HEARING ON PENDING HEALTH CARE LEGISLATION

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THURSDAY, MAY 9, 2013

United States Senate,

Committee on Veterans' Affairs,

Washington, D.C.

The committee met, pursuant to notice, at 10:03 a.m., in Room 418, Russell Senate Office Building, Hon. Bernard Sanders, chairman of the committee, presiding.

Present: Senators Sanders Begich, Burr and Boozman.

OPENING STATEMENT OF CHAIRMAN SANDERS

Chairman Sanders. Okay. We have got a lot of work to cover. Let us get going. Welcome to today's hearing to examine health legislation before this Committee.

This Committee intends to be aggressive in bringing forth legislation to do it right. We need to have stakeholders, people who are familiar with the issues that we are dealing with comment, criticize the concepts that we are bringing forth; and then we make those modifications that make sense.

Today’s agenda reflects important work by Senators on both sides of the aisle. We have a number of pieces of legislation that members on this Committee have authored and members who are not on this Committee.

I think people are aware of the fact that veterans

throughout this country are addressing many serious issues, and I think you are seeing on both sides of the aisle in this Committee, outside of this Committee, members who want to introduce legislation to address some of those problems.

In the 111th Congress, I was pleased to support the Caregivers and Veterans Omnibus Health Services Act of 2010, which expanded services and benefits for caregivers of post-9/11 veterans. The Caregiver Program allows these seriously wounded veterans to receive care at home, provided by a family caregiver. As of the end of February, more than 8,600 veterans and their caregivers have benefitted from this important program.

For as long as injured veterans have returned from the battlefield, family members have worked tirelessly to provide the safe environment for these heroes to live comfortably at home.

Historically, these caregivers have done this without any support from the Federal Government. This changed with the 2010 law when, for the first time, veterans' caregivers became eligible for supportive services and benefits.

These benefits included: a tax-free monthly stipend, reimbursement for travel expenses, health insurance, mental health services and counseling, training, and respite care. These benefits and services gave caregivers the support they needed to provide the best possible care for their loved

ones. I am very proud of the success of that piece of legislation.

However, when the law was passed, these services were only made available to post-9/11 veterans and family members. The legislation I have introduced, S. 851, expands the caregiver program and extends these services and benefits to the caregivers of veterans of all eras.

Through this expansion, family members who have been providing care to eligible veterans from all other eras will be able to access the same supportive services as the caregivers of our most recent generation of veterans.

I hope that my colleagues will join with me in passing this important program so that all of our veterans and the their families will be able to get the support that they need. There are so many families out there who have done the right thing by their loved ones, people who have been injured in war, and I think we need to support them.

The other piece of legislation that I am working on, I think, is a very consequential piece of legislation, and that is, I know in Vermont and all over this country there is more and more understanding that health care is not just treating illness but it is preventing disease, and it is supporting wellness, and it is also looking at complementary and alternative programs as well.

These are growing in leaps and bounds. I can remember

not so many year ago, Senator Burr, you may remember where chiropractor care was thought to be somewhat outside of the mainstream, and that has certainly come big time into the mainstream. It is practiced within VA health care right now. We have some legislation coming forward, Senator Blumenthal, to expand that.

We have acupuncture now being practiced. We have meditation, yoga now being utilized in VA centers. I was recently in Brooklyn, New York, their very large VA center and out in LA, and what the clinicians there tell me is that many veterans utilize these what we call complementary medical programs with success, and they enjoy it, and we have studies that support that.

So, we are going to be introducing legislation to expand those concepts. I will go into that in more length, but Senator Burr, why do you not say a few words. Then we have Senator Landrieu here, and I know she has legislation that she wants to talk about. We look forward to hearing from her.

OPENING STATEMENT OF SENATOR BURR

Senator Burr. Thank you, Mr. Chairman. Thank you for calling this important hearing. I welcome all of our witnesses today and look forward to your testimony.

I also want to especially thank Tom Bowman for being here. Boy, somebody who has devoted a career to the VA and

we are grateful for that and I am grateful that you are here today testify.

Mr. Chairman, as we consider all the bills on today's agenda, I think it is just as important to consider a few things especially before creating or expanding programs. I believe we should start by considering how well existing programs work and identify any gaps in services and inefficiencies that exist.

By examining current programs, this will help us focus on changes that are truly needed and avoid creating any duplication or overlapping which is often very frustrating for veterans and their families.

Lastly, it is also important to consider the fiscal challenges facing our Nation. We need to know the costs of any program before that program is moved forward, and we must find responsible ways to pay for all of these programs.

With all that in mind, I look forward to a productive discussion about the bills on today's agenda. To start, I would like to mention several of those bills which I have sponsored.

One is S. 543, the VISN Reorganization Act of 2013. This legislation would reform VA's Veterans' Integrated Service Networks, or VISNs. In 1995, the veterans' health care system was divided into 22 geographic areas. That is now 21 VISNs. Each region had its own headquarter with a

limited management structure to support the medical facilities in that region.

Since that time, there has been a huge growth in staff at the VISN headquarters and increasing duplication in the duties they carry out. So, this bill would consolidate the boundaries of nine VISNs, move some oversight functions away from VISN management, and limit the number of employees at each VISN headquarters. All of this should make these networks more efficient and, more importantly, should allow resources to be reallocated to direct patient care.

Another bill is S. 529, which would change the start date for eligibility of hospital care and medical services in connection with exposure to the contaminated water at Camp Lejeune, North Carolina.

This legislation is very simple. It would change the date from January 1, 1957 to August 1, 1953 which is based on letter sent to Under Secretary Hickey from Dr. Christopher Portier, the Director of the National Center for Environmental Health and Agency for Toxic Substance and Disease Registry.

In this letter, Dr. Portier states--and I quote--according to our water modeling, we estimate that the first month any VOC exceeded the current EPA MCL in finished water was August 1953, and at least one VOC exceeded its current MCL in Hadnot Point drinking water from August 1953 through

January 1985." End quote. Therefore, I believe there is credible evidence that warrants the change in the commencement date.

I would ask unanimous consent at this time that this letter be made a part of the record.

Chairman Sanders. Without objection.

[The letter follows:]

/ COMMITTEE INSERT

Senator Burr. Lastly, I would like to touch on one other, S. 825, which is a bill Chairman Sanders and I introduced together which would improve VA homeless prevention programs and VA transitional housing.

This legislation will reduce barriers many homeless veterans face including providing legal services, provide services to dependent children of those veterans seeking services through the transitional housing program and ensure the safety of women by requiring facilities to meet the gender-specific needs of homeless women veterans.

Mr. Chairman, all of these bills would provide common-sense solutions to real issues affecting our Nation's veterans, their families, and their survivors. I look forward to working with you and with the rest of our colleagues to see that these and other worthwhile bills on today's agenda can soon become law.

I thank the Chair.

Chairman Sanders. Senator Burr, thank you very much and thank you for your support on the Homeless Veterans' Prevention Act of 2013, and I look forward to working with you to make sure that we pass that important piece of legislation.

I also want to concur with you. Our job is, as an oversight committee, to make sure that we do not see duplication, we do not see waste. I happen to believe that

by and large the VA has a very strong health care system. They are doing a good job. But it is a huge system and nobody, I think, can tell us that everything is perfect. Our job is to see how we can improve it, make it cost effect, and add new programs which strengthen it.

With that, I am delighted to welcome our colleague from Louisiana who is here to talk about a very important issue.

Senator Landrieu, thank you very much for being here.

STATEMENT OF HONORABLE SENATOR MARY L. LANDRIEU, A UNITED STATES SENATOR FROM THE STATE OF LOUISIANA

Senator Landrieu. Thank you so much, Senator Sanders, and thank you, Senator Burr for your focus on the needs of our veterans and improving our outreach to them and our health care to them. I thank you for the diligence, Mr. Chairman, that you bring to this issue particularly.

I wanted to bring to both of your attention a bill that I have filed, S. 412, and I am happy that Senator Blumenthal, Senator Isakson and Senator Hirono have joined me as cosponsoring this important legislation that is pending before your Committee.

The bill is called Keep Our Commitment to Veterans Act. It would give the go ahead to authorize major medical facilities that have been in a holding pattern due to an unexpected and recent change in the CBO scoring.

I am sure your Committee has heard many complaints about this. I am sure both of you are very familiar with it but I wanted to bring it to your attention today very briefly.

Last September, the Veterans' Affairs Committees in the House and the Senate were not able to authorize the VA-requested fiscal year 2013 major medical facility leases in the annual construction and extenders package due to a new scoring method.

CBO changed the scoring method for major medical facilities, significantly increasing the costs of these facilities. Now, we find ourselves here in a situation in Louisiana where we have had two clinics, Mr. Chairman, on the board now in proposal for several years that are now in complete limbo, and we have 20,000 veterans in this area of our State which is in southwest Louisiana, a growing, vibrant area of our State, without access to a clinic.

Under the old scoring method, these 13 clinics would be $126 million. Under the new scoring method, it is $1.4 billion. We have got to find, I think, and administrative way forward here, not just for the clinics in Louisiana, of course, which I am here to advocate for and the veterans communities that are really in desperate need of these facilities and have been promised year after year. But I understand, Mr. Chairman, that this affects other states as well. I am sure you are well aware.

So, just on behalf on the 20,000 veterans and their families that I am here to represent, please I look forward to working with you to find a solution to help these veterans that have served our Nation so proudly and so ably.

We need to fix this situation. As an appropriator I am most certainly understand the challenges in our budget but perhaps with some work between the Appropriations Committee and this good oversight and authorizing Committee, we can

find a way forward.

It is an opportunity for us to make clear to our veterans that the promises we make to them we want to hold to those promises.

Thank you, Mr. Chairman, and I will submit the rest of my statement for the record, and thank you, Senator Burr.

[The prepared statement of Senator Landrieu follows:]

Chairman Sanders. Senator Landrieu, thank you very much for focusing on an issue which, as you indicated, goes well beyond Louisiana.

One of the great advances made by the VA in recent years has been the expansion of the CBOC program which is what you are talking about, Community Based Outreach Clinics.

I think we all know that when veterans or nonveterans are able to access affordable primary health care that keeps the healthier, keeps them out of the hospital, it in the long run saves our system money. The CBOC program has been very successful in Vermont and all over this country. I do not want to see an impediment from the way the OMB, CBO rather, deals with this issue limit our ability to expand CBOC.

So, you raise a very important question which is something that this Committee has got to address. Senator Burr, did you want to add anything to that?

Senator Burr. No. As one who participated before the CBO determination and exercise, the lease option I understand the benefits that it provided especially at the clinic and outpatient level, and I look forward to working with you on this.

Chairman Sanders. We will be dealing with CBO on this issue to do our best.

Thank you, Senator, very much.

I would now like to bring up our first panel which is Dr. Robert Jesse, Principal Deputy Under Secretary for Health at the Department of Veterans' Affairs. Dr. Jesse is accompanied by Susan Blauert, Deputy Assistant General Counsel.

Thank you both very much for providing the department's perspective on the pending health care legislation. We look forward to hearing your testimony, and Dr. Jesse, why do you not begin please?

STATEMENT OF ROBERT JESSE, MD, PHD, PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS' AFFAIRS, ACCOMPANIED BY SUSAN BLAUERT, DEPUTY ASSISTANT GENERAL COUNSEL

Dr. Jesse. Good Morning, Chairman Sanders and Ranking Member Burr and members of the Committee. We thank you for the opportunity to address the bills on today's agenda and to discuss the impact of these bills on Veterans' Administrating health care delivery.

As you mentioned, joining me today is Susan Blauert, VA's Deputy Assistant General Counsel.

Chairman Sanders, we greatly appreciate your continued efforts to support and improve veterans' health care. VA is carefully reviewing two of your bills, one concerning complementary and alternative medicine and the other expanding the Family Caregiver Assistance Act.

We anticipate providing full views on these bills soon. In the meantime, we will work with your staff to provide technical assistance. We believe we can provide valuable insight as to how VA can better integrate complementary and alternative medicine into our mission to provide personalized proactive and patient-driven care that support the health and wellbeing of veterans.

In my oral remarks, I am going to briefly explain VA's position on a few of the bills being considered today. A

much more detailed discussion of all the bills on the agenda can be found in my written statement.

Generally, VA supports bills expanding services to veterans. These bills include S. 325, which would increase the maximum age for eligibility of children covered under CHAMPVA Program and S. 455, which would make permanent our ability to use paid drivers to expand access to VA health care for individuals traveling for the purposes of medical care.

The VA also supports S. 529, which would expand the period of eligibility for benefits for the Camp Lejeune veterans by four years. I would like to thank our Ranking Member Burr for his ongoing efforts to support our Camp Lejeune veterans.

VA has made a number of recommendations on the Camp Lejeune program to make it easier to implement and easier for family members and veterans alike. These include simplifying the administrative eligibility requirements and shifting to DOD the determination of whether the veteran and qualified family members meet the 30-day requirement on Camp Lejeune. We believe these modifications to S. 529 would greatly improve our ability to implement the Camp Lejeune law.

We support much of bill S. 131, which would permit VA to provide expanded reproductive services, including in-

vitro fertilization for certain veterans and their spouses suffering from infertility. However, we do not support extending these services to engage in surrogates who would bear children for veterans primarily because variations and complexities in the state laws and policies would make a surrogacy provision extremely difficult to implement. We are concerned about our authority to support veterans in dealing with the entirety of the many complex issues involving surrogates.

So, a few of the provisions in this bill will require a little more time before VA can provide a position. For now, we remain hopeful, though, that Congress will enact the much-needed extension of our authority to operate our existing child care pilot so that we can continue to collect and analyze cost and utilization data.

VA supports the intent of S. 422, the Chiropractic Care Available to All Veterans Act of 2013, which would expand access to chiropractic care to all veterans. However, VA believes that the health administration is best situated to determine the parameters of such an expansion.

Decisions regarding the delivery, care through staffing versus a fee basis should be predicated both on demand and local capability. That would include the availability of licensed chiropractic professionals for hire into the VA system or through referral to them in the community.

We acknowledge that there is need for a thorough assessment of our current chiropractic services. In fact, such a study is now nearing completion, and we would welcome the opportunity to work closely with the Committee to ensure that legislation in this area supports veterans' preferences.

And finally, I would like to address S. 543, which would consolidate our existing 21 VISNS into 12 and proscribe a specific VISN organizational structure and staffing model.

As we discussed last year, VA shares the goal of increasing the efficiency of our operations. However, we do not support the imposition of a staffing and organizational structure that is not based on a complete assessment of business needs.

Last month, we provided the Committee staff an update on our progress towards implementing our internal reorganization and realignment. Standards have been established and we expect all VISNs to have completed the first phase of the reorganization by the end of this year. This will enhance quality and consistency of the management processes and will enable VHA to better assess cost effectiveness.

For phase two, a work group has been charted to undertaken an analysis of VISN geographic boundaries and

contemporary referral patterns. A process we believe is necessary to form any decision about redrawing the VISN scope. We look forward to keeping the Committee advised on our analysis and the status of work in this area.

I would like to conclude by thanking you all for the opportunity to testify before the Committee and I will be pleased to respond to questions that you or the other members have about the bills I have touch upon or other bills that were addressed in my written statement.

Thank you.

[The prepared statement of Dr. Jesse follows:]

Chairman Sanders. Thank you very much. Dr. Jesse, as you know. I have introduced legislation to expand VA's caregiver program--

Dr. Jesse. Yes.

Chairman Sanders. --to veterans of all eras. While VA did not provide written testimony on this particular bill, I would very much appreciate your providing this Committee with information on the progress of how the program is going in general. My understanding is that it is filling a real need.

Can you say a few words on that? How many, for example, if you have in front of you information about the number of veterans and their families who have accessed the program to date?

Dr. Jesse. Sir, I do not have those numbers in front of me but we will get them to you for the record. I will say that we have briefed senior management on the progress of the program. As you know, I think a report is due two years after the implementation of the program which would be at the end of this month.

Chairman Sanders. Can we expect to receive that report at the end of this month?

Dr. Jesse. I can hope so but not promise. How is that?

Chairman Sanders. Sometimes this Committee has had a

problem with getting reports in a timely manner. So, please take back to whoever you take it back to that we expect it at the end of this month.

Dr. Jesse. I shall. I think the program is quite successful. In terms of expanding the program, you, I think, are well aware that the equity issue to all veterans of all generations is important to us; and expanding this program I think very much fits within that. Of course, the question is the cost and the eligibility issues that would have to be well-defined.

But these are important issues to us. We very much appreciate the opportunity to have started off in this initial view of the post-9/11 veterans and clearly can see the impact of having this capability.

Chairman Sanders. In other words, what you are telling us is you think, and we look forward to the report, but at this point you think that program is filling a real need.

Dr. Jesse. I believe so, yes.

Chairman Sanders. Okay. And that it is hard to argue from an equity point of view and why it is only available to post-9/11 families?

Dr. Jesse. Yes.

Chairman Sanders. Okay. Let me ask you this, and Senator Burr raised the issue that he and I are working together on the homeless issue. Let me applaud you. I know

it is easy to beat up on the VA but the VA has made, under General Shinseki, some significant improvements and steps forward dealing with what I believe to be a national embarrassment, and that is homelessness among veterans. We have made some progress in that area.

The VA has set an ambitious goal of ending homelessness among veterans by 2015. That is an ambitious goal, and we are making progress on that issue.

The VA's homeless programs serve a number of populations with different needs. Senator Burr and I have introduced legislation to make common sense improvements to some of VA's programs for homeless veterans, including making transitional housing programs more accessible to the growing population of homeless women veterans.

Last December, the Interagency Council on Homelessness released the report that detailed challenges around stabilize housing for veterans in rural areas and tribal lands. The report included several recommendations on how to improve services for this population. My question is two-fold.

First, does VA believe that we can continue to make significant progress in dealing with the tragedy of homelessness in our veterans' population and especially the growing needs of women veterans?

And secondly, what actions is VA taking to address the

needs of homeless veterans in rural areas and on tribal lands?

Dr. Jesse. Senator, the first question is are we making significant progress, and I think the answer to that is simply yes. We have in place a multitude of programs across both urban and rural venues.

I will say that I think the homeless program in VA has taught us an incredibly important lesson, and that is that the success of programs like this are not necessarily predicated on what we ourselves do but our ability to partner with the incredibly dedicated local, state, and other federal agencies that are addressing these issues.

I had the opportunity a year or so, a couple of years ago to go to some of the veteran homeless stand-downs that we were conducting and was just thoroughly impressed that the comments from the local both government, faith-based, and NGOs about the role that the VA was playing to supporting the communities.

And, granted out authority is to take care of the homeless veteran but much of the capability to do that requires interacting with all the local folks. I think the best comment I had gotten was that they were very pleased whenever they identified a homeless person as a veteran because they knew one phone call and that person would be engulfed with services.

So, I think we are making great strides in those areas. I went to the Point-in-Time count this year out in LA and was equally impressed by the fact they were not necessarily counting homeless people because they knew them all. And, that is a far more important statement because when you know who the homeless people are, you know how to serve them best and get them the appropriate services.

The rural and tribal areas, I confess I cannot speak to the tribal areas. I can get that back for you for the record. The rural areas, I think we are equally dedicated to and it just is a matter of working in lower volume areas but again supporting the local communities who are working in these areas.

Chairman Sanders. Okay. Let me just say this. Senator Burr and I have introduced that I think is sound legislation, and we are going to do our best to see that it is passed and look forward to working with you for the implementation of it.

Senator Burr.

Senator Burr. Thank you, Mr. Chairman.

Dr. Jesse thank you for being here. I have great affection for the entire VA workforce--

Dr. Jesse. Thank you.

Senator Burr. --for what they commit to do, and I am appreciative that the VA supports my Camp Lejeune bill. I

am concerned, though, that the family members at Camp Lejeune and the veterans are waiting to access benefits provided by the current law.

In an explanation of the health care benefits provided by Camp Lejeune Act, VA's budget justification indicated the VA would start treating family members in fiscal year 2015.

Let me ask you. Why are these family members who are fighting cancer and other devastating diseases being forced to wait 18 months for the health care they need right now?

Dr. Jesse. So, part of that answer was embedded in the initial legislation which required the authorization, appropriation of the funding to do so. We have been engaging with the family members. We have, I think, at this point identified approximately 500 but in terms of actually beginning to disburse money to pay for their health care--

Senator Burr. I do not want to cut you short. The authorization is in this year's continuing resolution. It is in this year's. It is in next year's. There is no explanation as to why it would take to 2015 except that we have thrown a dart on a map and that was the date that came up.

Dr. Jesse. I would like to get back to you for the record.

Senator Burr. I would ask only this of you. Go back and read the act.

Dr. Jesse. Okay.

Senator Burr. It is now law. Go back and look at the CR. The authorization is there. The Act when it was adopted was offset. The money was there. I am just going to be real candid. There is no excuses. To do this is to turn your back on individuals that are reliant on the VA partnership to provide them health care.

And, let me just say for all my colleagues. We did not put VA in the primarily spot. They are secondary. These people have to turn to their own insurance first. VA is a backstop. It is there for any overage. It is there if they do not have insurance. These are folks that in many cases are in terminal illness. They may not make it to 2015.

Dr. Jesse, you testified that VA was reviewing the staffing structure of the VISN headquarters to streamline and standardize their operation and that you were doing to go back and determine geographically what the number was.

Now, I am not a bureaucrat. I am a business guy. It makes sense to me that you would go in and figure out how many geographically you needed before you looked at how to streamline it.

Have it got it backwards or do you?

Dr. Jesse. So, I am a cardiologist. I think the ability to reconfigure the entire administrative organization of the VA is complex and probably more than

just determining what the right number of VISNs is, and the ability go to in and look at the efficiency and the effectiveness of the existent VISN structure is a relatively straightforward process.

What it really required us to do, and I think frankly was very important is to really speak to what is the role of the VISN structure. It has changed over time from their original conception back in 2008 when they were put together. And if you are trying to understand why there was such a great variance across the sizes of the VISNs regardless of the scope of size of--

Senator Burr. Do you intend to sort of go back to the original intent of the creation of the VISNs to use the template to look at the current numbers?

Dr. Jesse. So, the original VISNs were built on the structure both geographic including referral patterns. I think having, you know, done the first part which is we have said we have done and we briefed your staff on, we have leaned down the size of the VISNs. The next thing to do is really go look at the referral patterns.

Frankly, there are a lot of people for care cross VISN lines which creates at some level of both confusion and complication. If we can re-adjust them on what are the contemporary VISN patterns, I mean, I think we can make some significant changes in how the preferred VISN structures are

aligned. But I do not know if 12 is the right answer or 15 is the right answer.

Senator Burr. VA's own testimony states that they are unclear why VISN 19 and 20 are consolidated and VISN 6 would be untouched and stated VA would appreciate the opportunity to review the Committee's criteria for determining these boundaries. I am ready. I think we have been very specific.

Let me just, Mr. Chairman, ask one last question. You stated that if this VISN Reorganization Act were to become law, veterans would, could potentially, and I quote, be forced to travel to different locations for care because the space for clinical operations would be used to comply with the provision calling for VISN offices to be co-located within a medical center.

Since the bill outlines the process for VA to enter into leases, how in the world would this provision change where a veteran received their care?

Dr. Jesse. So, I think what that statement refers to is or let me back that up and say one of the reasons why many of the VISN headquarters are not on the grounds of a medical center is because the space needs in those medical centers was to deliver clinical care and it felt it was more appropriate to move an administrative function that was not directly attached to that medical center off site and use

the space for delivery of care.

The notion is if we then had to collapse the space to deliver care, we would have to distribute that care somewhere else. I think that is what it is referring to.

Senator Burr. I thank the Chair.

Chairman Sanders. Senator Begich.

Senator Begich. Thank you, Mr. Chairman.

Thank you both for being here this morning. Let me ask you in reference to two bills that I have. One is S. 287, which is a bill to amend Title 38 of the Code to expand definition of homeless veterans for the purpose of benefits under the administration.

The purpose of eligibility or what it would change through the VA, the bill includes veterans, families fleeing from domestic or dating violence, sexual assaults, stalking and other dangerous life threatening as well as children who may be at risk or jeopardized. There is no other types of residency. The idea is expand the definition of homelessness. Last year, you all supported it but this year you have no comment.

Can you tell me where you are on this? Just give me your thought on that.

Dr. Jesse. Sure. Ms. Blauert.

Ms. Blauert. Yes, sir. We did provide views in September of last year; and to be honest, we were not really

satisfied coming back to you with essentially the same view this year. We want a little bit more time to dig in and look at the issues and exactly what the impact would be on our existing programs with expanding who we capture with that term homeless veteran. You can be assured that VA does not turn away a veteran who is out on the streets and in need.

Senator Begich. I understand that. But what I guess I am trying to--if that was September of last year, it is now May. I battled this issue before with HUD because what they always would say is we hear you, the definition of family, and some other definitions. But what it would do is statically change their numbers. In other words, it would show that you had more homeless. Well, of course, because now you have increased the definition. I hope that is not one of the reasons. That is now one of the reasons, correct?

Ms. Blauert. No. Absolutely.

Senator Begich. Okay. Then when can I see a response, because it seems logical that we would want to make sure veterans and families fleeing domestic violence or dating violence or other situations of this nature that become homeless would be even a higher risk because of the situations they were in, now they are on the streets. So, is there philosophical opposition to it?

Ms. Blauert. No, I do not believe there is philosophical opposition to it. It is my understanding that there is interest in making sure that we have clinicians and services available to treat the needs of these persons. Some of them are going to be different than the current population that we consider homeless

Senator Begich. I understand.

Ms. Blauert. I understand that VHA recently undertook a task force to specifically look at the domestic violence issue.

Senator Begich. We could break a bit of the discussion away from the definition of homeless and speak to our ability and frankly our desperate need to attend to his very vulnerable population.

You know, we take the issue of domestic violence incredibly seriously. As you know, the women's health program in VA has been doing just some magnificent work over the past couple of years. They have a task force which has just completed its report on domestic violence.

Dr. Jesse. Does the task force, did they deal with the issue of homelessness?

Senator Begich. I do not know what they specifically addressed the issue of homelessness. What they are specifically addressing is how we support and care for victims of domestic violence which would generally mean

getting them out of the living environment that they are in into some other environment. I only have limited time here so I want to be right to it.

Dr. Jesse. Yes.

Senator Begich. So, the task force is done. They have done a report. When will that be public?

Dr. Jesse. That I do not know but I know that the report has been done and we would see the recommendations coming out shortly. We can get that back to you.

Senator Begich. Okay. That would be great.

Second, if it does not deal, because here is works. If you are subject to domestic violence or sexual assault in a home environment, you are leaving. Right. Okay. So, they become couch-hoppers where they are going from house to house or they are on the street. This is not the population you want on the streets.

Dr. Jesse. No.

Senator Begich. So, I am hopeful, if that is a draft report, that if it does not address this, it should address it and then refer to the bill itself because the definition is what helps make sure resources follow these individuals.

Dr. Jesse. Exactly.

Senator Begich. That is really important.

Let me go to one last quick thing, and that is there was another piece of legislation, S. 877, is the Veterans

Fair Research Transparency Act. This is very simple.

The National Institute Health does this now, and a lot of the work that they do they can share and, therefore, the data helps with other research and everything else going on.

Why cannot the VA replicate what the National Institute of Health does in the sense of creating a data base and ability for sharing of information? Of course, not individuals by names and so forth. Why cannot we do that if another federal agency does that now?

Dr. Jesse. Well, I do not think it is an issue that we cannot. I think the issue is we just have not had the time to look at exactly the best way to do this. I fully agree with you that the NIH does this now. They require any NIH funded study to make that journal article free of charge.

Senator Begich. So, let me ask you this. Again philosophically, does the VA oppose this?

Dr. Jesse. No. No.

Senator Begich. So, really it is about looking at this legislation and seeing how you can implement it?

Dr. Jesse. The simple answer might be just to tag on to the NIH's role.

Senator Begich. Can you again, the same thing. I would like to get a--I know, Mr. Chairman, all the time when we get, if we have all these bills it is hard to get agencies to say, yea, nay, or here are the five things we need fixed.

All I am asking for is, I know when I was mayor of a city, my legislative body asked, we would respond and say we do not like it; we do like it; or we have problems and here are the six things we need fixed. Can you do that on this bill?

Dr. Jesse. We can.

Senator Begich. Thank you. That is all I have. My time was up. I am sorry I had to rush you. I am respecting the Chairman here, and I do not want to get in trouble.

Chairman Sanders. I was a mayor too. This place does not work.

Chairman Sanders. Senator Boozman.

Senator Boozman. Thank you, Mr. Chairman, and thank you for being with us, Dr. Jesse.

Dr. Jesse. Yes, sir.

Senator Boozman. We have gotten caught up in the backlog of the disability, and this and that. But I do think that we have a really good story to tell in regard to the homelessness, and you all have done a good job in doing that and that is something we need to talk more about.

In the last 15 years, I was on the, I have been on the VA Committee in the House or the Senate now for a long time and just the increase in veterans health care in general has improved dramatically. We have still got a long way to go in the sense of just fighting the battle but it really is

much better.

We currently have just completed, we are going to dedicate a expansion in Fayetteville, Arkansas, providing a lot more outpatient services. That has become a large VA now with a tremendous number of veterans population. It is very much needed. But it truly is state of the art.

I was out visiting, you know, our clinics, you know, located. The advances that we are using, telemedicine, you know, things like that, those are good things. So, those are things that we can be very proud of.

I also appreciate your comments about recognizing in regard to homelessness the value of state, local, faith-based, and other NGOs, the partnerships, and that has been a big factor in pushing us forward in that regard.

I hope that we will do the same thing in regard to suicide and some of these other things that we are doing and really make a concentrated effort.

I guess what I am interested in, I want things that work, and you know, I think in the homeless thing at some point we kind of threw our hands up and said, you know, the government has the want-to but they do not have the heart to get these things done and allowed others to come in and help. I hope that we will do that again with the suicide.

In a second, I will let you comment about these things. We have been working with Senator Begich on the bill. I am

an original cosponsor of the one that he mentioned. I guess the thing there is, you know, going out rural states like ours you will have communities that do an excellent job, you know, helping with those people that are put in very difficult situations, you know, where essentially the community provides. Then, you have other places where there are no resources at all.

Until we can get this done, and I am committed to getting this thing done as quickly as we can, but until then, you mentioned, you know, the fact that you could provide resources. Can we do this somewhat administratively in the sense that when people are in this situation, does that qualify them for homelessness in another way? You see what I am saying.

Dr. Jesse. Yes, I see what you are saying. My gut answer is I would sure hope so. If there is a technical reason we cannot, I am not aware of it but I will try and find that out. I think that one of the other brilliant parts of the homeless program that is under-recognized is the prevention piece of it.

Senator Boozman. Right.

Dr. Jesse. VBA watches the mortgages real carefully. As people look like they are defaulting, they have interventions. They can keep people in their homes. Keeping people employed, opening up the GI Bills to get

people in school so at least they are getting educated if they cannot get a job. All these things contribute to the prevention of homelessness which I think are part of the bigger story.

But in terms of that specific, I will have to get a technical answer to that. But I would sure hope that we do not deny somebody there. Again, I think that providing a safe place to live for a victim of domestic violence is absolutely key. Whether they are called homeless or not is less important than making sure that they are safe.

Senator Boozman. You know, short term until we can reach agreement and get this thing sorted out officially, I think that would be very helpful in trying to, because that is one of the things that we all agree on needs to be done.

Dr. Jesse. Yes, we do.

Senator Boozman. The other thing is, you know, in doing that, you know, these folks are going to be eligible a long the line as far as other things.

So, you know, if you can kind of always head these things off at the pass, invariably it costs a lot less money in the future because then you do not get into destructive behavior and the things like that that are such, so difficult to deal with.

Dr. Jesse. That is a great statement because that applies even to things like the transportation bills, that

getting people to their appointments, while it is difficult to quantitate the savings, we know from both the U.S. Health Care and other national health care systems that people who do not make appointments that is what costs because getting to those appointments allows you to help patients manage their chronic diseases best and is part of our commitment to the use of telemedicine and all its derivatives to keep engaged with patients rather than relying just on those point-to-point visits.

Senator Boozman. Thank you. I have lost my time. The only thing I would say, you do not have time to respond, but I would hope that you support the Veterans' Drug Courts. I think that is another answer that is a big deal.

Chairman Sanders. Okay, panelists, thank you very much. And, Dr. Jesse, remember again the law says we should get that report at the end of this month.

Dr. Jesse. Yes, sir.

Chairman Sanders. We will be looking at our mailbox.

Dr. Jesse. Okay. Thank you for having us. Thank you for your support.

Chairman Sanders. I would like to welcome our second panel.

[Pause.]

Chairman Sanders. Clearly, if this Committee is to do its job well, we want to hear not just from representatives

of the VA but we want to hear from people on the ground who will be impacted by legislation that this Committee passes or does not pass. So, we are delighted to have a wonderful panel with us, people who have devoted years of their lives to the needs of American veterans.

We are going to begin with Rick Weidman, who is the Executive Director for Policy and Government Affairs at the Vietnam Veterans of America.

We will then hear form Dr. Wayne Jonas, who is the president and Chief Executive Officer of the Samueli Institute.

Then we will hear from Heather Ansley, Vice President for Veterans Policy at VetsFirst. And then, Matt Gornick, Policy Director for the National Coalition for Homeless Veterans.

And then Thomas Bowman, Former Chief of Staff of the Department of Veterans' Affairs. And we thank all of you very much for being with us.

Mr. Weidman, why do we not begin with you?

STATEMENT OF RICK WEIDMAN, EXECUTIVE DIRECTOR FOR POLICY AND GOVERNMENT AFFAIRS, VIETNAM VETERANS OF AMERICA

Mr. Weidman. Mr. Chairman, thank you for inviting Vietnam Veterans of America to share some of our views on the issues before the Committee today.

The first issue I want to touch on is the issue of children of Vietnam Veterans with spina bifida; and with the help of your staff and that of Senator Donnelly, we are finally making some progress in that regard in terms of taking care of one case, Honey Sue Newby, who had come to our attention.

Our concern, though, is with the other thousand children as nobody knows whether or not they are being taken care of. It once again comes back to the same issue that you and your colleagues have touched on this morning of accountability for things that were clearly defined in the statute sometime ago.

It is that accountability issue that we struggle with with the Veterans' Administration in all facets of it. In regard to the Veterans' Health Equity Act, we think it is important for the states that do not have any medical center and that whole access to care, whether it be in the State of Vermont or New Hampshire or Wyoming or North Dakota is very important and we thank Senator Shaheen for that.

The Women Veterans and Other Health Care Improvements of 2013, introduced by Senator Murray, we are for this bill strongly. We recognize one of your staff who worked on this bill as congressional staffer of the year for the 112th Congress.

And, it proves many additional steps toward what was envisioned by Senator Inouye 30 years ago when we started this process of making the VA responsive to the needs of women veterans and it is another important milestone.

We support Senator Begich's broadening the definition of homeless veterans and would, for the record, make the point that we have always defined as Vietnam Veterans of America homeless veterans as those without a permanent home.

VA does not define it that way. They only define it if you are on the street. Most people before they hit the street have stayed on couches or in basements or in attics, friends' houses, relatives, et cetera; and it is only have they have exhausted all of those other opportunities that they end up on the street. And, we need to catch them before they hit the street and that is where VA often falls down.

I wanted to touch on the Reorganization Act because while we applaud the effort, Senator Burr, to get at the administrative overhead, not sure necessarily that this is the way to get at it.

We were told when they reorganized into VISNs that it would reduce administrative overhead and, in fact, it has gone exactly the other way. There is more admin overhead at the medical centers than there was before; and yet, on top of that, you have the admin overhead at the VISNs.

We have never quite figured out that what the heck is a nurse executive. That is a person trained as a nurse who does not work as a nurse anymore?

All of those kinds of euphemisms trouble us deeply, And their new reorganization plan reminds some of us of a certain age of the old Kelvinator washers, and it looks like a big wash tub.

It is so confusing that even though we have tried to understand it, we cannot. And, what they have done is divide operations from policy, and anytime you divide that, what you do is neuter the policy people who really know what ought to be done from the operations people; and the operations people will always trump the policy people.

So, we think that they far too many people that have been hired with that extra ordinary increase since 2006 that VHA has gotten that have not gone into hiring more clinicians who actually directly serve veterans. And, that really is the heart of the matter that we would encourage the Committee to do and to look into deeply and possibly a GAO report about how this has shaken out, what percentage of

those new funds have actually gone to care deliverers versus people, more people in the admin overhead.

The chiropractic, we thank very much Senator Blumenthal for stepping forward on that one. This is yet another case where Congress has spoken clearly just like in the case of physician assistants and VA ignores it.

Chiropractic care was clear ten years ago that the Congress wanted chiropractic care to be available to any veteran who needed it within the VA and yet VA has dragged its heels.

So, it is really a question of VA not being responsive and not fulfilling the will of the Congress, and it is the accountability issue that bothers us.

I see I am out of time but I would just mention that we are strongly in favor of the Homeless Veterans' Prevention Act of 2013, and we have shared in our written statement some specific ideas and concepts that we would appreciate your looking at before that bill comes to markup.

Mr. Chairman, distinguished senators on the committee, thank you very much for hearing our views.

[The prepared statement of Mr. Weidman follows:]

Chairman Sanders. Thank you very much, Mr. Weidman.

Dr. Jonas.

STATEMENT OF WAYNE B. JONAS, MD, PRESIDENT AND CHIEF EXECUTIVE OFFICER, SAMUELI INSTITUTE

Dr. Jonas. Thank you very much, Mr. Chairman, Senator Sanders, members of the Committee. It dawned on me as I was coming here actually last night that I am not only a veteran that I am a four-generation veteran.

I had forgotten that my great-grandfather actually was in the Philippines in the military and rode in the Rough Riders. My grandfather was with Patton going across Germany, and my father was a 30-year chaplain in three wars in the Army.

So, when I became a family physician after medical school, there was no question I was going to be an Army doctor. I had the great opportunity during those 24 years to also run the Office of Alternative Medicine at the NIH, run a WHO traditional medicine office that looked at traditional practices from around the world and sit on the White House Commission for Complementary and Alternative Medicine and run a research program at Walter Reed Army Institute of Research.

I now run an institute called the Samueli Institute which is a non-profit 501(c)(3) research institute that examines the inherent healing capacity of individuals with a scientific lens in order to determine how they can be implemented into whole systems, into large systems in these

areas. We do a lot of work with active duty, DOD, and with veterans.

I fully support the integration of evidence-based, whole person health promotion, and complementary medicine practices into veterans' care.

After ten years of wars, we have tremendous suffering of which only the tip of the iceberg is seen when people walk into the clinic in the veterans' area.

Right now when someone walks into a clinic anywhere, whether it is veterans or non-veteran clinic, military clinic, because of the structure of medicine, you get divided up.

If you have psychological issues, PTSD, you go see the behavioral medicine person. If we were told you got hit in the head or you claimed you were exposed to trauma, you go see the neurologist. If you lost a leg or had surgery, you go see the arthropod.

And yet, people do not experience this suffering that way. People experience this suffering as whole persons, from the physical pain to the psychological injuries to the cognitive difficulties to the energetic problems to the spiritual and moral injuries that have occurred in war. That spreads then into the social, family areas and they experience the suffering also.

We need a whole system, whole person approach to

dealing with these things the way people experience them, not a divided, disintegrated system. Thus, we need practices that can help them reset, reheal, tap into their inherent healing processes and, more importantly, teach them the skills that they need in order to build resilience for the long run.

Many of the folks from the current wars are young and they have a lifetime of suffering. We do not want that to be a lifetime of dependency. We want it to be a lifetime of optimal healing and functioning.

These practices have the potential if they are properly evaluated and integrated not simply to treat a disease but, in fact, to provide that resetting.

We just published, actually one of our funders, that we publish the first randomized controlled trial published in spine of lowback pain with chiropractic, demonstrating that chiropractic added on to usual care, significantly improved chiropractic in active duty populations who had carried big loads for many years.

We have just completed a study at Walter Reed in partnership with Walter Reed looking at the use of acupuncture for posttraumatic stress syndrome.

One month of eight treatments of acupuncture reduced posttraumatic stress syndrome by 56 percent and improved all the other symptoms of the trauma spectrum including pain,

improved sleep, reduced medication, and even to my surprise, improved cognitive function.

On a study published about four or five months ago that we did in conjunction with Scripts and the Camp Pendleton Marines in posttraumatic stress syndrome took a very simple relaxation, self-care practice taught by nurses to induce a relaxation skills training program an individual's posttraumatic stress syndrome, added on to usual behavioral care significantly reduced posttraumatic stress syndrome.

When that was then followed up as was the acupuncture one, after those were finished, three months later they continued to maintain improvement. In other words, it was not a one-off treatment. It was actually a reset, a rehealing of those practices.

Those types of self-care practices can be taught to families and become a normal part of what goes on not requiring the system. These practices should be a main part of the integration into the system but they have to be done and evaluated in a careful way in order to determine how the benefits can be properly induced, what are the economic drivers.

There are no economic drivers for these self-care practices. They are not a device. They are not a new drug. They do not have a new company behind them throwing millions of dollars trying to get them into the system.

Thus, they incrementally and slowly creep into the system only to the extent that veterans pay attention to them. That requires a coordinated and concerted effort in those areas. I think that kind of a coordinated, concerted effort can be done. There are several blue prints to do that.

I want to highlight this book that was just completed by the Institute of Medicine on chronic multi-symptom illness with veterans. They actually show a blueprint for bringing healing oriented processes and systems into the Veterans' Administration, and I would urge the Veterans' Administration to pay close attention to that.

Thank you very much for my time and attention.

[The prepared statement of Dr. Jonas follows:]

Chairman Sanders. Thank you very much, Dr. Jonas.

Ms. Ansley.

STATEMENT OF HEATHER ANSLEY, ESQ., MSW, VICE PRESIDENT FOR VETERANS' POLICY, VETSFIRST

Ms. Ansley. Chairman Sanders, Ranking Member Burr and distinguished members of the Committee, thank you for inviting VetsFirst to share our views and recommendations regarding the legislation that is before the Committee this morning.

My oral testimony will focus on S. 131, S. 324, S. 455, S. 633, and S. 851. First, we support the Women Veterans and Other Health Care Improvements Act of 2013. After more than a decade of war, many severely disabled veterans who have experienced trauma-related improvised explosive devices and other conditions of warfare may experience infertility.

For many of these same veterans have the ability to start or grow their families represents an important part of moving forward with their lives.

S. 131 takes important holistic steps toward addressing infertility. VetsFirst supports the addition of fertility counseling and treatment including treatment using assisted reproductive technology to the definition of medical services.

We are also pleased that this legislation not only expands the definition of medical services to include these treatments but also provides them to veterans' spouses or surrogates. Importantly, this legislation also provides the

opportunity for veterans to grow their families through adoption.

VetsFirst also supports the efforts of S. 131 to improve access to VA services for women veterans. To ensure that women veterans have full access to medical services, VA must continue to improve efforts to address the unique needs and concerns of women veterans.

Increasing the avenues for women to receive information through portals such as VA's new Womens' Veterans Hotline which is a requirement of S. 131 is an important step forward.

We also support increasing access to mental health and readjustment counseling by providing opportunities for child care for all veterans.

Second, VetsFirst supports S. 325, which would increase the maximum age for children eligible for medical care under the CHAMPVA program. Children who are CHAMPVA beneficiaries typically lose their coverage at age 18 unless they are full time students in which case they can maintain their benefits to age 23.

The Affordable Care Act or the ACA allows children to remain on a parent's health insurance until age 26. However, TRICARE and CHAMPVA beneficiaries were not covered by this provision. TRICARE has since been brought into alignment with the ACA but CHAMPVA has not. S. 325 would

correct this injustice by allowing those beneficiaries to receive health care benefits until age 26.

Third, we support S. 455 which would provide VA with the authority to provide transportation for veterans who need assistance to and from VA facilities. Lack of transportation options remains a barrier for some veterans who need to travel to VA facilities for health care services. For many veterans riding with family members and friends, using public transportation, or driving themselves allows them to travel to a VA facility when needed.

For veterans who do not have a network of friends and family, they are not able to drive. They do not live near public transportation. They have to seek other options.

In January 2013, the President signed the Dignified Burial and Other Veterans' Improvements Act, which authorized VA to transport individuals to and from VA facilities for these purposes. This authority will expire in 2014. And, we support S. 455, which would extend it to ensure most importantly that no veteran is left without the ability to access critical VA services.

Fourth, VetsFirst supports S. 633, which provides beneficiary travel benefits for all veterans who have spinal cord injuries, vision impairments, and multiple amputations, and need to travel to receive inpatient rehabilitation services.

For those veterans who need these services but are not eligible for travel benefits, the ability to pay for travel which may include traveling a great distance can be very burdensome, and every effort must be made to reduce the barriers that limit access to these services, primarily because without those, that assistance, a veteran can become, lose their independence and may end up in a higher cost care somewhere.

Lastly, VetsFirst supports the Caregiver Expansion and Promotion Act of 2013. Many families of disabled veterans play a crucial role in providing needed services and supports that allow veterans to return to and remain in their homes.

Spouses and family members, however, often must leave the work force to assist their husbands, wives, adult children in their efforts to rehabilitate and reintegrate into their communities. That sacrifice may include lost income and other benefits, including health insurance. S. 851 would extend enhanced caregiver benefits originally provided to family caregivers of post-9/11 veterans with serious injuries to caregivers of veterans of all eras who have serious service connected disabilities.

Many of these caregivers have sacrificed for decades in order to be able to provide assistance to their veterans and gladly have done so.

But we would hope that this would be an opportunity to recognize their significant contributions that they have made for, in several cases, many years to keep those veterans independent, working, and living in their communities.

Again, thank you for the opportunity to share VetsFirst's views of the legislation today. This concludes my testimony.

[The prepared statement of Ms. Ansley follows:]

Chairman Sanders. Thank you very much, Ms. Ansley.

Mr. Gornick.

STATEMENT OF MATT GORNICK, POLICY DIRECTOR,
NATIONAL COALITION FOR HOMELESS VETERANS

Mr. Gornick. Chairman Bernie Sanders, Ranking Member Richard Burr, and distinguished members of the Senate Committee on Veterans' Affairs, I am honored to appear before this Committee as the policy director of the National Coalition for Homeless Veterans.

On behalf of the 2,100 community- and faith-based organizations NCHV represents, we thank you for your steadfast commitment to serving our Nation'S most vulnerable heroes.

My testimony today will focus on three bills currently before this Committee: S. 62, the Check the Box for Homeless Veterans Act of 2013; S. 287, a bill to expand the definition of homeless veteran for purposes of benefits under the laws administered by the Secretary of Veterans Affairs; and S. 825, the Homeless Veterans Prevention Act of 2013."

Since their inception, federal assistance programs for homeless veterans have received overwhelming bipartisan support from Congress. While critical, some of these investments have been modest in consideration of the full range of problems associated with veteran homelessness.

Sen. Barbara Boxer's Check the Box for Homeless Veterans Act would help address some of the shortfalls by

establishing a National Homeless Veterans Assistance Fund, supported through designated tax overpayments and other direct contributions.

This fund would be used for two purposes: One, to develop and implement new and innovative strategies to prevent and end veteran homelessness; and two, to provide services through any homeless veteran program administered by the VA, HUD, and Labor.

This fund's primary purpose should be to help close gaps in service delivery systems for veterans. It will be counterproductive to reduce appropriations for homeless veteran assistance simply due to this fund's establishment.

The next bill I would like to discuss is S. 287. Over the past few years, VA's homeless programs have evolved to accommodate the growing number of homeless women veterans and single veterans with dependent children.

Unfortunately, the department still defines homeless veteran based on an incomplete citation of the McKinney-Vento Homeless Assistance Act. The full definition of "homeless" under this act includes individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions in their housing situation.

Senator Mark Begich's S. 287 serves a straightforward

purpose: to include this provision in VA's definition of homeless veteran.

Although some veterans who meet this expanded definition may already qualify for VA homeless assistance due to the nature of their circumstances, we must ensure that they are not denied the help that they need.

The last bill that I would like to discuss is Chairman Sander's and Ranking Member Burr's S. 825, the Homeless Veterans Prevention Act of 2013.

The breadth of this bill is a testament to this Committee's leadership in the effort to prevent and end veteran homelessness. Among its many important provisions, S. 825 would reauthorize competitive grant programs for community- and faith-based veteran service providers.

These programs include the Grant and Per Diem Program, Homeless Veterans' Reintegration Program, and Supportive Services for Veteran Families Program.

NCHV concurs with VA in its fiscal year 2014 Budget Proposal on the following items, which are not reflected in this bill. The Grand Per Diem Program should be permanently authorized at $250 million. This program has the capacity to serve 30,000 homeless veterans each year and is vital to VA's mission to end veteran homelessness.

The Supportive Services for Veteran Families Program should be permanently authorized at $300 million. This

program will serve as the foundation of VA's strategy to prevent veteran homelessness well beyond 2015.

Lastly, the grant program for homeless veterans with special needs should also be permanently authorized. Therefore, NCHV recommends that the Homeless Veterans Prevention Act be amended to accommodate these proposals. Without these extensions, VA cannot adequately plan for these programs' future.

Additionally, while this bill would provide increased per diem payments for service providers implementing a Transition in Place housing model, the need to reform the per diem payment method remains.

This Committee helped pass legislation that became Public Law 112-154, which requires VA to study all matters relating to the per diem payment method, including anticipated changes in the cost of providing services to homeless veterans.

VA must report to Congress on its findings less than three months from today. Anything short of a proposal to thoroughly modernize this outdated reimbursement policy from a flat per diem rate to a flexible, cost-of-services payment method should be deemed insufficient.

In closing, thank you for the opportunity to present this testimony. It is a privilege to work with this Committee to ensure that every veteran in crisis has

reasonable access to the support services they earned through their service to our country.

Thank you.

[The prepared statement of Mr. Gornick follows:]

Chairman Sanders. Thank you very much, Mr. Gornick.

Mr. Bowman.

STATEMENT OF THOMAS BOWMAN, FORMER CHIEF OF STAFF, DEPARTMENT OF VETERANS' AFFAIRS

Mr. Bowman. Chairman Sanders, Ranking Member Burr, and Distinguished Members of the Committee, it is a pleasure to be here and offer my comments on S. 543, the VISN Reorganization Act of 2013.

I believe the proposed legislation is both timely and necessary to ensure that the VA with predictable regularity, reviews, reorganizes or right sizes, as appropriate, its VISN organizational structure and operation to more efficiently and effectively oversee and manage the budgetary and planning responsibilities for the respective networks.

At the outset, I believe it important to state that I receive all my health care through the VA at the Bay Pines VA Medical Center in St. Petersburg, Florida. Although I have many other health care options available to me, I choose the VA because I believe in its mission and its people.

My comments have been influenced most particularly by my last three and a half years experience as an employee of VA, day to day, as the senior advisor to the VISN 8 network director.

There has been no serious review or right-sizing of the VISN geographic boundaries in approximately 18 years until prompted by the proposed legislation.

The legislation reduces the number of VISNs from 21 to 12 by combining existing geographic boundaries and eliminating excess VISN headquarters, and assisting the transfer or reassignment of affected personnel to nearby VA medical centers or other VA facilities. Many could fill existing vacancies at these facilities based upon their exceptional skill sets.

With the closure of 9 VISN headquarters under the reorganization, the funding saved could be provided to other VA medical centers to support their clinical needs, other capital asset upgrade and maintenance, as needed.

I have provided the Committee a map reflecting the proposed realigned boundaries. The map also reflects the current location of existing VA medical centers, community-based outpatient clinics and VISN headquarters.

The geographic combinations result in a re-balancing across VA of the aggregate number of today's veteran beneficiaries under one VISN director instead of two or possibly, in one case, three separate VISN headquarters.

Some might argue that despite smaller unique or enrolled patient numbers, you need to separate VISNs because of the challenge presented by the number of VA Medical Centers or the expansion of geographic areas that the combinations would entail.

VA Medical Centers are not all the same complexity

level or size. The same management process and procedures for budgeting and planning can be applied by a VISN director whether the number of medical centers is 8, 14, or in the largest proposed VISN combination, VISNs 1, 2 and 3 would be 20.

The management tools, reports, information technology capability, tele and video communications venues and site visits available to a VISN director and staff are significant and effective, if appropriately utilized.

It should be noted that the realignment of the VISN geographic boundaries would not adversely impact individual veteran patient referral patterns as they exist today. They would continue as before.

Patients would still be cared for by their VA Medical Center staff or wherever they may be referred for care. The VISN headquarters does not currently, nor under the proposed restructuring, provide direct patient care.

What would change is that the VA Medical Center directors in realigned VISNs would have a new VISN director to which they will be accountable, and a new boss.

The proposed legislation states, in essence, that a VISN headquarters is to be located on the grounds of a VA medical center. At the same time, however, it provides that the Secretary can justify keeping the VISN headquarters in a leased location off campus by justifying his decision in a

report to appropriate Congressional oversight committees.

The Secretary, in providing that report, then is offering his justification for keeping a lease that may be in existence or to possibly move into an offsite location.

In the absence of an unanticipated exigent circumstance--natural disaster or other unforeseen emergencies--there is very little justification for not being able to balance the VISN books at the end of the fiscal year.

VISNs begin to plan for the closure of their books, and VA Central office is generally well aware of any deficiencies well in advance of the end of the fiscal year. VA Central Office has the ability to transfer reserve funds held at their level to cover the deficiencies in VISN accounts in advance of the end of the fiscal year where and when they propose to do so.

In addition, the Under Secretary for Health has a number of means and methods by which to hold VISN directors accountable for year-end budget deficiencies.

Mr. Chairman, this concludes my comments. I offer other in my written statement.

[The prepared statement of Mr. Bowman follows:]

Chairman Sanders. Mr. Bowman, thank you very much. All of the testimony was excellent and I thank you. I have read it and will study it and you all have made an important contributions to the discuss as to how we go forward.

Dr. Jonas, let me start with you, if I might. As you may or may not know, your statement is fairly revolutionary. As I hear it, what you are suggesting is that what has in recent years been called complementary medicine, or alternative medicine, really should be integrated into our health care system. What you are suggesting is that if we move aggressively in areas like meditation, acupuncture, chiropractic care, I suspect nutrition, and other areas, we can ease suffering for veterans and we can save the system substantial sums of money because many of these things have limited side effects.

Is my characterization correct, and if so, what would you suggest that we do with the VA, how aggressive should we be? The VA has already made efforts in all of these areas. They have been probably ahead of the curve compared to our medical health care system in general.

What would you like to see the VA do and is my characterization correct?

Dr. Jonas. I think your characterization could be correct provided these practices are integrated in the proper way. They are not simply tagged on as if they were

another treatment system for another condition and a specialty is created.

So, my first suggestion is that the VA, and they have made a lot of progress in these areas, get outside help. And what I mean by that is that by definition, these things are not part of the mainstream system. That is why they are called complementary and alternative medicine. They are outside of the way things normally are done.

That means the skills in terms of the delivery of them are not things that are normally part of the educational part of the practitioners that are in the VA. They are integrated into medical records, for example. They are not part of the benefits system. They are not tightly linked to the priorities such the personalized person-centered care center.

So, we will go into a patient-centered medical home. In the VA version, it is a pact, and we will look for whether these practices are even on the radar screen; and in most cases they are not or they are on the side. They are not fully integrated.

We will go into the distribution system for primary care enhancements, for example, called the Scan System. That infrastructure is there to do it but you do not see integrative practices as part of that.

There needs to be a retraining program and an

evaluation and quality assurance program that is coordinated with current existing practices so that they are systemically designed and evaluated as they are put in to the system.

Chairman Sanders. Are there any health care systems in this country which are doing a better job than the VA that we can learn from?

Dr. Jonas. In these area there are, and I suggest the VA really look at some of those care systems that have demonstrated improvements in pain, improvements in function, reduction and costs in those areas.

There is a number of them. The Allina System, for example, up in Minnesota, for example, has a wonderful inpatient example of how to integrate complementary practices into mainstream in a systematic way.

Chairman Sanders. And their results have been positive?

Dr. Jonas. Very positive, yes, reductions in pain, anxiety, cost, length of stay in the hospital, this type of thing.

There are some examples within the VA also but they tend to be champion driven so that if you have a passionate person who is organized in the VA, it is done. Salt Lake City had a wonderful one, for example, that showed, documented and published major improvements in outcomes,

reductions in costs, including impact on homelessness and that type of thing through a whole person integrated practice.

But when the medical director of that retired and left, it largely went away. It was not embedded into the system, into the benefits, for example, into the training and education of the entire system.

So, these are the kinds of things that need to be coordinated.

Chairman Sanders. My impression, non-scientific impression, is that allover the country people are gravitating more to these type of procedures. My impression also, having visited a number of VA centers, is that many veterans look forward and want to access these types of alternative treatments. Is that accurate?

Dr. Jonas. That is absolutely right. Surveys done, at least on the DOD side, and also on the VA side, show that the use of these practices tends to be even higher in those populations than they are out in the civilian population, especially for stress-related pain and those types of conditions, mental health conditions.

Chairman Sanders. The VA and all of us are wrestling epidemic of PTSD.

Dr. Jonas. Right.

Chairman Sanders. It is a huge problem. You touched

in your testimony that you think there are treatments, alternative treatments. Say a word on that.

Dr. Jonas. Well, I mentioned two. One a relaxation treatment that we tested out at Camp Pendleton that was delivered by nurses. It induced a deep relaxation. It actually involved trained skills, in other words, training veterans and their families how to do that. We are doing another one of those programs down at Fort Hood and at some VAs that show improvements in that.

Those are the kinds of practices. They are skill-based training. They are not treatments per se. They are not something where you have a pill or you have even a needle or a manipulation where you require a professional. Self-care practice.

Chairman Sanders. You have done that within the DOD but there is no reason why that could not be done, I presume, within the VA, is there?

Dr. Jonas. There are mind, body, and relaxation practices going on in the DOD. Few of them have been evaluated. There have been some that have had impact in those areas.

They need to be designed with experts from the outside that get involved, subject matter experts, and done in coordination with the VA practitioners so they learn how to actually deliver them because they are the implementation

experts.

So, that is why a team approach is required in those areas.

Chairman Sanders. Thank you very much. My time has expired.

Senator Burr.

Senator Burr. Mr. Chairman, thank you, and to the panel. I found it to be fascinating. I will probably need another round just to let you know now because I want to cover as much ground as I can today.

Tom, thank you for being here and retirement looks like it is treating you well.

The VISN Reorganization Act would create regional support centers, and they were set up to measure the efficiency and the effectiveness of the VISNs.

Now, the VA has testified that these centers would likely increase staffing, are not the best functions to be moved to a regional level, and could produce conflicting oversight programs.

Let me ask you. Do you believe that this function could be carried out without additional staff?

Mr. Bowman. Senator, I do. And, by way of background, the functions that have been identified in the legislation, you know, finance, compliance, outreach, womens veterans, homelessness, and could be others. In each VISN, there are

individuals that are responsible for those taskings and responsibilities of analysis and oversight of what is occurring in the medical centers within the respective VISN.

If you were to move forward with the regional support centers, what you are doing is you are taking what would be a number of personnel. Now, it could be a one, two, or three personnel office that would be looking at a larger number of VA medical centers. It would not be an expansion or an explosion of additional FTE.

And in fact, in the legislation, the approach that is taken is that you would attempt to move individuals who had those responsibilities in VISNs where there were a closure of the VISN headquarters and move them into the regional support center.

An important point to remember is that at the VISN level, the individuals who are conducting those responsibilities, those analysis and assessment responsibilities are accountable to the VISN director.

If their functions are moved to a regional support center and they are looking at more VISNs, you gain the ability to assess good practices, good implementation across a larger number of headquarters.

I am aware that there has been some comments about a confusion in the chain of command. So, if you create a regional support center, do you now blur the chain of

command, the answer is no, because as the legislation is discussed, the regional support center would be looking at a predetermined number of VISNs as determined by the Under Secretary or the Secretary.

Then, they would take a look at whether or not they are performing, those medical centers are performing. If they are not performing, the VISN director is going to be made aware of it by reports and information that would come down from VA central office. The regional support centers would be a field entity where accountability by the VISNs can be taken to the VISN level of accountability back up to VA central office.

Senator Burr. So, to some degree, some VISNs or some directors might look at this as a threat because there would actually be data that they could not influence what it said that makes its way to central office.

Mr. Bowman. Yes, there would be a concern there.

Senator Burr. You know, Tom, I noticed in your written testimony you mentioned the lack of succession planning, and specifically you state that VISN deputy directors should be at the SES level to match the VA medical center directors.

I am wondering. Can you expand on that to some degree?

Mr. Bowman. At the present time, the way VISNs are constructed and the way medical centers are constructed, you have an SES as a VISN director and you have an SES as a

medical center director. At the present time and by exception in one case, VISN 8, the deputy network director is not an SES.

Now, from an operational standpoint that I witnessed for three and half years is that when a deputy director is not a VISN, if there is a gap or an absence on the part of the VISN director, either they were relieved for cause or they retire or for some other reason are going to be gone for a long period of time, VA has to pull in either an existing medical center director to act temporarily as the VISN director which means he or she is no longer managing the business of the medical center from which they came or they are going brought in from an outside VISN to be the VISN director until the personnel process of replacing the VISN director occurs. And, as we know, that is not a very quick process.

The other point is is that if you have the deputy network director as an SES, it becomes a position that career employees as they advance in their rank within the VHA structure, it will be a position that they look to compete for because of the advantage of experience to be gained.

It becomes part of a succession planning venue because, if you have individuals who have served as deputy network directors, they then become good candidates to be looking at

or to be considered for medical center directors because they have gained the advantage of the experience and background of what a VISN operation is like as they oversee medical centers.

It would also at the same time allow the medical center directors to feel more comfortable in bringing to the attention of a deputy network director issues sensitive in nature, whether they be business or personal as it relates to happenings within the VISN much more so than somebody who is not at the SES level.

Senator Burr. Great. Thank you, Mr. Chairman.

Chairman Sanders. Thank you, Mr. Bowman.

Senator Boozman.

Senator Boozman. Thank you, Mr. Chairman.

Rick, you mentioned the, and Dr. Jesse really alluded to it earlier in the sense of having HUD, you know, look at in preventing, sometimes we do not talk about the prevention of homelessness, you know, which again are very, you know, are so beneficial.

I think you make an interesting point of you have the, it might be an intervention there. If that does not resolve, then the next step is that you are sleeping on somebody's couch. That is another opportunity to intervene before the bad things happen where you are physically out on the street.

So, I think you make a really good point there. Perhaps, you know, there is something that we can do to, you know, figure out how we can, you know, do that step. And, you know, certainly would like to work with you in that regard.

I just want to thank all of you all. We really can be proud of a lot of things that have happened in the last several years and your advocacy in different ways really has made a huge difference, working with the VA. And so, we really do appreciate it.

The other thing is you mentioned the spina bifida and that is something that I would like to look at. You know, you have, we all have personal, you know, things where you have, you know, the Vietnam era is my era.

And I can recall somebody that just a wonderful employee whose husband died very, very young that was up to his eyebrows in Agent Orange. And then, had two children that had multiple problems, you know, as a result of this.

So, we all have those kind of stories. But like I said, I would like to be involved in that and I will get with you on that.

You mentioned, Mr. Bowman, again I think you have got some great ideas and I do appreciate your service and have enjoyed working with you now for the last several years.

And again, you know, we have got a great story to tell

in regard to making changes. I guess, you know, good ideas were there for, you know, quite a while. Person of importance. I am sure that, you know, you are frustrated in the sense of getting some of those ideas done then, okay, as we all are.

I have been on the Committee for a long time. We have all been working in these areas. What is your recommendation? How do we actually get those good ideas that you had, you know, in your position and were able to implement some?

What is the next step in actually getting some of this stuff done in regard to perhaps looking at reorganization, looking at, I guess what I would like to know is how do we get that done?

And then the other things is what is the low hanging fruit out there that you think that again not in an effort of I got you or this or that. The Committee, the VSOs, the nonprofits, what are some of the low hanging fruit that we can help VA? And I think a lot of this stuff, you know, probably the vast majority VA wants to be helped, you know, to implement.

What are the things we need to address that we could actually get done fairly quickly?

Mr. Bowman. Well, sir, in the area of veterans' health and the operation at the field level, I think the one thing

that needs to occur to be able to kind of pave the way for ideas to be immediately identified as beneficial is that the more opportunity that senior officials in the VA central office have to go into the field and spend time in the field, a two-day visit down to a particular medical center is not going to gain a senior official an opportunity to fully understand or grasp what may be an issue. They can get that based upon a briefing in their office.

When senior officials come down, they are going to then be able to see what is being commented upon as needs. I believe that the collaboration and close coordination with veteran service organizes and their state-level entities is exceptionally important because of lot of the day-to-day adjustments and practice of outreach, of information flow is accomplished by and through and with the veteran service organizations and what I saw in my three and a half years down at the VISN 8 area was the community- and faith-based organizations were more interested in what was happening through, you know, the process of conveyance of information.

The low hanging fruit I believe--

Senator Boozman. So, in regard to the other, some of that is just the tyranny of the urgent that you dealing with that prevents you from, you know, it is interesting. I think, you know, the advice that you are giving is good advice for us.

I mean, we are in the same position as senior, you know, officials in having oversight and getting out in the field, you know, spending time. You know, we just simply do not do enough of that, and I am not being critical. We are the people who are actually interested in spending a lot of time but I think that is good advice for all of us.

Mr. Bowman. The follow-up comment is that with my time in central office and then down in the field in VISN 8 that the impact of a visit by a senior official or a member of Congress on the morale of the employees at the operational level in the medical center is tremendous--oftentimes it may go overlooked--because the mere fact you have taken the time to go down there sends a very clear signal that you are interested and that you are aware.

And then, what will happen is I think there is doing to be an exchange of information through staff because they believe, I mean, if you were to come down an say, what do you need here?

Intuitively and institutionally, it will either find its way into the vapor, you know, the higher it goes up through the chain of command, now some of it has to go up through the chain of command and should because senior officials within the VA chain of command should be made aware.

However, if a members of Congress comes down and talks

to a medical center director and says, is there anything that I can do for you; and if that medical center director has already, you know, expressed that, I believe there should be the latitude, the internal belief that he could be candid with the member of Congress.

That is not the feeling, and I think that the morale out there in tough times can be significantly enhanced by very small events and that is by "small" I mean it could be one or two days but the fact that you have oversight individuals, whether they be senior officials at the headquarters level but especially members of Congress.

Senator Boozman. Thank you.

Chairman Sanders. Thank you, Senator Boozman.

Senator Boozman, at one of our recent hearings, you raised an issue that I want to pick with Dr. Jonas right now. I think you raised a concern that many of us have heard about, over medication of many of our veterans.

We have heard that time and time again. So, I am going to get back to you, Dr. Jonas. I am assuming that an emphasis on complementary and alternative medicine would address, to some degree, the problem of over medication.

Is over medication a problem and how would complementary medicine and alternative medicine address that?

Dr. Jonas. Over medication is a large problem. We

spend less than .01 percent of our research budget on pain treatments, for example, that are not some type of intervention or medication aspect, the vast majority of that. And we wonder why that is the tool that the physicians have to use to do that.

Sir, I know you saw Escape Fire. I would recommend it to the rest of them. There was a service member there who gets the typical kinds of medical treatment for multiple problems. Each of these practitioners that I mentioned that you go to has their own special medication that they treat for sleep, for anxiety, for depression, for pain, et cetera.

Part of the trauma spectrum is medication addiction used for treating pain and these other aspects. So, many of these things, in fact, can substitute for that and can lower that. In fact, some of the demonstration projects that I mentioned to you have all demonstrated that as ways of substituting for medications in many of these areas.

Chairman Sanders. Thank you very much.

Rick, we have introduced legislation to expand the Caregivers Expansion and Improvement Act. I think you heard from the VA today that we are making good success with the families of post-9/11 veterans.

Is there any reason in your judgment why we should not expand that to Vietnam era veteran families, Gulf War families, Korean War families, et cetera?

Mr. Weidman. Senator, when the bill was first advanced in the Congress, people said, what is your contribution in getting this law enacted, and I said, our contribution at Vietnam Veterans of America is we are going to be quiet.

In other words, our folks, we have a lot of our members who are alive today because their spouse has been taking care of them for 40 years and without any assistance from the government and saving the government over that period of time billions of dollars that otherwise would have had to go into custodial care or long-term care of one form or another.

We had always hoped that, and the White House at that point assured us, that they would follow on with expanding it to all generations based on medical needs or life situation needs. Yet, that has not happened from there and we just very pleased that it is happening from the Committee and we are strongly in favor of expanding it to every generation.

Chairman Sanders. Thank you.

Mr. Weidman. May I one thing if I may, sir?

Chairman Sanders. Sure.

Mr. Weidman. This was when Senator Boozman, you asked about the question about what can VA do that is low hanging fruit. What VA can do is implement the executive order that was issued on January 21st, 2009, having to do with open

government, transparency, and participation of stakeholders.

It is not followed anywhere in VHA. They give lip service to it. We have a quarterly meeting as an example at the VISN level that is mostly what we used to call a dog and pony show where they fill the air with talk for two hours and 45 minutes of a three-hour session. And then, you have 15 minutes to ask questions and then everybody has go to go.

That is not participation in our view and it is not either the letter or the spirit of that executive order. I might suggest, if I may, Mr. Chairman and Ranking Member, that you even consider taking that and enacting that into statute so it will live beyond this presidency.

Chairman Sanders. Mr. Bowman, as I understand the essence of your testimony, what Senator Burr is trying to get at, is to not support bureaucracy but put our resources into providing care to veterans which is certainly a noble goal that I support but something that I want to take a hard look at.

But above and beyond that, let me ask you as somebody who has a lot of experience. How many years have you worked with the VA?

Mr. Bowman. Almost 11 before I retired.

Chairman Sanders. Okay. And you worked at the national level and the local level.

Mr. Bowman. Yes, sir.

Chairman Sanders. And I was interested. You began your testimony by saying to get your health care the VA. Overall, understanding the problems, that every health care system has its share of problem including the VA, does the VA do a fairly good job for our veterans, do you think, in terms of health care?

Mr. Bowman. In the delivery of health care to veterans at the medical center level, I would say yes, they do. My concern would be as I look at my experience in VISN 8 is that there are more veterans out there who belong in the VA system and they are not there because of an outreach deficiency.

Chairman Sanders. Let me pick up on that point. You know, we had a hearing just on that issue.

Mr. Bowman. Yes, sir.

Chairman Sanders. So, what you are telling me, and excuse me. VISN 8 is where?

Mr. Bowman. VISN 8 is essentially of all Florida except for a little chunk of the panhandle.

Chairman Sanders. Okay. You have got a lot of veterans there.

Mr. Bowman. Yes, sir.

Chairman Sanders. So, what you are telling this Committee is there are veterans who are eligible for and in need of VA care who do not know how to access the system, is

that what I am hearing?

Mr. Bowman. Yes, sir, and I know it may sound strange with all of the publicity that has been--

Chairman Sanders. No, it does not sound strange to me, I mean, you know, all of us up here no matter what our political views may be, share one understanding. You do not get elected unless you figure out how to communicate with the people in your State, right? And sometimes bureaucracies do not know that. What I am hearing you say just confirms why we held that hearing.

Mr. Bowman. Yes, sir.

Chairman Sanders. Is that I want to see every veteran in this country who is entitled to benefits to get them or at least know about them. You agree with that?

Mr. Bowman. Yes, sir.

Chairman Sanders. You are telling me that in the Florida area that is a problem?

Mr. Bowman. I believe it is a problem in the Florida area, and from my time in Washington, I believe that it is a problem across the country that there needs to be more aggressive outreach.

Chairman Sanders. Good. I very much share that concern.

Senator Burr.

Senator Burr. Dr. Jonas, you mentioned that there is

recent research that has shown the effectiveness of complementary and alternative medicines. In standard research studies, they include experimental groups and control groups. Did any of that research that was done adopt this standard of two different groups?

Dr. Jonas. Yes, sir, all the studies that I mentioned in my testimony were done in what is called randomized control trials which is not only two different groups but they are equally distributed into the comparison and the control group so that they start at the same level when they are looking for comparative benefits, yes.

Senator Burr. If there is an executive summary to that research that is out there, I hope you will provide it for the Committee. If it is in your testimony I apologize, or is it in the book?

Dr. Jonas. So, we just supplied the IOM. I was on this Committee for the IOM, and we just supplied them with an analysis, a comprehensive analysis of complementary medicine and guidelines and what are called meta analysis which is where you look at these kinds of studies and look for the quality and the quantity of them into this book. And so, they are available, especially Chapter 6, which really talks about that.

Senator Burr. In your professional opinion, is the reluctance to utilize more alternative treatment unique to

the VA or is it across medicine as a whole?

Dr. Jonas. This is a cross medicine as a whole. This is not unique at all to the VA. In fact, as the Senator Sanders said, the VA tends to be ahead of the curve in the use of this compared to a civilian population where these things do not get paid for.

Senator Burr. So, is this the ignorance of understanding that your research is out there or a disregard for its conclusion?

Dr. Jonas. It is partly ignorance and it is partly the squeaky wheel. When you have billions and billions of dollars dumped into technologies that are then advertised and pushed on the system, and I get them in my medical bag as a primary care practitioner and I have .01 percent of the research dollars going into my medical bag, going into drugless approaches like this, it is no wonder I cannot find them in the bag. They are buried underneath that other types of things.

There is no economic drivers actually to deliver these low cost self-care types of practices. That is a large part of it. And so, I never learned about it. I did not learn about nutrition, for example, in my medical school, and yet I know it is a very important part of brain function, of cardio vascular disease, hypertension, you know, depression, et cetera.

Senator Burr. So, when you talked earlier about evidence-based, you would not be out highlighting that VA or the health care system in this country should adopt anything that there is not clinical reason to implement.

Dr. Jonas. Absolutely. This has to be evidence-based. If we do not do this, then we end up doing things that not only are wrong but they may actually harm people. And so, it has to be that way.

Senator Burr. Good. Mr. Gornick, in your testimony, you talked about short falls that exist that would be solved by establishing a national assistance fund. Describe for me, if you would, what are those short falls that exist?

Mr. Gornick. Thank you for that question.

Some of the different things that I layed out in my written testimony include providing child care assistance for veterans and employment assistance programs, helping veterans make security deposits and pay utility hook-up fees for housing placements.

These are things, the former one, I mean the latter one, could be addressed by the SSVF program; but generally with a limited amount of funds, that is not where the dollars go.

For a veteran that receives a HUD-VASH voucher, for instance, that veteran now has a rental subsidy indefinitely so long as Congress provides funding for that. But that

does not pay for the bed. That does not pay for the couch. That does not pay for, you know, the down payment that we need to make on an apartment. Therefore, that veteran could, you know, persist or continue being homeless without these additional forms of help.

Senator Burr. So, we have a lot of different pieces out here. We are hopeful because we say we have got a homelessness program and they all come together to fill the need of an individual, whatever that gap is.

But what you are saying is there is still, if everything came together perfect, there is still some shortfalls that are out there that are relatively inexpensive but that blow up the whole model if we do not address them. Is that an accurate statement?.

Mr. Gornick. Undoubtedly.

Senator Burr. Well, you know, Dr. Jonas talked about a holistic approach and I think I share this with the Chair. We do have a lot of programs, and I think we have got a passionate commitment on the part of the Secretary and members and everybody within the VA to end homelessness for veterans.

What do not do is a good job of holding accountable that all these pieces come together. I think there is a tendency to say when the roof goes over somebody's head, we walk away and we sleep well that night because we know that

they are no longer under a bridge.

I would suggest to you that our goal should not be to end there. It is to make sure that the complementary, wraparound, holistic services come to that veteran so that the mental health treatment is there, substance abuse treatment is there.

Our goal cannot be temporary relief from veterans' homelessness. It has to be constructed for permanent transition. So, Mr. Chairman, I hope if there are more than what you have listed in your testimony, you will provide those to the Committee so that we can begin to work with VA to see if there are ways to fill those gaps.

I thank all of you.

Chairman Sanders. Well, thank you very much Senator Burr. And let me thank all of our witnesses. I have enjoyed your testimony very much and I thank you for being here, and we will continue this discuss with a new panel next week.

So, thank you all very much.

This hearing is adjourned.

[The statement for the record of the American Legion follows:]

[Whereupon, at 11:53 a.m., the Committee was adjourned.]