to the National Guard and Reservists. With particular emphasis on Vet Centers to help meet demand, the CARE for Reservists Act acknowledges that VA—in consultation with the Department of Defense (DOD)—can help remove barriers to care that exist for a population that interacts with the military health system differently than their active duty counterparts.

As VA and DOD work together in their collective pursuit to reduce veteran and military suicides, the CARE for Reservists Act addresses critical risk factors that

[7] https://www.prosthetics.va.gov/psas/About—PSAS.asp
[8] https://www.gao.gov/assets/700/697736.pdf

can help connect at-risk National Guard and Reservists with mental health care. According to the DOD Suicide Event Report for Calendar Year 2016, the suicide mortality rates for the Reserve Component (22.0 deaths per 100,000 reservists) and the National Guard Component (27.3 deaths per 100,000 members of the Guard population) were both higher than the suicide mortality rates for the Active Component (21.1 deaths per every 100,000 Active Duty Servicemembers). Moreover, the average at-risk Guardsman is between the ages of 17 and 24—an age consistent with VA data that reflects a higher rate of suicide among younger veterans (ages 18 to 34) than any other age cohort.

Permitted VA is adequately staffed and resourced to handle an influx of National Guard and Reservist patients, a concern addressed in Section 5, WWP supports the CARE for Reservists Act of 2019 and its intent to lend VA resources to help National Guard and Reservists successfully readjust to civilian life.

S. 746—DEPARTMENT OF VETERANS AFFAIRS WEBSITE ACCESSIBILITY ACT OF 2019

Wounded Warrior Project remains vigilant in addressing the needs of those with severe physical and cognitive injuries. According to the DOD & VA Extremity and Amputation Center of Excellence, as of March 2019, there have been a total of 1,724 battle injured amputees treated in Military Treatment Facilities. A large portion of those patients were treated following high-impact or blast-related injuries—injuries that often include immediate or eventual visual impairment. Additionally, the 2018 WWP Survey reflects that 41.2 percent of the 33,067 warriors who completed the survey self?reported to have a Traumatic Brain Injury (TBI). This population includes those with severe TBI who experience significant cognitive issues.

According to DOD's Vision Center of Excellence, eye and head trauma, or exposure to a blast, can result in immediate and longer-term vision loss and dysfunction that can be difficult to initially detect, making those affected with TBIs more prone to vision problems in the future.[9] Research also notes more than 75 percent of all TBI patients experienced short- or long-term visual dysfunction, including double vision, sensitivity to light, and inability to read print, among other cognitive problems.[10] As veterans rely more on internet access and use of smart devices and computers, the likelihood of a veteran or a servicemember with a physical or cognitive disability relying on or utilizing an electronic or information technology web-based system to seek their care or communicate with VA is extremely likely. As VA introduces new technologies or modifies old systems, it must recognize the potential of inadvertently removing accessibility features that were once in place. The VA must ensure that website developers follow industry-standard accessibility guidelines to ensure compatibility with screen reading software utilized by visually impaired persons. Additionally, as VA executes the implementation of the MISSION Act and the electronic health record management system, which will have a robust external facing platform, it must do so with thoughtful consideration of end users who may have visual or cognitive deficiencies.

The Department of Veterans Affairs Website Accountability Act of 2019 would direct VA to conduct a study regarding the accessibility of VA websites to determine is whether such websites are accessible to individuals with disabilities in accordance with Section 508 of the Rehabilitation Act of 1973 (29 U.S.C. 794d). WWP supports this legislation and encourages Congress to continue to exercise oversight once the study has been completed.

S. 785—COMMANDER JOHN SCOTT HANNON VETERANS MENTAL HEALTH CARE IMPROVEMENT ACT OF 2019

Suicide prevention is the Department of Veterans Affairs' highest clinical priority, and among the greatest challenges, WWP is trying to address in the community we serve. Congress has an important role to play in improving access to mental health care and supporting the development of a comprehensive network of education and support that can protect against isolation and veteran suicide. WWP encourages a wide-ranging approach anchored in evidence-based treatment and research. This foundation should support private and non-profit sector partnerships that keep VA at the center of care and strengthen holistic approaches to wellness—important tenets that are captured by the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019.

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[9] DOD Vision Center of Excellence. Vision Problems Associated with TBI

[10] DOD Armed Forces Health Surveillance Center, Medical Surveillance Monthly Report (MSMR), vol. 18, no. 5, "Eye Injuries, Active Component, U.S. Armed Forces 2000–2010," May 2011, 2–7.

This bill contains 35 provisions that span from transition to community grants and incorporate proposals affecting clinical care and non-clinical support. Given the immense gravity and importance of ensuring that our community works collectively and more effectively to improve access to care and prevent veteran suicide, we believe it is critical to move forward with as much concurrence as possible on legislative solutions that unite our community's efforts. In this spirit, we offer our perspective on key proposals that we believe can make the biggest impact based on organizational experience.

*In Focus: Section 101*—This section would extend VA health care eligibility to transitioning veterans for a full year after their separation or discharge from the Armed Services. WWP supports this provision as it aligns with Joint Action Plan for Executive Order 13822 and the cross-agency recommendation and goal of proving immediate and continuous access to VA health care for all transitioning servicemembers during the first 12 months post-transition—a time when suicide prevention efforts can align with heightened risk.

As highlighted by DOD's Defense Suicide Prevention Office, servicemembers transitioning out of DOD are at a higher risk of suicide within the first 90 days of separation—a trend consistent over a 14-year period. Over that period, approximately 50 percent of suicide deaths occurring in the first three months of separation happened within the first 17 days of separation. As Congress continues to work with the executive branch to improve and monitor military-to-civilian transition, WWP supports Section 101 as a primary tool to help mitigate suicide risk for transitioning servicemembers.

*In Focus: Section 201*—This provision would create a new grant program aimed at organizations that provide and coordinate mental health services for veterans not receiving care at VA. As our community strives to reach more veterans and connect them to the care and services they need, not just to survive but to thrive, this initiative to empower community-based organizations through partnerships with VA is critically important. While WWP would defer to the judgment of Congress and VA on the specific composition of how grants are awarded, we can provide firsthand perspective on our approach to grantmaking and the impacts those grants have on ensuring healthy military-to-civilian transitions.

While WWP has many successful direct programs serving needs of warriors and their families, we alone cannot meet every need this generation of wounded servicemembers and veterans face. WWP knows no one organization can fully meet veterans' needs. To this end, we proudly partner with other organizations to help our Nation's veterans. Since 2012, WWP has granted $80.9 million to 158 other veteran and military service organizations. In FY 2018 alone, we executed 38 grants to organizations totaling more than $13.6 million in additional impact to support our warriors and their families. These efforts reflect the value that comes with working with others to harness subject matter expertise, reach a greater number of injured veterans, and provide a more comprehensive network of support.

Our approach to grants and partnerships has evolved over time and currently reflects leading research in the military-veteran community. Together with the Henry Jackson Foundation (HJF), and partners from the public and private sectors, WWP has funded a longitudinal study of transitioning veterans to better understand the components of well-being and the factors necessary for ensuring a healthy military-to-civilian transition. Findings from this study—The Veterans Metrics Initiative—suggest there are four components of well-being: Social Relationships; Health; Finances; and Vocation. Our investments for direct services and programming are considered and categorized on this evidence-based criteria, and we engage WWP's metrics team to measure our collective work and outcomes.

As a community of service organizations, we each focus on complementary initiatives across missions (sometimes, generations) and together we are forging partnerships, providing cross-referrals and providing a stronger, expanded network of support. We must all work together to serve those who need us most throughout their care continuum. When assessing potential partnerships, WWP evaluates existing and potential partners based on how a program complements WWP by:

- *Filling a gap in WWP direct services* by providing a program or service WWP does not offer;
- *Augmenting WWP direct services* by doubling down on services that are in high demand;
- *Amplifying messaging* around issues affecting post-9/11 wounded/ill/injured veterans, caregivers, and their families;
- *Building relationships and collaboration* with organizations serving veterans and families;
- *Growing small organizations with potential* that can have the ability to scale and offer innovative programming

In sum, WWP supports Section 201 and its implicit recognition that community-based organizations can extend VA's reach across the country and into the lives of veterans who are not currently connected to the system. A strong network of clinical care and community support is a protective factor in suicide prevention.

*In Focus: Section 205*—This section would commission a study on the feasibility and advisability of providing certain complementary and integrative health treatments such as yoga, meditation, acupuncture, and chiropractic care, at all VA medical facilities, either in person or through telehealth when applicable. Section 205 would also permit VA to provide these treatments. While we would defer to VA and Congress to determine the appropriate timing of implementing such a study and practice, WWP endorses the utility of complementary and integrative health treatments in a holistic approach to mental health care.

To illustrate this point, WWP's signature Warrior Care Network is an innovative program and partnership between WWP and four national academic medical centers (AMCs): Massachusetts General Hospital, Emory Healthcare, Rush University Medical Center, and UCLA Health. Warrior Care Network delivers specialized clinical services through innovative two- and three-week intensive outpatient programs that integrate evidence-based psychological and pharmacological treatments, rehabilitative medicine, wellness, nutrition, mindfulness training, and family support with the goal of helping warriors thrive, not just survive.

Through these two- to three-week cohort-style programs, participating warriors receive more than 70 direct clinical treatment hours (e.g. cognitive processing therapy, cognitive behavioral therapy, and prolonged exposure therapy) as well as additional supportive intervention hours that incorporate many (and more) of the complementary therapies listed in Sections 205 and 206. Warriors in the program receive approximately 16 hours of complementary services during treatment. Available therapies at each AMC include acupuncture, massage, yoga, art therapy, and equine therapy. These services are provided in both individual settings and in groups that include warriors and family members. Each instance of supportive therapy is documented and overall trends are used to develop future complementary therapy offerings in the WCN program.

Providing warriors with best in class care that combines clinical and complementary treatment is still only part of the Warrior Care Network's holistic approach to care. While AMCs provide veteran-centric comprehensive care, aggregate data, share best practices, and coordinate care in an unprecedented manner, a Memorandum of Agreement (MOA) between WWP and VA has been structured to further expand the continuum of care for the veterans we treat. In February 2016, VA signed this MOA with WWP and the Warrior Care Network to provide collaboration of care between the Warrior Care Network and VA hospitals nationwide. Four VA employees act as liaisons between each site and VA, spending 1.5 days per week at their respective sites to facilitate coordination of care and to meet with patients, families, and care teams. Each VA liaison facilitates national referrals throughout the VA system as indicated for mental health or other needs, but also provides group briefings about VA programs and services, and individual consultations to learn more about each patient's needs. In November 2018, that MOA was renewed with a growing commitment from VA—VA has created full-time billets for liaisons at each AMC to enhance their contribution to the partnership. All told, this first-of-its-kind collaboration with VA is critical for safe patient care and enables successful discharge planning. At WWP, we believe cooperation and coordination like this can serve as a great example of "responsible choice" in the VA health care system.

Warriors who complete the Warrior Care Network program are seeing results. Prior to treatment, over 83 percent of patients reported PTSD symptoms at the severe to moderate range based on the PCL–5 clinical assessment, with the aggregate average being 51.1 (severe PTSD). Following treatment in the intensive outpatient programs, PTSD symptoms decreased 19.4 points to 31.7 (minimal PTSD).[11] A similar pattern was seen for symptoms of depression, with a mean score of 16.0 at intake and a decrease to 10.2 at follow-up on the PHQ–9 assessment. These changes translate into increased functioning and participation in life, based on the decrease of psychological distress caused by severe to moderate levels of PTSD and depression.

It is also worth noting that, although effective if completed, many who begin evidence-based mental health treatment (cognitive processing therapy and prolonged exposure) in non-intensive outpatient (IOP) formats—including highly controlled

[11] Note: A change in score greater than 5 is indicative of clinically significant change rather than statistical change.

and selective clinical trials [12]—discontinue care before completion. While drop-out rates in those formats are between 30 and 40 percent,[13] the IOP model used by Warrior Care Network has a completion rate of 94 percent. When combined with clinically significant decreases in mental health symptoms, this figure is illustrative of the successful approach the Warrior Care Network has taken—and patients agree. Ninety-six percent (96.3 percent) of warriors reported satisfaction with clinical care received, and 94 percent of warriors indicate they would tell another veteran about WCN, a possible indication of reduced mental health stigma.

As WWP and its partner AMCs remain committed to pioneering this innovative approach to treat warriors with moderate to severe PTSD, we support further research—and potential expansion of VA authority(ies) to provide similar care—into the efficacy of combining complementary and integrative treatments with evidence-based treatments to deliver first-class mental health care to veterans. For these reasons, we support Section 205.

In Focus: Section 305—This provision would install a Precision Medicine for Veterans Initiative at VA in order to identify and validate brain and mental health biomarkers. Section 305 places an emphasis on biomarkers for PTSD, TBI, anxiety, and depression—challenges that face a significant portion of warriors who reach out to WWP for help.

According to results of the 2018 WWP Survey, and for the fourth year in a row, Post Traumatic Stress Disorder (PTSD) was the most frequently reported health problem from service (78.2 percent), followed closely by depression (70.3 percent), anxiety (68.7 percent), and even sleep problems (75.4 percent), an issue frequently linked to mental health challenges. Accordingly, mental health programs are WWP's largest programmatic investment—in 2018, WWP spent $63.4 million on our mental health programs.

Wounded Warrior Project's investments to address these challenges extends beyond programming, and our interest in biomarker research aligns with the intent behind Section 305. Specifically, WWP supports work being performed and funded by Cohen Veteran Bioscience (CVB) to fast-track the development of diagnostic tests and personalized therapeutics for the millions of veterans and civilians who suffer the devastating effects of trauma to the brain. Recent research published in *Science Translational Medicine* and funded in part by CVB, identifies a PTSD brain imaging biomarker.[14] This biomarker is important because it may help determine which people with PTSD will respond to PTSD first-line treatment of behavioral therapy, and which individuals with PTSD who don't respond to first-line treatment may respond to other options. This personalized approach may help connect people to the right PTSD treatment sooner.

Wounded Warrior Project supports continued research and collaboration into biomarkers for mental health and Traumatic Brain Injury treatment. VA would be an integral partner to work already being done in the community and as such, we support Section 305.

*In Focus: Section 406*—This provision focuses on identifying transition and mental health programing operated by the Department of Veterans Affairs and the Department of Defense and establishing a Joint DOD/VA National Intrepid Center of Excellence Intrepid Spirit Center in a rural or highly rural area. These agencies share common goals to increase efficiencies, eliminate redundancies, and improve health care outcomes. WWP supports the establishment of a center focused on mental health that would foster collaboration in treatment, research, and prevention initiatives. At its core, research would permit for the quantification of successful treatment modalities, ultimately leading to the creation of a successful clinical model (i.e., clinical intervention hours, clinical interventions to use and supportive services) that could be shared and duplicated at different locations.

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[12] Imel, Z., Laska, K., Jakcupcak, M., Simpson, T. (2013). Meta-analysis of Dropout in Treatments for Post-traumatic Stress Disorder. Journal of Consulting and Clinical Psychology, 81(3), 394–404.

[13] Kehle-Forbes, S., Meis, L., Spoont, M., Polusny, M. (2015). Treatment Initiation and Dropout From Prolonged Exposure and Cognitive Processing Therapy in a VA Outpatient Clinic. *Psychological Trauma: Theory, Research, Practice, and Policy*, 8(1), 107–14.; Gutner, C., Gallagher, M., Baker, A., Sloan, D., Resick, P. (2015). Time Course of Treatment Dropout in Cognitive-Behavioral Therapies for Posttraumatic Stress Disorder. *Psychological Trauma: Theory, Research, Practice, and Policy*, 8(1), 115–21.

[14] Amit Ekin et al. "Using fMRI connectivity to define a treatment-resistant form of Post Traumatic Stress Disorder." *Sci. Transl. Med.* 11, eaal3236 (2019).

S. 805—VETERAN DEBT FAIRNESS ACT OF 2019

The Veteran Debt Fairness Act of 2019 addresses issues related to VA's debt collection practices. Historically, VA has been reputed to be an aggressive debt collector. The agency has a history of practices that include withholding disability benefits payments and sending incurred debts to aggressive third-party debt collection agencies.

Sections 1 and 2 of S. 805 would require VA to update their information technology (IT) system to allow veterans to update dependency information. Although we find that VA currently has this function, we are interested in seeing if VA can make this more user friendly, and not have veterans who have adopted, stepchildren, or those who have dependent children in college be penalized for needing to submit documents that the automated system often fails to recognize. This will help address overpayments to veterans who have changes in the dependency status. Additionally, VA will be required to electronically notify the veteran that a debt has been established. This is critical as many veterans have noted that they never received the physical letter notifying them that a debt has been incurred. Section 3 of this bill would require VA to conduct an annual audit for debt errors on at least 10 percent of all debts created. Additionally, this section would allow veteran 120 days to contest a debt, allowing the veteran time to address possible debt errors before the VA starts the collection process.

These proposed changes, especially to the IT system, would facilitate faster dependency claim processing times. Also, the definitions of what constitutes a lawful debt will directly affect countless warriors, especially Reservists and National Guard, who often end up accumulating debt due to their failure to complete and return, or have VA acknowledge the submission of a VA Form 21–8951, Notice of Waiver of VA Compensation or Pension to Receive Military Pay and Allowances when they are activated.

Wounded Warrior Project is pleased to see language in this legislation that would limit the number of funds the VA can deduct from a veteran's disability payment to 25 percent. We would also recommend defining "reasonable efforts" on page 6, line 17, regarding efforts made to notify a veteran of their rights.

WWP is encouraged by S. 805 and supports this legislation.

S. 850—HIGHLY RURAL VETERAN TRANSPORTATION PROGRAM EXTENSION ACT

For veterans who live in highly rural areas, transportation to VA facilities can be a major barrier in obtaining VA health care. The Highly Rural Veteran Transportation Program Extension Act would amend section 307(d) of the Caregivers and Veterans Omnibus Health Services Act of 2010 to add one additional year to a program that provides grants to Veterans Service Organizations for transportation to VA facilities. The grant amount may not exceed $50,000, and a total of $3,000,000 is appropriated each fiscal year.

The 2018 WWP Survey indicates that 29.2 percent of veterans who do not use VA as their primary health care provider cited that it was due to their distance from a VA care center.[15] In this context, WWP feels that any program that helps transport veterans to and from a facility is imperative in addressing barriers to receiving care.

Wounded Warrior Project supports this legislation.

S. 857—A BILL TO AMEND TITLE 38, UNITED STATES CODE, TO INCREASE THE AMOUNT OF SPECIAL PENSION FOR MEDAL OF HONOR RECIPIENTS, AND FOR OTHER PURPOSES

This bill would increase the special pension given to Medal of Honor recipients from $1,000 a month to $3,000 a month. The Medal of Honor special pension has not been increased since 2002 via Public Law 113–66 which increased the pension from $600 to $1000. Medals of Honor recipients are frequently asked to attend speaking events to help promote national pride in the military. They often pay the cost of attending these events by using their pension for out-of-pocket expenses. This legislation aims to help offset these expenses by increasing the pension amount.

Wounded Warrior Project is proud to support S. 857.

S. 980—HOMELESS VETERANS PREVENTION ACT OF 2019

According to our 2018 survey, 5.6 percent of responding warriors were homeless or living in a homeless shelter during the past 24 months of taking the survey. Ad-

[15] https://www.woundedwarriorproject.org/media/183005/2018-wwp-annual-warrior-survey.pdf

ditionally, those that were homeless showed varied rates regarding how long they were homeless:

> "Among them [homeless veterans], 26.4 percent were homeless for less than 30 days, 49.1 percent were homeless for 1–6 months, 12.9 percent were homeless for 7–12 months, and 11.4 percent (10.1% in 2017) were homeless for 13–24 months. Female warriors showed somewhat higher rates of homelessness over the past 24 months than males (7.1% for females vs. 5.3% for males). Homelessness among female warriors was 7.2% in 2017 and 6.1% in 2016.[16]"

There are an estimated 50,000 homeless veterans in the U.S., and another 1.4 million considered at-risk of homelessness.[17] Additionally, one of the most notable deficiencies for this population is legal assistance.[18] Legal assistance is critical in helping veterans access healthcare, veteran disability benefits, and housing vouchers. This legislation will authorize VA to fund pro-bono lawyers and community legal clinics to help homeless veterans understand their rights. Additionally, S. 980 will authorize VA dental care for homeless veterans, increase resources for very low-income veteran families, and authorize per-diem payments to furnish care to dependents of certain homeless veterans.

Wounded Warrior Project supports the majority of the sections in S. 980 but recommends removing Section 8, on page 8. This section would repeal a required annual report on assistance available to homeless veterans. While this information is duplicative of similar studies at the Department of Housing and Urban Development (HUD), WWP feels that homeless veterans are more likely to search for information through the Department of Veterans Affairs over the Department of HUD.

Additionally, Section 6, on page 7, of S. 980, conflicts with Section 202 in S. 514, the Deborah Sampson Act, in that both provisions amend Section 2044 of Title 38 but at different dollar amounts. We recommend the Committee deconflict these two sections if both pieces of legislation were to move forward.

Wounded Warrior Project supports S. 980 with the above amendments.

S. 1101—BETTER EXAMINER STANDARDS AND TRANSPARENCY FOR VETERANS ACT OF 2019

In 2018, it was revealed that a Logistic Health Incorporated (LHI) physician performing medical disability examinations (MDE) had previously pled guilty to seven counts of fraud and that their medical license was revoked. Currently, Public Law 104–275 allows contract physicians to perform examinations in a state other than their state of licensure if the physician meets the statutory description of physician meeting the following requirements: (1) has a current unrestricted license to practice, (2) is not barred from practicing in any State; and (3) is performing authorized duties for the VA under a contract.[19] Under VA's current interpretation of the law, only physicians that are operating across state lines are required to meet the above three requirements thereby opening a loophole that allows physicians that have revoked licenses to perform MDEs if they are not practicing outside their state of licensure.

The Better Examiner Standards and Transparency for Veterans Act of 2019 would close this loophole and prohibit contract health care providers who have had their licenses revoked in any state from performing MDEs. Additionally, it would require VA to ensure that only licensed health care providers are conducting MDEs and require VA to submit a yearly report to Congress on the outcomes of third-party contractors administering MDEs.

Wounded Warrior Project agrees with the provisions in the legislation that relates to closing this obvious loophole. Wounded Warrior Project supports S. 1101 but recommends looking at lines 1 through 8 on page 4 and expanding on the intent to minimize the second and third order effects of this proposal.

S. 1154—DEPARTMENT OF VETERANS AFFAIRS ELECTRONIC HEALTH RECORD ADVISORY COMMITTEE ACT

Wounded Warrior Project believes the electronic health record modernization (EHRM) will provide efficiencies and greater quality inpatient and prescription data, all of which will lead to greater quality of care, identify high-risk patients related to suicide and opioid abuse, and a greater quality of life. With an investment of $16

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[16] https://www.woundedwarriorproject.org/media/183005/2018-wwp-annual-warrior-survey.pdf
[17] *The Invisible Battlefield* (2016)
[18] The Veterans Administration annual Community Homeless Assessment, Local Education, and Networking Groups (CHALENG) survey (2016)
[19] https://www.Congress.gov/104/plaws/publ275/PLAW-104publ275.htm

billion and an implementation timeline of 10 years, successful implementation will deliver—for the first time—a uniform platform to manage records and provide seamless capabilities across DOD and VA. WWP believes Congress needs to exercise vigilant oversight of the implementation process to ensure high levels of interoperability and data accessibility between VA, DOD, and commercial health partners. Just as important, key stakeholders must also remain vigilant to ensure the VA takes account the voices of all stakeholders and veterans. Equally important to implementation is ensuring the VA is considering an ever-changing IT environment to ensure EHR "modernization" does not become outdated or obsolete.

The Department of Veterans Affairs Electronic Health Record Advisory Committee Act would establish a VA Advisory Committee on Implementation of Electronic Health Record, which acts as an independent, third-party oversight entity that will ensure that on-the-ground stakeholders have a voice.

Wounded Warrior Project supports S. 1154.

DRAFT—JANEY ENSMINGER ACT OF 2019

The Janey Ensminger Act of 2019 would require the Center for Disease Control and Prevention's Agency for Toxic Substance and Disease Register (ATSDR) conduct scientific analysis and review of scientific literature that may be relevant to those affected by contaminated water in North Carolina's Camp Lejeune between 1953 to 1987. Although ATSDR has found that servicemembers, including their families, suffered from increased risk of cancers and other health risks due to contaminated water at Camp Lejeune, VA has failed in accepting ATSDR's findings for health care treatment. The scientific analysis that ATSDR would conduct will include a list of illnesses and conditions that are prevalent due to exposure to toxic substances at Camp Lejeune, NC, which will be critical in ensuring there is no delay in health care assistance.

WWP has placed toxic exposure issues as one of its top 2019 legislative priorities. This advocacy does not only include toxic exposures during military service while deployed but also to those affected stateside and the families of servicemembers.

Wounded Warrior Project supports this legislation.

DRAFT—A BILL TO AMEND TITLE 38, UNITED STATES CODE, TO EXTEND THE AUTHORITY OF THE SECRETARY OF VETERANS AFFAIRS TO CONTINUE TO PAY EDUCATIONAL ASSISTANCE OR SUBSISTENCE ALLOWANCES TO ELIGIBLE PERSONS WHEN EDUCATIONAL INSTITUTIONS ARE TEMPORARILY CLOSED, AND FOR OTHER PURPOSES

This draft legislation will increase the time limit an institution of higher learning can be temporarily closed and still allow their student veterans to draw from their GI Bill Basic Allowance for House stipend from 4 weeks to 8 weeks. When a school is affected by a national disaster, student veterans are sometimes required to attend classes online because the school campus is temporarily closed. When this happens, the student's Basic Allowance for House (BAH) is reduced to 50 percent of the national average. This legislation will minimize the hardship of a natural disaster by ensuring that student veterans continue receiving appropriate BAH payments for a reasonable amount of time.

Wounded Warrior Project supports this draft bill.

Senator BOOZMAN. Thank you, Mr. Richardson.

Mr. Nembhard.

## STATEMENT OF GREG NEMBHARD, DEPUTY DIRECTOR OF CLAIMS SERVICES, THE AMERICAN LEGION

Mr. NEMBHARD. Thank you, Chairman Boozman, Ranking Member Tester, and distinguished Members of the Committee. On behalf of National Commander Brett P. Reistad, and the nearly two million members of The American Legion, we thank you for this opportunity to testify on our position on pending legislation. As the largest veterans service organization in the United States, The American Legion appreciates the Committee's focus on these critical issues that affect veterans and their families.

We believe, and continue to advocate for, a strong VA, a VA that is fully staffed, trained, and equipped to provide the highest quality care in the country. Since 2003, The American Legion has con-

ducted more than 500 nationwide visits to VA medical centers and regional offices. We assess the quality and timeliness of veterans' health care and provide feedback from veterans about the care and service provided by the VA.

The VA lists integrity as its first value, and VA employees make the promise to act with high moral principles and adhere to the highest professional standards. We believe that the vast majority of VA health care providers are well trained, caring public servants who work hard to care for veterans.

This, however, does not mean we should neglect the need for accountability. The Veterans Affairs Provider Accountability Act would impose new oversight measures on the VA. These measures would help ensure negative incidences do not go unreported, therefore safeguarding the safety and well being of veterans. The American Legion supports legislation and programs that ensure the safety of our Nation's heroes while holding the VA to its core values. The American Legion supports the Veterans Affairs Provider Accountability Act.

Mr. Chairman, to maintain a fully staffed VA, the Department must have an onboarding process that does not shun applicants. The American Legion is deeply troubled by critical staff shortages within the Veterans Health Administration, especially shortages among Department leadership, physicians, and medical specialists. Since the inception of our System Worth Saving program in 2003, The American Legion has identified and reported staff shortages and other critical deficiencies at VA medical facilities to the VA Central Office, Congress, and the President of the United States.

Our findings were reinforced by the VA's own reporting of more than 33,000 full-time vacancies in 2018. Additionally, the VA's Office of Inspector General filed a report that identified medical officers, nurses, psychologists, physician assistants, and medical technologists among the occupations with the most critical shortages, consistent with the VA's own reporting.

Through American Legion Resolution No. 115, Department of Veterans Affairs Recruitment and Retention, and Resolution No. 377, Support for Veteran Quality of Life, we support legislation to require the Secretary of Veterans Affairs to carry out a pilot program to expedite the onboarding process to reduce the time it takes to hire new medical providers.

Suicide prevention is one of The American Legion's top priorities. It is estimated that more than 20 veterans die by suicide every day. Of these 20, 14 have received no treatment or care from the VA. On April 24, 2019, National Commander Brett Reistad teamed up with Dr. Keita Franklin, VA's Executive Director of Suicide Prevention, and penned a letter that was sent to American Legion members, families, and friends, to let them know how we are working together to adopt a public health approach toward suicide prevention to involve peers, family members, and the community in preventing suicide.

This is a top priority for the VA but they need help from dedicated partners like The American Legion to reach veterans outside the VA health care system. The letter provides links to VA's National Strategy for Preventing Veteran Suicide, a toolkit that includes a guide to online suicide prevention resources, and a re-

source locator for contacting local VA Suicide Prevention Coordinators.

The Commander John Scott Hannon Veteran Mental Health Care Improvement Act will improve outreach to veterans. Among its many provisions, suicide prevention and access to treatment, the legislation directs the VA to work with the Office of Personnel Management to create an occupational series for mental health counselors. The VA needs to identify and attract qualified medical professionals as soon as possible, to ensure quality, consistent care for our veterans.

Mr. Chairman, the provisions of this bill address many areas of concern raised by The American Legion. Therefore, we support S. 785 as written.

I want to thank this Committee for the opportunity to share The American Legion's position on these vital issues impacting veterans and their families. This concludes my remarks and I look forward to answering any questions you may have.

[The prepared statement of Mr. Nembhard follows:]

PREPARED STATEMENT OF GREG NEBHARD, DEPUTY DIRECTOR, NATIONAL VETERANS AFFAIRS & REHABILITATION DIVISION, THE AMERICAN LEGION

S. 123; S. 221; S. 318; S. 450; S. 514; S. 524; S. 711; S. 746; S. 785; S. 805; S. 850; S. 857; S. 980; S. 1101; S. 1154; AND ALL SUBSEQUENTIAL DRAFT BILLS

CHAIRMAN ISAKSON, RANKING MEMBER TESTER, AND DISTINGUISHED MEMBERS OF THE COMMITTEE, On behalf of National Commander Brett P. Reistad, and the 2 million members of The American Legion, we thank you for this opportunity to testify regarding The American Legion's positions on pending legislation. Established in 1919, and being the largest veterans service organization in the United States with a myriad of programs supporting veterans, we appreciate the Committee focusing on these critical issues that will affect veterans and their families.

S. 123

*To require the Secretary of Veterans Affairs to enter into a contract or other agreement with a third party to review appointees in the Veterans Health Administration who had a license terminated for cause by a State licensing board for care or services rendered at a non-Veterans Health Administration facility and to provide individuals treated by such an appointee with notice if it is determined that an episode of care or services to which they received was below the standard of care, and for other purposes.*

The American Legion has taken no previous position on this matter. As a large, grassroots organization, The American Legion takes positions on legislation based on resolutions passed by our membership. With no resolutions addressing the provisions of the legislation, The American Legion is researching the material and working with our membership to determine the course of action that best serves veterans.

The provisions in this bill fall outside the scope of established resolutions of The American Legion. The American Legion does not have a resolution that addresses the authorization of appropriations in the VA for awarding grants to VSOs for transportation in highly rural areas.

The American Legion does not have a resolution to support or oppose S. 123.

S. 221

*To amend title 38, United States Code, to require the Under Secretary of Health to report major adverse personnel actions involving certain health care employees to the National Practitioner Data Bank and to applicable State licensing boards, and for other purposes.*

S. 221 would require the VA to report major adverse actions to the National Practitioner Data Bank (NPDB) and state licensing boards within 30 days after the date a major adverse action is taken against a VA employee. The NPDB is a U.S. Government program that collects and discloses, only to authorized users, negative in-

formation on health care practitioners, including malpractice awards, loss of license, or exclusion from participation in Medicare or Medicaid. It would also prohibit VA from signing settlements with terminated VA employees and would forbid VA from concealing serious medical errors or to purge negative records from employees' personnel files.

The VA lists integrity as its first core value, and VA employees make the promise to act with high moral principle and adhere to the highest professional standards. The vast majority of VA healthcare providers are well-trained, caring, public servants who work hard to take care of this Nation's veterans. Just like in any healthcare system, though, there are bad apples. This legislation would help ensure that incidences of malpractice do not go unreported by imposing new oversight measures on the VA, thus safeguarding the safety and wellbeing of those who are cared for by the VA healthcare system.

Through Resolution No. 377, The American Legion urges Congress and the VA to enact legislation and programs within the VA that will enhance, promote, restore or preserve benefits for veterans and their dependents, including, but not limited to, the following: timely access to quality VA health care; timely decisions on claims and receipt of earned benefits; and final resting places in national shrines and with lasting tributes that commemorates their service.

The American Legion supports bill S. 221.

S. 318

*To amend Section 1786 of title 38, United States Code, to authorize the Secretary of Veterans Affairs to furnish medically necessary transportation for newborn children of certain women veterans, and for other purposes.*

Title 38 U.S.C. 1786 currently authorizes the Secretary of Veterans Affairs to furnish post-delivery care services, including routine care services, that a newborn child of a woman veteran who is receiving maternity care furnished by the Department at a facility of the Department; or another facility pursuant to a Department contract for services relating to such delivery.

Since VA healthcare facilities do not offer a full-range of newborn care, women veterans are referred to community hospitals for post newborn and routine services at VA expense. The only exception is VA is not authorized to pay for medically necessary transportation for newborn children of certain veterans. This bill would provide the VA Secretary the authority to furnish medically necessary transportation for newborn children, which The American Legion supports and believes is the right thing to do.

Through Resolution No. 147, The American Legion works to ensure that the needs of the current and future women veteran populations are met; and that the VA provides full comprehensive health services for women veterans Department-wide, including, but not limited to, increasing treatment areas and diagnostic capabilities for female veteran health issues, improved coordination of maternity care, and increase the availability of female therapists/female group therapy to better enable treatment of Post-Traumatic Stress Disorder from combat and MST in women veterans.

The American Legion supports S. 318.

S. 450

*To require the Secretary of Veterans Affairs to carry out a pilot program to expedite the onboarding process for new medical providers of the Department of Veterans Affairs, to reduce the duration of the hiring process for such medical providers, and for other purposes.*

The American Legion has testified on similar issues concerning identifying and attracting quality candidates to provide health care for the Nation's veterans.

The American Legion is deeply troubled by the Department of Veterans Affairs (VA) leadership, physicians and medical specialist staffing shortages within the Veterans Health Administration (VHA). Since the inception of our System Worth Saving program in 2003, The American Legion has identified, and reported staffing shortages at every VA medical facility and reported these critical deficiencies to Congress, the VA Central Office (VACO), and the President of the United States.

In 2018, VA reported there were more than 33,000 full-time vacancies.[1] Many of these vacancies included hard-to-fill clinical positions, as well as occupations identified under 38 U.S.C. 7412. These findings were reinforced by a VA's Office of Inspector General (VAOIG) report determining the largest critical need occupations are medical officers, nurses, psychologists, physician assistants, and medical technologists.[2] The VA needs to identify and attract as many qualified candidates as possible as soon as possible.

Through American Legion Resolutions No. 115, Department of Veterans Affairs Recruitment and Retention,[3] and No. 377, Support for Veteran Quality of Life, we support legislation addressing recruitment and retention challenges, and any legislation or programs within VA that enhance, promote, restore or preserve benefits for veterans and their dependents, including, but not limited to, the following: timely access to quality VA health care, timely decisions on claims and receipt of earned benefits, and final resting places in national shrines with lasting tributes that commemorate their service.[4]

The American Legion supports S. 450.

S. 514

*To amend title 38, United States Code, to improve the benefits and services provided by the Department of Veterans Affairs to women veterans, and for other purposes.*

Women veterans have consistently been overlooked by the Department of Veterans Affairs for decades. The American Legion feels that it is time that we thank this growing military demographic with, at a minimum, the healthcare they deserve. Women veterans are the fastest growing demographic serving in the military, so we can expect the number of women veterans using Department of Veterans Affairs (VA) healthcare to increase dramatically. The United States has more than 2 million women veterans who live in every Congressional district in the Nation, and the number of women veterans seeking VA health care has doubled since 2000.

Although the VA has made improvements in women's healthcare, many challenges remain. The Deborah Sampson Act would help rectify many issues women veterans face by improving the ability of the VA to provide women's care, improve services, and change its culture to embrace this growing population. It does so by *inter alia*:

- Enhancing services that empower women veterans to support each other,
- Establishing a partnership between the Department of Veterans Affairs and at least one community entity to provide legal services to women veterans,
- Make adjustments to care that the VA can provide newborns,
- Addressing significant barriers women veterans face when seeking care,
- Require the VA to collect and analyze data for every program that serves veterans, including the Transition Assistance Program, by gender and minority status, and require that they publish data as long as it does not undermine the anonymity of a veteran.

The American Legion recommends the following change to the bill. A separate track to address specific needs of women veterans attending the Transition Assistance Program. It has been noted that women veterans are more likely to seek assistance by talking with other women on gender-sensitive assistance. For example, the VA Trauma Service Program (TSP) allows women veterans to choose to partake in a TSP information session with a group or with an individual woman coordinator. More women veterans opt to conduct the information session with an individual woman coordinator. Additionally, The American Legion requests the Department of Defense transfer contact information of all transitioning women veterans to the VA and the Department of Labor (DoL). This would provide an opportunity for the VA, DoL, and Veterans Service Organizations to follow-up with women veterans after separation to offer additional support, programs, and services. American Legion Resolution No. 147, Women Veterans, calls on The American Legion to work with Congress and the VA to ensure that the needs of current and future women veteran populations are met. It calls on the VA to provide full comprehensive health services for women veterans department-wide.

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[1] VA Vacancies—https://www.washingtonpost.com/world/national-security/trump-says-veterans-wait-too-long-for-health-care-vas-33000-vacancies-might-have-something-to-do-with-that/2018/04/10/d20bc890-3ccf-11e8-974f-aacd97698cef_story.html?noredirect=on&utm_term=.58facbebf668

[2] VAOIG Report 17-00936-835

[3] The American Legion Resolution No. 115 *Department of Veterans Affairs Recruitment and Retention*

[4] The American Legion Resolution No. 377 *Support for Veteran Quality of Life*

American Legion Resolution No. 364, Department of Veterans Affairs to Develop Outreach and Peer to Peer Program for Rehabilitation supports the President of the United States and the U.S. Congress passing legislation to call on the Secretary of Veterans Affairs to develop a national program to provide peer to peer rehabilitation services based on the recovery model tailored to meet the specialized needs of current generation combat-affected veterans and their families.

The American Legion supports passage of S. 514.

S. 524

*To establish the Department of Veterans Affairs Advisory Committee on Tribal and Indian Affairs, and for other purposes.*

The American Legion has not passed a resolution specific to the topic at hand. However, through our congressional engagement on behalf of Veterans, VA Mobile Vet Centers will be used to visit Native American reservations to provide counseling and other psychological services to Veterans. Additionally, American Legion Posts 143 and 165 have supported the National Native American Veterans Memorial project's community consultations, events, and programs.[5] We believe that the Native communities at one of the most underserved population of Veterans and that they are not receiving the benefits and critical care they, like their veteran counterparts, are entitled to. The American Legion supports legislation aimed at directly enhancing veterans' quality of life by expanding their VHA, VBA, or NCA benefits.[6]

The American Legion supports S. 524.

S. 711

*To amend title 38, United Sates Code, to expand eligibility for mental health services from the Department of Veterans Affairs to include members of the reserve components of the Armed Forces, and for other purposes.*

Suicide prevention and mental healthcare remain a top priority of The American Legion. As a response to the high rate of veteran suicide The American Legion established the TBI/PTSD Committee to study and recommend best practices. Access to mental health has been identified as a barrier, according to the Department of Veterans Affairs (VA) 14 out of the 20 veterans who commit suicide were not receiving treatment from a VA medical facility. A veteran may not be eligible for VA benefits including mental health treatment due to their characterization of discharge or duty status. As a response to close the gap in access The American Legion passed resolution No. 23 to allow veterans with other than honorable discharges to receive mental health treatment at the VA. In an effort to reduce the number of veterans and Servicemembers who commit suicide The American Legion believes that service through the VA should be a viable option.

The American Legion supports S. 711

S. 746

*To require the Secretary of Veterans Affairs to conduct a study on the accessibility of websites of the Department of Veterans Affairs to individuals with disabilities, and for other purposes.*

The American Legion has not passed a resolution specific to website accessibility. We recognize the barriers that veterans with certain disabilities face when trying to navigate and utilize certain VA websites and believe that it is essential that we work to remove these barriers. Every veteran should have equal access to and the ability to navigate VA websites.

We believe that no veteran should be inhibited in their efforts to participate in or benefit from VA programs. The VA should bring into compliance, websites that are not currently accessible to individuals with certain disabilities. Veterans should not encounter unavoidable barriers to benefits and critical care they, like their veteran counterparts, are entitled to. The American Legion supports legislation aimed at directly enhancing veterans' quality of life by expanding their VHA, VBA, or NCA benefits.[7]

The American Legion supports S. 746.

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[5] The American Legion Resolution No. 130 *Support for Vet Center Expansion to Rural Communities*

[6] The American Legion Resolution No. 377 *Support for Veteran Quality of Life*

[7] The American Legion Resolution No. 377 *Support for Veteran Quality of Life*

S. 785

*To improve mental health care provided by the Department of Veterans Affairs, and for other purposes.*

It is estimated that more than twenty veterans die by suicide every day. Of those twenty, fourteen have received no treatment or care from the VA. Suicide among veterans continues to be higher than the rest of the population, with an even sharper increase among younger veterans. VA data released in September showed the rate of suicide among veterans ages 18 to 34 had significantly increased. Forty-five of every 100,000 veterans in the 18 to 34 age group committed suicide in 2016.

In 2018, VA reported there were more than 33,000 full-time vacancies. Many of these vacancies included hard-to-fill clinical positions, as well as occupations identified under 38 U.S.C. 7412. These findings were reinforced by a VA's Office of Inspector General (VAOIG) report determining the largest critical need occupations are medical officers, nurses, psychologists, physician assistants, and medical technologists. The VA needs to identify and attract as many qualified candidates as possible as soon as possible.

The Commander John Scott Hannon Veterans Mental Health Care Improvement Act will improve outreach to veterans and their mental health care options. Among its many provisions regarding suicide prevention and access to treatment, the legislation directs the VA to work with the Office of Personnel Management to create an occupational series for mental health counselors.

The bill also would mandate that the Secretary of Veterans Affairs submit a staffing plan that would increase the hiring of mental health counselors to the Senate and House Veterans' Affairs Committees within 270 days of passage. The VA would also be required to report on the specific number of mental health counselors it has hired based on the staffing plan.

The provisions of this bill address many areas of concern The American Legion has raised recently. The American Legion remains deeply troubled by the Department of Veterans Affairs (VA) leadership, physicians, and medical specialist staffing shortages within the Veterans Health Administration (VHA). Additionally, mental healthcare is a major concern for The American Legion, we have seen the hardships faced by our veterans and their dependents dealing with PTSD, TBI, Suicide Ideation, and many other mental health issues. The American Legion has created a TBI/PTSD Committee and has a dedicated staff member for the sole purpose of advocating on behave of veterans dealing with the before mentioned mental health issues.

Further, last month, National Commander Brett Reistad with Dr. Keita Franklin, VA's Executive Director of Suicide Prevention, penned a letter to nearly 850,000 American Legion members, family, and friends, to let them know we are working to adopt a public health approach to suicide prevention.

The public health approach looks beyond the individual to involve peers, family members and the community in preventing suicide. We understand preventing veteran suicide is a top priority for VA and we encourage VA to look to dedicated partners to reach veterans outside the VA health-care system. The letter provided links to VA's National Strategy for Preventing Veteran Suicide, a toolkit that includes a guide to online suicide prevention resources, and a resource locator for contacting local VA Suicide Prevention Coordinators.

The American Legion supports S. 785.

S. 805

*To amend title 38, United Sates Code, to improve the processing of veterans benefits by the Department of Veterans Affairs, to limit the authority of the Secretary of Veterans Affairs to recover overpayments made by the Department and other amounts owed by veterans to the United States, to improve the due process accorded veterans with respect to such recovery, and for other purposes.*

The VA is responsible for distributing monthly earned benefits to veterans and their beneficiaries. Currently, when the VA makes an overpayment in error to a veteran, the VA can then withhold some or all of a veteran's benefit, without limitation, including monthly disability benefit payments. For veterans who live on a fixed income, withholding a benefit payment due to no fault of their own can present an undue hardship in their ability to pay rent or buy groceries.

The VA annually sends as many as 200,000 overpayment notices totaling thousands of dollars to veterans and their families, sending them into crippling debt and withholding future benefits payments until the debt is paid. These overpayments are often a result of the VA's own accounting errors, but the VA puts veterans and their families on the hook for repaying the debt.

Debt caused by VA overpayments are a major concern for The American Legion, we have seen the financial hardship veterans and their dependents end up and in many cases through no fault of their own. Since 1978 The American Legion has retained a dedicated staff member at the Debt Management Center for the sole purpose of advocating on behave of veterans and their dependents facing garnishment.

If enacted, the Veteran Debt Fairness Act, will prevent the VA from collecting debt if caused by errors at the VA. The bill would allow the VA to recoup overpayments only if the debt was due to an error or fraud on the part of the veteran or beneficiary. Additionally, to reduce the risk of financial hardship, the legislation states that the VA cannot deduct more than 25 percent from a veteran's monthly payment in order to recoup overpayment. It also requires the VA to provide veterans with a way to update dependency information on their own, eliminating a common delay that may affect a veteran's benefits.

The American Legion has testified and recommended many of the above changes, if passed the legislation would greatly improve the way VA manages debt collection while minimizing the negative impact for veterans.

The American Legion supports S. 805.

S. 850

*To extend the authorization of appropriations to the Department of Veterans Affairs for purposes of awarding grants to veterans service organizations for the transportation of highly rural veterans.*

The American Legion has taken no previous position on this matter. As a large, grassroots organization, The American Legion takes positions on legislation based on resolutions passed by our membership. With no resolutions addressing the provisions of the legislation, The American Legion is researching the material and working with our membership to determine the course of action that best serves veterans.The provisions in this bill fall outside the scope of established resolutions of The American Legion. The American Legion does not have a resolution that addresses the authorization of appropriations in the VA for awarding grants to VSOs for transportation in highly rural areas.

The American Legion takes no position on S. 850.

S. 857

*To amend title 38, United Sates Code, to increase the amount of special pension for Medal of Honor recipients, and for other purposes.*

The American Legion has testified before the Subcommittee on Veterans' Affairs in support of improved benefits for Medal of Honor Recipients. We have also passed resolutions supporting expanded benefits for Medal of Honor Recipients. The Medal of Honor is the highest military decoration awarded to a member of the United States Armed Forces and the recipients have earned this award by displaying heroism and bravery while risking their lives during service to this great Nation. The American Legion fully appreciated the service of those awarded the Medal of Honor and supports legislation that would expand the benefits to Medal of Honor recipients.[8]

The American Legion supports S. 857.

S. 980

*To amend title 38, United States Code, to improve the provision of services for homeless veterans, and for other purposes.*

Generally, the causes of homelessness can be grouped into three categories: economic hardships, health issues, and lack of affordable housing. Although these issues affect all homeless individuals, veterans face additional challenges in overcoming these obstacles, including: prolonged separation from traditional supports such as family and close friends; highly stressful training and occupational demands, which can affect personality, self-esteem and the ability to communicate upon discharge; and non-transferability of some military occupational specialties into the civilian workforce. The Departments of Veterans Affairs (VA) and Housing and Urban Development (HUD) reported a little over 40,000 homeless veterans on a single night in January 2017. We witnessed a slight uptick in homeless veterans last year, due mostly to high cost rental markets. Please note—positive progress has been driven by consistent action at all levels of government and across all sectors.

[8]The American Legion Resolution No. 366: *Honoring those who have Earned the Medal of Honor Origin: Convention Committee on Veterans Affairs & Rehabilitation*

Much progress has been made; however, there is still room for significant improvement with access to resources for at-risk and homeless veterans.

The American Legion supports S. 980 because it would allow the VA to enter into partnerships with other entities to expand the legal services available for veterans experiencing homelessness. The legislation would also require housing providers to take steps to better meet needs of women veterans, and would amend VA rules to ensure the children of homeless veterans are allowed to live in VA-run transitional housing programs. S. 980 would also authorize the VA to provide dental care to homeless veterans, which has been a top ten need in the VA's Project CHALENG (Community Homelessness Assessment, Local Education and Networking Groups) survey for many years. Last, the bill would increase the authorization limit for the Supportive Services for Veteran Families (SSVF) Program to $500 million, opening the door for the renewal of surge grants set to expire at the end of the year.

The American Legion maintains a sustained focus on the prevention of veteran homelessness ("get them before they get on the street"). We offer support to at-risk and/or homeless veterans and their families in the forms of informal advice and counseling, assistance with obtaining VA healthcare and benefits, temporary financial assistance (TFA), aid from the Child Welfare Foundation (CWF), and assistance with employment through our Career Fairs and Veteran-Owned and Service-Disabled Veteran-Owned Small Business Development Workshops (educational forums). This kind of assistance is available from the Post level up to The American Legion's national organization.

Last, based upon the small rise in veteran homelessness, this is no time to stop funding Federal programs or not look to adding necessary resources to assist homeless veterans in obtaining housing, treatment, and financial stability. Consequently, on behalf of the 2 million members of The American Legion, we express support for S. 980, the Homeless Veterans Prevention Act of 2017. The American Legion applauds Congress for its substantial funding for homeless programs, while giving major thanks to VA, HUD, and the Department of Labor, for the implementation of their programs that have literally saved the lives of thousands of veterans. We strongly believe that with the path VA has begun in eliminating veteran homelessness and the proper utilization of the resources at the state level and in local communities, we can continue to make tremendous progress.

Resolution No. 324, *Funding for Homeless Veterans*, supports any legislative or administrative proposal that will provide medical, rehabilitative, and employment assistance to homeless veterans and their families.

The American Legion supports S. 980.

S. 1101

*Ensuring only licensed health care providers furnish medical disability examinations under certain Department of Veterans Affairs pilot program for use contract physicians for disability examinations.*

The provisions of this bill fall outside the scope of established resolutions of The American Legion. As a large, grassroots organization, The American Legion takes positions on legislation based on resolutions passed by the membership or in meetings of the National Executive Committee.

With no resolutions addressing the provisions of the legislation, The American Legion is researching the material and working with our membership to determine the course of action, which best serves veterans.

S. 1154

*To amend title 38, United States Code, to establish an advisory committee on the implementation by the Department of Veterans Affairs of an electronic health record.*

The VA is currently undertaking a decade-long transition to bring veterans' health records into the 21st century by ensuring that veterans can have access to a seamless electronic health record across the VA and Department of Defense health systems. The Department of Veterans Affairs Electronic Health Record Advisory Committee Act, would establish a third party oversight group to monitor the VA's $16 billion EHR rollout. The 11-member EHR Advisory Committee would include medical professionals, IT and interoperability specialists, and veterans receiving care from the VA. This Committee would operate as an independent entity.

The American Legion, through resolution, has long endorsed and supported the Department of Veterans Affairs (VA) in creating a Lifetime Electronic Health Records (EHR) system. Additionally, The American Legion has encouraged both

DOD and the VA to either use the same EHR system, or, at the very least, systems that were interoperable.

The American Legion recognizes the advantages of a bi-directional interoperable exchange of information between agencies. Collaborating with DOD offers potential cost savings and opportunities for VA. Opportunities include capitalizing on challenges DOD encounters deploying its own Cerner solution, applying lessons learned to anticipate and mitigate issues, and identifying potential efficiencies for faster and successful deployment. The EHR is a high-priority initiative that ensures a seamlessly integrated healthcare record between the Department of Defense and VA, by bringing all patient data into one common system.

The American Legion supports S. 1154.

S. ____, JANEY ENSMINGER ACT OF 2019

*A bill to amend the Public Health Service Act with respect to the Agency for Toxic Substances and Disease Registry's review and publication of illness and conditions relating to veterans stationed at Camp Lejeune, North Carolina, and their family members, and for other purposes.*

This draft bill would allow the Agency for Toxic Substances and Disease to collect information regarding servicemembers, veterans, and family members who suffer from a variety of illnesses due to contaminated drinking water at Camp Lejeune , NC. Additionally, this bill would require the Secretary of Veterans Affairs to allocate two million dollars a year to assist servicemembers, veterans, and their families affected by contaminated water at Camp Lejeune, in applying for health benefits through the VA.

During the early parts of the 1980s, contaminants were found in two wells that provided water at Camp Lejeune. These contaminants included the volatile organic compounds trichloroethylene (TCE), a metal degreaser, perchloroethylene (PCE), dry cleaning agents, and vinyl chloride, as well as benzene, and other compounds. It is estimated that the contaminants were in the water supply from the mid-1950's until February 1985 when the wells were shut down. Additionally, there is evidence of an association between certain diseases and the contaminants found in the water supply at Camp Lejeune during the period of contamination.

United States Marine Corps (USMC) servicemembers and their families living at the base, between the 1950's to 1985, bathed in and ingested tap water contaminated with harmful chemicals at concentrations ranging from 240 to 3400 times higher than appropriate safety levels. An undetermined number of former base residents later developed cancer or other ailments, which may be associated with the contaminated drinking water. Victims claim that USMC leaders concealed knowledge of the problem and did not act appropriately in resolving it or notifying former base residents that their health might be at risk.

The American Legion is appalled that military members serving our Nation, and their families, were exposed to harmful chemical contaminants at Camp Lejeune. We are equally shocked that the USMC was potentially aware of the issue and did nothing to mitigate the risk associated with the water contamination at this military instillation. This bill would allow individuals affected by water contamination at Camp Lejeune to receive healthcare provided by the VA and claim any benefits due to them. Resolution No. 377: Support for Veteran Quality of Life supports legislation that would allow access to quality VA health care and timely decisions on claims and receipt of earned benefits.[9] The American Legion strongly supports this draft bill.

The American Legion supports this draft bill.

S. ____, A BILL TO AMEND TITLE 38

*A bill to amend title 38, United States Code, to extend the authority of the Secretary of Veterans Affairs to continue to pay educational assistance or subsistence allowances to eligible persons when educational institutions are temporarily closed, and for other purposes.*

Presently, when a school closes traditional, non-veteran students have Federal protections that support them. Effected students with Federal student loans have the ability to discharge their student loans. Students who received Pell Grants can have their eligibility periods reset for the time spent at a closed institution. The American Legion believes strongly that veterans are entitled to the same protection as their civilian counterparts. Over 6,000 student veterans were attending ITT Tech

[9] http://www.indystar.com/story/money/2016/09/06/why-veterans-have-most-lose-if-itt-tech-closes/89710280/ "Why ITT closing hits veterans hardest"

when they abruptly shut down their campuses,[9] and more school closures will inevitably occur, and The American Legion applauded provisions in the Harry W. Colmery Veterans Educational Assistance Act that restored these veterans.

Despite this victory, the Forever GI Blil provisions only restored benefits for schools tha tclosed between 2015 and 2017. Congress must not forget about the student veterans affected by school closures outside of this time period, including most recently Argosy University.

Through resolution No. 21: *Education Benefit Forgiveness and Relief for Displaced Student-Veterans.* The American Legion supports legislation that restores lost benefits to student-veterans attending schools that abruptly shut down.[10]

The American Legion supports this draft bill.

CONCLUSION

The American Legion thanks this Committee for the opportunity to elucidate the position of the 2 million veteran members of this organization. For additional information regarding this testimony, please contact the Legislative Associate of the Legislative Division, Mr. Ernest J. Robinson, at The American Legion's Legislative Division.

Senator BOOZMAN. Thank you, Mr. Nembhard.

General Phillips.

## PREPARED STATEMENT OF MAJOR GENERAL (RET.) JEFFREY PHILLIPS, EXECUTIVE DIRECTOR, RESERVE OFFICERS ASSOCIATION

General PHILLIPS. Senator Boozman, good to see you again.

Senator BOOZMAN. It is good to see you.

General PHILLIPS. We add our thanks to Chairman Isakson and Ranking Member Tester for the invitation to come out today.

ROA, the only national military organization that exclusively supports America's Reserve and National Guard appreciates the opportunity to testify today on legislation that would affect members of the Guard and Reserve, their families, and veterans who served in the Reserve components.

We commend the Committee on proposed legislation that shows great commitment to ensuring these patriots, male and female, get prompt, attentive, and effective care, and that the challenges of the homeless and those considering suicide are addressed.

ROA's focus on our Reserve components is exclusive, as I said, and so I will address certain bills that apply, in particular, to our Reserve force.

The Deborah Sampson Act, S. 514, continues our Nation's progress in providing services to women veterans. An essential component of this service is outreach to service women to both explain VA's offerings and to assure them that they are veterans who qualify for care and benefits.

On the ROA staff is a woman who served more than 14 years in the Air Force Reserve. Several medical events and conditions qualified her for VA disability and medical treatment, yet it took more than a decade for her supervisor to convince her to submit a disability application. She finally confided that she did not feel that she was a real veteran. Well, she is, and she just recently got rated for her disabilities—promptly, we are pleased to say. She is now getting treatment from the VA medical center here in Washington

[10] The American Legion Resolution No 21: *Education Benefit Forgiveness and Relief for Displaced Student-Veterans*

and receiving her benefits. A good ending, yes, but regrettably, not an isolated situation.

The next bill ROA supports is the Care and Readiness Enhancement for Reservists Act of 2019, S. 711, to expand mental health services from VA. The Reserve components, unlike the active component, only perform duty on demand. They are on orders for the period of deployment, for example, and then off orders until the next demand. Behavioral and mental issues, however, show no respect for the duration of a set of orders. Manifestation can and often does occur well after the Reservist reassumes his or her civilian list.

A Reservist's medical documents can be scattered around various military and civilian health care locations. Getting copies of specific documents, for example, to prove a service-connected condition, can be excruciatingly difficult. An electronic health record that consolidates all these records would represent an improvement in readiness and access to care because it would facilitate the right care.

The last bill I will discuss is the Veteran Debt Fairness Act of 2019, S. 805. As we have seen, Reserve component servicemembers get hit with repayment action from both DOD and VA, and debt collection methods can be very aggressive. Members of the Guard and Reserve, largely unlike their comrades in the active force, can conceivably receive benefits while still serving, from DOD, VA, and other Federal agencies. Thus, it is possible for debt collection to hit Reservists from both DOD and VA, wreaking havoc in their personal finances, ravaging credit scores, and depleting funds for a family's daily needs.

As we have seen, overpayments can and do occur through no fault of the servicemember, yet our Federal bureaucracy takes no notice as it claws back the money. It is easy to blame the warriors themselves for accepting payments, and that is precisely what some bureaucrats tend to do. But, GIs, busy with a war, may be forgiven for failing to scrutinize an increase in pay and allowance, especially given the often-confusing array of deployment-related pay schemes and bonuses. Young warriors tend to trust the government to know what it is doing.

ROA appreciates that this bill will improve due process, government accountability, and basic decency, and we hope that DOD will take the same approach. ROA is committed to working with VA and, indeed, any and all, to enhance understanding of our reserve components. These citizen warriors, which I think is a great name for them, whatever their service affiliation, serve America in ways fundamentally different from their comrades in the active force. In many cases, they need a correspondingly different approach to benefits and care. The bills before show that you understand that and are committed to providing meaningful help.

Thank you for your support of our young men and women in the National Guard and the Reserve, their families, and veterans of Reserve service. I welcome any questions you have, Senator, or other Members of the Committee.

[The prepared statement of Maj. Gen. Phillips follows:]

## PREPARED STATEMENT OF RESERVE ORGANIZATION OF AMERICA

### STATEMENT

ROA appreciates the opportunity to discuss pending legislation that affects National Guard and Reserve servicemembers. While I will not address every proposed act, this does not indicate ROA's support for or opposition to these other bills. ROA's focus today aligns with our congressional charter, "...to support and promote the development in execution of a military policy for the United States that will provide adequate national security."

### S. 514, DEBORAH SAMPSON ACT

To amend title 38, United States Code, to improve the benefits and services provided by the Department of Veterans Affairs to women veterans, and for other purposes.

This act will help eliminate impediments to the care of women veterans. It will help ensure the Department of Veterans Affairs can address the needs of women veterans who face homelessness, unemployment, and life without health care.

Women veterans are a growing population. Many VA facilities provide adequate care or services to them but as issues specific to women veteran are identified, services must keep pace. The Deborah Sampson Act would help ensure that VA meets the needs of these women veterans by providing access to health care and services to prevent homelessness and unemployment.

There were 3,219 homeless women veterans at the point-in-time count that occurred during a single night in January 2018 as reported in The 2018 Annual Homeless Assessment Report to Congress: Part 1. Unfortunately, homeless counts and other Department of Veterans Affairs data are not identifying National Guard and Reserve members which have different circumstances then those from active duty.

Understanding what military service the veteran population comes from is important. In this instance there were 159,749 women serving in the Selected Reserve in 2017; there were 655,367 men in the Selected Reserve. The Reserve Component population is significant enough that it should be considered as a separate data point.

If National Guard and Reserve information were available, military associations like ROA could better use their resources to help members and veterans of the Reserve Components with homelessness, unemployment and other issues.

This legislation is crucial in improving care for women during and after military service, and it has ROA's support.

### S. 524, DEPARTMENT OF VETERANS AFFAIRS TRIBAL ADVISORY COMMITTEE ACT OF 2019

To establish the Department of Veterans Affairs Advisory Committee on Tribal and Indian Affairs, and for other purposes.

According to the Department of Defense 2017 Demographics Report, for the Selected Reserve, 26.1 percent of the force is identified as minority. Of that number Black or African Americans are 16.4 percent; those identified as Asian are 4.2 percent; Other/Unknown are 2.5 percent; Multi-racial are 1.6 percent; American Indian or Alaska Native members are 0.8 percent; Native Hawaiian or Other Pacific Islander members are 0.7 percent. The report did not include a Hispanic category, but ROA knows they are a sizable portion of the minority population. For example, the Army Reserve has 16 percent of their soldiers identified as Hispanic.

Much of this minority population lives in rural locations that provide access to care challenges for VA. American Indians and Alaska Natives are served by the Indian Health Service, a Federal health program for them and should be part of the VA health care consideration. They are also part of tribal governments that should be consulted. Bringing these organizations under an advisory committee makes sense to reach an agreement on practices of care.

This Committee could help in areas such as unemployment; the Bureau of Labor Statistics identified that American Indians and Alaska Natives suffer unemployment rates exceeding other minorities and Caucasians, 7.8 percent in 2017.

ROA supports this legislation.

### S. 711, CARE AND READINESS ENHANCEMENT FOR RESERVISTS ACT OF 2019 OR THE CARE FOR RESERVISTS ACT OF 2019

To amend title 38, United States Code, to expand eligibility for mental health services from the Department of Veterans Affairs to include members of the reserve components of the Armed Forces, and for other purposes.

The CARE for Reservists Act of 2019 would expand mental health services offered by VA to those serving in the reserve components of the military, regardless of their deployment status. This Act would permit VA to offer a comprehensive, individual exam to those members of the reserve components with either a behavioral health condition or psychological trauma.

Currently, members of the National Guard and Reserves undergo annual health assessments to identify medical issues that could affect their deployable status, but any follow-up care is usually at the servicemember's expense.

This Act further specifies that members of the reserve components would be included in certain VA mental health programs, such as the suicide prevention program.

ROA appreciates that the bill also allows members of the Guard and Reserve to access Vet Centers for mental health screening and counseling, employment assessments, education training and other services to help them return to and succeed in civilian life.

ROA supports this legislation.

### S. 785, COMMANDER JOHN SCOTT HANNON VETERANS MENTAL HEALTH CARE IMPROVEMENT ACT OF 2019

To improve mental health care provided by the Department of Veterans Affairs, and for other purposes.

This Act would expand health coverage for veterans by providing grants for transition assistance from the Armed Forces to civilian life. It is a comprehensive approach to connect more veterans with the mental health care they need. The bill seeks to improve care from VA by strengthening the VA's mental health workforce and increasing access to care in rural areas.

A major issue in the prevention of suicides is our ability to find veterans who are not seeking treatment at a VA facility. Of the approximately 22 veterans who commit suicide each day, 14 have received no treatment or care from VA.

The Department of Defense fiscal year Quarterly Suicide Report through June 2018 shows that the military's reserves lost 56 servicemembers to suicide that quarter and the National Guard lost 88. The information for the fourth quarter has not been published.

If the transition process better equips servicemembers to get off to a good start in their next stage of the journey, ROA thinks it will reduce unemployment, homelessness, and it will reduce suicides.

ROA is concerned that Section 101, Expansion of Health Care Coverage for Veterans, uses the limiting term of "active service," that only applies to active duty or full-time National Guard duty. We ask that the Committee change the proposed insert to Section 101, "(B) to any veteran during the one-year period following the discharge or release of the veteran from active military, naval, or air service; and" be changed to insert after the word service "and active status; and" which would include reserve component members leaving a participating reserve position as defined by Title 10, Section 101.

ROA appreciates that Section 301, Program to Provide Veterans Access to Computerized Cognitive Behavioral Therapy, is written such that it includes members of the Reserve and National Guard.

ROA is particularly pleased with Section 506, Comptroller General report on Readjustment Counseling Service of Department of Veterans Affairs, and the requirement to assess the use of Vet Centers by National Guard and Reserve who were never activated and for recommendations on how to better reach those members.

ROA is concerned that the bill includes so much that implementation could be difficult. An incremental approach might give enough time to evaluate the effectiveness of each recommendation before committing more resources.

With the edit ROA recommends to Section 101, we support this legislation.

### S. 805, VETERAN DEBT FAIRNESS ACT OF 2019

To amend title 38, United States Code, to improve the processing of veterans benefits by the Department of Veterans Affairs, to limit the authority of the Secretary of Veterans Affairs to recover overpayments made by the Department and other amounts owed by veterans to the United States, to improve the due process accorded veterans with respect to such recovery, and for other purposes.

This act requires the VA to waive the collection of overpayments if the agency was responsible for the mistakes leading to overpayment.

Often, the veteran is unaware of overpayment. The money recovered is often the veteran's only source of income; recovery can cripple the veteran's ability to pay

mortgages, utility bills, health care, groceries, etc. This can increase undue stress as well as mental illness issues.

ROA believes the Department of Defense should adopt this approach when debt is incurred through no fault of the member. The department's aggressive debt collection process operates with little congressional oversight and does not differentiate between debt resulting from deception and debt caused by government error.

ROA supports this legislation.

S. 980, HOMELESS VETERANS PREVENTION ACT OF 2019

To amend title 38, United States Code, to improve the provision of services for homeless veterans, and for other purposes.

This act is imperative in helping homeless veterans care for their families while the Department of Veterans Affairs helps them become employable. Helping care for veteran families during this time may help break the cycle of homelessness, when the children become adults.

"We know from the Adverse Childhood Experiences study that childhood trauma has lifelong negative effects on physical and mental health," said Dr. Ellen Bassuk who wrote *Child Homelessness: A Growing Crisis*. Childhood trauma can occur in shelters where homeless families are housed. Dr. Bassuk writes, "There is no privacy or safe place for children to play, and boys over the age of 12 are often not permitted. If families do not quickly find permanent housing and are forced to remain in the shelter system, 40 to 50% of them will break up within 5 years, with children being sent to live with relatives or placed in foster care. These children face almost insurmountable obstacles as they become adults and are often trapped in a cycle of poverty, ill health, and significant social disadvantages."

The bill would also provide dental care for those that are homeless and provide preventive care and counseling for people who are at risk. The best way to address this issue is to prevent it. "To end homelessness in America," the United States Interagency Council on Homelessness explains, "we must strengthen our ability to prevent it in the first place. To do that, we must take a multi-sector approach that focuses on housing needs, housing stability, and risks of homelessness across many different public systems."

The council includes healthcare, child welfare, and legal assistance which are in this bill.

The more programs the VA has available, the more access our veterans will have to the VA. In turn, the VA will have the time they need to asses and treat a multitude of issues that may be contributing to the veteran's wellbeing.

As with S. 514, ROA believes data on homelessness should identify National Guard and Reserve members, whose circumstances differ from the active duty population.

S. 1154 DEPARTMENT OF VETERANS AFFAIRS ELECTRONIC HEALTH RECORD ADVISORY COMMITTEE ACT

To amend title 38, United States Code, to establish an advisory committee on the implementation by the Department of Veterans Affairs of an electronic health record.

S. 1154 would establish the independent, 11-member Electronic Health Record (EHR) Advisory Committee, comprised of medical professionals, information technology and interoperability specialists, and veterans currently receiving care from the VA. The Committee's duties include specific requirements that will ensure a viable EHR and continue to monitor effectiveness after launch.

National Guard and Reserve members encounter many problems when trying to establish service-connected disabilities. This is mainly due to how their medical records are scattered among multiple locations from their home of record to military schools, to deployment locations to places of temporary duty. Added on top of this are the records that reside with civilian providers. A centralized EHR will help draw these records together.

ROA believes a VA/DOD Reserve Component Committee should be established to act as an advisor to the EHR Advisory Committee and other VA committees. The complex organization of the Reserve Component requires direct knowledge in order to properly advise on programs, policies and legislation that falls under VA.

ROA supports this legislation.

JANEY ENSMINGER ACT OF 2019 (NO BILL NUMBER)

To amend the Public Health Service Act with respect to the Agency for Toxic Substances and Disease Registry's review and publication of illness and conditions relat-

ing to veterans stationed at Camp Lejeune, North Carolina, and their family members, and for other purposes.

The bill is directed to veterans and family members who lived at Camp Lejeune, however, ROA is concerned that Individual Mobilization Augmentees who may have performed duty at Camp Lejeune are not included in any legislation to treat toxic exposure. Camp Lejeune also provides amphibious assault and parachute training and individuals who attended this training may have been exposed to hazardous ground water.

ROA supports this legislation.

GI BILL EDUCATIONAL ASSISTANCE DURING TEMPORARY CLOSURES
(NO BILL NUMBER OR TITLE)

To amend title 38, United States Code, to extend the authority of the Secretary of Veterans Affairs to continue to pay educational assistance or subsistence allowances to eligible persons when educational institutions are temporarily closed, and for other purposes.

According to a May 2019 CBO report, *The Post-9/11 GI Bill: Beneficiaries, Choices, and Cost*, National Guard and Reserves servicemembers make up about 17 percent of beneficiaries in any given year which is approximately 136,000 servicemembers. The average age of this group is 37 years old which indicates that most beneficiaries pay mortgage or rent. This monthly obligation does not disappear if or when the school they're attending is closed temporarily.

The CBO report also stated, "The average payment for veterans from the National Guard and reserves was considerably lower ($12,500) than payments for all other veterans. . .".

ROA believes assistance should be provided during temporary school closures when Reserve Component members are using their 9/11 G.I. Bill and supports this legislation.

CONCLUSION

ROA appreciates the opportunity to offer thoughts regarding these important bills. Because of the unique nature of service in the Reserve Components, its members may simultaneously receive care and benefits from VA, the departments of Labor and HHS, as well as DOD.

All too often military and veterans' law and policy are developed without an understanding of or appreciation for the important distinctions between reserve and active duty service. The members of the Guard and Reserve invariably lose out. And so, too, their families.

America is experiencing perhaps unprecedented challenges to our security, and commensurately great reliance on the Reserve and National Guard.

Thus, helping these men and women transition more successfully in and out of active duty and deployments, helping them gain access to care, and helping their families thrive—all these pieces of legislation directly or indirectly enhance readiness and represent an insightful and praiseworthy focus on those patriots we call our citizen-warriors.

Senator BOOZMAN. Thank you, General Phillips.

Senator Tester.

Senator TESTER. Thank you, Mr. Chairman. I am going to start with you, Ms. Bryant. Thanks for coming today, representing IAVA, and thanks for everything that you guys do every day. I appreciate it. You have been a great partner in crafting many of the bills that are on the docket here today.

You are also the only woman on this panel, I noticed, and a combat veteran. You have seen—I should say have lived first-hand some of the issues that women veterans face in access to care within the VA. Just give me kind of an overview on what passing the Deborah Sampson Act would mean for a woman veteran.

Ms. BRYANT. Passing the Deborah Sampson Act will not only give the expanded mothers' care, newborn care that we have talked about earlier in this hearing, but the peer-to-peer counseling, the expansion of that, being able to use it in an environment in which we can be able to talk to someone who looks like us. No offense to

my esteemed colleague sitting to my left, but it is not necessarily the same message that we receive.

And, as Senator Boozman explained, from your constituents of what you have heard about women's experiences, I have to say personally that they are universal. I have experienced that at the DCVA, where they have asked me, "Where is my sponsor?" "Where is my husband?" Then, when I said that I felt harassed walking into the VA, which is another problem that VA is trying to grapple with—ending harassment there—there is group of folks who loiter outside. I was told, "Well, you can come in the back door." I should never have to come in the back door. My father did not have to go in the back door, so why should I?

So, that is what the Deborah Sampson Act does, is that it gives recognition to our service, as well as the type of specialty care that we need. Our anatomies are simply different, so we need to have that kind of care, we need to have privacy ensured when we go there, and we need to feel safe and welcome. That is really the biggest difference that the Deborah Sampson Act would make for women.

Senator TESTER. I want to touch a little bit on the safety issue as it applies to retrofitting the environment. Can you talk about that a little bit? How important is retrofitting to make sure that the care is there for women, in appropriate conditions?

Ms. BRYANT. Absolutely. The VA, in many facilities, has done some of that retrofitting, but it has not been universal, as I have stated before, like many things, that is having—be it just a curtain that separates you from someone else who is walking into an examination room. Imagine a woman who is receiving a pelvic exam who is in stirrups, and there is merely a curtain that separates you from someone else walking in. You are most vulnerable.

Imagine those who are loitering within the women's clinic or outside the clinic. The cat-calling. It is very real and it is disconcerting.

So, having that safety, feeling welcome just walking in the front door, then into the women's clinic door, and then, when you are your most vulnerable, when you are unclothed and someone is giving you an examination, or when you need to talk about something like the trauma that you experienced through military sexual assault while you were on active duty, or in the Guard and Reserve, that is something you need to be able to talk with a trusted provider about; that retrofitting is key to being able to feel that level of comfort to expose your weakest moments.

Senator TESTER. Thank you.

General Phillips, you addressed the CARE Act, the Care for Reservists Act in your statement. Would your organization agree that mental health is an urgent issue as it applies to our Guards and Reservists?

General PHILLIPS. Absolutely. In fact, it may be more accentuated in the Guard and Reserve because unlike the active component, Senator Tester, we scatter back to our communities. We get together at drills and when we are deployed and mobilized, but we do not tend to have the support of the unit, of the organization, that an active component servicemember has.

Senator TESTER. So, could you just give me your perspective a little bit on Vet Centers and how they can assist the Guardsmen and Reservists with the mental health issues, when compared to—and the VA too, as far as that goes, especially when compared to civilian medical providers?

General PHILLIPS. Well, not to give a history lesson on the Vet Center, but it was formed during the Vietnam years because veterans of the Vietnam War were loathe to go to the VA. The Vet Center was invented by VA. It was not supposed to look like a VA facility, so the vet would feel more free to go to it.

It achieved great success. It is part of the solution, as Dr. Carroll said earlier, and as my colleague, Mike Richardson, said. It is part of a total solution. The Vet Center is in the community. It is normally staffed by people who have an association with or knowledge of the military, so it is very much a part of the solution.

Senator TESTER. OK. Mr. Richardson, I want to touch a little bit on the Commander Hannon Mental Health Improvement Act. Could you speak to the importance of alternative methods—and you can go down any road you want—yoga, acupuncture, meditation, chiropractic care, whatever you want. Fishing, whatever. Could you speak to the importance of that and how it impacts your membership?

Mr. RICHARDSON. Absolutely. Again, a great question, because there are emerging trends using alternative—complementary and alternative therapies.

Now within Wounded Warrior Project—and I will specifically speak to Warrior Care Network, to where it is anchored in evidence-based, while surrounded by complementary and integrative services and alternative therapies. Equine therapy is one of those as well. I know there is some challenge in there, where equine therapy is not evidence-based, but it is moving toward evidence informed, as many of these alternative therapies are. So, we strongly support the use of complementary and alternative therapies in addressing not only mental health challenges, but physical health and wellness as well.

Senator TESTER. So, on any of these questions I could have asked just about anyone, maybe not the women's care that I talked about at the beginning. I do want to ask you, Mr. Nembhard, on the debt fairness issue, most everybody has touched on it. But, could you just kind of discuss, from The American Legion's point of view, the kind of financial and mental toll that the veteran goes through when they are trying to repay a debt that, quite frankly, they did not think they were obligated for to begin with?

Mr. NEMBHARD. Thank you for that question, Ranking Member. This is actually quite devastating to not just the veterans but their entire families. It is tantamount to debt collectors banging down your door. And, if you are already suffering with other conditions, it just extenuates the problem.

So, it does create mental health challenges for veterans. It also creates a feeling of distrust for the VA, because they feel the VA is supposed to be taking care of them and not harming them. Do no harm.

Senator TESTER. Yeah. I think one of you pointed out, if not more than one of you, about the myriad of payments that could come

through, and, quite frankly, money is hard to come by. When you get these checks and think, "Well, that is cool," and then all of a sudden bing, bang, boom, the wolf is at the door.

I want to thank you all for your testimony and the people that you represent. I also want to thank the VA staff for sticking around and listening. I always appreciate that. You guys need to hear from the folks you serve directly. We need to do more of that. Thank you all very much.

Thank you, Mr. Chairman.

Senator BOOZMAN. Senator Blumenthal.

**HON. RICHARD BLUMENTHAL,**
**U.S. SENATOR FROM CONNECTICUT**

Senator BLUMENTHAL. Thank you, Mr. Chairman, and thank you all for being here today and for your service.

I want to ask a question about the Caregivers Act. I realize it may not be new legislation, but if you could relate to us what you are hearing from your memberships about how this act is working I would appreciate it.

Ms. BRYANT. Yes, Senator Blumenthal. I will speak from IAVA's perspective, in that we appreciate the expansion of the Caregivers Act to pre-9/11, but, of course, we do not want to see that at the detriment of those who are receiving it for the post-9/11 generation. We are still a generation at war, 18 years into this, and we do not want to see our caregivers left behind for those who are coming home with injuries over the last two decades.

Senator BLUMENTHAL. Is that what you are seeing?

Dr. BOYD. We are not seeing it just yet, but that is the fear that we are going to see it, that there is going to be a slowness in benefits being distributed to caregivers within the post-9/11 community.

Mr. RICHARDSON. Senator, if I could add, I can absolutely concur with Melissa in that we need to make sure, for the pre-9/11 caregivers that it is funded, to make sure that management is there so we can provide that support and service to them.

I am responsible for a program called Independence Program, under Wounded Warrior Project, which is for those service men and women that have moderate to severe Traumatic Brain Injury. Most of them have a caregiver. So, we have a very tight community and we hear of the many, many issues that are there. This is great progress in addressing issues for the caregivers, so we appreciate that. We just need to make sure we move in a very deliberate fashion with the funding.

Mr. NEMBHARD. Senator, just to echo my colleagues here, we think it is a fantastic program. It is helping veterans and we just want to make sure that the program continues in the right direction instead of going backwards.

Senator BLUMENTHAL. General?

General PHILLIPS. I echo my colleagues. I will add to that, I understand there is some difficulty in becoming certified as a caregiver. It can be kind of an awkward, clumsy program. Navigating can be difficult. But, at heart, it is a good program.

Senator BLUMENTHAL. I think there have been reports about a number of difficulties, that being one of them, and the other being premature ending or discharges for folks who continue to need

caregivers, or caregivers who are tending to folks who need it. I would appreciate your keeping us up to date about difficulties that you are seeing, because this initiative—and I give thanks to Senator Murray and Senator Tester—a number of us are very, very interested in it. I think it is part of our future, particularly for the post-9/11 generation, as well as previous generations.

What would you recommend in terms of the outreach? You know, there is so much talk now about veteran suicide, about veterans who are not in the system, which, for the VA, sometimes feels like an excuse for not reaching them—they are not part of our system. But, there is a responsibility to reach out to them, and I think the VA is beginning to recognize that. What recommendations would you have for us, and the VA?

Ms. BRYANT. At IAVA we recognize that this is a whole of government, whole of community solution that needs to be applied. If there were a silver bullet for suicide prevention and mental health awareness we would have used it by now. So, a lot of what we are talking about are ways in which you can reach out to those who are not enrolled in VA care, because we do know that those who are enrolled in VA care have a greater probability of survival of suicidal ideation. But, it does not let VA off the hook.

So, you have to spend all of your outreach budget in order to ensure that you are reaching everyone. It needs to have a highly visible digital component, because we know for our younger veterans that is the best way we are going to reach folks. Even for our older veterans, my father, a Vietnam veteran, throws away mail regularly. So, it cannot just be outreach through snail mail of how we are reaching out to folks; it needs to be all-hands, all methods of outreach. Leave no stone unturned, in order to let people know that there are the resources out there.

So, the hope is that, in 2019, given this groundswell of messaging around—and we appreciate the efforts, the bipartisan efforts of Congress, both in the House and the Senate, to draw attention to this matter—the hope is that we will get to a part where we can ensure that people at least know what resources are out there.

Mr. RICHARDSON. Sir, if I could just add, in addition to the community outreach, our peer-to-peer networks are critical in the communities themselves. In addition to that, I would just say—and I mentioned this in my testimony before Congress in September—is getting left of the bang. Before they transition, let's get them engaged in health care, understanding, and breaking down the stigma through the transition process out of the service; or as the National Guarders are demobing to make it normal, normalize the conversation so that when they are back in their communities they are engaged with mental health care and it is not a stigma any longer.

Mr. NEMBHARD. Senator, as I mentioned in my testimony, The American Legion is already working with the VA on a suicide prevention approach, dealing with reaching out to the community, peers, family members. I think if the VA continues to work with all the VSO partners who have resources out in the communities that would be one of the essential steps that can help with that progress.

General PHILLIPS. Senator, as a Bush appointee, I was in charge of VA's public affairs, 2001 to 2004, when I went voluntarily to Baghdad on active duty. Then I was the Deputy Chief of Public Affairs for the Army in 2007, as we were grappling, in the Army, with suicide. General Chiarelli was Vice Chief of Staff pat of that period. And here we are, 10, 15, 20 years, whatever, later, and we still have 22 suicides a day.

This is a big problem and no one is blaming the VA for not doing enough. I think the VA has bent over backwards. I think when I was a Bush appointee in VA we thought about sending out a message on people's tax forms, anything we could get out to the veterans who are not enrolled in VA care and do not get communications from VA. That is very expensive. We thought about it.

I think the solution here, if there is one, is what my colleagues are talking about, what I think you talked about, and that is engaging entire communities, both governmental and non-governmental communities in support and understanding and discussions, so people can talk about it, they understand that it is OK to talk about it.

I went through clinical depression myself, and it took an Army chaplain to help me through it. Someone I could talk to at my level, a peer level, a colleague, who helped me understand that what I was going through was fairly normal and I was going to get through it, which is what it took.

But, I am not going around blaming the VA for not doing enough, or blaming the Pentagon for not doing enough. I think they are trying very hard.

Ms. BRYANT. If I may just dovetail on General Phillips, and also to Michael, it does start with a continuum of service. It starts in DOD, making that conversation normalized. Like General Phillips, I have also, you know, spoken with those who are my soldiers under my charge who were attempting—we had an attempted suicide, had died by suicide, or were contemplating suicidal ideation, and being able to say that I am not OK, and being able to report that through your chain of command, or talk to a chaplain, or any of the other multiple avenues, if they are out there. There is still a stigma that is within the uniformed community that we still have not breached yet, and being now 18 years into this it is something that we absolutely must address from not just a VA perspective. We have to go back to the stressors that come out of military service that we need to talk about more freely and openly.

Senator BLUMENTHAL. Well, I appreciate your very thoughtful comments. You know, let's be very blunt here. There is a stigma in the military but there is a stigma, more generally, in society. It may be somewhat greater within the military for all the reasons that we understand here. But, mental health and physical health are so inextricably connected, yet we still, in the civilian world, find resistance to mental health parity. In other words, providing insurance benefits in the same way for mental health as we do for physical health. I have fought this battle for more than a decade, in the civilian world.

I agree with you that we cannot sort of blame. Blame does not get us anywhere. And, I am convinced that the VA is trying to find

solutions, but we have not gotten there yet, so we need to continue that effort.

Ms. BRYANT. What we need to work on collaboratively, sir, if I may, is that we need to look at firearms also within our community. That is the third rail that people do not want to necessarily jump on. It is within that Venn diagram of veterans who have familiarity with a lethal—and access to firearms. It accounts for lethality of our suicidal ideation that then turns to death by suicide. We know that 69 percent of the deaths by suicide within our community are due to firearms. So, in our messaging we have to talk about that as well. We have got to find a way to thread the needle between those who feel as though it is government overreach and taking over their weapons versus having a safe plan of action when you know that you are in crisis.

Senator BLUMENTHAL. Well, I know I am way over my time, Mr. Chairman, but I would just add at that point it is very, very salient. We have a couple of bills, and I am hoping we will have bipartisan support for them, that, in effect, provide for court orders when someone who is talking about suicide in the family says we need to take away the firearms, temporarily, with a showing about danger to himself or others, and likewise, safe storage, so that there is some preventive action.

It is complicated. I thank you for your attention to it. Thank you, Mr. Chairman.

Senator BOOZMAN. No, thank you. That was a good discussion.

Mr. Richardson, in that light, you all have come out in support of S. 785. Can you talk a little bit about how it would be beneficial to have VA as a collaborative partner regarding mental health research?

Mr. RICHARDSON. Absolutely. Research is the forefront of the solution for tomorrow. We have got the treatment for today, evidence-based complementary, but what we need to get into is in the research of tomorrow, biomarker research, in particular. VA is already doing much of that, and it is critical that we are able to set biology to get the right person to the right care at the right time, doing it with precision medicine. We are close to doing that. There has been a biomarker discovered for Traumatic Brain Injury and one recently for PTSD, as well.

So, the VA is already well in that space, but we need everybody on board to get into the research so that mental health can then become precision medicine, much more so than it is today.

Senator BOOZMAN. Very good. General Phillips, you talked about data collection in regard to the homeless. Tell us about that. Tell us how better data collection would help strengthen our efforts to address homelessness.

General PHILLIPS. Well, of course, some of those homeless veterans are members of the Guard and Reserve or veterans of the Guard and Reserve, or conceivably family members or former family members. Right now, our granularity is such that we do not really know. This is part of a larger conversation about the Guard and Reserve in America that they have. I think it is an artifact of the fact that they have been a strategic Reserve since, well, really World War I, when they had been used occasionally, and more increasingly, of course, since Desert Storm.

But, they have not been paid attention to, so we do not have the systems, the knowledge, and the collection for them that we do for the active component. Obviously information is power. The more information we can have on who is out there in the Guard and Reserve, the more organizations like ROA, NGAUS, and EANGUS can help.

Senator BOOZMAN. I think that makes all the sense in the world.

Ms. Bryant, you note IAVA's support for grant programs to support both transition and mental health services for veterans. Should we be thinking about these types of services as distinct and separate from each other or does it make better sense to look at them from a whole health perspective on veterans' overall well being?

Ms. BRYANT. Senator Boozman, absolutely the latter; it should be considered as part of the whole health solution. Again, there is no one way in which we can address mental health and suicide prevention within our community. We also have to recognize the part that the family has in that as well.

So, retreats and things that have worked under SSVF could now be applied under what we could call an SSSP for suicide prevention. That is something that absolutely would be a part of a compendium of services that are offered through the community as well as through the VA, with the endorsement of the VA, in order to find the right fit for everyone.

Senator BOOZMAN. Thank you. Mr. Nembhard, can you talk to us, just for a second, about increasing the Medal of Honor recipients' allocation; what the Legion thinks about that and the importance of that?

Mr. NEMBHARD. At The American Legion, Mr. Chairman, we value greatly the contributions of those veterans, to the military and to society as a whole. We, the Legion, support that and we support increasing that amount for them.

Senator BOOZMAN. Good. Well, thank you very much. Thank you, panel. You did a great job. I think we had a really good discussion today and we appreciate your frankness. I would also echo Senator Tester in regard to the people at the VA that are working hard. I know you all are busy and have lots to do, but I think you add a lot by hanging around and being supportive of the VSO panel.

With that, I want to note that the hearing record will be left open for 5 days, should any Senators wish to add to their statements, to the hearing record, or submit questions to the witnesses for the record.

With that we are adjourned.

[Whereupon, at 4:07 p.m., the Committee was adjourned.]

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JON TESTER TO U.S. DEPARTMENT OF VETERANS AFFAIRS

*Question 1.* When can I expect technical assistance from the Department on S. 785, the Commander John Scott Hannon Veterans Mental Health Care Improvement Act?

Response. This technical assistance has been in-progress on a section-by-section basis and is largely concluded. We have also had several productive meetings with Committee staff.

*Question 2.* What is VA currently doing to ensure that veterans at highest risk for suicide are being followed-up with and cared for appropriately?

Response. To ensure that Veterans at highest risk for suicide are being followed-up with and cared for appropriately, the Veterans Health Administration (VHA) has implemented specific clinical procedures of care with accountability metrics.

For follow-up care, providers identify Veterans at high risk of suicide and notify facility Suicide Prevention Coordinators (SPC). SPCs activate a High Risk for Suicide Patient Record Flag (HRS-PRF) on the Veteran's electronic health record (EHR). This flag serves as an alert to any staff accessing the Veteran's EHR that the Veteran requires enhanced care.[1] This enhanced care is provided by the Veteran's treating providers in conjunction with SPCs and includes all the following:

- Completion of a Suicide Prevention Safety Plan including mitigating access to lethal means;[2]
- Four mental health follow-up appointments within 30 days of activation of the HRS-PRF and/or discharge from an acute care facility;[3]
- One mental health follow-up appointment every 30 days thereafter for as long as an HRS-PRF remains on a Veteran's EHR;
- Ensuring follow-up for no-shows to scheduled mental health appointments including four separate contacts and by an appropriately trained staff member whose scope of practice includes evaluation and triage of high-risk behavior;[4] and
- Collaborating with treating providers and ensuring review and update of the HRS-PRF every 90 days.[5]

Veterans who have left against medical advice or otherwise receive an irregular discharge from an inpatient mental health unit or residential rehabilitation treatment program may be at higher risk for suicide and are required to receive follow-up within 24 hours of leaving the facility.[6] Also, no less than two appointments on separate days must be offered during the 7-day post-discharge period.[7]

Metrics related to the stated enhanced care delivery interventions have been developed that track care of Veterans clinically identified as being at the highest risk for suicide. The Suicide Prevention Quarterly Dashboard reports metrics on core suicide prevention priorities, tracking trends, needs, and gaps for quality improvement. Specifically, the dashboard maps Veterans who have recently been identified as high risk for suicide and placed on our HRS-PRF system. This dashboard tracks the percentage of high-risk Veterans that:

- Have a Safety Plan documented within 7 days before or after flag initiation, or on or before discharge;
- Received at least 4 mental health encounters within 30 days of flag initiation, and at least one mental health follow-up appointment every 30 days thereafter for as long as an HRS-PRF remains on a Veteran's electronic health record; and
- Received a new assignment, reactivated, or continued HRS-PRF who received a case review within 100 days after flag initiation.

These specific measures have also been incorporated into Strategic Analytics for Improvement and Learning Value (SAIL)[8] model, which measures, evaluates, and benchmarks quality and efficiency at medical centers to promote high quality, safe, and value-based health care. In addition to these three measures, additional metrics specific to high risk Veterans are part of the Mental Health Continuity of Care measure on SAIL, such as the percentage of high-risk patients diagnosed with Serious Mental Illness, who have a mental health visit every 6 months, and the percentage of individuals discharged from inpatient mental health or residential treatment who are engaged in outpatient treatment within 30 days.

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[1] VHA Directive 2008–036, Use of Patient Record Flags to Identify Patients at Risk for Suicide; and VHA Directive 2010–053, Patient Record Flags; these policies are currently being updated.

[2] VHA Memorandum Patients at High Risk for Suicide, April 24, 2008.

[3] VHA Memorandum Guidance on Post-Discharge Follow-Up for Mental Health Patients, July 17, 2013.

[4] VHA Directive 1230(1), Outpatient Scheduling Processes and Procedures, and VHA Notice 2019–09(01), Minimum Scheduling Effort Required for Outpatient Appointments: Updates to VHA Directive 1230 and VHA Directive 1232(1).

[5] VHA Directive 2008–036, Use of Patient Record Flags to Identify Patients at Risk for Suicide,Supra, note 1.

[6] VHA Memorandum, Eliminating Veteran Suicide: Enhancing Acute Inpatient Mental Health and Residential Rehabilitation Treatment Program Discharge Planning and Follow-up, June 12, 2017.

[7] VHA Memorandum, Eliminating Veteran Suicide: Enhancing Acute Inpatient Mental Health and Residential Rehabilitation Treatment Program Discharge Planning and Follow-up, June 12, 2017.

[8] https://www.va.gov/QUALITYOFCARE/measure-up/Strategic_Analytics_for_Improvement_and_Learning_SAIL.asp.

*Question 3.* Is there routine monitoring of and outreach to at-risk veterans by Suicide Prevention Coordinators, Licensed Clinical Social Workers, or other PACT members?

a. Are these veterans being offered and receiving follow-up care?

b. What are the protocols for outreach and follow-up care for veterans in crisis?

Response. As noted in the response to question 2, Veterans identified at high risk for suicide must be offered and receive follow-up care, outreach, and routine monitoring by their care teams and the facility suicide prevention team. This may include providers across various services to include social workers, Suicide Prevention Coordinators (SPC), and/or PACT members.

Tracking and assessment methods involve monitoring of and outreach to at-risk Veterans through a variety of approaches. This includes ensuring the following after a high-risk flag has been placed: completion of a Suicide Prevention Safety Plan including mitigating access to lethal means; four mental health follow-up appointments within 30 days of activation of the HRS-PRF and/or discharge from an acute care facility; and one mental health follow-up appointment every 30 days thereafter for as long as an HRS-PRF remains on a Veteran's electronic health record.

Any Veteran reporting or identified as being in crisis will receive an immediate crisis response. Each VA health care system must ensure the establishment and implementation of localized processes to provide immediate crisis response. As part of the My VA Access Initiative, each health care system across VHA was required to ensure local standardized operating procedures were in place to address the need for immediate care for any Veteran voicing suicidality either by phone or in person.[9] The Veterans Crisis Line (VCL) is also available by phone, text, or chat to address the needs of Veterans in crisis. Since the VCL's inception in 2007, more than 3 million calls have been answered, and emergency services have been dispatched to those in imminent crisis nearly 78,000 times.[10]

In addition to responding to Veterans in crisis, VA also proactively works to identify those who are at risk who may not self-disclose suicidal thoughts on their own. VA has implemented a standardized suicide risk identification process for all Veterans receiving VA care.[11] The process is comprised of three components and implements population-based mental health screening for those with unrecognized risk (universal), for those who may be at risk (selected), and for those at elevated risk (indicated). The components include standardized primary and secondary screens specific to risk of suicide and a comprehensive suicide risk evaluation for Veterans with a positive secondary screen, helping to proactively identify Veterans in crisis.

Additionally, VA works to use analytic strategies to identify Veterans at high risk to begin to engage them in additional interventions. These include the following:

- Recovery Engagement and Coordination for Health—Veterans Enhanced Treatment (REACH VET) identifies patients at statistical risk of death by suicide in the next month. Using REACH VET, VHA clinicians can contact the identified Veterans to collaboratively review health conditions and risk factors, ensure access to care, and consider care enhancement strategies such as safety planning and increased monitoring during stressful life events.
- The Stratification Tool for Opioid Risk Mitigation (STORM) identifies patients at statistical risk of overdose or suicide-related health care events or death in the next year by using predictive modeling to estimate the risk of adverse events for patients receiving or considering opioid therapy. It also provides information on risk factors, monitoring of applicable risk mitigation interventions, treatment alternatives, and information to guide care coordination by clinicians.

*Question 4.* Have any policies or protocols been changed or created since the events in Georgia, Austin, Texas, and Cleveland, Ohio?

Response. Since the tragic events in Georgia, Austin, Texas, and Cleveland, VA created initial guidance[12] to help medical facility leadership, supervisors, and suicide prevention teams respond to this type of tragedy. This guidance provides concrete recommendations on how to manage patient care, notify the family, alert other parties, and support employees affected by a Veteran suicide on campus. Guidance is not considered policy, but it provides recommended actions. The initial guidance was emailed to Veterans Integrated Service Network (VISN) Chief Mental Health

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[9] VHA Memorandum, My VA Access: Mental Health Breakthrough Initiative, April 22, 2016.

[10] VA Office of Mental Health and Suicide Prevention Guidebook (2018).

[11] VHA Memorandum 2018–05–21, Suicide Risk Screening and Assessment Requirements, May 23, 2018; VHA Memorandum 2018–11–02, Eliminating Veteran Suicide: Implementation of Suicide Risk Screening and Evaluation November 2, 2018; VHA Memorandum 2019–02–17, Eliminating Veterans Suicide: Update on Suicide Risk Screening and Evaluation, February 22, 2019.

[12] Guidance for Action Following a Suicide on a VA Campus, June 2019.

Officers and Suicide Prevention Coordinators/Team Members in June 2019. Stakeholder feedback on the initial guidance is currently being collected. The guidance will be updated and more broadly disseminated to VISNs and medical centers when stakeholder feedback is incorporated.

In general, the initial guidance is geared toward facility leaders and supervisors to equip them to respond to the tragedy and support affected employees. It enhances existing facility procedures when responding to a Veteran suicide by adding to what management and suicide prevention teams can and should do to care for employees and the Veteran's family.

In addition, VA has continued to implement ongoing improvements for Veterans at high risk for suicide. VA has required all medical facilities with an acute mental health unit to install door top alarms on swinging corridor doors of patient rooms effective January 1, 2020.[13] VISN Network Directors are required to certify this action has been taken no later than February 1, 2020.[14] VA facilities also complete Environment of Care Rounds that include identification and recommendations for remediation of potential safety issues, including those specific to suicide and suicidal behavior. VA's Mental Health Environment of Care Checklist is designed to assist units with environmental surveys meant to reduce risk of harm.[15] Mental Health Units are required to use the Checklist at least every 6 months to identify and mitigate safety risks.[16] In addition, Mental Health Residential Rehabilitation Treatment Programs (MH RRTP) stand down clinical operations annually to focus on safety, security, and quality of care as part of the VA's ongoing Culture of Safety Stand Down.[17] Suicide Prevention Coordinators are required to participate in the Stand Down and in the Annual Safety and Security Assessment.

VA conducts ongoing monitoring of on-campus suicide attempts and deaths to inform policy and practices that ensure the safety of our Veterans and staff. This work includes regular tracking and analyses as part of ongoing suicide surveillance. Summary reports are routinely generated for leadership review. Source information comes from facility-reported Issue Briefs (*IB*) and from the Office of Security and Law Enforcement (OSLE). VA police report information is provided to the Office of Mental Health and Suicide Prevention (OMHSP) for inclusion in ongoing surveillance, and OSLE has also completed a review of on-campus suicide events indicated in police reports. The National Center for Patient Safety conducts regular reviews of Root Cause Analyses related to on campus suicides as well. These processes are intended to examine if any changes in policies and procedures are warranted at the facility level.

*Question 5.* Does VA have the appropriate protocols and training in place for staff who are dealing with a veteran in immediate crisis?

a. What are those protocols?

b. If those protocols are in place, have all VA facilities adopted those protocols, and are they being implemented appropriately?

Response. VA has the appropriate protocols and trainings for staff who respond to Veterans in immediate crisis.

Whenever eligible Veterans have an urgent need for mental health care, appropriate mental health services must be provided.[18] Evaluations and treatment for mental health conditions can be provided in mental health care services through primary care and other medical care settings or by arrangements with non-VA community services.[19]

All sites with Emergency Departments (ED) or Urgent Care Centers (UCC) must provide safe and secure mental health services during all hours of operation.[20] Per VHA policy, all patients presenting to the ED or UCC are screened at some point during the visit for suicide and homicide risk.[21]

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[13] VHA Memo, Use of Over-the-Door Alarms for Corridor Doors in Acute Mental Health Units Treating Suicidal Patients, May 10, 2019.

[14] Ibid.

[15] VHA Directive 1167, Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients, May 12, 2017.

[16] Ibid.

[17] VHA 10N Memorandum, Ensuring Safety and Security in the Mental Health Residential Rehabilitation Treatment Programs (MH RRTP): Annual Safety and Security Assessment and Culture of Safety Stand Down, September 14, 2018.

[18] VHA Handbook 1160.01, Uniform Mental Health Handbook, Page 18.

[19] VHA Handbook 1160.01, Uniform Mental Health Handbook, Page 17.

[20] VHA Directive 1101.05, Emergency Medicine, Page 25.

[21] Ibid.

VA implemented a standardized suicide risk identification process for all Veterans receiving VA care, as described above.[22] The process is comprised of three components and implements population-based mental health screening for those with unrecognized risk (universal), for those who may be at risk (selected), and for those at elevated risk (indicated). The components include standardized primary and secondary screens specific to risk of suicide and a comprehensive suicide risk evaluation for Veterans with a positive secondary screen (more details are provided in the response to question 7).

VA is in the process of expanding the use of suicide prevention safety plans and follow-up care in the ED.[23] Veterans presenting to the ED who have been assessed as at risk of suicide but are safe to be discharged home receive suicide safety planning intervention prior to discharge and follow-up outreach to facilitate engagement in outpatient mental health care.

VA has expanded requirements for suicide prevention training related to Veterans who are experiencing suicidal crisis.[24] All staff are required to receive suicide prevention training within 90 days of entry to duty and annually thereafter.[25] The training teaches staff to identify and respond to a Veteran who is at risk of suicide. The Signs of suicidal thinking, Ask questions, Validate the person's experience, and Encourage treatment and Expedite getting help (S.A.V.E.) Training is required for all staff (clinical and non-clinical) and Suicide Risk Management Training for Clinicians is required for all clinical staff. These trainings are tracked through VA's Talent Management System (TMS).

*Question 6.* How are facilities and providers held accountable to ensure adherence to these protocols?

a. How does VA monitor adherence to those protocols, and how are facilities and providers notified and retrained when protocols are not being met?

Response. Oversight regarding adherence to the standards of clinical care is conducted by VAMCs. VHA policies outline quality management expectations for facility, VISN, and VHA offices.[26] Facilities maintain Morbidity and Mortality Review Boards (which includes psychological autopsies) to foster clinical conversations among clinicians regarding the care provided to individual patients. Facilities engage in Medical Records Reviews to assess the adequacy of medical record documentation about the completeness, timeliness, and clinical pertinence of care.

In addition, facilities engage in Focus Reviews (Protected Peer Reviews, Root Cause Analyses) which address specific issues (consequences of patient care processes) or specific incidents (a discrete episode of care). For situations involving a specific patient-provider episode of care, completion of an internal VHA Peer Review results in a rating of care. Protected Peer Reviews are non-punitive, quality improvement activities. Corrective actions, such as additional training, assigned reading, shadowing care, etc., can be generated. Providers with identified gaps in care or adherence to protocols can be assigned a Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluations (OPPE), which monitors performance over time to ensure ongoing compliance and quality.

*Question 7.* How is VA training providers to perform crisis interventions in a way that is safe for both the provider and the veteran?

Response. For crisis intervention training related to suicide risk, it is VHA policy that all VHA employees must complete a required suicide risk and intervention training module. Clinicians complete Suicide Risk Management Training for Clinicians and must pass the post-module test, and non-clinicians complete S.A.V.E. training within 90 days of entering their position and an annual refresher course.[27] It is also policy that all employees must complete the appropriate annual refresher training specific to their position.[28] VHA has also developed a Suicide Risk Manage-

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[22] VHA Memorandum2018–05–21, Suicide Risk Screening and Assessment Requirements, May 23, 2018; VHA Memorandum 2018–11–02, Eliminating Veteran Suicide: Implementation of Suicide Risk Screening and Evaluation, November 2, 2018; VHA Memorandum 2019–02–17, Eliminating Veterans Suicide: Update on Suicide Risk Screening and Evaluation, February 22, 2019.

[23] VHA Memorandum 2018–09–22 Suicide Prevention in Emergency Departments (SPED): Suicide Safety Planning and Follow Up Interventions, September 7, 2018.

[24] VHA Directive 1071, Mandatory Suicide Risk and Intervention Training for VHA Employees, December 22, 2017.

[25] Ibid.

[26] VHA Directive 1026, VHA Enterprise Framework for Quality, Safety, and Value, August 2, 2013; VHA Directive 2008–077, Quality Management (QM) and Patient Safety Activities that Can Generate Confidential Documents, November 7, 2008; and VHA Directive 1190, Peer Review for Quality Management, November 21, 2018.

[27] Supra, note 24.

[28] Supra, note 24.

ment Training for Registered Nurses that may be assigned annually as an alternative training option to Suicide Risk Management Training for Clinicians for nursing staff.

As noted in question 5, OMHSP implemented a national, standardized process for suicide risk screening and evaluation, using high-quality, evidence-based tools and practices.[29]

- The Primary Screen is a single item intended to broadly screen for individuals who may be at increased risk for suicide throughout VHA clinics. Those who screen positive receive the second level screen.
- The Secondary Screen is conducted using the Columbia Suicide Severity Rating Scale (C-SSRS). The C-SSRS consists of three to eight additional questions that specifically query about suicidal thoughts, plan, intent, and behavior. Those who screen positive receive the VA Comprehensive Suicide Risk Evaluation CSRE.
- The Tertiary Assessment, VA CSRE, was developed by a team of subject matter experts to include evidence-based factors to determine acute and chronic risk levels and inform a risk management plan.
  - This plan is developed to meet the individual needs of the Veteran and can be initiated at the time the Veteran is being seen and reporting suicidal ideation or behavior, regardless of setting type.
  - Using one instrument across all VA settings results in standardization of evaluation and management, thereby improving quality of care for at-risk Veterans and helping reduce stigma associated with discussions about suicide.

Prior to the implementation of the Suicide Risk Identification Strategy in May 2018, an informational memo was distributed to the field outlining the new strategy.[30] A Suicide Risk Screening and Assessment SharePoint site was established, a single technical assistance email group was established, and all facilities identified a Facility Champion/Point of Contact for training and questions. Educational Webinars were held throughout August and September, which were made available on VA's training platform—Talent Management System (TMS)—for sites to utilize. Weekly technical assistance calls were also held during this period.

Assignment and management of training and education are done locally. Local facilities may assign training to appropriate staff and track this training through TMS.

Virtual training provides details and guidance on VA's new, national three-stage screening and evaluation process. Three courses are available in TMS, including Suicide Risk Identification Strategy—Overview,[31] Primary and Secondary Screening Tools,[32] and CSRE.[33] VA's Suicide Risk Identification SharePoint training documents folder includes training resources such as Frequently Asked Questions, Suicide Risk Identification Clinical Reminder Flowchart, and Suicide Risk Stratification Table. In addition, the SharePoint site hosts a discussion board for questions. In August 2019, additional trainings in support of CSRE implementation are being hosted by Employee Education Services (EES). The VA Suicide Risk Identification Technical Assistance Group hosts a weekly technical assistance phone call with an email group for questions.

To ensure that facilities are made aware of updates related to national memos, release of educational materials, changes to requirements or guidance documents and any other information related to the risk identification process, each facility was required to identify a Facility Champion/Point of Contact. The Facility Champion receives updated information as it becomes available and disseminates the information to the local facility.

The Suicide Risk Management Consultation Program is available to consult on a specific case or talk about suicide risk management strategies more generally.

*Question 8.* After the tragic shooting in Yountville, CA, and other incidents across the country where veterans have brought guns into VA facilities, many VHA employees have expressed concerns to the Committee about their physical safety. What protocols are in place to ensure the safety of VA staff, both clinical and non-clinical, at all VA facilities where a veteran in crisis may present?

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[29] VHA Memorandum 2018–05–21, Suicide Risk Screening and Assessment Requirements, May 23, 2019; VHA Memorandum 2018–11–02, Eliminating Veteran Suicide: Implementation of Suicide Risk Screening and Evaluation, November 2, 2019; and VHA Memorandum 2019–02–17, Eliminating Veterans Suicide: Update on Suicide Risk Screening and Evaluation, February 22, 2019.

[30] VHA Memorandum 2018–05–21, Suicide Risk Screening and Assessment Requirement, May 23, 2018.

[31] TMS item number VA 36829.

[32] TMS item number VA 36816.

[33] TMS item number VA 36830.

Response. VA is deeply committed to the safety and security of all persons who are in VA facilities. VHA's Workplace Violence Prevention Program (WVPP) meets, and often exceeds, the community practice and regulatory standards for violence prevention in health care settings. Although the urge may be strong to bar individuals from health care whose behaviors undermine a culture of safety, VHA's WVPP operates on the foundation that full engagement in the resources available through health care access promotes the protective factors that reduce violence risk.

It is understood that comprehensive violence prevention involves physical security measures and active threat responses that address environmental realities of health care delivery venues. It is within that context that VHA's WVPP model emphasizes a data-driven, evidence-based approach to the early identification, clinical assessment, and individualized management of behaviors that undermine a culture of safety.

PROGRAM DESCRIPTION AND RATIONALE

Utilization of multidisciplinary teams are the current published standard for threat assessment and management in health care. Such an approach is not new, having been promoted as best practice in education and general workplaces. VHA adapted these models for ethical and appropriate use in health care venues, requiring their national implementation in 2003. VHA's WVPP model includes threat assessment and management teams as the essential "Assess" and "Management Plan" components of the 5-element model (see Figure 1).

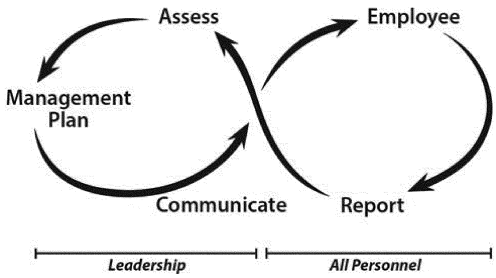


Figure 1. Healthcare Workplace Violence Prevention Program Model

*Employee.* The personnel populating health care environments are our greatest safety asset. Employee education and training is most successful when relevant to the violence-related hazards personnel experience in their respective and unique workplaces. VHA's premier education program in this area, Prevention and Management of Disruptive Behavior (PMDB), emphasizes knowledge and skills necessary for employees to successfully identify situations that have the potential to escalate toward violence and address them verbally at the earliest levels of disruption. If health care personnel experience situations during the course of their duties that are not ameliorated by verbal de-escalation, then they also should be trained in personal safety skills and therapeutic containment techniques that do not leverage pain-based or tissue-damage compliance. By being prepared to address disruptive behaviors spanning a spectrum of severity, employees report increased willingness to intervene at the earliest stages of escalation.

*Report.* Data about the type, location, severity, and frequency of disruptive behavior inform WVPP improvements in, and the relevance of, employee education. In VHA, these data are obtained through the Disruptive Behavior Reporting System (DBRS). Underreporting of potentially dangerous behavioral events in health care is a well-documented concern. Additionally, health care administrators and leaders are challenged by receiving disruptive behavior event reports through numerous different reporting systems that do not integrate all information into a comprehensive database.

One successful strategy for overcoming the underreporting challenge is use of secure, Web-based, user-friendly event reporting systems that allow for anonymous reporting. DBRS is one such system, specifically designed in VHA for health care venues. It is short and easily accessed by all VHA employees through any computer terminal across the entire health care system. DBRS has 5 reporting pages with a total of 32 questions, comprised primarily of radio button and check-box responses, that elicit data regarding the time and location of the disruptive behavior event

(e.g., night shift in the emergency department, day shift in the outpatient behavioral health clinic, etc.), the person who experienced the event (e.g., a direct care nurse, another patient, an administrative support worker, etc.), the person who reported the event (e.g., the person experiencing the event, a person witnessing the event, etc.), the person involved in creating the event (e.g., a patient, a visitor, another staff member, etc.), and a description of the event itself (e.g., involved verbal behavior only, involved physically disruptive behavior, involved behavior with weapons resulting in injury, etc.). DBRS automatically and immediately delivers an electronic event entry notification to both the reporter and the threat assessment team.

*Assess.* Leadership's credibility that violence prevention matters hinges largely upon its ability to demonstrate action in response to event reports. Every incident reported should be assessed by a multidisciplinary team trained in violence risk and threat assessment. The current state of the science involves the use of Structured Professional Judgment (SPJ) guides to ensure that assessment teams focus on evidence-based risk and protective factors. Threat assessment in health care exists to determine whether a reported behavior poses a threat to the delivery of safe and effective health care. As such, they operate under the authority of the facility's chief medical officer and are chaired by senior clinicians trained in evidence-based, data-driven threat assessment practice. Members of these teams also include, but are not limited to, professionals from security/law enforcement, documented high-risk workplaces, legal counsel, and labor union safety representative(s).

*Management (Treatment) Plan.* If the behavior reported to the threat assessment team is determined to pose a threat, then a customized management plan must be developed and implemented. Employing a continuum approach to graded levels of invasiveness permits such plans to range from non-confrontational interventions (e.g., special appointment to determine the patient's understanding of why his/her behavior became disruptive, change of health care provider, etc.), to more direct interventions (e.g., written letters expressing behavioral expectations, redirection of communication with the health care system through a personalized point of contact, etc.), to more restrictive interventions (e.g., placing limitations upon the time, place, and/or manner of health care service delivery). At no time may a behavioral threat management/treatment plan in VHA permanently bar individuals from receiving health care; venue and manner of health care delivery may vary, but health care will be offered consistent with the provisions of 38 CFR 17.107.

*Communicate.* Violence prevention programs must include mechanisms for ensuring the safety/treatment plan developed by the multidisciplinary threat assessment team is communicated to personnel effectively and ethically. Electronic health record alerts (EHRA) that provide a 1–2 sentence summary of the problem behavior and a 1–2 sentence description of actions personnel should take to promote safety are known to be part of an effective strategy for reducing violence in health care. EHRAs convey information about customized interventions; that said, they are communication tools, and placing an EHRA per se is not an intervention in and of itself. The value of using EHRAs to convey information necessary to know at the initial moments of a patient encounter to promote safety must be balanced carefully with potential for inadvertently stigmatizing patients. Signal-to-noise value of EHRAs must be maintained, thus over-use of EHRAs should be avoided.

Employees learn of the safety/treatment plan, implement the actions described in the EHRAs, and safely provide health care. Through continued reporting, assessing, and safety/treatment plan evolution, health care systems are empowered to retain even the most behaviorally challenging patients, thus promoting access to risk-reducing protective factors.

PHYSICAL AND INFRASTRUCTURE SECURITY

VA has re-assessed physical security and infrastructure, identifying risks that could impact medical facilities, and we are also continuously evaluating and developing mitigation strategies to reduce the opportunity for a severely dangerous events to occur. VAMCs have implemented the following: panic buttons, badge restricted access to certain areas, limited guest hours, security camera monitoring, emergency preparedness training, and more. Universal signs are posted throughout all VA properties alerting all Veterans, staff, and visitors that no weapons of any kind are allowed on the property and that possession of weapons or explosives on VA property violates Federal law.[34]

In addition to physical security enhancements, VA police have increased their visibility on campuses to which they are assigned. Medical Center Police Chiefs, and other appointed personnel, are also connected to fusion centers that are located in

[34] 18 U.S.C. § 930; 38 CFR § 1.218(a)(13).

the corresponding geographical area to each respective medical center. These fusion centers gather, analyze, and facilitate the sharing of sensitive intelligence between Federal, state, tribal, and territorial partners which heightens situational awareness and allows VA to make informed decisions concerning issues that could impact VA properties.

The effectiveness of an integrated response to an identified threat situation can be enhanced through proper training and preparation. VA police undergo substantial and varied training, including continuing training at their respective assigned facilities, and have been provided with the necessary equipment to appropriately respond to violent threat situations. Focused training specific to the facility is provided locally and allows for the incorporation of multiple variations of site-specific scenarios involving the necessitated response to threat incidents involving dangerous weapons or other specific threats. VA Police additionally offer training at all VA properties to all employees regarding active threat/shooter incidents and VA facilities conduct mock and live drills regularly that are designed to identify vulnerabilities, inform needed improvements, prepare for eventualities, and to prevent violent acts from occurring.

In addition to the existing mandatory PMDB employee training in VHA addressing verbal de-escalation, personal safety, and therapeutic containment skills, the Law Enforcement Training Center also offers an optional Verbal Defense in Health Care training program, designed for employees to use communications skills to de-escalate potential incidents that could result in a Veteran, staff, or visitor from reacting violently during contact with them.

*Question 9.* In December 2018, the Government Accountability Office released a report that highlighted how VA's Office of Mental Health and Suicide Prevention (OMHSP) mismanaged funding and spent a mere fraction of its suicide prevention outreach budget. Have these problems been addressed? Please explain how OMHSP plans to spend Fiscal Year 2019 and future funds appropriated for suicide prevention and mental health outreach.

Response. VA is addressing suicide prevention outreach budget concerns. Regarding oversight, VA staff and leadership are regularly briefed on paid campaign progress. This includes monthly reports highlighting both the current status and accomplishments of each campaign as well as historical comparisons to past campaigns to gauge growth and provide additional context. VA is on track to spend the full $6 million allocated for paid media efforts; the Executive in Charge of VHA oversees these efforts as well.

Measurement and evaluation are essential components of VA of paid media efforts. VA measures every online interaction with our paid media campaign materials to ensure we are reaching the right people with the right information. Interactions measured include the following:

- Site usage patterns: traffic to site, time on site, number of pages visited;
- Online engagements with the Veterans Crisis Line (VCL): calls, chats, texts originating from the Web site; and
- Engagements with other key resources: downloads of campaign and materials, uses of S.A.V.E. training, views of our educational videos and Public Service Announcements (PSA).

Targets were developed at the outset for metrics designated as key performance indicators and are continually assessed throughout the life of a campaign. In March 2019, VA launched a keyword search campaign targeting people searching for crisis support for Veterans. The targets for that campaign were oriented around the following VeteransCrisisLine.net key performance indicators:

- Site traffic consisting of 20,000 visits per month originating from paid ads;
- Online calls and texts totaling 2,000 calls and 2,000 texts per month through the VCL Web site (does not account for calls that do not originate on-site);
- Crisis chats totaling 2,000 chats per month originating from paid ads; and
- Self-check quiz uses totaling 1,200 link-outs to the self-check quiz that originated from paid ads.

VA deployed additional digital paid media strategies during the summer of 2019, for which targets have been set. These targets are based on engagement with specific online resources, including but not limited to VA-produced toolkits and trainings.

VA also assesses the digital effort's impact on VCL call volume. When VA advertises the VCL, there is a measurable increase in call volume.

Last, a number of special paid media activations have been executed or are currently in process, including an advertisement in Times Square, placements in Major League Baseball (MLB) gameday programs, and rollout of a national billboard advertising campaign in partnership with PSA Advertising, Inc.

*Question 10.* Congress has provided VA authority to deliver counseling services to active duty servicemembers, and members of the National Guard and Reserve who have experienced Military Sexual Trauma (MST). I am disappointed in how VA is implementing this authority, only allowing MST survivors to access counseling services at Vet Centers rather than at all VA facilities. While I acknowledge the potential privacy issues involved when using an interoperable electronic health record (EHR) that shares information with DOD, I support VA exploring a work-around that would allow MST survivors to access care at all VA facilities, not just Vet Centers. This, and other authorities that allow VA to provide care to veterans who are not traditionally eligible for VA care but are particularly at-risk for suicide, such as those with other than honorable discharges or those within the first 12 months of separation, must be utilized to the fullest degree in order to reach the 14 veterans per day who commit suicide with no interaction with VA in the previous 24 months.

a. Are there any plans to expand MST services to VA facilities in compliance with Public Law 115–91?

b. What are those plans, if any?

VA Response 10a and 10b: VA and the Department of Defense (DOD) have a strongly shared commitment to ensure all Veterans and Servicemembers have access to the care they need to recover from military sexual trauma (MST). Active duty and Reserve Component Servicemembers can currently receive MST-related counseling, care, and services at VA medical facilities with a DOD referral or in emergency situations. Further, per 38 United States Code (U.S.C.) § 1720D(a)(2), VA "may," in consultation with DOD, provide Active duty and Reserve Component Servicemembers VA MST-related services without a referral from DOD. The Departments have worked closely together to develop a strategy to implement this discretionary authority in a way that expands services as much as possible, while maintaining the trust of sexual trauma survivors and protecting mission readiness. As noted in the question, VA and DOD's joint decision was to implement this authority at VA Vet Centers, meaning that Servicemembers can receive MST-related counseling services from more than 300 VA Vet Centers without a referral from DOD. As 38 U.S.C. § 1720D(a)(2) authorizes, but does not mandate, VA to provide this care to members of the Armed Forces without a referral, the decision to implement this authority at only Vet Centers complies with the law.

A number of intractable barriers exist to expanding implementation to VA medical facilities, and the Departments have fully explored all possible avenues for addressing them. Indeed, in 2016, the VA/DOD Joint Executive Committee (JEC) specifically directed creation of an ad hoc VA/DOD Workgroup to establish a strategy to expand access to VA medical centers. The Departments worked intensively to develop this strategy, including working with VA's Office of Information and Technology (OIT) to identify the system-wide IT modifications necessary to ensure confidentiality of Servicemembers' VA medical records with respect to DOD. Unfortunately, no solution was readily available to allow complete confidentiality. At best, records could be marked as "sensitive," but they would remain available for DOD clinical providers to access. Moreover, even if an IT solution were available to ensure confidentiality, limiting information-sharing of MST-related care records entirely would pose risks as well, as medical conditions or treatment (e.g., psychoactive prescription medications) that could degrade mission performance or deployment readiness of Servicemembers would be unknown to DOD medical providers or command unless communicated by Servicemembers themselves.

In 2018, the VA/DOD JEC approved maintaining the current course of action, with implementation of this authority at VA Vet Centers only. The Departments do not currently have plans to expand implementation to VA medical facilities, as sufficient privacy of MST-related information cannot be ensured even with IT modifications. VA believes that maintaining confidentiality is crucial to maintaining patient trust and preserving Servicemembers' sense of VA as a source of help, not only during their service, but also after transitioning to being Veterans. Ethics consults from the American Medical Association and the VA National Center for Ethics in Health Care support this perspective and underscore the importance of implementing this authority in a way that preserves confidentiality. Vet Centers are a widely available resource for confidential, high-quality MST-related counseling and referral services for Service- members who wish to seek care without a referral from DOD. Vet Center counselors are fully trained and licensed mental health professionals who are clinically experienced in treating psychological trauma and associated issues such as suicide risk, anxiety, depression, and substance abuse. Counseling services available are comparable to those available at VA medical facilities. Vet Center Client Records are maintained independent of, and governed by, policies different than VA's medical facility records.

c. Are there plans for additional outreach efforts to veterans with other than honorable discharges?

d. What are those plans?

VA Response 10c and 10d: With respect to outreach, VA's Office of Mental Health and Suicide Prevention (OMHSP) is responsible for national coordination of VA's general outreach efforts to raise Veterans' and public awareness of MST and VA's MST-related services. Ongoing policies and initiatives help provide information about VA's MST-related services to Veterans with an Other-Than-Honorable discharge, as well as Veterans more broadly. As a brief overview, under VA policy (VHA Directive 1115, Military Sexual Trauma (MST) Program, paragraph 4.d.(9)), every VA medical facility Director must ensure information regarding VA's services related to MST is visibly posted or displayed. Every health care system has a designated MST Coordinator, whose responsibilities include directing and engaging in outreach activities within the system's facilities and with community allies. This includes regular, ongoing activities (such as overseeing the public display of MST information within facilities) as well as high-visibility facility events (e.g., Clothesline Projects in honor of Sexual Assault Awareness Month) and representation at community events that serve Veterans. The MST Coordinator also serves as the point person for MST-related care issues within the health care system and can assist Veterans, including those with an Other-Than-Honorable discharge, with accessing MST-related care.

Additionally, OMHSP initiates and supports MST outreach efforts at a national level. Information about MST and VA's related services is available on VA's Internet site, and outreach resources are available to MST Coordinators and other staff on VA's Intranet. Resources include a range of graphic and digital media, such as brochures, posters, infographics, fact sheets, and outreach videos. OMHSP has initiated additional national-level campaigns, for example to assist facilities' efforts to raise awareness specifically of male survivors of MST. As implementation continues for recent legislative changes expanding eligibility for Veterans with an Other-Than-Honorable discharge, OMHSP ensures that its suite of outreach resources and materials remain up to date and inclusive of this population. OMHSP continues to ensure that MST Coordinators are well aware of new policies as they are implemented and provide ongoing guidance and assistance as needed. OMHSP also continues its efforts to ensure the broader population of individuals with Other-Than-Honorable discharges is aware of available emergency services and potential eligibilities for ongoing care. OMHSP's Internet website is a key source for the most current information regarding these services. VHA will also continue to pursue educational outreach efforts at facility level Town Halls and Veterans Services Organization meetings.

*Question 11.* How will the roadmap slated to be created by the task force outlined in Executive Order 13861 be different than the already existing National Strategy for Veteran Suicide Prevention 2018–2028?

a. What will become of the National Strategy once the task force's roadmap has been completed?

b. Will progress toward the goals and objectives laid out in the National Strategy continue, or be put on hold pending the release of the roadmap?

Response. Influenced by the National Strategy for Preventing Veteran Suicide, the Executive Order 13861 (the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide, or PREVENTS) Roadmap outlines the specific strategies needed to effectively lower the rate of Veteran suicide among our Nation's Veterans, analyzing opportunities for collaboration within Federal, state, local, tribal, and non-government entities. The Roadmap will buildupon the National Strategy for Preventing Veteran Suicide as its foundation and is currently, through environmental scans, identifying other initiatives across governmental agencies and States, counties, and communities Nation-wide as potential strategies to include within the roadmap. The National Strategy will continue to be the beacon for public health strategies across the Nation for Veteran suicide prevention.

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RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. THOM TILLIS TO U.S. DEPARTMENT OF VETERANS AFFAIRS

*Question 1.* Does VA have a position on S. 1563, the Janey Ensminger Act of 2019? Does VA oppose any specific provisions of the Janey Ensminger Act? If so, which provisions does VA oppose and why?

Response. VA is now preparing full views on the Janey Ensminger Act of 2019, which will be provided to the Committee separately.

*Question 2.* If enacted, could VA fully implement the Janey Ensminger Act, as written? If not, could you please provide Technical Assistance that would enable VA to fully implement the Act?

Response. VA's pending formal views on the bill will address potential implementation issues with the Janey Ensminger Act of 2019. VA will be glad to provide technical assistance to the Committee, although, as always is the case with such assistance, we cannot guarantee that satisfactory language can be found to mitigate specific concerns.

*Question 3.* If VA and ATSDR found evidence supporting a causal link between Camp Lejeune toxic exposure in utero with birth defects (such as Congenital Heart Disease), would VA have the authority to furnish hospital care and medical services to said dependent, and would VA have the authority to reimburse for such hospital care or medical services provided to a family member?

Response. Birth defects, including congenital heart disease, is not one of the 15 illnesses and conditions identified in 38 United States Code (U.S.C.) 1710(e)(1)(F). VA's authority to furnish health care to family members of Veterans who resided at Camp Lejeune, North Carolina during the specified time period is limited to hospital care and medical services "for any of the illness or conditions described" in section 1710(e)(1)(F). As such, VA could not, under its existing authority at 38 U.S.C. 1787, furnish hospital care and medical services to a dependent for birth defects such as congenital heart disease even if VA and the Agency for Toxic Substance and Disease Registry found evidence supporting a causal link between such birth defects and Camp Lejeune toxic exposure in utero. Accordingly, VA would not have the authority to provide payment or reimbursement for such hospital care or medical services provided to a family member for such a condition under the Camp Lejeune Family Member Program.

*Question 4.* Would VA support the establishment of a registry of servicemembers exposed to contaminated water at Camp Lejeune, similar to the existing VA Airborne Hazards and Open Burn Pit Registry?

Response. If the question is asking whether VA would support legislation establishing such a registry, VA would need to review specific statutory language before it could advise on whether it would support such a bill.

*Question 4a.* Does VA currently have the authority to implement such a registry, or would it need additional statutory authority to do so?

Response. VA has authority to initiate such a registry; however, it would require extensive coordination with other executive branch agencies and additional funding. We do not believe establishment of a new registry is necessary. The U.S. Marine Corps already maintains and regularly uses an extensive registry database of names and addresses for the purpose of notifying Veterans and family members who lived at Camp Lejeune during the period of concern.

We also should note that for the sake of future research, there are significant inherent limitations in the use of registries to draw inferences regarding the presence or strength of an association between an exposure and a health outcome. Recall bias, self-reporting bias, and self-selection bias all severely hinder the use of registry data in research of this kind. Camp Lejeune Veterans and family members are best served in this regard by well-designed, state-of-the-art epidemiologic studies.

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RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. PATTY MURRAY TO U.S. DEPARTMENT OF VETERANS AFFAIRS

*Question 1.* Please provide and explain VA's cost estimate for S. 318, the VA Newborn Emergency Treatment Act, including:

*Question 1a.* What is the average cost of medically necessary transportation by mode and projected number of cases that were used to calculate the estimates?

Response. In Fiscal Year (FY) 2020, VA estimates that approximately 3,523 Veterans/newborns will access ground ambulance transportation for either delivery and subsequent care of the newborn or for treatment of a newborn or Veteran that cannot be provided by the initial treating facility. VA calculated an average specialty care ground ambulance rate of $1,068.35 per one-way transport based on data in the Ambulance Fee Schedule (AFS) Public Use Files of the Centers for Medicare & Medicaid Services (CMS).

Additionally, it is estimated that approximately 293 Veterans/newborns will require air ambulance transportation either delivery and subsequent care of the newborn or for treatment of a newborn or Veteran that cannot be provided by the initial treating facility. VA calculated an average air ambulance rate (averaged across both

fixed wing and rotary wing air ambulances) of $2,684.04 per one-way transport based on CMS data.

An annual inflation rate of 3.9 percent for the cost of air and ground ambulance costs were applied to estimate the FY 2021 through FY 2029 costs.

*Question 1b.* How many cases of newborns needing care beyond seven days does this estimate project would be covered under this bill?

Response. We estimate that there will be 647 newborn deliveries needing care beyond 7 days in FY 2020, increasing to 672 in FY 2021, and then slowly declining to 559 in FY 2029 as the female Veteran population ages.

*Question 1c.* What is the average cost of care for newborns that would be covered under this bill, average cost of care beyond seven days, and average length of stay for newborns in these situations?

Response. The estimated average cost of care for each newborn staying more than 7 days is $114,000 in FY 2020. Of this amount, approximately $25,000 per newborn is already covered through the current newborn benefit, leaving an additional cost of approximately $89,000 per newborn. The average length of stay for those admits over 7 days is 29 days.

*Question 1d.* What other factors or data were taken into account to calculate this estimate?

Response. This estimate considers projected changes in the number and age distribution of female VHA enrollees to determine expected births. We then use VA data on newborn care together with publicly available data on newborn lengths of stay to estimate the number of newborns requiring a length of stay greater than 7 days and the associated number of additional bed days of care; this estimate accounts for a higher expected morbidity risk associated with the Veteran enrollee population. For ground and air ambulance transportation, costs are based on the applicable CMS average specialty ambulance rates.

# A P P E N D I X

PREPARED STATEMENT OF HON. RICHARD BURR,
U.S. SENATOR FROM NORTH CAROLINA

CHAIRMAN ISAKSON, RANKING MEMBER TESTER, MEMBERS OF THE SENATE COMMITTEE ON VETERANS AFFAIRS, Thank you for the opportunity to submit testimony regarding S. 980, the Homeless Veterans Prevention Act and S. 1563, the Janey Ensminger Act.

The Homeless Veterans Prevention Act is dedicated to reducing the root causes of homelessness in the veteran population. In 2017, the Department of Housing and Urban Development (HUD) released data that revealed roughly 40,000 veterans were living on the street, representing a 57% decline since 2010. VA reports indicate almost half a million veterans and their families have been permanently housed, rehoused, or prevented from homelessness from 2010 to 2017. This is an encouraging trend, but effectively ending the problem must be about facilitating greater self-determination, not just residential stability.

As a Senator for North Carolina, I'm proud of the tremendous leadership and generosity that communities in my state have shown to address the homeless veteran issue. With one of the largest veteran populations in America, North Carolina has a lower rate of homelessness than the national average, and serves as a model for the reforms S. 980 would direct the Veterans Administration to implement. The North Carolina Bar Association has helped provide attorneys that volunteer their time at the Salisbury VA Medical Center and the Fayetteville Vet Center, where they cover a variety of civil legal areas. Perhaps not coincidentally, Forsyth and Cumberland counties, which house the Fayetteville and Salisbury VA markets, boast an effective rate of zero homeless veterans.[1]

Moreover, law schools at North Carolina Central University, the University of North Carolina at Chapel Hill, and Wake Forest University, all have veteran-specific legal clinics that focus on military record correction and discharge upgrades. Recently, a North Carolina Vietnam veteran came to one of these clinics with an Other Than Honorable (OTH) discharge for misconduct related to PTSD. Until he sought these legal services that assisted him with a discharge upgrade, he was unable to receive mental healthcare and benefits he needed. S. 980 includes a provision that would authorize VA to engage in public-private partnerships on a continuing basis with entities to provide vital legal services such as these to homeless veterans.

Time and again, my staff and I hear from veterans who have been unable to fully participate in existing programs because their children were not allowed to live in the transitional housing or in-patient domiciliary care. S. 980 addresses this shortcoming, increasing the availability of housing for homeless veterans with dependents.

S. 980 repeals the sunset on the authority of the VA and the Department of Labor to carry out referral and counseling services for veterans transitioning from certain institutions, including penal institutions. North Carolina has had great success with the system of Veteran's Treatment Courts in the State. Since receiving a Federal grant in 2016, Harnett County's Veteran's Court sees veterans from as far away as 70 miles. Forty-four veterans made their way through the program last year, and although the judges who sentence some of these veterans cannot reduce a minimum sentence, many of the veterans stay in the program to help resolve their issues long-term. Incarcerated veterans certainly represent a group that have been more prone to legal issues, and could use help to get their life back on track after they serve their sentence. Finally, the bill directs the Comptroller General to assess and measure the capacity of programs for entities that receive grants or per-diem payments

[1] https://www.usich.gov/solutions/collaborative-leadership/mayors-challenge

to assist homeless veterans, and use that information to ensure those programs are serving the needs of these veterans effectively.

The Homeless Veterans Prevention Act is a bi-partisan bill, and I am pleased that the American Legion, VFW, and several legal service providers and organizations like the American Bar Association have offered their support. Surely everyone can agree—the downward trend in homelessness among our Nation's veterans population has been remarkable. But we can, and should, do more. S. 980 would address four of the top ten unmet needs among our homeless veteran population, and I urge Committee members to support its passage.

S. 1563, the Janey Ensminger Act of 2019, is another common-sense, bipartisan bill included in today's hearing. As a result of the Camp Lejeune Families Act of 2012, the Department of Veterans Affairs extends health care to veterans and reimburses medical expenses for qualified family members who have diseases and conditions that resulted from exposure to contaminated well-water at Camp Lejeune. If enacted, the Janey Ensminger Act would require the Agency for Toxic Substances and Disease Registry (ATSDR) Administrator to more frequently review scientific literature related to exposure of contaminated well-water at Camp Lejeune and specific illnesses or conditions incurred by individuals who served or lived there for not fewer than 30 days between 1953 and 1987. Furthermore, the Administrator would be required to categorize the level of evidence for these conditions, and publish the information on the Health and Human Services' (HHS) website.

The transparency that would result from the passage of the Janey Ensminger Act is critical because, despite ATSDR determining that a number of cancers and other health conditions were caused by the Camp Lejeune water contamination, the Veterans Administration continues to challenge these findings. This bill will remove the Veterans Administration's ability to deny, delay, or dispute the health care benefits owed veterans and their family members who are sick because of exposure to a toxic substance at Camp Lejeune. Care for veterans and their families should not be further delayed by the VA's failure to accept ATSDR's findings.

Thank you again to the Chairman and Ranking Member for the opportunity to submit written testimony, and I appreciate this Committee's consideration of S. 980 and S. 1563. These proposals ensure we keep our promise to support the brave men and women who have volunteered to protect and served this great Nation. Thank you.

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PREPARED STATEMENT OF HON. MARCO RUBIO,
U.S. SENATOR FROM FLORIDA

Chairman Isakson and Ranking Member Tester, thank you for scheduling today's hearing, which includes the Better Examiner Standards and Transparency for Veterans (BEST for Vets) Act. I am proud to have worked with Senator Sinema on this bipartisan legislation, and I appreciate your consideration today.

To determine a veteran's eligibility for disability compensation, the Veterans Benefits Administration (VBA) often relies on information gathered as part of a medical disability examination (MDE). The VBA has increasingly relied on contractors to conduct a large portion of these MDEs in an effort to avoid delays in the disability claim process.

Last year, media reports revealed that contract physicians with revoked medical licenses have been performing MDEs on behalf of the Department of Veterans Affairs (VA). For example, in my home state of Florida, a physician was conducting MDEs on behalf of the VA despite the fact that her medical license had been revoked in two other states and was on probation in another due to a Federal tax fraud conviction. A loophole in current law is allowing this to happen. This is unacceptable, and legislation is needed. The BEST for Vets Act would address this issue by ensuring only licensed health care providers are conducting medical disability examinations on behalf of the VA.

Health care providers who have had their medical licenses revoked have no business conducting MDEs that determine the benefits that our Nation's heroes receive. Our veterans not only deserve the highest quality care, but they have earned it.

I would like to thank the Veteran Service Organizations supporting this legislation, including Paralyzed Veterans of America, Veterans of Foreign Wars, and Disabled American Veterans.

I appreciate the Committee's consideration of the BEST for Vets Act and look forward to working together to pass this important, bipartisan bill.

## LETTER FROM THE AMERICAN BAR ASSOCIATION

Defending Liberty
Pursuing Justice

**Robert M. Carlson**
President

**AMERICAN BAR ASSOCIATION**

321 North Clark Street
Chicago, IL 60654-7598
(312) 988-5109
Fax: (312) 988-5100
abapresident@americanbar.org

May 21, 2019

The Honorable Johnny Isakson
Chair, Committee on Veterans Affairs
United States Senate
Washington, D.C. 20510

The Honorable Jon Tester
Ranking Member, Committee on Veterans Affairs
United States Senate
Washington D.C. 20510

Re: American Bar Association support for S.980, the Homeless Veterans Prevention Act

Dear Chairman Isakson and Ranking Member Tester:

On behalf of the American Bar Association, I write to express our strong support for S.980, the Homeless Veterans Prevention Act (HVPA). This bipartisan legislation would authorize proven strategies for removing chronic barriers blocking homeless veterans from receiving the promised benefits, services, and treatment they need for self-sufficiency and success. We applaud the Committee's historical support for this legislation, and we urge that you report the bill out favorably so that it may proceed to the full Senate, and to the House, and be signed into law this Congress.

The progress over the past decade in reducing the number of veterans on the street has been promising, in large part due to Congress' willingness to support programs that target specific obstacles veterans encounter. For nine years in a row, according to the Department of Veterans Affairs' Project CHALENG (Community Homelessness Assessment, Local Education and Networking Groups), one barrier—unresolved legal problems—comprise half of the top ten unmet needs of veterans. Several of these legal problems arise as a consequence of living on the street, but each unresolved legal issue can either lead to homelessness or prevent those already homeless from benefitting from VA programs or support. Nonetheless, the VA is neither permitted to provide legal help nor permitted to enter into community partnerships to have others help resolve these problems for homeless veterans. For decades, pro bono and civil legal assistance lawyers have provided free legal services to veterans in their communities, but this is not a sustainable or systemic solution to the chronic need.

Section 3 of the HVPA would solve this problem in a budget-neutral way by allowing the VA Secretary to enter into suitable private-public partnerships to deliver legal services to veterans experiencing homelessness. In this way, the VA would be able to provide the national leadership and support necessary to better ensure that the right kinds of legal services are available where

and when they are needed most. The VA is to be commended for the role it already plays in removing certain regulatory barriers, sharing data, educating and training lawyers, and helping to support innovative delivery models, such as medical-legal partnerships, homeless court at Stand Down, and law school clinical programs. These initiatives, and many others, illustrate what might be accomplished in meeting veterans' needs when closer collaboration between the VA and the legal community is authorized.

Unfortunately, according to the 2018 U.S. Department of Housing and Urban Development "Point-in-Time Count," there are more unsheltered veterans today than there were two years ago We should no longer tolerate legislative obstacles to ending the scourge of veteran homelessness, and Section 3 of S.980 would remove one such obstacle, allowing the development of a national strategy for removing several of homeless veterans' most persistently unmet needs. The legal community welcomes the opportunity for partnership, and the ABA stands ready to assist in support of this legislation and the collaborations it would make possible.

If you have any questions or concerns, please contact me or Kenneth Goldsmith in the ABA Governmental Affairs Office at (202) 662-1789 or kenneth.goldsmith@americanbar.org.

Sincerely,

Robert M. Carlson

cc: Members of the Committee on Veterans Affairs

## PREPARED STATEMENT OF AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

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

The American Federation of Government Employees, AFL-CIO and its National Veterans Affairs Council (AFGE) appreciates the opportunity to submit a statement for the record on the bills before the Committee today. AFGE represents more than 700,000 federal and District of Columbia government employees, 260,000 of whom are proud VA employees. In our comments on bills before the Committee today, we will discuss how these proposed bills will impact the frontline workforce and the veterans they serve every day. We appreciate your serious consideration of our recommendations, and we stand ready to work with the Members of the Committee to make adequate changes as highlighted in this statement.

**S.123, Ensuring Quality for Our Veterans Act**

S. 123, the "Ensuring Quality for Our Veterans Act," would allow the Secretary to enter into contracts with third party oversight providers in order to review non-VA healthcare providers whose license was terminated for cause by a state licensing board. AFGE has said for years that when a veteran receives care outside of the VA there is little accountability when it comes to private providers and the quality of care. However, there is an egregious double standard whereby outside providers are not held to the same quality and timeliness standards as the in-house VA workforce. The solution to this problem is not entering into agreements with more contractors. The VA has several oversight and investigative bodies comprised of career VA employees who understand the department and the needs of veterans. The VA is also the entity which enters into agreements with non-VA providers in the "community" who provide care to veterans. As such, the VA should be responsible for providing oversight of non-VA providers, as well as serve as the point of contact for veterans if it is found that they received substandard care or saw a problematic provider.

AFGE does not think that contractors should "police" other contractors providing care to veterans, and it is for this reason that we oppose this legislation.

**S.221, Department of Veterans Affairs Provider Accountability Act**

S. 221, the "Department of Veterans Affairs Provider Accountability Act," would significantly expand existing requirements for reporting VA medical personnel to the National Practitioner Data Bank (NPDB) and state licensing boards to include minor infractions unrelated to patient care. This bill would also drastically restrict the rights of every VA employee working at medical facilities, benefits offices and VA cemeteries including thousands of low-wage, service-connected disabled veterans, to enter into settlement agreements involving their personnel files in matters completely unrelated to patient care.

***Reporting to the NPDB and state licensing boards***

Section 2(a) of S. 221 would require the Under Secretary to report every adverse action taken against a Title 38 employee appointed under Section 7401(1) to the National Practitioner Data Bank (NPDB) and applicable state licensing board. This reporting requirement would affect every VA physician, dentist, registered nurse, physician assistant, podiatrist, optometrist, chiropractor, and expanded-function dental auxiliary.

These proposed reporting requirements would apply regardless of how minor the infraction or if the infraction was completely unrelated to patient care. This is because the bill requires the reporting of every "major adverse action" which is defined by 38 USC 7461 as every suspension, every transfer,

and every demotion as well as termination. In contrast, the NPDB already maintains reports on medical malpractice payments, licensure actions, loss of clinical privileges, health-care related criminal convictions and civil judgments, exclusions from Medicare, and other adjudicated actions.[1]

These proposed requirements also directly contradict current VHA policy (Handbook 1100.17) that only requires VHA to file a report with the NPDB if a payment was made as the result of a settlement or judgment of a claim of medical malpractice or an adverse clinical privileges action that affects privileges for more than 30 calendar days (Section 3 of Handbook 1100.17).

AFGE strongly supports accountability for actions that adversely impact patient care. However, neither VA health care accountability nor the objectives of the NPDB and state licensing boards are well served by requiring reports of minor infractions such as a resident's failure to turn in notes to the proper supervisor-physician or a two-day lapse in a nurse's license due to lost paperwork at the licensing board. Such extreme reporting requirements will also greatly undermine the VA's ability to compete with other health care employers in the recruitment and retention of medical professionals in short supply who would not face these threats to their careers in other workplaces.

Therefore, AFGE requests the following change to Section 2(a) of the bill:

*Limit reporting in section (a) to "major adverse actions involving payments made as the result of a settlement or judgement of a claim of medical malpractice or a major adverse action that affects privileges for more than 30 calendar days".*

***Restricting the ability of every VA employee to clear his personnel file through a settlement agreement.***

Section 2(b) of this bill contains two prohibitions. The first would no longer allow any VA employee to enter into a settlement agreement that would conceal a serious medical error. Second, it would prohibit any VA employee from entering into a settlement agreement that purges a negative record from the employee's personnel file, even when there is no issue related to patient care.

The Merit System Protection Board recognizes the ability to include "clean record agreements" in settlements as a highly efficient form of resolving personnel matters (See *Clear Record Agreements and the Law*, MSPB, December 2013). Opponents of federal workplace rights have made repeated attempts in past Congresses to pass legislation to eliminate the rights of VA employees and employees of other agencies facing termination to enter into settlement agreements that clear their personnel files.

Section 2(b) of this bill is a backdoor attempt to severely weaken this commonsense workplace right under the guise of health care accountability and patient care. This bill as currently drafted would also restrict the rights of employees of the National Cemetery Administration, Veterans Benefits Administration and employees of the Veterans Health Administration who do not provide direct patient care.

Therefore, AFGE requests the following change to Section 2(b) of the bill:

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[1] https://www.npdb.hrsa.gov/hcorg/whatYouMustReportToTheDataBank.jsp

*Limit the "personnel/settlement file" provision in section (b) to pure 7401(1) employees and limit the type of negative record to "a negative record related to professional conduct or competence."*

In summary, AFGE opposes S. 221 in its current form and looks forward to working with the Committee to address these concerns.

**S.318, VA Newborn Emergency Treatment Act**

AFGE takes no position on this piece of legislation.

**S.450, Veterans Improved Access and Care Act of 2019**

AFGE takes no position on this piece of legislation.

**S.514, Deborah Sampson Act**

S. 514, the "Deborah Sampson Act," is the culmination of many years of advocacy from members of the Veteran Service Organization (VSO) community. At the heart of this legislation is a directive that the VA address one of the fastest growing cohorts in the veteran community: female veterans. This legislation would take several steps toward making the VA more inclusive and responsive to the unique needs of female veterans. Among the proposals in the legislation, S. 514 would create a "mini-residency" program for primary and emergency care providers centering around female veteran health, provide reintegration and adjustment assistance, expand maternity services for female veterans giving birth at a VA, and ensure each facility is staffed with at least one provider who specializes in women's health.

AFGE commends the work the VSOs have done on this legislation and hopes to see more women go to the VA to receive the care they have earned. The VA provides world class, veteran-centric care that is unlike anything available in the private sector, and this legislation would go a long way to make sure all veterans – especially women – have the same opportunity to receive these benefits at their local VA.

Similarly, we hope that the Administration will take this legislation as a serious first step to increase VA's internal staffing. In order to meet the needs of the veteran population and to adequately care for all veterans the VA must be fully staffed. We would be remiss if we did not mention that out of the nearly 50,000 vacancies systemwide at the VA, approximately 43,000 of those are in the Veterans Health Administration (VHA).

The intent of this legislation is clear – provide greater access to the VA for female veterans. The Administration should not use this call for greater access as a way to ship more care to the private sector.

AFGE supports this legislation and looks forward to seeing Congress pass this bill with funding for additional hiring, and honor all of those who have borne the battle.

**S.524, Department of Veterans Affairs Tribal Advisory Committee Act of 2019**

S. 524, the "Department of Veterans Affairs Tribal Advisory Committee Act of 2019," would require the VA Secretary to establish an advisory committee to provide advice and guidance on matters relating to Indian tribes, tribal organizations and Native American veterans. AFGE thanks Ranking

Member Tester (D-MT) for introducing this legislation and seeking broad participation on this proposed advisory committee.

AFGE represents employees of the Indian Health Service (IHS) including many veterans. AFGE plays an important role in safeguarding the rights and working conditions of frontline IHS employees who see firsthand management practices that may undermine the agency's mission. Therefore, AFGE urges the inclusion of current federal employees as voting Committee members of the advisory committee under this bill. AFGE believes that an employee designee can play a valuable role both as a voting member and as a meeting attendee.

AFGE cannot support this bill if employees are not provided a meaningful role on the advisory committee as stated above.

**S.711, The Care and Readiness Enhancement (CARE) for Reservists Act of 2019**

S. 711, the "Care and Readiness Enhancement for Reservists Act of 2019," or the "CARE for Reservists Act of 2019," would increase the eligibility of National Guardsmen and Reservists to receive mental healthcare within the VA. AFGE is both proud to represent the dedicated employees who provide high quality mental healthcare at the VA and supports all members of the armed services receiving that healthcare within the VA, with National Guardsmen and Reservists being no exception. AFGE applauds the efforts of Senator Tester (D-MT) and Senator Moran (R-KS) to extend eligibility to receive mental healthcare to veterans who were previously excluded. AFGE also wants to take this opportunity to remind Members of the Committee that this change would increase demand for mental healthcare at the VA, and AFGE encourages you to continue to ask why the VA has failed to fill nearly 50,000 vacancies, including those related to providing mental healthcare and processing those claims.

AFGE supports S. 711.

**S.785, Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019**

S. 785, the "Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019," aims to improve VA mental health services. AFGE's comments on this bill are limited to Title V of the bill, Medical Workforce and Title VI of the bill, Improvement of Telehealth Services.

VA psychologists are currently in the Hybrid Title 38 personnel system that applies a mix of Title 5 and Title 38 personnel rules. As a result, they have full Title 5 bargaining rights, earn pay under the Title 5 GS system, but are covered by the Title 38 hiring and promotion processes that are subject to full VA Secretary discretion.

This bill proposes to move VA psychologists from the 38 USC 7401(3) "hybrid" appointment group to the 38 US 7401(1) appointment group that covers physicians, registered nurses (RN) and other Title 38 clinicians. The proponents of this change assert that VA psychologists will receive higher pay and greater professional respect. Neither benefit is certain.

However, what is certain is that this change will vastly reduce the collective bargaining rights of VA psychologists. Their bargaining rights will be defined by 38 USC 7422 ("7422") instead of 5 USC 7114 and as a result, they will no longer be able to grieve over pay errors, assignments, schedules and other routine working conditions.

AFGE has fought for more than a decade to secure legislation to restore full bargaining rights to Title 38 clinicians and greatly appreciates the leadership of Senator Sherrod Brown (D-OH) for introducing S. 462. This is also a fight for veterans and the future of the VA health care system in the face of severe privatization threats. Unequal bargaining rights and the silencing of frontline clinicians have devastated workplace morale and severely limited the ability of the VA to recruit and retain medical providers. If the VA cannot maintain a strong workforce of physicians, RNs, other clinicians and now, psychologists, the vacancies will worsen, and VA funding will continue to go from the VA into the private sector.

With regard to pay, there is simply not enough evidence that this personnel system change will make psychologists better off. If this bill becomes law, psychologist pay will be based on three tiers: base pay (a national pay table), market pay (set at each facility) and performance pay (also set at the facility). Therefore, like physicians, dentists and podiatrists, market and performance pay will be completely subject to the discretion of managers.

In addition, there has not been an adequate study of how local market forces will impact psychologist market pay. Podiatrists were recently added to this pay group and are widely dissatisfied with their new pay rates.

AFGE has advocated for years to make the market pay system fairer for frontline physicians and dentists. The VA blocks virtually all AFGE pay grievances by using "7422," claiming any aspect of pay is not negotiable, even when managers utilize unfair market pay setting processes that apply the wrong market data or when they refuse to provide any market pay adjustments.

The VA also blocks the union's challenges to management performance determinations with "7422." Performance pay criteria are often delayed and inappropriate; in other cases, management's measures of performance are inconsistent, resulting in pay of only nominal awards or claims there is no money for any award.

As far as professional respect, many of our members would disagree that joining the same personnel system as physicians is a guarantee of greater professional respect for psychologists. AFGE would be happy to share the views of frontline psychologists on all of these matters.

Therefore, AFGE opposes Section 501(a) as currently drafted. AFGE strongly urges the Committee to remove Section 501(a) from the bill and instead, undertake a study of the impact of this proposed personnel change that considers the input of frontline psychologists and their employee representatives.

AFGE also strongly opposes Section 501(b) that would include psychologists in the list of positions that can be contracted out. The VA has approximately 43,000 health care vacancies. The VA is a few weeks away from implementation of the Mission Act, which AFGE believes will inevitably expand the amount of private care provided to veterans.

AFGE urges the Committee to strike section 501(b) from the bill.

Sections 502 and 503 of the bill would develop staffing plans for mental health professionals. Staffing plans will only be truly effective if the input of frontline mental health professionals and their employee representatives is considered. AFGE urges the Committee to include the same language that is in Section 521(a) of the bill: "include a means for ensuring employee involvement (for bargaining unit employees, through their exclusive representatives)."

Section 508 would mandate a study of alternative work schedules (AWS) for VHA employees. AWS is a critical staffing tool and AFGE supports it fully. In order to ensure that it is offered in the most effective and equitable way, the input of frontline employees and their employee representatives is essential. Again, AFGE strongly urges inclusion of the following language: "include a means for ensuring employee involvement (for bargaining unit employees, through their exclusive representatives.)"

AFGE opposes Section 521 of the bill. AFGE believes that this provision as unnecessary. VHA already has enormous flexibility in hiring under Title 38 and that it possesses many hiring and retention tools that are underutilized including the pay incentives already mentioned with regard to Section 501(a) of the bill. It should also be noted that Chapter 33 does not apply to Title 38 under current law.

Therefore, AFGE opposes Sec. 521.

Section 601 of the bill would authorize partnerships between the VA and non-VA organizations to expand VA's telehealth capabilities. AFGE strongly opposes this section. VA is a national leader in telehealth. The cornerstone of VA telework is the ability to reach all geographic areas where veterans reside. There is no justification for contracting out any VA telehealth.

In summary, AFGE cannot support S.785 in its current form. We hope to work with the Committee to address our stated concerns.

**S.805, Veteran Debt Fairness Act of 2019**

AFGE takes no position on this piece of legislation.

**S.850, Highly Rural veteran Transportation Program Extension Act**

AFGE takes no position on this piece of legislation.

**S.857, A bill to amend title 38, United States Code, to increase the amount of special pension for Medal of Honor recipients, and for other purposes**

AFGE takes no position on this piece of legislation.

**S.980, Homeless Veterans Prevention Act of 2019**

S. 980, the "Homeless Veterans Prevention Act of 2019," amends Title 38 to allow for the improvement of services for homeless veterans. This legislation would allow monetary benefits to be given to caregivers of homeless veterans, provide greater access to legal services, expand access to dental care, provide counseling services to transitioning veterans who are at risk of homelessness, and give financial assistance to very low-income veterans and their families. This bipartisan legislation has a noble goal and purpose; if there is even one veteran homeless in our country that is one homeless veteran too many. AFGE applauds the introduction of this legislation and hopes that the bill advances quickly for a vote before the Chamber.

**S.1101, The Better Examiner Standards and Transparency for Veteran Act of 2019**

S. 1101, the "Better Examiner Standards and Transparency for Veterans Act of 2019," or the "BEST for Vets Act of 2019," is designed "[t]o ensure that only licensed health care providers furnish disability examinations under a certain Department of Veterans Affairs pilot program for use of contract physicians for disability examinations." According to Senator Rubio (R-FL), "This bill closes [a] loophole and ensures that only health care providers who meet the VA's requirements are able to treat our service men and women." While AFGE agrees that "only health care providers who meet the VA's requirements" should treat veterans, AFGE would like to point out the fact that this is another example of the overuse of contract providers who in many cases provide sub-standard services compared to services provided by the VA. This bill also raises the broader question of why the VA has vastly increased the use of contractors to conduct compensation and pension exams (C&P).

AFGE would like to highlight last year's GAO report titled "VA DISABILITY EXAMS: Improved Performance Analysis and Training Oversight Needed for Contracted Exams."[2] AFGE was not surprised by the GAO finding that "VBA reported that almost all contractors missed VBA's quality target of 92 percent in the first half of calendar year 2017."[3] Additionally, it is concerning that the GAO reports that "VBA's lack of reliable data on the status of exams, including insufficient exams—exam reports that VBA returns to contractors to be corrected or clarified—limits its ability to effectively oversee certain contract provisions."[4] Moreover, it is unacceptable that "VBA relies on contractors to verify that their examiners complete required training, […] VBA does not review contractors' self-reported training reports for accuracy or request supporting documentation, such as training certificates, from contractors."[5]

AFGE has the strongly held belief that veterans' medicine is a specialty all its own, and that contractors should have the same experience, training, and familiarity with veterans' unique needs as VA clinicians who spend years exclusively treating veterans. Surely, that is what is "BEST for Vets."

AFGE opposes S. 1101.

**S. 1154, Department of Veterans Affairs Electronic Health Record Advisory Committee Act**

S. 1154 would establish an advisory committee of experts and stakeholders to provide guidance regarding implementation of a new VA electronic health record system.

AFGE commends Ranking Member Tester (D-MT) for seeking broad input into this major health care technology undertaking. AFGE members are also stakeholders who possess valuable expertise as users of the existing electronic health care record system. AFGE is very proud of the important role that the union played in implementation of the VA's first electronic health record through ongoing labor-management cooperation supported and encouraged by former Under Secretary of Health Dr. Kenneth Kizer.

AFGE is not able to support the bill as currently drafted. However, we would fully endorse the bill if Section 2(a) was amended to add a new subsection to 38 USC 7330(D) that includes two individuals appointed by the union, one of whom is a veteran enrolled in the VA healthcare system.

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[2] U.S. Gov't Accountability Office, GAO-19-13, "VA DISABILITY EXAMS: Improved Performance Analysis and Training Oversight Needed for Contracted Exams (October 12, 2018).

[3] *Id*. at 11.

[4] *Id*. at 20.

[5] *Id*. at 24.

**The Janey Ensminger Act of 2019**

The Janey Ensminger Act of 2019 would amend the Public Health Service Act by expanding the number of specific illnesses and conditions the VA will cover for veterans and their families related to toxic substance exposure while stationed at Camp Lejeune, North Carolina between 1953 and 1987. AFGE agrees that all veterans should receive the treatment they need as a result of their military service and is proud to represent the employees who both treat these veterans and process their claims to ensure they get the care they need. AFGE applauds Senator Burr for introducing this legislation and trying to rectify some of the many wrongs caused by the Camp Lejeune contaminated water exposure (Camp Lejeune claims).

As the Committee considers this legislation and its possible implementation, AFGE would like to raise two specific points for its consideration. First, with the number of veterans continuing to grow, and more medical conditions of the past potentially being covered by the VA, including both Camp Lejeune claims and Blue Water Navy Veterans, AFGE hopes the committee works to increase both the number of employees working within the VA to process claims and treat veterans, as well as make sure veterans continue to receive their benefits and other essential services as quickly as possible.

Second, like all VA compensation claims, Camp Lejeune claims go through a process where they are evaluated by both Veteran Service Representatives (VSRs) and Rating Veteran Service Representatives (RVSRs) within the Veterans Benefits Administration (VBA) to ensure that veterans get the benefits they have earned. While all claims go through a similar process, different types of claims require different amounts of attention and time based on their complexity. Relative to other claims, Camp Lejeune claims can be highly labor intensive and require specialized attention.

Camp Lejeune claims can take significantly more time to process than most claims. In particular it takes more time to gather evidence for these claims both because of the significant amount of time that has elapsed since the period of Camp Lejeune contaminated water exposure and the specificity of evidence required to corroborate an entitlement to benefits. However, as a result of existing VBA performance standards, VBA does not adequately consider the complex nature of claims handled by VSRs and RVSRs. As a result, VSRs and RVSRs have been unfairly penalized for handling claims that take additional time. While VSRs and RVSRs are qualified and capable of processing these claims, the system of evaluating these employees should take into account the complexity of Camp Lejeune claims and the time and attention needed to accurately process and evaluate them for the benefit of both employees and the veterans they serve.

In turn, as the Committee considers the Janey Ensminger Act of 2019, and its eventual implementation, AFGE urges the Committee and VBA to consider steps to rectify the system of evaluating VSR and RVSR performance, particularly for labor intensive and complex claims. Specifically, AFGE urges the Committee and VBA to appropriately adjust the performance standards to reflect the complexity of cases reviewed and processed by VSRs and RVSRs. Those adjustments should be reestablished for the benefit of both VBA employees and the veterans they serve.

AFGE supports The Janey Ensminger Act of 2019.

**S. Educational Assistance**

AFGE takes no position on this draft legislation.



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PREPARED STATEMENT OF JOSEPH CHENELLY, EXECUTIVE DIRECTOR, AMVETS

CHAIRMAN ISAKSON, RANKING MEMBER TESTER, AND MEMBERS OF THE SENATE COMMITTEE ON VETERANS AFFAIRS, I appreciate the opportunity to present you with our views on proposed legislation in the Senate.

As the largest veteran nonprofit to represent all of our Nation's veterans, we are dedicated to pursuing those issues that are most negatively affecting our veterans or that stand to provide the greatest positive benefit to them. As such, the three most pressing issues AMVETS is working to address this Congress are: addressing the mental healthcare crisis and suicide epidemic, addressing the critical needs of women veterans, and providing timely access to high-quality healthcare. We are pleased that the Committee is taking time today to discuss legislation that will af-

fect all three of those categories and we are proud to put our support behind a number of those bills.

PRIORITIZE THE MENTAL HEALTH EPIDEMIC

There are two pieces of legislation referring to the mental health epidemic that we will address today. One of these bills is a common sense change that would amend Title 38 to allow the VA to furnish mental health services to members of the reserve components of the Armed Forces. The other bill is a comprehensive piece that would improve care during transition, provide suicide prevention resources, launch programs and studies on mental health, increase oversight of VA's mental health care and suicide prevention efforts, enhance VA's medical workforce and telehealth services, and many other components that we know all factor into providing our veterans with the mental health services they need.

AMVETS is pleased to support S. 711—CARE for Reservists Act of 2019. S. 711 allows the Department of Defense to fund needed behavioral or mental healthcare, regardless of whether that reservist is within his or her pre-deployment window or has never deployed at all. This bill also allows members of the Guard and Reserve to access Vet Centers for mental health screening and counseling, employment assessments, education training and other services to help them return to civilian life.

AMVETS specifically supports Section 5 of this bill which requires the Secretary of Veterans Affairs to report back to the Committee on the increase of the number of individuals that use readjustment counseling or outpatient mental health care from the Department of Veterans Affairs. We believe it is crucial that the VA collects and shares data on their mental health practices. We urge the Committee to take this report even a step further by requiring VA not only to report on the number veterans using their care, but to report on how effective this care was for them. Congress could gauge this effectiveness by requiring VA to track symptom reduction, quality of life/stress management, and posttraumatic growth and cognitive flexibility by using the instruments: DASS–21 (Depression Anxiety Stress Scale), The Insomnia Severity Index (ISI), The Brief Michigan Alcoholism Screening Test (bMAST), The Positive and Negative Affect Schedule (PANAS), Couples Satisfaction Index (CSI), Perceived Stress Reactivity Scale (PSRS), The Ego Resiliency Scale (ER89), The Posttraumatic Growth Inventory-Expanded (PTGI-X), The Integration of Stressful Life Experiences Scale (ISLES), The Self Compassion Scale-SF (SCS-SF), and The Gratitude Questionnaire-Six Item (GQ–6). Further, the effectiveness of treatments utilized by VA should be measured over significant periods of time, perhaps every 6 months for two years, not only for short durations following their treatments. Most evidence based practices limit their scope of study to the effectiveness of treatments within 90 day windows and we simply don't believe this is an accurate portrayal of the real effectiveness of these treatments.

AMVETS is pleased to support S. 785, The Commander John Scott Hannon VA Mental Health Improvement Act, which addresses all three of AMVETS legislative priorities. This Congress, our organization is dedicated to finding legislative solutions for the mental health and suicide epidemic, women veterans, and veteran health care access. The Commander John Scott Hannon VA Mental Health Improvement Act is a positive start to Congress' and VA's duty to address these challenges. The Commander John Scott Hannon VA Mental Health Improvement Act seeks to improve VA mental health care by improving care during transition, providing suicide prevention resources, launching programs and studies on mental health, increasing oversight of VA's mental health care and suicide prevention efforts, and enhancing VA's medical workforce and telehealth services.

However, there is a great deal of room for improvement, and we are concerned that the legislation offers particular emphasis on increased "access" to traditional mental health models, while offering few meaningful changes to explore alternatives that are having better outcomes. We have been chasing the "access fallacy" for over a decade, while Congress has failed to articulate why most veterans will never select VA mental healthcare in the first place, and those that do quickly stop utilizing the treatment, or why those that do largely retain their diagnoses, or in worse case scenarios utilize VA healthcare and still commit suicide, as was the case with John Scott Hannon. Little is known about the true proportion of veterans who have received VA services only to later commit suicide. VA has been highlighting a questionable figure of "only" 6 of 20 veterans who commit suicide were actively utilizing the VA in the past two years.

AMVETS is particularly supportive of Section 203 regarding Post-traumatic Growth (PTG) Partnerships. PTG is defined as a positive change after experiencing trauma, including an increased appreciation for life, improved relationships with others, a realization of new possibilities in life, increased personal strength, and

spiritual change. We have been compelled by the limited but significant approach of groups like Boulder Crest that are looking at how their programs affect veterans over as many as 18 months, not within a limited scope of 90 days. They have focused on helping veterans live their best lives versus the existing focus on symptomology reduction and endless research, which surprisingly is scant in its abilities to show increases in the quality of veterans life over time. We have faith that programs like this will help our veterans, while the Clay Hunt report gives us little reason to believe that our traditional approach is providing any meaningful outcomes as the data therein and the continued suicides state that it does not.

AMVETS is pleased that this bill recognizes the need for gender-specific treatment, includes funding for telehealth services that will reach rural veterans, expands health care options to other than honorable veterans, and requires VA to develop and track their goals and objectives regarding suicide prevention.

However, while this is a strong start to the issues plaguing VA mental health care, AMVETS will not be satisfied with legislative action that simply calls for more reports on the same methodologies to be provided back to the Committee 4 years from now as was done with the "2018 Annual Report: VA Mental Health Program and Suicide Prevention Services Independent Evaluation" required by the Clay Hunt SAV Act. In the interim of that 4 year period, more than 24,000 veterans lost their lives, while suicide at DOD has grown to record highs only to see little effort given by Congress to explore the effectiveness of existing practices at VA. Veterans can no longer tolerate Congress and VA relying on the fallacy of sunk costs when it comes to finding effective mental health treatments for our Nation's veterans.

CLOSING THE GAP FOR OUR WOMEN VETERANS AND SERVICEMEMBERS

AMVETS thanks the Committee for recognizing the unique challenges women face during their service and after. Women are the fastest growing group of veterans, and we must find a way to give VA facilities the ability to provide equitable care or services to women veterans. There are two pieces of legislation to be discussed today that we believe will positively support our women veterans.

AMVEST supports S. 318—VA Newborn Emergency Treatment Act. This bill clarifies that the VA can cover the costs of transportation for newborn babies of certain women veterans. The Act ensures that qualified newborns do get access to VA covered medical care and, importantly, waives any outstanding debt women veterans may face with medically-necessary emergency transportation services for a newborn incurred by the veteran.

AMVETS is pleased to see Section 506 included in the bill. Section 506 requires the VA to submit a report to Congress on the staffing of VA relating to the treatment of women. This Section of the bill will importantly require the VA to report on the number of women's health centers, the number of patient aligned care teams of the Department relating to women's health, the number of full- and part-time gynecologists of the Department, the number of designated women's health care providers of the Department, the number of health care providers of the Department who have completed a mini-residency for women's health care through Women Veterans Health Care Mini-Residency Program of the Department during the one-year period preceding the submittal of the report, and the number that plan to participate in such a mini-residency during the one-year period following such date, and the number of designated women's health care providers of the Department who have sufficient female patients to retain their competencies and proficiencies.

AMVETS supports S. 514—The Deborah Sampson Act. S. 514 was introduced to eliminate barriers to care and services that many women veterans face and would help ensure the VA can address the needs of women veterans who are more likely to face homelessness, unemployment, and go without needed health care. The Act expands group counseling for veterans and their family members and call centers for women veterans; increases the number of days of maternity care VA facilities can provide; increases the number of gender-specific providers in VA facilities, training clinicians, and retrofitting VA facilities to enhance privacy and improve the environment of care for women veterans; authorizes additional grants for organizations supporting low-income women veterans and increases resources for homeless women and their families; and improves the collection and analysis of data regarding women veterans, expands outreach by centralizing all information for women veterans in one easily accessible place on the VA website, and requires the VA to report on the availability of prosthetics made for women veterans.

This year AMVETS has urged DOD and VA to enhance their programs to ensure that women veterans receive high-quality, comprehensive primary and mental healthcare services in a safe and sensitive environment at every VA health-care fa-

cility. S. 514 pushes this priority forward and that is why we support the passage and full implementation of this bill.

TIMELY HIGH-QUALITY ACCESS TO HEALTH CARE

The VA has pledged to serve our veterans' health care needs, but the means to accessing this care is different for every veteran. We are pleased to now discuss with you our views on the proposed bills in today's hearing that will affect veteran's health care.

AMVETS supports S. 123—Ensuring Quality Care for Our Veterans Act. S. 123 requires the VA to enter into a contract with an organization to conduct a clinical review for quality management of hospital care or medical services furnished by covered providers. If this review comes to show that the standard of care was not met during an episode of care, the VA will notify the individual who received such care from the provider.

AMVETS supports S. 221—Department of Veterans Affairs Provider Accountability Act. S. 221 requires that whenever the VA brings charges based on conduct or performance against a 7401 (1) employee and as a result of those charges a major adverse action is taken against the employee, the VA will transmit to the National Practitioner Data Bank and the applicable State licensing board the name of the employee, a description of the major adverse action, and a description of the reason for the major adverse action.

AMVETS supports S. 450—Veterans Improved Access and Care Act of 2019. At the end of last year, the VA had 49,000 vacancies. We know a veteran's access to care will be affected when there is no medical professional working in the specialty of care they need. AMVETS realizes that the best healthcare option for veterans will provide a strong, well run, and fully staffed VA first. AMVETS will support any legislation that provides a solution to VA's high rate of vacancies, a simply unacceptable situation.

S. 450 requires the VA to carry out a pilot program to expedite the onboarding process for new medical providers. The goal of the program is to reduce the length of time onboarding to no more than 60 days. The VA shall also submit a strategy to Congress on ways to reduce the duration of the hiring process for licensed professional medical providers.

AMVETS supports S. 850—Highly Rural Veteran Transportation Program Extension Act. There are an estimated 4.7 million rural and highly rural veterans who face a unique combination of factors that create disparities in health care not found in urban areas, such as inadequate access to care. Rural residents only account for 17 percent of the entire U.S. population, yet more than 44 percent of recruits come from rural areas and more than 460,000 are veterans of Iraq and Afghanistan.

S. 850 extends the authorization of appropriations to the VA for the purposes of awarding grants to VSO's for the transportation of highly rural veterans. AMVETS recognizes in the strongest terms the need for appropriate levels of funding to care for the physical and mental health care of rural and highly rural veterans. We know transportation is critical to veterans who need to access this care. We will continue to advocate for rural veterans and support legislation that addresses the gaps in care for rural and highly rural veterans.

AMVETS supports S. 1101—Better Examiner Standards and Transparency for Veterans Act of 2019. We are pleased that this legislation was introduced after reports surfaced that physicians with revoked medical licenses were conducting MDEs for the VA because of a loophole in current law. We also urge the House Committee on Veterans Affairs to introduce a companion bill in their chamber to fix this loophole.

S. 1101 ensures that only licensed health care providers furnish disability examinations under a certain VA pilot program for the use of contract physicians for disability examinations.

AMVETS supports S. 1154—Department of Veterans Affairs Electronic Health Record Advisory Committee Act. The VA is currently undertaking a decade-long transition to bring veterans' health records into the 21st century by ensuring that veterans can have access to a seamless electronic health record across the VA and Department of Defense health systems.

S. 1154 establishes an advisory committee on the implementation of the VA's electronic health record. The 11-member Committee would operate separately from the Departments of Veterans Affairs and Defense and would be made up of medical professionals, Information Technology and interoperability specialists, and veterans currently receiving care from the VA. The Committee will analyze the VA's strategy for implementation, develop a risk management plan, tour VA facilities as they transition to the new system and ensure veterans, VA employees and medical staff,

and other participants have a voice in the process. The Committee will meet with the VA Secretary at least twice a year on their analysis and recommendations for implementation.

AMVETS supports The Janey Ensminger Act of 2019. This act was named for Janey Ensminger, daughter of Marine Corps member Jerry Ensminger, who died from leukemia when she was just nine years old. Years later, her father discovered that she likely developed cancer after exposure to contaminated water at Camp Lejeune in North Carolina, where his family lived when Janey was born. As many as 900,000 may have been exposed to toxic contaminants in the water at the base between 1953 and 1987. The Janey Ensminger Act makes it possible for non-military family members to apply for VA benefits for healthcare related to exposure to these toxins. This bill amends the Public Health Service Act to direct the Agency for Toxic Substances and Disease Registry to review the scientific literature relevant to the relationship between the employment or residence of individuals at Camp Lejeune, North Carolina, for at least 30 days during the period 1953 to 1987, and specific illnesses or conditions incurred by those individuals and determine whether and to what extent the evidence shows that toxic substance exposure is a cause of an illness or condition; and publish and update a list of each illness and the categorization of evidence for which a determination of cause has been made.

AMVETS aggressively urges Congress and the Department of Veterans Affairs to invest adequate resources to fully research, diagnose, and treat conditions associated with toxic exposures. Any significant developments stemming from the previously mentioned activities should be shared with veterans as it becomes available. AMVETS encourages the VA to extend presumptive service-connection to all veterans suffering from conditions associated with toxic exposures while serving in the military.

There are several bills that were considered at this hearing that did not fall under the scope of our three main priorities. Although they are not our top priority, we believe S. 857, S. 980, S. 524, S. 746, S. 805, and Mr. Cassidy's draft bill on education assistance cover important topics and we offer no objection to them.

CONCLUSION

Chairman Isakson, Ranking Member Tester, and Members of the Committees, I would like to thank you once again for the opportunity to present the issues that impact AMVETS' membership, active duty servicemembers, as well as all American veterans. As the VA continues to evolve in a manner that can improve access to benefits and healthcare, it will be imperative to remember the impact that any changes to those systems have on millions of individuals who defended our country. We cannot stress enough the need to preserve and strengthen the VA as a whole, across all administrations, in order to ensure the agency can deliver on President Lincoln's sacred promise now and in the future.

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JOINT WRITTEN TESTIMONY OF HON. TIM S. MCCLAIN, CHAIRMAN, BOARD OF DIRECTORS; AND MR. JAMES LORRAINE, PRESIDENT & CEO, AMERICA'S WARRIOR PARTNERSHIP, AUGUSTA, GA

Testimony in Support of:

- S. 318 To authorize the Secretary of Veterans Affairs to furnish medically necessary transportation for newborn children of certain women veterans."
- S. 514 To amend title 38, United States Code, to improve the benefits and services provided by the Department of Veterans Affairs to women veterans, and for other purposes.
- S. 524 To establish the Department of Veterans Affairs Advisory Committee on Tribal and Indian Affairs and for other purposes.
- S. 711 To amend title 38, United States Code, to expand eligibility for mental health services from the Department of Veterans Affairs to include members of the reserve components for the Armed Forces, and for other purposes.
- S. 785 Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019
- S. 805 Veterans Debt Fairness Act of 2019
- S. 850 Highly Rural Veteran Transportation Program Extension Act
- S. 857 A bill to amend title 38, United States Code, to increase the amount of special pension for Medal of Honor recipients, and for other purposes.
- S. 980 Homeless Veterans Prevention Act of 2019
- A bill to amend title 38, United States Code, to extend the authority of the Secretary of Veterans Affairs to continue to pay educational assistance or sub-

sistence allowances to eligible persons when educational institutions are temporarily closed, and for other purposes.

CHAIRMAN ISAKSON, RANKING MEMBER TESTER, AND MEMBERS OF THE COMMITTEE: Thank you for the opportunity to provide testimony today on several pieces of proposed legislation that offer the potential to have a tremendous impact on our Nation's veterans. I am Tim McClain and have had the honor of serving our country on active duty for more than 20 years as a Navy Surface Warfare Officer and JAG Corps Officer, and the privilege of serving as a former General Counsel for the U.S. Department of Veterans Affairs (VA).

I am currently the Chairman of the Board of Directors of America's Warrior Partnership, a nonprofit organization serving veterans and their families. Our mission at America's Warrior Partnership is to empower communities to empower veterans. Our approach to the mission takes many forms, but it starts with connecting community organizations with local veterans to understand their unique needs and situations. After gaining this knowledge, we connect local veteran-serving organizations with the appropriate resources, services, and partners that the veteran requires. Our ultimate goal is to create a better quality of life for all veterans.

Our Community Integration model provides the framework for organizations to conduct proactive outreach to veterans and holistically serve all of their needs. We have seen incredible results from this model, which has established relationships with more than 48,000 veterans since February 2014 in our eight Affiliate Communities across the country. Proactive outreach is having a tremendous impact on these veterans. More than 90% of our veterans self-report that America's Warrior Partnership's proactive engagement and support give them a greater level of overall satisfaction, and they believe their community cares about their well-being. America's Warrior Partnership's Community Integration model works.

Providing testimony with me today is the president and CEO of America's Warrior Partnership, Mr. Jim Lorraine, who is also a veteran of our great country having served for 22 years as an Air Force Officer and Flight Nurse. Before founding America's Warrior Partnership, Mr. Lorraine served as the founding director of the United States Special Operations Command Care Coalition, a wounded warrior advocacy organization recognized as the gold standard in supporting more than 4,000 special operations force wounded, ill, or injured and their families. He has also served as Special Assistant for Warrior and Family Support to the Chairman, Joint Chiefs of Staff, during which time he transformed the Chairman's "Sea of Goodwill" concept into a strategy. Mr. Lorraine will provide America's Warrior Partnership's testimony regarding four pieces of proposed legislation.

Thank you, Mr. McClain. In my testimony today, I will address a number of the draft legislative proposals related to our work at America's Warrior Partnership. As an organization that has developed, operated, and replicated community-based veteran serving programs throughout the Nation we recognize the positive impact a community integration approach has on the hopefulness and improved quality of life for the veterans, their families, and their communities. To help frame our testimony related to the legislation you are considering I would like to share what we've learned from veterans across the country. Every month we measure the services being sought and successfully provided to over 48,000 veterans across the Nation additionally, through our annual survey of the same population we correlate the holistic services they are seeking with their level of hopefulness or hopelessness. We've learned that 49.7% of veterans surveyed are seeking greater opportunities for recreation or sports, 45% are seeking networking with other veterans, and 35% are seeking volunteer opportunities. Additionally, access to Veterans Affairs benefits and better employment opportunities round out the top 5 opportunities that veterans are seeking.

When looking at the veteran's level of hope our research indicates that 56% of veterans are very hopeful or what we call "thriving," with 32% hopeful or what we call "in transition," and 13% of veterans as hopeless or "stuck." This 13% is consistent across our communities regarding the percentage of veterans who are seeking critical life services. In our research, we correlate the veterans level of hope with the services they are seeking. Those that are thriving are seeking networking with other veterans, better employment, and improved education. Those in transition are seeking short term financial assistance, legal support, and housing. While those veterans who are struggling are seeking access to transportation, short-term financial assistance, spiritual support and legal assistance. To summarize our research, those who have access to transportation are 22% more hopeful than those who do not. Those veterans with self-sustained housing are 13% more hopeful than those who do not have stable housing. Those veterans with a Bachelor's Degree or higher are 10% more hopeful than those without a college degree. And those with access to

healthcare (86.4% of veterans surveyed have health insurance) are 13% more hopeful than those without health insurance.

I provide this information to the Committee to frame America's Warrior Partnership's support of legislation that builds stronger more collaborative communities around veteran employment as captured in S. 785 but would suggest we look beyond encouraging community-based collaboration around a single issue and rather focus on holistically improving veterans hope and quality of life. We strongly support legislation that builds on a plan to improve the quality of life for all veterans and their families through alternative care, recreational therapy, and engagement outside of the Veterans Affairs services.

We feel that changing the eligibility criteria for Veterans Affairs care for Dishonorable and Other Than Honorable as written in S. 785, Section 104 would help those with this characterization of discharge, but should be re-thought due to the fact that millions of honorably discharged veterans who served without adverse impact are not eligible for Veteran's Affairs care and should be first for eligibility modification.

While we agree with the services outlined in S. 785, Section 102 for transition services we feel that without corporate and educational institutions acknowledging the skills acquired within the military the services that are outlined do not fully meet the transition needs of the veterans.

Last, we completely support both the S. 857 A bill to amend title 38, United States Code, to increase the amount of special pension for Medal of Honor recipients, and for other purposes and a bill to amend title 38, United States Code, to extend the authority of the Secretary of Veterans Affairs to continue to pay educational assistance or subsistence allowances to eligible persons when educational institutions are temporarily closed, and for other purposes. It is vital that we support those we recognize as providing the greatest sacrifice to our Nation. We also must recognize that those using their GI Bill must have the stability of income during the most trying periods of natural disaster or government shut-down that are beyond their control or ability to plan.

I appreciate the opportunity to comment on these critical areas and will now let Mr. McClain conclude our testimony.

Thank you, Mr. Lorraine. Chairman Isakson, thank you for inviting us to provide testimony today. We are both honored and pleased to have this opportunity. Our mission is the same as the mission of this Committee: to ensure that all veterans are taken care of and provided the benefits that they have rightfully earned through their service to our country. There is much work to be done, and we look forward to continuing collaborating with the Department of Veterans Affairs and our partners across the country to empower veterans from all walks of life as they transition to civilian life. Thank you again for the invitation to share our testimony today.

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## PREPARED STATEMENT OF KEN FALKE, CHAIRMAN, BOULDER CREST & EOD WARRIOR FOUNDATION

May is Mental Health Awareness Month, an opportunity to raise awareness of the millions of veterans—and Americans—battling mental health challenges, and perhaps more importantly, to discuss what should be done to ensure these men and women can live great lives—filled with meaning, purpose, connection, and growth.

When it comes to the subject of mental health and veterans, there is no doubt that much is done to raise awareness of their plight. However, far too little is done when it comes to talking about and taking action on the second part of the story—the journey from struggle to strength, pain to purpose, tragedy to triumph.

As a 21-year US Navy service-disabled combat veteran, and the Chairman of the EOD Warrior Foundation and Boulder Crest, which owns and operates two privately-funded wellness centers—Boulder Crest Retreat Virginia and Boulder Crest Retreat Arizona—as well as the Boulder Crest Institute for Posttraumatic Growth, I have a unique perspective, from considerable personal and professional experience, on the struggles of veterans and their family members, and on their opportunities to grow in the aftermath of trauma.

In March 1989, I was severely injured in a military parachuting operation. I broke my back in two places, dislocated my shoulder, and was knocked unconscious, suffering a severe concussion. I was told that my military career was over. In December of the same year, I was back to full active duty primarily thanks to my personal motivation and a private medical resource—a chiropractor. You see, the Navy assigned me an E–3 physical therapist and bottles of pain killers and Motrin 800 mg. I am convinced that if I would have stuck to the Navy's regime, I would have been discharged. I went on to do a full 21-year career and ultimately retired as a Master Chief Petty Officer, the Navy' s senior enlisted rank.

In 1989, Chiropractors were looked upon as "witch doctors." This is not the case today. My hope is that we can transform the mental health community like we have physical therapy and pain management and further hope that it doesn't take 30 years!

On that front, I am heartened by the language included in S. 785 related to Posttraumatic Growth, and I am grateful for the opportunity to share some of what we are learning on our journey.

BOULDER CREST RETREAT VIRGINIA

In September 2013, we opened Boulder Crest Retreat Virginia—the Nation's first privately- funded wellness center dedicated exclusively to combat veterans and their families. Our vision was to create a place—and programs—where servicemembers and veterans could transform struggle into strength and growth and receive what they required to be as productive at home as they were on the battlefield. For our first nine months, we invited innovative nonprofits to use Boulder Crest Retreat Virginia, for free, as a platform to deliver their programs. These programs ran the gamut—from 1–15 days, clinical to non-clinical, focused on everything from Military Sexual Trauma (MST) and Posttraumatic Stress Disorder (PTSD) to relationship and familial challenges.

It soon became clear to us that these programs would not be sufficient to allow us to achieve our ambitious vision. Every program we witnessed struggled with four key challenges:

First, the programs were, by their very nature, catch-and-release. Participants would come for 1–15 days, experience the program, and receive a pat on the back and warm wishes that everything would be different now. How to cope with their "new normal'. Rarely was that the case. Second, there was no curriculum related to these programs—no sense of what was being done, or how one could scale effective programs. Third, there was little to no evaluation being conducted into efficacy of these programs. While we know that, in the words of Irwin Bernstein, "the plural of anecdote is not data," far too often, these programs relied on anecdotes to demonstrate effectiveness. Last, those who provided care or delivered programs were often "wounded healers," people struggling with their own mental health issues and challenges, that significantly impaired their ability to connect with and guide others.

In May 2014, leveraging all we had learned thus far, I began a journey to understand what actually worked when it came to mental health, PTSD, and suicide. I was committed to ensuring that my brothers and sisters could live great lives and thrive in the aftermath of trauma. I traveled around the country and met with leading psychiatrists, psychologists, social workers, life coaches, and trauma experts. Time and time again, when I asked them, "What works to allow people to live great lives in the aftermath of trauma?"—I was told, "Nothing."

In principle this is true because it is not what our mental health system—broadly speaking—is focused on accomplishing. The mental health system is nearly exclusively focused on one thing when it comes to its clients and patients—managing and mitigating the symptoms associated with times of struggle; often through a combination of medication and talk therapy. This approach is not working for far too many people—something made obvious by the highly distressing statistics around veteran's mental health, and also by the words of one of the world's most esteemed medical journals, the Journal of the American Medical Association (JAMA).

In August 2015, JAMA called for a new and innovative approach to PTSD for veterans. In January 2017, JAMA Psychiatry declared that, "These findings point to the ongoing crisis in PTSD care for servicemembers and veterans. Despite the large increase in availability of evidence-based treatments, considerable room exists for improvement in treatment efficacy, and satisfaction appears bleak based on low treatment retention . . . we have probably come about as far as we can with current dominant clinical approaches."

The first glimmer of hope I encountered on my journey would be found at the University of North Carolina, Charlotte, in the person of Dr. Richard Tedeschi. Dr. Tedeschi, along with his colleague, Dr. Lawrence Calhoun, coined the term Posttraumatic Growth (PTG) in 1995 to describe the ways in which people reported growth in areas of their life in the aftermath of traumatic events and experiences.

I asked Dr. Tedeschi if he was interested in partnering with us to develop a training-based program for combat veterans that would, for the first-time ever, be designed to cultivate and facilitate Posttraumatic Growth in those who were struggling. Dr. Tedeschi agreed, and since 2014, we have been hard at work at the development and delivery of Warrior PATHH.

WARRIOR PATHH AND PTG

Warrior PATHH is an 18-month program that begins with a 7-day intensive and immersive residential initiation. The 7-day initiation is supported by Boulder Crest's custom-built myPATHH technology platform, which connects and supports students through the remaining 77 weeks—providing ongoing training, connection, and accountability.

Warrior PATHH trains combat veterans through the proven framework of PTG: educating them about the value of struggle and what stress and trauma do to the mind, body, heart, and spirit; teaching proven non-pharmacological techniques designed to regulate thoughts and emotions; creating an environment of trust and safety to facilitate disclosure of past challenges from combat and pre-combat experiences, which is supported by a delivery team composed primarily of combat veterans; beginning to craft a new story that harnesses the lessons of the past and looks forward; and a renewed commitment to service—to one's family, community and country—here at home.

In January 2016, after more than two years of research, development, piloting, and success, the Marcus Foundation funded the development of the first-ever curriculum effort designed to cultivate and facilitate Posttraumatic Growth. The curriculum effort included Student and Instructor Guides, a Journal, Syllabus, and Schedule; four pilot programs; and an 18-month longitudinal study.

The 18-month study, led by Dr. Tedeschi and Dr. Bret Moore, was completed in January 2019, focused on exploring the impact of Warrior PATHH in three key areas: Symptom Reduction, Quality of Life improvement, and Posttraumatic Growth experienced. With responses at the pre, post, 1, 3, 6, 12, and 18-month marks and the use of 24 well-respected and bespoke measurement tools, this effort represents one of the most robust evaluations of a mental health effort ever initiated. The evaluation effort included 8 Warrior PATHH Programs (49 students) and a response rate of 95 percent. Key highlights include:

*Symptom Reduction:*

- 54% sustained reduction in PTSD symptoms
- 52% sustained reduction in depression symptoms
- 41% sustained reduction in anxiety symptoms
- 39% sustained reduction in Insomnia
- 44% sustained reduction in drug use
- 24% sustained improvement in positive emotions experienced; and 25% sustained reduction in negative emotions experienced

*Quality of Life Improvement:*

- 14% sustained improvement in Couples Satisfaction
- 33% sustained reduction in stress reactivity
- 11% sustained improvement in physical activity
- 26% sustained improvement in nutrition
- 12% sustained improvement in financial wellness

*Posttraumatic Growth:*

- 56% sustained improvement in personal growth (PTG)
- 78% growth in Spiritual-Existential Change
- 69% growth in Deeper Relationships
- 58% growth in New Possibilities
- 36% growth in Personal Strength
- 26% growth in Appreciation for Life
- 32% sustained improvement in ability to change perspective/psychological flexibility
- 23% sustained improvement in capacity to integrate problematic life experiences.
- 22% sustained improvement in self-compassion
- 40% sustained increase in reading
- 9% sustained decrease in disruption to core beliefs

In short, we developed a program that achieved the vision that we set forth—to ensure combat veterans could be as productive at home as they were on the battlefield, and live great lives—filled with passion, purpose, growth, connection, and service—at home. In response to this unparalleled success, we are now working with partners so that Warrior PATHH can be scaled to ten locations across the country.

SOLVING THE BIGGER PROBLEM

Regarding PATHH as merely a program, however, is to miss the larger point. What we are learning along our journey about what did and didn't work transcended the normal divide between so-called clinical and non-clinical efforts. We had the opportunity to talk to and be guided by not just experts in the psychological and psychiatric community, but the very veterans we are seeking to help. What they told us speaks volumes about what would represent the new and effective approach that so many are calling for. They aren't interested in being pathologized or reduced to a diagnosis or set of symptoms. They aren't interested in accepting that times of struggle, despair, or trauma serve as limiting factors to a great life. They aren't interested in accepting their "new normal," a life where they must grow accustomed to a diminished life, that is a fraction of what it once was. They aren't interested in being permanently medicated, and living a life filled with a constant sense of numbness and disconnection that inhibits joy, connection, and purpose.

What veterans are interested in is learning how to maximize the value of their struggle, training, and experiences. What they insist upon is training, support, accountability, direction, and forward movement. What they deserve is the opportunity to grow and live great lives.

The experts are saying we must have a new and innovative approach; and the veterans—voting with their feet—are too. We know that half of all veterans who might benefit from mental health will never go. That of those who do, between 50–80 percent will drop out of treatment before the protocol is finished. That of those who complete the protocol, only 40 percent will experience meaningful benefits—often just a minimal and short-lived reduction in symptoms.

In a May 2017 editorial entitled "Changing Mindsets to Enhance Treatment Effectiveness," JAMA noted that "...growth mindsets are also proving critical in health care. While more research is needed, what is clear is that instilling a growth mindset in patients about their belief in the capacity to change is an important precursor to health and healing." The editorial also stated that, "Effective communication and the patient physician relationship are central—not superfluous—aspects of medical care."

The work that Boulder Crest has done over the past six years in applying, cultivating, and facilitating PTG is at the heart of the new and innovative approach that is required. It speaks to a philosophical and systemic approach that looks beyond current struggles, and toward a future that is authentic, fulfilling, and purposeful. This attitudinal distinction, combined with robust program evaluation and decades of research into PTG, serves as the foundation for such an approach, and has the potential to not only deliver results in PATHH programs, but to substantially enhance the effectiveness of current approaches. In large part, this is due to the recognition and strong evidence base demonstrating that patient education can be as or even more effective than therapeutic treatment.

PTG AND VETERANS MENTAL HEALTH

Something must change when it comes to mental health and veterans. For years now, we have done the same thing over and over again and expected a different result. As a bomb disposal technician, I cannot abide this. I come from a field where you don't get the chance to make a mistake twice; a career field with the motto, "Initial Success or Total Failure."

We must work toward new and innovative approaches—leveraging the legions of well- meaning mental health professionals, organizations, and peers—to drive better outcomes, and instill a sense of hope, possibility, and agency in veterans who struggle. The focus of our efforts must be in line with what drove my wife and I to open Boulder Crest Retreat Virginia, nearly six years: to ensure that our Nation's veterans can live great lives. This means our focus must be far beyond preventing suicide or marginal improvements in outcomes; our focus must be on ensuring we are training struggling veterans to understand and experience Posttraumatic Growth in their own lives because the opposite of suicide isn't prevention, its creating a life worth living.

To that end, Boulder Crest has partnered with the VA in an effort to train clinicians, peers, and front-line staff in the principles and practices related to PTG. But more must be done—and done quickly. As the leading organization focused on PTG in this country, and with a strong track record of success within the military and veterans community, we strongly support the language in S. 785, calling for the VA to enter into partnerships with nonprofit mental health organizations to facilitate Posttraumatic Growth among veterans. This language—and the possible impact—represents a strong start to exploring differential, and more growth-oriented ap-

proaches to times of struggle, and to the mental health crisis surrounding our Nation's veterans.

S. 785 is also noteworthy for its call for greater collaboration between the Department of Defense and VA, another important gap in current approaches. The truth is that while the focus tends to be on VA when it comes to the subject of veterans, DOD plays a critical role, particularly when it comes to transition. While we believe that the transition language included in S. 785 would lead to meaningful improvements related to community support, we also think that it is too narrow to be transformative.

The current transition approach is myopically focused on helping veterans get a job; a laudable and important next step, but not a panacea. If it were the answer—at a time of miniscule veteran's unemployment—we would see dramatic improvements in mental health statistics. But we are not.

Transition is challenging for the vast majority of servicemembers—as demonstrated by VA data showing that the largest mental health challenge for transitioning servicemembers is not PTSD, it is depression. More notably, as Mobbs and Bonanno wrote in the Clinical Psychology Review:

> Recent population survey studies have suggested that 44% to 72% of Veterans experience high levels of stress during the transition to civilian life, including difficulties securing employment, interpersonal difficulties during employment, conflicted relations with family, friends, and broader interpersonal relations, difficulties adapting to the schedule of civilian life, and legal difficulties (Morin, 2011). Struggle with the transition is reported at higher, more difficult levels for post-9/11 veterans than those who served in any other previous conflict (i.e. Vietnam, Korea, World War II) or in the periods in between (Pew Research Center, 2011). Crucially, transition stress has been found to predict both treatment seeking and the later development of mental and physical health problems, including suicidal ideation (Interian, Kline, Janal, Glynn, & Losonczy, 2014; Kline et al., 2010).

The military does a tremendous job when it comes to bringing people into the service in a relatively short period of time. The Marine Corps Museum boasts of how the Corps "transforms ordinary civilians into Marines." When it comes time for the transition, we subject our transitioning servicemembers to a week of "death by PowerPoint."

We have had countless instances of a veteran who has transitioned poorly, self-medicated in response, damaged relationships in the process, and found themselves in a mental health office. They are then mis-diagnosed with PTSD, medicated, turn to disability payments, and become unproductive, unfulfilled, unworthy, and suicidal. What was a temporary issue of adjustment became a permanent diagnosis. We can and must do better to prepare transitioning servicemembers not just for a post-military job; we must prepare them for a post- military life. Critical elements of our program, particularly focused on education, could be used to that end, and a clear-eyed look of how transition goes wrong is critical to understanding how veterans end up at the brink of suicide.

In short, we cannot simply wait for veterans to get to the point of crisis or fail to acknowledge what the data and the veteran are telling us—whether you served for four years or forty, getting out is hard. We must do a better job of getting "left of boom."

## CONCLUSION

As a retired disabled combat veteran and a retired CEO, I know the power of military experience and the challenges associated with combat experiences and long deployments. I also know that I am the man I am because of the United States Navy. More than two thousand years ago, the Athenian general and philosopher Thucydides said it best: "We must remember that one man is much the same as another, and that he is best who is trained in the severest school."

Rather than focusing on suicide prevention and more of the same in terms of mental health services, we should be focused on ensuring veterans can live great lives at home—lives filled with joy, passion, love, service, and purpose. We should ensure my fellow veterans can use the great military training they receive as a launching pad for a productive and purposeful life as a Warrior at home. We must ensure that, to paraphrase the words of a good friend and USMC General officer, their time in the service cannot be the greatest accomplishment of their lives. Doing so requires an integrated and collaborative approach, and we look forward to being a part of the solution and any questions that arise from this written testimony.

## PREPARED STATEMENT OF THE BLINDED VETERANS ASSOCIATION

### INTRODUCTION

Thank you, Chairman Isakson, Ranking Member Tester, and distinguished members of the Senate Committee On Veterans Affairs, for giving the Blinded Veterans Association this opportunity to comment on the legislation under consideration by this Committee. BVA is the only congressionally chartered Veterans Service Organization that is exclusively dedicated to serving the needs of blinded veterans and their families. On behalf of our members and their families, we are pleased to support several of the bills under consideration by this Committee. Congressional approval of two of these bills is of the highest priority to our membership. These include S. 850, The Highly Rural Veterans Transportation Program Extension Act, and S. 746, The Department of Veterans Affairs Website Accessibility Act. We will comment on these in detail in the following paragraphs. We will also outline our reasons for supporting the following bills: S. 318, the VA Newborn Emergency Treatment Act; S. 514, the Deborah Sampson Act; S. 711, the Care and Readiness Enhancement for Reservists Act; S. 785, the Commander John Scott Hannon Veterans Mental Health Care Improvement Act; S. 805, the Veteran Debt Fairness Act; S. 857, a bill to increase the amount of special pension for Medal of Honor Recipients; and S. 450; The Veterans Improved Access and Care Act. Our organization has not yet taken positions on the other bills that are under consideration at this hearing.

*I. S. 850, The Highly Rural Veteran Transportation Program Extension Act*

BVA is very pleased to support this legislation, because transportation is the most significant, and sometimes insurmountable, barrier that stands between our members and their healthcare. When veterans lose their eyesight, they also lose their ability to drive. When that happens, they do not automatically acquire the assistance of another person who will drive them to the places they need to go. Efforts to locate such assistance are especially problematic in rural areas, where public transit options are few or nonexistent, and alternative services are either excessively expensive or unavailable. We believe that it is absolutely imperative that Congress provide the Department of Veterans Affairs with both the incentive and the resources to address this barrier. This legislation will go a long way toward this goal by encouraging the development of additional transportation options for veterans, but the provision that we are particularly pleased to see is the permanent authorization of the Veterans Transportation Program. This is long overdue. The current situation makes participation in this program by VA medical centers too precarious and burdensome, and this fact has harmful consequences for the veterans they serve. Having said that, we would be even happier with this bill if it provided that once the program is permanently authorized, participation by VA medical centers is mandatory, at least in rural areas. For veterans with catastrophic disabilities that prevent them from driving, lack of transportation can force them to choose between health care and food, or to delay getting care, thus risking worsened medical conditions that would have been treatable if cared for earlier. It is not uncommon for veterans, faced with the prospect of paying $100 each way for a trip to their doctor's office, to decide to forego treatment because getting to it is too costly. This is an unnecessarily harsh situation to put some of our Nation's most vulnerable veterans in, and it is avoidable. Avoiding it can begin with passage of S. 850.

*II. S. 746, The Department of veterans Affairs Website Accessibility Act*

The VA currently faces myriad challenges on multiple fronts, and many issues compete for the attention of its leaders. Not the least of these concerns the capacity of VA's IT infrastructure to meet the demands resulting from ever-changing expectations regarding communications between Federal Government agencies and those who utilize their programs and services. Federal agencies are now expected to make ever-increasing amounts of information accessible through a rapidly growing number of media and devices, and VA has struggled to keep up with these demands. One area where VA has struggled the most is the area of compliance with accessibility guidelines for the design and dissemination of electronic information. We believe that this struggle will continue unless and until the issue of accessible communications becomes a priority of VA's senior leadership. We believe that by directing the VA Secretary to evaluate and report to Congress on the accessibility of VA's electronic communications, S. 746 will provide an impetus for VA's leadership to make the commitment that is needed to insure these issues will be addressed in a meaningful manner.

WHY ACCESSIBILITY MATTERS

Statistics indicate that our Nation's veteran population contains a growing number of individuals who have visual impairments. Studies conducted by the Veterans Health Administration in 2018 estimated that there were 131,580 legally blind veterans in the U.S. Just over 42,000 of these veterans had cases open with a visual impairment services team coordinator at that time. Further, these numbers are expected to grow as the U.S. population, including its veterans, ages over the next 20 years. Veterans who experience vision loss will want and need to access VA's websites, apps, kiosks, tele-health tools, claims process, and other benefits, programs, and services administered by the VA, both now and for the foreseeable future. Already, since many veterans are comfortable with today's myriad technologies, they want access to all of the communications options the VA offers to other veterans. Therefore, when concerns about the accessibility of websites, documents, and other equipment and media used to communicate with veterans are minimized or ignored, some of our Nation's most vulnerable veterans, those with catastrophic disabilities, are left behind. Furthermore, when these veterans are denied access to information and services, there is a risk that they will suffer serious consequences, such as further aggravation of their disabilities, and in some cases, suicide. The longer we wait, the greater this risk.

WHAT IS THE PROBLEM?

In the following paragraphs, we will discuss some of the most common, and most serious, accessibility barriers that both blind veterans, and VA employees who have visual impairments, face on a regular basis. Before doing so, we do need to acknowledge that BVA has appreciated the efforts of VA's Section 508 compliance Office to correct problems promptly, particularly as they relate to VA websites. Both the staff, and contractors who work with them, are responsive when we alert them to the existence of accessibility barriers. Additionally, thanks to the involvement of that office and its contractors, most of the applications VA makes available to veterans at this time are accessible to and usable by veterans who use adaptive software on their computers and smart devices. The problems veterans face in accessing VA's new websites have decreased in number as well, though unfortunately, website access continues to be a major challenge.

VA's websites are generally the first point of contact veterans have with the Department. Therefore, the layout and content of those sites necessarily changes frequently. As a result, there are lots of occasions when things can go wrong. It is not uncommon for veterans to find that a web page that was easily accessed one day cannot be read or navigated during the next visit to the site. Some of the reasons this happens include:

- Tables that are not designed so they can be navigated cell by cell to allow users of screen-readers and magnification software to read them;
- Buttons that are too small, or hidden among other items, thus making them hard to locate;
- Elements (such as checkboxes and buttons) that are not properly labeled;
- Pop-Ups that cannot be dismissed and interfere with the user's ability to navigate the web page by redirecting the focus of a screen-reader;
- Forms that are not designed to allow a screen-reader or magnification program to be used while filling them out; and a problem specific to the va.gov website, Password requirements that exceed industry standards. This last item creates major challenges for those veterans (especially seniors and others with cognitive disabilities) who need to create and remember unnecessarily complex passwords.

With regard to documents circulated by the VA, there has been some recent improvement, as VA now generally posts accessible Pdf documents on their public-facing websites. However, individuals, such as Veteran Service officers who assist veterans with claims, and VA employees, who need access to VA's internal documents, are not nearly so fortunate. VA still continues to utilize inaccessible PDF formats for much of its internal communications. This practice makes it very difficult for individuals who have disabilities that require them to use screen-readers to do their jobs and serve our veterans.

In our testimony at the joint hearing held by the full House and Senate Committees on Veterans Affairs earlier this year, we highlighted another long-standing access issue related to a vital VA website used by Veteran Service Officers. The TRIP Training site is itself compliant with accessibility guidelines. However, it is off limits to anyone who uses adaptive software because it must be entered through a portal that does not follow those guidelines. There is, as of this writing, no indication that this situation will be corrected any time soon.

In addition to website accessibility barriers, the kiosks VA has deployed at medical facilities nationwide present major access barriers for visually impaired veterans. These devices are supposed to be used by veterans to check in when they arrive for appointments, so they serve as the veteran's first introduction to the facility. A complicated or unsuccessful check-in process can impact the remainder of the veteran's experience. For a blind veteran, kiosks are, by their very nature, at best intimidating, and frequently unusable, due to their perfectly flat screens, and the absence of any tactile or audible features to give the potential user an idea of how to make them operate. Fortunately, such flat screens are becoming fairly common, and as they have been incorporated into other devices, such as ATM machines and voting machines at some polling places, industry has developed standards and best practices that make them accessible to people who have reading disabilities. To begin with, such kiosks generally have a 3.5mm headphone jack located in a prominent place on the machine, and insertion of a headphone into this jack activates an audio feature, which speaks information into the user's ear about where to touch on the screen in order to make it function. Such instructions often begin with a brief orientation to the screen and a brief tutorial on what to expect while using the machine. Repeat users can skip such introductory material if desired, and all users can adjust things like speaking rate and volume. Further, instructions for performing various tasks are also read out loud to the person wearing the headset. The machines also provide audible feedback whenever the user attempts to perform those functions, to indicate whether or not the attempt was successful. Therefore, since kiosks can be quite usable, and they do serve a beneficial purpose for VA, we don't necessarily object to their deployment. What we object to is that the kiosks in use at VA medical centers do not comply with the industry standard accessibility guidelines described above.

As recently as April, 2019, BVA received a complaint about the accessibility of the kiosk in the Washington D.C. VA Medical Center. First, plugging in a headset did not activate any audio features. Instead, the veteran who was attempting to use the machine stated that a sighted bystander told her that a notice had appeared on the screen which said, "If you are blind, press this button." One wonders how a "blind" person is supposed to know this information was visible on the screen. Once the person who did see it had pressed the appropriate button, the instructions did begin and they were audible through the veteran's headset. However, the veteran continued to encounter problems, because unlike other similar devices, which require users to touch a particular area of the screen, such as the bottom right corner, the top left corner, or the center, in order to make selections or move through various functions, this kiosk required the user to locate and press particular buttons to perform each task. This required a degree of accuracy in locating and then pressing each button. Because this particular user had no vision, that degree of exactitude was not achievable. This is not an accessible kiosk. We should note that VA has recently rolled out new software for its kiosks which were supposed to improve their accessibility, and this veteran had hoped to have a much different experience as a result. Unfortunately, she was disappointed. BVA is also disappointed that VA's supposed accessibility improvements did not accomplish anything better than this. After four or five years of discussions with VA, about how to address these issues, and repeated assurances from VA that they would be addressed in the next software update, this veteran's report was extremely unsatisfactory. If VA is going to truly modernize its IT infrastructure, and expand its use of electronic communications to provide access to services, VA must pay greater attention to accessibility concerns beginning with the rollout phase of devices and software. Each time retrofits or replacements are required, there is also unnecessary expenditure of funds; funds that could be used to improve services to veterans. Incorporating accessibility in the first place is much more cost effective.

Section 508 of the Rehabilitation Act requires Federal agencies to ensure that all electronic and information technologies developed, procured, maintained, or used in the Federal environment provide equal access for people with disabilities, whether they are Federal employees or members of the public. Section 508 implementing regulations, together with web accessibility guidelines (WCAG) compiled periodically over the years by the Worldwide Web Accessibility Consortium, have sought to make it clear to Federal agency personnel how to comply with these guidelines and regulations. Unfortunately, our experience indicates that while the VA has made significant progress toward compliance, the department is a long way from consistent compliance. BVA's national officers and staff meet regularly with staff of the Section 508 Compliance Office and they are generally responsive to the concerns we raise. They address the accessibility barriers we bring to their attention promptly. However, all too often, those same barriers, are erected again a few months later when websites are updated, or a new website is rolled out. The scenario that is most

disturbing is when accessibility features are put in place, only to be broken the next time the site is updated. In fact, any time website administrators add tools, redesign features, or update content such alterations can render aspects of that site inaccessible, unless the industry standards for website accessibility are followed. The same can be said for software that is developed for use by VA. Best practices that insure accessibility are mature and widely accepted throughout the IT industry. VA must be encouraged to incorporate them into all aspects of its IT infrastructure sooner rather than later. BVA believes this can only be done effectively if the initiative comes from the Department's leadership. We urge Congress, therefore, to send a message, through passage of S. 746, and its companion bill in the House, that this is a priority deserving of leadership's attention.

Before concluding our discussion of this bill, there is one final question we want to raise. What will Congress do with the report called for in this legislation? It is our hope that the members of both the Senate and House Veterans' Affairs Committees, will exercise greater oversight of VA's compliance with accessibility guidelines in the future. While the report called for in this legislation can highlight what needs to be done, it doesn't make its accomplishment a foregone conclusion. We urge Members of this Committee to hold VA accountable for addressing the barriers and implementing the plan set forth in any report Congress receives on the accessibility of VA's websites and other electronic communications to people with disabilities. To that end, we urge Members of this Committee to require additional reports from VA on their progress toward addressing the accessibility barriers that are identified in their initial report to Congress. We recommend that VA be required to provide this Committee with updates at least every 180 days until all of the issues have been addressed. Further, we recommend that the Committee on Veterans Affairs seek regular reports from VA on its efforts to incorporate accessibility features into new web content, and to insure that updates to existing content are made in a manner that allows the content to be accessed by all members of its intended audience, regardless of disability. We believe this is a necessary step, if Congress wishes to insure that VA plans for accessibility when new initiatives are launched, rather than adding accessibility features in only after receiving complaints from users. It would also give this legislation a greater impact on the effectiveness of future communications between VA and our Nation's disabled veterans. We urge you to consider amending this legislation to include such measures, thereby putting VA on notice that Congress is serious about insuring compliance with accessibility guidelines, not only for the present, but for the long term.

*III. S. 318, The Newborn Emergency Treatment act*

BVA supports this legislation because it addresses some serious needs faced by veterans at a time when they and their families are most financially and emotionally vulnerable; the birth of a new child. This legislation corrects some unfortunate shortcomings in the coverage VA can provide those newborn children under current law. We join with other veteran service organizations in urging Congress to approve these changes.

*IV. S. 518, The Deborah Sampson Act*

This legislation is long overdue. VA needs to address the practical needs of a growing number of women veterans who are enrolled in its health care system. We believe that failure to do so now will only exacerbate the needs and further alienate the women who have served this country. On behalf of the female veterans who have become members of our organization, and continue to serve both us and their country with distinction, we urge this Committee to approve this legislation.

*V. S. 711, The Care And Readiness Enhancement For Reservists Act*

This legislation provides essential services to reservists who face the same challenges and have the same needs for care during their transition to civilian life as other veterans do. It is particularly imperative that these veterans have access to as many options for mental health care as possible, in order to help them deal with the stresses associated with this time of transition.

*VI. S. 785, The John Scott Hannon Veterans Mental Health Care Improvement Act*

We support this legislation because it takes a comprehensive approach to addressing the mental health care needs of our Nation's veterans and servicemembers. It also encourages collaboration among all of the stakeholders involved in the fight to end suicide within this population. Piecemeal approaches that address one issue or fund one program at a time, have not worked. If we are to prevent further loss of life, we need to martial all available resources and begin thinking and acting outside the box. We believe this legislation will help make that happen.

*VII. S. 805 The Veteran Debt fairness Act*

The Department of veterans Affairs should never be allowed to make veterans pay for its mistakes. If a veteran, or a member of his family, knowingly collects benefits or receives services to which they are not entitled, it is reasonable for the VA to take steps to recoup its losses. However, when the veteran, or his or her beneficiary, is not at fault, it is unconscionable for the government of the United States to treat that individual as if they had deliberately defrauded the Department and seek to remedy their error by demanding repayment. We support this legislation, because it makes such principles of fairness a part of the law. It also urges VA to address one of the primary reasons why mistakes are made by Va, and thereby provides a practical means of reducing the problem in the future.

*VIII. S. 857*

A bill to increase the amount of special pension for Medal of Honor Recipients, and for other purposes. These veterans have demonstrated by their heroic actions and continued service to community and country, the need for this legislation. Their family members, who come along side them, as they serve, deserve everything we can do to help them assist their loved one.

*IX. S. 450, The Veterans Improved Access and Care Act*

We support this legislation because the VA faces a nationwide shortage of medical personnel. The current onboarding process is much more onerous than any process medical professionals encounter in the private sector. As such, it serves to deter, rather than encourage prospective employees. If the VA is going to meet its personnel needs, VA must find ways to make recruitment and onboarding more efficient. This legislation will allow VA to explore the viability of additional options for accomplishing this objective.

CONCLUSION

Thank you, once again, for the opportunity to speak with you about the above legislation. If you would like any further information, or have questions regarding the above comments, please feel free to contact Melanie Brunson, Director of Government Relations, at mbrunson@bva.org.

LETTER FROM CONNECTICUT VETERANS LEGAL CENTER

CONNECTICUT VETERANS LEGAL CENTER



May 21, 2019

Dear Sen. Isakson and distinguished members of the Committee on Veterans' Affairs,

I write on behalf of the Connecticut Veterans Legal Center ("CVLC") in support of S.980, the Homeless Veterans Prevention Act of 2019. CVLC strongly supports passage of S.980, which includes critical provisions to address the urgent nature of veterans' legal needs in Section 3 of the bill ("PARTNERSHIPS WITH PUBLIC AND PRIVATE ENTITIES TO PROVIDE LEGAL SERVICES TO HOMELESS VETERANS AND VETERANS AT RISK OF HOMELESSNES").

CVLC is a civil legal aid organization and 501(c)(3) non-profit whose mission is to lower the legal barriers to housing, healthcare, and income for veterans recovering from mental illness and homelessness. In 2009, CVLC started the first medical-legal partnership in the country to integrate free legal help into care for veterans. This model creates interdisciplinary teams of medical providers and lawyers working shoulder-to-shoulder to resolve legal issues that destabilize veterans' housing, health care, income, and family relationships. The Department of Veterans' Affairs (VA) recognized this path-breaking partnership with its National Community Partnership Award in 2015.

But the real testament to the need for legal services is the lived experience of at-risk veterans.

When we met one of our clients, Mr. S., he was 70 years old and living in his car. He was looking for assistance adjusting an old debt, but the root cause of his homelessness was his sudden loss of VA benefits. Mr. S. was a Vietnam veteran recovering from PTSD and the discontinuance of his VA benefits left him with only limited social security payments as income. CVLC not only renegotiated his debt, but was also able to get his VA benefits reinstated. Today, Mr. S. has health care, a monthly pension, and stable housing.

He is not alone. In the past ten years, CVLC has represented over 2,400 veterans across Connecticut, handling cases for approximately 600 clients last year alone. Nationwide, the VA's annual CHALENG survey shows the deep need for legal services among homeless veterans. According to the 2018 CHALENG report, legal assistance in seven areas (child support issues, financial guardianship, eviction and foreclosure prevention, restoration of driver's license, assistance with outstanding warrants and

CONNECTICUT VETERANS LEGAL CENTER, INC.
114 Boston Post Road, 2nd Floor ★ West Haven, CT 06516
PHONE: 203 794-4291 ★ FAX: 203 889-0111
ctveteranslegal.org

fines, discharge upgrade and credit counseling) were seven of the top ten unmet needs of homeless male veterans. For homeless female veterans, legal needs were five of the top ten unmet needs (financial guardianship, credit counseling, child support issues, eviction and foreclosure prevention, and discharge upgrade). These unmet needs have been remarkably consistent over time. For the last decade, legal needs have been reliably half or more of the top ten unmet needs for homeless veterans.

The legal community has responded to the legal needs of veterans by opening over 160 clinics in VA facilities across the country. VA leadership nationally and locally has embraced the mission of these clinics resulting in continued demand and growth. While we were once the only medical-legal partnership in the VA healthcare system, today the VA reports that more than two dozen of the 160 free legal clinics are medical-legal partnerships.

Unfortunately, the capacity of existing legal aid programs pales in comparison to the scope of the problem. CVLC remains the only legal aid organization in the country to provide full-time hours of operation at a VA center and even we cannot meet the full legal needs of homeless veterans in our state. Of the remaining facilities, only one other organization provides three days of operation and many legal programs serving veterans are volunteer-only, providing advice once a month on a limited number of legal topics. Most importantly, few – if any –veterans in rural areas have any access to legal help at all.

The Homeless Veterans Prevention Act of 2019 can help address these problems. Medical research has increasingly established that social determinants such as income and housing can have an equal or greater impact on a person's physical and mental health as medical treatment. Section 3 of S.980 will provide the resources to address these "social determinants of health" within the veterans' healthcare system. This will provide new pathways to reach homeless veterans and increase the reach of existing programs, filling an urgent need in a cost-effective way that reduces homelessness and improves mental health for veterans everywhere.

CVLC applauds the Committee's leadership in considering this important legislation to address the legal needs of our nation's veterans. Please do not hesitate to contact us if we may provide any additional information or assistance.

Sincerely,

Liam Brennan
Executive Director
Connecticut Veterans Legal Center
114 Boston Post Rd.
West Haven, CT 06516
203-903-2852
lbrennan@ctveteranslegal.org

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PREPARED STATEMENT OF ADRIAN ATIZADO, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS (DAV)

CHAIRMAN ISAKSON, RANKING MEMBER TESTER, DISTINGUISHED MEMBERS OF THE COMMITTEE: Thank you for inviting DAV (Disabled American Veterans) to submit testimony for the record of this legislative hearing of the Senate Veterans' Affairs Committee. As you know, DAV is a non-profit veterans service organization comprised of more than one million wartime service-disabled veterans that is dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity. DAV is pleased to offer our views on the bills under consideration by the Committee.

S. 123, ENSURING QUALITY CARE FOR OUR VETERANS ACT

This bill would require VA to enter into a contract with a third-party to conduct clinical peer review to evaluate care provided by VA appointed clinicians, whose

state license was terminated for cause for care rendered in non-VHA facilities. If a determination is made that substandard care was provided, VA is to notify such veteran of such care.

In light of the increasing use of non-VA providers under the "John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018," (Public Law 115–182), we urge the Committee to amend the bill to allow such third-party to also conduct clinical peer review to evaluate care furnished by non-VA providers that was authorized or purchased by VA, and to notify veterans of any substandard care they received.

S. 221, VA PROVIDER ACCOUNTABILITY ACT

The measure would require VA to report any adverse actions taken against certain providers to be reported to the National Practitioner Data Bank and applicable state licensing boards.

We bring to the Committee's attention the need to further clarify the definition of "major adverse actions," without which it may inadvertently be more broadly applied than intended as well as specify in greater detail to whom the prohibition under Section 2(b) of the bill applies.

DAV is unable to take a position on this bill until further clarification is provided on the definition of "major adverse actions," which as currently written may inadvertently be applied more broadly then intended as well as greater specificity is provided as to whom the prohibition under Section 2(b) of the bill applies.

S. 318, VA NEWBORN EMERGENCY TREATMENT ACT

S. 318 would allow VA to furnish transportation for newborns of women veterans receiving maternity care through VA if a newborn requires care that is not available from the facility at which the newborn was delivered. The transportation could be for the newborn alone or with his or her parents.

Increasing numbers of women veterans returning from recent deployments has spiked the number of veterans seeking maternity care from VA. Between 2000 and 2015, the number or women receiving maternity care increased more than 14 times (14.4).[1] Women veterans in childbearing years (18–44) are also highly likely to be service-connected (73%)[2] and the growth in women 35 years of age or older with obstetric deliveries increased more than 16 times (16.2).[3]

Advanced age and maternal disability are risk factors for adverse pregnancy outcomes such as low birth weight or premature birth that imperil both women veterans and their newborns. These conditions often require specialized care for infants that is not widely available. While VA is authorized to provide emergency transportation for women veterans, if the infant must travel alone for medically necessary care, VA's authority to provide this transportation was unclear. S. 318 would provide clear authority for VA to furnish emergency transportation to newborn children of women veterans.

DAV fully supports this bill, in accordance with Resolution No. 019, which calls for enhanced medical services and benefits for women veterans.

S. 450, VETERANS IMPROVED ACCESS AND CARE ACT OF 2019

This bill would require VA conduct a pilot program across 10 regionally diverse VA medical facilities to expedite the onboarding process of new clinicians to no more than 60 days. A report to Congress is required from VA no later than 180 days for a strategy to reduce by half the duration of VA's hiring process.

We support the objectives of this legislation based on DAV Resolution 129, which supports a simple-to-administer alternative VHA personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.

S. 514, DEBORAH SAMPSON ACT

S. 514, the Deborah Sampson Act, a comprehensive measure addressing gender disparities, aims to improve and expand VA programs and services for women veterans. DAV is pleased to support this important legislation, which will achieve

[1] Women's Health Services. Office of Patient Care Services. Veterans Health Administration. Department of Veterans Affairs. Sourcebook: Women Veterans in the Veterans Health Administration Vol. 4: Longitudinal Trends in Sociodemographics, Utilization, Health Profile, and Geographic Distribution. February 2018. P. 71.

[2] Sourcebook. P. 36

[3] Sourcebook. P. 72

many of the objectives DAV first identified in our 2014 women veterans report, Women Veterans: The Long Journey Home and again in our 2018 follow up report, Women Veterans: The Journey Ahead. It is also consistent with DAV Resolution No. 019, calling for VA to enhance its programs and services for women veterans.

Section 101 of the bill would permanently authorize counseling for veterans recently separated from military service and accompanying family members in group retreat settings, including in women-exclusive settings. The social connections, goal-setting and role modeling women veterans are exposed to in such retreats have significant and lasting effects according to program participants.

We are pleased to support Section 202, which would extend authority and increase funding for families who are precariously housed and live at or below the poverty line. This important program has stopped thousands of veterans and their family members from becoming homeless. It would also earmark $20 million for women veterans. Section 203 would require a "gaps analysis" of programmatic deficiencies in meeting the needs of homeless or precariously housed women veterans, as we recommended in Women Veterans: The Journey Ahead.

Section 301 would extend the number of days, from seven to 14, VA may cover the cost of care for newborns of women veterans. As we stated in our support of S. 318, women veterans who use VHA have a heavy burden of service-connected disability, especially those in childbearing years, and are often at advanced age (35 years or older) for childbearing, which puts them at risk for adverse birth outcomes. Increasing the time VA will reimburse their newborns' care will ensure that most of their needs can be addressed before they are discharged.

Title IV addresses eliminating barriers to access including ensuring that environmental care standard deficiencies are addressed through adequate retrofitting; that there is at least one designated women's health provider in each VA facility; that funds are available for training additional primary and emergency providers through VA mini-residencies; that training materials are developed for community providers in the new Veterans Community Care Program to be launched in June 2019; and that VA completes a study to determine the adequacy of staffing for Women Veterans Program Managers, determine the need for an Ombudsman in each medical center and ensure proper training for the individuals in these positions.

Title V requires VA to conduct a number of studies, including:

- Use of various primary care models serving women veterans;
- Staffing levels of women's health providers including PACT team members and gynecologists;
- Data collection and reporting on all VA programs serving veterans, by gender and minority status;
- Availability of prosthetics for women veterans; and
- Centralizing all information for women veterans in one easily accessible place on VA's website.

DAV fully supports S. 514 and is eager to work in support of its approval.

S. 524, DEPARTMENT OF VETERANS AFFAIRS TRIBAL ADVISORY COMMITTEE ACT OF 2019

This measure would establish a VA Tribal Advisory Committee to better facilitate agreements between VA and other agencies within the Federal Government. The Committee would be composed of 15 members, including one from each of the 12 Indian Health Service areas.

We believe this measure would facilitate addressing DAV Resolution 224 supporting the rights and receipt of benefits earned by service-connected Native American or Alaska Native Veterans and look forward to its favorable consideration.

S. 711, CARE AND READINESS ENHANCEMENT FOR RESERVISTS ACT OF 2019

The Care and Readiness Enhancement for Reservists Act, or CARE for Reservists Act of 2019, would allow the Department of Defense to fund needed behavioral or mental health care for reservists, regardless of whether that servicemember is about to deploy or whether they have deployed at all. Currently, members of the National Guard and Reserves undergo annual health assessments to identify medical issues that could impact their ability to deploy, but any follow-up care must generally be pursued at their own expense.

DAV has no resolution specific to extending mental health care to National Guard and reservists, but believes the intent of this legislation is in keeping with the goal of ensuring that all servicemembers have the health care necessary to readjust successfully after deployments. We also recognize that the number of suicides among

Guard and Reservists who have not been federally activated has grown in recent years.[4] We therefore have no objection to this legislation's favorable consideration.

S. 746, DEPARTMENT OF VETERANS AFFAIRS WEBSITE ACCESSIBILITY ACT OF 2019

This bill would require the Secretary of Veterans Affairs to examine and report on all websites (including attached files and web-based applications) of VA to determine whether such websites are accessible to individuals with disabilities in accordance with section 508 of the Rehabilitation Act of 1973.

We are troubled by the inability of vision impaired veterans to fully access VA websites, thus confounding their ability to claim and access their earned benefits. DAV was founded on the principle that this Nation's first duty to veterans is the rehabilitation and welfare of its wartime disabled and to ensure that all disabled veterans receive all benefits they have earned.

DAV supports S. 746 as it is in accord with DAV Resolution No. 001 and would help to ensure that all VA websites and associated files are accessible by all veterans, especially those with disabilities and impairments as noted.

S. 785, Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019

S. 785, the Commander John Scott Hannon Veterans Mental Health Care Improvement Act, would improve eligibility and access to transitioning servicemembers and veterans to Federal programs such as transitional assistance programs and health care, including mental health care, to reduce suicide rates and improve mental health among veterans.

The VA mental health program experienced tremendous growth (86%) between 2005 and 2017. Troops returning from deployments in Iraq and Afghanistan required mental health care services including treatment for Post Traumatic Stress Disorder (PTSD), substance use disorders, depression, and anxiety. During this time, VA also identified an upward trend in suicides among veterans. Homelessness and unemployment were considered contributing factors, particularly for some subgroups in the veterans' population such as women and minorities.

Title I of the bill would improve transition programs for servicemembers separating from military service. Research has demonstrated that the first three years of readjustment is a time when veterans are particularly vulnerable to suicidal ideation.[5]

This section would:

- Improve access to transition services for veterans by extending VA health care eligibility to a year after discharge from military service;
- Create a grant program to help veterans obtain employment and help identify the many non-profit programs available to veterans in their communities; and
- Require an annual report on utilization of VA medical services by veterans with other than honorable discharges.

Title II of the bill would develop community resources for addressing suicide prevention. These programs will enhance VA programs to prevent suicide and create care outlets for the many veterans (70%) who do not use VA health care,[6] and whose rates of suicide over time are surpassing rates of suicide among veterans who use VA.[7]

Programs developed under this title include:

- Creation of a new suicide prevention program to include new grant programs designed to reach veterans at risk of suicide who are not obtaining VA mental health care;
- Facilitation of post-traumatic growth services through community partners;
- Requirement that VA designate annual Buddy Check Week to encourage peer support by organizing education and awareness activities;
- Requirement that VA track and report on goals and objectives in its suicide prevention plan and direct the Government Accountability Office to evaluate VA's case management program for veterans at high risk of suicide.

Title III of the bill addresses programs, studies and guidelines on mental health for veterans. These programs include:

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[4] Department of Veterans Affairs. Office of Mental Health and Suicide Prevention. VA National Suicide Data Report: 2005–2016. September 2018. P. 10.

[5] Ann Epidemiol. 2015 Feb;25(2):96–100.

[6] Department of Veterans Affairs. National Strategy for Preventing Veteran Suicide 2018–2028. P. 6.

[7] Department of Veterans Affairs. Office of Mental Health and Suicide Prevention. VA National Suicide Data Report 2005–2016. September 2018. P. 3.

• Study of feasibility and advisability of providing access to computerized cognitive behavioral therapy to veterans;
• Study of living at high altitude and development of suicide risk factors among veterans;
• Requirement for VA to update guidelines on suicide prevention including using gender specific risk factors and treatment options:
• Establishment of a Precision Medicine Initiative to identify and validate brain and mental health biomarkers;
• Creation of VA treatment guidelines for trauma comorbid with chronic pain and substance abuse.

Title IV of the bill would develop a number of oversight vehicles to ensure that VA's efforts in mental health care and suicide prevention are accessible, effective and on target:

• Require focus group studies of effectiveness of suicide prevention and mental health outreach of VA followed by a representative survey of the veteran population from focus group themes;
• Require VA to develop oversight measures for assessing VA's outreach efforts with media;
• Require a report on VA's progress in addressing Executive Order 13822 which requires that VA assist servicemembers within the first year of separation from armed services;
• Require oversight reports on:
  – VA's mental health and suicide prevention efforts;
  – Integration of mental health into primary care;
  – Joint mental health programs run by VA and the Department of Defense including transition assistance programs, centers of excellence in Traumatic Brain Injury and Post Traumatic Stress Disorder and ancillary programming including employment, housing and financial literacy and establish an additional Intrepid Spirit Center in a rural area.

Title V of the bill would make changes to assist VA in developing its mental health workforce. Despite VA adding 1000 or more staff to aid mental health efforts in recent years, VA's Inspector General (IG) continues to identify psychiatrists and psychologists among its professions that VA medical centers most frequently identify as being in short supply ranking 1 and 4 in the IG's most recent survey.[8]

• Convert VA psychologists from "hybrid" title 38/title 5 employees to title 38 employees;
• Require VA to develop a staffing improvement plan for psychiatrists and psychologists;
• Create occupational series for licensed mental health counselors and marriage and family therapists within VA;
• Require staffing improvement plan for peer support specialists who are women;
• Create a Readjustment Counseling Service Scholarship program;
• Require a report on Readjustment Counseling Service regarding the adequacy and types of services provided; efficacy of outreach and recommendations for improvements; use of telehealth; expanding eligibility and costs of such expansions; use by Reservists; use by eligible family members, and assessment of training of group therapists.
• Create an annual report from the Readjustment Counseling Service looking at resources required to meet needs.
• Create studies of alternative work schedules for VHA employees;
• Require one suicide prevention coordinator at each VA medical center;
• Create direct hiring authority for certain health care positions within VHA.

While DAV is in favor of most of the provisions within this title, we would ask that the Committee give further consideration to Section 501 which would re-categorize psychologists now under Hybrid Title 5/Title 38 authority to Full Title 38 authority. While DAV supports a single, simple-to-administer alternative personnel system under DAV Resolution No. 129, we are unclear if this measure would improve recruitment and retention of psychologists—an occupation that VA's Office of Inspector General has identified as having a large staff shortfall for the past several years. DAV would instead ask that the Committee study both strengths and bar-

[8] Statement of Michael J. Missal, Inspector General, Department of Veterans Affairs, Before the Subcommittee on Health, Committee on Veterans' Affairs, US House of Representatives, More than Just Filling Vacancies: A Closer Look at VA Hiring Authorities, Recruiting, and Retention." June 21, 2018. P. 6 (based upon data from Veterans Health Administration's Occupational Staffing Shortages for Fiscal Year 2018.)

riers to using the current system and identify benefits within Title 38 and "Hybrid" systems that VA psychologists value. For example, are practices such as collective bargaining, leave policies, pay practices, and retirement benefits valued by current employees and job candidates? How would moving from one system to another affect such practices and would the change impact VHA's ability to recruit or retain these scarce clinical personnel?

In addition, DAV has some concerns about potentially weakening veterans' preference and merit based hiring practices in favor of an unproven system that may or may not lead to more expedient hiring proposed under Section 521. In DAV's view, it would be more prudent to understand barriers to effective use of current hiring flexibilities and pay incentives under Title 38.

Title VI of the bill would improve VA's Telehealth Services. Telehealth and other technologies have expanded care options for veterans and made care available to populations that might not be eligible (such as active-duty veterans, family members, and those with less than honorable discharges). VA has apps and web-based curriculum that are accessible and effective means of bringing evidence-based practices to more individuals in need. Telehealth which is increasingly used by VA to distribute scarce health resources (such as specialized care) is known to be effective and patients are pleased when seeking specialized care does not have to take them far from their homes and communities.

Specifically, the bill would:

- Expand use of telehealth between VHA, other Federal agencies and community partners, especially in rural communities by offering grants for "partnerships" to upgrade hardware, infrastructure and security and train staff.
- Implement a national protocol for telehealth security.

DAV also suggests the addition of a reporting requirement for VHA's Special Committee on PTSD. While it is our understanding this group of mental health providers and researchers continues to meet and report internally, Congress does not benefit from the Committee's guidance and recommendations for improving the program in VA.

The following resolutions lead DAV to strongly support S. 785. DAV Resolution No. 293 supports program improvement and enhanced resources for VA mental health programs, emphasizing the importance of timely access to mental health and readjustment services for transitioning servicemembers. DAV Resolution No. 304 urges Congress to monitor programs in place to assist those servicemembers transitioning to civilian life with access to appropriate Federal programs.

### S. 805, VETERAN DEBT FAIRNESS ACT OF 2019

This legislation would require the VA Secretary to improve the processing of veterans benefits, limit the authority of the Secretary to recover overpayments and improve the due process accorded veterans with respect to such recovery.

It is a reasonable expectation that recipients of overpayments are required to repay the debt; however, the current overpayment and debt system allows the VA to collect debts regardless of when or how the debt was created. Current debt collections by the VA include complete recoupment of the veteran's monthly benefit payments and, in many cases, put the veteran at risk of financial hardship. It is important to note that additional amounts of debt created by the VA's lack of timely action are often added to the debt, thus creating an inequity on the veteran.

S. 805 will allow veterans and beneficiaries to choose how to receive debt notification and address several root causes of VA overpayments, including:

- Only allowing the VA to collect debts that occur as a result of an error or fraud on the part of a veteran or their beneficiary;
- Prohibiting VA from deducting more than 25 percent from a veteran's monthly payment in order to recoup overpayment or debt. This deduction may be further limited if it puts that veteran at risk of financial hardship, for example if the veteran is living on a fixed income;
- Preventing the VA from collecting debts incurred more than five years prior (Currently there is no time limit on how long after a payment a veteran can be billed);
- Requiring the VA to provide veterans with a way to update their dependency information on their own, eliminating a key processing delay for veterans which frequently contributes to the VA making overpayments.

S. 805 will institute common-sense protections for veterans and reduce the potential negative financial impact on veterans and their families. DAV strongly supports S. 805 as it is in accord with DAV Resolution No. 172.

S. 850, THE HIGHLY RURAL VETERAN TRANSPORTATION PROGRAM EXTENSION ACT

The VA Highly Rural Transportation Grants (HRTG) program was established to help highly rural veterans travel to VA or VA-authorized health care facilities by providing $50,000 grant funding to Veteran Service Organizations and State Veterans Service Agencies to provide transportation services in eligible counties. The program's authority was intended to operate for five fiscal years beginning in 2010, but has since been extended five times until 2020.

DAV understands the importance of transportation to enable veterans to access VA health care and benefits. The DAV National Transportation Network operates a fleet of vehicles around the country to provide free transportation to VA medical facilities for injured and ill veterans. We stepped in to help veterans get the care they need when the Federal Government terminated its program that helped many of them pay for transportation to and from medical facilities. These vans are driven by volunteers, and the rides coordinated by more than 178 Hospital Service Coordinators around the country.

DAV Departments and Chapters, along with our long-time partner Ford Motor Company, have purchased 3,517 vehicles at a cost of more than $80.1 million, which have been donated to VA medical centers nationwide since the program began in 1987 to ensure that injured or ill veterans are able to get to their medical appointments.

We recognize HRTG as one of three programs administered by VA's Veterans Transportation Program (VTP) to provide veterans little to no-cost travel solutions to and from their VA health care facilities. VTP also administers the Beneficiary Travel program and the Veterans Transportation Service (VTS). Each program, however, has certain limitations and areas of concern.

VTS is intended to provide veterans with convenient and timely access to transportation services and to overcome barriers to receiving VA health care and services, and in particular to increase transportation options for veterans who need specialized forms of transportation to VA facilities; however, there is wide variation in eligibility for VTS transportation across the VA health care system that is not consistent with overcoming barriers to receiving health care provided or purchased by the VA to service-connected veterans.

Beneficiary travel is a critical program, but is not available to all service-connected disabled veterans with mobility challenges, policies do not comport with VA's current access to care policies, and it is a source of confusion among local VA facilities due to vague policies for using special-mode transportation, such as a wheelchair van, as well as eligibility issues for veterans with visual impairments.

HRTG provides grants to assist only veterans in highly rural areas through innovative transportation services to travel to VA medical centers.

While DAV supports enactment of this measure to extend by one year HRTG, we urge this Committee to consider addressing the lack of a consistent and comprehensive VA transportation policy for all service-disabled veterans across all established VA transportation and travel programs, benefits and services.

S. 857, A BILL TO INCREASE THE AMOUNT OF SPECIAL PENSION FOR MEDAL OF HONOR RECIPIENTS

S. 857 would amend 38 U.S.C. § 1562 by increasing the Medal of Honor Special Pension from $1000.00 a month to $3,000.00 a month. DAV does not have a resolution on this issue; however, we would not oppose the enactment of this bill.

S. 980, HOMELESS VETERANS PREVENTION ACT OF 2019

The Homeless Veterans Prevention Act of 2019 authorizes the VA to provide per diem payments for furnishing care to the dependents of certain homeless veterans, provide for partnerships to provide legal services to homeless veterans and those at risk of homelessness, expand the VA's authority to provide dental care to homeless veterans, repeal the sunset on counseling services for homeless veterans, and extend the financial assistance for supportive services for very low-income veteran families in permanent housing. In addition, this legislation would require the Comptroller General of the United States to study the VA's Homeless Veterans Programs and provide an assessment as to whether these programs are meeting the needs of the veterans who are eligible for assistance.

DAV supports this legislation in accordance with the following resolutions approved by our membership—DAV Resolution No. 291 calling for sustained and sufficient funding to improve services for homeless veterans; and Resolution No. 173, which supports enactment of legislation authorizing VA to provide child care services and assistance to veterans attending VA homeless and rehabilitative programs.

S. 1101, BETTER EXAMINER STANDARDS AND TRANSPARENCY FOR VETERANS ACT OF 2019

The Better Examiner Standards and Transparency Act of 2019, would amend title 38, United States Code, section 5101 to prohibit contract health care providers who have had their licenses revoked in any state to provide VA Compensation and Pension examinations and to ensure that only licensed contract health care providers are conducting the examinations. S. 1101 would also require the Secretary to submit annual reports to Congress addressing both of these concerns.

A VA examination by an unlicensed health care professional would be considered an inadequate VA examination and a violation of VA's duty to assist as noted in title 38, United States Code, section 5103A. Under the recently implemented Appeals Modernization Act, appeals at the Board of Veterans' Appeals will be returned to the agency of original jurisdiction for duty to assist errors. Thus, S. 1101 will lessen the potential for additional appeals processing by ensuring that all VA contract examiners are licensed and not confound the VA's duty to assist.

Veterans' medical disability examinations are incredibly critical in ensuring veterans obtain service connection and accurate examinations will directly impact disability evaluations. As such, ill and injured veterans deserve to have these examinations conducted by qualified clinical providers, including those whom VA contracts with to provide these important examinations.

DAV supports S. 1101 as it is in accord with DAV Resolution No. 001. It is part of DAV's foundation that wartime disabled veterans should receive high-quality hospital and medical care from VA as well as adequate compensation for the loss resulting from such service-connected disabilities.

S. 1154, THE DEPARTMENT OF VETERANS AFFAIRS ELECTRONIC HEALTH RECORD ADVISORY COMMITTEE ACT

This bill would establish an independent, 11-member Electronic Health Record (EHR) Advisory Committee, which would be comprised of medical professionals, information technology and interoperability specialists, and veterans currently receiving care from the VA. The Advisory Committee would, among other things, be required to analyze VA's implementation strategy, developing a risk management plan, and tour VA facilities as they transition to the new EHR system. The Committee would also be required to report to Congress twice a year for the first two years of its establishment recommending any administrative or legislative action necessary.

DAV supports the intent of this bill and agrees that the $16 billion 10-year commitment must not suffer the same setbacks as has unfortunately been known to occur with numerous other VA information technology projects. We recognize the VA will be going live with Cerner's product around March/April 2020 at the Mann-Grandstaff, Seattle and American Lake VA medical centers as well as accelerate the timetable to complete deployment of a scheduling package across the VA health care system in the next five years.

DRAFT BILL, TO EXTEND THE AUTHORITY OF THE SECRETARY OF VETERANS AFFAIRS TO CONTINUE TO PAY EDUCATIONAL ASSISTANCE OR SUBSISTENCE ALLOWANCES TO ELIGIBLE PERSONS WHEN EDUCATIONAL INSTITUTIONS ARE TEMPORARILY CLOSED

This legislation would amend title 38, Section 3680(a) (2) of the United States Code to provide continued subsistence allowances to eligible veterans who are pursuing a program of education under chapter 31, 34, or 35 of this title when that educational institution is temporarily closed not to exceed a period of eight weeks. Current legislation limits the total number of weeks for which allowances may be paid over a 12-month period to four weeks.

While DAV does not have a resolution specific to this issue, we support the intent of this legislation and look forward to its favorable consideration.

DISCUSSION DRAFT: JANEY ENSMINGER ACT OF 2019

The proposed legislation, consistent with the Comprehensive Environmental Response, Compensation, and Liability Act, title 42, United States Code, section 9601, directs the Agency of Toxic Substances and Disease Registry to provide a report not later than one year after the date of enactment and not less frequently than once every three years thereafter. The report is to concern:

- Review the scientific literature relevant to the relationship between the employment or residence of individuals at Camp Lejeune, North Carolina for not fewer than 30 days during the period beginning on August 1, 1953, and ending on December 21, 1987, and specific illnesses or conditions incurred by those individuals;

• Determine each illness or condition for which there is evidence that exposure to a toxic substance at Camp Lejeune;
• With respect to each illness or condition for which a determination has been made, categorize the evidence of the connection of the illness or condition to exposure described as—
– "(i) sufficient to conclude with reasonable confidence that the exposure is a cause of the illness or condition;
– "(ii) modest supporting causation, but not sufficient to conclude with reasonable confidence that exposure is a cause of the illness or condition; or
– "(iii) no more than limited supporting causation.

The VA established presumptive diseases recognized as being causally linked to the contaminated water at Camp Lejeune from August 1, 1953 to December 21, 1987, in title 38, Code of Federal Regulations, section 3.309. However, this presumptive is not codified nor does it carry a requirement for continuing reports, research and diseases noted to be causally linked to said exposure.

DAV supports this proposed legislation as it is consistent with DAV Resolution No. 090 and will provide an avenue to consider additional diseases or conditions that can be linked to the contaminated water. However, we do seek clarification if the proposed use of three categories of evidence would provide any conflict or controversy with the National Academy of Sciences, Engineering, and Medicine accepted four categories of evidence.

Mr. Chairman, this concludes DAV's testimony. Thank you for inviting DAV to submit testimony for the record of today's hearing. I would be pleased to address any questions related to the bills being discussed in my testimony.

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PREPARED STATEMENT FROM DANIEL ELKINS, LEGISLATIVE DIRECTOR, ENLISTED ASSOCIATION OF THE NATIONAL GUARD OF THE UNITED STATES AND THE VETERANS EDUCATION PROJECT

S. 123: ENSURING QUALITY CARE FOR VETERANS ACT

The Enlisted Association of the National of the United States (EANGUS) supports S. 123, Ensuring Quality Care for Veterans Act, which provides additional oversight over Veterans Health Administration's (VHA) appointees.

The Department of Veterans Affairs is one of the largest Federal agencies, and VHA's task is monumental in scope and need. We are therefore supportive of providing a contracted third party, independent of the Federal Government, to review VHA appointees who have had their license terminated for cause by a State licensing board for care or services rendered at non-VHA hospitals, and to review the quality of care provided to Veterans by such individuals. If it is found that the quality of care or services provided to Veterans fell below the standards of care, EANGUS agrees that such Veterans should be notified by the Secretary of VA.

S. 221: DEPARTMENT OF VETERANS AFFAIRS PROVIDER ACCOUNTABILITY ACT

The Enlisted Association of the National Guard of the United States is supportive of S. 221, Department of Veterans Affairs Provider Accountability Act.

Providing additional accountability to section 7401(1) employees will improve quality of care for Veterans, as current accountability measures do not go far enough to curb inadmissible conduct and poor performance of appointed employees. EANGUS believes VHA should have more power to discipline unacceptable behavior of 7401(1) employees, and extending additional recourses such as reporting to the National Practitioner Data Bank and State Licensing Boards will strengthen the accountability necessary to ensure quality of care for our Veterans.

S. 318: VA NEWBORN EMERGENCY TREATMENT ACT

The Enlisted Association of the National Guard of the United States currently does not have a stance on S. 318, VA Newborn Emergency Treatment Act.

S. 450: VETERANS IMPROVED ACCESS AND CARE ACT OF 2019

The Enlisted Association of the National Guard of the United States is supportive of S. 450, Veterans Improved Access and Care Act of 2019.

Currently, there are not enough VHA providers to care for our Nation's Veterans, and VHA providers are not yet geographically diverse enough for Veterans to receive appropriate care. The creation of a pilot program to expedite the hiring process of new providers to no longer than 60 days, and for this pilot program to focus on geographically diverse regions that face hiring shortages of providers, will do much

to meet the medical needs of Veterans. EANGUS believes this expedited onboarding process can be accomplished without compromising on necessary procedures, such as certifying the medical provider's credentials, performing a background check, assessing their health status, and other necessary actions that ensure these medical providers will provide the best care to Veterans.

S. 514: DEBORAH SAMPSON ACT

The Enlisted Association of the National Guard of the United States is supportive of S. 514, the Deborah Sampson Act.

Women Veterans are a growing population, and currently VA facilities and staff are not equipped to provide quality care necessary for women Veterans. This legislation plans to improve women Veterans transition and care in commonsense ways, like providing additional legal counsel, improved VA care and updated facilities, and better data tracking and analysis. EANGUS applauds that this legislation provides preventative measures against homelessness, unemployment, and lack of health care with expanded transition programs, and plans to implement specialized program managers for women Veterans at VA facilities.

S. 524: DEPARTMENT OF VETERANS AFFAIRS TRIBAL ADVISORY COMMITTEE ACT OF 2019

The Enlisted Association of the National Guard of the United States does not have a stance on S. 524, Department of Veterans Affairs Tribal Advisory Committee Act of 2019.

S. 711: CARE AND READINESS ENHANCEMENT FOR RESERVIST ACT OF 2019

The Enlisted Association of the National Guard of the United States is highly supportive of S. 711, the Care and Readiness Enhancement for Reservist Act of 2019.

Of the nearly 20 Veteran suicides daily, on average five are from the Reserve components, and three have never been federally activated, and are ineligible to receive VA mental health care. EANGUS is currently in the process of finalizing a Memorandum of Agreement with VHA to combat suicide in the National Guard and Reserve components, and we recognize that mental health care must be made available to these Servicemembers, regardless of their Veteran status. The Care and Readiness Enhancement for Reservist Act of 2019 provides the legislative fix necessary to care for these overlooked Servicemembers who are currently unable to receive the mental health care they deserve.

S. 746: DEPARTMENT OF VETERANS AFFAIRS WEBSITE ACCESSIBILITY ACT OF 2019

The Enlisted Association of the National Guard of the United States is generally supportive of S. 746, Department of Veterans Affairs Website Accessibility Act of 2019.

It is important that disabled Veterans be able to navigate the various websites of the Department of Veterans Affairs and be able to access the information they need. However, we believe that VA should consult with various Veteran Service Organizations while updating their websites, and should not neglect the vast amount of expertise these organizations can provide VA in order to make sure these updates do not create new problems for Servicemembers and Veterans.

S. 785: COMMANDER JOHN SCOTT HANNON VETERANS MENTAL HEALTH CARE IMPROVEMENT ACT OF 2019

The Enlisted Association of the National Guard of the United States is generally supportive of S. 785, Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019.

EANGUS encourages the exploration of alternative treatment options and partnering with non-VA mental health providers, but desire to see these treatments and care extended to National Guard and Reserve members who have never been federally activated.

Section 101, Expansion of Health Care Coverage for Veterans, uses the limiting term of "active service," that only applies to active duty or full-time National Guard duty. We ask that the Committee change the proposed insert to Section 101, "(B) to any veteran during the one-year period following the discharge or release of the veteran from active military, naval, or air service; and" be changed to insert after the word service "and active status; and" which would include reserve component members leaving a participating reserve position as defined by Title 10, Section 101.

We are highly supportive of tracking suicide-related data, and disaggregating data by potential contributing factors, such as Traumatic Brain Injury and anxiety. Additionally, we support this legislation's aim to increase mental health assessments,

but desire to see mental health assessments provided during MEPS pre-examinations in order to identify at-risk applicants, and screen out high-risk applicants.

EANGUS supports this legislation, but we are concerned with the feasibility of its implementation. We suggest that it be implemented in incremental, achievable measures to evaluate its efficacy.

S. 805: VETERAN DEBT FAIRNESS ACT OF 2019

The Enlisted Association of the National Guard of the United States is supportive of S. 805, the Veteran Debt Fairness Act of 2019.

For a variety of reasons, including delays in processing dependency changes, and communication errors between IT systems, VA sometimes makes overpayments to Veterans. Because these payments are automatic and monthly, these overpayments add up significantly over time, and they are not the fault of the Veteran. The Veteran Debt Fairness Act of 2019 will limit VA's ability to recoup overpayments only when it is the fault of the Veteran, and VA may withhold no more than 25 percent of a Veteran's monthly benefit check—as opposed to withholding entire monthly checks from Veterans on fixed incomes. This provision safeguards Veterans and their families who depend upon their monthly benefits, while incentivizing VA to fix their erroneous data systems. Further, we support that this legislation requires VA to perform yearly audits in order to eliminate the systematic errors that cause overpayments.

S. 850: HIGHLY RURAL VETERAN TRANSPORTATION PROGRAM EXTENSION ACT

The Enlisted Association of the National Guard of the United States currently does not have a stance on S. 850, the Highly Rural Veteran Transportation Program Extension Act.

S. 857: INCREASE SPECIAL PROVISIONS FOR MEDAL OF HONOR RECIPIENTS

The Enlisted Association of the National Guard of the United States is highly supportive of S. 857, Increase Special Provisions for Medal of Honor Recipients. These heroes deserve all the recognition and support we can give, and increasing their monthly pensions to $3,000 monthly will do much to alleviate undue economic stress.

S. 980: HOMELESS VETERANS PREVENTION ACT OF 2019

The Enlisted Association of the National Guard of the United States is supportive of S. 980, the Homeless Veterans Prevention Act of 2019.

Alleviating economic stress for homeless Veterans and their dependents via Per Diem support allows for the exploration of permanent solutions, and ensures these Veterans have the ability to seek and access to further resources—whether that is mental, physical, or legal help. Private and public partnerships to provide legal counsel to homeless Veterans and their families provides another means of protection and stability, and will potentially prevent further homelessness among at-risk Veterans in the midst of financial or marital distress.

EANGUS recommends that National Guard and members of the Reserve components be disaggregated in collected data, as the nature of their homelessness differs from the active duty population. Understanding the differences between active duty population and the Reserve Component population will enable us to determine correlative factors that contribute to each population's homelessness, and to draft better legislation to strengthen preventative measures.

S. 1101: BETTER EXAMINER STANDARDS AND TRANSPARENCY FOR VETERANS ACT OF 2019

The Enlisted Association of the National Guard of the United States supports S. 1101, Better Examiner Standards and Transparency for Veterans Act of 2019.

When evaluated for disability ratings, Veterans should be confident their examiner is a licensed health care provider that is professionally qualified to conduct an accurate analysis and give trustworthy recommendations. Anything less would be an insult to these Veterans.

S. 1154: DEPARTMENT OF VETERANS AFFAIRS ELECTRONIC HEALTH RECORD ADVISORY COMMITTEE ACT

The Enlisted Association of the National Guard is generally supportive of S. 1154, the Department of Veterans Affairs Electronic Health Record Advisory Committee Act.

Generally, members of the National Guard are not seen at military facilities, and it becomes incumbent on National Guard members to ensure their medical records from civilian providers are placed in their military medical records—something rarely done. Our understanding is that, as GENESIS matures, the plan is for it to include the EHR from several private commercial health plans for even more access to civilian medical records by DOD and VA. It must include Guard and Reserve members to be effective. EANGUS therefore recommends that National Guard and Reserve Component be represented on the EHR advisory committee to ensure that our members' medical records are properly integrated.

S. ___: JANEY ENSMINGER ACT OF 2019

The Enlisted Association of the National Guard of the United States does not have a stance on the Janey Ensminger Act of 2019.

S. ___: PAY EDUCATIONAL ASSISTANCE ETC.

The Enlisted Association of the National Guard of the United States is highly supportive of this yet untitled bill submitted by Senator Cassidy.

In the wake of multiple closures of institutions of higher education, Student Veterans have had no recourse for reimbursement, nor the necessary benefits to transition into another program. This piece of legislation will empower the Secretary of VA to continue to pay subsistence allowances and educational assistance for up to eight weeks, greatly aiding Student Veterans to weather temporary closures, or provide them the resources necessary to transition and persist at another institution of higher education.

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LETTER FROM CAROL WILD SCOTT, ESQ., LEGISLATIVE AND VETERANS AFFAIRS CHAIR, VETERANS & MILITARY LAW SECTION, FEDERAL BAR ASSOCIATION

FEDERAL BAR ASSOCIATION.

Hon. JOHNNY ISAKSON, *Chairman,*
Hon. JON TESTER, *Ranking Member,*
*Committee on Veterans' Affairs,*
*U.S. Senate, Washington, DC.*

RE: COMMENTS ON S. 785

DEAR CHAIRMAN ISAKSON AND RANKING MEMBER TESTER: The Veterans & Military Law Section (V&MLS) of the Federal Bar Association respectfully submits the following comments for the record on this important legislation addressing the improvement of mental health care provided by the Department of Veterans Affairs (VA). V&MLS asks the Senate Committee on Veterans' Affairs to review and then respond to our carefully crafted recommendations to improve and enhance S. 785, a bill V&MLS strongly supports.

For several years, V&MLS has brought our concerns to Congress regarding the diminished availability of VA programs, benefits, and health care to Native American veterans, particularly those located on or near tribal lands in rural areas. We are pleased to see the inclusion of Native American veterans in S. 785.

V&MLS recommends the inclusion of Native Americans should be specific in several provisions of the legislation. This is of paramount importance because veteran suicide in Indian Country is largely unidentified. V&MLS understands that VA keeps no record of Native American veteran suicides. As a result, this vital information is not included in VA's national statistics. We believe that tracking mental health care and suicide among Native American veterans, including for those with other than honorable discharges is crucial, as they appear to be more prevalent among Native American veterans.

We also believe that it is essential for VA to do much more than VA currently does to provide prompt access as well as to furnish culturally competent health and mental health care to this underserved segment of the veteran community. Thus, V&MLS recommends the following changes to the bill, as shown in italics:

COMMENTS FOR TITLES I–IV:

Title I, Sec. 104(c)(iv) (Add: *"including identified tribal reservations;"*
Title II, Sec. 1720J(b)(4) (Add: *"(v) to coordinate and tailor culturally competent mental health needs of Native American veterans*.
Title II, Sec. 204(a) (Add a provision that requires the development, in partnership with Indian Health Service, Tribal Health Systems and Bureau of Indian Af-

fairs metrics for identifying and tracking Native American veteran suicide on tribal lands.)

Title II, Sec. 205(b) [Renumber (5) as (6) and insert (5) *Traditional Native American healing*.]

Title II, Sec. 206(c)(2) [Add: *"(3) or has received health care through IHS or a Tribal Health System (THS) during the two year period preceding the initial participation of the veteran in the program"*]

Title III Sec. 301(b) [Add: "(3) *or has received health care from IHS, a THS during the two-year period preceding the initial participation of the veteran in the program*]

Title III Sec. 304(b)(1) [Add: *"(E) Ethnic gender-specific risk factors for suicide and suicide ideation; (F) Ethnic gender-specific treatment efficacy for depression and suicide prevention; (G) Gender-specific efficacy of Native American traditional healing when provided for Native American veterans*]

Title III Sec. 304(b)(2)(A) [Renumber (x) as (xi) and insert: *(x) Traditional Healing for Native American veterans.*]

Title IV Sec. 401(b)(2) [Add: to (A): "...including Native American tribal lands."]

Title IV Sec. 405(b) (1) (Add: *"and culturally competent tradition-based mental health care."*)

Title IV Sec. 405(b)(2)(D) (Add: *"and culturally competent tradition-based mental health care."*) with conforming additions to (D)(i) and (ii). Include as well the addition of *"culturally competent tradition-based"* to (E)-(G).

Title IV Sec. 406(a)(2)(B)(iv) (Add: *"...including those of Native American servicemembers."*) with conforming addition to (a)(2)(C)(iv).

Title IV Sec. 406(a)(2)(E) (Add: *"including Native Americans."*

COMMENTS FOR TITLE V:

V&MLS believes the single greatest barrier to mental health care for Native American veterans is the nearly total lack of mental health professionals capable of delivering culturally competent mental health care on or near tribal lands. According to VA data, there are only 12 Native American psychologists employed by VA. V&MLS was unable to obtain data on the number of psychiatrists employed by VA. The majority of Native Americans, veterans or not, often seek care from traditional healers. However, VA medical providers and claims adjudicators do not recognize traditional care. It is critical to this population of veterans that VA actively recruit Native American mental health providers at all levels of licensure and recognize traditional healers and healing for both treatment and disability claim decisions.

Title V Sec. 502(a). (Add: "... a plan to address staffing shortages of psychiatrists and psychologists, *including Native American psychologists and psychiatrists...")*

Title V Sec. 504(a)(2)(B) (Add: *"to include Native American women"*)

Title V Sec. 504(a)(2)(C) (Add: "The number and proportion of women peer specialists *to include Native American women peer specialists...")*

Title V Sec. 504(c)(1) (Add: "...to hire additional qualified peer specialists who are women, *to include Native American women..."*

Sec. 7699(a) (Add: "In General-An individual, *including a Native American..."*

Title V Sec. 506(b)(1) (Add: "...other services provided at Vet Centers, *including those located on or mobile to tribal lands..."*

Title V Sec. 506(b)(2) (Add: "...for how outreach efforts can be improved, *including such efforts on tribal lands."*

Title V Sec. 506(b)(7) (Add: "...how better to reach those family members, *including those on tribal lands."*

Title V Sec. 507:

The reporting requirements on Readjustment Counseling Services (RCS) should include requirements for detailed accounts of efforts made to bring RCS treatment to tribal lands. V&MLS was present at Pine Ridge Reservation in May 2018, meeting with the Tribal Veteran Service Officer (TVSO) and local veterans when a mobile Vet Center vehicle arrived along with representatives from other VA programs and services. No one on the Reservation had ever seen any of these people or these VA programs before.

The poverty on or near many reservations and tribal lands because of the lack of a viable economy presents significant barriers to the ability to purchase fuel or even borrow transportation for a Native American Veteran to travel from the reservation to a VA facility for health care. With Vet Centers, it is possible to provide mental health care on tribal lands in settings comfortable for veterans who by and large do not trust U.S. Government. The Vet Centers should be

staffed with those able to provide culturally competent counseling and provide an opportunity for interface with Traditional Healers, which requires recruiting counselors with cultural skills.

Our recommendations are worthy of the Committee's attention because they impact hundreds of thousands of Native American Veterans. In 2017, VA's "Vantage Blog" noted that, "Native Americans serve in the military among the highest rate, per capita, compared to other groups . . . ." According to the 2010 Census, there were more than 150,000 American Indian and Alaska Native Veterans (Kevin Gover, Director, Smithsonian National Museum of the American Indian, *Huffington Post*, May 22, 2015).

The Veterans & Military Law Section of the Federal Bar Association is honored to provide the Committee with our comments on this vital legislation. The recommendations are the product of V&MLS only. In summary, we believe S. 785 provides a meaningful opportunity to provide for the development of culturally competent mental health care to Native American veterans who have earned VA care through their sacrifice and service to our country.

Respectfully submitted,

CAROL WILD SCOTT, ESQ.
*Legislative and Veterans Affairs Chair,*
*Veterans & Military Law Section.*

LETTER FROM FEDERATION OF STATE MEDICAL BOARDS SUBMITTED BY HON. CORY GARDNER, U.S. SENATOR FROM COLORADO


February 15, 2019

The Honorable Cory Gardner
United States Senate
354 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Gardner:

On behalf of the Federation of State Medical Boards (FSMB), I am writing to express our support of ***S. 221: Department of Veterans Affairs Provider Accountability Act.***

The FSMB applauds the noble mission and dedication of the VA in serving the nation's veterans, and believes strongly that veterans and their dependents deserve the same level of quality care and appropriate regulatory oversight and accountability that is available to the general public. The sharing of detailed information from the VA with the National Practitioner Data Bank (NPDB) and appropriate state medical board(s) to expediently and efficiently identify unsafe providers operating within the VA system as required in *S. 221* is an excellent step toward achieving this goal.

Improved sharing with the NPDB and state medical boards will significantly help the boards protect patients, both within and outside of the VA system. Providers who have been deemed unqualified or unsafe to practice by the VA should not be allowed to practice outside of the VA, nor be able to conceal their disciplinary actions with discreet settlement arrangements. Proper notification of provider disciplinary proceedings will help ensure that unsafe and dangerous physicians are not allowed to treat patients outside of the VA.

Founded in 1912, the FSMB is the national non-profit organization representing the 70 state medical and osteopathic boards of the United States, its territories and the District of Columbia. The FSMB serves as a resource and voice on behalf of state medical boards and provides services and initiatives that promote patient safety, quality health care and regulatory best practices.

The FSMB is pleased to offer its strong support for *S. 221*, which will improve the quality and safety of health care both within and outside of the VA system. We commend you and Senators Manchin, Moran, Collins and Cassidy for your bipartisan leadership on this important issue and welcome the opportunity to work with you and Congress in support of the *Department of Veterans Affairs Provider Accountability Act*.

Sincerely,

Humayun Chaudhry, DO, FACP
FSMB President and CEO

LETTER FROM ALIE MUOLO, STAFF ATTORNEY AND MICHELE LEVY, MANAGING ATTORNEY, HOMELESS ADVOCACY PROJECT

HAP
HOMELESS ADVOCACY PROJECT
"..Legal Aid to break the cycle of poverty and homelessness"

1429 Walnut Street, 15th Floor
Philadelphia, PA 19102
(215) 523-9595
(800) 837-2672
Fax: (215) 523-9599
Email: info@haplegal.org
www.haplegal.org



May 22, 2019

The Honorable Johnny Isakson
Chairman
U.S. Senate Committee on Veterans Affairs

The Honorable Jon Tester
Ranking Member
U.S. Senate Committee on Veterans Affairs

*Re: S.980, the Homeless Veterans Prevention Act of 2019*

On behalf of the Homeless Advocacy Project (HAP), a non-profit organization that provides free legal services to homeless veterans in Philadelphia, we write to express our full support for Section 3 of S.980, the Homeless Veterans Prevention Act of 2019 (HVPA).

For the last 20 years, HAP has provided civil legal services to countless homeless veterans in Philadelphia. As a result, HAP attorneys know firsthand that civil legal aid is an indispensable component to ending veteran homelessness. The harsh reality, however, is that veterans lack access to critical civil legal services because the resources allocated to this population are inadequate. By passing HVP A, however, the VA can partner with legal service providers to ensure that veterans have access to skilled attorneys dedicated to resolving the legal issues that perpetuate their homelessness.

In 2012, HAP and the Philadelphia VA Medical Center (V AMC) began exploring a partnership, at the VAMC's request, to establish a free legal clinic onsite at the VAMC to serve its patients receiving medical and psychiatric care. In particular, VAMC staff wanted HAP to offer veterans access to legal representation in HAP's highly successful SOAR (SSI/SSDI Outreach, Access and Recovery) Project, a program intended to expedite and increase access to Supplemental Security Income and/or Social Security Disability Insurance for disabled adults who are homeless or at risk of homelessness. The HAP/VAMC legal clinic, however, hit a wall due to VA restrictions on financially supporting free legal services. Fortunately, HAP subsequently secured a two year grant from the Independence Foundation, a private foundation dedicated to supporting the work of organizations that provide free legal aid to underserved populations.

With the Foundation's financial support, HAP established a free legal clinic for homeless veterans at the VAMC in September 2014.

Throughout the two year grant, HAP collaborated with VA social workers and medical providers to provide a holistic approach to addressing the legal needs of homeless veterans in Philadelphia, especially their need to secure mainstream income supports (SSI and SSDI) to prevent or resolve their housing instability. HAP's first SOAR case from its VAMC legal clinic involved an Army veteran who suffered from Post-Traumatic Stress Disorder. While he was stationed at Fort Bragg, the infamous Jonestown Massacre occurred. In response to the mass suicide, the United States sent military personnel to assist in the bagging and loading of over 900 bodies to be sent back to the United States. This veteran volunteered to assist with the military cleanup and the horrific images he witnessed greatly impacted his mental health. Within just one month of our initial meeting, HAP secured SSDI benefits for this veteran via SOAR. With this income, this homeless veteran rapidly secured stable housing and was better able to focus on his mental health treatment and recovery from the trauma he experienced in the military. He is now employed at the Free Library of Philadelphia. While this particular veteran stands out as an example of the importance of free legal representation for homeless veterans, his story is not unique. For the last 20 years, HAP attorneys have been successfully representing homeless veterans in cases ranging from landlord/tenant disputes and expungements to VA Compensation claims for veterans who experienced the traumas of war or sexual assault.

When HAP initially applied for private foundation funding to establish its VAMC legal clinic, S.825, the Homeless Veterans Prevention Act of 2013, was introduced in the Senate. We were hopeful that the bill would pass so that we could seamlessly extend our services at the VAMC at the completion of the grant period. Despite its success and overwhelming need, however, once the Independence Foundation grant ended and without VA support, HAP was forced to drastically reduce its legal services offered at the Philadelphia VAMC. From a monthly legal clinic, HAP is limited to holding a legal clinic at the VAMC only 4 times annually. Consequently, we are serving far fewer veterans in need of legal representation.

Nearly six years after our initial optimism, we are hopeful that Congress will now pass Section 3 of S.980, the Homeless Veterans Prevention Act of 2019. Our veterans, especially those experiencing homelessness and suffering from a myriad of mental health and physical impairments, deserve no less.

Thank you for your leadership on this important issue. If you have any questions concerning the Homeless Advocacy Project or the legal services we provide to homeless veterans in Philadelphia, feel free to contact Alie Muolo at (215) 523-9579 or amuolo@haplegal.org.

Sincerely,

Alie Muolo
Staff Attorney

Michele Levy
Managing Attorney

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PREPARED STATEMENT OF THE INSTITUTE FOR VETERANS & MILITARY FAMILIES
SYRACUSE UNIVERSITY, SYRACUSE, NY

The Institute for Veterans and Military Families (IVMF) at Syracuse University is grateful to Chairman Isakson, Ranking Member Tester, and the Members of the Committee for the opportunity to submit written testimony on the subject of S. 785 or, be it enacted, the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019.

Over the past decade, the research and programmatic efforts of the IVMF have generated actionable insights into the social and economic determinants of veteran health and wellness, particularly as impacted by the servicemember's lived experience navigating the transition from military to civilian life. For that reason, it is our position that those insights are uniquely positioned to inform the focus and substance of the Act as currently proposed. It is our hope that this testimony contrib-

utes to your ongoing efforts to meaningfully address the critically important issues impacting the transition from military to civilian life—and by doing so, advance the mental and physical well-being of our Nation's veterans.

Today the IVMF operates vocational and community coordination programs across the United States, designed to complement public-sector efforts in support of a holistic transition from military to civilian life for our servicemembers, veterans, and their families. Each year more than 25,000 servicemembers, veterans, and their families leverage IVMF programs as a means to navigate the transition out of uniform and toward civilian careers, schools, and communities. Those programs include interventions designed to support business ownership, career preparation, vocational skills training, and also the effective and efficient provision of social services within the communities our veterans call home.

Importantly, all IVMF programs are available to servicemembers, veterans, and their families without any financial barriers to access. It is through the generosity of the IVMF's corporate and foundation partners—such as JPMorgan Chase, the Schultz Family Foundation, First Data, Walmart, USAA, and many others—that we're able to design and deliver our vocational and community coordination programs without any cost to those who benefit.

Most simply, acting on the opportunity to enhance and improve the transition experience for servicemembers and their families *is the mission* of the IVMF. For that reason, we have leveraged the academic resources of Syracuse University and other partners, to conduct extensive research related to the social, cultural, and economic factors that impede or enhance the transition from military to civilian life.

One consistent finding from that research is a clear and enduring linkage between the lived transition experience of servicemembers and their families, and the overall mental and physical health of the veteran, both during and long-after transition.

For example, recent findings from the annual Blue Star Families Military Family Lifestyle Survey, conducted in partnership with the IVMF, suggests a strong relationship between transition experience, preparation for transition, and stress. Specifically, this research illustrates a strong correlation between the transition experience and mental distress (i.e. stress), which is heightened in instances where planning and time pressures are compressed. High levels of stress, in turn, significantly compromise mental health. This is likely why complementary research demonstrates higher rates of suicidal ideation among veterans within five years of military separation, as compared to populations five or more years removed from the transition experience.

In short, our research—and related research conducted by others—demonstrates clearly that 'getting transition right' is central to mitigating those factors likely to otherwise compromise long-term wellness and mental health among veterans. Alternatively, a negative transition experience is highly likely to set a veteran (and the veteran's family) on a trajectory of compromised wellness and mental health, from which it is often exceedingly difficult to recover.[1]

For this reason, it is our position that the substance and intent of the proposed legislation must be framed in the context of the lived transition experiences of veterans and military families. Such a framework is most likely to generate actionable strategies, best positioned to positively impact long-term mental health outcomes for our community.

Accordingly, our programmatic and research experiences suggest three areas of focus most strongly aligned with enhancing the transition experience, in a way that powerfully undercuts the social and economic factors demonstrated by research to erode the mental health of transitioning servicemembers and veterans. Those three areas of focus, we suggest to be critical to consider relative to the intent and administration of S. 785 as proposed, are as follows:

1. Support for effective and efficient navigation—by or on behalf of the veteran—to public and private sector resources positioned to bolster the economic and social determinants of wellness and mental health.
2. Enhanced access to educational and vocational services and supports—before, during, and after transition—most strongly aligned with post-service job and career opportunity.
3. Purposeful and robust pathways connecting veterans and their families to the communities in which they live, work, and raise their families.

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[1] Sonethavilay, H., Maury, R. V., Hurwitz, J., Linsner Uveges, R., Akin, J., De Coster, J. L., & Strong, J. D. (2018). Military Family Lifestyle Survey. Blue Star Families. Retrieved from https://bluestarfam.org/survey

In what follows we address each area of focus, and the associated implications for S. 785 or, be it enacted, the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019.

ISSUE AREA 1:

*Support for effective and efficient navigation to public and private sector resources, positioned to bolster the economic and social determinants of wellness and mental health.*

A major study conducted by the IVMF and focused on the transition experiences of more than 8,000 servicemembers, found that effective and efficient navigation of available services, resources, and benefits to be the most commonly cited challenge associated with the transition from military to civilian life.[2] Further, robust data generated by the IVMF's AmericaServes initiative highlights that nearly half of those who transition experience co-occurring needs for transition support—needs that typically require assistance from multiple providers and across multiple sectors and domains (e.g. employment and education; health and transportation).

The issue of co-occurrence is critically important to acknowledge and understand in the context of any legislation proposed for the purpose of enhancing mental health outcomes for veterans and their families. This is because any clinical mental health intervention is most effective when aligned with quality housing, financial stability, social connectivity, and employment supports.[3] Importantly, it is often the case that such complementary services and supports ARE ALREADY FUNDED AND IN PLACE within the communities our veterans call home, however those resources are too often unknown or inaccessible to veterans.

In fact, this insight represents the seminal premise of the IVMF's AmericaServes program; that is, the recognition that the physical and mental health of our veterans is impacted in ways that go beyond clinical care, but extends to the many social determinants of health and mental well-being. These social determinants include meeting basic needs (food, shelter), vocational success and fulfillment, and regaining positive connections with family, friends, and the broader community, among others.

Importantly, acknowledging these co-occurring needs is, by itself, insufficient.

Instead, government, industry, and non-profit partners must act with intent to support effective and efficient navigation to public and private sector resources, positioned to bolster the economic and social determinants of health and mental well-being. The IVMF's AmericaServes program, and other initiatives like AmericaServes, represent practical validation of this premise.

Today, in 17 communities across the U.S.—including New York City, Pittsburgh, Charlotte, San Antonio, and Dallas—AmericaServes provider networks represents the backbone infrastructure supporting effective and efficient navigation to public and private sector resources aligned to advance social, economic, and wellness outcomes for veterans and their families. To date, more than 25,000 veterans have registered more than 52,000 requests for community-connected, human service support (spanning 20 health and human service categories) through the navigation and care coordination infrastructure provided by the AmericaServes network.

All of this is to assert that, for the intent of the proposed legislation to be realized, it is critical to consider the means and mechanisms appropriate to empower those veterans seeking care and services, to efficiently and effectively navigate the full complement of services and supports available to them.

*Summary Conclusion:* As drafted, S. 785 includes (Title II) funding for robust and meaningful tools that undercut the crisis of veteran suicide, such as grants to local providers, feasibility studies related to complementary mental health services, and new interventions including outdoor therapy. Yet, as currently drafted, S. 785 could include a greater acknowledgement—and therefore practical focus—related to the persistent challenges cited by veterans associated with navigation and coordination, in the context of the holistic provision of wellness, mental health, and associated social services.

Most simply, to maximize the efficacy and impact of the investments detailed in S. 785 as currently drafted, our research and practical experience suggest that it is

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[2] Maury, R. & Zoli, C. (November 18, 2015). Missing perspectives: servicemembers' transition from service to civilian life. *The Institute for Veterans and Military Families.* Retrieved May 17, 2019 from https://ivmf.syracuse.edu/article/missing-perspectives-servicemembers-transition-from-service-to-civilian-life/

[3] The Institute for Veterans and Military Families. (December 2018). A case for patient philanthropy, supporting jobs and careers for military-connected americans. Retrieved May 17, 2019 from https://ivmf.syracuse.edu/wp- content/uploads/2019/02/Schultz-Report_A-Case-for-Patient-Philanthropy-1.31.19.pdf

imperative to engage local community and government organizations, capable and willing to provide care coordination and navigation services at the community level. The objective of such a focus should be to transparently connect veterans experiencing compromised mental health, to local providers representing the full spectrum of human service categories. Examples of how this engagement could proceed include incorporating specific grant funding to support care coordination and navigation services in local communities; making funding accessible to local government to support city and or county-level care coordination; and funding for community-level resource mapping, aligned with the objective of enhancing information available to veterans related to the full spectrum of public, private, and non-profit providers of social and human services within a given community.

ISSUE AREA 2:

*Enhanced access to educational and vocational services—before, during, and after transition—aligned with post-service jobs and careers*

Another opportunity, often less understood in the context of efforts to enhance mental health outcomes for veterans, relates to the importance of employment and associated vocational training at the time of transition. The consequences of unemployment and under-employment for the veteran and his or her family, particularly immediately following the transition to civilian life, are profound and well-documented.

For example, unemployment or underemployment at the time of transition has been demonstrated to undermine the long-term financial health of the family unit, contribute to marginalized health outcomes, and has even been linked to an increased rate of suicidal ideation among veterans.[4] [5] The IVMF's research has contributed to this strongly supported finding, particularly as situated in the post-9/11 generation of veterans and military-connected families.

For example, research conducted jointly between Blue Star Families and the IVMF recently found that 16% of veteran respondents who were not currently working, but were seeking employment, reported (serious) suicidal ideations in the past year. This compares to 7% of those who were currently working full-time (who seriously considered suicide in the past year), 8% of those working part time, 9% of those who were not currently working and not seeking employment, and 7% of those who were retired.[6]

Veteran unemployment is low, but some research suggests that the economic and financial gains of military families may be slowing.[7] In fact, employment data alone reveals very little about the nature of the employment secured by those veterans who are successful finding work after service. In truth, a great many veterans find themselves underemployed with respect to their level of skill, experience, and education.[8] Further, recent studies reveal that more than 50% of veterans leave their first job after the military within a year, suggesting a sub-optimal employment transition with regard to issues of 'fit.'[9]

Given the compelling relationship between employment and mental health, it is imperative that we remain focused on the importance of employment and associated vocational training at the point of transition. While approximately 65% of veterans report participating in the Transition GPS or some type of government- sponsored transition programming, only half (50%) of those who attended felt that the pro-

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[4] Ibid.

[5] Kline, A., Ciccone, D., Falca-Dodson, M., Black, C. & Losonczy, M. (December 2011). Suicidal ideation among national guard troops deployed to iraq: the association with postdeployment readjustment problems. *The Journal of Nervous and Mental Disease*. Volume 199 Issue 12 pp. 914–920. Retrieved May 17, 2019 from https://journals.lww.com/jonmd/Abstract/2011/12000/Suicidal_Ideation_Among_National_Guard_Troops.4.aspx

[6] Sonethavilay, H., Maury, R. V., Hurwitz, J., Linsner Uveges, R., Akin, J., De Coster, J. L., & Strong, J. D. (2018). Military Family Lifestyle Survey. Blue Star Families. Retrieved from https://bluestarfam.org/survey

[7] Hosek, J. & Wadsworth, S. (Fall 2013). Economic conditions of military families. *The Future of Children*. Retrieved May 17, 2019 from https://www.questia.com/read/1G1–349721081/economic-conditions-of-military-families

[8] Barerra, Cathy and Phillip Carter. *Challenges on the Home Front: Underemployment Hits Veterans Hard*. Santa Monica, CA: The Call of Duty Endowment, 2017. Retrieved at https://d3n8a8pro7vhmx.cloudfront.net/callofduty/pages/1236/attachments/original/1510192920/ZipCODE_Vet_Report_FINAL.pdf?1510192920.

[9] Maury, Rosalinda V., Brad M. Stone, Deborah A. Bradbard, Nicholas J. Armstrong, and J. Michael Haynie. Workforce Readiness Alignment: The Relationship Between Job Preferences, Retention, and Earnings. (Workforce Readiness Briefs, Paper No. 3). Syracuse, NY: Institute for Veterans and Military Families, Syracuse University, August 2016. Retrieved at https://ivmf.syracuse.edu/wp-content/uploads/2016/08/USAA_paper3_8.30.16_REVISED_digtial.pdf.

gramming prepared them to successfully transition from active duty to civilian life.[10]

The IVMF's Onward to Opportunity (O2O) represents a blueprint for what is possible when public-private partnership is positioned to address the relationship between post-service jobs and careers, and veteran health and well-being.

The O2O program is a first-of-its-kind transition initiative, built to support a holistic approach to post-service career preparation, search, and placement. The O2O model supports participant access to specialized training and certification opportunities—both in-residence at 18 military installations, and online—representing 32 in-demand learning pathways, and a network of more than 800 post-training partners and employers across the United States and the globe. Today the O2O program represents the largest national footprint among the DOD approved Career Skills Programs. Specifically, since the program's inception in 2015, the O2O program has served as a pathway to jobs and careers for more than 13,000 veterans, transitioning servicemembers, and spouses, and supported thousands more to higher-education and vocational training.

Most simply, the intent of the O2O program is to complement TAP GPS, in a way that is aimed at improving the long term career trajectory of our veterans. Certifications like project management, cybersecurity and IT provide participants with actionable skills training that will improve their immediate job marketability and set them up for long term employment success.

A long-term focus on employability at transition—made possible by programs such as Onward to Opportunity—is critically important both for the veteran, and for all Americans.

Current projections related to the costs associated with veteran's benefits—to include unemployment compensation—are expected to exceed $1 trillion.[11] Moreover, given the strong linkage between employment and wellbeing, this estimate would trend significantly higher in the face of any extended period of economic depression, which would in turn create an additional financial burden on the Department of Veterans Affairs, private health care systems, and on other Federal supportive services.

Most simply, sustained and meaningful employment represents a seminal building block supporting a happy and healthy post-service life. Given purposeful efforts to address moralized mental health and suicide among veterans, it is therefore important to assume a broad view of the means and mechanisms positioned to bolster mental health outcomes associated with the veterans' community.

That broad view must include enhanced access to educational and vocational services aligned with post-service jobs, careers, and long-term employability. Without qualification, employment represents a central pillar supporting the foundation of mental wellness during and after the transition to civilian life.

*Summary Conclusion:* Title I of this Act, focused on improvement of transition experience for veterans, offers an opportunity to draw a legislatively mandated connection between improved mental health and quality employment transition programs. Our experiences have shown us that quality employment programs are also suicide prevention programs. As drafted, section 103 calls for a study of community-based transition programs. While this is an important step, the opportunity for more immediate action is real and should be considered by the Committee.

Mental health related dollars would be best directed for impact, in those instances where funding is aligned with complementary efforts to support long-term employability of veterans, in the face of a rapidly changing workforce. We emphasize the role of non-public organizations because government services can be even more effective when enhanced and supplemented by the ecosystem of other service providers.

Specifically, the Committee should explore opportunities to work with the Committee on Armed Services to assess and, where appropriate, expand the current SkillBridge authority as a strategy to enhance connections between veterans, employers, and those non-public entities already equipped to deliver employment services to veterans and their families; create new and enhanced access to TAP GPS for the Nation's employers; incorporate grant opportunities to expand the scale and scope of those non-public entities already equipped to deliver employment services to veterans and their families; and mandate and fund a longitudinal study focused on informing the relationship between TAP GPS and related access to employment programs, and the long-term mental health situation of veterans and their families.

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[10] Sonethavilay, H., Maury, R. V., Hurwitz, J., Linsner Uveges, R., Akin, J., De Coster, J. L., & Strong, J. D. (2018). Military Family Lifestyle Survey. Blue Star Families. Retrieved from https://bluestarfam.org/survey

[11] Bilmes, Linda J. (2016). A Trust Fund for Veterans. Democracy 39, no. 16 (2016).

ISSUE AREA 3:

*Purposeful and robust pathways connecting veterans and their families to the communities where they live, work, and raise their families*

Less acknowledged in the context of both veterans policy and public discourse, is the fact that our post-9/11 wars are the first in the Nation's history to be shouldered by a military composed entirely of volunteers. One consequence of that fact is a real and significant social and cultural divide, present between those who have served, and those who have not. This "civilian-military divide" serves to, in insidious ways, foster among some veterans a feeling of social isolation and disconnectedness. Social disconnectedness, in turn, is powerfully and directly linked to compromised mental health and suicide among veterans.

Decades of scholarly research highlight how and why enhancing social connectedness—for all people—correlates directly to enhanced mental and even physical health. Research specifically situated in the veterans' community demonstrates that social and community connectedness during transition is strongly associated with the quality of a veteran's mental health. This is true even among servicemembers long out of the military, indicating that transition experiences, particularly tied to one's sense of belonging to broader community, have a long-term impact on health and well-being.[12]

Too often, well-intentioned policy fails to leverage opportunities to purposefully engage the community of non-public sector providers, for the specific purpose of 'building community' in a way that fosters social and community connectedness among veterans. With approximately 45,000 nonprofit organizations serving veterans and military families—and tens of thousands more providing social services to the general public—a tremendous opportunity exists for the private and independent sectors to work in partnership with government on the issue of enhancing social connectedness in support of the wellness needs of veterans and their families.[13]

For veterans, effective interventions supporting social connectedness must be rooted in their communities, alongside an integrated continuum of supportive services. Yet, we know from research and practice that these and other services are often fragmented and siloed. We also know that many community-based organizations and service providers lack the ability to offer culturally competent care to veterans in their community, simply because the opportunity to learn and understand the military service experience isn't broadly available to many of those who would otherwise act in support of this community.

Any and all efforts to improve transition—and to improve veteran mental health outcomes—must be foundationally grounded in support for community-based organizations and service providers, so as to enable those organizations and providers to offer culturally competent care and better integrate and coordinate their activities across a culturally competent continuum of supportive services in the places where our veterans live, work, and raise their families. When providers and communities are able to create a culturally competent continuum of supportive services, such action fosters trust, connectedness, and enhanced mental and physical health.

*Summary Conclusion:* There is an extensive ecosystem of providers across the country equipped to serve veterans and improve their mental wellness. As drafted, this legislation makes considerable investment in new public sector programs, delivered through the VA, and developing the workforce needed to deliver them. While this enhanced support is needed and appropriate, it must be paired with focused effort to leverage and maximize existing capacities of local providers across the country.

It is our recommendation that investment focused toward enhancing the clinical workforce equipped to deliver service through the VA, should be complemented with investments positioned to educate and engage non-public sector providers—specifically those entities and organizations who offer services and supports positioned to foster social and community connectedness among veterans. Doing so would prove cost effective over the long-term, and generate enduring gains related to the mental health of our veterans.

In practice, this suggests the current legislation should consider mechanisms to incentivize local providers to bridge there services and supports to veterans in their community; enhanced opportunity for community organizations and non-profit providers to access military cultural competency training; enhanced opportunity for em-

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[12] Ibid.

[13] Government Accountability Office. (April 2014). 2014 annual report: additional opportunities to reduce fragmentation, overlap and duplication and achieve other financial barriers. GAO–14–343. Retrieved May 17, 2019 from https://www.gao.gov/assets/670/662327.pdf

ployers and educational institutions to engage veterans and their families prior to and during the transition to civilian life; a purposeful public information campaign, targeted toward human service providers and local governments, focused on the opportunities associated engaging veterans across the spectrum of community issues and concerns.

CONCLUSION

In conclusion, on behalf of the veterans and military-connected families we serve in partnership with this Committee, thank you for the opportunity to provide written testimony on S. 785, be it enacted, the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019.

Our testimony reflects the accumulated insights of our research and programmatic experience, supporting the transition experience of veterans and their families over the past decade. Those learnings suggest that central to any holistic strategy positioned to support the overall mental wellbeing of our veterans, are effective and efficient navigation to community-connected wellness and mental health resources, enhanced access to educational and vocational services and supports, and accessible pathways connecting veterans and their families to their communities.

To that end, grant-making represents a powerful mechanism of the Federal Government related to driving community action on an issue such as mental health and suicide prevention. Federal grants like Supportive Services for Veteran Families (SSVF) can serve as a model for how Federal action can empower communities to act—with intent and accountability—related to impacting this nationally important issue.

In that vein, we respectfully suggest that S. 875 can be further enhanced by grant funding opportunities beyond clinical interventions, to include expanded access to complementary human services and vocational supports, and also innovations enhancing community-connected care coordination and navigation. An investment of this type will enhance and extend the impact of funds directed to clinical mental health interventions, and most importantly best serve the enduring health and wellness concerns of our veterans and their families.

## LETTER FROM NEAL LOIDOLT, PRESIDENT/CEO, MINNESOTA ASSISTANCE COUNCIL FOR VETERANS

MINNESOTA ASSISTANCE COUNCIL FOR VETERANS

SERVING VETERANS THROUGHOUT MINNESOTA

May 29, 2019

The Honorable Johnny Isakson
Chair, Committee on Veterans Affairs
United States Senate
Washington, D.C. 20510

The Honorable Jon Tester
Ranking Member, Committee on Veterans Affairs
United States Senate
Washington, D.C. 20510

RE: Support for S.980, the Homeless Veterans Prevention Act of 2019

Dear Chairman Isakson and Ranking Member Tester:

I write on behalf of the Minnesota Assistance Council for Veterans (MACV), an organization dedicated to ending veteran homelessness in Minnesota. Our housing services include legal aid programs. Because legal issues are inextricably linked to housing stability in homeless or at-risk veterans, I strongly encourage you to support the passage of S.980, the Homeless Veterans Prevention Act of 2019. This bill provides necessary tools to support our servicemembers as they transition back to the communities they served.

If passed, the Department of Veterans Affairs (VA) could "enter into partnerships with public or private entities to fund a portion of the general legal services… that are provided by such entities to homeless veterans and veterans at risk of homelessness." The bill highlights legal issues related to housing, family law, income support, and criminal matters. Each of these have been identified both in Minnesota and nationwide as among the top 5 legal issues faced by veterans through local surveys and the VA's own CHALENG report. And when veterans lack access to the resources to pay for an attorney, their risk of homelessness increases dramatically.

The Minnesota veteran community has benefited greatly from the legal aid services provided by veteran-specific legal support through counsel, legal clinics, and partnerships with legal professionals in the community. In 2018 alone, the MACV Vetlaw Program provided legal aid to over 2,200 veterans. Many of these veterans lacked access to legal services and protections afforded by the legal system when faced with challenges that threatened their housing and employment. As you are probably aware, preventing an episode of homelessness – whether through legal intervention or other services, acts to stabilize not just the veteran and their family but also the community they call home.

In many regions of the state, the Minnesota Department of Veterans Affairs has declared "functional zero" veteran homelessness. This is due in no small part to the accessibility of legal services. Financial support from the VA for legal aid will enable us to continue to end veteran homelessness and prevent veterans from becoming homeless once they are stably housed.

2700 E. Lake Street, Suite 3200, Minneapolis, MN 55406
OFFICE 612.726.1327 • FAX 612.200.9156
www.mac-v.org

Minnesota has found success in combating veteran homelessness by integrating legal services into its housing support model. Unfortunately, many communities simply do not have a legal aid network prepared to serve veterans experiencing housing crises. No matter which state you call home, an eviction is an eviction, child support needs to be paid, and somewhere, a veteran is in need of legal services that they cannot afford. In addition to bolstering preexisting legal aid organizations that serve veterans, the passage of the Homeless Veteran Prevention Act of 2019 would enable communities lacking legal aid services to partner with the VA and develop legal aid programs targeted at ending veteran homelessness.

MACV has demonstrated firsthand just how impactful the availability of legal aid is to housing stability among veterans. Given that each of the top five most common legal issues faced by the veteran community can be directly tied to housing, the continued need for veterans to have access to the legal resources to avoid homelessness is self-evident. We have made great progress but there is still significant work to be done to end veteran homelessness, and maintain functional zero once achieved, and legal services are critical to achieving this goal.

I respectfully encourage you to promote the passage of S.980, the Homeless Veteran Prevention Act of 2019, so that the VA can support the development of veterans' legal services. Your support puts our country one step closer to ending veteran homelessness for good.

Sincerely,

Neal Loidolt

Neal Loidolt
President/CEO
Minnesota Assistance Council for Veterans

Cc: Members of the Senate Committee on Veterans Affairs

2700 E. Lake Street, Suite 3200, Minneapolis, MN 55406
OFFICE 612.726.1327 • FAX 612.200.9156
www.mac-v.org

STATEMENT FROM MILITARY OFFICERS ASSOCIATION OF AMERICA

CHAIRMAN ISAKSON, RANKING MEMBER TESTER, AND MEMBERS OF THE SENATE COMMITTEE ON VETERANS' AFFAIR, The Military Officers Association of America (MOAA) is pleased to submit its views on pending veterans' legislation under consideration.

MOAA does not receive any grants or contracts from the Federal government.

EXECUTIVE SUMMARY

On behalf of the 350,000 members of the Military Officers Association of America, the largest military service organization representing the seven uniformed services, including active duty and Guard and Reserve members, retirees, veterans, and survivors and their families, thank you for holding this hearing and for your continued commitment to the Department of Veterans Affairs (VA) and support to our Nation's servicemembers and veterans and their families.

MOAA offers our position on the following bills:

- S. 318, *VA Newborn Emergency Treatment Act*
- S. 514, *Deborah Sampson Act*
- S. 711, *Care and Readiness Enhancement for Reservists Act of 2019*
- S. 746, *Department of Veterans Affairs Website Accessibility Act of 2019*
- S. 785, *Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019*
- S. 850, *Highly Rural Veteran Transportation Program Extension Act*
- S. 1154, *Department of Veterans Affairs Electronic Health Record Advisory Committee Act*
- DRAFT Bill, *Janey Ensminger Act of 2019*

The association recommends funding be appropriated to support any legislative provisions directing expansion of VA programs or services in the bills listed above, where funding has not been identified but will be required, or for the establishment of new programs and services not already provided for in VA's current and advance budget authorities.

MOAA takes no position on: S. 123, Ensuring Quality Care for Our Veterans Act; S. 221, Department of Veterans Affairs Provider Accountability Act; S. 450, Veterans Improved Access and Care Act of 2019; S. 524, Department of Veterans Affairs Tribal Advisory Committee Act of 2019; S. 805, Veteran Debt Fairness Act of 2019; S. 857, A bill to amend title 38, United States Code, to increase the amount of special pension for Medal of Honor recipients, and for other purposes; S. 980, Homeless Veterans Prevention Act of 2019; S. 1101, Better Examiner Standards and Transparency for Veterans Act of 2019; and, Draft Bill, A bill to amend title 38, United States Code, to extend the authority of the Secretary of Veterans Affairs to continue to pay educational assistance or subsistence allowances to eligible persons when educational institutions are temporarily closed, and for other purposes. These bills are outside of our scope of expertise or familiarity with the current state of the issues.

PENDING LEGISLATION

*S. 318, VA Newborn Emergency Treatment Act (Senator Patty Murray, D-Wash.)*

MOAA supports the legislation.

The association has long supported legislation to extend health care coverage to newborn children of women veterans. This bill would:

- allow VA to furnish medically necessary transportation for newborns,
- provide a waiver process for the extension of that care if there is a medical need,
- allow the Secretary to waive the current seven-day restriction on health care coverage, and
- close an existing gap to allow newborn coverage for mothers who delivered before they reached the hospital, who would otherwise qualify for the coverage.

MOAA is appreciative of the Committee's work in recent years to provide care and services for a growing population of women veterans who are of child-bearing age. This bill is not only critical to the long-term health of both the child and mother, but also will help new parents avoid the hardships and significant costs associated with delivery under emergency conditions.

The association would respectfully request the Committee consider adding to the bill an extension of care from the mandatory seven days to 14 days to cover all newborns. This change would align with S. 514, the Deborah Sampson Act, under

consideration by the Committee today and supported by MOAA and other veterans' organizations during the last two congressional sessions.

*S. 514, Deborah Sampson Act (Senator Jon Tester, D-Mont.)*

MOAA supports the legislation as we endorsed in the 115th Congress.

The measure would improve a number of services and benefits provided by VA to women veterans. Generally it would:

- expand group counseling and the department's women veterans call center capabilities,
- expand the number of days of maternity care, including newborn care, from seven to 14 days,
- increase staffing of gender-specific health care providers and training to non-VA community providers,
- retrofit existing medical facilities to improve privacy and environmental care conditions for women veterans, and
- increase grants for organizations supporting low-income women veterans, including legal services and additional resources for homeless women and their families.

While VA has worked hard in recent years to get ahead of the growing demand of women seeking health care in the department's medical facilities (at higher rates than their male peers), barriers still exist preventing women from accessing medical care or feeling welcomed and safe.

Eliminating these barriers will require additional funding and resources to implement massive system improvements and services in order to meet the current and future needs of women veterans. MOAA is pleased the Committee and VA continue to work hard to provide the authorizations and appropriations necessary to help the department succeed. This legislation starts to put in place the parameters and governance needed to monitor and evaluate VA's progress in addressing the needs of this unique veteran population.

*S. 711, Care and Readiness Enhancement for Reservists Act of 2019 (Senator Jon Tester, D-Mont.)*

MOAA supports the legislation.

The bill would expand eligibility for mental health services in VA for reservists of the Armed Forces. In consultation with the Department of Defense (DOD), the VA may furnish a comprehensive assessment and counseling to any member of the reserve components who has a behavioral health condition or psychological trauma. DOD may fund the needed care regardless of whether the reservist is within his or her pre-deployment window.

Guard and Reserve members also may access confidential VA readjustment counseling services, known as "Vet Centers," for mental health screening and counseling, employment assessments, education training, and other services to help them transition successfully back to civilian life.

MOAA considers this legislation critical and timely to addressing the mental health needs of the total force and not just active duty servicemembers. However, MOAA urges the Committee to expand the legislation to include servicemembers of all the uniformed services, as the U.S. Public Health Service and the National Oceanic and Atmospheric Administration Commissioned Corps also play a vital role in national security and emergency response efforts.

This legislation will complement VA's current efforts aimed at improving mental health care and support to Guard and Reserve members and help mitigate the rising rates of mental health conditions and suicides being reported in the reserve components.

*S. 746, Department of Veterans Affairs Website Accessibility Act of 2019 (Senator Robert Casey, D-PA.)*

MOAA supports the legislation.

The measure would require the Secretary to conduct a study of the accessibility of VA websites to individuals with disabilities.

MOAA and veterans service organizations (VSOs) continue to hear from veterans with disabilities, particularly those with hearing or visual impairments, about their difficulty accessing information, products, and services in a manner that helps them effectively communicate with VA in appropriate accessible formats. Accessing VA website information has frequently been a source of frustration to this population of veterans, who believe VA has not been able to keep up with the technological changes and/or has not devoted adequate resources to ensure compliance with Section 508 of the Rehabilitation Act of 1973, 29 U.S.C. 794d, which "applies to all Federal agencies when developing, procuring, maintaining, or using electronic and infor-

mation technology. Under Section 508, agencies must give disabled employees and members of the public access to information comparable to the access available to others."

The department would be required to conduct a study of all websites within 180 days after enactment of the Act and to submit a report to both the Senate and House Veterans' Affairs Committees, to include a list of websites not accessible to individuals with disabilities and a plan for bringing the sites into compliance or identifying barriers preventing VA from meeting the requirements of Section 508.

*S. 785, Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (Senator Jon Tester, D-Mont., and Senator Jerry Moran, R-Kan.)*

MOAA supports the legislation.

The association is grateful for this comprehensive and innovative piece of legislation aimed at improving mental health care delivered in the VA health system by:

- providing care for transitioning servicemembers,
- providing suicide prevention resources,
- launching programs and studies on mental health,
- increasing oversight of mental health care and suicide prevention efforts, and
- enhancing medical workforce and telehealth services.

MOAA is particularly pleased to see the incorporation of a variety of ideas and contributions from multiple stakeholders, including veterans' organization like ours, mental health awareness groups, and other advocacy organizations to produce this landmark bill.

As stated in our testimony at the Senate and House Veterans' Affairs Committee Hearing March 12, 2019, there is no doubt VA has made great strides in expanding its health care services to help veterans with mental health conditions. However, these efforts aren't enough to address the growing demand for mental health services and the frightening statistics related to veteran suicides.

This legislation is exactly what is needed to close existing gaps so VA can deliver the kind of wrap-around services and continuity of care so desperately needed by veterans suffering from mental health or traumatic conditions.

*S. 850, Highly Rural Veteran Transportation Program Extension Act (Senator Dan Sullivan, R-Ark.)*

MOAA supports the legislation.

This legislation would extend VA's authority to award grants to VSOs who provide transportation to veterans in highly rural areas.

Extending the program helps ensure coverage of underserved populations, including American Indians and Alaska Natives.

Additionally, transportation for aging veterans and those with disabilities continue to be a barrier to accessing care in VA. This legislation not only builds on the existing work the VA has undertaken to improve access for Native Americans and rural veterans but also supports the larger and growing population of aging veterans who not only have mobility issues but also are at or below poverty level or live on fixed incomes, preventing them from seeking critical health care services.

Currently, VA covers travel expenses for care at VA medical centers and community-based outpatient clinics. Vet Centers provide a critical capability within VA's health system, thus inclusion of these facilities for purposes of payment for beneficiary travel and allowances should also be a covered benefit for consistency and continuity of care throughout the system.

MOAA recommends funds be appropriated to support the extension of the program to continue providing grants to VSOs to help augment VA's current efforts to provide transportation to this unique population of highly rural veterans with special needs. We believe medical care and services, including associated travel expenses and allowances, are central components to opening up access and delivering high-quality health care to our veterans.

*S. 1154, Department of Veterans Affairs Electronic Health Record Advisory Committee Act (Senator Jon Tester, D-Mont.)*

MOAA supports the legislation.

This bill would require the establishment of an advisory committee to provide guidance to the Secretary and Congress on the implementation of the electronic health record (EHR) and the department's transition to the new system. Duties of the advisory committee include touring VA facilities as those medical centers begin using the electronic health record to analyze implementation and to solicit feedback from employees. MOAA believes it is important to ensure the voices of stakeholders, veterans, and other participants in the transition process of moving to a new EHR are heard and elevated to leadership.

We are encouraged and view this legislation as a positive step toward providing better accountability through enhanced stakeholder representation, which importantly includes clinical and technical expertise, as well as key VSOs. It is important to have a committed external audience reviewing the EHR implementation actions to help identify and mitigate risks for veterans.

MOAA believes successful transformation to a more veteran-centric health care system will only occur once VA fully implements and achieves an integrated, interoperable EHR system—something MOAA, Congress, and other veterans stakeholders have been pressing hard to achieve for two decades.

*Draft Bill, Janey Ensminger Act of 2019 (Senator Richard Burr, R-N.C.)*

MOAA supports the legislation.

This measure would require the VA to provide medical care for all diseases scientifically associated with exposure to toxic chemicals found at Camp Lejeune, N.C. The bill also requires the Agency for Toxic Substances and Disease Registry, an agency within the Centers for Disease Control and Prevention, to review all significant scientific literature every three years to determine if links have been found between toxic exposures found at Camp Lejeune and additional diseases and conditions.

Establishing a national center for research on the diagnosis and treatment of health conditions of the descendants of individuals exposed to toxic substances during service is a reasonable manner in which to collect information related to the long-term health effects of these exposures. An advisory board taking responsibility for advising the national center, determining health conditions that result from toxic exposure, and studying and evaluating cases of exposure is also a reasonable mechanism to ensure VA weighs the relevant evidence and information in its implementation and continued engagement.

CONCLUSION

MOAA greatly appreciates the hard work of the Committee in holding this hearing. We are especially grateful for your efforts in bringing forward legislation from previous years for consideration, and for introducing new bills—all aimed at improving the health and well-being of our uniformed servicemembers, veterans, and their family members. The association looks forward to working with the Committee to ensure swift passage of the bills through Congress.

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LETTER FROM JOHN P. MOSER, MSGT USAF (RET.) TO HON. SHERROD BROWN, U.S. SENATOR FROM OHIO

SENATOR BROWN, I wish to convey to you my personal interest in Veteran's Debt Fairness Bill.

My interest in this bill stems from 10 years of over payments by the VA totaling some $26,000. These over payments were the result of negligence by the VA regarding adjusting compensation due to concurrent receipt of Air Force Reserve Drill Pay and VA Compensation. I received the notices each year from Defense Manpower stating that I had served so many days and did I wish to waive my drill pay or my VA Comp. Each year I waived comp as it was considerably less than my reserve pay. Each year nothing would happen. The compensation was never adjusted and the VA never sent any notices stating they were going to adjust for concurrent receipt. After several years, multiple phone calls, etc., I gave up. I noticed on the "notice of concurrent receipt," a statement, which I took to heart. It stated, " Should we not receive your waiver request, we will assume you waive your VA compensation for the year and days indicated." It was then I decided that I do not need to waste my time, my commander's time, effort, etc. if the compensation was to be waived anyway. The compensation was never adjusted.

I retired in September 2015. After 23 years of faithful and honorable service, some 11 deployments (that I can remember), 50 combat and combat support missions in the Middle East, the VA determined that it was time to collect for every year I received concurrent benefits, 2005–2015. The debts/overpayments totaled some $26,000. $3000 or so was the result of an education benefit error on my part, which I accepted responsibility for and paid. In September 2016, the VA took my entire monthly benefit. I counted on that compensation for car payments. I had received a couple of letters/notices in the mail stating the benefit would be reduced and that I had an overpayment. Each notice of overpayment/debt was very confusing and difficult to understand. When I called the VA Regional office, they were of no help. I only grew more confused. In January 2018, I finally have a payment plan in place with Debt Management. It only took some 18 months to settle and the burden of

proof was 100% on me. Ironically, it only took the VA less than 60 days to start garnishing my compensation once they found the overpayment. I currently have an active waiver claim on file with the VA and process can take 3–7 years. Is this fair to our Nation's veterans?

Sir, it is my belief that the Veteran's Debt Fairness Bill would prevent this from happening to future veterans and maybe even help current ones as well. It states in the proposed legislation that if there is no fault of the veteran then the VA can do nothing about that over payment. The VA also has no timetable to recoup these over payments. The bill would limit their time to 5 years if my understanding is correct. It is also my understanding and experience that the VA can withhold a veteran's entire benefit until debts are recovered. I ask you Sir, is this fair? What if that veteran's only income was VA compensation? What if he/she was already dealing with a failed marriage, PTSD, struggling to reintegrate to society after serving, or homeless? What then Sir? This bill would limit the amount the VA can garnish to 25% of the veteran's compensation.

The VA is in dire need of reform. I truly believe this bill is an excellent start.

I would be willing to testify before your committee about my experiences and tribulations with the VA and its debt collection practices to support this bill.

I have been involved with many veterans who share my experiences. In 2016 alone, some 200,000 over payments totaling over $1.06 trillion dollars were sent to veterans. These over payments can not all be the fault of the veteran. Let's change this!

Thank you for your attention in this matter and for your considerations of my testifying in support of Veteran's Debt Fairness Bill. Our veterans deserve it!

Sincerely,

*John P Moser,*
MSgt USAF (Ret.).

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PREPARED STATEMENT OF ANGELA KIMBALL, ACTING CHIEF EXECUTIVE OFFICER, NATIONAL ALLIANCE ON MENTAL ILLNESS

CHAIRMAN ISAKSON AND RANKING MEMBER TESTER, on behalf of the National Alliance on Mental Illness (NAMI), I am pleased to offer our organization's strong support for the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (S. 785). NAMI urges this Committee to advance this important bipartisan effort to reduce veteran suicide and improve mental health outcomes through expanded access to care, better diagnostic tools, and increased oversight of U.S. Department of Veterans Affairs (VA) programs.

NAMI is the Nation's largest grassroots mental health organization, dedicated to building better lives for the millions of Americans affected by mental illness. NAMI envisions a world where all people affected by mental illness experience resiliency, recovery, and wellness.

NAMI commends both you, Senator Tester, and your colleague Senator Moran for introducing S. 785. We are proud to join you in celebrating the legacy of retired Navy SEAL Commander John Scott Hannon, who served for 23 years and fought a courageous battle with post-traumatic stress, Traumatic Brain Injury, and bipolar disorder. CDR Hannon embodies the strength of veterans living with mental health conditions, and this bill exemplifies his passion and efforts to improve access to veterans' mental health care as a member of NAMI Montana.

NAMI is proud to have worked with a bipartisan group of legislators on key components of the bill, including increasing access and continuity of care for veterans in need of coordinated support. NAMI advocates for improving mental health and brain condition diagnostics because an accurate, quick, and early diagnosis has the potential to save countless lives and is a critical step to effective care. We are dedicated to working with the VA, legislators, and researchers to improve the process and get veterans the treatment and care they need for their recovery.

As NAMI Montana Executive Director Matt Kuntz has noted about his friend CDR Hannon, "He was a long-time mental health advocate for America's veterans and believed strongly that the VA mental health care system, like every system, needs to take concrete steps to improve its ability to conduct its mission." This bill is a tangible step in the right direction to ensure that every veteran has the right care available to them at the right time.

S. 785 seeks to improve veterans' mental health outcomes by increasing veterans' access to mental health care, particularly during transition, supporting innovative suicide prevention initiatives, launching programs and studies on mental health, increasing oversight of VA's mental health care and suicide prevention efforts, and enhancing VA's medical workforce and telehealth services. This legislation builds upon

the President's Executive Order Number 13822 and recommendations from mental health organizations, Veterans Service Organizations, the U.S. Government Accountability Office, and VA Advisory Committees.

This bill aims to make improvements to VA mental health care that will have a lasting effect on the future of the diagnosis and treatment for mental health conditions. Among the many important provisions in this bill, NAMI is particularly grateful for the inclusion of the following in S. 785:

- Extending VA health care eligibility to veterans for a full year after transitioning from the Armed Forces and requiring the promotion of this eligibility during the Transition Assistance Program (TAP) and on VA's website.
- Directing the VA to conduct a computerized Cognitive Behavioral Therapy (CBT) program as a supplement to VA mental health care and carry out a study of veterans living at high altitudes who might be at an increased risk for dying by suicide.
- Creating the Precision Medicine for Veterans Initiative, modeled after the National Institutes of Health's All of Us program, in order to identify and validate brain and mental health biomarkers, with a focus on Post Traumatic Stress Disorder, Traumatic Brain Injury, depression, and severe anxiety disorders.
- Directing the GAO to conduct a management review of the Office of Mental Health and Suicide Prevention, report on how VA manages patients at high-risk for suicide, and report on the effectiveness of VA's efforts to integrate mental health care into a primary care setting, both within VA and between VA and community-based providers.
- Providing $10 million in funding to increase the number of locations for VA telehealth care.

Mr. Chairman, NAMI is grateful to this Committee for the continued focus on ending veteran suicide and improving the lives and care of America's veterans. We wish to express our gratitude to the Committee for the invitation to submit a statement for the record on S. 785. It is a devastating tragedy that our Nation continues to lose an average of 20 veterans each day to suicide. We continue to commit our organization to working shoulder-to-shoulder with Congress, VA, the Department of Defense, and our advocacy partners to achieve our shared goal of the reduction, and eventual elimination, of suicide among veterans in America.

NAMI congratulates Senators Tester and Moran for bringing forward this important legislation. We urge swift passage of S. 785 to improve mental health care among our Nation's veterans and advance the important cause of suicide prevention.

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## PREPARED STATEMENT OF THE NATIONAL CONGRESS OF AMERICAN INDIANS

### INTRODUCTION

On behalf of the National Congress of American Indians (NCAI), thank you for holding this hearing on legislation to support veterans. Founded in 1944, NCAI is the oldest and largest representative organization serving the broad interests of tribal nations and communities. Tribal leaders created NCAI in 1944 in response to termination and assimilation policies that threatened the existence of American Indian and Alaska Native (AI/AN) tribal nations. Since then, NCAI has fought to preserve the treaty and sovereign rights of tribal nations, advance the government-to-government relationship, and remove historic structural impediments to tribal self-determination.

NCAI is grateful for the Committee's consideration of legislation intended to better fulfill the Federal Government's commitment to providing for the wellbeing of Native veterans when they return home.

*S. 524, the Department of Veterans Affairs Tribal Advisory Committee Act of 2019*

Tribal nations have always held tribal citizens that serve in all branches of the U.S. Armed Forces in the highest esteem. Per capita, American Indians and Alaska Natives (AI/ANs) serve at a higher rate than any other group of Americans and have served in all of the Nation's wars since the Revolutionary War. Despite this long history of service, too often Native veterans have difficulty accessing the benefits they earned through their military service.

S. 524, the Department of Veterans Affairs Tribal Advisory Committee Act of 2019, would begin to help address the challenges faced by Native veterans. This legislation establishes the Veterans Affairs Tribal Advisory Committee (VATAC), which would provide vital opportunities for collaboration, communication, and coordination between the Department of Veterans Affairs (VA) and tribal nations. Specifically, the VATAC would advise the Secretary on how to improve programs and services

for Native veterans, identify timely issues related to Department programs, propose solutions to identified issues, provide a forum for discussion, and help facilitate getting useful feedback from across Indian Country.

Building a strong relationship between the VA and tribal nations will increase awareness and understanding across the VA of the unique issues affecting Native veterans in tribal communities. This awareness, paired with more direct interaction with tribal leaders who regularly hear from Native veteran constituents will ultimately produce faster solutions and better services for AI/ANs that have served this country.

Accordingly, NCAI supports the immediate passage of S. 524.

*S. 785 and S. 980*

NCAI would also like to provide testimony on two other bills: S. 785, the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019; and S. 980, the Homeless Veterans Prevention Act of 2019. Although not tribal-specific, each of these bills includes provisions that would help address significant issues impacting Native veterans across the United States.

American Indians and Alaska Natives experience high rates of depression and psychological distress, which contributes to Native people having the highest suicide rate of any group in the United States.[1] Suicide continues to be a major concern for AI/AN veterans. S. 785 includes provisions that could support mental health wellness services to Native veterans who face barriers in accessing mental health care services directly from the VA. Building capacity and increasing accessible mental health care services for Native veterans is a positive step toward ending this epidemic and ensuring a healthy future for tribal citizens that served this country. NCAI would like to work with the Committee to ensure that the provisions of this legislation will significantly reduce suicide rates among Native veterans.

Additionally, when Native veterans return home from their military service, it is all too common that they face barriers to reestablishing themselves in civilian life, especially when it comes to obtaining safe and affordable housing. S. 980 would help eliminate those barriers by expanding access to legal assistance for housing and other purposes. Creating partnerships to increase access to legal services for Native veterans who are homeless or at risk of being homeless will help ensure that Native veterans can find housing and utilize other benefits provided through the VA.

CONCLUSION

Thank you for the opportunity to provide testimony on this legislation, and we greatly appreciate the work of this Committee to address the many challenges and barriers faced by Native veterans. We look forward to working with this Committee to pass S. 524 and advance other Federal policies that support those who have served our Country.

[1] Leavitt RA, Ertl A, Sheats K, Petrosky E, Ivey-Stephenson A, Fowler KA. Suicides Among American Indian/Alaska Natives—National Violent Death Reporting System, 18 States, 2003–2014. MMWR Morb Mortal Wkly Rep 2018; 67:237—242. DOI: http://dx.doi.org/10.15585/mmwr.mm6708a1

LETTER FROM DAVID C. BENTON, RGN, PHD, FRCN, FAAN,
CHIEF EXECUTIVE OFFICER, NATIONAL COUNCIL OF STATE BOARDS OF NURSING


April 18, 2019

111 E. Wacker Drive, Suite 2900 · Chicago, IL 60601-4277

The Honorable Cory Gardner
United States Senate
354 Russell Senate office Building
Washington, D.C. 20510

Dear Senator Gardner,

The National Council of State Boards of Nursing (NCSBN) is pleased to support the Department of Veterans Affairs Provider Accountability Act (S. 221). We are excited to see efforts to address provider accountability within the Veterans Health Administration (VHA) and proper reporting to the National Practitioner Data Bank (NPDB) and state licensing boards (SLBs) in this legislation.

NCSBN is an independent, non-profit association comprising 59 boards of nursing (BONs) from across the U.S., the District of Columbia and four U.S. territories. BONs are responsible for protecting the public through regulation of licensure, nursing practice, and discipline of the 4.7 million registered nurses (RNs), licensed practical/vocational (LPN/VNs) and advanced practice registered nurses in the U.S. with active licenses. NCSBN was created by these BONs to act and counsel with one another and to lessen the burden of government. The mission of NCSBN is to provide education, service, and research through collaborative leadership to promote evidence-based regulatory excellence for patient safety and public protection. Through NCSBN, BONs work together on policy matters that will affect patient safety, the future of nursing and health care.

SLBs help maintain patient safety by licensing providers in their respective professions practicing in VHA facilities. It is crucial that any action taken against the provider in the VHA, especially those that affect patient safety, are disciplinary in nature, or result in termination of employment, is reported to the NPDB and the appropriate SLBs. These measures will ensure that our nation's veterans are being treated by safe and competent providers that meet the same public protection standards as those in the private sector. This legislation ensures there is an open line of communication between the VHA and SLBs, encouraging our nation's veterans feel confident they are receiving high quality care by safe, competent providers.

In November 2017, the Government Accountability Office (GAO) published a report entitled, "*Improved Policies and Oversight Needed for Reviewing and Reporting Providers for Quality and Safety Concerns*," which analyzed the history of five VA medical centers (VAMCs) reporting to the NPDB and SLBs. The study found that, "selected VAMCs did

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not report to the NPDB eight of nine providers who had adverse privileging actions taken against them or who resigned during an investigation related to professional competence or conduct, as required by VHA policy, and none of these nine providers had been reported to SLBs."[1] The report exposed a significant patient safety and public protection gap in the VA. We are pleased that your bill seeks to address this problem in a meaningful way.

If you have any questions or would like any additional information, please do not hesitate to contact us. Elliot Vice, NCSBN's Director of Government Affairs, can be reached at evice@ncsbn.org and 202-624-7781. We look forward to helping you advance this important piece of legislation through Congress in the coming months.

Sincerely,

David C. Benton, RGN, PhD, FRCN, FAAN
Chief Executive Officer

CC
The Honorable Jerry Moran
The Honorable Joe Manchin
The Honorable Susan Collins
The Honorable Bill Cassidy

[1] U.S. Government Accountability Office. "VA Health Care: Improved Policies and Oversight Needed for Reviewing and Reporting Providers for Quality and Safety Concerns." *U.S. Government Accountability Office (U.S. GAO)*, 27 Nov. 2017, www.gao.gov/products/GAO-18-63.

PREPARED STATEMENT OF PARALYZED VETERANS OF AMERICA

CHAIRMAN ISAKSON, RANKING MEMBER TESTER, AND MEMBERS OF THE COMMITTEE, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to submit our views on the broad array of pending legislation impacting the Department of Veterans Affairs (VA) that is before the Committee. No group of veterans understand the full scope of care provided by the VA better than PVA's members—veterans who have incurred a spinal cord injury or disorder. Most PVA members depend on VA for 100 percent of their care and are the most vulnerable when access and quality of care is threatened. Several of these bills will help to ensure veterans receive timely, quality care and services.

S. 123, THE "ENSURING QUALITY CARE FOR OUR VETERANS ACT"

PVA supports S. 123. This legislation requires VA to establish a third party process for the review of any instance in which a veteran has been treated by a VA provider later found to have a revoked license. It also requires VA to notify veterans if it is determined that an episode of care or services they received was below established levels for acceptable care. PVA supports this common sense approach to help protect the health and well-being of our Nation's veterans.

S. 221, THE "DEPARTMENT OF VETERANS AFFAIRS PROVIDER ACCOUNTABILITY ACT"

PVA supports S. 221, which requires VA to report major adverse personnel actions involving certain health care employees to the National Practitioner Data Bank and to applicable state licensing boards. We believe the key to providing exceptional health care to veterans starts with quality providers. If those providers have major adverse personnel actions, they should be reported to the proper licensing authorities to ensure they are unable to practice elsewhere within the VA health care system.

S. 318, THE "VA NEWBORN EMERGENCY TREATMENT ACT"

PVA strongly supports S. 318. This legislation would correct a cruel oversight in newborn care furnished by VA. While women veterans' newborns may receive health care coverage up to seven days after birth, VA is not authorized to pay for any emergency transportation that a newborn may require to reach a different medical facility. Currently, veterans must pay the full cost of any ambulance or helicopter transportation needed to transport their newborns for emergency medical care. This legislation will ensure no veteran receives bills for this type of care again. Additionally, this legislation would waive any outstanding debts associated with medically-necessary emergency transportation services for a newborn. It would also expand the seven days of VA provided coverage through a waiver process for medically necessary care. We urge Congress to move quickly to advance this crucial legislation.

S. 450, THE "VETERANS IMPROVED ACCESS AND CARE ACT OF 2019"

PVA supports many efforts to bolster staffing levels at VA facilities, particularly within the Spinal Cord Injury System of Care, which historical data shows is one of the most difficult areas to recruit and retain nursing staff. S. 450 would create a limited pilot project to expedite the onboarding process for new medical providers. PVA agrees with this legislation's intent, but believes a pilot program unnecessarily delays this critical need at a time when Congress should be enacting legislation that directs VA to expedite its hiring processes department-wide.

S. 514, THE "DEBORAH SAMPSON ACT"

PVA supports S. 514, which helps address some of the quality of care barriers that are unique to women veterans. From transition services, to health care access, to the availability of prosthetics, this bill is a critical and timely step to enhancing the health and well-being of women veterans and their families. As women veterans are the fastest growing population of veterans, we urge Congress to enable VA to fully meet the need for specialized services for women.

This bill would initiate a program for peer-to-peer counseling for women veterans transitioning out of the military and make permanent the availability of readjustment counseling services in group retreat settings. Of the existing readjustment counseling retreats provided through VA, participants consistently showed better understanding of how to develop support systems and to access resources at VA and in their communities. They work with counselors and peers, building on existing support.

If needed, there is financial and occupational counseling. These programs are marked successes and the feedback is overwhelmingly positive for women veterans, who show consistent reductions in stress symptoms as a result of their participation. Other long lasting improvements included increased coping skills. It is essential for women veterans that Congress make this program permanent. We believe the value and efficacy is undeniable.

Importantly, the bill would also authorize hospital stays of up to 14 days for newborns under VA care. VA currently allows a maximum stay of seven days. As the average stay for a healthy newborn is two days, any newborn needing additional coverage is likely to be facing complications immediate after birth or a severe infant illness. The current seven day coverage is in a non-department facility for eligible women veterans who are receiving VA maternity care. Beyond the seven days, the cost of care is the responsibility of the veteran and not VA, even if complications require continued care beyond the coverage period. Post-natal health is critical to newborn health which directly impacts the lives and well-being of veterans and their families. PVA is particularly concerned about those veterans with catastrophic disabilities that can cause high-risk pregnancies or pre-term deliveries. A seven day limit arguably impacts veterans with disabilities at a greater rate than other veterans. Extending newborn coverage to 14 days is the right thing to do.

The legislation also aims to eliminate barriers to care. For example, it would ensure that every facility has at least one full-time or part-time women's health provider. Furthermore, an additional $20 million would be authorized to carry out the retrofitting of existing facilities to improve privacy, safety, and environmental needs for women veterans. Finally, the bill would require data collection and reporting by gender and minority status on VA programs serving veterans and a reporting requirement on prosthetic availability for women veterans.

This bipartisan legislation ensures women veterans receive the care and benefits they earned and we support its swift passage.

S. 524, THE "DEPARTMENT OF VETERANS AFFAIRS TRIBAL ADVISORY COMMITTEE ACT OF 2019"

PVA supports S. 524 which seeks to establish a VA Advisory Committee on Tribal and Indian Affairs. This advisory committee would help to foster better communication and understanding between VA and Tribal governments. The result will be improved access to VA health care programs, benefits, and services for Native American veterans.

S. 711, THE "CARE AND READINESS ENHANCEMENT FOR RESERVISTS ACT OF 2019"

PVA supports S. 711, which allows the Department of Defense (DOD) to fund behavioral or mental health care for reservists, regardless of whether they are within the 180 day pre-deployment window, or have never deployed. It also directs VA to furnish mental health services for members of the National Guard and Reserves, and allows them to access veteran centers for mental health screening and counseling, employment assessments, education training, and other services to help them successfully transition to civilian life.

Access to mental health services is a universal issue and we need to make certain that everyone who is serving or has served in uniform has access to the behavioral health services needed to help ensure no veteran is lost to suicide. This legislation compliments existing efforts to reduce this unnecessary loss of life by ensuring all members of the Reserve components have access to needed care.

S. 746, THE "DEPARTMENT OF VETERANS AFFAIRS WEBSITE ACCESSIBILITY ACT OF 2019"

PVA supports S. 746, which directs VA to study the accessibility of its website and related resources for veterans with disabilities and provide a report of its findings to Congress. Following the study, VA would be required to identify applications that are not accessible to such individuals and VA's plan to make each of them accessible.

Section 508 of the Rehabilitation Act of 1973 requires Federal Government agencies to develop and maintain information and communication technology that is accessible to persons with disabilities. A formal review of VA's website and related resources to ensure compliance with the law is appropriate.

S. 785, THE "COMMANDER JOHN SCOTT HANNON VETERANS MENTAL HEALTH CARE IMPROVEMENT ACT OF 2019"

PVA supports S. 785, which seeks to strengthen and improve VA's mental health care services. Passage of this bill would enable VA's mental health workforce to

serve more veterans by giving VA direct hiring authority for more mental health professions, offering scholarships to mental health professionals to work at Vet Centers, and placing at least one Suicide Prevention Coordinator in every VA medical center. It also improves rural veterans' access to mental health care by increasing the number of locations at which veterans can access VA telehealth services and offer grants to non-VA organizations that provide mental health services or alternative treatment to veterans.

This legislation also provides greater support and assistance to servicemembers transitioning out of the military by giving them a full year of VA health care when they leave the military and improves services that connect transitioning veterans with career and education opportunities. We are further pleased that it expands veterans' access to animal, outdoor, or agri-therapy, yoga, meditation, and acupuncture, and investing in VA mental health research. Most importantly, it includes a host of studies and resources provisions specially targeted toward evaluating and improving VA mental health care programs and service with the goal of reducing veteran suicides in mind.

We lose too many veterans each day to suicide and a concerted approach to reducing these numbers is badly needed. S. 785 offers a comprehensive approach toward improving the diagnosis and treatment for mental health conditions which, in the long term, will undoubtedly save lives.

S. 805, THE "VETERAN DEBT FAIRNESS ACT OF 2019"

PVA supports S. 805. Failure to resolve debt issues in a timely manner can have a lasting, catastrophic impact on a veteran. If the Veterans Benefits Administration (VBA) sends out a notice of an overpayment of benefits, or some other circumstance producing a debt owed by the veteran, it is essential that VBA know whether that notice actually reached the veteran prior to the veteran going into default. Unfortunately, it is not uncommon for veterans to find that one part of VA has updated their contact information, while other parts of VA have not.

We understand and support the Secretary's need to recover on debts, however, it must be done in a manner that maintains due process rights and is not unduly detrimental to the veteran. It is important to ensure that veterans are not going into default for lack of notice, especially in circumstances where the debt itself is a product of VA's mistakes and overpayments.

S. 850, THE "HIGHLY RURAL VETERAN TRANSPORTATION PROGRAM EXTENSION ACT"

PVA supports extending the authorization of appropriations to VA for purposes of awarding grants to veterans service organizations for the transportation of highly rural veterans. Access to transportation is critical to ensuring that veterans receive the health care that they need in a timely manner.

S. 857, A BILL TO INCREASE THE SPECIAL PENSION FOR MEDAL OF HONOR RECIPIENTS

PVA supports S. 857. It has been close to fifteen years since the pension amount for Medal of Honor recipients was increased. With the great honor of this award comes a responsibility from them to share their stories and inspire their fellow citizens. Often times, this requires traveling and participating in events around the country. This responsibility should never become a financial burden on those who have already sacrificed so much. We support this bill which more than doubles the current pension amount to $3,000.00 per month.

S. 980, THE "HOMELESS VETERANS PREVENTION ACT OF 2019"

PVA generally supports S. 980. Specifically, we support the provisions in this bill that would help keep veteran families together by allowing VA to house the children of homeless veterans in transitional housing programs; direct VA partnerships with public and private entities to provide legal services for homeless veterans and veterans at risk of becoming homeless; and grant VA the authority to provide dental care to homeless veterans.

However, we do not support the provision allowing VA to stop reporting annually on its assistance programs for homeless veterans. The most recent figures show that 38,000 veterans across the country are without stable housing on any given night in America. Congress needs to continue to hold VA accountable, and require them to report on what programs are being provided.

S. 1101, THE "BETTER EXAMINER STANDARDS AND TRANSPARENCY FOR VETERANS ACT OF 2019"

PVA supports S. 1101, which would ensure that only licensed health care providers are conducting medical disability examinations on behalf of VA. Veterans must be able to receive their disability examinations from providers they can trust. We support its swift passage.

S. 1154, THE "DEPARTMENT OF VETERANS AFFAIRS ELECTRONIC HEALTH RECORD ADVISORY COMMITTEE ACT"

S. 1154 creates an additional layer of accountability and oversight to ensure the development and roll out of the new Electronic Health Record (EHR) goes smoothly. The 11-member Committee would operate separately from VA and DOD and would be made up of medical professionals, Information Technology and interoperability specialists, and veterans currently receiving care from the VA. The Committee will analyze the VA's strategy for implementation; develop a risk management plan; tour VA facilities as they transition to the new system; and ensure veterans, VA employees and medical staff, and other participants have a voice in the process.

The development of an integrated DOD/VA electronic health record has been beset with problems for years. We support the intent of S. 1154 because it is a positive step forward. We suspect, however, the Committee's efforts will only be successful if they are given equal latitude to work with, evaluate, and advise DOD on its portion of the EHR as well.

S. ___, THE "JANEY ENSMINGER ACT OF 2019"

PVA understands and supports the intent of the draft legislation known as the "Janey Ensminger Act of 2019." This legislation would amend the Public Health Service Act with respect to the Agency for Toxic Substances and Disease Registry's (ATSDR) review and publication of illnesses and conditions relating to veterans stationed at Camp Lejeune, North Carolina, and their families. The bill would require the ATSDR Administrator to review the scientific data pertaining to the relationship between individuals at Camp Lejeune and the suspected resulting illness or condition. The ATSDR Administrator would be required to determine each condition that may be caused by toxic exposure, categorize the level of evidence for these conditions into three categories: sufficient with reasonable confidence that the exposure is a cause of the illness or condition, modest supporting causation, or no more than limited supporting causation. This information would then be published and continually updated on the Department of Health and Human Services' website. Newly registered veterans and family members would receive care based on the list provided by the ATSDR Administrator.

Research regarding toxic exposures and the subsequent credibility of presumptive conditions has traditionally been the charge of the Institute of Medicine (IOM). The bill does not discuss the processes that should be implemented if the ATSDR conflicts with the findings of the IOM and we hope you will consider this in your deliberations on this measure. That aside, PVA supports this effort to ensure periodic literature reviews of the existing body of research on the relationship between toxic exposures at Camp Lejeune and adverse health conditions.

S. ___, A BILL TO AMEND TITLE 38, UNITED STATES CODE, TO EXTEND THE AUTHORITY OF THE SECRETARY OF VETERANS AFFAIRS TO CONTINUE TO PAY EDUCATIONAL ASSISTANCE OR SUBSISTENCE ALLOWANCES TO ELIGIBLE PERSONS WHEN EDUCATIONAL INSTITUTIONS ARE TEMPORARILY CLOSED, AND FOR OTHER PURPOSES.

PVA generally supports this draft language which would extend educational assistance or subsistence allowances for a brief period of up to two months to ensure stability of Forever GI Bill users when their educational institution closes unexpectedly.

PVA would once again like to thank the Committee for the opportunity to submit our views on the legislation considered today. Enactment of much of this proposed legislation will significantly enhance the health care services and benefits available to veterans, servicemembers, and their families. We look forward to working with the Committee on their passage, and would be happy to take any questions you have for the record.

## LETTER FROM JAMES POWERS, VETERAN, COLUMBUS, OH

### STATEMENT OF SUPPORT FOR S. 805 VETERAN DEBT FAIRNESS ACT OF 2019

Here we are, 18 months after I came before this Committee and gave a veteran's perspective of VA services in Ohio. Never did I expect that elements of my field hearing on a November day in Columbus, Ohio would find their way into purposeful legislation to prevent unnecessary hardship for Veterans.

S. 805 puts measures into place to prevent financial hardship on Veterans that incur from an overpayment of benefits. The current policies in place provide little protection the Veteran. The appeals process is one-sided, and the collection processes is a nightmare. In my own case that I spoke of in my testimony, had an audit process been in place my debt far more easily could have resolved itself. If the VA's IT systems allowed for a veteran to make dependency changes that immediately updated benefit amounts, many of these overpayments could be avoided. This bill is as much about helping Veterans as it is about improving the agency that is here to serve Veterans. It is common sense to want a government agency to do a better job handling this country's money. Especially when it is for our Veterans. Error or not, government money should not be able to cause a hardship. The VA is currently doing just that by not automatically capping monthly repayment at 25%. Had the VA followed their normal debt collection method in my case, I would have gone 3+ months with no benefits payments. This easily would have caused me to need emergency financial assistance. That assistance would have come from state and local resources—resources that could be better appropriated to helping veteran homelessness, suicide prevention, and outreach. But, instead, it gets used to pay rent or utility bills for the Veteran who is getting all of his disability compensation garnished. It seems counterproductive when you look at it like that. Especially when the solution is right here in this bill.

Section 3 of this bill builds on a practice already in place to prevent overpayment of DOD and VA benefits. Currently, when a servicemember retires the DOD automatically verifies VA compensation amounts to prevent overpayment of retirement benefits. With this bill, the DOD would quarterly verify Drill pay for guard/reservist to the VA. This simple reconciliation would remove the reporting/recording issue facing the Veteran/VA. No longer would the VA find itself recouping benefits that occurred over a long period of time.

Many of these policies are not new to the Federal Government. They exist in similar context within the Social Security Administration. Many of these debt collection practices also come straight from similar protections a Veteran may find when dealing with a private debt and the CFPB.

So, I ask this Committee to continue "to not let my words fall upon deaf ears" as I said in my previous testimony, but to work toward making S. 805 Veteran Debt Fairness Act of 2019 the next law showing this country's continued commitment to honor, care for, and in this case, protect its Veterans.

Previous Committee testimony: https://www.veterans.senate.gov/download/powers-testimony_11212017

Signed,

*James Powers.*

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## PREPARED STATEMENT OF STUDENT VETERANS OF AMERICA

CHAIRMAN ISAKSON, RANKING MEMBER TESTER AND MEMBERS OF THE COMMITTEE: Thank you for inviting Student Veterans of America (SVA) to submit our testimony on pending legislation before the Committee.

Established in 2008, SVA is a national nonprofit founded to empower student veterans as they transition to civilian life by providing them with the resources, network support, and advocacy needed to succeed in higher education. With over 1,500 Campus Chapters across the U.S. and in four countries overseas, serving 750,000 student veterans, SVA establishes a lifelong commitment to each student's success, from campus life to employment, through local leadership workshops, national conferences, and top-tier employer relations. As the largest chapter-based student organization in America, we are a force and voice for the interests of veterans in higher education, and SVA places the student veteran at the top of our organizational pyramid.

Edward Everett, our Nation's 20th Secretary of State, and the former President of Harvard University was famously quoted as stating, "Education is a better safeguard of liberty than a standing army." While we have the finest military that the world has ever known, the sentiment remains; the importance of education to our

Nation's national security continues to be critical and we thank the Committee for putting forth thoughtful legislation that speaks to this importance.

S. 805, VETERAN DEBT FAIRNESS ACT OF 2019

The Veteran Debt Fairness Act of 2019 would make certain improvements to the Department of Veterans Affairs (VA) debt collection process and limit the authority of VA to recover overpayments made to veterans due to VA accounting errors.

VA sends out up to 200,000 overpayment notices to veterans every year.[1] Most are health-related, but based 2015 GAO study, roughly one out of every four veterans using the Post-9/11 GI Bill also received an overpayment notice.[2] These notices demand the debt—a number we have seen reach as high as $75,000—be repaid in full within thirty days or the veteran's benefits will be withheld.[3] This short window of time to respond to a wholly unexpected and life-changing letter can be a challenge for veterans on its own, but is also further reduced by VA's outdated and disconnected address databases and years-long reliance on physical mail, meaning many veterans have not received these notifications in time to engage in their appeals or repayment options.[4]

The causes of overpayments and poor dissemination of these notices due to inadequate infrastructure is a well-worn discussion, but in some cases the root issue is not related to IT but VA's internal processes. The VA's Office of the Inspector General released a report in December of last year regarding 1,300 disabled veterans receiving Dependent's Educational Assistance (DEA) overpayment notices totaling $4.5 million—an average of $3,400 each.[5] The report found that 25 of the 58 regional VA offices had roughly 4,600 unread emails in their respective DEA inboxes dating back to August 2016, sixty-seven percent of which (~3,100) were about DEA benefits.[6] [7] Seven of the offices reported not checking those inboxes at all because there was no VBA standard in place.[8]

With overpayment letters on the rise—nearly tripling from 2013 to 2017—an ever-increasing number of our veterans and families are being threatened with or experience financial harm.[9] The serious nature of these notices and the impact they can have on families requires that stronger guardrails be placed around the processes that enable them. This bill is a step in that direction.

SVA strongly supports the bill's language on limiting VA's recoupment of debts to only those made by errors from the veteran or beneficiary, capping the benefit deduction at 25%, and only those debts that were incurred in the last five years.

SVA also supports the requirement that the VA provide veterans with the ability to update their dependency information online, which eliminates a potential processing delay and cause of overpayments. We continue to emphasize VA's need to improve and modernize its IT infrastructure and see this as another opportunity to provide greater service to our veterans.

DRAFT LEGISLATION, TO AMEND TITLE 38, UNITED STATES CODE, TO EXTEND THE AUTHORITY OF THE SECRETARY OF VETERANS AFFAIRS TO CONTINUE TO PAY EDUCATIONAL ASSISTANCE OR SUBSISTENCE ALLOWANCES TO ELIGIBLE PERSONS WHEN EDUCATIONAL INSTITUTIONS ARE TEMPORARILY CLOSED.

This legislation would extend the period that VA is able to continue paying housing allowances during a school's temporary closure due to an Executive order of the President or because of an emergency situation from four weeks to eight.

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[1] Senator Sherrod Brown. (March 2019). Brown, Tester, Boozman Work to Stop Veterans from Being Punished for VA's Miscalculations. https://www.brown.senate.gov/newsroom/press/release/brown-tester-boozman-work-to-stop-veterans-from-being-punished-for-vas-miscalculations

[2] U.S. Government Accountability Office (October 2015). Additional Actions Needed to Help Reduce Overpayments and Increase Collections. https://www.gao.gov/products/GAO-16-42

[3] Horne, Chris. (May 2019). VA overpayment puts Marine vet, Navy officer on hook for $75,000. https://www.wavy.com/news/military/navy/va-overpayment-puts-marine-vet-navy-officer-on-hook-for-75-000/1995067521

[4] Office of Servicemembers' Affairs, Consumer Finance Protection Bureau. (January 2019). 2018 Annual Report. https://files.consumerfinance.gov/f/documents/cfpb_osa_annual-report_2018.pdf

[5] VA OIG (December 2018). Delays in the Processing of Survivors' and Dependents' Educational Assistance Program Benefits Led to Duplicate Payments. https://www.va.gov/oig/publications/report-summary.asp?id=4601

[6] Ibid.

[7] Ibid.

[8] Ibid.

[9] Jerving, Sara. VICE (March 2017). *Indebted.* https://news.vice.com/en_ca/article/ywn9xb/va-veterans-overpayment

As has been made all too clear in the past few years, natural disasters dramatically impact the lives of students and the communities that surround them. In 2017 and 2018, we saw at least 43 separate college and university closures of over 10 days. In Georgia, those included Albany Technical College, East Georgia State College, Georgia Southern University-Armstrong, and the Savannah School of Art and Design. In North Carolina, Fayetteville Technical Community College and Craven Community College temporarily shuttered. And some, like Lone Star College's Kingwood and Atascocita campuses, closed for a full month. When schools close in the aftermath of a catastrophic event, student veterans must navigate their own recovery while the ticking clock of the four-week benefits extension hangs over their head.

It is important to understand that significant disaster events are occurring more frequently and more intensely than ever before. Since 1980, the United States has faced an average of six billion-dollar storms in a given year.[10] In the past 5 years, however, we have faced an average of thirteen.[11] It is clear our students face a growing threat from the environment and we believe that preparing policy to more adequately, and proactively, address these issues is the best option. We should not wait until our veterans are suffering to enact this positive change.

SVA strongly supports giving VA the authority to extend the current timeframe when natural disasters are so severe an institution needs more than a month to reopen campus. We believe this is a common-sense, proactive policy change providing student veterans more than a few weeks' time to figure out a new plan when facing catastrophes.

If the Committee would like to continue the conversation on ways to better serve our student veterans responding to natural disasters, one area that students still need relief is with post-disaster relocation. If a student must relocate due to a natural disaster and cannot immediately return to school upon reopening, VA is unable to continue making payments to them or assist with relocation needs. This compounds the student's existing problems and causes undue hardship.

We would also like to encourage the Committee to consider ways to provide assurances for housing allowances in the wake of natural disasters without having to lose a month or more of educational assistance eligibility due to circumstances beyond students' control.

We applaud Congress' efforts thus far to provide common-sense relief to our student veterans who are impacted by natural disasters. With each proactive step, Congress sends a powerful message to our veterans that our country is committed to serving them when they need help the most.

In addition to the legislation listed above, SVA also supports S. 785, the Commander John Scott Hannon Veterans Mental Health Care Act of 2019, which makes continued improvements to the Transition Assistance Program and authorizes a scholarship program for veterans seeking certain degrees.

The success of veterans in higher education is no mistake or coincidence. Research consistently demonstrates this unique population of non-traditional students is far outpacing their peers in many measures of academic performance.[12] Further, this success in higher education begets success in careers, in communities, and promotes family financial stability, holistic well-being, and provides the all-volunteer force with powerful tools for recruitment and retention when recruits know military service prepares them for success after service.

We thank the Chairman, Ranking Member, and the Subcommittee Members for your time, attention, and devotion to the cause of veterans in higher education. As always, we welcome your feedback and questions, and we look forward to continuing to work with this Committee, the Senate Veterans' Affairs Committee, and the whole of Congress to ensure the success of all generations of veterans through education.

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[10] Stein, Jeff; Van Dam, Andrew. *Washington Post*. (April 22). Taxpayer spending on U.S. disaster fund explodes amid climate change, population trends. https://www.washingtonpost.com/us-policy/2019/04/22/taxpayer-spending-us-disaster-fund-explodes-amid-climate-change-population-trends/?noredirect=on&utm_term=.2b49a5ca45db

[11] Ibid.

[12] Cate, C.A., Lyon, J.S., Schmeling, J., & Bogue, B.Y. (2017). *National Veteran Education Success Tracker: A Report on the Academic Success of Student Veterans Using the Post-9/11 GI Bill*. Student Veterans of America, Washington, DC, http://nvest.studentveterans.org/wp-content/uploads/2017/03/NVEST-Report_FINAL.pdf.

LETTER FROM JAMES CRAIG, J.D., ED.D, PRESIDENT,
UNITED VETERANS COMMITTEE OF COLORADO (UVCC)

Dr. James Craig J.D.,Ed.D
18784 E. Burlington Pl
Denver, CO 80249
720-737-3686

21 May 2019
Honorable Senator Cory Gardner

Ref: S. 450, the Veterans Improved Access and Care Act of 2019

We at the UVC are regularly confronted by veterans who are pleased with VA but are concerned by the lengthy process necessary to fill empty café giver positions. The capability for VA medical centers and clinics to bring qualified applicants on board as necessary health care providers is compromised by an overburdened application process, which hinders VA's ability to hire properly vetted licensed medical staff.

The current onboarding process prevents expedient hiring which places VA at a disadvantage in competitive health care environments. We at the UVC would like to congratulate Senator Gardner for sponsoring S450 and Representatives Tipton and Crow as well as all other sponsors/co-sponsors on both sides of the isles whose bipartisan/bicameral efforts will create pilot projects in at least 10 VA medical facilities allowing for an evaluation of the current hiring process leading to proposed solutions to expedite VA's ability to hire sorely needed health care providers.

With your efforts, the future for our VA and our veterans is surely to be bright.

Respectfully submitted;

Dr. James Craig J.D., Ed.D
President UVC

PREPARED STATEMENT OF CARLOS FUENTES, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

CHAIRMAN ISAKSON, RANKING MEMBER TESTER, AND MEMBERS OF THE COMMITTEE, On behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, thank you for the opportunity to offer our views on legislation pending before the Committee.

S. 123, ENSURING QUALITY CARE FOR OUR VETERANS ACT

The VFW supports this legislation which would require the Department of Veterans Affairs (VA) to conduct a clinical review of care furnished by VA health care professionals who had their licenses to practice terminated for cause.

It is unacceptable to endanger the lives of our Nation's veterans by hiring health care professionals with suspended licenses. There have been several egregious examples of VA doctors who commit malpractice under VA's watch, but should never have been allowed to provide care to veterans. This bill would rightfully ensure VA health care professionals who had their licenses terminated in the past and are currently employed by VA are providing high-quality care. If not, VA would be required to provide a clinical disclosure of adverse events to impacted patients. Doing so would ensure patients know their rights and options for recourse.

S. 221, DEPARTMENT OF VETERANS AFFAIRS PROVIDER ACCOUNTABILITY ACT

The VFW supports the intent of this legislation, which would codify VA's reporting requirements to the National Practitioner Data Bank and state licensing boards, and has suggestions to improve it.

Several instances of VA medical errors have been made public in the past couple of years, where VA health care providers have been held accountable or fired, but the instances were never reported to state licensing boards or the National Practitioner Data Bank. This legislation would ensure such providers are not allowed to continue to endanger the lives of their patients, whether it is at VA or outside of VA, by requiring VA to report all major adverse actions to the National Practitioner Data Bank within 30 days of such actions. This legislation would also prohibit VA from purging negative records from personnel files except in situations where the record is found not to be legitimate by the Office of Accountability and Whistleblower Protection.

The VFW urges the Committee to amend the legislation to require VA to report incidents VA is investigating. It is common practice for private sector health care facilities to report incidents to state boards when the facility begins a medical error investigation and when adverse actions have been carried out. This legislation only requires VA to report medical errors after the adverse actions have taken place. This is a particular concern in instances where a provider may choose to retire before an adverse action is carried out. In such instances, the state medical board where the provider is licensed may investigate and discipline the provider even though VA has lost its opportunity to do so.

S. 318, VA NEWBORN EMERGENCY TREATMENT ACT

The VFW supports this legislation which would expand VA's current authority to cover the cost of emergency transportation for eligible newborn babies. Under current law VA is authorized to provide seven days of medical coverage for newborn children, but that coverage does not include emergency transportation.

The VFW has long supported expanding the length of time a veteran's newborn child is provided medical coverage by VA, and believes also expanding current legislation to include emergency transportation is common sense. If a veteran gives birth to a child who then has an emergency medical situation which the birthing facility is unable to address, VA must be able to cover the cost of transporting such newborn to a facility that can provide the required care. Veterans in this situation are already under a great deal of stress, and it is unjust to then add the burden of emergency transportation costs.

During the first seven days, the transportation must be covered as it is part of the treatment. Medical services and surveillance would be needed during the transport as a matter of life or death to the infant. This legislation provides Congress with an easy way to increase the quality of care women veterans rightfully deserve. The VFW urges the Committee to swiftly pass this bill.

S. 450, VETERANS IMPROVED ACCESS AND CARE ACT OF 2019

The VFW supports this legislation to require VA to assess the feasibility of expediting the process of onboarding new medical providers and require VA to create a plan to reduce the hiring process for health care professionals.

The VFW continues to hear that VA's licensing and credentialing process is excessively long and should be modified to make certain VA is able to hire high-quality doctors on a timely basis. The VFW has also heard from providers who work at VA that they face delays transferring to underserved areas because they are required to undergo burdensome onboarding processes again, even though VA policy authorizes streamlined transfers between VA medical facilities. Veterans want more doctors at their VA medical facilities. Requiring doctors who want to serve veterans to jump through hoops deters them from doing so.

S. 514, DEBORAH SAMPSON ACT

The VFW supports this legislation to improve VA benefits and services for women veterans. The VFW has adamantly worked alongside Congress and VA to improve access, care, and benefits to women veterans. This legislation would address issues and concerns regarding access to care, recognition, and homelessness which the VFW has identified in direct feedback from women veterans.

As the women veteran population continues to grow, VA must ensure it provides care and services tailored to their unique health care needs. Women veterans deserve access to the best treatment and care this Nation has to offer. That is why it is crucial VA outfit existing facilities with basic necessities, such as curtains for privacy in women's clinics. These clinics also need to maintain at least one primary care provider with expertise in women's health who is able to train others. However, the VFW recommends removing the option of one part-time provider. A part-time provider would limit access to care for women veterans and decrease the provider's ability to maintain gender-specific expertise.

For women veterans who rely on VA for postnatal care, the VFW urges Congress to extend the number of days newborn care is covered by VA. Currently, VA only covers newborn care for seven days. One week is not enough to provide coverage for critical care that may be necessary in the first weeks of a child's life—especially in the relatively common instance of false-positive newborn disease testing—nor is it enough to ease the new mother of unnecessary stress. The VFW supports the provision of this bill which would expand newborn coverage for veterans who use VA while receiving maternity care.

In addition, this legislation would provide many other improvements to women veterans' needs within VA. Some of these improvements include analysis of staffing needs, the establishment of a women veteran training module for non-VA health care providers, expansion of legal services for women veterans, and information to be added to the VA website relating to women veteran programs.

S. 711, CARE AND READINESS ENHANCEMENT FOR RESERVISTS ACT OF 2019

The VFW supports this legislation to expand eligibility for VA Vet Centers for members of the reserve component of the U.S. Armed Forces.

According the Department of Defense Suicide Events Report, members of the reserve component have higher rates of suicide than active duty servicemembers. Lack of access to mental health care and possible impact on career are common reasons reserve component servicemembers do not receive the care they need to cope with mental health conditions, despite their high frequency of deployment. This bill would ensure they have access to the high-quality and confidential care provided by VA's more than 300 Vet Centers around the country.

S. 746, DEPARTMENT OF VETERANS AFFAIRS WEBSITE ACCESSIBILITY ACT OF 2019

The VFW supports this legislation which would require VA to ensure its websites and kiosks meet accessibility requirements. With VA's increased reliance on websites to communicate with veterans, and kiosks at VA medical centers to check in for appointments, VA must ensure all veterans have the ability to utilize such modalities.

S. 785, COMMANDER JOHN SCOTT HANNON VETERANS MENTAL HEALTH CARE IMPROVEMENT ACT OF 2019

The VFW supports this comprehensive legislation which would significantly improve VA's suicide prevention efforts.

Eliminating suicide among our Nation's veterans continues to be a top priority for the VFW. The most recent analysis of veteran suicide data from 2016 found suicide

has remained fairly consistent within the veteran community in recent years. An average of 20 veterans and servicemembers die by suicide every day. While this number must be reduced to zero, it is worth noting that the number of veterans who die by suicide has remained consistent in recent years, while non-veteran suicides have continued to increase.

The Office of Inspector General report determining Veterans Health Administration staffing shortages continues to list psychiatry clinics as having the most need, with the fourth being psychology. Out of 141 facilities surveyed, 98 had a shortage for psychiatrists and 58 had a shortage for psychologists. By not adequately staffing VA, the capacity to serve veterans and provide the necessary access to mental health care needed by so many will continue to be limited. With the entire nation experiencing a critical shortage of mental health care providers, such need cannot be sufficiently addressed by simply increasing use of community care. This legislation would make improvements to VA's mental health care workforce to ensure veterans with mental health care concerns have timely access to high-quality care.

The VFW is proud to be part of the solution. Through Project Advancing Telehealth through Local Access Stations (ATLAS), the VFW has worked with VA and Philips to leverage VA's anywhere to anywhere authority to expand telehealth options for veterans who live in rural areas. In this partnership, VA has identified highly rural areas where veterans must travel far distances to receive VA health care. The VFW identifies posts in those areas to serve as access points for VA health care. Once the post is modified to VA's specifications, it is equipped with Philips-donated telehealth technology to provide veterans access to VA health care at a convenient veteran-centric location. More than 20 VFW posts have been identified as possible telehealth centers. The primary use for the first Project ATLAS site in Eureka, Montana, will be for mental health care. Veterans in Eureka must travel more than 70 miles to the nearest VA clinic for mental health care. The VFW is glad this legislation would expand such opportunities through a grant program. Doing so would provide veterans the ability to receive VA health care closer to home.

VA is making concerted efforts to ensure it appropriately uses pharmaceutical treatments when providing mental health care. Under the Opioid Safety Initiative, VA has reduced the number of patients to whom it prescribes opioids. Prescribed use of opioids for chronic pain management has unfortunately led to addiction to these drugs for many veterans, as well as for many other Americans. VA uses evidence-based clinical guidelines to manage pharmacological treatment of Post Traumatic Stress Disorder and substance use disorder to ensure better health outcomes. However, many veterans report being abruptly taken off opioids they have relied on for years to cope with their pain management, without a proper treatment plan to transition them to alternative therapies. Doing so leads veterans to seek alternatives outside of VA or to self-medicate. VA must continue to expand research of non-traditional medical treatments, such as medical cannabis and other holistic approaches, for mental health care conditions. This bill would require VA to expand access to such therapies to ensure veterans are able to access care that works best for them.

S. 805, VETERAN DEBT FAIRNESS ACT OF 2019

The VFW supports this legislation which would improve the processing of veterans benefits by VA, limit the authority of the Secretary of Veterans Affairs to recover overpayments made by the Department and other amounts owed by veterans to the United States, and improve the due process afforded veterans with respect to such recovery.

While the VFW understands that overpayments must be recouped in order for benefit programs to work efficiently, it is important for debt notices to be clear and provide concise information regarding what steps veterans must take in order to resolve any outstanding debts as soon as possible. Ultimately, a veteran should be responsible for repaying the overpayment, if it is indeed legitimate. Due to the inconsistencies regarding communication of overpayments from VA, as well as the general lack of information regarding the nature of such debt, many veterans are simply unable to meet the deadline imposed on them by VA. To further complicate things, the VFW's interaction with VA's Debt Management Center personnel has made it very clear that VA employees lack a proper understanding of VA policy and procedures regarding debt recoupment. The VFW believes this legislation would address these concerns, and strongly urge Members of this Committee to support its passage.

S. 850, HIGHLY RURAL VETERAN TRANSPORTATION PROGRAM EXTENSION ACT

The VFW strongly supports this legislation, which would expand the authority for VA to partner with veterans service organizations and state veterans agencies to provide transportation services for veterans in rural areas.

Lack of transportation is a significant barrier to accessing health care for veterans who live in rural and remote areas. Such veterans often do not have the opportunity to use public transportation like their fellow veterans who live in urban areas. While VA provides benefits for veterans who travel long distances for care, veterans may not have the resources to pay for the cost of travel up front. VFW posts and departments in North Dakota, Maine, California, and Texas have partnered with VA through the Highly Rural Transportation Grants to eliminate this barrier for veterans. The VFW supports a one-year expansion of this important program, but urges this Committee to make it permanent.

S. 857, TO INCREASE THE AMOUNT OF SPECIAL PENSION FOR MEDAL OF HONOR RECIPIENTS

This legislation would increase the Medal of Honor pension. The VFW supports this legislation and has a recommendation to improve it.

Veterans who have been awarded the Medal of Honor have made extraordinary sacrifices for our country and are rightfully awarded a special pension for those heroic acts. The special pension for Medal of Honor recipients has been increased to adjust to cost of living increases, but has not been significantly increased since 2002. The VFW agrees that it is time to update this modest benefit for America's most cherished heroes.

The loved ones of our most honored heroes often forgo careers to become full time caregivers. This means they become dependent on the Medal of Honor pension to make ends meet. However, the Medal of Honor pension ends with the death of the recipient and their spouses often do not qualify for VA benefits upon that death. Our nation has continued pensions for surviving spouses in the past, such as pensions for members of the Grand Army of the Republic. It is fitting that our Medal of Honor veterans' spouses should continue to receive Medal of Honor pensions until their remarriage or death. The VFW recommends this Committee authorize the continuation of the pension for the Medal of Honor recipient's surviving spouse until the surviving spouse remarries or dies.

S. 980, HOMELESS VETERANS PREVENTION ACT OF 2019

This legislation would improve benefits afforded to homeless veterans. The VFW supports this legislation and would like to offer a suggestion to strengthen section 3.

The VFW firmly believes that no veteran who has honorably served this Nation should have to suffer the indignity of living on the streets. We praise the great progress that has been made in reducing veterans' homelessness in recent years as a direct result of coordinated efforts across multiple government agencies to provide transitional housing, rapid rehousing, and employment programs for veterans in need.

The VFW generally supports section 3 of the bill which would allow the Secretary to enter into partnerships with public or private entities to fund a portion of certain legal services for homeless veterans. While the VFW recognizes that legal issues are often a significant barrier to homeless reintegration and must be addressed, we are concerned that some for-profit legal entities would view this program as an opportunity to exploit the availability of government resources in exchange for poor or inadequate services. For this reason, we suggest that the language in this section be changed to allow VA to enter into partnerships with only public or non-profit private legal entities that provide services to homeless veterans.

S. 1101, BETTER EXAMINER STANDARDS AND TRANSPARENCY FOR VETERANS ACT OF 2019

The VFW supports this legislation which would require VA to ensure contracted health care providers who perform VA compensation and pension examinations are qualified to conduct such important examinations.

Veterans are dependent on the medical opinion of contract physicians who perform their disability evaluations to access their earned VA care and benefits. To maximize the effectiveness of the contracted compensation and pension examinations, Congress authorized a national license to practice for such providers, similar to VA health care providers. This means contracted providers may perform an examination in a state other than the one where they are licensed. This legislation would rightfully prohibit health care providers who have their licenses revoked in any state from conducting important compensation and pension examinations for

veterans. Doing so would ensure veterans do not receive inaccurate examinations, which could lead to the wrongful denial of much-needed benefits.

S. 1154, DEPARTMENT OF VETERANS AFFAIRS ELECTRONIC HEALTH RECORD ADVISORY COMMITTEE ACT

The VFW supports this legislation, which would establish an Electronic Health Record Advisory Committee to oversee VA's Electronic Health Records Modernization.

This bill would authorize the advisory committee to conduct periodic risk assessments and evaluations, and develop recommendations to mitigate prominent risks. It would also require the Committee to submit annual reports to the Secretary of Veterans Affairs and the House and Senate Committees on Veterans' Affairs. These would contain recommendations for legislative actions as they see appropriate. This legislation would also provide the ability for impacted stakeholders to participate in oversight of the implementation VA electronic health record modernization.

DRAFT LEGISLATION, JANEY ENSMINGER ACT OF 2019

This legislation would require the Agency for Toxic Substances and Disease Registry (ATSDR) to conduct periodic literature reviews of the existing research regarding the relationship between exposure to toxic water at Camp Lejeune and adverse health conditions. The VFW supports the intent of this legislation, but has a serious concern with the threshold it sets for medical research, which we hope this Committee will address before advancing this legislation.

The approximately 650,000 veterans and family members who served on Camp Lejeune between 1953 and 1987 deserve to know if their health conditions are related to water they drank that was contaminated with trichloroethylene, tetrachloroethylene, vinyl chloride, and other toxins. That is why the VFW fully supports periodic literature reviews of the existing body of research on the relationship between contaminated water at Camp Lejeune and the health conditions prevalent among veterans and family members exposed to such toxic substances.

However, this legislation would require the ATSDR to evaluate whether a health condition is caused by exposure to contaminated Camp Lejeune water, which is an unreasonably high bar for determining a relationship between adverse health conditions and toxic exposure. This legislation would require the ATSDR to place related health care conditions into three categories: sufficient with reasonable confidence that the exposure is a cause of the illness or condition; modest supporting causation; or no more than limited supporting causation. This would mean that the majority of the health conditions the ATSDR considers to be associated with exposure to trichloroethylene, tetrachloroethylene and vinyl chloride in drinking water would fail to meet this threshold.

Research regarding toxic exposures has traditionally used the Institute of Medicine's (IOM) six categories of associations: sufficient evidence of a causal relationship; sufficient evidence of an association; limited/suggestive evidence of an association; insufficient evidence to determine whether an association exists; inadequate/insufficient evidence; and limited/suggestive evidence of no association. These six categories are aligned with the nature of epidemiological research and can be used to guide future research. The VFW strongly urges this Committee to reduce the threshold from causation to IOM's six categories of association.