

**STATEMENT OF  
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**DEPARTMENT OF VETERANS AFFAIRS (VA)  
BEFORE THE  
COMMITTEE ON VETERANS' AFFAIRS  
U.S. SENATE**

**JUNE 24, 2015**

Good morning Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee. Thank you for inviting us here today to present our views on several bills that would affect VA benefits programs and services. Joining us today is Catherine Mitrano, Deputy Assistant Secretary for Resolution Management, and Jennifer Gray, Staff Attorney in VA's Office of General Counsel.

We do not yet have cleared views on the Draft Biological Implant Tracking and Veteran Safety Act of 2015 or on S. 1117, the Ensuring Veteran Safety Through Accountability Act of 2015. Additionally, we do not have cleared views on sections 203, 205, 208, and 209(b) of S. 469, sections 3 through 8 of S. 1085, section 2 of the draft bill referred to on the agenda as "Discussion Draft" or sections 101-106, 204, 205, 403 and 501 of The Jason Simcakoski Memorial Opioid Safety Act. We will be glad to work with the Committee on prioritization of those views and cost estimates not included in our statement.

**S. 469      Women Veterans and Families Health Services Act of 2015**

VA is providing views on Title II- Reproductive, Adoption, and Child Care Assistance for Veterans except for sections 203, 205, 208, and 209(b).

Section 201 would amend the definition of "medical services" in 38 USC 1701 to include "Fertility treatment and counseling, including treatment using assisted reproductive technology." This amendment would in effect require VA to provide these services and override VA's regulation prohibiting the provision of in vitro fertilization at 38 CFR 17.38(c)(2). VA supports section 201 conditioned on the availability of the additional resources needed to implement this provision. The provision of fertility treatment and counseling, including assisted reproductive technologies (ART) is consistent with VA's goal to restore to the greatest extent possible the physical and mental capabilities of Veterans and improve the quality of their lives and that of their families. For many, having children is an important and essential aspect of life. Those who desire but are

unable to have children of their own commonly experience feelings of depression, grief, inadequacy, poor adjustment, and poor quality of life.

Section 202 would require VA to furnish fertility treatment and counseling, including the use of ART, to a spouse, partner, or gestational surrogate of a severely wounded, ill or injured Veteran who has an infertility condition which was incurred or aggravated while on active duty. This treatment would be furnished regardless of the sex or marital status of the Veteran. In vitro fertilization would be limited to 3 completed cycles or 6 attempted cycles to a spouse, partner or gestational surrogate. Section 202 would not require VA to find a gestational surrogate for a Veteran or furnish additional maternity care. For a spouse, partner, or gestational surrogate of a Veteran who is not severely wounded, ill or injured, VA could only coordinate fertility treatment and counseling.

VA supports section 202 in part, conditioned on the availability of the additional resources needed to implement this provision. VA supports providing fertility services and counseling to an enrolled severely wounded, ill, or injured Veteran and his or her spouse or partner. However, VA does not support coverage of gestational surrogates. The complex legal, medical and policy arrangements of surrogacy vary from state to state due to inconsistent local regulations. If implementing this provision, VA would need to consider potential conflicts with state and local laws governing surrogacy arrangements. VA acknowledges that surrogacy may offer the only opportunity for Veterans and their spouses/partners to have a biological child. There may be other options to consider when exploring how best to compensate these Veterans for their loss and to facilitate procreation.

VA estimates costs associated with enactment of the draft bill to be as follows: \$177 million (consisting of approximately \$64 million for Veterans and \$113 million for eligible spouses). Expenditures are expected to decline to approximately \$80 million in FY 2017, gradually increasing to \$154 million by FY 2025. Total expenditures from FY 2016 to FY 2025 are expected to be approximately \$1,207 million (approximately \$437 million for disabled Veterans and \$769 million for eligible spouses). Expenditures for pregnancies resulting from fertility services are estimated to be \$28.9 million from FY 2016 through FY 2025.

Section 204 would require VA to submit an annual report to Congress on the fertility treatment and counseling furnished by VA. VA has no objection to this provision.

Section 206 would require VA to facilitate research conducted collaboratively by the Secretary of Defense and the Secretary of Health and Human Services to help VA meet the long-term reproductive health care needs of Veterans with service-connected disabilities affecting Veterans' ability to reproduce.

Generally, VA supports implementing research findings that are scientifically sound and that would benefit Veterans and improve health care delivery to Veterans. VA's goal is to restore the capabilities of Veterans with disabilities to the greatest extent possible, and we utilize new research into various conditions to improve the quality of care we provide. VA expects the costs of this provision would be nominal; however, if facilitation is intended to mean direct funding, proposal reviews, and additional staff, costs would be greater.

Section 207 would require VA to enhance the capabilities of the Women Veterans Call Center (WVCC). VA supports section 207 to improve the WVCC by extending its current capability to host an interactive, secure chat capability. In addition to the efficient handling of both incoming and outgoing calls, the system would provide real-time messaging collaboration ("Live Chat" or "Text") with WVCC Contact Representatives (CR) upon user (Veteran) request. This would provide women Veterans who have questions and/or concerns about VA health care and benefits with an online, one-to-one "Live Chat" service, in addition to the already provided WVCC telephone-based service.

Section 209(a) would require VA to carry out a program to provide assistance to qualified Veterans to obtain childcare so that the Veterans can receive health care services. Such assistance may include stipends for payment of child care by licensed centers, direct provision of child care at VA facilities, payment to private child care agencies, and collaboration with other Federal facilities or programs. VA would be required to carry out the program at each VA medical center not later than five years after the date of enactment of this bill.

VA is aware of the challenges faced by Veterans with children in regard to access to medical appointments and other medical care, counseling, and care giving services. With the growing numbers of younger Veterans and the increasing demands placed on grandparents to care for grandchildren, lack of child care can create a barrier to access to health care services at VA facilities. With the projected doubling of the number of women receiving health care through VA in the next several years and the projected number of those women who are of child bearing age, in addition to the reality of single-parent households with men as well as women serving as the parent, facilitating child care as a means of enhancing access to services is an important consideration. VA recognizes that the lack of competent, accessible child care negatively impacts the ability of Veterans who are primary caretakers of a child or children to attend scheduled appointments.

VA cannot responsibly provide a position in support of creating a new child care assistance program for veterans without a realistic consideration of the resources necessary, including an analysis of the future resources that must be available to fund

other core direct-to-Veteran health care services. That consideration includes the budget levels included in the fiscal year 2016 budget resolution adopted by Congress, S. Con. Res 11, as well as the fiscal year 2016 Military Construction/VA appropriations measures passed in the House and awaiting action in the Senate (H.R. 2029).

## **S. 901            Toxic Exposure Research Act of 2015**

In general, S. 901 would require the Secretary to establish a National Center (Center) charged with researching the diagnosis and treatment of health conditions of descendants of individuals who were exposed to toxic substances while serving in the Armed Forces. It would also establish an Advisory Board (the “Board”) that would oversee and assess the work of the National Center, meet with the National Center, review the annual report of the National Center, and advise the Secretary on various matters.

VA is committed to working with other Federal departments and agencies to ensure that Veterans exposed to toxic substances receive the best possible care we can provide and the benefits for which they are eligible. With respect to military exposures, VA is working closely with DoD to ensure that those who have transitioned to Veteran status are identified and provided information about their exposures. VA will also ensure their records document their exposures and they are provided access to the health care and benefits for which they are eligible.

Section 2 would define several terms for purposes of the bill, including the term “toxic substance,” which would mean any substance determined by the Administrator of the Environmental Protection Agency to be harmful to the environment or hazardous to the health of an individual if inhaled or ingested by or absorbed through the skin of that individual.

Section 3 would require VA, in consultation with the Board established by section 4 of the bill, to select, not later than one year after the date of enactment, a VA medical center to serve as the Center for research on the diagnosis and treatment of health conditions of descendants of individuals exposed to toxic substances while serving in the Armed Forces that are related to such exposure. It would also establish selection criteria for the site and require the Center to conduct research on the diagnosis and treatment of health conditions of such descendants. In conducting such research, the Center would be required, at the election of the individual, to study individuals whom the Secretary has determined to be descendants of individuals who served as members of the Armed Forces who were exposed to a toxic substance while serving as a member of the Armed Forces; and who are afflicted with a health condition that is related to such exposure.

Section 3 would require the Secretary of Defense or the head of another Federal agency to make available to VA, for review, records held by DoD, an Armed Force, or that Federal agency, as appropriate, that might assist the Secretary in making the determinations required above. To this end, VA and DoD or the head of the appropriate Federal agency would be compelled to jointly establish a mechanism for the availability and review of records by VA. This measure would also require the Center to reimburse the reasonable cost of travel and lodging of any individual participating in a study at the Center, plus those of any parent, guardian, spouse, or sibling who accompanies the individual. In addition to other reporting requirements, the Center would further be required to submit a report to the Congress, at least annually, that summarizes, for the preceding year, the functions of the Center, its completed research efforts, and the research that is still on-going. Finally, section 3 would require the Center to employ not less than one licensed clinical social worker to coordinate access of individuals to appropriate Federal, State, and local social and health care programs and to handle case management.

Section 4 would, in general, require the Secretary to establish, not later than 180 days after the Act's enactment, the Board, which would, among other things, be charged with advising the Center and overseeing and assessing its work, plus advising the Secretary of Veterans Affairs with respect to the work of the Center. The measure would also establish specific requirements related to composition of the Board, selection of members, terms of service, and duties. The Board would be required to review the annual reports submitted by the Center and advise the Secretary of Veterans Affairs on issues related to the Center's research; health conditions of descendants of individuals who were exposed to toxic substances during service in the Armed Forces that are related to such exposure; health care services that are needed by these descendants; and, any determinations or recommendations that the Board may have with respect to the feasibility and advisability of VA providing health care services to these descendants. This section would also establish separate Congressional reporting requirements for the Board.

Section 5 would require the Secretary of Defense to declassify documents related to any known incident in which no fewer than 100 members of the Armed Forces were exposed to a toxic substance that resulted in a least one case of a disability that a member of the medical profession has determined to be associated with that toxic substance. It would limit such declassification to information necessary for an individual who was potentially exposed to a toxic substance to determine: whether that individual was exposed to that toxic substance; the potential severity of the exposure; and any potential health conditions that may have resulted from the exposure. Declassification would not be required, however, if the Secretary of Defense "determines that

declassification of those documents would materially and immediately threaten the security of the United States.”

Section 6 would require the Secretary of Veterans Affairs, in consultation with the Secretaries of Health and Human Services and Defense, to conduct a national outreach and education campaign directed toward members of the Armed Forces, Veterans, and their family members. Specific details about the type of information to be included in this program and the manner of its dissemination are also set forth in this section.

Section 7 would prohibit additional funds from being authorized (to be appropriated) to carry out this Act; VA would be required to carry it out using amounts otherwise made available for this purpose.

VA does not support this bill. Unlike VA, other Federal Departments and agencies are chartered and funded to support research on the multi-generational health effects of toxic exposures. VA would be better designated as a collaborator with these organizations. To determine health effects of exposure for what are expected to be relatively rare health outcomes, large populations need to be studied over many years, perhaps decades. A proposed Center focusing solely on military toxic exposures would likely not have the statistical basis to support conclusive findings.

VA's approach to date has been to monitor Veterans' health, conduct surveillance studies, and remain abreast of findings from well-conducted studies in other populations. Based on that evidence, new Veteran-centric studies are then conducted as appropriate, that is, when indicated by findings from clinical care, surveillance, or recommendations from the clinical/scientific community for such studies—and particularly when they are likely to yield new insights.

Examples of current VA activities include collaborations with CDC to improve national surveys and databases to better understand Veterans' health, and communications research investigators from the Agency for Toxic Substances and Disease Registry regarding studies of Veteran populations. If enacted, this Act would effectively force VA to redirect already scarce funds - necessary for Veterans' care - to this Center. Any effort to study health conditions of descendants of individuals exposed to toxic substances should focus on rigorous scientific studies. The legislation's direction for the Center to conduct research on the diagnosis and treatment of descendants of Veterans would not contribute to the scientific understanding we believe are at the center of the bill's purpose.

This new Center, as proposed, would clearly duplicate work already being done by the National Institute of Environmental Health Sciences, the Agency for Toxic Substances and Disease Registry, other non-governmental agencies, as well as work already within VHA programs, such as the War Related Illness and Injury Study Center, the Office of Research and Development, and the Office of Public Health). These existing organizations have for many years conducted research on the impact of environmental

exposures on human health. In addition, the Department of Justice advises us that it opposes the inclusion of section 5 in the Toxic Exposure Research Act on the ground that it interferes with the President's exclusive authority to "classify and control access to information bearing on national security." *Dep't of Navy v. Egan*, 484 U.S. 518, 527 (1988).

Without authorization for additional appropriations to carry out the program established by the bill, resources would have to be diverted from existing Veterans' health care programs. VA estimates the costs associated with enactment of the draft bill to be \$7.2 million for FY 2016; \$96 million over a 5-year period; and \$222 million over a 10-year period.

### **S. 1082 Department of Veterans Affairs Accountability Act of 2015**

Section 2 of S. 1082 would give the Secretary of Veterans Affairs the same authority for VA non-Senior Executive employees granted to him for VA Senior Executives under 38 U.S.C. § 713. Under section 2, the Secretary could remove a VA non-Senior Executive employee from the civil service or demote the employee, either through a reduction in grade or annual rate of pay. If the individual being removed or demoted is seeking corrective action from the Office of Special Counsel (OSC) the Secretary could not take an action under this section without approval from OSC. Individuals removed or demoted under section 2 could appeal that action to a Merit Systems Protection Board administrative judge (AJ), who would be required to issue a decision on the appeal within 45 days. Decisions issued by an AJ would be final and not subject to further appeal.

Section 3 of this bill would require all new VA employees who are competitively appointed or appointed to the Senior Executive Service at VA to serve a probationary period of at least 18 months. The probationary period could be extended past 18 months by the Secretary.

S. 1082 is the latest in a series of legislative proposals targeting VA employees by providing extraordinary authority to sanction them, not available in other Federal agencies. Last summer, section 707 of the Veterans Access, Choice, and Accountability Act of 2014 added 38 U.S.C. § 713, establishing an expedited removal authority that strictly limits VA Senior Executives' post-termination appeal rights. While that provision gave the Secretary additional flexibility in terms of holding VA Senior Executives accountable for misconduct or poor performance, it constrained the Secretary's ability to retain gifted senior leaders by singling out VA Senior Executives for disparate treatment from their peers at other agencies.

It is likely that S. 1082 would result in unintended consequences for VA, such as a loss of qualified and capable staff to other government agencies or the private sector. Section 2 of this bill, which is based on 38 U.S.C. § 713, would apply to all VA employees regardless of their grade or position. VA's workforce consists of a diverse array of employees, including employees with advanced degrees in business, law, and medicine. Many of these employees accept lower pay to serve at VA, and a large number of these employees are Veterans. While VA's employees are motivated first and foremost by a desire to serve Veterans, another motivation to accept lower pay shared by many federal employees is the job security afforded by protections such as appeal rights that attach at the end of a probationary period. Diminishing those appeal rights or expanding the probationary period will reduce the motivation to pursue public service at VA.

Section 2 of the bill poses due process concerns, due to its failure to provide the employee with a chance to be heard prior to losing the benefits of employment and its failure to guarantee that an employee's case will be fairly judged before the sanction becomes final.

Section 3 of this bill would also adversely impact recruitment at VA by extending the probationary period for employees from what is usually 12 months to 18 months and authorizing the Secretary of Veterans Affairs to extend the probationary period beyond that time at his discretion. In general, the probationary period serves as a way of examining whether an employee is suitable for his or her position. The 12-month cap of probationary periods serves a dual role: it gives management a finite amount of time within which to gauge an employee's performance, and it gives the employee a reasonable period of time within which he or she would be made a permanent Federal employee. By expanding that time to 18 months and allowing the Secretary to extend the probationary period past 18 months, section 3 of this bill may impact VA's ability to recruit employees. Like the diminishment of due process and appeal rights, the longer probationary period simply makes VA less competitive for the candidates seeking job security. In effect, S. 1082 would create a new class of employees in the government, a "VA class." These "VA class" employees could be removed or demoted at the discretion of the Secretary, would receive fewer due process rights and abbreviated MSPB appeal rights in actions taken under section 2 of the bill and would serve longer probationary periods than their peers at other government agencies. This will hinder VA efforts to make the "VA class" of employee the very finest employees to serve our Veterans and ensure that they timely receive the benefits and care to which they are entitled.

By singling out VA employees, the legislation would dishearten a workforce dedicated to serving Veterans and hurt VA's efforts to recruit and retain high performing employees.

VA will continue to work with the Committee and VSO's on how the Secretary can best hold employees accountable while preserving the ability to recruit and retain the highly skilled workforce VA needs to best serve Veterans.

### **S. 1085      Military and Veteran Caregiver Services Improvement Act of 2015**

The Caregivers and Veterans Omnibus Health Services Act of 2010, Public Law 111-163, signed into law on May 5, 2010, provided expanded support and benefits for caregivers of eligible and covered Veterans. While the law authorized certain support services for caregivers of covered Veterans of all eras, other benefits were authorized only for qualified family caregivers of eligible Veterans who incurred or aggravated a serious injury in the line of duty on or after September 11, 2001. These new benefits for approved family caregivers, provided under the Program of Comprehensive Assistance for Family Caregivers, include a monthly stipend paid directly to designated primary family caregivers and medical care under CHAMPVA for designated primary family caregivers who are not eligible for TRICARE and not entitled to care or services under a health-plan contract.

Section 2 of S. 1085, the Military and Veteran Caregiver Services Improvement Act of 2015, would remove "on or after September 11, 2001" from the statutory eligibility criteria for the Program of Comprehensive Assistance for Family Caregivers, and thereby expand eligibility under the program to Veterans of all eras who otherwise meet the applicable eligibility criteria. Family caregivers could not receive assistance under this expanded eligibility until Fiscal Years 2016, 2018, or 2020 depending on the monthly stipend tier for which their eligible Veteran qualifies. Section 2 would also add "or illness" to the statutory eligibility criteria, and thereby expand eligibility to include those Veterans who require a caregiver because of an illness incurred or aggravated in the line of duty. In addition, the bill would expand the bases upon which a Veteran could be deemed to be in need of personal care services, to include "a need for regular or extensive instruction or supervision without which the ability of the Veteran to function in daily life would be seriously impaired."

The bill would also expand the assistance available to primary family caregivers under the Program of Comprehensive Assistance for Family Caregivers to include child care services, financial planning and legal services "relating to the needs of injured and ill veterans and their caregivers," and respite care that includes peer-oriented group activities. The bill would ensure that in certain circumstances VA accounts for the family caregiver's assessment and other specified factors in determining the primary family caregiver's monthly stipend amount. In addition, the bill would require VA to periodically evaluate the needs of the eligible Veteran and the skills of the family caregiver to

determine if additional instruction, preparation, training, or technical support is needed, and it would require certain evaluation be done in collaboration with the Veteran's primary care team to the maximum extent practicable.

Section 2 of S. 1085 would also authorize VA, in providing assistance under the Program of Comprehensive Assistance for Family Caregivers, to "enter into contracts, provider agreements, and memoranda of understanding with Federal agencies, States, and private, nonprofit, and other entities" in certain circumstances. It would expand the definition of family member to include a non-family member who does not provide care to the Veteran on a professional basis, and it would amend the definition of "personal care services." The bill would also end the Program of General Caregiver Support Services on October 1, 2020, but would ensure that all of its activities are carried out under the Program of Comprehensive Assistance for Family Caregivers. Finally, the bill would amend the annual reporting requirements for the Program of Comprehensive Assistance for Family Caregivers.

In September 2013, VA sent a report to the Committees on Veterans' Affairs of the Senate and House of Representatives (as required by Section 101(d) of the Public Law 111-163) on the feasibility and advisability of expanding the Program of Comprehensive Assistance for Family Caregivers to family caregivers of Veterans who incurred or aggravated a serious injury in the line of duty before September 11, 2001. In that report, VA noted that expanding the Program of Comprehensive Assistance for Family Caregivers would allow equitable access to seriously injured Veterans from all eras (who otherwise meet the program's eligibility criteria) and their approved family caregivers.

In the report, however, VA noted difficulties with making reliable projections of the cost effect of opening the Program of Comprehensive Assistance for Family Caregivers to eligible Veterans of all eras, but estimated a population range of 32,000 to 88,000 additional Veterans in the first year (estimated for FY 2014), at a cost of \$1.8 billion to \$3.8 billion in the first year (estimated for FY 2014). After VA provided this report to Congress, the RAND Corporation published a report titled, "Hidden Heroes: America's Military Caregivers," which estimates a significantly larger eligible population (1.5 million) that may be eligible if the program were expanded to caregivers of pre-9/11 Veterans. VA's estimates in the 2013 report did not account for expansion to eligible Veterans with an illness incurred or aggravated in the line of duty, other Veterans who would become eligible for the program based on the amendments in section 2 of S. 1085, or the additional assistance that would become available to primary family caregivers under the bill.

VA cannot responsibly provide a position in support of expanding the Program of Comprehensive Assistance for Family Caregivers without a realistic consideration of the

resources necessary to carry out such an expansion, including an analysis of the future resources that must be available to fund other core direct-to-Veteran health care services. That consideration includes the budget levels included in the fiscal year 2016 budget resolution adopted by Congress, S. Con. Res 11, as well as the fiscal year 2016 Military Construction/VA appropriations measures passed in the House and awaiting action in the Senate (H.R. 2029). This is especially true as VA presses to strengthen mental health services and ensure the fullest possible access to care across the system.

While VA has not provided views on section 7 of S. 1085, the Department of Justice advises that it has constitutional concerns with that provision, which it will provide to the Committee under separate cover.

We wish to make it very clear that VA believes an expansion of those benefits that are currently limited by era of service would result in equitable access to the Program of Comprehensive Assistance for Family Caregivers for long-deserving caregivers of those who have sacrificed greatly for our Nation. However, VA cannot endorse this measure before further engaging with Congress on these fiscal constraints, within the context of all of VA health care programs. VA welcomes further discussion of these issues with the Committee.

#### **H.R. 91      Veteran's I.D. Card Act**

H.R. 91, the ``Veteran`s I.D Card Act,`` would establish a program under which VA would issue a Veteran identification card, produced by VA, upon request by a Veteran who was discharged from the Armed Forces under honorable conditions. The Veteran would have to present to VA a copy of his or her DD-214 form or other official document from his or her official military personnel file describing his or her service, as well as pay a fee set by VA to recoup the cost of implementing the program.

The bill makes clear that issuance of a card would not serve as proof of entitlement to any VA benefits, nor would it establish eligibility for benefits in its own right. The purpose of the card, made clear in section 2(a)(3) and (4) of the bill, would be for Veterans to use the card to secure goods, services, and the benefit of promotional activities offered by public and private institutions to Veterans without having to carry official discharge papers to establish proof of service. Furthermore, the bill would clarify that the new Veteran's I.D. Card would not affect identification cards provided by the Secretary to Veterans enrolled in the health care system established under 38 USC 1705.

Veterans in 45 States and the District of Columbia may apply for a driver's license or State-issued ID card that designates veteran status. The remaining states (California, Hawaii, Illinois, Minnesota, New Jersey, and Washington) are either pending legislation or have legislation that has been signed into law but is not yet effective. We believe the availability already of this Veteran designation can meet the intent of the legislation without creating within VA a new program that may not be cost-efficient. It is not known whether enough Veterans would request the card to make necessary initial investments in information technology and training worthwhile.

Also, another VA-issued card could create confusion about eligibility. Although the bill states that a card would not by itself establish eligibility and would not affect other identification cards provided by VA to Veterans enrolled in the VA health care system, there could nonetheless be misunderstandings by Veterans that a Government benefit is conferred by the card. As the Committee knows, entitlement to some VA benefits depends on criteria other than Veteran status, such as service connection or level of income. Confusion may also occur because the Veterans Health Administration issues identification cards for Veterans who are eligible for VA health care, and recently issued every enrolled Veteran a Veterans Choice Card. Having several VA-issued cards creates the potential for confusion on several levels.

Because it is difficult to predict how many Veterans would apply for such a card, VA cannot provide a reliable cost estimate for H.R. 91. Although the bill is intended to allow VA to recoup its costs by charging Veterans for the cards, in reality VA could be assured of recouping its costs only if it knew in advance what those costs would be, and those costs cannot be reliably estimated without knowing how many Veterans would request the card.

## **Discussion Draft**

Section 1 of the Discussion Draft would require the Secretary of Veterans Affairs to work with institutions of higher learning to develop partnerships for the establishment or expansion of programs of advanced degrees in prosthetics and orthotics with a goal of improving and enhancing the availability of prosthetic and orthotic care for Veterans.

VA provides rehabilitation services to Veterans with a mix of providers, including physical medicine and rehabilitation physicians, physical therapists, occupational therapists, prosthetists and orthotists all of whom work with the Veteran to enable the best possible rehabilitation given the individual's needs. VA offers in-house orthotic and prosthetic services at 79 locations across VA. In addition, VA contracts with more than 600 vendors for specialized orthotic and prosthetic services. Through both in-house staffing and contractual arrangements, VA is able to provide state-of-the-art

commercially available items ranging from advanced myoelectric prosthetic arms to specific custom fitted orthoses. Nationally, VA has approximately 312 orthotic and prosthetic staff.

With regard to training and development, VA offers one of the largest orthotic and prosthetic residency programs in the nation. In fiscal year 2015, VA's Office of Academic Affiliations allocated \$877,621 to support 20 orthotics and prosthetics residents at 10 Veterans Affairs Medical Centers. The training consists of a yearlong post-masters residency, with an average salary of \$44,000 per trainee. In recent years, VA has expanded the number of training sites and the number of trainees, but expansion has been limited due to a lack of certified supervisors for the training programs.

While VA supports means to improve and enhance the ability to hire and retain prosthetists and orthotists, it cannot support the proposed bill. Under the proposed bill, VA would be required to partner with colleges and universities for the establishment or expansion of programs of advanced degrees in prosthetics and orthotics. These programs, however, would not directly benefit VA or Veterans as the legislation does not require that the programs affiliate with VA or send their trainees to VA as part of a service obligation.

Tying the granting of funds to the establishment or expansion of programs of advanced degrees that would directly benefit VA and Veterans is one of the changes that VA recommends for this legislation. VA looks forward to working with the Committee to craft a bill that more directly enhances advanced degrees in prosthetics and orthotics while benefiting VA and Veterans.

### **Draft Legislation: Jason Simcakoski Memorial Opioid Safety Act**

Section 201 would establish within the Office of the Under Secretary for Health an office to be known as the "Office of Patient Advocacy". The Office would carry out the Patient Advocacy Program of VA. This section would also establish the responsibilities of patient advocates at VA medical facilities.

VHA currently has a Patient Advocacy program established to ensure that all Veterans and their families served in VHA facilities and clinics have their complaints addressed in a convenient and timely manner. The program operates under a philosophy of Service Recovery, whereby patient complaints are identified, resolved, classified, and utilized to improve overall services to Veterans.

As health care continues to evolve, so does the role of the Patient Advocate. The role of the advocate in VHA has traditionally been more reactive, i.e. responding to issues as they arise, hearing and reacting to patient complaints as they bring them forward. With a heightened awareness of the importance of a positive, patient experience, VHA is on the pathway to transform the program including the role of the Patient Advocate to focus on a more proactive approach by all staff that would result in a more positive patient experience.

Earlier this month, to maintain the highest standard for responding to patient issues while continually improving the advocacy program, VHA established the Client Services Response Team (CSRT), reporting directly to the Office of the Under Secretary for Health. The CSRT is charged to centralize and streamline internal processes to improve VHA's overall responsiveness to the concerns of Veterans, employees and other key stakeholders.

The proposed bill reflects the existing Patient Advocacy program but does not account for the strategy to transform the Patient Advocate role to keep pace with private sector advances in patient experience. The model has been successfully demonstrated in VHA pilots and private sector health care systems<sup>1</sup> and is consistent with VA's vision of providing world-class customer service. This vision will engage staff from across the organization as well as Veterans to be actively involved in the transformation process. VA is thus very supportive of the concept in section 201, but has concerns that detailed statutory directives could restrict the evolution and breadth of the Patient Advocacy program.

VA supports section 202 which would require VA Medical Centers and Community Based Outpatient Clinics to host community meetings, open to the public, on improving health care from the Department. This section is consistent with current practices of hosting Town Hall meetings to hear from Veterans, families, and other stakeholders.

Section 203 would require VA display at each VA medical facility the purposes of the Patient Advocacy Program, contact information for the patient advocate, and the rights and responsibilities of patients and family members. VA supports increasing the awareness of the Patient Advocacy Program and the Rights and Responsibilities of Veterans and family members. This section is consistent with current practices of posting this information in medical facilities and would only require the addition of posting the Patient Advocacy Program's purpose.

VA supports the intent of title III which seeks to expand research, education and delivery of complementary and integrative health (CIH) to Veterans. VA is committed to

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<sup>1</sup> Merlino, J (2015). *Service fanatics: how to build a superior patient experience the Cleveland Clinic way*. New York, NY: McGraw-Hill Education.

expanding the research, education and delivery of complementary and integrative health services to Veterans. Aligning with VA's Blueprint for Excellence VHA leadership identified as its number one strategic goal "to provide Veterans personalized, proactive, patient-driven health care." This approach to health care prioritizes the Veteran and their values, and partners with them to create a personalized strategy to optimize their health, healing, and well-being. Many of the strategies that may be of benefit extend beyond what is conventionally addressed or provided by the health system and includes CIH. To this end, VA is establishing the Integrative Health Coordinating Center within the Office of Patient Centered Care and Cultural Transformation (OPCC&CT).

OPCC&CT, along with Patient Care Services, deployed a national survey on CIH to better understand the evolution of how these services are being provided across the system and to advance further implementation. The survey was deployed to all VA parent medical facilities with a 100% completion rate. This report is being finalized this month for review by VHA and VA leadership.

VA is preparing the current workforce through a focus on education of the clinical staff. OPCC&CT developed the Whole Health Clinical Education Program which is designed to educate clinicians in providing a proactive, whole person approach. This includes learning how to effectively integrate CIH approaches. This inter-professional training includes VA physicians, nurses, dietitians, chaplains and other clinical staff. The core curriculum was designed and launched in 2014 and targets traditional healthcare providers across VHA.

The evaluation demonstrated that clinicians had improved attitudes towards Integrative Health, as well as changes in intentions to integrate mindful awareness in interactions with Veterans, encourage the use of self-care strategies, encourage the use of integrative health strategies during clinical encounters, and to co-manage patients with practitioners outside their own medical paradigm.

To implement safe and effective management of pain, VHA's National Pain Program office oversees several work groups and a National Pain Management Strategy Coordinating Committee representing the VHA offices of nursing, pharmacy, mental health, primary care, anesthesia, education, integrative health, and physical medicine and rehabilitation. Working with the field, these groups develop, review and communicate strong pain management practices to VHA clinicians and clinical teams.

VHA has multiple projects, coordinated under the National Pain Program office, to support and educate clinicians and Veterans about safe and effective stepped pain management, including use of opioids. Programs such as the Opioid Safety Initiative (OSI), the Joint Pain Education and Training Project (JPEP) with Department of Defense (DoD), the Tiered Acupuncture Training Across Clinical Settings (ATACS) with

DoD, the Pain Mini-residency, Pain Specialty Care Access Network (SCAN ECHO), asynchronous Web-based training, and Community of Practice calls all reach across the VHA to train primary care providers in all settings in the assessment and treatment of pain and in the use of patient education in self-management, the use of multiple modalities such as behavioral, integrative medicine (Complementary and Alternative Medicine, or CAM), and physical therapies and the use of consultant specialists in pain, mental health, and CAM.

For example, on the topic of opioids safety, all the education programs listed above, except ATACS which is focused on acupuncture skill training, have presentations on universal precautions and risk management in opioid therapy for pain, including clinical evaluation, written informed consent, screening such as urine drug monitoring, use of state monitoring programs, and safe tapering. Related specifically to safe opioid prescribing, the VHA has implemented the Opioid Safety Initiative, a mandatory academic detailing program that identifies targets of risky practices (e.g, high opioid doses, co-prescribed benzodiazepines, use of urine drug screens) and universally monitors these practices in VHA at the provider and facility/VISN level through appointed VISN and facility OSI and Pain Management Point of Contact, or POCs. A POC is a clinician appointed and supported at the VISN level who is an appropriately trained, experienced and credentialed in pain medicine, pain management, or another credential appropriate to the clinical discipline. These individuals identify targets of risky practices through regular monthly and 'on-demand' progress reports, and provide education and counseling for facilities and prescribers whose patterns of prescribing and pain management practices require remediation.

To provide clinical education and resource support to providers and facilities for successful OSI implementation, the National Pain Program office established the interdisciplinary OSI Toolkit Task Force to systematically peer-review and standardize clinical education and patient education materials for distribution throughout VHA. The OSI Toolkit Task force has completed peer-review, revision and approval of the below trainings and materials and meets regularly to peer-review, revise, and publish new "strong practices" that are identified in VHA.

Most recently, in March 2015, the National Pain Management launched the new Opioid Therapy Risk Report tool which provides detailed information on the risk status of Veterans taking opioids to assist VA primary care clinicians with pain management treatment plans. This tool is a core component of a reinvigorated focus on patient safety and effectiveness.

In 2014, VA's Office of Academic Affiliations in conjunction with Physical Medicine and Rehabilitation Services launched a national VA Chiropractic residency program. The VA Chiropractic program has been engaged in chiropractic education and training for a

decade. Since 2004 over 1,500 chiropractic students have completed clinical rotations at 24 VA facilities. The VA chiropractic residency program focuses on Integrated Clinical Practice, with training emphasizing the provision of chiropractic care in an integrated healthcare system, collaborating with primary care Patient Aligned Care Teams (PACTs), specialty care, and other medical and associated health providers and trainees. Individual residencies are administered by the respective local VA facilities. Each VA facility partners with its affiliated Council on Chiropractic Education accredited chiropractic school in conducting the program.

VA Research is actively engaged with the community of scientists in establishing the evidence base for complementary and integrative health treatments for physical and mental conditions, the latter including examining the benefit of CIH therapy for PTSD, suicide prevention, and mood disorders. As these studies are completed, results will be evaluated to determine potential impact on Clinical Practice Guidelines. The VA Evidence-based Synthesis Program in conjunction with OPCC&CT and Patient Care Services has examined the scientific literature on various CAM services and have presented the findings in the form of “evidence maps.” An evidence review and map in acupuncture, yoga, Tai Chi and mindfulness has been completed. The findings from these reviews are helping to inform decisions on how to best use CAM within VA and identify areas for further research.

Section 401 would require that as part of the hiring process VA reach out to state medical boards to ascertain whether a prospective employee has any violations over the past twenty years, or has entered into a settlement agreement related to the employee’s practice of medicine. VA does not feel that additional legislation is needed to accomplish this. VHA policy, already in place, requires the verification of all current and previously held licenses for all licensed health care providers. At the time of initial appointment all current and previously held licenses are verified with the state licensing board issuing the license. Verification requires querying the state licensing board for not only the issue date and expiration date, but also any pending or previous adverse actions. If an adverse action is identified, the verification requires obtaining all documentation available associated with such action, including but not limited to copies of any agreements. At the time of expiration of a license as well as at the time of reappraisal, VHA policy requires querying the state licensing board to confirm renewal of the license as well as whether or not there have been any new pending or previous adverse actions. If the license is not renewed, VHA policy requires confirmation that the license expired in good standing and if not, what was not in good standing.

At the time of initial appointment, all health care providers are queried through the National Practitioner Data Bank (NPDB). The NPDB is a national flagging system that serves as a resource for hospitals and other healthcare entities during the provider credentialing process. The NPDB provides information about past adverse actions of

health care providers. VHA also enrolls all independent, privileged providers in the NPDB's Continuous Query program for ongoing monitoring of not only adverse actions taken against a credential, but also paid malpractice. VHA receives notification of a new report within 24 hours of the report being filed with the NPDB.

Additionally, at the time of initial appointment, all physicians are queried through the Federation of State Medical Boards (FSMB) Federation Physician Data Center, a nationally recognized system for collecting, recording and distributing to state medical boards and other appropriate agencies data on disciplinary actions taken against licensees by the boards and other governmental authorities. The report returned from the FSMB Physician Data Center not only identifies if there are any adverse actions recorded against a physician's license but also lists all of the physician's known licenses, current or previously held, serving as double-check that the physician reported all licenses during the credentialing process. In addition, the licenses of all physicians are monitored through a contract with the FSMB's Disciplinary Alert Service (DAS). Through this contract, all physicians are enrolled in the DAS which offers ongoing monitoring of physician licensure. If a new action against a physician's license is reported to the FSMB DAS, VHA receives a notification of the report within 24 hours. The staff at the physician's facility then contacts the reporting state licensing board to obtain the details of the action.

If the facility learns of an adverse action taken against a provider license, the staff at the facility must obtain information from the provider against whom the action was taken and consider it as well as the information obtained from the state licensing board. This review is documented to include the reasons for the review, the rationale for the conclusions reached, and the recommended action for consideration and appropriate action by the facility.

Section 402 would require VA to provide the relevant state medical board detailed information about any health care provider of VA that has violated a requirement of their medical license. We also believe in this case additional legislation is not required. VA has broad authority to report to state licensing boards those employed or separated health care professionals whose behavior or clinical practice so substantially failed to meet generally-accepted standards of clinical practice as to raise reasonable concern for the safety of patients. The authority to report those professionals is derived from VA's long-standing statutory authority, contained in 38 USC 7401-7405, which authorizes the Under Secretary for Health, as head of VHA, to set the terms and conditions of initial appointment and continued employment of health care personnel, as may be necessary, for VHA to operate medical facilities. This authority includes requiring health care professionals to obtain and maintain a current license, registration, or certification in their health care field.

The Veterans Administration Health-Care Amendments of 1985, Public Law 99-166, and Part B of Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, are Acts require VHA to strengthen quality assurance and reporting systems to promote better health care. Pursuant to section 204 of Public Law 99-166, VA established a comprehensive quality assurance program for reporting any licensed health care professional to state licensing boards who:

- (1) Was fired or who resigned following the completion of a disciplinary action relating to such professional's clinical competence;
- (2) Resigned after having had such professional's clinical privileges restricted or revoked; or
- (3) Resigned after serious concerns about such professional's clinical competence had been raised, but not resolved.

The statutory provisions of 38USC 7401-7405, augmented by Public Laws 99-166 and 99-660, provide VHA ample authority to make reports to state licensing boards when exercised consistent with Privacy Act requirements for release of information. VHA policy requires the VA medical facility Director to ensure that within seven calendar days of the date a licensed health care professional leaves VA employment, or, information is received suggesting that a current employee's clinical practice has met the reporting standard, an initial review of the individual's clinical practice is conducted to determine if there may be substantial evidence that the individual so substantially failed to meet generally-accepted standards of clinical practice as to raise reasonable concern for the safety of patients.

Usually this review is conducted and documented by first and second level supervisory officials. When the initial review suggests that there may be substantial evidence that the licensed health care professional so failed to meet generally-accepted standards of clinical practice as to raise reasonable concern for the safety of patients, the medical facility Director is responsible for immediately initiating a comprehensive review to determine whether there is, in fact, substantial evidence that this reporting standard has been met. This review involves the preparation of a state licensing board Reporting File. VHA policy defines the process for collecting evidence; notifying the provider of the intent to report which affords the provider the opportunity to respond in writing to the allegations; and then the review process to assure that VHA has complied with the Privacy Act prior to reporting.

It is VA's policy to cooperate whenever possible with an inquiry by a state licensing board. VA medical facilities must provide reasonably complete, accurate, timely, and relevant information to a state licensing board in response to appropriate inquiries.

Mr. Chairman, thank you for the opportunity to present our views on the legislation today and we will be glad to answer any questions you or other members of the Committee may have.