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**STATEMENT OF
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BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
JUNE 23, 2021**

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

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

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

S.372—Ensuring Quality Care for Our Veterans Act

S. 372 would require the VA Secretary to enter into a contract with a third party to review clinical providers (appointees) in the Veterans Health Administration (VHA) who had a health care license terminated for cause by a state licensing board for services rendered at a non-VHA care facility. The bill would also require the third party to review patients records for the purposes of quality of care management and, if it is determined that the standard of care was not met, VA would be responsible for notifying the patient of that finding.

States might terminate licenses for clinicians for a variety of reasons—for example, sexual misconduct, insurance fraud, running “pill mills,” patient abuse, convictions, or substance abuse. When a medical license is revoked, the state bans the clinician from practicing within its boundaries and usually reports the clinician to the National Practitioner Data Bank—which VA may use as a credentialing resource.

Looking at trends in disciplinary actions taken against medical doctors, in 2019 the Federation of State Medical Boards reported that of the more than one-million licensed physicians in the U.S., 266 had their licenses revoked. This number does not include all medical professions and there are potentially more individuals who surrender

their license prior to revocation or who receive lighter penalties such as suspension or probation that the bill does not address.

Maintaining safety and ensuring quality care for all VA patients is critically important. VA is responsible for ensuring proper credentialing of clinical providers and oversight of disciplinary actions that occur while employed by VHA or while under contract for providing health services to VA patients. The Office of Inspector General (OIG) is also often called upon to investigate incidents of substandard care. While DAV does not object to a third party review as prescribed in the bill, we believe a more comprehensive approach to improve VA's credentialing, privileging and monitoring processes is necessary to ensure the quality of VA care. Therefore, we recommend the Committee work with VHA to determine a comprehensive plan and best practices for oversight of actions reported by relevant entities to monitor medical malpractice claims, medical license revocation, penalties, suspension and probationary actions.

S.539—Requires VA Secretary to submit a report to Congress on the use of video cameras for patient safety and law enforcement at VA medical centers

This bill would require the VA Secretary to submit a report to Congress on increasing the use of video cameras, along with recommendations on video monitoring to improve patient safety and law enforcement at VA medical centers.

The report must contain information about patient safety, to include how cameras are used to monitor staff and patients, areas in which cameras are used to protect patients, procedures used to position cameras and how to ensure that cameras used in drug storage areas are properly monitored. The report should also include recommendations that improve patient safety as well as law enforcement practices. Additionally, the bill requires information on data storage, the number of staff required to monitor video footage and funding necessary to establish routine use of interior and exterior video use to protect patient safety. We recommend that the report also include analysis and recommendations about best practices for ensuring that use of security cameras protects patient privacy to the greatest extent possible.

While DAV does not have a specific resolution calling for a report on video camera use at VA medical facilities, we do support a safe and welcoming environment for all veterans using VA health care services. This legislation would help VA determine best practices for ensuring patient safety and enforcement of policies to help promote a safe environment for both patients and staff at all VA health care facilities. For these reasons, we have no objection to the Committee's favorable consideration of the legislation.

S.544—Directs the VA Secretary to designate one week each year as "Buddy Check Week" and provide training for peer wellness checks for veterans

This bill would require that VA designate one week each year as “Buddy Check Week” and organize outreach events to educate veterans on how to conduct peer supported wellness checks for veterans. The bill would require VA to collaborate with people and organizations that work with or serve veterans and provide educational materials on conducting peer wellness checks and information on available resources veterans may need. All educational training materials must be made available on VA’s website and include resiliency training and how to transfer calls to the Veterans Crisis Line. The proposal also includes provisions to ensure the VA Crisis Line can handle an increased number of calls during the designated “Buddy Check Week”.

DAV is pleased to support S. 544, a bill aimed at assisting veterans with mental issues and reducing suicide in the veteran population through a targeted outreach initiative and training program for peer-supported wellness checks. This legislation is in line with DAV Resolution No. 307, which supports improvements in VA mental health programs and suicide prevention efforts.

S. 612—Improving Housing Outcomes for Veterans Act of 2021

This bill would require the VA Under Secretary for Health to ensure best practices information is shared between VA homelessness service providers, public and private community organizations and partners including the Department of Housing and Urban Development (HUD) through the coordinated assessment systems operated by the Continuum of Care Program. In addition, it would require the Under Secretary to communicate information about the performance measures of homelessness programs and how to obtain and provide feedback about such measures with VA employees whose responsibilities are related to homelessness assistance.

This legislation follows a 2020 Government Accountability Office report (GAO-20-428), which noted that despite significant gains in reducing homelessness among veterans over the past decade, improvements could be made in the administration of services by VHA’s Homeless Program Office to better support collaboration with local partners and other federal agencies, including HUD. The report also found shortcomings in VHA’s communication with VA medical centers, service providers, and local partners regarding the delivery of services for veterans experiencing homelessness, in collaboration with local “Coordinated Entry” systems.

DAV is pleased to support this legislation which seeks to improve collaboration between VA and its partners with a goal of more effective delivery of homelessness services to veterans. S. 612, is in accordance with DAV Resolution No. 369, which supports VA’s initiative to eliminate homelessness among veterans and strengthen the capacity of its homeless program and services.

S. 613—PAWS for Veterans Therapy Act

S. 613, the Puppies Assisting Wounded Servicemembers (PAWS) for Veterans Therapy Act, would require the VA to carry out a five-year pilot program to award grants to one or more non-government agencies to assess the effectiveness of a service dog training program for veterans suffering from post-deployment mental health issues and post-traumatic stress disorder (PTSD). Veterans would need to be referred to the program by a qualified health care provider and may participate in the program in conjunction with VA's compensated work therapy program.

To remain eligible for the program, veterans must see a VA mental health care provider who is treating them for PTSD at least once every six months. VA would be required to develop metrics and measure effectiveness of the program on reducing veterans PTSD symptoms and their overall progress over a five-year period. The bill would require a GAO report to evaluate the methodology established for determining a veterans' overall improvement with respect to psychosocial function, therapeutic compliance, and reducing dependence on certain medications. Finally, the bill includes a provision to authorize VA to provide service dogs to veterans with mental illness regardless if they have a mobility impairment. We note that VA has the authority to prescribe a service dog to a veteran with mental illness including PTSD under title 38, United States Code (USC), section 1714.

DAV understands that many veterans would like the opportunity to try alternative mental health treatments to reduce symptoms associated with PTSD, an often severely debilitating condition, without taking medication. While we do not object to a pilot project looking at the therapeutic medium of training service dogs on reducing the severity of symptoms of veterans with PTSD, we want to ensure there is a consistent application of benefits provided to service-disabled veterans who are prescribed a service dog by a VA provider related to a service-connected condition.

Recently, VA completed a multi-site study of the differential effectiveness of service dogs and emotional support dogs on assisting veterans with PTSD. According to the study report released in January 2021, of the 227 study participants, 181 veterans were paired with either a service dog or emotional support dog and followed for a period of 18 months. Researchers evaluated outcome measures for overall disability and quality of life. Secondary outcomes included PTSD symptoms, suicidal ideation, depression, sleep and anger. The study concluded that both groups showed some improvements in outcomes but that there were no marked differences between having a service dog compared to an emotional support dog in terms of improvements in quality of life and in limiting the effects of their disabilities. Among veterans paired with a service dog there was a reduction in the severity of PTSD symptoms compared to

participants paired with an emotional support dog along with fewer suicidal behaviors and ideations, particularly at 18 months post-pairing.¹

Currently, under title 38, USC, Section 1714 a service-disabled veteran diagnosed as having a visual, hearing, mental illness (including PTSD) or substantial mobility impairment may be prescribed a service dog if, in the clinical judgement of the veteran's VA provider, it is deemed a trained service dog could assist the veteran to manage his or her impairment and live independently. A service dog prescribed to a veteran with service-connected PTSD may be trained to perform specific tasks that enable the veteran to maintain their independence, the ability to function in the community and interact with other people. For example, such dogs may be trained to "sweep" a room for signs of danger, to recognize and deter veterans' destructive behaviors, such as self-mutilation, and to navigate veterans out of situations in which they have become anxious or confused—they may even be trained to remind veterans to take prescribed medication.

VA prescribes service dogs, which are then obtained by veterans through a non-profit agency. Veterinary health insurance benefits are provided for an accredited service dog under title 38, Code of Federal Regulations (CFR), Section 17.148(c) for veterans prescribed a service dog for a visual, hearing or substantial mobility impairment. The dog and veteran must successfully complete a training program offered by an organization accredited by Assistance Dogs International (ADI), the International Guide Dog Federation (IGDF), or both (for dogs that perform both service and guide dog assistance). We note that "mental illnesses including PTSD" (included in the statute) is not included in the regulation authorizing veterinary benefits to veterans with service dogs that have successfully completed training by an accredited organization described above. We urge VA to amend the regulations to match the statute and provide equity to veterans prescribed a service dog for mental illnesses or PTSD.

We also note that the FY 2021 National Defense Authorization Act passed in the 116th Congress (Public Law 116-283), included a provision (in Section 745 of Title VII Subtitle D) that requires the DOD Secretary to establish a Wounded Warrior Service Dog Program to provide service dogs to service members and veterans with certain disabilities, including: blindness or visual impairment; loss of use of a limb; paralysis or other significant mobility issues; loss of hearing; traumatic brain injury; PTSD; or any other disability that the Secretary considers appropriate. It appears that DOD has called for grant applications to implement this provision of the law, and we are eager to understand more about this important new benefit for service-disabled veterans.²

¹ Department of Veterans Affairs A Randomized Trial of Differential Effectiveness of Service Dog Pairing Versus Emotional Support Dog Pairing to Improve Quality of Life for Veterans with PTSD Office of Research and Development Veterans Health Administration Department of Veterans Affairs Washington, DC January 5, 2021.

² Federal Grant Opportunity for Wounded Warrior Service Dog Program (WWSDP) FY2021 HU000121USU0001. Posted Dec 4, 2020. Due Feb 3, 2021. Department of Defense. CFDA 12.750 -

We urge the Committee to clarify how the Wounded Warrior Service Dog Project under Public Law 116-283 will affect disabled veterans' access to service dogs and ensure there is a standardized benefit package available to all veterans with a clinical need of a service dog regardless of the type of disability they have. As currently written, we believe S. 613 would contribute to the confusion and inequity in VA policy regarding service dogs. If one disability group receives a trained service dog at no out-of-pocket cost then other disability groups should also receive a trained service dog at no cost. We further believe that all service dogs should be trained by an accredited organization that is recognized by VA under title 38, CFR section 17.148(c) and receive the same veterinary benefit. For example, if a veteran participating in the pilot program benefits from training a service dog and elects to keep the service dog, that service animal should be eligible for the veterinary health insurance benefit available to other veterans to whom service dogs have been prescribed.

S. 727—CHAMPVA Children's Care Protection Act

This legislation would increase the maximum age for children eligible for medical care under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) until the child's 26th birthday, regardless of the child's marital status.

We are pleased to support S. 727, the CHAMPVA Children's Care Protection Act, in accordance with DAV Resolution No. 081 which calls for legislation to allow dependent children eligible for CHAMPVA to remain covered until the child's 26th birthday regardless of their marital status.

S.796—Protecting Moms Who Served Act of 2021

The Protecting MOMs Who Served Act would require the VA to increase support for its maternity care coordination activities and requires GAO—the Government Accountability Office to report on maternal mortality and morbidity among veterans using VA health care services with a focus upon racial and ethnic disparities in these adverse outcomes.

Women using VA health care have a number of factors such as advanced age, mental health conditions, including post-traumatic stress disorder and substance abuse, and physical disabilities that may put them at higher risk of adverse birth and health outcomes. Maternity services for women veterans are provided through VA's Community Care Network. In order to ensure that women veterans are receiving high

Uniformed Services University Medical Research Projects. Accessed on <https://govtribe.com> on 6/19/2021.

quality care, VA has instituted a Maternity Care Coordination policy. Unfortunately, this important care coordination position is often a collateral duty and coordinators prioritize direct care duties when they become overburdened.

This legislation would provide additional resources to VA to ensure training is available and that staff have adequate time to execute VA's maternity care coordination policy. This bill also require the Comptroller General to use existing data to assess maternal mortality and severe morbidity among veterans using VA.

DAV Resolution No. 020 calls upon DAV to support program enhancements and improvements including gender-specific services for women veterans. DAV Resolution No. 133 is supportive of VA's efforts to identify and research associations between military service and impact on health. In accordance with these resolutions, DAV strongly supports this bill.

S. 887—VA Supply Chain Resiliency Act

S. 877—the VA Supply Chain Resiliency Act, requires the Department to submit a report containing a description and quantities of items that are critical to the VA's ongoing response to the COVID-19 pandemic and any potential future epidemic, pandemic, emergency, national emergency, or natural disaster.

It also requires VA to enter into an agreement with the Department of Defense (DOD) for participation in the Warstopper Program of the Defense Logistics Agency (DLA)—a program established to satisfy requirements for sudden and sustained increases in production of critical industrial and medical items.

Under this agreement, the DLA must:

- Ensure the maintenance and stability of items the VA identifies as critical in its report,
- Establish guidance for VA's participation in the program, and
- Use existing and new contracts and agreements to reserve the supply of critical items.

Finally, the VA would be required to submit a report on the planned implementation of the program and ensure it does not exclusively rely on holding regional, physical inventories of critical items in order to respond to greater than expected needs during an epidemic, pandemic, emergency, national emergency, or natural disaster situations.

The VA carries the responsibility of serving as a backup for DOD, responding in concert with the Department of Homeland Security, and coordinating with the Department of Health and Human Services to fulfill its indispensable role in our nation's emergency preparedness strategy. Lessons learned from the pandemic illustrated the

serious consequences when normal supply chains for critical medical supplies and personal protective equipment are disrupted, and the need for alternative preparedness plans.

For these reasons, DAV supports S. 877, in accordance with DAV Resolution No. 96, which recognizes and supports VA's critical fourth mission of providing needed assistance during natural disasters and national emergencies.

S. 951—Puppies Assisting Wounded Servicemembers (PAWS) Act of 2021

The PAWS Act of 2021, would require the VA to establish a three-year program to authorize grants of up to \$25,000 to eligible organizations to pair veterans suffering from severe post-traumatic stress disorder (PTSD) with service dogs. In addition to initial pairing costs, the grant funding to a non-profit organization would cover:

- The veterinary health insurance policy for the life of the dog;
- Service dog hardware if clinically determined to be needed to perform tasks; and
- Payment for travel expenses for the veteran to obtain the original service dog.

In order for an organization to be eligible for the VA grant, it must be (1) a non-profit organization that provides service dogs to veterans with PTSD; (2) accredited by Assistance Dogs International (ADI), the International Guide Dog Federation (IGDF) or other organization the VA secretary deems to meet its accreditation standards; (3) have expertise in the unique needs of veterans with PTSD.

To be and remain eligible to participate in the pilot program a veteran must: (1) be enrolled in the VA health care system; (2) have completed a course of evidence-based treatment for PTSD but remain significantly symptomatic; (3) continue to see their VA health care provider at least once every 6 months to determine if the veteran continues to benefit from the service dog.

The bill includes provisions to ensure a veteran furnished a service dog under the program may elect to keep the dog for the life of the service animal, regardless of the continued participation of the veteran in the program or return the dog to the grant organization if he or she is unable to safely care for the dog.

The Comptroller General would be required to submit a report on the program, which must contain an evaluation of the approach and methodology used to help veterans with severe PTSD return to civilian life, to include findings for participants related to psychosocial function and therapeutic compliance and reducing the dependence on prescription narcotics and psychotropic medications.

DAV does not have a specific resolution calling for a pilot grant program described in the legislation, but we are supportive of alternative, non-pharmacological,

mental health therapies and treatment options for veterans suffering from unrelenting PTSD symptoms and who are at high risk for suicide.

DAV recognizes that trained guide and service dogs can play a significant role in maintaining functionality and promoting maximal independence for individuals with disabilities. As noted above in relation to our testimony on S. 613, we do want to ensure there is a consistent application of benefits provided to service-disabled veterans who are prescribed a service dog by a VA provider for a service-connected condition. This bill does address a number of the concerns we commented on in S. 613, but it would still establish a precedent for a non-VA entity (non-profit organization) to provide lifetime veterinary insurance benefits for a service dog if the veteran elects to keep the service animal—specifically, putting veterans at risk for liability of covering veterinary insurance costs should the non-profit organization be dissolved. DAV also notes that only providing service dogs to veterans with PTSD, while excluding veterans with other severe mental health conditions, raises questions of equity to this benefit.

S.1040—Expansion of Eligibility for VA Medical Services to World War II Veterans

S. 1040 would require the VA to offer hospital care and medical services to veterans of World War II regardless of service-connected disabilities, income level or other eligibility criteria. It would also authorize the VA to provide nursing home care if it determines the need for such care. DAV does not have a resolution on this issue and takes no formal position on the bill.

S.1198—Solid Start Act of 2021

This bill would strengthen and codify the Solid Start program, created by the VA in 2019. The Solid Start program requires VA representatives to make calls to newly separated service members over the first year post-transition period to help them navigate the process for accessing their VA benefits or any other resources they may need for a successful transition from military service. During these calls, VA representatives check on the veteran's overall transition experience, answer questions and direct veterans to needed resources, supportive services and programs.

The "Solid Start Act of 2021" strengthens this program by including specific language to help connect women veterans to VA resources and a provision that recommends the VA provide information about state and local resources, as well as contact information to local chapters of VSOs. It also directs the VA to focus these efforts on separating service members who accessed mental health services prior to separation.

In accordance with DAV Resolution No.100 we are pleased to support S. 1198, and the efforts of Congress to monitor, improve, and report on this important program to

ensure that all transitioning service members have the tools and support they need to establish productive lives after military service.

S.1220—United States Cadet Nurse Corps Service Recognition Act of 2021

S. 1220, the United States Cadet Nurse Corps Service Recognition Act of 2021 would amend Title 38, United States Code, to recognize and honor the service of individuals who served in the United States Cadet Nurse Corps during World War II. This act would require Department of Defense (DOD) to discharge certain nurse corps cadets of service and allow them burial benefits (except at Arlington National Cemetery) and would create an award for their service to the nation. The bill does not include provisions that would make them eligible for VA disability compensation or health care benefits.

DAV recognizes the great service and sacrifice made by the uniformed women who stepped in to save the U.S. medical system from collapse during World War II so professional nurses could attend to the needs of the military and our injured service members. We take this opportunity to thank the surviving members of the U.S. Cadet Nurse Corps for their support and service to our nation however, we have no resolution on this matter and therefore take no formal position on the bill.

S.1280—Veteran Families Health Services Act of 2021

S. 1280, the Veteran Families Health Services Act would support the needs of veterans with a diagnosis of infertility or the inability to conceive or safely carry a pregnancy to term. The bill would make assisted reproductive technology (ART), including in-vitro fertilization, available to all enrolled veterans unless the conditions rendering them infertile were acknowledged before military service.

VA and DOD currently offer this benefit to a limited group of service disabled veterans who are legally married and can produce their own genetic material. Single veterans, with or without partners, and veterans with same-sex partners, even those who are legally married, are prohibited from accessing these services due to existing provisions that do not allow the use of surrogates. The Veteran Families Health Services Act would correct existing inequities by allowing all enrolled veterans access to this benefit regardless of the cause of their infertility, marital status, gender identity or sexual orientation. Partners would be required to agree to clinical participation in the process but would not be eligible for maternity care benefits unless they were eligible as a veteran.

Currently, this benefit is limited to veterans with grave disabilities generally involving biomechanical impediments, such as spinal cord or genitourinary injuries. Yet, there is a growing body of evidence that commonly-experienced conditions often related

to military service, such as post-traumatic stress disorder, depression, anxiety and exposure to toxic or hazardous materials, can be associated with infertility.

DAV Resolution No. 381 calls for VA to improve the care provided to veterans with service-connected disabilities affecting the ability to procreate and allows DAV to support S.1280—Veteran Families Health Services Act of 2021.

S. 1319—VA Quality Health Care Accountability and Transparency Act

S. 1319, the VA Quality Health Care Accountability and Transparency Act would require VA to improve the way it discloses health care measures and staffing levels at its facilities to help ensure veterans have access to information they need to make informed decisions.

This bill calls for VA to streamline its disclosure of wait times; safety, quality of care and outcome measures; staffing and vacancy information; and other indicators related to veteran-centered care via the department's Access to Care website. The bill authorizes VA to work with outside entities to contract website redesign to enhance the usability and presentation of information for patients and consumers. Additionally, this legislation would require an annual audit of information published on this site to ensure accuracy and completeness, and to identify any deficiencies.

We believe publishing this information in a user-friendly, accessible format can not only aid veterans in making educated health care decisions, but it would also help identify facility locations that require more attention and resources. One suggested area for long-term improvement would be to publish better, more comparable data between VA facilities and specific non-VA community care providers in lieu of community averages or benchmarks.

DAV supports S. 1319 in accordance with DAV Resolution No. 368, which calls for the strengthening and reform of the VA health care system, to include measures that enhance transparency, efficiency and accountability.

S. 1467—Cannabis Research Act

S. 1467, the Cannabis Research Act would require the VA to conduct clinical trials on the effects of medical-grade cannabis on the health outcomes of veterans with chronic pain and PTSD.

The study is required to evaluate if medicinal cannabis has an effect on osteopathic pain, inflammation, sleep quality, as well as increase or reduction in certain medications and alcohol use. The study is also required to evaluate the effects of cannabis use on PTSD symptoms to include changes in mood, anxiety, social functioning, and frequency of night terrors or nightmares. The clinical trials may include

an evaluation of the effects of cannabis use on several health systems such as pulmonary function, cardiovascular events, head, neck and oral cancer and certain mental health conditions. In conducting the study, VA is required to use various forms of cannabis to include whole plant raw materials and extracts and no less than 7 unique plant cultivars with specific tetrahydrocannabinol/cannabidiol ratios.

Finally, a provision is included in the legislation to ensure veterans participating in the clinical study will not be affected or denied eligibility or entitlement to other VA benefits, as a result of such participation.

In accordance with DAV Resolution No. 076, we support more comprehensive and scientifically rigorous research by the VA into the therapeutic benefits and risks of cannabis and cannabis-derived products as a possible treatment for service-connected disabled veterans.

S.1863 - Guaranteeing Healthcare Access to Personnel Who Served (GHAPS) Act

S. 1863, the Guaranteeing Healthcare Access to Personnel Who Served (GHAPS) Act, would make a number of changes to current laws and regulations intended to improve veterans' access to health care, including to VA's new Community Care Networks (CCNs).

Section 101 of the bill would codify VA health care access standards adopted by regulation in June 2019 as required by the VA MISSION Act. Specifically, the bill would make permanent the current access standards for primary care, mental health care and non-institutional extended care services which are 20 days waiting time for an appointment or 30 minutes average driving time from the veteran's residence. For specialty care and services, the current access standards are 28 days waiting time or 60 minutes average driving time. The bill would apply these same access standards to CCN providers and would also codify a waiver process for the Third Party Administrators (TPAs) of CCNs for geographic areas that have a scarcity of medical providers. This section would also require VA to review these access standards at least once every three years.

DAV does not support Section 101 of the bill. We believe it is premature to codify access standards that have already been adopted by regulation without sufficient evidence that doing so would improve the access to or quality of health care provided to enrolled veterans.

Last November, in its Report to Congress on Access Standards, VA found that neither VA nor the TPAs were able to fully meet the current access standards. The report, which only reported data on new patients, found that VA was unable to meet the 20-day standard for primary care more than a third of the time. For specialty care, VA could not meet the 28-day standard for new patients between 22% and 44% of the time, depending on the specialty.

The TPAs had to meet different access standards based on their contracts with VA. For wait times, the TPA contract standard was 30 days for both primary and specialty care, rather than the VA standards of 20 and 28 days, respectively. VA indicated that the TPAs were meeting or close to meeting the 30-day CCN timeliness standard, but that for specialty care referrals, the TPAs were unable to meet the wait time standard between 10% to 30% of the time, depending on the type of service. For drive times, the TPA contract standards ranged from 30 minutes in urban areas up to 180 minutes in highly rural areas, significantly different than the VA standards.

VA's November 2020 report did not include any findings or recommendations about whether the current access standards were appropriate or effective, or whether they should be modified in any manner. The report included only wait time data on new patients, leaving out critical information on existing patients. The VA report also noted that the ongoing COVID-19 pandemic significantly impacted veterans normal health care usage and utilization patterns, with many veterans deferring care over the past 15 months. Furthermore, the new CCNs were not fully implemented and functioning until last year, making it difficult to make firm judgements about their performance.

Under the VA MISSION Act, VA is required to undertake a review of the access standards by June 6, 2022, and submit its findings to Congress with recommendations for modifications (Title 38, USC, Section 1703B(e)). We believe it would be premature to codify access standards before VA completes this review next year.

We note that in Section 101 there is a provision mandating that in determining a veteran's eligibility to receive community care, VA "...shall not take into consideration the availability of telehealth..." which would seemingly diminish VA's provision of telehealth services, even if proven to be as effective as in-person care. Over the past year, VA significantly increased its provision of telehealth and other virtual care modalities in response to the pandemic. While we supported this expansion, we also have concerns about whether all medical services can be provided through telehealth as effectively as in-person care. As such, DAV does support section 201 to have VA develop a strategic plan for telehealth and section 203 to have GAO conduct a study on the efficacy and effectiveness of telehealth. However, we believe it would be shortsighted to completely eliminate consideration of telehealth when making judgements about veterans' access to quality care. For many patients who are homebound or remote it may be a preferable option to difficult and long travel. Even as the pandemic winds down, VA and the private sector are likely to continue to use telehealth as an alternative for in-person care and many veterans will continue to choose it.

Section 101 also includes a waiver provision for TPAs based on the unavailability of health care providers in a geographic area. Currently, the TPAs have provisions in their contracts allowing VA to waive network adequacy requirements when there is a scarcity of providers in a geographic region. As with codifying access standards, DAV believes it is premature to codify TPA waivers until access and quality standards for

CCNs are equivalent to VA's standards. Veterans should have assurance that they will receive the same quality of care and health outcomes when they elect to go to CCN providers.

Section 102 would require VA to develop a strategic plan to ensure continuity of care under the Community Care Program in the event of the closure of a VA health care facility. When the upcoming Asset and Infrastructure Review (AIR) process concludes in a couple years, it is likely that some VA facilities, or parts of facilities, may be closed or realigned, and affected veterans will instead be furnished care from community partners. We believe that the intent of this provision is to ensure that in every instance VA is prepared to ensure a seamless transition. DAV agrees with the intent of this provision, but recommends that it be modified to ensure that VA has operational plans, not just strategic plans, to ensure continuity of care. Furthermore, we recommend that language be included to mandate that VA may not close a VA health care facility unless it has an up-to-date operational plan that will ensure a seamless transition of veterans to alternate care providers, without any reduction in the timeliness or quality of care.

Sections 111 thru 114 would require VA to establish a pilot program to allow veterans to self-schedule community care appointments through the Internet. The pilot program would begin within 120 days at 5 locations, and run for 18 months, at which time VA would determine whether to roll out the self-scheduling system to other VISNs.

For years, veterans have called for, and VA has worked towards, allowing the ability to self-schedule medical appointments. As part of its work on the electronic health record modernization (EHRM), Cerner is working on developing a Centralized Scheduling Solution that would help to establish a common platform for VA and community care appointment scheduling, a critical step towards universal self-scheduling. At present, however, VA is only capable of offering limited self-scheduling opportunities for just a few services in some locations. During recent VSO stakeholder briefings, VA's Office of Community Care indicated that a comprehensive Internet-based self-scheduling solution for VA appointments was likely years away, and one that incorporated community care networks was not yet on the horizon. Both TPAs also confirmed this assessment during separate briefings with VSO stakeholders.

While DAV agrees with the basic intent of this provision—to allow veterans greater control over scheduling their medical appointments—we believe this provision would only address one part of veterans' medical care scheduling needs. A foundational principle of VA's community care program is that veterans must be fully informed about both their VA and CCN options. Currently, veterans are referred to TPAs when VA cannot meet an access standard, without knowing whether a CCN provider can offer quicker, more conveniently-located and at least equal quality care. A true self-scheduling system must provide direct comparisons among all VA and VCN options about the wait times, driving times, locations, quality metrics, patient satisfaction and other critical information to allow veterans to make informed decisions about what is in their best medical interest. As such, we believe that it makes little sense to rush out a

limited self-scheduling system only for community providers. Instead, VA must work with the TPAs to develop a single comprehensive scheduling solution for both, one that includes the most robust and informative self-scheduling system practicable.

DAV supports sections 121 and 122 of the legislation which aims to strengthen credentialing verification for VCN providers to better ensure that veterans receive care from fully qualified clinicians.

As noted above, DAV supports sections 201 and 203 which would require VA to develop a strategic plan for telehealth and have GAO conduct a study on the efficacy and effectiveness of telehealth. Over the past 15 months, the provision and use of telehealth, not just in VA, grew dramatically across the country in response to the emergency need to provide medical care that was socially distanced. While we support the expanded use of telehealth, we also agree there needs to be a strategic review and plan developed to ensure that telehealth is used only when it is proven to be at least as effective as in-person care.

Sec. 202 requires a GAO study of third-party transportation services to rural veterans to determine if there are gaps that could and should be covered through additional programs and services, including potentially contracting with taxis, Uber and Lyft.

As you may know, DAV operates a national transportation program that provides free rides for veterans to their VA health care appointments. Since 1987, we have deployed DAV vehicles in every state and nearly every congressional district serving our nation's ill and injured veterans. The DAV Transportation Network is the largest program of its kind for veterans, staffed by 155 hospital service coordinators and more than 7,600 volunteer drivers at VA medical centers across the country. During FY 2020, our volunteer drivers spent over 675,000 hours transporting veterans to their VA medical appointments. Despite challenges due to the COVID-19 pandemic, these volunteers logged almost 10 million miles and provided more than 243,000 rides to VA health care facilities, saving taxpayers more than \$18.4 million. Since our national transportation program began in 1987, more than 19.6 million veterans have been transported over 760 million miles.

Last year, DAV donated 111 new vehicles to VA facilities to use for transporting veterans, at a cost of more than \$3.6 million. To date, DAV departments and chapters have donated 3,558 vehicles to the VA for transporting veterans to their medical appointments, at a cost of more than \$83 million. This year, we plan to donate an additional 73 vehicles to the VA, at a cost of over \$2.3 million. We also want to recognize the contributions of Ford Motor Company, which has supported this effort by purchasing 239 vehicles, including eight more this year, to donate to VA at a cost of more than \$5.6 million.

However, despite the success of our program, we recognize that there are still parts of the country, particularly in rural and highly rural areas—where neither the DAV nor any other third-party transportation program is available for some veterans. As such,

we agree that having additional modes of transportation to supplement what already exists could help to improve veterans access to care, and we have no objection to the study.

Section 301 would require VA to study the feasibility and advisability of expanding its comprehensive caregiver assistance program to eligible veterans in the Republic of the Philippines. Section 302 would require a GAO study of the foreign medical program for veterans living overseas. DAV has no resolutions regarding care for veterans living overseas, but has no objections to these studies that may benefit service-disabled veterans.

Section 401 requires VA to assess the feasibility and advisability of expanding mental health interventions for treatment-resistant major depressive disorders, such as electro-convulsive therapy and repetitive transcranial magnetic stimulation. DAV supports expansion of innovative evidence-based practices in mental health treatment, and thus supports further studies about their efficacy and effectiveness.

Section 402 would modify VA's resource allocation system (VERA) to include peer specialists. DAV strongly supports this provision as a means of expanding the use of peer support throughout VA.

Section 403 would require VA to undertake a gap analysis of its use of psychotherapeutic interventions that are recommended in widely used clinical practice guidelines. DAV supports this provision to help determine whether there should be greater use in VA of evidence-based psychotherapeutic interventions, and what barriers may exist to their usage. DAV supports this study to ensure veterans continue receiving the highest quality mental health care.

Section 501 would require VA to develop an online health education portal that contains interactive modules for veteran patients on such matters as eligibility for community care, telehealth, the VHA appeals process, navigating VHA resources and a variety of services lines such as primary care, mental health and women's health care. DAV supports this section, which includes a requirement to consult with VSO stakeholders, in order to ensure veterans have access to information about their VA medical benefits and rights.

Section 502 would exclude VHA's research activities from the requirements of the Paperwork Reduction Act, the same as the National Institutes for Health receives for sponsored research. DAV supports this provision to help remove unnecessary delays and obstacles to critical biomedical research.

S.1875 Veterans' Emergency Care Claims Parity Act

S. 1875 would establish a deadline of 180 days for the submission of claims for payment for veterans' emergency care treatment in non-VA facilities. The bill would ensure that veterans are not held liable for claims submitted after the 180-day deadline

due to administrative errors made by the provider or VA. It would also ensure that VA makes information available to non-VA providers to improve claim submissions including a summary of VA authorities for reimbursing costs for emergency care with corresponding deadlines for submission of claims; an illustrated summary of steps to ensure “clean” claim submission; and contact information for questions related to the claims process.

A 2019, VA OIG report found a significant number of veterans’ emergency care claims were inappropriately denied and many rejected claims were inappropriately processed, with some leading to wrongful denials and rejection of claims. DAV is aware of veterans who have been held liable for health care costs billed to them long after services were rendered when they had assumed that VA had handled any financial obligations for such care. These unfortunate billing surprises often wreak havoc on their personal finances, can damage a veterans’ credit and often cause confusion and unnecessary anxiety.

DAV is pleased to support S.1875, the Veterans’ Emergency Care Claims Parity Act, which is in accord with DAV Resolution No. 79 supporting legislation to address barriers to emergency care and payment or reimbursement for such care for disabled veterans.

S. 1965—Planning for Aging Veterans Act of 2021

This bill intends to strengthen long-term care (LTC) for veterans by requiring VA to develop a strategic long-term care plan for providing both institutional LTC through VA’s Community Living Centers (CLCs), State Veterans Homes (SVHs) and community nursing homes, as well as non-institutional care through home and community-based services. The bill would also make a number of modifications to improve the oversight and operation of SVHs.

With more than half of the veteran population aged 65 or older, the need for a broad and effective range of long-term care options will continue to increase in the years ahead. In accordance with DAV Resolutions 072 and 372, DAV supports this legislation.

Earlier this year, DAV and our Independent Budget partners (Paralyzed Veterans of America, Veterans of Foreign Wars) called for VA to “develop a new strategic plan that estimates the number of veterans who will require institutional LTC and the number of veterans that VA will support in LTC facilities. Additionally, [VA] should develop a plan to build, maintain, and subsidize sufficient LTC facilities within the VA’s nursing homes (CLCs), and SVHs.”³ Section 2 of this legislation would accomplish that goal and we strongly support this provision.

To improve oversight of State Veterans Homes, the bill would require VA to conduct quarterly reviews of the quality of inspections conducted on SVHs by VA

³ <http://www.independentbudget.org/117-congress/healthcare>

contractors. The bill would also require that all deficiencies found during an inspection be reported to VA, and that VA publish such inspection reports on its website. DAV supports increased transparency and public information about the quality of SVHs and all long-term care options to better inform veterans.

Section 4 of the bill would authorize VA to establish a geriatric psychiatry pilot program at SVHs to provide care for aging veterans with severe mental health and behavioral issues. Today, neither VA's CLCs, SVHs nor community nursing homes are well situated to handle the intensive and expensive needs of such veterans. DAV supports this provision to conduct pilot programs at SVHs to help develop models for providing such care.

The bill would also call on VA to work with public housing authorities and local organizations to expand supportive services for aging veterans at risk of homeless. DAV supports this provision to help prevent homelessness among older veterans.

S. 2102—SERVICE Act of 2021

S. 2102, the Supporting Expanded Review for Veterans in Combat Environments Act—or SERVICE Act of 2021, would revise the VA's standards for mammography screenings to include those veterans who have served in locations known to have been associated with toxic exposures.

The bill would expand eligibility for these life-saving screenings beyond the commonly-advised age and risk scope to encompass those who have served in specific locations and timeframes, including Iraq, Afghanistan, and areas of Southwest Asia, as well as other areas where U.S. military forces utilized burn pits. Finally, the bill requires a report to Congress comparing the rates of breast cancer among troops deployed to areas with known exposures with service members not deployed to those locations and to the civilian population.

VA historically outperforms the private sector in providing breast health screenings for women, and this bill will bolster those efforts ever further. Better screening and early detection, especially among those with known risk factors, can help save lives.

A 2014, DOD Defense Health Agency research report to Congress mandated by Public Law 112-239 (FY 2013 NDAA Sec. 737) indicates that women who have served in the military have an elevated risk for breast cancer compared to their non-veteran peers. Nearly half of the growing demographic of women veterans is under age 45, and after nearly two decades of war many will have had exposure to various toxins during service including milieu of toxins associated with exposure to burn pits. It is imperative these veterans have access to early breast cancer detection services that align with their history of toxic exposures during military service.

DAV strongly supports the SERVICE Act of 2021, in accordance with DAV Resolution No. 20, which calls for enhanced medical services for women veterans.

Draft: Building Solutions for Veterans Experiencing Homelessness Act of 2021

This bill proposes to strengthen and expand services to veterans who are experiencing homelessness or are at risk of becoming homeless. Specifically, the Building Solutions for Veterans Experiencing Homelessness Act of 2021, would:

- Adjust the grants awarded by the VA for comprehensive homeless service programs;
- Increase the maximum rates of per diem payments provided by the VA;
- Provide technical assistance to low income families receiving grants;
- Establish a report on the rental assistance program to include information on serving special populations, i.e., elderly veterans, women and minority veterans and disabled veterans
- Create a program to provide services to assist veterans with navigating housing and health care resources;
- Create a grant program for homeless veterans that coordinates alcohol and substance use disorder recovery services;
- Increase and extend the appropriations for homeless veterans re-integration programs;
- Require the Comptroller General of the United States to provide a report on the availability of affordable housing for veterans who have participated in any program administered by the Homeless Programs Office of the VA; and
- Create two pilot grant programs to care for elderly homeless veterans and to improve public transportation services to veterans.

We supports this bill in accordance with DAV Resolution No. 369 which supports legislation to maintain and improve VA's programs and services to eliminate veteran homelessness. While DAV supports this legislation, we would like to point out two sections in the bill we recommend be amended to more accurately reflect the economic needs of homeless veterans.

First, related to section 3 of the bill, we appreciate the increase of the per diem rates to eligible entities in the Grant and Per Diem (GPD) program from 115% to 200% of the authorized State Home per diem rate for domiciliary care and from 150% to 200% for a homeless veteran in housing that will become permanent. However, we recommend that the maximum allowable rate be maintained at the 300% level that was authorized in Veterans Health Care and Benefits Act of 2020 (P.L. 116-315). The higher amount would cover continued rising costs, higher cost-of-living areas, and costs for additional staff.

Second, DAV supports the Homeless Veterans Reintegration Program (HVRP) reauthorization of \$75 million through 2025 as outlined in Section 8 of the bill, but we believe that additional funding may be needed. HVRP is an employment focused competitive grant program of the Department of Labor, Veterans' Employment and Training Service (DOL-VETS)—the only federal grant to focus exclusively on competitive employment for homeless veterans. However, we believe that an effective program such as this will likely need to expand to encompass the overflow from the Veteran Rapid Retraining Assistance Program—or VRRAP that is on pace to max out its funding before it achieves its 17,250 participant mark. The popularity of the VRRAP program shows that programs such as HVRP are still in high demand among unemployed veterans and we recommend it be expanded to address the growing demand.

Again, DAV is pleased to support this bill and look forward to working with Committee to pass this important legislation for our nation's homeless veterans.

S. 2041—Department of Veterans Affairs Provider Accountability Act

This draft bill, the Department of Veterans Affairs Provider Accountability Act would require the Secretary of Veterans Affairs to enforce compliance with all credentialing requirements for VA medical providers by:

- Ensuring VA medical centers compile, verify, and review documentation for each health care professional;
- Continuously monitoring changes to licensure, certification or registration, including registration with Drug Enforcement Administration (DEA) to prescribe controlled substances;
- Requiring a consistent quality review process for each VA medical center in monitoring performance and quality of health care professionals and completing timely reviews when substandard care is alleged;
- Requiring notification of state licensing, certification and registration entities; DEA and the National Provider Data Bank if substandard care is substantiated;
- Requiring training for employees involved in credentialing and quality care reviews; and
- Requiring audits by an independent agency and reports to Congress to ensure VA compliance with these measures.

DAV supports S. 2041, in accordance with DAV Res. No's. 82 and 89, which call for assurances of quality of VA care through appropriate funding, various management initiatives and effective recruitment and retention practices. DAV is supportive of the checks and balances required in this draft bill, but does note that adding layers of review and oversight to the existing credentialing and privileging process could impede timeliness required for VA to recruit scarce medical professionals and cautions the Committee to consider ways to expedite this already lengthy process when it deliberates this bill. In recent years, VA has been able to improve its hiring and

onboarding activities to more quickly hire clinicians who have recently completed their medical education. That said, DAV recognizes the importance of ensuring patient safety and appreciates the gravity and potential consequences of not applying enough rigor to these processes.

Unfortunately, too often, Human Capital Management seems to receive limited attention from VA leadership and other Federal Government leaders. A 2017 GAO report (GAO-17-627T) found that throughout the federal government, human resources specialists often lack the skills to lead strategic Human Capital Management activities. Earlier that year, a GAO report (GAO-17-30) had determined that VHA had limited human resources capacity to monitor its training activities and align its performance management system with leading human resources practices. VHA may be long overdue for a comprehensive third-party review of its human resource policies and practices and a strategic plan for VA to develop internal expertise which would better ensure some of the provisions in this draft bill could be adequately addressed.

Annual training, quality review and assurance audits and potentially adding new databases and resources for VA Human Resources Management personnel to complete these activities with integrity is likely to require additional employees and funding to fully implement all the provisions of this comprehensive bill.

Mr. Chairman, this concludes my testimony. I will be pleased to answer any questions you or members of the Committee may have.